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ABSTRACT

Women have historically been under-represented in the medical profession in part because the norms of feminine behavior have deviated from behavior expected of physicians. To determine the career and family expectations of current medical students, 320 medical students were surveyed. Results confirmed the hypothesis that even sex-role-modern women perceive family rewards to outweigh the benefits of maximizing career rewards. Abortion attitudes tended to correlate with attitudes about women's rights and sex roles; female medical students held more proabortion attitudes than males. Contrary to prediction, women medical students experienced more role strain than men. Most women students expected equal sharing of child care and household responsibilities while men expected to contribute less. The findings suggest that recognition of the importance of family relationships may help reduce the emotional and psychological stress of being a physician. (Author/JAC)

Sex Differences in Career Goals, Family Plans, and Abortion Attitudes of Medical Students

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Historically, women have been underrepresented in the medical profession. In part, this was because the norms of "feminine" behavior deviated from the behavior considered desirable in physicians[1-3]. In addition, medical schools considered women to be poor investments because surveys indicated that women physicians often did not devote themselves to the practice of medicine full-time over a lifetime career[4,5].

Studies have identified contradictions in role expectations for physicians and for women[1,3,6]. Broverman et al.[1] used the term "masculine" to describe such traits as aggression, dominance, achievement orientation, and intellectual understanding. Gross and Crovitz[3] suggested that these traits formed a "cluster of generalized competence which is probably necessary for students to become successful physicians". They also suggested that traditionally "feminine" women are "supposed to be dependent, submissive, passive, emotional, and family oriented"

For women physicians motherhood presents a likely area of role strain, i.e., of a discrepancy between one's real and ideal role behaviors, and of role conflict, where one's goals do not match societal role expectations. Women physicians may be caught in a double role strain: If the reality of their role behavior as women approaches the idealized norms for their role as physicians, then the reality of their behavior as physicians may deviate from the idealized norms of their role as women. Perhaps this explains, at least in part, the relatively high rates of suicide, depression, and anxiety which have been reported among women physicians[7-9]. Some writers have denied the importance of the childbearing role, suggesting that women have been socialized to accept that role but can, and perhaps should, be socialized to prefer other roles[10]. Others have suggested that many women have a biologically motivated desire for motherhood[11]. When women want to utilize their professional abilities and also

want to exercise their capacity for motherhood, role strain and role conflict are likely to develop.

To some extent the present generation of medical women may be reducing role strain. Recent studies suggest that women physicians and medical students are choosing a middle ground of expectations, less traditionally feminine than most women, but also less competitive and less aggressive than their male colleagues[6,12]. O'Connell and Beighton's[13] study of Australian fourth-year medical students revealed significant differences between males and females in their expectations regarding careers, marriages, and family responsibilities. The Australian women medical students often expected to marry physicians, expected to have an average of three children, expected their husbands to share equally in child rearing and household responsibilities, and most expected to interrupt their careers for child rearing purposes. The men more often expected to work long hours, to earn more money, and to interrupt their careers only for travel or further training. Nearly half of the men expected their wives to bear the major responsibility for child rearing and household tasks.

Several hypotheses can be derived from the literature on sex roles[14,15]; from studies of the personalities and careers of American physicians[2,3,5,6,12]; and from the Australian study[13]. Nye[14] suggested that most women perceive the rewards of staying home with their young children to outweigh the costs of interrupting their employment. We predicted that contemporary American women medical students would also perceive child rearing rewards to outweigh the benefits of maximizing career rewards and would be more likely than male medical students to choose to interrupt their careers for child rearing, to work shorter hours, and to choose more flexible specialties. If medical student women do perceive child rearing rewards to outweigh the benefits of maximizing career rewards (for both husband and wife) then the women would also be likely to favor equal

participation in child rearing. However, because surveys suggest that many women do not perceive the rewards of housework to outweigh career rewards, we predicted that the women in our sample would also advocate equal sharing of household tasks.

In our socie men may have been channeled in one direction--achievement in the workplace--without perceiving other options. Today some men may be questioning their traditional concentration on career achievement at the expense of family and other personal interests. Concurrently, later marriage, smaller families, and changing societal norms regarding sex roles have left women many years of life which can be filled with achievements other than, or rather, in addition to, child rearing. Women medical students seem to be actively choosing to integrate their traditional roles with new roles. For these reasons we predicted that female "ideal" career and family plans would resemble female "real" expectations more closely than male "ideal" plans would resemble male "real" expectations. That is, there would be greater disparity in male real/ideal expectations than in female real/ideal expectations. Support for this hypothesis would suggest that male medical students presently suffer more role strain than do female students.

