PROFESSIONAL IDENTITY AND PRIVATE LIFE: A SOCIOLOGICAL PERSPECTIVE ON MULTIPLE IDENTITIES AND THEIR ARTICULATION

by

Robert S. Broadhead

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Sociology

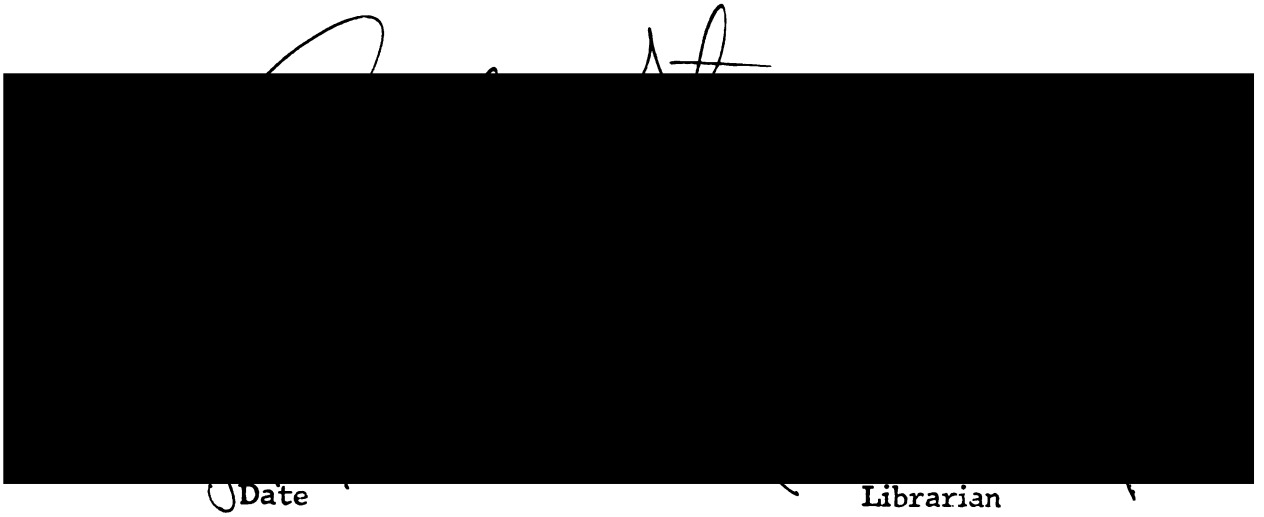
in the

GRADUATE DIVISION

(San Francisco)

of the

UNIVERSITY OF CALIFORNIA



Date Librarian

Degree Conferred: . . . . . .

Abstract

This study is an examination of the experience that medical students face in articulating their identities as budding professionals in relation to the multiple identities and relationships that they share with others in their private lives. Using qualitative data, and based on a "grounded theory method of analysis," a theoretical perspective is developed on multiple identities and the process of their articulation.

As an overall process, articulation attends to resolving the experential problem of how individuals assemble their multiple identities in terms of relating them to one another, symbolically, as well as relating them to one another in behavior, within situations and across time.

Multiple identities are articulated with one another, symbolically, in terms of the convergence and divergence of assumptions, definitions, attitudes and values that exist between the perspectives of different identities. While, for any given person, the specific meanings which make up a relationship, or a "symbolic calculus," between identities is problematic, there are a number of distinct forms that any given symbolic calculus can take. For some medical students, mostly those who are men, husbands and fathers, such identities are seen as essentially "blended" with one another, so that the student's involvement in medical school becomes a simultaneous fulfillment or

expression of all of the remaining identities. The symbolic calculus between identities can also take "instrumental" or "diversionary" forms. However, some symbolic calculi remain essentially "problematic." Particularly for women, and for students who see themselves as adults, articulation of these identities is ongoingly troublesome and unresolvable, which leads to a number of problems in students' lives, such as feelings of being stigmatized, sexually neutered, and infantilized.

Multiple identities are articulated with one another, behaviorally, in terms of the ways in which individuals negotiate, with themselves and others, the allocation of the time, energy, interests and resources necessary for the expression of one identity, or identities, over others. For individuals in medical school, the behavioral articulation of their lives exists as an immense problem because the largely unnegotiable demands of medical school tend to inundate their private lives, threatening to flood out the possibility of expressing and fulfilling competing identities.

Multiple identities have their own, relatively distinct temporal careers, and individuals continuously grapple with the future in terms of scheduling the expression of certain identities over others. In this sense, participation in medical school involves a structured and highly scheduled status passage that provides clear markers as to when one's identity as a medical

student must take precedence over other identities, as well as the date of possible "pay-off" when the realization of becoming a physician can then become a means for the realization, expression and support of other identities.

However, as training evolves, many students begin to envision that the inundation of their lives with medicine threatens to carry over following graduation. Thus, in terms of minimizing such an event, students' visions of the future, particularly as it appears to affect their private lives, feed back upon and influence many of the important decisions that they must make in the present regarding their training situation.

Articulation of multiple identities within specific situations involves a dialectic process of situations defining identities, identities redefining situations and, indeed, identities defining altogether new situations. In this sense, students' adjustment to the medical training situation is not merely an adaptation; "situational adjustment" is much more of a creative process of students partially constructing the training situation itself by interjecting their own perspectives into it. Moreover, such perspectives are grounded in identities that students embrace which are derived from groups and relationships found outside of the training situation.

Acknowledgements

I owe this dissertation, and all of my graduate education, to the unending support and encouragement which I received from many different people.

Professors Leonard Schatzman, Anselm Strauss, Barney Glaser and Fred Davis taught me my most important lessons in sociological theory, analysis and methods of social research, as well as served as committee members for my qualifying exams and dissertation committee. A fair prediction is that their influence on my development as a researcher and a sociologist will evidence itself in all the remainder of my work. Little more can be said.

I wish, however, to pay a very special thanks to Leonard Schatzman. Professor Schatzman worked with me on virtually a day-by-day basis throughout my graduate studies. He became an intellectual and personal mainstay from whom I gained sound advise and counseling in matters both academic and practical. I thank him for bringing me back down to earth on more than several occasions, and for forgiving me of the many moments of ineptitude and foolishness that I displayed in his presence. I also wish to thank Professor Schatzman for relating to me as both professor, colleague and friend, and for his unabashed genuineness and hilarious sense of humor.

I owe a special thanks to Professor Barney Glaser's analysis seminar in 1974 and 1975 which served as a very important beginning to the dissertation research itself.

I am also grateful to Don C. Gibbons and Ray C. Rist for the instruction and encouragement I received from them while taking my Master's degree at Portland State University.

I wish to thank Patrick Biernacki for his colleagueship and tremendous friendship. Joseph Damrell also played a very unique and important role in my life while in graduate school. As fellow students of mine, I wish to thank Marsha Rosenbaum and Irma Zuckerman for the pleasure of their association.

I wish to thank Terri Wetle, Roberta Rosen and Norman Trondson for reading drafts of the dissertation and for making important suggestions for improvement. I thank Pamela Wood for typing the manuscript, and for her patience in dealing with my compulsiveness.

I am grateful to the Human Development Program, UCSF, for awarding me with financial support in terms of a three

year traineeship in Adult Development and Aging. I wish to thank the Graduate Division of UCSF for awarding me a Regent's Fellowship for the academic year 1977-78. I also wish to thank Professors Schatzman and Strauss for offering me a number of short-term teaching and research assistantships over the last three years.

I wish to thank Elaine McLarin and Pat Rodden who, as staff members of the Graduate Program in Sociology, UCSF, helped me immensely over the last few years in terms of expediting paper work, arranging appointments with professors, and making the bureaucratic machinery of the university work.

Finally, I want to thank several people who, although not directly involved in my graduate training, helped me in ways which I shall not even attempt to explain: Suzanne Lee Smith, Anne and Stan Smith, Bill Thomas, Lynda and Jurgen Woelke, and my mother and father.

This dissertation is dedicated to my daughter, Emily Ann.

TABLE OF CONTENTS

"Let me say that the cloistered existence of the doctor until well into his thirties makes him a late arrival in the Game of Life...Inevitably, however, there comes a day when he understands, slowly at first, then more fully. But by then he has given too many hostages. He is no longer that pure entity, a doctor. He has become an impure mixture of husband, father, colleague and doctor whose responsibilities to others, whose commitments and promises have begun to outweigh the pure considerations of the healing science" (Dr. X, 1965:19).

Chapter One

The Multiple Self

Introduction

There have been a number of important studies on the processes through which professionals are "produced" within society, the nature of professional socialization, and the relationship between major socializing institutions and their inductees (cf. Becker and Geer et al., 1961; Merton and Reader et al., 1959; Olesen and Whittaker, 1957; Lovell, 1964; Warkov and Zelan, 1965; Bloom, 1963; Coombs and Vincent, 1971). However, one notable feature of these studies is an almost exclusive focus on the individuals being socialized, or their cohorts. Yet, to the extent that all students are simultaneously members of other groups and associations by virtue of being friends, spouses, parents, and so on, a seemingly important, but largely unanalyzed substantive problem remains: How the changes the student undergoes in becoming a professional affect and relate to the multiple identities and relationships that the student shares with others. As Olesen and Whittaker (1968) observed, there have been a number of "thoughtful statements" by various educators and researchers on the relationship between the process of becoming a professional and the fulfillment of other and competing "lateral" roles, but no systematic or analytic study is

yet available (for instance, see Coombs and Vincent, 1971); Eagle and Smith, 1968; Bruhn and DuPlessis, 1966; Perlow and Mullins, 1976).[1]

Accordingly, the study presented here is an examination of the experience that medical students face in fashioning their identities as budding professionals in relation to the multiple identities and relationships that they share with others in different social contexts.

Theoretically, the general research problem at issue here is not actually concerned with the nature of professional socialization per se, or with refining existing theory about socialization. Rather, given the fact that all individuals are socialized to, strive for, and take on a number of different identities (one possible identity being that of a "professional"), the theoretical problem becomes explaining how the process of fashioning an identity in one context affects, and how the process itself is impinged upon and affected by, individuals' identities and relationships with others in altogether different social situations. Or, put simply, the problem is explaining how individuals articulate multiple identities, whether those identities are in the process of emerging, or are already established. Obviously, to the extent that in the course of a single day an individual can assume any number of episodic identities such as those of "customer" or "pedestrian," that have virtually no, or only minimal, relation to one another, the identities that are at issue

here are "primary" identities; identities that are trans-situational and central to any given individual's person-hood, such as one's developmental, sexual, relational, ethnic and occupational identities. To this extent, the study offered here is concerned with understanding how individuals articulate their emerging identities as professionals with other primary identities, such as those of "adult," "spouse," "parent," "intimate," and so on, that are situated within relatively different social contexts and relationships with others.

The problem of multiple identities and their articulation is not new to sociology or social psychology itself. Certainly since William James (1910) and George Herbert Mead (1934), symbolic interactionists in particular have spoken of the multiple "me's" that individuals embrace and are capable of calling out in themselves and in others. And they have spoken of the fact, particularly in modern societies, that individuals must ongoingly articulate multiple identities within the various situations that they find themselves. For instance, as Lindesmith and Strauss et al. (1975:488) recently re-emphasized:

> The articulation of [multiple involvements and identities] is surely a central practical problem for the citizens of modern nations, just as it is a central theoretical problem for social scientists who wish to understand life in these "complex" societies.

However, while acknowledging that, indeed, individuals in everyday life ongoingly articulate their identities and

involvements, the process itself has never been taken as a problem for research. Rather, it has been regarded as a taken-for-granted, social psychological fact. The promise of this study, therefore, is in the service of explicating, on the basis of empirical research, a theoretical problem fundamental to the larger perspective of symbolic interactionism, but one that has never been treated as a problem to be explained: How, indeed, do individuals articulate multiple identities, and what are the consequences on their identities and relationships with others that derive thereof.

Before turning to the substance of the research and findings of this study, perhaps it would be worthwhile to briefly examine why, in fact, the problem of multiple identities and their articulation has been largely neglected in past sociological research.

Sociological Homunculi

As Schutz (1962) revealed, sociologists are inevitably doomed to the use of homunculi in analyzing the human situation: There is no ultimate epoche performable that can yield a documentation of the phenomenological experience of others, or even of one's own experience. As such, all sociological theory and research must utilize hapless puppets, caricatures and models of persons and, no doubt, some homunculi are more imaginative and convincing than others, but never lively enough. Of course, because the

very attempt to frame others' lived experiences into a symbolic representation produces nothing more than a secondary construction qualitatively removed from those experiences themselves, the "analyses" of other types of writers, such as novelists and poets, and the works of artists, inevitably suffer the same inadequacy as that of sociologists. However, in terms of convincing portrayals, if nothing else, writers of novels and biographies, for example, have been unquestionably more effective in capturing and conveying the multifaceted, elusive, and moving qualities of human spirit and vibrance than have sociologists. Indeed, sociologists have been guilty, historically, of fracturing persons into the most narrow, frequently mechanical, one-dimensional figures imaginable. As Laing (1959:23) mused, if an individual describes himself as a "machine" or a "robot," such persons are rightly regarded as crazy: "Yet why do we not regard a theory that seeks to transmute persons into automata or animals as equally crazy?" One of the great strengths and contributions of social psychology within sociology has often been its very powerful critiques of the images of man that prevailing theories implicitly contain. Wrong's (1961) documentation of the "oversocialized conception of man" in modern systems theory is the most classic criticism (see also Blumer, 1956; Broadhead, 1974). As a result, systems theorists have been behooved to reconsider their analyses. As a leading thinker in systems theory noted, modern

systems theorists

> ...represent an attempt at a rather complete overhaul of contemporary consensus theory by a return to social psychological basics and a rebuilding, from the ground up, of a balanced and dynamic conception of complex social organization (Buckley, 1967:105).

