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"Their Voices Speak: Women Physicians and their Current Role in American Medical Society"

Kelly Birdwell
College Scholars Project
April 21, 1997

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Part I

Introduction

Phenomenal changes have occurred in medicine in recent years. Medical technology is ever-increasing and more precise, providing a vast wealth of knowledge about the structural complexity of the human body and its coordinated functions. Revolutionary gene mapping and genetic engineering have brought scientific ethical debate to a new height. Continued pharmaceutical research has introduced new and more effective medications. The economic and administrative nature of medicine has shifted with managed care options and increased social demands for more universal health care. Finally, the composition of the care-takers themselves has changed with greater presence of women physicians.

Although women have assumed various roles, they have always been a part of American medicine. Women enjoyed an amazing level of freedom during colonial times as every individual's talents were needed for overall survival, thereby allowing some women to serve as unofficial doctors (Morantz, Pomerleau, and Fenichel 5). Until the 1830's, midwifery was a particularly common service of women, but the emergence of childbirth as a "new science" and the Victorian ideal of delicate women changed this (Morantz, Pomerleau, and Fenichel 7). However, in the mid-nineteenth century, women were reshuffled into the medical arena in hopes of defusing popular criticism of medicine due to unprofessionalism and quackery in medical practices (Morantz, Pomerleau, and Fenichel 15-16). In fact, America trained more women as physicians by the end of the

century than any other western nation (Braus 42).

The infusion of women into medicine was to be short-lived, however. In efforts to reform the institution of medicine, some medical schools began to close and others gave way to sexual discrimination, leaving only one medical school open for women in the early twentieth century (Morantz, Pomerleau, and Fenichel 24-25). The number of women physicians, therefore, declined markedly by mid century (Braus 42). With the emergence of feminism in the late 1960's, once again women began to enter medical society among a host of other professional careers (Morantz, Pomerleau, and Fenichel 33). Medical schools responded positively by shifting policies to encourage women to apply for admission (Braus 42).

Current statistics from the Association of American Medical Colleges (AAMC) demonstrate the growing presence of women in today's medical world. In 1970, women accounted for only eight percent of American physicians, whereas now (1996) they make up twenty percent (AAMC 32). This figure is expected to continue to increase to thirty percent by 2010 (Perry 215), and by 2050 it is estimated that half of all physicians will be female (Zuger 62).

These incredible changes are fueled by the rise of women applicants to medical school. The number of applications in 1970-71 included 2,734 women and 22,253 men compared to 19,779 women and 26,812 men in 1995-96 (AAMC 32). Therefore, about forty-two percent of applicants currently are women, bringing the average medical school enrollment for females to about forty-two percent for 1995-96 (AAMC 31). However, individual schools acceptance of

entering females greatly varies, anywhere from twenty-four point three to sixty-three percent (AAMC 32). For the past five years, the average acceptance rate of first year medical students has been about equal for males and females, most recently at thirty-seven percent (AAMC 36). Unfortunately, the number of women in academic leadership positions has not been as encouraging. Although numbers are increasing for females, thirty-two percent of men faculty are full professors compared to ten percent of women (AAMC 32).

With the strong emergence of women in present day medicine, many new questions are raised. There is little doubt that their presence will reshape the medical community and delivery of care. Will women become more interested in administrative or academic leadership positions, or will they prefer direct patient care? What specialties will be most appealing? Do male physicians and society accept women as medical professionals? Will the role of mothering conflict with the desire for a career? These and many other questions are formed daily as women continue to explore their choices and define their interests in medicine.

Current popular literature addresses all of these issues and many more. Commonly found subjects deal with possible salary discrepancies between men and women, the impact of family on career, the empathetic nature of women physicians, harassment, and the future leadership role of women in health care. All these issues have lead to critical and informed debate. However, most of this information is presented in the terms of facts and figures and not in the experiences of real people. A survey of sources

presenting more in-depth looks at the lives of women physicians shows little investigation of the topic. Although there is a surprisingly large number of books on women engaged in medical careers, these are mostly historical in nature, dealing with times such as the pioneer days or those of the famous Elizabeth Blackwell. Other books do address issues like career, status, and power, but the majority of these are from the seventies and mid eighties. Considering how much the role of women in medicine has changed in the last fifteen to thirty years, these sources do not seem adequate for a description of current women physicians.

As a result of this search, the possibility an interesting study arose. I thought a paper providing a closer view of contemporary women physicians compared and contrasted with facts found in current popular literature would be ideal. My original purpose would be to listen to the stories of individual women to see what issues they had personally encountered as practicing physicians. I was particularly interested in what influence personal decisions, professional biases, and stereotypes had on the development of a medical career. Hopefully, my results would provide insightful information on the position of women physicians in the 1990's. I formulated these ideas into a prospectus (See Appendix A).

I decided the best method for conducting the study was the use of personal interviews. With the help of the defense committee, I selected and invited five women physicians of the Knoxville area to be participants. The women represent five

different fields of interest: internal medicine, surgery, obstetrics/gynecology, internal medicine focused on student health, and pediatrics. The interviews took place in the individual physicians' offices. After initial introductions, each physician was given a copy of my prospectus and asked to sign a form of consent (See Appendix B) to be an official part of the project. I then interviewed each physician using a general framework of questions (See Appendix C) I had formatted earlier. The participants were encouraged to speak freely about any subjects they deemed relevant. I tried to word the questions carefully so that they would be neutral in tone. Each tape recorded interview lasted about an hour.

Transcripts of the interviews were made, and I carefully checked them against the tapes for correct content. The transcripts formed the main body of research material because I judged the narratives of the women to be the most important for the purpose of the study. Concurrently, I gathered popular literature that reflected the issues presented in the interviews. A meticulous examination of the interview material brought several powerful themes to light. These themes are presented along with relevant popular literature in Part III after brief descriptive biographies of each physician.

The conclusion describes my personal motivation for this study. It addresses both my preconceived notions of what information I thought would be found, and what I learned in reality. It also shows what powerful role models women physicians

can be for anyone devoted to setting priorities, pursuing personal interests, and achieving high goals.

Part II

Personal Biographies

*Please note: All names have been changed for confidentiality.

A. Dr. Anna Bowen

Dr. Bowen attended medical school at the University of Tennessee, Memphis from 1980-84. Continuing at the same institution, she completed a residency in obstetrics and gynecology from 1984-88. She has been in private practice in affiliation with St. Mary's Medical Center since 1988. Dr. Bowen is a thirty-seven-year-old mother of three and is married to an area pediatrician.

B. Dr. Tricia Coady

Dr. Coady, a 1984 graduate of Case Western Reserve School of Medicine, is thirty-nine years old. Her field of medicine is internal medicine. Previously employed with a walk-in center, Dr. Coady now works for the student health clinic as part of the University of Tennessee Medical Center in Knoxville. She is married to another physician and has four children.