Abortion attitudes tend to be correlated with attitudes about women's rights and sex roles. Therefore we predicted that even though the women in our study might be more likely to compromise their career goals in order to raise children they would also be more likely to favor access to abortion as a solution to an unwanted pregnancy.

Methods

Questionnaires were mailed to a sample of 320 medical students, stratified by sex and randomly selected from the second through fourth year classes at two

private medical schools in North Carolina. Questionnaire design and mailing procedures followed the method of Dillman[16]. On the questionnaires students indicated their real and ideal expectations regarding income, hours of work, career interruptions, and location of practice. Similarly, they indicated their real and ideal expectations regarding marriage, spouse's occupation, number of children, and respondent's age at birth of first child. Respondents also indicated whether they expected to contribute more or less than, or equally with spouses, to child care, child financial support, and certain household tasks. We included a Likert-type scale which assessed abortion attitudes[17]. Finally, the students indicated their age, race, sex, year in medical school, and religious preference.

Results

The response rate was 82%. Of the sampling frame, 25% were women; 28% of the respondents were women. Only seven students (less than 3%) were over age 29; the oldest was 34. The sexes did not differ significantly by race or religion.

Most respondents of both sexes would prefer to practice in a small town but, realistically, most expect to practice in a large city. Only 5% expect to practice in a rural area.

Realistically, 69% of the women and 5% of the men expect to interrupt their careers to rear children. Ideally, 44% of the women and 7% of the men would choose such interruption. Ideally, 5% of the women and 10% of the men would choose to interrupt their careers to accommodate their spouses' careers. Realistically, 18% of the women and 10% of the men expect such interruption. Three quarters of the men and about half of the women expect to work more than 50 hours per week. Only four women (6%) and one man (0.5%) expect to work less than 40 hours per week. Ignoring inflation, 60% of the men, but only 29% of the women, expect realistically to earn over $60,000 in 1991. Ideally, 80% of the men and 65% of the women would earn that much.

These results offer some support for our hypothesis that the women would, more often than the men, place the rewards of family and home above the benefits of maximizing career rewards. However, a significant number of women expected, but did not want, less income and more career interruption.

The four most preferred specialties for men were surgery (25%); internal medicine (23%); family practice (18%) and pediatrics (7%). For women the most preferred specialties were internal medicine (24%); pediatrics (23%); family practice (16%) and obstetrics-gynecology (15).

Ideally, 98% of both sexes would choose to marry. Realistically, only 90% of the women expect to marry, compared to 98% of the men. Nineteen percent of the women and 25% of the men were already married. Half of the women and 9% of the men expect to marry a nonphysician professional person.

Ideally, the women would have an average of 2.3 children, but realistically they expect to have 1.9 children. Ideally, the men would have an average of 2.4 children and realistically they expect 2.2 children. Ideally, about 5% of each sex would choose to remain childless. Realistically, 7% of the women and 4% of the men expect to do so. Ideally, most respondents of both sexes would be in their late twenties when they had their first child. Realistically, 59% of the women and 45% of the men expect to have their first child after age 30. These sex differences in ideal expectations concerning marriage and family support our predictions, but the disparities in real/ideal expectations suggest that women more often feel compelled to compromise their expectations.

Role strain was operationally defined as the disparity between real and ideal expectations. We hypothesized that women in this American sample would experience less role strain than their male colleagues. However, our data do not support that hypothesis. Women experienced more, rather than less, role strain than the men. Nearly half of the women indicated role strain relative

to income, location of practice, spouse's occupation, number of children, and age at birth of first child. Sex differences in real expectations regarding these areas were significant at $p < .01$. There were also significant sex differences in role strain with regard to marriage and spouse's occupation.

Over half of the women and 40% of the men indicated role strain with regard to career interruption. Women expect more interruption for child rearing than they would choose. Over two-thirds of the women expect to interrupt their careers to care for their children. Nearly half of all the women would choose such interruption but about one quarter would prefer to work out some way of combining children and career without interrupting their professional careers. Few expect to work part-time. Women more often expect to interrupt their careers to accommodate their spouses' careers. A majority of both sexes experienced role strain with regard to work hours.