In terms of the problems of identity, the single most important reason why there is no existing theory or perspective on the nature of multiple identities and their articulation is because sociologists have inevitably analyzed individuals as if they only had one identity. Sociological literature is replete with analyses of a person's role, or identity, or function, as if any given individual only has one role, identity, or function. Indeed, the implicit assumption in particularly structural analyses (a la Parsons, 1951) is that if one can identify an individual's role and identity as given by the system, then one can largely explain and predict the individual's subsequent behavior. A long standing comment among theorists in the area of deviance is that sociologists always speak of the robber, or the check-forger, knowing full well that, for the most part, robbers and check-forgers engage in the same everyday activities that most everyone else does. And yet, the absurdity of such narrow perspectives toward individuals has never been dealt with seriously.[2]

For instance, in the socialization literature, as mentioned above, there are no analyses of how an

individual's emerging identity affects, or is affected by, all other possible identities. At the most, as in the literature on professional socialization of medical students, there are a number of studies that correlate various extraneous and arbitrary "variables," such as an individual's social class, religious affiliation, ethnicity, family membership, and educational level, etc., as they relate to predicting students' performance in medical school (cf. Fredrick and Mundy, 1976; Coombs and Vincent, 1971). However, assuming that the combination of these variables represent multiple identities, there is no attempt in such analyses to specify the meaning among these identities as they relate to the identity of being a medical student, which in effect would provide some insight into the way individuals "symbolically" articulate one identity with another. Nor is there a discussion of how changes in one identity affect other identities. And finally, there is no discussion on the methods that individuals use to ongoingly articulate multiple identities with one another. In this sense, such studies more or less regard students as having a single identity, that of being a medical student; and the socialization experience through which they are processed leads them to another, specific identity, that of being a physician. The analyses of past socialization research, therefore, by restricting the focus to specific identities, yield a stark, highly fractured view of the multiple selves that individuals actually

embrace, and an analysis that ignores the manifold processes that individuals utilize in assembling their multiple selves into the coherency of a person.

A theoretical exception to the fractured images of persons contained within particularly structural, systems and behavioralistic theories in sociology is symbolic interactionism. Interactionists have explicitly critiqued other sociological theories by drawing attention to this very issue (cf. Blumer, 1956; Bolton, 1963; Scott, 1970), and in turn they have attempted to "breathe more flesh" into images of man by emphasizing a number of postulates about persons hitherto ignored by most sociologists. Namely, by inserting into their analyses the enormously important factor that individuals have selves, and that, on the basis of ongoing communication and interaction, individuals continuously call out in themselves and others multiple ways of acting and being, interactionists have portrayed an image of persons that is far more humanized and experientially congruent. However, even in emphasizing the multiplicity of selves, and the fact that individuals must continuously articulate their multiple identities and involvements, interactionists have neglected to seriously take up the process of articulation itself as a problem to be researched and explained. Several reasons for this neglect can be outlined.

First, in the existing literature bearing upon the multiplicity of identities that individuals embrace by

virtue of their concurrent memberships in frequently a great number of rather diverse reference groups, social worlds and "scenes" (cf. Strauss, 1977; Irwin, 1977), interactionists have characteristically treated such memberships, and their accompanying identities, as highly compartmentalized and separated from one another. For instance, as Shibutani (1967:167) suggested:

> Most people live more or less compartmentalized lives, shifting from one social world to another as they participate in a succession of transactions. In each world their roles are different, their relations to other participants are different, and they reveal a different facet of their personalities. Men have become so accustomed to this mode of life that they manage to conceive of themselves as reasonably consistent human beings in spite of this segmentalization and are generally not aware of the fact that their acts do not fit into a coherent pattern.

In much the same manner as Shibutani, interactionists generally have emphasized the immense social plurality, diversity, and emergent features of urban societies, and the multiplicity of individuals' involvements. Indeed, much of the contribution of interactionists to sociology has been analyses that address these very features of urban societies as equally characteristic of modernism as the features of rationality, bureaucratization and institutionalization. However, in emphasizing the apparent separateness and compartmentalization between reference groups and social worlds, interactionists have produced an image of man as being certainly multifaceted, but essentially a kind of "quick change artist," whose multiple identities

are drastically and tightly partitioned from one another, and from others in different social contexts. Thus, if addressed at all, the problem of identity articulation has been reduced to the question of how individuals keep their multiple identities largely separated and isolated from one another. Articulation as a process has thereby been treated as largely composed of techniques of concealment, passing, strategies of disguise, and creation of fronts. Indeed, the work of dramaturgical interactionists has exclusively concentrated on these strategies of "being." The point is, however, that while such techniques are certainly types of articulation, they constitute only one aspect of the larger process itself; not on how individuals symbolically and interactionally assemble, relate, configure and present multiple identities, <u>but how they do not</u>. Thus, what perspective on identity articulation that interactionists have provided is basically a "non-perspective;" a perspective that "explains" articulation by essentially denying it. It is a perspective that suggests, as Shibutani described above, that individuals may naively conceive of some consistency and interrelationship among their many selves, when in fact there really is none.

This brings up a second reason why interactionists have largely neglected to examine the process of articulation as a problem to be researched and explained. Interactionist theory and research characteristically focuses at the episodic and situational levels of analysis. The

promise of this is that, by methodologically bracketing their focus, interactionists have been able to examine the ways in which individuals themselves build their lines of action together on the basis of communication and interpretation, rather than by explaining away interaction as determined by, or expression of, various external "variables" such as norms, roles, rules and conventions. As such, interactionists have been adept at examining the processes through which individuals enter situations and proceed to mutually fashion their respective identities, roles, and "business at hand" through processes of interaction.

For instance, Foote's (1967) classic paper on identification emphasized that, in contrast to explanations of behavior as offered by systems and role theorists, individuals frequently find themselves in situations where roles and rules that presumably govern interaction are highly ambiguous, in conflict with one another, or simply nonexistent. The resolution of this problem, as offered by Foote (1967), as well as interactionists generally, such as Turner (1962), Stone (1970) and Blumer (1967), is that individuals discover and appropriate an identity, and thereby a role, by devising a performance on the basis of what they anticipate to be the perspective and understandings of others within a situation, and in terms of what respective interactants communicate and call out in one another: "As a process, [identification] proceeds by naming;

its products are ever-evolving self-conceptions - with the emphasis on the con - that is, upon ratification by significant others (Foote, 1967:347, emphasis in the original). Thus, as Turner (1962:23) explained:

> The actor is not the occupant of a position for which there is a neat set of rules - a culture or set of norms - but a person who must act in the perspective supplied in part by his relationship to others whose actions reflect roles that he must identify.

However, by exclusively focusing on how an interactant's identity and role emerges and becomes validated within specific episodes and situations, the identity of the individual tends to be seen as a rather specific one. Moreover, the identity remains specific to the emergent definition of the situation itself. Thus, while interactionists preface their analyses by emphasizing that individuals come to situations with an immense potential repertoire of identities and roles that they can play, the specific identity that eventually emerges within the situation is treated as unrelated to, and largely dissociated from, all other identities that the individual brings to the situation.[3] Essentially, interactionist analyses frequently exhibit the same myopia that is characteristic of structural and systems analyses of interaction; while certainly process, interaction and communication is emphasized, interactants are typically portrayed as acting in terms of the definition of the situation, the identity given by others within the situation, and

presentation of the self. Interactionists have therefore neglected to develop a perspective on multiple identities and their articulation because they have neglected to develop a perspective on, for example, the presentation of selves.

Finally, interactionists have paid considerable attention to the pervasive search for identity that individuals exhibit in modern societies (cf. Strauss, 1969; Klapp, 1969; Lofland, 1966; Shibutani, 1961). They have noted that, whether it be derived from a profound sense of meaninglessness and alienation, expressions of creativity and self-actualization, or transformations inherent in regularized status-passages, individuals are continuously in the process of taking on new identities, discarding old ones, and refashioning the calculi of their selves.

Travisano (1970) provided a useful distinction between transformations that are either "alternations" or "conversions." Alternations involve the appropriation of a new identity, but in such a way that it becomes merely an addition to, or an extension of, an individual's prior identities: "These changes are logical; they are extensions or addenda to formerly established programs; they are cumulative identity sequences" (Travisano, 1970:603). As such, alternations

> are relatively easily accomplished changes of life which do not involve a radical change in universe of discourse and informing aspect, but which are part of or grow out of existing programs of behavior...Little change is

> noticed by most of the persons' others. There is no trauma" (Travisano, 1970:601).

Conversions, on the other hand, involve the appropriation of an identity that necessitates a reformulation, or radical redefinition and reorganization, of an individual's prior identities:

> Conversions are drastic changes in life. Such changes require a change in the "informing aspect" of one's life and biography. Moreover, there must be a negation (often specifically forbidden) of some former identity. Conversion is signaled by a radical reorganization of identity, meaning, and life (Travisano, 1970: 600).

Travisano's analysis emphasizes, therefore, that the crucial difference between a conversion and an alternation is determined by the nature of the process through which a newly acquired identity is integrated and aligned with an individual's prior identities. Alternation involves a process of integration that is unproblematic, and that results in no significant reorganization of the relationship between existing identities. Conversion involves resolving a major malintegration between a newly acquired identity and existing identities, which then results in a qualitative reorganization and redefinition of the relationship between them. As Travisano (1970:602) explained:

> The actor and all his others see his change as monumental and he is identified by himself and others as a new or different person. The actor has a new universe of discourse which negates the values and meanings of his old ones by exposing the "fallacies" of their assumptions and reasoning.

For our purposes, the interesting point that Travisano and other theorists underscore is that, whether the

appropriation of a new identity involves an alternation or a conversion, integral to both processes is the fact that individuals relate, integrate, and in various ways align a newly acquired identity with all others. Whether the process is difficult, traumatic, or totally reorganizaing in its effect is quite beside the point. In order to achieve such articulation, such a process may or may not involve a total reworking of the nature of, or the relationship between, all existing identities of the individual. But the problem of articulation itself is fundamental to both processes.

However, although theorists have emphasized that articulation of multiple identities is an ongoing, integrative, social psychological process, they have neglected to examine the process itself; how articulation is achieved, and what is the nature of the process. The result, therefore, is that there is no interactionist perspective to date on the process of articulation of multiple identities even though, theoretically, the process itself is fundamental to an interactionist approach to explaining the nature of self and social interaction.[4]

In general, therefore, sociology is in need of greater attention given to the problem of multiple identities and their articulation, how they affect and impact upon one another, and how they are mutually fashioned and presented in situations and across time.

Research Perspective and Theoretical Format

The ways in which identities are related to one another are not objectively given. Rather, identities are articulated with one another in terms of the meanings that individuals assign as constituting the relationship between them. Thus, to understand both "why" and "how" articulation is accomplished, one must ascertain the meanings that individuals themselves embrace as determining the relationship between one identity and another.

For this reason, the perspective offered here in analyzing the problem of multiple identities and their articulation is a symbolic interactionist perspective. That is, in the same way that interactionists have theorized that the nature of identity is an emergent feature of social reality, arising out of symbolic interaction and communication, the process through which multiple identities are articulated is also a totally social activity. Articulation is based on communication and interaction with one's self and others. As an overall process, articulation attends to resolving the experiential problem of how individuals themselves assemble their multiple identities in terms of relating them to one another, symbolically, as well as relating them to one another in behavior, within situations, and across time.

As such, what is offered below is an examination of the meanings that medical students, and their significant others, assign toward students' involvement with becoming

a professional, and how they interpretively relate this emerging identity as a "professional" toward the relationships and identities that they mutually share outside the situation of medical school. In this sense, an essential *a priori* assumption of a symbolic interactionist perspective is that the ways in which students' emerging identity as a professional is articulated with all concurrent identities and relationships with others are highly problematic and variable, being dependent on the meanings that students and others themselves use in assembling their multiple selves. For instance, if married, a student's involvement in medical school could be perceived by his or her spouse as a simultaneous fulfillment, in and of itself, of the student's identity and role as a spouse. At the other extreme, students and spouses could perceive such involvement as totally unrelated, or as an obstruction, to fulfilling a spouse's role. A symbolic interactionist perspective would thus assume that meanings of such an altogether different nature would in turn produce completely different patterns of marital life and activity, different types of identities as "spouses," and different "problems" that each married couple has to face.