C. Dr. Jennifer Corley

Dr. Corley graduated from Eastern Virginia Medical School in 1990. She then completed an internal medicine residency in 1993 at the University of Tennessee Medical Center in Knoxville, and she now is employed there as part of a group practice and residency instructor. Dr. Corley is thirty-five years old, married, and has

two children.

D. Dr. Sarah Daly

Dr. Daly is a surgeon at the University of Tennessee Medical Center in Knoxville. She was a medical student at the University of Tennessee, Memphis from 1981-85. She then did one year of residency at Missouri but did not like the program there, so she began anew in Memphis. Following her residency, she completed a critical care fellowship at Vanderbilt University. Thirty-seven years old, Dr. Daly is now married with one child.

E. Dr. Karen Larsen

Dr. Larsen, who is thirty-eight years old, completed her medical degree at East Tennessee State University School of Medicine in Johnson City, Tennessee in 1984. After graduating, she went to South Carolina to do a residency in pediatrics, which she finished in 1987. She now is part of a private practice group in Knoxville. She is married with three children.

Part III

Their voices speak: women physicians as family members, professionals, and care-givers

Every individual has his or her own story, a personal and unique narrative that defines who that individual is. These stories also tell the circumstances and beliefs that create the environment surrounding these narrators. By interviewing each of the five women physicians, I was able to enjoy one slice of these women's lives, to catch a fleeting glimpse of their individual experiences. A taste of such "stories" soon produces a flavorful world of words that tells one much about what it means to be a woman physician in today's medical world. The meanings behind the words are overt in some expressions and hidden in others, and among the five women common, if not interwoven, themes can be heard. There are five that seem to be especially prevalent: the balancing of profession with family, the busy pace of their lives, job self-gratification, the empathetic and caring nature of their profession, and their treatment as women professionals. A careful review of these themes says much about what issues women face in modern medical society.

A. Balancing the profession with family

All the women interviewed are married with one to four children. Obviously then, they must balance having a career with the demands of having a family. These women are typical of the majority of their women colleagues; of all practicing women physicians, two-thirds have children (Braus, 43). They all

expressed how important family was to them. The timing of marriage and children seemed to have a definite impact on their profession. Depending upon where they were in their careers, this impact affected them in different ways. For Dr. Jennifer Corley, the desire to be with her husband greatly influenced her residency choice. Having commuted separately throughout medical school, the two were ready to be in the same city. Since her husband already had a job with the University of Tennessee, Dr. Corley opted to do her residency program in Knoxville. This same decision partially determined her choice of field of medicine as well. She had considered other specialties in which she had an academic interest, but to pursue any of these would have meant that she would have to be separated longer from her husband. "My husband and I knew we would have to commute another three years, and we both agreed that we didn't want to do that at this point in life," she notes.

While Dr. Anna Bowen was completing her residency in obstetrics and gynecology she was pregnant. She admits it wasn't the easiest time to be pregnant, but "my husband is eight years older than me so part of the reason why I got pregnant during residency was so he could be young while still having children." Dr. Karen Larsen still wonders if she should have followed her residency with a fellowship. At the time, however, that would have meant another move, so although she applied to several programs, she decided not to interview for the positions. "We already had one child, but we were ready to have a family. I wanted to have my kids close together and that was important to me," she thoughtfully

remarks.

A key point in balancing the two worlds of medicine and family seems to be flexibility. Several of the women noted that this flexibility helps life flow more smoothly. Many careers, as Dr. Corley points out, have the traditional eight to five business hours so that the employees, like nurses or secretaries, cannot leave. With medicine, however, she found that one had the ability to schedule patients and appointments according to one's own time table. Dr. Corley realizes,

> I can leave and help out with the kids for an hour and come back. Some ways it is better to be on a professional level so you can have that flexibility, and it is your own time. Of course if you leave that hour you still have that hour to make up, but overall it is easier.

Dr. Larsen, as a private practice physician, also sees how the flexibility found in medicine can help make family life work. Her choice to be in that practice, as compared to working in a hospital for instance, gives her the freedom to keep the balance. She notes however, that the flexibility can only go so far, because patients depend on her, and that is a responsibility she must fulfill.

Dr. Tricia Coady has opted for flexibility in a somewhat different manner. When she first moved to Knoxville with her husband and one child, she was pregnant. Taking advantage of the transition, she did not work at first. When she began working again she applied for an opening at the University of Tennessee student health clinic. It was not a position she had considered previously, but the regular hours have been a great asset to her personal life. She works from eight to five with the summers off

and is on call a half a day twice a week. Such regularity gives her the flexibility to plan for her family of four children and husband. Although she still see life as "chaos," she explains that, "My husband is a physician and you have to make a family life work. I like the regular hours rather than the unpredictability." Dr. Coady has found student health her best option for family time over other internal medicine opportunities. She also feels that the field of internal medicine itself has given her a better lifestyle choice than other specialties like surgery or obstetrics, although she found her medical school experience with these interesting and enlightening. Ultimately considering her personal as well as her career goals, she found internal medicine the best way to achieve them.

Flexibility, however, does not work as well for all specialties, nor does it make up for the hectic family life many of these women experience in addition to their busy practices. Dr. Corley feels she has the time to do about one child activity a week, like helping with her youngest's school art projects. She comments, "I don't do the organization stuff; I just don't have time for that." Nor does she have much time for herself. She tries to swim three or four days a week, really her only activity.

> Maybe in the future. I would like to give a night to the Interfaith Clinic, but my daughter is only three. As long as everything is like the same during the week, my children are set in that schedule, and they are fine. If it changes, it confuses them.

As with most of the women interviewed, Dr. Corley's extracurricular activities are thus centered on her family. It appears that there

is very little time for it to be any other way.

Dr. Bowen, a mother of three, had much to say about her role in balancing her career and family. As an obstetrician and gynecologist, she chose her field of medicine without regard to her future lifestyle or thoughts of a family. When asked if she would choose the same field of medicine if she could begin her medical career again, she responded slowly and thoughtfully,

> If I was making a decision for myself, yes; if I was making the decision based on what I think would be the best for my children, if I could find something that has more flexibility but would still make me happy, I would be willing to change. ...From the married standpoint,it would also be easier on my husband....Working full time for me has not been an issue because I went into medicine with the feeling that if I was going to take this block that could have been somebody else's then I was going to do the job. Being full time is a commitment I made right or wrong a long time ago.

Dr. Bowen obviously takes her role as a dedicated physician very seriously, as she does her role as a wife and mother. As a result, she often suffers from pressing guilt, from not being able to give her practice nor her family as much attention as she wants. The guilt pushes her to maintain an overly hectic schedule, but one about which she laughs good naturedly. For example, on this particular day she is being interviewed, she was at Kroger's by five a.m. so she could get home, unload the groceries, then serve as room mother at her daughter's class before beginning her office at a purposefully late nine thirty a.m.