In O'Connell and Beighton's study[13], 14% of the men and 60% of the women expected to interrupt their careers to rear children, compared to 5% and 69%, respectively, of the American sample. Realistically, 91% of the Australian men and 60% of the women expected to work more than 40 hours per week, compared to 99% and 94%, respectively of the Americans. Ideally, over 80% of the Americans would choose to work that much, compared to 40% of the Australian men and 13% of the Australian women. Half of the Australian men said they had no preference about their wives' profession, whereas 9% of the American men expected to marry a physician, 49% expected to marry a woman with other professional training, and only 25% said they had no preference.

For the Australian men and women[13] the modal response was equal sharing of child and household responsibilities. Sharing was the modal response for American women, but American men expect to contribute less to child care ($X^2 = 117$. $p < .001$); and housework ($X^2 = 98.2$, $p < .001$); and more to child expenses

(X^2 = 112.9, $p < .001$); yard work (X^2 = 82.2, $p < .001$); and home repairs (X^2 = 95.4, $p < .001$). Male response to the item on spouse's occupations implies that most men also expect to support their wives financially in the traditional pattern. Despite the high expected incomes, only one person (male) suggested hiring someone to do the housework. American men expected to marry professional women more often than did their Australian counterparts, but American men much more often expected a traditional division of responsibilities within the marital dyad.

The women medical students more often agreed with the access-to-abortion position ($p < .01$ for most abortion items). Factor analysis with Varimax rotation indicated that the male responses loaded on two factors, one concerned with the general right of a woman to choose abortion, and the other having to do with requiring publicly funded hospitals and agencies to provide abortion services. For women, a third factor appeared. We called this factor the right to control one's own body. This factor included the questions on parental consent for minors and spousal consent for sterilization, as well as the general statement of the 1973 Supreme Court abortion decision.

Discussion

Results supported all of our predictions except that women medical students experienced more role strain than did the men. Most women expect, and 44% want, to interrupt their careers for child rearing purposes whereas few men anticipate such interruption. Nearly twice the percentage of women, as compared to men, expect to interrupt their careers to accommodate to a spouse's career. There were significant differences, in the hypothesized direction, regarding work hours and income. Most women expect equal sharing of child care and household responsibilities whereas most men expect to contribute less than their wives to

such tasks. As we predicted, the women more often favored access to abortion even though they want children, and want to spend more time with their children than do the men. This is consistent with other evidence indicating that abortion attitudes are related to sex role attitudes and general conservatism.

These data report expected behavior, not actual behavior, and decision making processes were not studied as such. Several respondents indicated that decisions about children and family responsibilities would depend on input from a future spouse. Only 19% of the women and 25% of the men in this sample were married.

Friedan[15] suggested that "as women enter the workplace and share the bread-winning, their family bonds and values--human values as opposed to material--seem to strengthen". In contrast, Scanzoni[10] said "A woman who is sex-role modern prefers rewards that are individualistic . . . role-modern women wanted to experience as few . . . familistic costs as possible in order to be less impeded in the pursuit of individualistic rewards" (pg. 10). One should not underestimate the importance of children in determining sex role choices. Medical students are a select group who have demonstrated high levels of academic achievement and strong motivation for professional success. Surely this sample of women medical students must be classified as sex-role modern, yet they clearly value children and family and they are willing to make compromises in their career plans in order to raise children. These women appear to fit Friedan's[15] model better than they fit Scanzoni's[10] model. Their interests include family as well as careers. This sample of highly educated, "achieving" women combines a strong commitment to family with a strong commitment to professional productivity. They are willing to accept less than maximal income in exchange for time to spend with their families. Only three of the 62 women (6% would choose, ideally, not to have children.

The question of achievement avoidance[18] is difficult to untangle. Do women avoid professional achievement because they are socialized not to achieve, or because they perceive child rearing to be an achievement of at least equal importance? Our results seem to confirm Nye's[14] hypothesis that many women perceive the rewards of childrearing to outweigh the benefits of maximizing career rewards. It may also be, however, that access to the more remunerative, higher status specialties is restricted by the predominantly male power structure or by patient prejudices which reject, for instance, women surgeons.

These women medical students would prefer to share the rewards and the responsibilities of home and family equally with their spouses. The attitudes of this sample may have significant implications for the medical profession and for the health care delivery system. If a third of the profession expects to work fewer hours and to take time off for childrearing, a higher physician/patient ratio may be needed.