The constituent elements of a symbolic interactionist perspective on multiple identities and their articulation are presented below in terms of the following *theoretical* format. Chapter Two focuses on the fact that individuals (in this case, medical students) are continuously in the

process of embracing, presenting, and fashioning multiple selves, and that due to the exigencies of social interaction and social organization, the articulation of those multiple identities is an imperative process, as well as an ongoing one.

In the following four chapters, an analysis is developed focusing on the various dimensions of the process of articulation itself. Specifically, articulation of multiple identities involves a symbolic dimension (Chapter Three): To have an identity is not only to be socially situated, or to be assigned membership in a particular group, "social world," or "scene." To have an identity is also to have a "perspective" consisting of certain assumptions, definitions, attitudes and values that individuals use as a frame of reference for organizing, or informing, their thoughts and actions toward self and others. However, inasmuch as individuals have multiple identities, they also have multiple perspectives. Multiple identities, therefore, are articulated with one another, symbolically, in terms of the convergence and divergence of assumptions, definitions, attitudes and values that exist between the perspectives of different identities.

Moreover, identities have different "social values;" there is a hierarchy of prestige and importance that exists between identities, although the social value of any given identity varies according to situations. Therefore, multiple identities are articulated with one another,

symbolically, not only in terms of the convergence and divergence of perspectives, but also in terms of the social value that one identity is assigned over another. Finally, individuals are capable of revealing and discussing the details of how one identity symbolically articulates with another, as well as specifying "problems" that may obtain in the relationship.

Secondly, the process of articulation involves a behavioral dimension (Chapter Four): Multiple identities are mutually fashioned and acted out in behavior and interaction. However, although individuals symbolically embrace multiple identities of themselves, the behavioral expression of many identities can be untenable or problematic simply due to the sheer lack of time, energy, emotion and resources. This is particularly a problem experienced by medical students simply because participation in medical school involves a behavioral inundation, at sometimes greater than others, of their energies, time and personal resources. Such inundation of the student's life with medical school results in flooding out and severely constricting the expression of competing identities.

Thirdly, the process of articulation involves a temporal dimension (Chapter Five): Identities have their own, relatively distinct, temporal careers, and individuals continuously grapple with the future in terms of scheduling the expression of certain identities over others. In this sense, participation in medical school involves a

structured and highly scheduled status passage that provides clear markers as to when the expression of certain identities must become subservient to others, as well as a date of "pay-off" when the realization of one identity, that of becoming a physician, can then become the means for the realization, expression, and support of other identities.

Finally, the process of articulation involves a situational dimension (Chapter Six): Situations in which individuals find themselves call out and define particular identities that are specific to situations themselves. Moreover, some situations, such as participation within medical school, tend to be highly specialized and truncated in terms of the specific identities that they call out in individuals. However, competing identities to which individuals are committed can serve to dialectically feed back into and partially redefine situations themselves. Thus, articulation of multiple identities within specific situations involves a dialectic process of situations defining identities, identities redefining situations, and indeed, identities defining altogether new situations.

What is offered, therefore, is an analysis that compliments and elaborates existing theory, particularly in symbolic interactionism, bearing on the nature of identity and the dramatic search for identity that characterizes the lives of individuals in post-industrial society. However, the promise of the analysis is that it

focuses less on the search for identity, and more on how identities once discovered are articulated into the lives of individuals themselves. Indeed, the emphasis of the following analysis suggest that, just as ours is a time when the search for identity is a dramatic process, an equally dramatic process in the lives of individuals is that of bringing those identities into a meaningful articulation with the totality of their remaining selves, biographies, futures, and relationships with others.

Chapter Two

Professional Socialization and Multiple Identities: The Case of Medical Students

Articulation as an Imperative Process

As interactionists have discussed previously, to have an identity is to be situated or placed in social terms, to be assigned membership in various groups, or to be recognized as belonging to a given era of time, history and future. As Stone (1970:399, emphasis in the original) noted:

> Almost all writers using the term imply that identity establishes what and where the person is in social terms...When one has an identity, he is situated - that is, cast in the shape of a social object by the acknowledgement of his participation or membership in social relations. One's identity is established when others place him as a social object by assigning him the same words of identity that he appropriates or announces.

However, individuals are continuously in the process of presenting, announcing, revealing, and projecting multiple identities. Many identities are worn on people's "cuff," as Goffman would say. For instance, one's age, as an identity, is relatively easy to assign within a general continuum ranging from childhood through old age. Ethnic and sexual identities are also visible. The accent in one's speech frequently gives away one's geographical place of origin as well as one's cultural and socio-economic beginnings. Individuals' names are immensely

revealing, as are peoples' clothing and general demeanor. As Goffman (1963) noted, individuals "give" and "give off" information, and the amount of information that is given off as to one's identities is indeed immense and very telling.

Moreover, in terms of one's primary relationships, collegues and friendships, people generally like to be thought of in many different ways, and they are quick and frequently eager to drop cues as to their other selves interests, history, and opinions. It is in the revealing and sharing of such information about our selves that provides the "deeper" images as to our character, our "essential" nature, and our uniqueness.

Thus, Stone's (1970:399) assertion that, "To situate the person as a social object is to bring him together with others so situated, and, at the same time, set him apart from still other objects...," needs some conceptual elaboration. To the extent individuals project, and are assigned, multiple identities, they are continuously situating themselves and others in multiple places simultaneously. The fact that an individual is one thing does not necessarily set him apart from being many others concurrently.

However, to the extent that individuals embrace and give off many different identities simultaneously, it is imperative for them to engage in a continuous process of articulating their multiple selves, emphasizing some and

discreetly deemphasizing others, and aligning and realigning them into differing configurations. This is because, due to the exigencies of social interaction and social organization, failure to articulate identities in ways that are appropriate to situations can create many different kinds of interactional problems. Many situations, particularly within formal organizations, call for only specific identities of the interactants, and explicit presentation or expression of competing identities can result in either heightening the ambiguity of situations, or bringing about a disruption of the interaction itself. In addition, if presented inappropriately, different identities can introduce the specter or suspicion of split loyalties and divided commitments, ulterior reasons, and signs of equivocation in terms of one's perspective or position. "Surprises" as to who we are can be troublesome and threatening to others in their consequences, causing confusion at the very least, as well as possible embarrassment, discreditation and shame (cf. Gross and Stone, 1970; Goffman, 1963; 1967).

For these reasons, it is not that individuals cannot and do not divulge information as to who they are, for indeed, the opposite is usually the case. Except for encounters between complete strangers, or in dealings with con men, most individuals live out the most personally significant aspects of their lives, whether that be with friends, colleagues, or intimates, in what Glaser and

and Strauss (1964) would describe as "awareness contexts" that are relatively open, or that strain toward openness. This is because, as the testimonies of homosexuals have poignantly revealed, living lives of pretense and concealment as to "who we are" is a trying and bitter business (cf. Cory and Leroy, 1963). Moreover, the extent to which individuals do live lives as con men and "Machiavellians" has been grossly overdrawn by some sociologists (this criticism has been increasingly made by others; cf., the discussion in Irwin, 1977). This is not to say that individuals never conceal portions of their lives, but rather individuals prefer to live as openly as is comfortable for them, even frequently in the face of rejection by others. This emphasizes that the problem individuals face in revealing the multiplicity of their identities is "how" such information is disclosed, which underlies the problem of "how" individuals must ongoingly articulate their multiple identities so that introducing them into interaction with others, or into organizational settings, is appropriate, supportive and conducive to the situations themselves.

In the case of medical students, the first and certainly most important occasion in which they, as students, must articulate their multiple selves with an eye toward others and institutions is in preparing their application for admission to medical school, and in presenting themselves for the admissions interview. An analysis of how medical students engage in this very delicate and

deliberate activity is immensely revealing of the process of articulation itself.

Face-work in Applying for Medical School Admission

Stereotypes notwithstanding, medical students are a very diverse lot, and prior to applying to medical school, many students lead extremely varied lives as individuals. Attending college itself in the pre-med years provides opportunities for exploring and expressing many different identities and engaging in a wide variety of activities. Prior to enrolling in medical school, many students are employed in occupations totally unrelated to medicine. Moreover, many students are spouses and parents. And students generally express interests in a wide assortment of avocations, sports and hobbies in which they are seriously engaged.

However, due to the demand structure of medical school, which eventuates in the selection of only the most highly qualified and motivated applicants, gaining admission requires that individuals articulate their many selves as if they were totally subservient to, and supportive of, their ultimate interest in becoming medical students. As one student expressed it, "The thing is that, in order to get in, you have to sell yourself that you will totally live medicine for the rest of your life, and that's all you want." In order to do so, therefore, it is imperative that individuals, as applicants, strategically articulate

their prior lives so that everything that they have been or have done previously attests to, and directly or indirectly prepares them for, the ultimate realization of becoming medical students. In doing so, applicants involve themselves in a complex articulation process that evolves through basically four, sequential stages. For the present purposes, these stages can be designated as those of 1) anticipatory identification; 2) aggregate identification; 3) individuation; and 4) normalization.

Anticipatory Identification: The first stage begins with the applicant identifying, on the basis of research, counseling, advice and rumor, the general parameters that medical schools use to initially screen in or out those individuals seeking admission. Accompanying this includes completing the long, uncertain years of pre-med training that invests students with the necessary prerequisite skills, experience and credentials that will approximate the parameters against which they will be judged. As one student expressed:

> First, you have to read everything that is available to you, and then you begin to see the kind of thing that they are looking for. You visualize it in terms of grade point averages, test scores, and letters of recommendation. You have to realize that in order to get into medical school, presenting yourself as yourself is the last step in the process. You first must think of yourself as a piece of paper that they're going to be looking at, and they can either throw it away or keep it.

Now, admittedly, some students are far more strategic in their effort to gain admissions than are others, and generally, those that are strategic are logically more likely to meet with success. Parenthetically, by strategic, I do not mean deceitful or phoney, but rather deliberate, well-organized, and reflexive of the application process itself.

As the student quoted above intimated, what students generally discover in the first stage of anticipatory identification is that, in preparing their application in terms of presenting themselves in the image of the ideal applicant, potential students are drawn to the conclusion that what is required of them is the sequential creation of two identities: first, the identity of a member of an aggregate, and later, the identity of a unique person. The first identity is, as the student above described, an identity "on paper" that consists of test scores, transcripts, GPA's, and the like. The second identity, that of a unique person, awaits to be presented at the time of the admissions interview.

Aggregate Identification: The second stage involves students articulating all of their personal identities and attributes in such a way that they appear on paper as members of an aggregate. The emphasis here is not in revealing one's uniquenesses or special attributes, but rather the attributes that the medical school emphasizes

in determining the initial, aggregate pool of serious considerations. Moreover, even in the "personal letter" that accompanies each application, there are good reasons why students, if they are to be strategic, are reluctant to discuss or divulge any other areas of their lives that do not directly contribute to their measuring up to the image of the aggregate. For instance, as a third-year student explained:

> I presented myself twice. The first time, I had a Masters degree and my son was very young, and I was married. I presented myself as a woman who had always been interested in science, and who was going to be able to be a good mother, and do a good job in medicine. And I didn't get one interview, not even one! I presented myself really honestly. I'm a woman who has worked hard, who has always been interested in science, and this is really important to me, and I'm going to show you how I can make medicine and my family fit together. My whole essay about myself talked about how I had worked out child care so I could be a medical student, how I was going to be a good mother - and I didn't get one interview!
>
> So the next year, I became more serious and looked into how to play the game. I then didn't even include any mention of my son in the next essay, and I just presented myself as a scientist who had done research, but that I felt that clinical science was better for me. And I told them all this stuff about science, and more or less took the attitude that the only thing that they were concerned about was an image of the epitome of the perfect medical student and scientist. So I came on hard-core as a scientist, and more or less omitted any other aspect of my life.

A third-year, male medical student said just about the same thing:

> The thing about the letter is that the theme was that I tried to integrate the technical and social things of my life. I said that I have all these technical skills and that I do well in science,

> but that I want some kind of social application. But I didn't discuss anything else, like my marriage or my private life.

The essence of creating an identity of an aggregate member is to relate to all other potential applicants on the basis of attributes that are externally determined by the medical school admissions committee. However, just as survey researchers find themselves hard pressed to locate, for instance, their ideal, statistical American family of white, Anglo-Saxon parents with 2½ children, making an income of $12,500, and owning two cars, so too applicants can only attempt to approximate the ideal medical student, and even then, only in terms of attributes that have little to do with their personal lives. The divulgence of that information, however, which still must be a selective, well-articulated divulgement at that, awaits for the third stage.

Individuation: Articulation and selective revealment of one's personal identities and attributes occur in the medical school interview. The applicant's objective at this stage of the process, once a given person has been identified as falling within the initial aggregate of potential students, is to dissociate oneself from the aggregate itself, and emphasize one's personal uniqueness. It is a time to take the offensive and make oneself look unique enough that a lasting impression of the applicant as an individual is preserved in the minds of the

committee members. For instance, as one student lamented, having been rejected by a number of schools the first year, and then gaining admission on the second go around:

> The problem that I had in the interview was not coming across forceful, and that I really wanted to do this. And then I have a tendency when I meet people to be somewhat withdrawn, and wait and see where they're coming from before I open up. And the second year I applied it was the same thing - more rejections.