This type of early morning ritual is not uncommon for Dr. Bowen. From giving birth to her children to spending holidays with them, she does not take time off unless it is scheduled for her to do so. She recounts,

> I can remember...being on call and wrapping Christmas presents at four in the morning. The first time I was home for Christmas Day was 1989, and my daughter was four and a half by then. They would come see me on the floor....When they were little it was easier because if I was working Christmas they would have Christmas some other time, but of course when they became school age they knew when Christmas was, when their birthday was. I think it is like being a preacher's kid-- they don't know any other lifestyle so they accept it.

Dr. Bowen is married to a pediatrician, as forty percent of all married women physicians are married to another physician (Zuger 66). With both of them having different call schedules in addition to their regularly scheduled patients, life is a definite juggling act for them. They do not try to coordinate their call schedule in a way so that one of them is home all the time because, as Dr. Bowen relates, "I felt for other people to have to work their lives around my life was just not fair to do, so we take it as it comes." As their children have grown, how they handle the responsibility has changed. Although she no longer worries about their falling down the steps or setting the house afire, Dr. Bowen expresses concern about her children's emotional needs being met. More than once she notes that she is lucky that her kids are healthy. "I don't know how people juggle a child's special needs and a career they have-- you just couldn't do it."

Although Dr. Bowen and her husband divide their responsibilities to her satisfaction, that is not always the case for other married physician couples. One study of these marriages showed that men fulfilled only nineteen percent of child care and twenty-six percent of household duties versus women's respective sixty-six and sixty-three percent (Braus 44). Regardless, many

women still feel that they do not give enough of themselves. Even Dr. Bowen notes that sometimes she feels badly for her husband because many of his male colleagues have domestic wives, and she is not able to accomplish all that they do in the home. Nonetheless, others do not seem to see it this way. If cookies are supposed to be baked for school, and it is one of the rare times she is unable to do it, she feels that the other mothers are uncritical of her:

> They cut me some slack...it takes a lot less of me as a mother to be a good mother....I know other people are working pretty darn hard, but they don't have the glamorous title of being a physician, so if they don't show up, they are labeled as bad mothers.

She still remains guilty, but she also knows if she were a full time mother that she would probably do a poor job because she needs her career. Therefore, she strives for quality time with her children.

Like Dr. Corley, Dr. Bowen also sees her outside activities revolving around her kids. Otherwise she does not really have time for her own activities, and usually she is too tired for them anyway. She looks to the future to pursue other interests when her kids are grown. She is not complaining, however; it must be strongly emphasized that she does these things by her own choosing. "I don't mean to paint a picture of gloom-- I do it by choice. I see part of my career choices as very selfish because it is what makes me happy."

Both Dr. Larsen and Dr. Coady share Dr. Bowen's sense of guilt. Again, this guilt comes from feeling that they are not fully giving everything the time they envision as adequate. Dr.

Larsen laughs, "I wish everybody else in the world only had the regular twenty-four hours a day, and I had about forty. Then I think I would be allright." As everyone else, she feels very limited in her time for outside interests. Her main goal is to juggle everyday family life and three children with her professional career:

> You add all the other stuff, like ball practice, ballet, etc. on top [of my busy schedule]. It is just crazy. We get up at six a.m. and get everybody out the door, and I write lists for everybody about who's going here, who's going there and try to line up things for the babysitter.

Dr. Larsen brings up the issue of outside help for her children, seen as an essential godsend to most of the women. However, for Dr. Coady, this is just one more source of guilt. She comments, "It's hardest when your kids are really young, and they need you so much, and you are paying somebody to do that role of mother, and nobody will do it quite like you." Although she felt very guilty as a resident with long hours that forced her to put her child in day care, she says most of that guilt has abated since three of her kids are gone most of the day attending school.

Dr. Sarah Daly, a surgeon, is the mother of one. Many current female medical students inquire about fitting in family with the rigors of surgery. Dr. Daly does believe it is possible and has a unique twist to her own story. Hearing her biological clock ticking but still not married, Dr. Daly outlined her goals for her life and decided to have a child on her own. Dubbing herself "pre Murphy Brown," she sees it as one of the best things she has ever done. Although she is now married, she is proud that she had a

child by herself while maintaining a career and utilizing the help of a nanny. Her son is a great source of joy to her, but at times her hectic schedule prevents her from enjoying him:

> It gets kind of frustrating. My son will say,"Momma, I am going to sell some honey and bread down the road so you don't have to go to work anymore," but then he wants me to go to the store and buy the honeybees. Bless his heart he just doesn't quite understand, but he wanted me to work on a farm one day so I didn't have to come back here. He doesn't really understand what I do, but he knows I have to come here, so he deals with it.

Fortunately, as discussed earlier, physicians' schedules can be flexible. In Dr. Daly's case, she had the opportunity to decrease her monthly call load and took it. It has calmed what had been some frazzling days:

> I was trying to take the same number of calls they [male colleagues] do; I would go home; I would then try to do everything their wives were doing all day long with their husbands and families and for their husbands and families. I would be trying to do that at night, and I was supposed to be doing research as well as my clinical practice, and I was just going crazy.

For these women, the choice of a bustling career did not keep them from choosing a family life as well. Although they admit it can be hard at times, the sparkle in their eyes and the love in their voices show that the balancing act is well worth it. Their families bring a happy responsibility, one that takes the place of most other outside activities. One will hear no sour notes in these voices. Having a family is a personal choice they made, and one by which they gladly live.

B. The busy pace of the daily work schedule

The hectic life a medical career will bring becomes a reality

with the first day of medical school. After four years of challenging study, exciting rotations, and nerve-racking board exams, the medical student must move onwards to the residency program. That process is like applying to medical school all over again with the lengthy applications and personal interviews, but this step will determine what field of medicine the physician will ultimately profess. Depending on the specialty chosen, the residency can be from one to six years or more. In some cases, physicians decide to sub-specialize by attending a two to three year fellowship once their residency is completed. Through all these stages the physicians become accustomed to long hours and some sleepless nights.

For those setting up clinical practices, the patient filled days and diverse medical responsibility continue, requiring tremendous energy of the individuals. The busy pace of a practicing physician is not exclusive to men or women. Both have a final goal: the best care for the individual patient. Considering the tough balancing act that many women maintain between family lives and full careers, this flurried work pace further demonstrates the vigorous lifestyles of practicing women physicians.

Interviews of the women physicians reveal two variables which seem to make the greatest impact on their daily schedules. The first is the type of practice. In all cases the practice groups are mixes of both men and women. Both Dr. Bowen and Dr. Larsen are involved with private practice, meaning they are self-employed and

have basic control in how the practice is run. Dr. Larsen enjoys the level of autonomy she has with the practice. However, she is quick to point out that, "In private practice it's a misnomer to say you can work as much as you want or work as little as you want because patients depend on you, and you have certain responsibilities you have to fulfill to the patients."