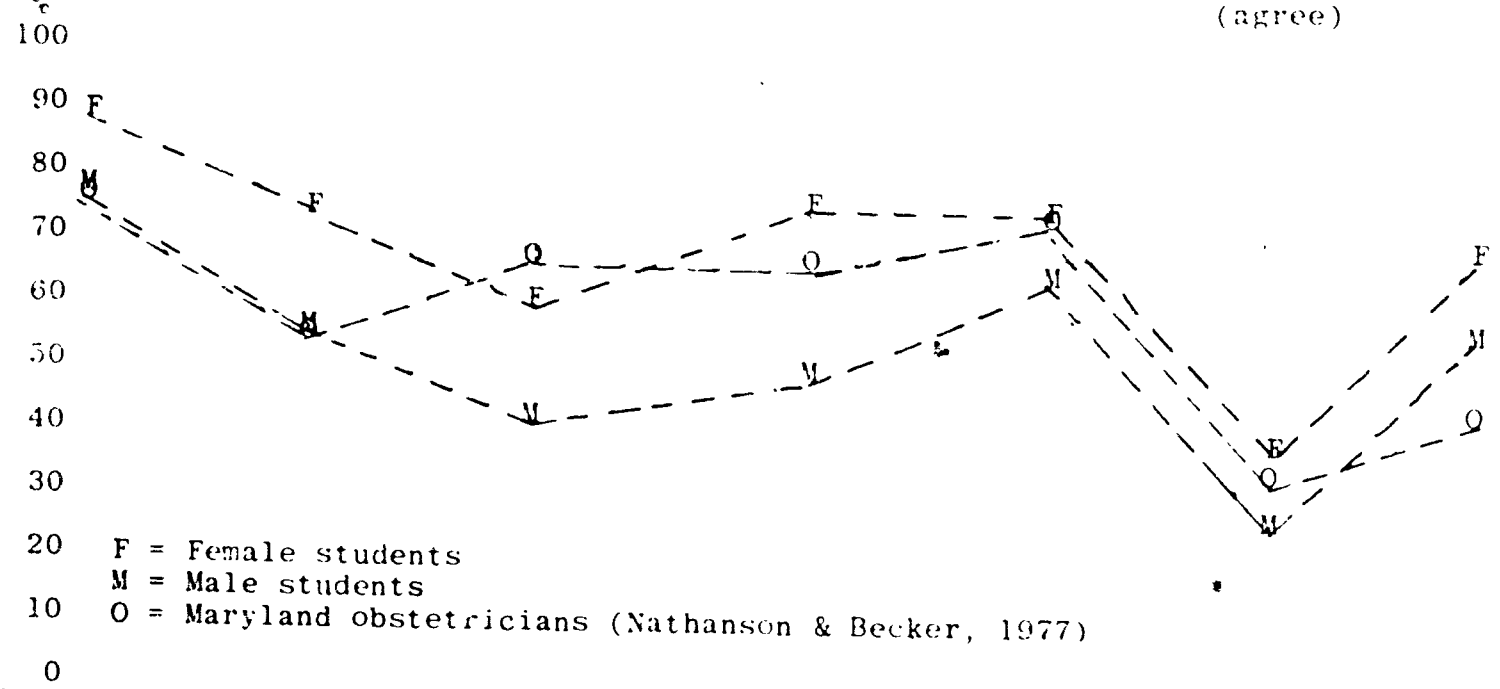
For many women in our sample increased personal time was more valued than a higher income. Friedan[15] suggested that employed couples often place more emphasis on human and family values than on career values. Perhaps adjustments should be made so that physicians, both men and women, can integrate family and career goals in ways which are satisfying and productive, and which reduce emotional stress and role strain. Flexible work hours and parenting leave need not be regarded as negative effects of increasing the number of women physicians. Recognizing the importance of family relationships could help reduce the emotional and psychological stress, the role strain, of being a physician.