Other students, however, pick up much faster on what the interviews are all about:

> First it occurred to me that they would not be looking for someone that was absolutely, centrally fixed on medicine. At the time that I applied, I realized that the trend was heavily away from that. The trend was more for people who were very well rounded, and had a lot of interests outside science. So I knew when I went for my interview that I had to look unique: many people would have excellent grades and test scores, and I knew that I had to separate myself from that group. I needed to make myself look like I was something special. First you have to get yourself into the pool of serious considerations, and then attempt to separate yourself from them in a positive way.

To bring about individuation, students point to a number of identities and attributes unique to themselves that separate them from the remaining aggregate of potential students. One student, who had previously been a professional magician, demonstrated his magic before the interviewing committee:

> I pulled it out and said, here it is. And I did that to make them aware that when I said that I <u>was</u> a magician, that I really was. That I wasn't just a mickey mouse that had a

> few tricks, but that I really was what I said I was. I told them that this was important to me and that I'll show you what I can do with it. And it made one realize that, for those people who interviewed me, that I did something a little bit different, and they'll remember me by it.

Other students discuss more mundane identities and attributes that separate them from the group, such as being adults, or spouses and parents:

> O.k., my pitch was that I was older, and that I have had a lot of experience, ie., that I was an adult. That I've had a lot of experience in other areas than just going to school; I've been around just a little bit more. Plus, I have a family, and I'm settled down in life. I'm steady, motivated, and for good reason!

Normalization: In articulating and presenting oneself as a unique individual who embraces identities and interests other than simply that of becoming a medical student, there is an element of risk involved. In making a "pitch," one runs the risk of raising eyebrows and questions, and indeed, all of the uniquenesses of a person can be seen by others as either assets or liabilities. This is the single most important reason why students are reluctant to divulge too much in the personal letter that accompanies the written application. Personal uniquenesses are problematic. For instance, the clothing that one wears at the time of the interview, and one's general appearance, has to be seriously considered. As one student explained:

> Everyone dresses formally, but maybe it doesn't make that much difference. You mainly don't want to look like someone who is going to buck the program. Of course, getting into medical school is loaded with probabilities, and you're hoping that somewhere you're going to hit the right combination. But generally, I played the odds, and I assumed that most of the people who interviewed me would be more conservative than liberal.

Because every personal identity or attribute that applicants reveal can potentially be seen by others as "questionable" or "problematic," what every applicant must be prepared to do is to "normalize" all possible liabilities into either irrelevancies, benign attributes, or, at the best, positive assets.[5] For instance, older applicants, in their late twenties or early thirties, frequently must justify their ages:

> My being older was in a sense a positive factor, and yet also a problem. So I had to think of some way to turn my being older into an asset. I had to make them think that being older was no problem - this is what makes me better than the next guy.

Many medical school admission committees regard a student being a woman as a very questionable identity, and particularly women with children. As one, first-year woman student discussed:

> I tried to make the fact that I was a mother an advantage to me. That I had learned about caring for people. And that there was a certain amount of maturity that comes along with a marriage and a family. But generally it was hard to use this as an advantage.

Another woman student put it this way:

> I said I have had my children. I have proven my competence as a student while being a

> mother. And that I didn't see why having kids would get in the way. And basically, I implied that I was not going to be dropping out of school or out of medicine in order to have our children; that basically our family was complete. But listen, I was put on the defensive more than once by people saying, "you're going to drop out of school to have more kids." And I could say, "how can you say that! This is what I did in school while having my children." And they would point to other women who have dropped out of medicine to have children. And I said, "well, I've already had my children!"

Thus, in having successfully advanced through the stages of anticipatory identification, aggregate identification, and individuation, potential students must finally be prepared to normalize any identities and attributes unique to themselves that they reveal to the medical school. The successful candidates are inevitably those who have been skillful in articulating their multiple selves with respect to the expectations of those individuals who represent the institution of medicine. Students thus create an image of their personhood wherein all accompanying identities and personal attributes flow into, and are seen as subservient to, the over-riding identity of their becoming medical students.

Professional Socialization to Multiple Identities

In order to gain acceptance to medical school, applicants articulate their multiple selves in such a way as to create the impression that becoming a medical student, and eventually a physician, is the single most

important identity to which they aspire. However, not only do students come to medical school with multiple identities, but inevitably professional socialization itself is seen as supportive of, if not a vehicle for, the fulfillment and expression of still other identities, particularly after training has been completed. As Becker (1968) noted, the commitment of individuals in general to any endeavor is based either on intrinsic or extrinsic "reasons." Extrinsic reasons, or "side bets," involve "linking of previously extraneous and irrelevant lines of action and sets of rewards to a particular line of action" (Becker, 1968:154).

In the case of medical students, undoubtedly the study of medicine is to some degree an absorbing and motivating experience in and of itself, as is earning the identity of "physician." However, as is common knowledge, there are many reasons to become a physician, or a professional in any field for that matter, that are extrinsic to the practice of medicine itself. And, for medical students, the professional socialization experience through which they are processed is in many ways seen as a spring-board for the attainment of a number of widely varying rewards, pursuits and identities. Moreover, due to the grueling experience, at times, of professional socialization itself, the "side bets" that students make as reasons to endure the process frequently become more compelling than the intrinsic reasons for doing so. As

one third-year student noted in the "heat" of a particularly tyrannizing clerkship:

> Like I have a fantasy of traveling, and building a log cabin, and getting an old car and fixing it up, and getting a little ranch with some horses. And I think these fantasies are realistic ones. And I would say in fact that these things are the motivating factor right now in finishing school. They are going to carry me through the last stretch, and then when I get out, things are going to be good, and then I can relax.

One of the reasons why extrinsic reasons can supplant intrinsic ones is that, in a way similar to the loss of idealism in medical school that some researchers have claimed (cf. Eron, 1955; Christe and Merton, 1958; see Becker et al., 1961 for an opposing view), the study of medicine - or more accurately, the study of illness and disease - can be a disenchanting experience. As one anatomy Ph.D. student commented, "I always thought I wanted to be a doctor until I realized in graduate school how much I hate being around sick people." A third-year medical student expressed a similar feeling:

> I originally expected to get more intrinsic rewards in dealing with patients. And now I find dealing with patients to be at times really frustrating, a lot more frustrating than I imagined. A lot of problems you simply can't do anything about and yet the expectations are there for you to be able to solve them. It's pretty frustrating to admit that you can't help somebody, and to fail.

Thus, partially due to disenchantment, or loss of idealism, or many other factors, students' investment in

becoming a physician frequently becomes an investment to become something else, or to acquire something else. For instance, almost all students see medicine as a way to support the identity of themselves as adults, spouses and parents. As one student expressed:

> Medicine is going to help because, when I'm through with training, I'm going to be able to have a resource that will allow me to do things that I'm interested in, particularly if I put my practice together in such a way. Thus, in ways, I can see medicine as a means to other ends, although not entirely. It's obviously important for me to develop a strong family, and I want to have a lot of time with them. I mean, medicine is supportive of this, although it depends on what specialty you choose. Some specialties are more amenable to having a family life.

In addition, medical students see medicine as a means to achieve the social realization of identities as "adults," an identity which they social psychologically embrace while in school, but which is undermined socially by virtue of them being in school itself. (This issue is discussed in greater detail in Chapter Three.) However, particularly for those individuals in medical school who have been students virtually all of their lives, professional socialization is seen as a status passage to adulthood itself. That is, they see medical training as a means to arrive at that stage in life where, socially, they at least have the wherewithal to live as they think adults should; responsible, respected, independent and socio-economically stable. As a 26 year old, married student noted:

> Being in medical school has in a lot of ways prevented me from living like I think I should be living at this age. I will go and visit my friends, and they've got homes, and they come home from work and they don't worry about a lot of things. But on the other hand, I think that eventually I will be in a lot better situation than them.

Interestingly, the "fact" that medical students embrace both intrinsic and extrinsic reasons for being in medical school, and that professional socialization as a process actually results in socialization to multiple identities, should be of no suprise. Yet, I think in terms of the existing ideology of what "is" a professional, as well as the existing theory concerning the nature of professional socialization, both "facts" pose, if not a surprise, then at least a problem.

First, a central ideological feature of professionalism is that the practice of the profession is an end in itself. Professionals are described as a special breed of individuals, steeped in the esoterica and specialization of their fields, and intrinsically committed to fulfilling the larger mission of the profession itself. While in part this may be true, it is a half-truth. Professionals, and students studying to become professionals, see their practice of the profession as a means to a wide and rich assortment to other ends, and their side bets are as much of a motivating force within the profession as is the practice of the profession itself. However, in emphasizing this, it is in no way meant as a

criticism of professionals. Ideologies are ideologies, part truth and part myth. Thus, as Dr. X (1967:16) confessed:

> Obviously, doctors are not boy scouts, nor are they deep-dyed dastardly villians. We are merely men living in a system of man's creation that tend to give rather disastrously free license to each of us to fulfill our own needs - or greeds - regardless of the cost to others. In this the doctor is no less guilty than many of his patients.

Regarding the second problem, in addition to the criticisms mentioned in Chapter One, existing theory on socialization suffers from another gross myopia. Particularly with respect to the research on the nature of occupational and professional socialization, theorists have tended to focus, probably for heuristic and analytic purposes, on only specific socialization processes, and they have tended to analyze such processes as if they prepare individuals for only specific roles and identities. As Davis and Olesen (1972:21) noted:

> This has led to an unwitting depiction of career socialization as a unidimensional, institutionally self-contained process in which the progress, travail, and rewards of the aspirant are analyzed wholly within the context of the occupational role per se.

Moreover, implicit in most existing theories on socialization is an unfortunate teleological bias that theorists fail to question seriously. Namely, it is assumed that all professional socialization processes have an objectively given purpose or goal that is inherent in the process itself, and that such purposes and goals exist

independently of the subjective interpretations of the individuals being socialized, or of the researchers themselves who are interpreting the process.

In contrast, if future research on the nature of professional socialization were approached via a symbolic interactionist perspective, researchers would first be required to "bracket" their taken for granted assumptions prior to the research itself (cf. Strauss and Schatzman et al., 1964; Becker and Geer et al., 1961). In doing so, what researchers would discover is that the ultimate meaning(s) and purpose(s) of a given socialization process varies immensely according to the meanings assigned to the process by the individuals that are involved in it, as well as according to the meanings assigned by the individuals officiating the process itself. This would reveal that individuals are not only involved simultaneously in multiple socialization processes that prepare them for different roles and identities (Davis and Olesen, 1972). In addition, individuals interpret and "use" <u>specific</u> socialization processes as a means of preparing them for <u>multiple</u> identities and roles. As has been discovered in this study, professional socialization processes are means, at least in part, for individuals to fashion and express a whole assortment of multiple identities, and that such processes serve multiple ends. To this extent, existing theory on professional socialization obscures the fact that, as individuals, students are striving to not only

become professionals, but also adults, spouses, parents, business people, and so on. Their socialization as professionals is both part and parcel of their means of realizing and preparing for such multiple identities and goals themselves.

Chapter Three

Multiple Identities in Articulation

The Symbolic Dimension

The Elements of Symbolic Articulation

To have an identity is not only to be socially situated, or to be assigned membership in a particular reference group, organization, social world or "scene." To have an identity is also to have a "perspective" consisting of certain assumptions, definitions, attitudes and values that individuals use as a frame of reference for organizing or informing their thoughts and actions toward self and others. As Foote (1967) emphasized some time ago, the identity of respective individuals provides an organizing and a "motivating" frame of reference toward oneself and others that, in turn, partially contributes to establishing the initial definitions of a situation within which interaction becomes built up. Or, as Stone (1970) noted, in elaborating Foote's analysis, there must be an identification of one another's identity, which is frequently revealed on the basis of nondiscursive symbols such as one's grooming, clothing, location and gestures, i.e., appearance, before an identification with one another can proceed. For instance, to be a professional involves taking a particular perspective toward oneself in terms of ways of acting and "carrying" oneself, ways

of appearing in dress and demeanor, certain attitudes toward others, and a license to engage in special types of activities specific to one's professional occupation.

At the most, the perspective that accompanies an identity provides only a rough guideline as to how individuals should think, act, and appear toward self and others. Moreover, there can be a definite lack of consensus between individuals as to what the particulars are of an identity in terms of its perspective, and what an identity actually "means" in terms of how individuals so identified should conduct themselves. Finally, many of the assumptions, definitions, attitudes and values that together make up the perspective of an identity can be called into question by individuals and deliberately changed. For instance, the identity of what is a "woman" has been significantly called into question over the last decade or so by various women's movements. The result has been that the perspective traditionally or culturally integral to the identity of "woman" has become problematic, and guidelines, for instance, on how a woman should "appear" as a woman, as well as how she should "act," in terms of vocations, emotional expression, participation in the division of labor, and so on, are now extremely vague and open-ended. As a third-year woman student explained, what the women's movement now emphasizes is that

> everyone should be the role that they feel comfortable in. Most women that I know

> feel like if a woman wants to be a house wife, and that's all they want, then that's great, just so it wasn't imposed on them. So I don't think there is a value judgement on them; you don't have to have a career to be a feminist if you are doing what you want to do. So now it's mostly fulfill your own potential, rather than everyone has to have their own career.