Dr. Corley, Dr. Daly, and Dr. Coady are all hired through the University of Tennessee. Therefore, their duties are split between their clinical practices and academic venues, mainly clinical research and the teaching of residents. The careers of the women in private practice do not really involve academic matters. In Dr. Corley's case, for example, two to three and a half days a week are spent in the internal medicine practice group, with the remaining days centered on more academic tasks. This is typical for eight months of the year. The other four months are used to educate the new residents.

Another interesting note about both practice situations is that all the women interviewed are working full time. Although in modern practice there is the possibility of working part time and sharing a practice, that did not appear as a desire by any of the women. In fact, when asked what they thought they would be doing ten years from now as professionals, most affirmed they would still be practicing in much the same conditions by their choice.

The second and more definitive variable concerning very busy schedules seems to be the choice of field of medicine. Each field comes with its own unique demands and responsibilities, and those

requirements are taken into account in choosing areas of specialty. In addition to the type of practice, the selected field also defines the actual practice schedule and the type of call.

Dr. Corley and Dr. Coady are both physicians of internal medicine and work for the University, but they have taken two different paths of practice. On days she is at her practice, Dr. Corley begins seeing patients around eight a.m. and continues to about five p.m. with an hour and half lunch break. After that she must do paperwork for another hour or so. On her academic days at the hospital, she does rounds around nine in the morning, examining both new and old patients. She then gathers residents to go over any care they gave, evaluating what was done well and what could be done better. She spends the afternoon on presentations and papers, ending the day around five p.m. As for phone calls, everyone in her group takes his or her own phone calls daily with the hospital service answering on weekends. She has to answer the calls of the hospital every fourth weekend.

Dr. Coady's schedule is quite different. Working for the university's student health clinic means she has no night, weekend, or summer work hours. The office runs from about eight to five daily, giving Dr. Coady time to see from thirty to thirty-five patients. She is on call half a day, two times a week, for the clinic. She likes this regularity of hours not typical of most internal medicine options, which are often laden with tough call schedules.

One can imagine that Dr. Bowen, as an obstetrician and

gynecologist, must have quite long and irregular hours. Beginning her work day at six or seven a.m., she first does some rounds, circumcisions, and a couple a days of the week performs surgery. Patients see her in her office from twelve to four until six in the afternoon, and then she usually finishes her days with more rounds. However, it is being on call that can really vary her schedule. A typical call block with her is an astounding seventy-two to eighty-four hours. She comments, "...going into it, I didn't know if I would be up the whole time, if I would be taking cat naps or whatever, because some days are lighter than others." During the time of the interview she is on an unusual one hundred twenty hour call block since her partner is on vacation. In theory, her rigorous call schedule demands her to be on call every other day, while still assuming all her previously mentioned duties. She has also seen the business end of her duties increase with the current demands of medical economics and insurance companies.

Dr. Daly is also engaged in a diverse array of responsibilities and heavy call schedules that cause her schedule as a surgeon to change from day to day. On lighter days, she will have only a few patients in the hospital, maybe a presentation or a meeting, and some clinical research to do. On the other days, she will come in at seven, begin rounds, and take the time to help the residents. She is also responsible for both surgical and trauma patients in the emergency room and the patients on the trauma floors. If a trauma resuscitation comes in, she must evaluate the patient by means of discussion, X-rays, and lab reports, deciding

if surgery is necessary. The surgeons are responsible for these trauma rounds a week at a time from seven a.m. to five p.m., and may have to forgo all other duties of the day if they get tied up with these emergencies. Around ten a.m., two days a week she meets with patients in the clinic, and two other days she performs operative procedures. In addition, she is involved with critical care rounds for twenty-four hours a day for a one week span. On top of that is night call, lasting from five p.m. to seven a.m. There is no question as to the demanding nature of this specialty. As Dr. Daly notes, "nobody gets night call for weeks at a time because you would be a vegetable."

As a pediatrician, Dr. Larsen also manages to stay quite busy. She has found that careful scheduling does not always keep her office running on time: "...two days a week I do consults with kids having problems with school, so you schedule time, but you get into more problems that you thought you had...". As a private practice physician, Dr. Larsen spends her days seeing patients from about eight to five, a hectic time that does not allow her enough "...time to go to the bathroom. We don't have time to sit down: as soon as we finish with one patient I'm right back with a patient again. I try to get a Coke somewhere along the way." She is only on call one day a week thanks to the sharing policy with her group colleagues, and the day after call is spent in the hospital doing patient rounds.

The brief schedules presented here are only a faint outline of the true time consuming and pertinent responsibilities filled by

these physicians, day by day. Not surprisingly, at times this busy pace can be almost too much. While Dr. Bowen was in medical school, she lost the ability to read for pleasure after a while, an activity she loved. She treated all books as medical texts: "I found myself skimming the book looking for the important information...it was painful to lose that ability [to read for pleasure], and it took a month or so to regain it." She was working so hard during the pregnancy of her second child that she did not gain any weight. Dr. Larsen says, "I constantly feel like I have possibly time to do two hundred things and five hundred things to do." For Dr. Corley, the hardest part is the sheer "physical endurance to get through it all...it is the hardest because you are tired." Dr. Daly mentions, "...there isn't a week that doesn't go by that sometimes I want to pull out my hair saying, 'is there something else I want to do...'." In reality, there is nothing else they want to do. Busy or not, these women truly enjoy their profession.

C. Job self-gratification

After seeing how incredibly busy these women are, one questions why they work as they do. Examining their feelings about their careers, one begins to see the many components that provide great job and personal satisfaction. Speaking generally, there is an obvious interest in the basic subject matter itself, including the science and study of the human body. Practicing physicians also have a desire to work closely with people in situations with

a variety of stress levels. In addition, a medical career usually offers stability because of job security (physicians will be needed as long as there are sick people) and a relatively comfortable income.

More personally speaking, there are certain interests individuals enjoy that push them to pursue a particular field of medicine. Popular specialties for women currently include pediatrics, in which women consist of fifty-nine percent of the specialty, obstetrics and gynecology with fifty-three percent, and family medicine with thirty-nine percent (Zuger 64). Although many argue that women have been forced into primary care positions in the past (Braus 44), the women in this study felt that their selected specialty had been their individual choice prompted by their medical interests. At the time the choice was made, little consideration seemed to be have been given to future realities, like the possibility of a family or actual practice environment.