Career and Family Expectations of Medical Students

	Women		Men	
Number of respondents	62	28%	193	72%
Race - Black & other		10		4
Caucasian		87		93
Religion - Catholic		13		11
NonCatholic Christian		56		64
Jewish		13		10
Other		18		13
	Really	Ideally	Really	Ideally
Career Interruptions - Children	69%	44%	5%	7%
For spouses' career	18	5	10	10
Practice location - Large city	38	27	35	21
Small town	30	37	35	57
Suburb	28	24	26	28
Rural	5	12	4	13
Hours of work per week				
Fewer than 40	6	16	0.5	19
40-50	39	79	26	66
More than 50	55	5	74	15
Income in 10 years-Under $30,000	3	3	1	.05
$30,000-$60,000	68	32	39	20
$60,000-$90,000	24	47	40	41
Over $90,000	5	18	20	39
Marriage-never	10	2	3	2
Eventually	71	82	73	75
Currently	19	17	24	23
Spouse's occupation-Physician	50	25	9	8
Other professional	31	51	49	48
Non-professional	6	7	16	15
No preference	13	18	24	26
Spouse won't be employed	0	0	2	3
Number of children-none	7	5	4	5
One	11	8	6	5
Two	74	51	59	54
Three	7	26	26	23
Four or more	2	10	4	15
Age at birth of first child-none	2	3	2	1
Under 25	0	5	3	9
25 to 30	38	73	44	60
31 to 36	59	18	44	26
Over 36	0	0	1	1
Age no consideration	0.5	0	2	3
Specialty-Surgery	0.5		24	
Internal medicine	24		23	
Family practice	16		17	
Pediatrics	23		7	
Obstetrics & gynecology	15		5	
Other	22		24	

PERCENTAGE OF MEDICAL STUDENTS AND PHYSICIANS SUPPORTING ACCESS TO ABORTION

A woman should have an abortion if she & her physician decide it should be performed** (agree)	Unmarried women under 18 should be required to obtain parental consent for an abortion.** (disagree)	Federally funded family planning programs should be required to provide abortions as well as contraception.** (agree)	Publicly supported hospitals should be required to provide abortion services.** (agree)	Medicaid coverage should be limited to abortions performed to save the life of the mother.* (disagree)	Federal funds should be denied to hospitals that refuse to allow abortions for moral or religious reasons. (agree)	Consent of the spouse should be required prior to sterilization. (disagree)



**p ≤ .01 (p-values for χ^2, sex differences in students' responses.)
*p < .05

References

1. Broverman I, Vogel S, Broverman D, Clarkson F, and Rosenkrantz P. Sex role stereotypes: A current appraisal. J of Social Issues. 1972; 28: 29-78.
2. Burstein AD, Louck S. Kabor JC and Stanton B. Psychological characteristics of medical students and residents. J of Medical Education. 1979; 54: 56-59.
3. Gross W and Crovitz E. A comparison of medical students' attitudes towards women and women medical students. J of Medical Education. 1975; 50: 390-391
4. Cartwright LK. Continuity and discontinuity in the careers of a sample of young women physicians. JAMWA. 1977; 32: 316-318.
5. Cohen ED and Korper SP. Women in medicine: A survey of professional activiti career interruptions, and conflict resolution. Connecticut Med. 1976; 40: 1
6. Cartwright LK. The personality and family background of a sample of women medical students at the University of California. JAMWA. 1972, 27: 260-266.
7. DeSole DE, Aronson S, and Singer P. Suicide and role strain among physicians. Internatl. J Social Psychiatry. 1969, 15: 294-301.
8. Welner A, Marten S, Wochnick E, Davis MA, Fishman P and Clayton PJ. Psychiatr disorders among professional women. Arch. of Gen Psych. 1969; 36: 169-173.
9. Steppacker RC and Mausher JS. Suicide in male and female physicians. J. of Amer. Med. Women's Assoc. 1974; 28: 323-328.
10. Scanzoni J. Sex Roles, Women's Work and Marital Conflict. Lexington, Mass. DC Heath & Co., 1978.
11. Rossi A. Maternalism, sexuality, and the new feminism. In Contemporary Sexual Behavior. Zubin J and Money J, eds. Baltimore: The Johns Hopkins Press, 1972; 145-173.
12. McGrath E and Zimet C. Female and male medical students: Differences in specialty choice selection and personality. J Med Educ., 1977; 52: 293-300.

13 O'Connell MA and Beighton F. Students' career plans and the medical profession. J Med Educ, 1979; 54: 509-511.

14. Nye FI. Family mini-theories as special instances of choice and exchange theory. J Marriage and the Family, 1980; 42: 479-490.

15. Friedan B. Feminism takes a new turn. New York Times Magazine, 1979; Nov. 18, 40.

16. Dillman DA. Mail and Telephone Surveys, The Total Design Method. New York: John Wiley & Sons, Inc. 1978.

17. Nathanson CA and Becker MH. The influence of physicians' attitudes on abortion performance, patient management and professional fees. Family Planning Perspectives, 1977; 9: (4) July/August, 158-163.

18. Horner M. Toward an understanding of achievement related conflicts in women. J Social Issues. 1972; 28: 157-175.