The point here, however, is that, for better or for worse, and there definitely is a broad range of opinion and controversy here (cf. Lum, 1975; Andelin, 1963; Epstein, 1971), what it means to be a woman in relation to the perspective traditionally associated with "womanhood" is now extremely problematic <u>because</u> of the controversy itself. Women are now having to carve out for themselves (and by themselves) to a much larger degree the definitions, attitudes, assumptions and values of what "is" a woman, and how they should relate to themselves and others as a woman.

In addition to a perspective, an identity also carries a "social value," and in general there is a hierarchy of prestige and important that exists between identities. For instance, newspapers frequently publish polls assembled on the basis of national surveys that report the comparison of a number of occupational identities in terms of relative prestige and respect accorded them by individuals generally. Physicians and astronauts usually rank very high, as well as most professional groups, while politicians, government bureaucrats and prostitutes rank very low.

Such a hierarchy of prestige also exists between devalued and low-status identities. For instance, Tringo's (1970) research indicated that the identity of "old age" ranks below that of "blindman," deaf mute" and "cancer victim," while it ranks above that of "epileptic" and "spastic." However, the social value of an identity does vary according to situations. For instance, generally, the identity of "medical student" and certainly "physician" receive a higher social value than that of "homemaker" or "mother." Yet, depending on the situation, the ranking can be reversed. As a fourth-year, woman medical student noted, "I don't get any 'goodies' at home for being a medical student...the kids could care less. All they know is that they need clean underpants."

However, inasmuch as individuals embrace multiple identities, they also embrace multiple perspectives in terms of relating to themselves and to others, and each of these identities carry a different social value. In terms of the process of articulation, therefore, multiple identities are articulated with one another, symbolically, in terms of the convergence and divergence of assumptions, definitions, attitudes and values that exist between the perspectives of different identities, as well as in terms of the hierarchy of social value that is symbolically assigned between identities. Put analogously, individuals articulate multiple identities, symbolically, in the same way social scientists relate theoretical perspectives to

one another, although not nearly as systematically. That is, individuals juxtapose, and compare and contrast the assumptions, definitions, attitudes and values that make up the perspectives of various identities with one another. Moreover, individuals are capable of revealing and discussing the details of how they see one identity as it symbolically relates to another, as well as specifying "problems" that may obtain in the relationship between them. Indeed, because such "problems" emerge in attempting to articulate multiple identities, particularly since such articulation is an imperative in the context of social interaction and social organization, individuals become extremely conscious of the ways in which identities do or do not symbolically articulate with one another, whether that be in terms of perspectives or social values. In such instances, individuals face the problem of having to work out what could be called a "symbolic calculus" as to how problematic identities can be articulated with one another. Such a symbolic calculus eventually provides whatever degree of rhyme or reason comes to exist, or that needs to exist, between identities, and it provides the logic that unites an individual's multiple identities into the coherency of a person.

In these respects, individuals as persons are more phenomenologically "together" than sociologists have traditionally portrayed them as being. For instance, as Strauss (1969) noted, "...sociologists sometimes use the

example of a man acting as a Christian on Sundays and a businessman on Monday, and they note that many men seem to be able to 'dissociate' or keep in water tight compartments the different role demands." In much the same way, Shibutani (1967:167) observed that, as quoted above, individuals' lives are compartmentalized from one "reference group" to another, and that their many roles and identities are extremely different from one another:

> Men have become so accustomed to this mode of life that they manage to conceive of themselves as reasonably consistent human beings in spite of this segmentalization and are generally not aware of the fact that their acts do not fit into a coherent pattern.

What needs to be emphasized here is that, because individuals "conceive of themselves as reasonably consistent human beings," then in <u>fact</u> they <u>are</u> reasonably consistent human beings. What establishes the consistency and coherence of individuals is not the decisions and observations of an external observer, the sociologist, who presumes to "really know," but rather the decisions and observations individuals themselves make that determine the relationship between their many identities and roles.

In general, except for those people suffering from extreme types of mental illness, or symbolic disembodiment (Laing, 1959), individuals do not conceive of themselves as dissociated, hypocritical, or schizophrenic. And if they are asked, "how can you be both a Christian and a businessman," they can reveal a symbolic <u>association</u>

between the two identities. In this sense, while individuals indeed belong to a multiplicity of groups, some which may possibly be partitioned from one another, the sum total of their lives come together and coexist phenomenologically. And the articulation of an individual's multiple identities is worked out in a symbolic calculus that determines, however problematically, the coherency and logic of the relationship between one identity and another.

The Symbolic Calculus of Identity Articulation

Individuals embrace many different identities, and see and express themselves in many different ways. However, the ways identities are related to one another are not objectively given. Nor are there any absolute reasons why certain identities must necessarily go together. In other words, why a "woman" also chooses to be a physician, or a nurse, or a Catholic, musician, spouse, or any other identity, is not objectively apparent. The ways in which identities articulate with one another, the reasons "why" they go together, are problematic simply because the "ways" and the "reasons" can vary immensely from one individual to another. Accordingly, in order to discover the nature of articulation, one has to discover "how" individuals symbolically relate one identity to another. The external observer, such as the social scientist, must discover the meanings that individuals themselves assign as making up the symbolic calculus among identities, rather than

imputing either their own "reasons," or even worse, glibly asserting that, in "reality," individuals are simply phenomenologically dissociated beings.

For instance, many women students symbolically articulate their identities as "women" and as "medical students" by emphasizing, or integrating, a number of themes that they see as shared between the perspectives of the two identities. For individuals who define "womanhood" in feminist terms, being a medical student is seen as integrating, or simultaneously fulfilling the attitudes, values, and definitions of themselves as women in terms of their being equal to men, that they can be autonomous unto themselves, and that they are capable of achieving such independence. Obviously, themes of autonomy, competence and individuality are also integral to the perspective of being a professional.

On the other hand, for individuals who define womanhood in more traditional terms, being a medical student is also seen as integrating, or simultaneously fulfilling, the attitudes, values and definitions of themselves as women in terms of belonging to a profession that involves a caring, nurturing orientation to people, a direct involvement in the protection and reproduction of life, and a service and devotion to others. As others have noted, traditionally, the relationship between being a woman and a healer has always, at least until very recently, been closely related to one another (cf. Ehrenreich,

1973). As one first-year, woman medical student noted:

> Women in medical school are able to express their femininity in terms of the way they are able to approach the patient, and their opportunity to care for people. I think women bring a tendency toward gentleness and tenderness, just in terms of physical things. Laying-on-of-hands kind of things that are needed, and that women seem to be able to do very easily. I think that laying-on-of-hands thing comes very easy to women.

In a similar vein, a third-year medical student who is also a professional magician was able to explain both "why" and "how" the two identities related to one another:

> There are certain fields in medicine where you can really break new ground, and this can be very enjoyable for you because you can really dream up the whole thing yourself, create the reality, which is a very satisfying thing. And the creation of new realities is the whole thing about magic too.

Others have also observed the similarity of themes between the practice of magic in medicine, and the practice of medicine in magic (cf. Kiev, 1964).

But, for our present purpose, the point is simply to recognize that the ways in which individuals articulate identities with one another, and the nature of the symbolic calculus between identities, are not objectively given, but rather are problematic in the life of each individual. What one must discover are the meanings that individuals themselves emphasize in both bringing together multiple identities, and in articulating the perspective and social value between one identity and another.

Forms of Symbolic Calculi

While the specific meanings that make up a relationship, or a symbolic calculus, between identities is problematic, there are a number of distinct forms that any given calculus takes. Identities can be symbolically articulated with one another in the form of an enblending calculus, a utilitarian calculus, a diversionary calculus, and a problematic calculus.

An enblending calculus involves symbolic articulation of two or more identities in such a way that the perspectives of the identities are seen as virtually one and the same, or evidence of one another. The quintessential example of symbolic enblendment of identities occurs in the lives of many medical students who also are men, husbands and fathers. Specifically, many married, male students, and frequently their wives, see the student's involvement in medical school as a simultaneous fulfillment or expression of their identities and roles of being a man, a husband and a father. For instance, the identity of being both a man and a medical student blend easily with one another. As one fourth-year, woman student noted, "I think that men are very sexy in their white coats and their ties, and that the doctor role is a very sexual, masculine role. And some men really turn on to that." Or, as another student expressed:

> I feel sexier now than any time in my life. Ya know, ya walk down the hall and women smile, sometimes rather seductively. I've

> never been treated that way before. I'm not even worried about going bald anymore because you feel like you're a good catch anyway.

In the same way, many students who are also husbands and fathers see their identity and their involvement in medical school as <u>being</u> a husband and a father. Indeed, when queried about possible distinctions between one and the other, male students frequently found themselves somewhat dumbfounded, or at a loss of words, at the question itself. Being a medical student is a simultaneous expression of one's masculinity, and it is a husbandly thing to do. As to any conflicts, some students note that the lack of time for being with one's wife and family is definitely real. But usually this does not call into question whether they are symbolically being good husbands or fathers.[6] As one student noted:

> My wife and her family are very supportive of my role as a medical student. In their value system, that is a good thing to be doing <u>as a husband</u>. As a husband, my wife obviously thinks that its tough, but she doesn't think about the obligations that the school requires as divisive between us. There is no questioning my role as a husband. If it's absolutely necessary for me to be at the hospital for God knows how long, then it's absolutely necessary. I get absolutely no flack about my responsibilities in medicine, as long as there is a good reason for me to be doing it.

Women students, who are also spouses and parents, inevitably find that their respective identities are not enblended. As one fourth-year woman noted:

> A lot of the time when I am able to be home, I simply don't have the physical energy to respond to my husband and children in ways

> that I should. The thing is, men can be in this position, but they don't feel like they are not being good husbands. Men get the double "goodies," but women don't.

A utilitarian calculus involves symbolic articulation of two or more identities in such a way that one identity is seen as a means of expressing other, relatively separate identities. For instance, many ethnic groups now see the opportunity for minority students to become professionals as a means of enhancing the social value of their culture and ethnicity. The appearance of increasing numbers of students who are Black or Chicano serves to dissolve and negate the degrading stereotypes of various ethnic and racial groups, as well as serves as a stimulus for increasing ethnic and racial pride and consciousness. Moreover, many ethnic groups see that, as increasing numbers of "their" people become socially and economically more upwardly mobile, ethnic group members, particularly as they intentionally foster a greater sense of ethnic identification (Hayes-Bautista, 1974), will return to their roots, thus strengthening the social and economic base of their people.

In addition, other social movements have attached themselves to the need for their members to achieve a professional status as a means of expressing and realizing the goals and philosophy of the movement itself. Most notably, as already briefly mentioned, the influx of women into professional education is a direct expression, along

with other sentiments, of the women's liberation movement. Instrumentally, becoming a professional, particularly of the status of a doctor or a lawyer, is a perfect social expression or "solution" for realizing the philosophy of feminism; that women are equal to men, that they should have the same opportunities and rights as men, that they deserve equal autonomy as individuals, and that they are as capable as men.

On a less grand scale, however, students see their identities as medical students, and eventually as physicians, as being instrumental in supporting and expressing a number of other identities that they personally embrace. For instance, many students see themselves as "travelers" and, indeed, many students who express a desire to travel and to live in other countries of the world are attracted to the health professions in particular because they are seen as providing the possibility of geographically mobile careers or "working holidays." As one student expressed:

> One good thing about being a physician is that if you go anywhere, there are reasons for you to do it, and if you ever want to practice, say in Africa, then there's work there for you. In other words, you can visit a primitive society - I mean you can not only see it, but you can become a part of it.

Or, as another student explained:

> I could well end up doing volunteer work in Mexico once a year, go down and spend a couple of weeks, or maybe a whole year. I mean, this isn't an escape thing with me. Last time I went down I had made plans to do a month's work of medicine, and then travel for two months. But I ended up doing medicine

> for practically the whole three months at this one clinic. So living in Mexico has gotten all wrapped up and really mixed in with what I want to do with medicine.

Finally, many students embrace a religious identity, and are committed members of various religious faiths and organizations. Becoming a medical student, and eventually a physician, is infused with, and is seen as a means of expression of, a religious faith and calling. As Truman (1951:2) discussed:

> Religions contribute further, relating the powers and persons of the physician with the drive to do good; the high evaluation of the healing art is typified in Matthew 4:23, "And Jesus went about teaching, preaching the gospel, and healing all manner of disease and all manner of sickness among the people." We have here not only an identification of the act of healing with the conception of the ideal person, but an identification of the act of healing with the powers of the diety, both of which can be found in nearly all religions.

A <u>diversionary calculus</u> involves the symbolic articulation of two or more identities in such a way that one identity provides an escape, or a respite, from another identity. In this sense, as in avocations or hobbies, there may be no relationship at all between an individual's identity as a student and the perspective of another identity, except that the latter provides the individual with a rather complete change in attitudes, emotions, and activities from those of being a student.