Dr. Daly, for example, chose surgery "strictly on what I would be doing without any hesitation or considerations." She stresses that it is important that people choose jobs they will be happy with for their whole lives, for everything else will then fall into place. From the beginning of her medical education, she felt she had a certain rapport with surgeons and students interested in surgery. Considering her medical school experience, she comments, "... you will notice there are personalities different or special....it is an entirely different flavor and to me it is the surgical versus the non-surgical..." She emphasizes that there is

a philosophy of surgeons that she saw in herself and enjoyed sharing with others in her field. Her residency reinforced her perceptions, especially because of relationships she developed with mentors. She relates, "I am still influenced by the fact that people I like and people I thought did the best job of taking care of patients, those were the people I seemed to be like..."

Similarly, Dr. Bowen chose obstetrics and gynecology because of a wonderful rotation experience coupled with strong mentors in a progressive program. Like Dr. Daly, she did not really concern herself with other issues such as type of practice, number of hours, or level of income, so she feels fortunate that she is happy overall. The happiness stems from certain needs being met:

> ...obstetrics and gynecology just kind of combined the best of everything. I like the surgery, the physical activity, seeing miracles with the delivery. I like the population of healthy patients. Death is not a big part of the practice, chronic illness is not that large part of the practice. Most of the patients were very happy to see me, and they thought of this as a happy opportunity...and our ethical dilemma was fairly clear cut.

Both Dr. Corley and Dr. Coady enjoyed their time rotating through other specialties, but they ultimately saw internal medicine as their best fit. Dr. Coady recalls having a difficult time deciding what she liked the best but finally decided upon internal medicine because it gave her the most options. Now that she is with a student health clinic, she especially enjoys the younger patient population because usually with this field one sees an older population with a variety of complex health problems.

Dr. Corley liked all the primary care rotations, but found family practice to be too broad and burdened with too much

information. After watching a child die, she decided that the emotional level of pediatrics was more than she wanted to bear daily. Of course she still has to deal with death, "but when it is an older person you can accept it more because you know it is natural and that they have lived part or most of their life." Her main draw to the field is the large amount of patient care she is able to give by analyzing a diverse set of problems. "It was a lot of problem solving; every patient came to you like an Encyclopedia Brown case. You had to figure out what was going on, and that was a lot of fun."

Although their fields of specialty tended to reflect their own personalties and defined interests, there were also many general characteristics that seemed appealing to all of them. One, for example, was challenge. Part of the challenge comes from the demanding physical schedule, but mostly this refers to the academic activity. Both Dr. Larsen and Dr. Daly mention the challenge of staying current within their fields. The growth of medicine is phenomenal as new techniques, drugs, and illnesses are discovered. According to Dr. Larsen, "...as a professional that is probably the hardest; keeping up in my field is very important to me. I want to be on top of things." Dr. Daly also wants to keep her clinical skills up to par: "There are new techniques and different things that come out all the time. If there is something new and appropriate, I am hoping I will be involved and doing it as well." She also likes the pure challenge of mastering the skill of surgery itself. If she does encounter some sort of complication in

surgery, she feels confident she can fix it.

The physicians also enjoy the variability of responsibilities they encounter. With evaluating patients comes actual discussion with the patients, lab reports, X-rays, the prescription of medicines, and dictation of a record of the visit. Physicians also spend time in the hospital seeing in-house patients and answering emergency room calls. There are many opportunities for teaching, whether it be to residents, the community, patients, or through staff presentations. Dr. Corley comments,

> I like the teaching part a lot because it is very challenging, and I have a lot of flexibility with seeing patients [at the practice] and at the hospital giving me a lot of variability in the day. I can see patients if I want or I can do some teaching, so it is never boring. It is never repetitive.

Likewise, Dr. Daly enjoys her mix of trauma, critical care, and general surgery along with teaching the residents.

In addition, the careers of these women seem to fulfill a side of their energetic personalities that could not be satisfied otherwise. When Dr. Bowen considers how it would be to be at home full time, she realizes that, "I just need this stress level, and I need this amount of adult contact, and I just need the challenge." Later she comments that, "there is a pretty big hunk of my self-definition that involves my work." Dr. Coady agrees, saying, "I like to work, I like what I do, and I have been home for stretches that I know I wouldn't last just doing that...I need to be productive...". It seems that all the women interviewed must feel this way to some extent because when they were questioned about the future, they all indicated they would still be happily

practicing in the years to come. Although many things appear to motivate them to practice, the most substantial seems to be the actual care of the people themselves and the manner in which the care is provided. Indeed, helping others emerges as a strong inspiration for these women, as discussed in the next section.

D. Empathy, service, and caring

Although specific interests led the women physicians to various specialties, underlying all their careers is the primary desire to serve others. Otherwise, these individuals probably could have found jobs of equal status and security with a less demanding lifestyle. It is the significant contact with people that produces the greatest amount of job self-satisfaction. It is not difficult for these physicians to find meaning every day of their careers.

Traditionally, women have always gravitated towards jobs that call for personal attention and hands-on interacting, like teaching, nursing, and social work (Braus 44). The same types of skills are utilized in medicine, such as talking and listening to the patient, or trying to explain a certain procedure to a resident. Dr. Bowen says, "the art of medicine is the personality, the listening skills, things like that." The relationships formed while performing these skills are important to physicians serving as care-takers. Dr. Coady worked for a walk-in clinic, but did not find that satisfying:

> What I didn't like about that [walk-in clinic] is that you don't get continuity or establishment of ties with patients,

> and so it wasn't very satisfying. Part of the reason you go into this is because you like dealing with people and helping people. You never feel like you get that follow-up to find out how people are progressing.

Now that she works for a student health clinic, she enjoys forming relationships and the chance "for education for making a difference." She also has the opportunity to help individuals cope with the stress of being away from their supportive network of home.

Dr. Corley has similar thoughts. Her amount of patient involvement was partly what pushed her into internal medicine:

> ...I liked the patient care in the clinical rotation... I also enjoyed talking with people and patients about problems and that was rewarding....also I like the long term care we get with internal medicine. You see people for years and years. You get to deal with them for a long period of time and get to know them.

Such ties can be very emotional. It is only reality that many patients will die just as many are healed. In some cases, it proves to be too much to bear. Dr. Corley relates that, "in pediatrics I watched a child die one day, and I felt I couldn't do that. It was too heart-rendering seeing that, and I knew I couldn't see kids sick like that." At other times, physicians may feel helpless. According to Dr. Coady:

> My VA clinic was very frustrating and unhappy because people were very poor. The VA structured what medicine you could give, and you were very limited in how you could help them. Most of them were in poor health also. I didn't often feel like I was helping anybody. I was just maintaining their medicines, helping them with their general medical care.

For those women involved with residency training, careful steps are taken to ensure that patients treated by residents are well served. Dr. Daly takes her responsibility of teaching

residents the best way to care for a patient very seriously:

> I am there at every single case and whether my hands actually do it, my eyes are watching to make sure that they [the residents] do everything the way I tell them they have to do it or I redo it because I am responsible for them....It is not only my responsibility to oversee, but to guide them through the care of a trauma patient...and make sure they are doing everything they can do.

Dr. Corley, who really likes the teaching aspect of her job, also goes to great lengths to know her residents are providing quality care. When doing rounds to see patients, she chooses one of two options:

> ...I either go with the resident or go by myself. There are advantages to both...you get to see how they interact with the patient. They know that the patient may be sick that day or getting better and you can pick that up....by yourself, you can see what the patient is saying about the resident. You get a lot of feedback...

Obviously patient care and good communication skills are necessary of anyone practicing medicine, and women physicians seem particularly adept at providing that care, or at least are perceived that way. Their nurturing nature is appreciated by both residents and patients. According to one study by the media communications and humanities department of Pima Community College in Arizona, medical students viewed women physicians as "more sensitive, more altruistic, and less egoistic" (qtd. in Braus 44-45). In another survey conducted by an all female practice, patients cited that their top reason for attending the clinic was because the doctors were female. More specifically, they thought that females were easier to talk to, more empathetic, and more attentive (Davidson 235). This opinion extends to residents as well. Both male and female patients report to be happier with care

from a female resident than a male resident (Braus 45). In addition, studies have shown that women physicians spend more time with each patient, and patients favor this extra attention (Zuger 62).

Female patients seem especially interested in women physicians providing their care. Dr. Daly comments, "...some [female] patients will come to me strictly because I am a female. Some will actually shop for a female." Several of the other physicians interviewed also saw being a woman as an advantage in this situation. As a result, women physicians are in greater demand. According to Dr. Young,

> Right now I think being a woman physician is an asset. I think there are a lot of practices looking for women physicians. I think a lot of women like to go to women, particularly for gynecological things. Often they feel more comfortable talking to a woman.

Women obstetricians and gynecologists are particularly popular. Not only do patients see them as more comfortable to be around, they also consider them to be more understanding. Dr. Bowen often sees this in her own practice:

> They seem to feel that I would relate to more things that they are going through. Especially during pregnancies because it is very important to the patient-- the patient will ask how many kids I have, how old my kids are....I can't think in all the years that somebody asked me if I was board certified or if I had done the surgery before or anything like that, but knowing I have children or that I am a female is very important to the patient.

Therefore, it appears that in general women possess certain innate qualities that make them excellent care-providers. They use their abilities and effective communication to accomplish the most crucial task of their careers-- serving the patient. Both Dr.

Larsen and Dr. Daly verbalize this. Dr. Daly remarks that, "My responsibilities don't change. The patient is the ultimate... the ultimate goal is doing the best you can for the patient." Besides characteristics natural to their gender, the miracle of becoming mothers also affects how they see their role as a physician. Dr. Bowen speaks of having children during her residency:

> ...it made me a better resident because it made me have more humanity, and it was comforting to the patients. I learned a lot. I changed my tune after having a child. I think I became a better physician....it made me more sensitive.

Finally, the emphasis these physicians place on service shapes their future goals. None of them is really very interested in administrative activities. "You know, some people go on and do administrative things, but I don't think that is for me," relates Dr. Coady, "I would rather see patients and take care of patients rather than do paperwork." Dr. Corley agrees, saying she sees herself "as doing more humanitarian projects." As she speaks of serving in poorer areas of America and the world, one again sees the same qualities of teaching and helping as central to her dreams. All these women measure a major amount of their success by the level of caring service they are able to give to humanity.

E. View of Women as professionals

Now that the career choices and resulting lifestyles of women physicians has been established, it follows to see how these women are treated in the professional world. Following the path to become medical professionals, the individuals asked about how their careers have been affected because of their gender have defined

their experiences in various ways. At times they feel their gender has been an asset, at other times a hindrance. Most commonly they believe gender really makes no difference at all. They agree that the situation is ever changing, mostly for the better. Situations they encountered ten years ago are not necessarily common today.

Several of the women recall incidents in medical school which revealed discriminatory attitudes. Dr. Corley believes being a woman played a significant role in hindering her acceptance to medical school:

> All my [male] friends got in the first time. I had the same grades and same MCAT scores, but I wasn't as confident and I think that kept me out of medical school the first time I applied. I think if I would have been a male I would not have had any problem....People would say things to me like I was 'too well-rounded.' If I had been a guy it never would have been an issue.

The most common issue faced in school was inappropriate comments by both students and professors. Most of the women concluded that the best way to deal with this was simply to ignore it. Dr. Larsen remembers, "Things would get said in classes, perhaps jokes would be told and they [women students] would get mad about that. I really do think it made things worse to acknowledge it." Her resulting attitude was to do the best job she could as a student. Dr. Bowen extends the same principle to women in all levels of medicine. "I think that when females in medicine identify themselves as separate, then they bump into problems," she states.

The same concerns surfaced in residency. Again, there were different sensitivities to potentially offensive situations. In Dr. Coady's eyes,

> I certainly didn't ever feel there was a disadvantage....there were individuals I think don't necessarily respect women, but nothing overt. I can't really give you an example of anything that was bothersome or that I felt was directed to me as a woman other than a little bit of offensive joking here and there that might qualify now as sexual harassment, but it wasn't bothersome enough to do anything about.

Only Dr. Corley had more vivid physical experiences which she did see more as harassment. One resident stuck his hand down her shirt pocket, and another referred to her as his wife, commanding her around the floor. The latter was kicked out of the program. Seventy-three percent of female residents informed a 1993 study that they had been sexually harassed (Begley, Biddle, and Gordon 54). Dr. Corley did not view other instances as intentional harassment, but as unwelcome advice. For example, it was suggested that as a woman she should pursue a field of medicine that would give her optimum family time, advice not given to her male colleagues.

Dr. Daly did not find gender to be an issue at all during her medical training. She feels that if she were ever treated badly, so were her male counterparts. "There is an attitude that women don't get a fair shake, that they are looked down upon. Again I didn't see that, I didn't find that in any of the people I dealt with," she remarks. She has her own thoughts on the matter:

> I have had people come up to me and say, 'How do you let him harass you like that?', and I didn't even notice they were harassing me because I was harassing them back just as much and totally ignoring that....I don't try to read anything into it like an ulterior motive; you accept it at face value and go with it. I don't know if it's just a blind spot I have or whatever, but..it just doesn't matter....It was all in fun, and I mean-- any support I needed I would just go in there...they would help me in any way. It is just an absolutely wonderful environment to be in.

The practice environment has brought some of the same and new issues. When Dr. Corley was preparing to enter practice, possibly with some female classmates, she felt that her gender hurt her once again. She comments that "doctors were calling to see who was graduating, but when they found out we were all female we never got calls....the males did, although they were not as strong residents as we were." Dr. Daly feels that some male physicians underestimate her abilities: "...they look down upon you as if you don't know what you are talking about, they don't trust you, and therefore what you say or do they just ignore and don't put any stock in it."