For instance, when many students were asked, what is the relationship between your being a medical student and a skier, golfer, tennis player, musician, or any number

of other identities, their answer is that such identities amount to nothing other than opportunities to "get away." Of course, to "get away," or to "do something different," is a reason why individuals assemble frequently a great number of identities. Individuals engage in different activities, and sometimes quite seriously, strictly for the "hell of it," or "just for fun." If anything, such identities articulate with the identity of being a medical student by not relating to it.

Finally, although most identities articulate with one another on the basis of a symbolic calculus that is relatively easily identifiable and problem free, the symbolic articulation of other identities is continuously unresolved, perplexing, unclear and incomplete. A problematic calculus involves the symbolic articulation of two or more identities in such a way that the relationship between them is, at best, partial, tentative and continuously shifting. In this sense, the perspectives between identities, or their social values, articulate in certain identifiable ways, yet there are also "issues" between them that conflict, contradict, or discredit one another. Thus, their articulation amounts to a symbolic makeshift relationship of sorts, workable for the time being, or in specific situations, but fundamentally unsatisfactory and disturbing. For students in medical school, a problematic calculus frequently exists in articulating their identity of "student" with that of being an "adult." And, for

women, a problematic calculus frequently exists in articulating the identity of "woman" with that of "medical student," and eventually, "physician." The problems and dilemmas of assembling a workable symbolic calculus in terms of the identities of medical student, woman, and adult are examined in detail below.

Medical Students as Women: Problematic Articulation

Women have proven beyond a doubt that they can be good, if not exceptional, medical students and physicians, and as a consequence they are being admitted to most medical schools in progressively increasing numbers. This emphasizes that more and more women, primarily due to the women's liberation movement, have increasingly been able to symbolically articulate their identities as women with that of being medical students. In other words, the perspective that women have increasingly held toward themselves, of being equal to men in competence, competitiveness and individuality, aligns itself easily with the perspective integral to being a medical student. And thus, women have had exceptional success in normalizing any lingering (sexist) skepticism that has been held against them by virtue of being women.

For instance, to this day, many medical school admissions committees see an applicant's identity as a woman as a "questionable" attribute that evokes doubts as to their commitment to endure training and eventually

practice medicine, as well as possible split loyalties and equivocations they may harbor in terms of relegating their desire to become wives and mothers beneath that of becoming physicians. Thus, as opposed to men applicants, women are frequently asked very pointed questions by admissions committees as to how they see their private lives as women fitting in with becoming a medical student. As one student noted:

> I've even talked with women who were asked what mode of contraception they were planning on using in order to avoid motherhood while in medical school. And these kinds of issues seem to be an area of fair game. Medical school admissions committees feel like they can ask a woman how she's going to avoid having children, or how she is going to cope with having a family. And I don't think that that is an issue with men.

The point, however, is that because an ever increasing number of women now see little conflict between their being a woman and a medical student, they have been able to successfully field such questions, and normalize any lingering doubts that may still be held against them as women.

On the other hand, while women have been successful in proving that they can be good medical students, <u>they are having trouble proving, both to themselves and to others, that medical students can be good women</u>. This is due to a number of reasons.

Many women find that being a medical student is a neutering experience. Specifically, they find that the

expression of their femininity as medical students, either in appearance or mannerisms, is undermined, or overshadowed, by their medical student image. There are even subtle kinds of institutional pressures in medical school that inhibit women from appearing to be anything else other than "professionals." As one student noted:

> I have a new dress that I made, and I've been wanting to wear it for about two weeks, but I'm anxious about that because I am afraid that it's too feminine to wear on the ward. And I've put it on and taken it off. But it's real flowing, and it's long, and it's dressy and new.

This is not to suggest that some women do not dress femininely, but for those who do, it creates a certain undercurrent of negative impressions, even among other women students. As one woman commented:

> But then there is one woman in our class that dresses very much like a fashion model. She will wear chinese pajamas, and she's very attractive, and she dresses in a striking manner. And most of us think that she sticks out like a sore thumb. She just doesn't look serious. And she's a very flirtatious person too. And thus she's talked about quite a bit by the women that I talk to.

But even more troubling is that many women see their medical socialization as turning them into men. For instance, much of the whole demeanor of professionals as cold, detached, emotionally unexpressive and rational, conforms to more of a masculine demeanor, and most physician role models are personified by men. A confirmation of this is illustrated in the experience that the following woman student described:

> When I was younger, right when I was waiting to find out whether I had been accepted, I had a lot of dreams, and in all the dreams I was a man medical student! And I would wake up and I couldn't believe that I had that dream, of being a man in a suit and a white coat. So I've definitely grown up in a culture where doctors are men.

Another woman medical student explained in more detail the "masculinizing" tendency in medical training:

> Being a medical student definitely does not enhance one's femininity. I think there is a real threat of being turned into a man. And I don't know exactly what that means, except I'm turned into someone that is driven and compulsive as so many men are, and who doesn't have feelings or hasn't got sensitivity, and who just has no appreciation of beauty in the world...I feel really funny about whether I am dressing too femininely on the wards, and I try to be just as low-keyed as possible about what I am wearing.

Finally, in addition to the neutering, if not masculinizing, effect of professional socialization, many women have experienced their identities as medical students as being stigmatizing. This is particularly the case for women students who are single. Such stigmatization pivots around a number of dimensions. First, being a medical student carries with it a very high social value or status. However, in comparison to the social status occupied by most men, such a high social status attached to a woman becomes a very real threat to men themselves. A woman whose occupational identity carries with it more social prestige and evidence of success than that of most men tends to beat men at their own status game. And in terms of the traditional battle between the sexes, men are

notoriously poor losers. Indeed, toward women who are medical students, many men feel so threatened that they would rather not get involved in the first place. Thus, as one student explained:

> The status difference between me being a medical student and most men really used to bother me. And I would meet men that I was really interested in, and that were really neat, then the subject would come up, what did I do, what did they do, and as soon as it got established what my social status was, he would feel really kind of nervous, and he would try to talk to me in a more intellectual kind of basis and try to impress me. And the whole relationship would just deteriorate because he wasn't being himself. And I'm speaking generally now - this has happened a number of times.

In reaction, many women try to hide their identities as medical students in the outside world. They pretend being "just students," or nurses, or airline stewardesses, at least for the time being. This is because, on first acquaintances, if they reveal their true identities, many men then lie about theirs. As the student just quoted above continued to say: "You know, when they found out what I did, they'd say, well I'm a lawyer, etc., and it turned out later that they were salesmen or something, and they had never been even near a law school." Thus, as another student described:

> I went through a period there where I wouldn't tell people what I did. I told them that I was a secretary. And that worked out fine, except I've been in situations where people would start making cracks about doctors, and other professional people, and I would start getting offended.

For most women, being stigmtized for being a medical

student is a bewildering and disheartening experience. They note that men medical students are, as one student described, "in deee-mannd! I mean, women get together and scheme on how to catch doctors." Yet women, particularly those who are single, almost always experience just the opposite:

> And I sit down and I watch, and I think, how come nobody is scheming on how to catch women doctors? I mean, everybody is avoiding us like the plague! And it's not just me. I've been in other hospitals and I've seen these interns and residents who are beautiful women, charming, intelligent women, and it's the same story. I mean, we just get together in the cafeteria and we bemoan our fate. And we all agree that we've got good positive kinds of qualities, and that's what makes it all the harder because, what makes us proud of ourselves is what is hurting us. So whatever kind of social success there is is almost self-destructive.

In addition, women experience stigma in being medical students not only in terms of the discrepancy between the status of their occupational identity in comparison to that of most men, but also because, due to the demand structure of medical training, they simply are not available, or do not have the time, to cultivate relationships with men. As one student described:

> When I meet new men friends, it's really hard to know what's going on. I don't have much time to really cultivate relationships, or to spend with people. I mean, medicine is a more demanding priority. And a lot of men say, "Look, men like women that they can see during the week, and that's available to go away with them during the weekends, and can always do things with him and his friends. And when she says she's always busy, and when she's always saying that she has to study, when she's always on call, and she's never got

time for you - who needs it!"

There are some very serious difficulties, therefore, that individuals experience in articulating their identities as medical students with that of being women. What articulation is achieved is ongoingly problematic, and the symbolic calculus between the two identities remains at best partial, shifting and tentative. To the extent, however, that articulation is an ongoing imperative process, women have attempted to resolve the discrepant "issues" between the perspectives of the two identities in a number of ways.

First, although professional socialization in medical school strikes many women as a neutering experience, women have responded by reevaluating their identities as medical students, endeavoring to find ways through thought and action of how their identities as women can be more effectively expressed. For instance, in discussing the neutering experience, one student commented:

> But I am finding that I am able to express my femininity in terms of the ways that I am able to approach the patient, my ability to take care of people, and I think that that means a lot. My ability to communicate with people. And I think that when you can come across with these added dimensions, you can really come across with an added rapport. And I know that this is an aspect of my femininity.

Moreover, there are some women that simply refuse to alter their feminine appearance into that of the uniform, white jacket and white shoes, even at the risk of being seen by others as "unprofessional" or "out of place."

> But there are a number of women who come in and just look like dolls, and they always have, even when we were sitting in class. Obviously, clothes and make-up and hair has always been very important to them. So, although there is strong pressure there, I don't think being a medical student necessarily robs one of opportunities to express their femininity.

Second, particularly single women students attempt to avoid the experience of rejection and stigma by others by simply narrowing their list of acquaintances to only those who can appreciate and understand them. Thus, many women, particularly in the later years of training, associate almost only with other medical, dental or graduate students whose identities are of equal social value to that of being a medical student, and whose lives are as equally constrained by demands on their time and energies.

Third, women medical students resolve a number of the issues between their being medical students and women by simply dissolving the stereotype of what a woman "is," and thereby individuating their identities as women. As one woman student put simply, "There are all kinds of men, and there are all kinds of women, and people are just more or less sensitive to different things." By individuating their uniquenesses, a number of the apparent conflicts and discrepancies between the identity of being a woman and a medical student simply disappear via fiat. Thus, as Berger and Luckman (1967) emphasized, people are both products of social reality as it is given, and the architects of that reality. If apparent problems arise in terms of conflicts

within reality as given, one available solution is to transcend the problems themselves by reexamining the assumptions of ourselves and others that are taken for granted, and simply recast them. Women in medical school, as well as women generally, have been seriously involved in the process of redefining the identity of "woman," both individually and collectively, for some considerable time now.

Fourth, most women attempt to resolve the "issues" between themselves being women and medical students by at least toying with the possibility of having to make a choice between having a career in medicine at the sacrifice of ever becoming wives or, even more likely, of ever becoming mothers. Some women possibly make the decision early on. For instance, in an admissions interview, one woman was interviewed by a woman surgeon who shared with the applicant what her experience had been:

> The one woman who interviewed me was a single woman, and had been all of her life. And we got to talking and she said that she never did have the time, and I believed her. She didn't feel that she could balance the demands of medicine and that of a husband and a family, and she wanted eventually to be a top-notched surgeon.

Or, as another woman student explained:

> There are a lot of contradictions about being a medical student and a woman. Being a medical student means that I probably will never have a family. I'm 31 now, and I have three more years to finish getting my residency done, and then I'll be 35, and then, oh...I think it has a lot to do with socialization too. Most of the women that I've talked to in medical school have found it really difficult to establish relationships with

> men, especially for single women who are older. For another thing, once you're 30 and single, there aren't that many single men around. And then a lot of men don't like to go out with somebody in medicine because they don't want to put up with shitty schedules.

However, it must be emphasized that, for most women, such major decisions are usually never made; rather, they are toyed with. But in doing so, women heighten the awareness of their lives, and in an anticipatory way, prepare themselves by conjuring images of the many different directions that their lives may take. Thus, as one woman student demonstrated:

> I think back on it now, and if there were ever a choice, I would be a doctor before I would have a career as a mother or wife. It would be too bad never to have a family, but it would be even worse to have never had a career. At one time, marriage and a family seemed so self-evident. Now I just don't know.

Finally, in articulating their identities of being medical students and women, many women deal with the problems of achieving a viable symbolic calculus between the two by simply living with the problems and the ambiguity that they face, and look forward to a change in the future. Yes, they become poignantly aware of the "issues" between their being women and medical students and, yes, they attempt to resolve those issues as much as is possible. But some issues are best solved by "putting them on ice" and living with them. Ambiguity is not the worst of all possible dilemmas for a person to discover

within themselves, or within their relationships with others; boredom, and the complete absence of conflict, is probably worse (Stone, 1970). And thus, a problematic calculus between one identity and another, while providing at least a workable, temporary articulation between the two, also holds open the possibility of surprise and creativity in fashioning a more complete gestalt of one's life in the future.

Medical Students as Adults: Problematic Articulation

The years that medical students spend in training constitute an ambiguous stage of life. Although almost all students hold a perspective toward themselves as adults, their perspective of being medical students, and their socio-economic dependence on the training institution, runs contrary to many assumptions and definitions of what they associate with adulthood itself. Age-wise, and social psychologically, medical students have "arrived" as adults. They evidence tremendous commitment to their work, and generally a great conscientiousness toward themselves and others. They are exceedingly responsible, capable of assuming heavy workloads, and enduring immense personal sacrifice for what they think is important, both for themselves and for others. And socially, many are also spouses and parents, and some are single parents. In short, these are mature beings, perhaps not experienced in many different worldly things, but exceedingly experienced in terms

of their education in science and medicine, and in other, more mundane matters such as hard work, responsibility, and commitment.