Dr. Corley interprets much of how male colleagues view her as having to do with her role as a possible or actual mother. As a result, she feels she must work more diligently to prove that she is equally serious about her medical career:

> I think they don't take women as seriously because they don't think the women will do this the rest of their lives. The men think they are doing their part and working full time but a woman would take time off to be with kids and stuff...You have to prove yourself. I think you have to show that you are going to be there and that you are interested more than the guys do.

She also identifies a double standard for women professionals. "Women can't talk about kids at work, but men can....If women talk about kids they must not be focused on work," she points out.

As might be imagined, then, pregnancy and maternity leave create a potentially stressful situation. Depending on the nature of the physicians in the practice, some groups are much more tolerant than others. Some women choose to make the best of an

often tense situation. Others, however, have recently gone other routes, including all-female practices or part-time practices. According to an article in Medical Economics, all-female practices are formed under office policies more sympathetic to maternity leaves and family issues, while still giving the physician the option to work full time (Davidson 230). Such practice situations are not limited to only women. A group of both males and females has been formed in Toledo, Ohio and nicknamed "The Mommy Docs" because they work part-time in order to ensure time with family (Lane 4).

On the other hand, those who do not opt for such environments can feel suffocating pressure at times. Dr. Bowen relates the realities of one of her pregnancies:

> There was a lot of pressure on you not to let your pregnancy interfere with anything and part of that was internal pressure....Our surgeries can take ten to twelve hours, and by golly, I wasn't going to break scrub to go to the bathroom even though I may have been nine months pregnant because that is not what you did. I can think back and remember wearing a foley catheter for eight to ten hours because as a pregnant person I knew I was going to have to go to the bathroom....It never crossed my mind to say, I am due in two weeks and I need to sit down a few minutes or I need to eat or whatever.

During another pregnancy she suffered a miscarriage while working the labor hall but was too busy to stop for just a minute. She never saw a better way of handling such situations because "if I wasn't there to do my work, then somebody else would have been away from their family." By the same principle, she took off no more than two weeks with each child.

Dr. Coady also believes maternity leave can cause problems depending how it is handled, but she does see the situation as

improving. Detailing her experience, she says,

> Men wouldn't take twelve weeks off out of their residency if their wife had a child, so they don't want you to do anything extra....I felt pressure to perform no matter what, to be there and not let my gender be a factor. I think I was the first woman to have a child in my residency program, and I felt pressure to make that work. I came back and did a good job because I didn't want anyone coming back, pointing fingers, or saying that, 'we can't do that again because you caused a disaster.'

Dr. Larsen found the best way to counter any resentful attitudes was to save up all her sick leave and vacation time so that no one could accuse her of taking extra days for maternity leave. However, she notes other women did take advantage of that, and "there were other ill feelings but not necessarily from other men, but women too because someone else has to do your work when you are not there."

Another consideration in practicing is the way women physicians are viewed by their patients. It has already been shown that a number of physicians see their gender as an asset because patients are drawn to their empathetic nature. The women interviewed find this true most of the time and rate their experiences with patients as positive. On the other side, women often see themselves as having to endure additional hassles. These range from being light and funny to extremely insulting. Dr. Daly laughs about being often called a nurse. "I can be anything from a custodian to a nurse, and my patients (and I do not know if they do this to the guys or not), they call me 'Miss Sarah', and I have some that hug my neck and give me kisses," she says with a smile. Dr. Corley cites similar incidents, like "they [the patients] will

say things like 'she is a female doctor but she's real smart.'"

Dr. Corley has had a variety of situations concerning her male patients. In some instances, she believes they prefer her to male physicians because they realize she has to work harder to be seen equal to her male colleagues, and as a result, she will be more competent. On the other hand, some men see her gender as a reason to treat her in a very unprofessional manner. She says, "It's irritating. Comments like, you are so pretty, that kind of stuff which is very inappropriate, or they come on to you." This is not uncommon nationwide. Seventy-seven percent of women physicians indicate they have been sexually harassed by patients, usually males, according to a study in The New England Journal of Medicine (Begley, Biddle, and Gordon 54). However, Dr. Corley does not think this is limited only to women. A single male colleague of hers often receives love letters from his female patients.

Salary discrepancies are a current popular topic. A study using data from 1994 revealed that women earned a net of $108,810 compared to men's $156,310 (Perry 219). Several factors contribute to this difference. Compared to men, women see fewer patients (because they spend more time with each individual), are more often involved in salaried positions rather than private practice, and prefer specialties that pay less money (Braus 40). An article in The New England Journal of Medicine contends that, with the exception of older physicians and certain specialties, if these factors are statistically accounted for there are no significant salary differences (Baker 963).

As internists, both Dr. Corley and Dr. Coady make the same salary as their male colleagues. Dr. Coady's salary has been raised several times to keep things equal, most recently when a male physician was hired at a higher salary. Fields in which women physicians are in demand, like obstetrics and gynecology, mean that women earn incomes comparable or higher than males (Perry 215). Dr. Bowen finds this to be true herself. She observes, "The salary discrepancy in OB/GYN is interesting right now because females are much more marketable than males are. A female can expect a higher salary...it is wrong, but that's the way it is."

Although these women have suffered some uncomfortable situations, they see changes in the face of medicine that make it more hospitable to females every day. They say mentoring programs, whether they be at the undergraduate, medical school, or residency level would be useful in telling women what to expect and providing them with knowledge to make informed decisions. Both Dr. Daly and Dr. Bowen cautioned that such programs should not necessarily be limited to just women because separation of genders can increase the differences. In the past it has been somewhat difficult for women to have role models because there are relatively few women in leadership positions. Figures from 1994 show that women are not in positions of power in medical schools: full-professor level was reached by only ten percent of women faculty who only account for twenty-four percent of all full-time faculty members (Kirschstein 982). In addition, three hundred and sixty-seven women served in assistant deanships of medical schools, but just four women were

deans (Kirschstein 983). Dr. Coady and Dr. Corley both stated that women mentors were scarce in their training days and feel they could have benefited from their examples. Interestingly enough, all the women interviewed are now serving as role models themselves while making daily decisions on their careers and personal lives.

In listening carefully to the words of these women, one hears several important themes. The themes are delicately intertwined, and a shift in one most definitely has consequences for the others. There is a struggle for separation of career, family, and gender, but it is the combined aspects of all of these that give women unique strength and skill to handle all three areas successfully.

Part IV

Personal remarks and conclusion

The topics covered in this paper are of special interest to me. I will be a first year medical school student in the fall semester of 1997. Now that the dream of medical school has become a reality, I find my focus shifting from what qualifications I needed for acceptance to what characteristics will lead me through a successful four years. Though the task of being a serious medical student looms large before me, I feel confident in my decision to pursue the path of medicine.

For me, medicine combines a most interesting array of responsibilities, which produces a very rewarding career. The very aspects that appeal to the women physicians interviewed are similar to the ones that motivate me. First and foremost, I have always been people-oriented. I believe the opportunity to serve others is one of life's greatest gifts because it gives one the chance to share talents, to grow emotionally and mentally through contact with others, and to embrace the qualities that make one human. In addition, I share these women's interest in the subject of medicine itself, as well as the challenge of constantly absorbing new material and addressing the distinct needs of patients. Moreover, I am excited by the variability of activities available through practice, research, and teaching.

These are the limited things I know of a career in medicine. More specifically, however, I want to know what it means to be a practicing physician day in and day out, since the call of patients

never ceases. As a woman myself, I am especially interested in the position of women in modern medicine. Therefore, the interviews I conducted have been a great learning experience for me. I also believe the women enjoyed sharing their stories because it crystallized their own thoughts for better personal understanding.

As I spoke with each woman, the themes discussed earlier slowly began to emerge and form concretely. I was initially surprised that the same themes so strongly linked individuals with such distinct personalities. However, it was soon obvious they found the same issues to be relevant as a practicing woman physician of the 1990's. I discovered the demanding pace of a lifestyle encompassing both career and family the most amazing. It is commonly believed that women exchange family plans for a successful career. These women, as the majority of female physicians, have proved that to be quite untrue.

Additionally, the physicians pushed me to think critically about issues now that I may not have considered until later. When the women made large career choices, some factored in work hours, salary, flexibility for family, and practice style while others did not. They all felt that they could have benefitted from a mentoring program that would have better educated them about their upcoming roles as doctors. The lack of women role models also kept them uninformed about possible situations they would encounter as females. I hope to use this insight to improve programming for the University of Tennessee Pre-health Advisory Committee. Although there is still an obvious shortage of female leaders in the

sciences, I feel fortunate to have my own women classmates and friends as well as these physicians as strong examples from which to learn. I also believe the gulf between the genders has significantly narrowed even since these women began their education in medicine.

Clearly then, these five women offer me valuable information as an upcoming student of medicine. However, I think the most important lesson they offer is much more universal. For everyone, these individuals serve as models for an overall happy and well-balanced existence. They have found the secret to juggling personal, professional, and family interests to create successful and fulfilling lives. At first glance, I deemed the women as super-human. They appeared to have the best of all worlds with style, glamour, and grace. In a sense, they do. However, I soon found my preconceived notions a little too idealistic.

Indeed, these women are amazing, not in just what they do but how they do it. Unlike superheroes, however, they become tired and limited in what they can accomplish in the face of time constraints. They have learned, however, how to make choices, and they make the decisions that best serve their unique situations. Instead of allowing their personal and professional lives to clash destructively, they integrate the best aspects of both for overall balance. Compromise is key. They are more than willing to give up individual interests outside of medicine to focus more time and energy on their families. They choose among career alternatives, such as the location of a residency, to accommodate the needs of

others in the family. Small sacrifices are made to maintain harmony.

Other personal skills are utilized as well. They are disciplined planners; organization of time is essential for the finishing of tasks. Priorities are carefully arranged to meet all responsibilities. Their attitudes are the most striking. Although they are all very different, they remain dedicated to the personal decisions they have made to lead this particular lifestyle and are committed to meet the demands it presents. Guilt and frustration can be felt from time to time, but ultimately they are rewarded with a rich and fulfilling life that meets their greatest needs. They know their choices to be worthwhile.

This view of these women only serves to reinforce lessons commonly heard but not always adhered to in life: the best things come from hard work, patience, commitment, and being loyal to your own interests. Such lessons remain true no matter what one's profession may be. Therefore, the experiences of these five women are pertinent to anyone searching for personal enrichment. I am thankful to these women for the people they serve, the families they love, and the role models they exemplify.

Appendix A

Kelly Birdwell

Senior Project

PROSPECTUS

Title: Current roles of practicing women physicians in American health care

Upon my decision to enter medical school in the fall semester of 1997, I find myself increasingly curious about the role I will play in the modern medical profession, particularly as a woman physician. Historically, women have had to fight to gain a place as legitimate practicing physicians next to their male colleagues. Now that women have asserted that right, modern medicine often continues to present obstacles for women physicians in the form of salary discrepancies, resentment over maternity leaves and time for child-rearing, sexual harassment, conditions that favor the selection of certain fields of medicine, and unequal distribution of medical leadership roles. Regardless, many women have pursued their chosen careers as practicing physicians, overcoming these and other barriers. On the other end of the spectrum, many women feel they have been fully assimilated into the field of medicine, with their gender having little or no consequence for their goals as physicians.

There are many successful women physicians in today's medical world. It is my interest to understand the various roles such women have assumed, and the path these women have followed to reach their current positions. Some women, for example, have chosen to work full time, becoming the main "breadwinner" for the family whereas others work part time to have time for other interests. Some seem to do it all. It is my assumption that both personal decisions and professional biases and stereotypes have heavily influenced the direction of these paths. Through my senior honors project, I would like to conduct a case study of five women physicians in the Knoxville area that have achieved differing roles in the field of medicine. By interviewing them, I hope to see what motivated them to make the choices that affected their careers and compare the results with current literature describing the position of women in the health care field. My conclusion will serve as an indication of some of the factors driving women physicians to their present roles as well as provide information about what women medical students and physicians can expect in today's medical society. As a practical application of the study, I will attempt to set plans for a mentoring program between women physicians and women pre-medical students through the Pre-Health Advisory Committee at the University of Tennessee.

Appendix B

Form of Consent

After reading the prospectus outlining the senior honors project of Kelly Birdwell, I agree to be a participant in the project. My main contribution to the project will be a tape recorded interview with Ms. Birdwell, who will then use selected information for her final paper. I am guaranteed complete confidentiality in the project, and my name will only be used with my permission. I am entitled to a copy of the final paper.

_______________________________ Name

____________________ Date

Appendix C

Interview questions for women physicians

1. General information/ basic biography
   - age
   - date of medical school attendance
   - field of medicine
   - number of years in practice

2. What experiences in medical school drove you to choose this field?

3. Please give me a description of your typical day.

4. Do you feel that your current role as a practicing physician has been shaped more by personal choices or available career activities?

5. Has it ever made a difference in your training or practice that you were a woman?

6. Has the position you have assumed presently in you profession differ from when you first began practicing? If so, how?

7. If you could begin your medical career again, would you choose the same field of medicine? Why or why not?

8. As a professional, where would you like to see yourself ten years from now?

9. What do you think of a mentoring program between women physicians and undergraduate women pre-medical students that would expose students to the different types of roles women physicians have assumed in today's health care system? Would you be willing to participate?

10. Considering some of the issues addressed in the prospectus, do you have any personal experiences or comments that you would like to add?

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