However, particularly in terms of their age, medical students, as Dr. X said, are "late arrivals in the game of life." For instance, Neugarten (1968:22-23) noted:

> Age norms and age expectations operate as prods or brakes upon behavior, in some instances hastening an event, in others, delaying it. Men and women are not only aware of the social clocks that operate in various areas of their lives, but they are aware also of their own timing and readily describe themselves as "early" or "late," or "on time" with regard to family and occupational events.

In terms of their age, medical students are actually both "early" and "late" in their arrival to the stage of adulthood. First, in terms of all the aforementioned characteristics (responsibility, commitment, etc.), medical students are early, particularly in view of their pre-med training. Moreover, the study of illness and disease, and their confrontation with serious illnesses, death, tragedy and misfortune carries with it an immense social psychologically maturing effect. As one student noted:

> Your life becomes stricter because you have been given responsibilities that are far greater than most people. Moreover, you have to adjust to seeing a very different side of people, mostly evolving around illness and death. What becomes common place to you, say, anal fissures, will gross the hell out of most people. That in itself requires a little more maturity than most people have. You have to learn to deal with it. And it matures you because it is a very sobering thing. And all the

> time you are going to medical school you are taking on more and more responsibility. So in many ways, there's a kind of heightened sense of being an adult.

However, in other respects, medical students are also "late" in their arrival to the stage of adulthood. First, socially, medical students are simply denied the where-withal while in school to live with the same socio-economic resources and the same sense of independence and security that they associate with what being an adult is all about. And for some, this provokes some tremendous consternation, frustration and feelings of powerlessness. Indeed, in their own right, such feelings in turn become powerful motivating forces for students to finish school and to get back into chronological step with respect to their friends and peers in other occupations.

But even more consternating than the discrepancy between their perspective of themselves as adults, while lacking for many adult years the socio-economic means to in fact live as adults, is their experience in medical school of being treated as if they were adolescents; some students say, infantiles. For instance, students feel that the nature of much of the training in medical school is based on a kind of adolescent humiliation and intimidation, or even less than adolescent. As one student noted:

> In the first two years of medical school, we were treated like third graders, and the information was just sort of poured on us, and we were supposed to memorize it and spit it back on the tests. And seldom were we even encouraged to think, or given any praise for thinking, and

> we definitely were not encouraged to think conceptually or independently.

However, as one fourth-year student expressed, being treated as a "third grader" applies to the clerkship years too:

> In this same rotation, where they are telling us that we should have the same responsibility as doctors, they then take roll at lectures! They're taking roll! And it's so degrading, you know. And they are filling up our time, as if we can't keep ourselves busy. For instance, today I had a patient that cancelled and they came in and wanted to know what I was doing with my time, like a kindergartner, so I wouldn't waste it. They take roll at lectures, as though you don't care about learning medicine, and like we have to have guilt induced into us; it's really disgusting.

Moreover, such feelings of humiliation and infantilization, which are directly communicated to students by medical school faculty and physicians, are compounded indirectly by the nature of the clerkship training. The effect of being moved to a new clerkship situation every four to six weeks can be a disorienting and confusing experience, wherein students never feel secure in "who" they are, or "what" they are, and never in full control of themselves. As expressed by a fourth-year student:

> I feel incompetent, confused, dependent, that most people around me know more than I do, know the system better than I do. And especially with this clerkship business, whenever I get moved to a new scene, I feel totally lost again.

Professional socialization in medical school, therefore, partially accelerates the sense on the part of students of being adults; yet, the process itself preempts,

in a number of significant ways, the possibility of students actually feeling or perceiving of themselves as adults. Accordingly, the ways in which students articulate their identities of being medical students with that of being an adult is inevitably achieved on the basis of a problematic calculus. Such a calculus involves, first, an acceptance of the ambiguity between the two identities of themselves. In doing so, students are thereby able to symbolically emphasize and acknowledge those aspects of being a medical student that do, indeed, enhance the sense of themselves as being adults; i.e., the themes of responsibility, maturity in dealing with life and death issues, commitment, and competence.

On the other hand, those aspects of being a medical student that tend to contradict students' sense of adulthood must simply be tolerated. However, as discussed in Chapter Six, such toleration is articulated with time. That is, professional socialization not only preempts aspects of students' sense of being adults; it also becomes a "solution" to the problem itself. As a highly scheduled and regularized career trajectory (Glaser and Strauss, 1971), professional socialization becomes a status passage to achieving full adulthood. Moreover, until the completion of that passage, professional socialization also serves as an unquestioned, socially validated rationalization or alibi that students use to neutralize the

discrepancies set up in the face of their being adults, yet "still just students." It, therefore, provides them an exemption from being less than adults in some ways, while instilling in them the capacity to face later in life, and to provide, more than what most individuals must ever do in being adults themselves.

Chapter Four

Multiple Identities in Articulation

The Behavioral Dimension

Inundation of Private Life

Multiple identities are mutually fashioned and acted out in behavior. However, although individuals symbolically embrace multiple identities of themselves, the behavioral expression of many identities, particularly those that are not simply worn on one's "cuff," can be problematic or untenable simply due to the sheer lack of time, energy, emotions or resources. Thus, multiple identities must be behaviorally articulated with one another in terms of time, energy, emotion and resources in order that the wherewithal necessary to express one identity or another is available. Put simply, individuals cannot "do" everything at once, even though, symbolically, they can "be" everything at once.

For individuals in medical school, the behavioral articulation of their lives exists as an immense problem. This is because their involvement in medical school tends to behaviorally inundate their lives, threatening to flood out the possibility of competing identities and relationships. For those students who also happen to be involved with others by virtue of being spouses and parents, such inundation of their lives and relationships has an even greater impact.[7] In turn, students, along with their

significant others, must by necessity engage themselves in a number of social processes, such as exemption, substitution, and scheduling that serve to behaviorally articulate whatever time, energy, emotions and resources remain for them to share as individuals, spouses and parents, after the fact of students' inundation with training.

In these respects, what is offered below is an analysis of the structural conditions, such as workload, schedules and priorities that create the inundation of students' lives with medical training. An analysis of the impact of such inundation on the families of those students who are also spouses and parents then follows, with specific focus on the processes that students and their families engage in to achieve a behavioral articulation of their family life. The analysis finally concludes with an examination of medical students as parents and spouses, and an analysis of a number of crises that can emerge in the process of behaviorally articulating those identities with one another.

The Inundation of the Medical Student's Life

As a process, inundation refers to an individual's life being flooded and dominated, at some times greater than others, by a substantively specific set of foci, concerns and rounds of activities. It involves an absorption and encapsulation of an individual's general range of identities, interests and activities into a far more

substantively delimited and radically focused order of events and concerns that usually pivot around a single, all informing identity. For instance, Lemert's (1967) brilliant analysis of societal reaction to deviant behavior examined how the multiplicity of an individual's life prior to arrest can become inundated with the overwhelming forces of criminal adjudication, incarceration and stigmatization, resulting in a life and identity that becomes centrally organized around the facts of crime, and of being a criminal.

In the case of medical students, for most individuals, becoming a doctor has been a "do or die" compulsion slowly kindled since early adolescence, further nurtured through years of grinding competitiveness, immersion in study and immeasurable sacrifice. Thus, it is conceivable that the inundation of some students with becoming a doctor is simply an extension of a "pre-med" attitude rooted extensively in personal identity and biography. Moreover, while the practice of medicine has traditionally been portrayed as a "magnificent obsession," the problem of actually getting into medical school for many individuals simply amounts to an obsession, pure and simple. And certainly, important criteria used by medical review committees in screening applicants are indices that reveal the degree to which students' prior dedication, studiousness and motivation over many years has been unflagging and total.

However, irrespective of any possible predisposing tendencies that may underlie each applicant's absorption in becoming a medical student, whatever unremitting drive or ambition that each may bring to medical school is easily matched, if not surpassed, by the demand conditions of the profound socialization processes that await each and every student. Moreover, it is precisely the nature of the socialization experience itself that yields the trained physician at the end of four years, as well as the latter's attending commitment to a professional oath and to the practice of medicine. This emphasizes that the forces that promote the possibility and reality of the inundation of students' lives with medical training are not rooted in individuals' personal psychology, or in their early socialization experience; i.e., medical students are not inherently "obsessive-compulsive," as some would say. Rather, their motivation is derived from, and a response to, the training situation itself within which they are situated. The properties "obsessive-compulsive" more aptly describe the nature of the training <u>situation</u>, rather than the students (see a similar arguement in Becker, 1968a). Thus, the forces that promote the possibility and reality of the inundation of students' lives with medical training are derived from, and rooted in, the professional socialization process itself.

The most apparent, inundating condition that each medical student immediately faces is a high demand workload.

To the extent that the objective of medical training is to elicit 100% performance from each student, the ongoing assignment of an imponderable workload both initiates and sustains the process. Medical students quickly discover that "you can never do all the work," and indeed the faculty typically forewarns each incoming cohort that "you'll never learn all that you can know, and just get used to it." Put simply, regardless of the volume of work or energy expended in any given day, there is always more work remaining. As one student expressed, "If I was to do all of the work, and read all that was assigned, I would be at it twenty-four hours a day."

A point worth underscoring, however, is that when it comes to the technique of studying, medical students are seasoned "pros," as it were. Regardless of the volume of work involved during midterms or finals, seldom do most medical students find themselves technically overloaded. Obviously, managing a workload is affected by a number of properties such as the skills, psychology, and previous educational experience of the student, as well as the number of competing problems that must also be managed outside of medical training. Thus, it is not uncommon to discover students who claim to find the workload in medical school neither intellectually or physically formidable. These are the students who "pooh pooh" what they see as the lingering, high anxiety "pre-med attitude" that many medical students continue to exhibit.

Nevertheless, irrespective of the extent to which most students may find themselves "pressed" or overloaded, the sheer volume of work that must be faced each day requires ongoing, conscientious attention, and in considerable quantity. Thus, whether some students find the workload to be exhilarating and a "snap," and other students find it to be grueling and painstaking, it is a condition that all of the students must continuously manage as best each one can. And it is a condition that is perpetually and endlessly absorbing. Structurally, there is always more work one can do, and one more hour out of each day that can be wisely invested in its behalf (cf. Becker and Geer et al., 1961).

A second condition that promotes the total immersion of students' lives with medical training is the fact that the nature of the training is inherently uncertain and risk-laden. Medical students complain of constantly "being on the spot," being caught off guard, having to face an endless number of exams and a myriad of changing problems, situations and expectations, as well as withstanding the brunt of constant faculty criticism. In terms of the latter, students describe what they call "pimping" by faculty members:

> It's really incredible, because on rounds and stuff, the staff will ask you questions that the students call "pimping." They will ask you questions, and they keep asking you questions until they make you feel about this high. They'll keep pushing you farther and farther

> until they've revealed the depth of your knowledge, or the strength of your ability to stay calm. And it keeps you constantly on your toes, and you read things for tomorrow in case they pimp you. Some physicians do this just to break you down, while others are simply trying to help you learn, and to find the end point of your knowledge, rather than as a put down.

Such problems provoke in students an unending anxiety and drive to always be on top, even though, as one student expressed in dismay:

> There is no way that you can win in that system. You will never be able to know all things, and therefore if you are asked something that you don't know, then you can be seen as a dummy. And you are always going to make mistakes, and people are always going to react at you for doing so.

Thus, the goal to always be on top can never be fully realized for exactly the same reason that all remaining work can never be finished.

To this extent, the problem each student faces on a day to day basis is that of gauging "when is enough enough?" For the first and second year medical students, practical resolution of the problem pivots around pacing oneself on the basis of structural indices; scheduled exams, classes, labs, and "breaks" provide definite benchmarks and goals that students can pace their energies toward in the knowledge that a respite is forthcoming. However, toward the end of the second year, the structure of exams, classes and the routine in general give way to a pace based more on keeping abreast from day to day.

Replacing the structure are "floating indicies" such as unscheduled events that develop in various classrooms, wards and clinic settings, ongoing exchanges with faculty, patient interviews and write-ups, problem cases and emergencies, special meetings and seminars, schedules that vary between nights and days, and shuttles between clinics, hospitals, classrooms, labs, libraries and home. For instance, as a second-year student explained:

> The first year, the objective was simply to anticipate and pass the tests. But the second year and beyond is different. Between working in the clinics, presenting cases, working up patients on one's own time, traveling, one has to keep day to day abreast of what's going on. You have to run wide-open, seven days a week. There are no clear benchmarks as to when one has done enough.

The result is that the pace becomes based more on the pace itself, which requires the maintenance of a certain continuous high level of activity and energy. Some students even rely on changes of bodily states and feelings as a measure of how much longer they can study, how many more hours they can put in before knocking off and getting some sleep. Upper-division students look back on the luxury of the 9 to 5 schedule in the first and second years, and the difficulties of having to now pace themselves "wide open" for indefinite periods of time. Which is to recognize that the progressive collapse of the structure of events and schedules from the first year through the fourth year of medical school, and the accompanying uncertainty of when one is "on" or "off," and for how long, feeds the drift in

the student's life toward inundation. As the pace becomes based on the pace itself, it generates a "natural" work orientation that strains toward a consumption of whatever private life of the student that many still remain.

In addition to the high demand workload, and the problem of pacing "when is enough enough," there are at least four other conditions that promote the inundation of the student's life in medical school. Regardless of the demand of the workload and the uncertainty of the pace and schedule, the study of medicine for many is an inherently fascinating and engrossing endeavor. It offers tremendous variation, drama, and wonderment; it can be extraordinarily challenging; and it provides innumerable opportunities to channel one's humanistic and expressive sentiments into the service of literally lifesaving and sustaining ends.

Secondly, training for the practice of medicine is imbued, both culturally and institutionally, with a large measure of moral and ethical meanings regarding "service," "duty," "professionalism," and even "mission." Many students even express a kind of guilt to the extent that, since they were blessed with the opportunity to be trained as a physician, it is in turn their duty in life to provide that service to those in need and live up to the standards of the profession. Such sentiments also include the very common feeling on the part of particularly minority students that, upon graduation, their intention is to remain in family medicine and make their skills available to many

of the lower classes and marginal groups in society.

Thirdly, the practice of medicine is one of the most highly valued and rewarded professions in society. Being a medical student, and certainly being a physician, carries with it tremendous social prestige, status, and authority. Such profound "reinforcement," along with the extensive moral overtones and the inherently fascinating nature of the work, all combine as an impetus toward a willing immersion on the part of students in achieving their ultimate goal.

And finally, in addition to all the above mentioned conditions that promote a life of total involvement, the unflagging commitment that the training requires of each student during medical school must thereafter continue to be sustained for an indefinite period of time. The commitment must be sustained through four or five years of medical school, and then through a year of internship, and then through three to five years of residency, and then through an unspecifiable number of years establishing and garnering the necessary reputation for participation within a professional referral system. This is to recognize that the commitment which underlies each student's capacity to manage both a high demand workload and a pace based on continual uncertainty, and to live up to the moral, professional and social expectations of the calling, strains inevitably toward an ever evolving, self-renewing, perpetual commitment through time indefinitely. Put simply,

due to the structure of the conditions that all medical students encounter their first day in training, preparing for and ultimately practicing medicine is not simply a job; it necessitates a total orientation to life.

The Impact of Professional Socialization on Family Life

Gaining acceptance to medical school is no small event. Not only does it instantly represent both a triumph and a consummation of many years of patient, ardous commitment and work, but as a rite de passage, it heralds the beginning of an entirely new status, identity, and occupation in the student's life. Among those accepted who also happen to be spouses and parents, the event is typically regarded by the student's family as an equally momentous opportunity. In such cases, attending medical school becomes a "master plan" for the family as a whole, a key to immense security, status and success, and a chance to share in a highly honored tradition and purpose. Accompanying the student to medical school is also looked upon by the family as a potentially exciting adventure, an opportunity to live among and meet new families and, not to be dismissed, a chance to possibly avoid the reputed routines, hang-ups, and "blahs" of a middle class, 9 to 5 family existence.

In these respects, upon gaining admission, the response on the part of the family in accompanying the student to medical school typically involves an enthusiastic and affirmative commitment. However, given the commencement of

training itself, as the strain toward inundation of the student's life gains momentum, its impact on family life is brought home by the student. Specifically, inundation of the student's life on one variable (occupation) generates complexity on all others. Competing relationships, events, activities and situtions have a geometrically greater chance of becoming problematic, stress ridden and hindering. Thus, when "push comes to shove," and the need for "give" emerges over time due to the nature of the demand characteristics of the medical school coupled with the student's own commitment, the "give" that must occur happens in the family. Certainly, it does not happen on the part of the medical school; nor, for all practical purposes, does it happen to much extent within the student's relationship toward the school. Thus, the initial commitment on the part of the family is put to an "acid test" by both the student and the medical school. Rather than remaining as a fantastic option for change in life, the commitment quickly becomes an unconditional requirement in order for the family to simply maintain itself.

On the part of the training institution, by its very design and structure, the medical school is oblivious to any competing priorities or needs other than its own. For instance, concerning the nature of the training program, in terms of its contents, schedules, demands and objectives, such concerns are dealt with by the faculty and

administration in a very protective, zealous manner for the exclusive good of medicine. Being charged as the keepers and executors of the "Holy Realm," those responsible are singularly committed to upholding and advancing the mission of medicine that they are both responsible for, and a vested part of.

In addition, this exclusivity of priority and focus also permeates the relationship of the medical school toward its students. Both morally and practically, the concern is to elicit optimal performance from each student. To this end, in screening and interviewing particularly those applicants who are also spouses and parents, the medical school is specifically intent on gaining the unequivocal assurances that the family will in no way be a hinderance or a drag on the student's total involvement and effort. This is because, given the commencement of training, the school is by and large not interested in having to deal with any excuses, exceptions or "problem" situations that derive from students' private life. Rather, the school is concerned that each student be in a position to assume total responsibility for their actions, and to be capable of performing in a way commensurate with that of practicing physicians, i.e., in an independent, responsible, self-motivating capacity. Indeed, the whole essence and thrust of the socialization processes in medical school is to yield the model professional: a super individual in terms of autonomy, judgement, commitment,

motivation and magnanimity.

Turning now to the student's relationship toward the medical school, the capacity for "give" in working out special arrangements or individually tailored programs is extremely limited. For sure, many medical students express the fact that arranging special circumstances is much more possible now than it was in the 1950's. Occasional course incompletes can be taken; students can elect to graduate in five years instead of four; Student Affairs, Student Health and various deans' offices are available for ameliorating and working out emergent difficulties such as illnesses, childcare hassles, economic problems, schedule conflicts, and personal and family problems. However, what needs to be emphasized is that such "difficulties" are still looked upon institutionally as just that - extenuating circumstances. Special arrangements are not to be assumed as a priori prerogatives or privileges in ways even remotely similar to the flexibilities and options characteristic of graduate level academic programs. In distinction from the latter, students are severely limited in fashioning their own programs, schedules, courses and pace; and options as to taking incompletes, dropping courses and taking leaves of absence are only grudgingly granted in individual cases.

Another factor that needs underscoring is that, for reasons already enumerated, the relationship of the student toward the medical school does not "naturally" drift in the

direction of sustained flexibility and individual accomodation. Due to the high demand workload, the uncertainty of the pace and schedule, and the moral, professional, and social attributes of the work, the commitment of the student strains towards a relationship of total involvement. And as indication of this, when pressures and demands in the life of the student accumulate, whether they be due to the exigencies of training, or from personal and family sources, the student will invariably sacrifice or postpone anything in order to stay in school and "on top" of it. As one woman student noted:

> If there are conflicts that develop between my family and the medical school, inevitably the medical school wins. It depends on what the situation is though. If I'm on call at the hospital, regardless of what happens at home, I'm going to be at the hospital. And that's just the way it is.

In general, students are very reluctant to approach the faculty requesting "special considerations" for fear that it will taint their hard won successes and make them look badly in the eyes of the very people they are striving to emulate. Moreover, arranging special considerations patently goes against the thrust of the student's whole objective. The point is to appear "together" regardless of the pressure, to be in control at all times, and to invariably act "sharp" regardless of the circumstances. Put simply, the standard against which all students are measured, and toward which each one strives, is that of the ideal professional personified in every action

situation.

Accordingly, when the need for "give" emerges, it is the family that must largely make the adjustments necessary to accomodate the unconditional commitment of the student to live up to the exceptionally high expectations of the medical school. Thus the so-called "test" of the family's commitment brought home from training by the student pivots around the family's success over time in balancing its own needs, activities and values in relation to the overriding priorities and imperatives claimed by both the medical school and the student. To this extent, in the face of the student's inundation with the process of professional socialization, the family must engage in a complex process of balancing its own imperatives and activities around, within, and after the fact of the inundation brought home by the student by virtue of the latter's participation in medical training.

Articulating Family Life in Medical School

As involvement and intensity with medical school increases, a reciprocal tendency on the part of students is to control and minimize all competing or ulterior demands and distractions on their lives. Indeed, for students who are single, this tendency can become so pronounced that some, particularly women students, express anxiety over whether they will ever be able to carve out the necessary time from their careers in order to bear children and

raise a family. For instance, as one woman student noted, who was already married and a mother of two children:

> A lot of my friends think that I am really lucky to have a family and kids. Especially some of the female students, because almost all of them think that they want to have families, but they have absolutely no idea when they'll be able to fit such a thing into their lives.

However, for those students who already are spouses and parents, the tendency to minimize all competing demands creates a dilemma for the family in that any claims or demands it may assert fall increasingly vulnerable to being seen or represented as obstacles and hinderances in the student's way. To balance its claims on the student, and thus defuse the potentiality of such a conflict, one of the many adjustments the family will make is to grant whatever degree of behavioral exemption from family life the student deems as necessary in order to live up to the standards of training. Moreover, the "reasons" for such exemption claimed by the student will in fact be the very same reasons that bring about the inundation of the student's life. The justifications for exemption will involve references to the unremitting workload ("because I have so much work to do"), or the uncertainty and continuousness of the pace ("because I can't afford to take time off and still keep up"), or the extraordinarily high moral, professional and social values bestowed on becoming a doctor ("because this is the most important thing in my life to do now").

It must be emphasized, however, that the exemption the family affords the student is a behavioral exemption, not a symbolic one. That is, as discussed in Chapter Three, most students' involvement in medical school is usually seen, symbolically, as either "blended" with, or "instrumental" of, their identities as spouses and parents. However, such symbolic articulation in many instances does not obtain. Thus, in situations where a student requires behavioral exemption, the exemption itself can be seen by others as compatible with, or as symbolic breach of, their identities and roles as spouses and parents. In turn, either definition creates a number of different consequences in the student's relationship with himself, as well as with others. The consequences produced by a symbolic breach are discussed in the last section of this chapter. For the present discussion, the features of behavioral exemption of the student from family life will be considered here within the context that the student's symbolic relationship toward himself and others remains essentially intact and unquestioned.

Students' behavioral exemption manifests itself in two different dimensions of family life. The first involves a "physical" exemption from those activities that generally constitute the work order of the family. Not only are students granted whatever time away from the home that, in their judgement, is necessary for training, they

are also granted a large measure of exemption from having to attend to such home related activities as, for example, cleaning clothes, washing and vacuuming floors, making beds, cleaning bathrooms, taking out garbage, running errands and buying groceries, babysitting, and shuttling children to and fro. Moreover, students typically find themselves exempt during the school year from having to provide a family income.

The second dimension involves a "social psychological" exemption of the student from, while being in the physical presence of the family, having to be either empathetically available, emotionally responsive, or engaged in many of the ongoing, spontaneous activities of the family. For instance, as one student noted:

> A lot of the time when I am able to be home, I simply don't have the physical energy to respond to my husband or children in the ways that I should. And this is almost directly proportional: the harder I am working at the hospital, the less energy I have for home.

Thus, in the midst of "being together," it is typical to find students silently working away at a modest pace, sustaining an active noninvolvement and disattention toward various family members and activities. Even on family outings, Sunday drives or picnics, it is not uncommon of students to drag along a book or two in the hope of taking advantage of a few precious moments on the road or elsewhere, time enough to review a dozen pages or memorize a few more facts. Every little bit helps. Indeed, a

characteristic boast of most medical students is their refined technique, developed over the years of training, of being able to maintain their concentration and study in the midst of all kinds of "distractions" and "disruptions." For the family, what this requires is exempting the student into a special status that allows them, social psychologically, to phase others in and out of immediate consciousness according to the student's discretion of what is most important at the time.

In addition to exemption, another important articulation process that the student and the family will make in order to strike a balance is that of substitution. Put simply, to the extent the student is exempt from attending to a number of activities and needs of the family, by necessity, someone else must compensate by assuming additional responsibilities. Medical students and their families speak frequently of the various "pressures" and "threats" that seemingly impinge upon their situation. Included here are not only the intrinsic problems of the student associated with attending medical school itself, but also the problems of the family associated generally with supporting the student in medical school year after year, as well as keeping the family financially and emotionally afloat in the meantime.

As discussed above, the inundation of the student's life leads to a highly focused, total kind of involvement toward medicine itself. Such a specificity of involvement

on the part of the student necessitates a reciprocal diversification of involvement on the part of remaining family members in order to meet those accompanying needs of the group that would otherwise go wanting. However, since there is an "ebb and flow" in student's inundation with training, during periods of slack time and on vacations, students are able to resume more of the activities as spouses and parents. As one student noted:

> The thing is, also, that my situation keeps changing so frequently as I change clerkships. And each change involves a change in time and emotions and energy. And like, this last clerkship in internal medicine, I needed my husband to be able to fill in all the gaps at home. All of the home responsibilities, etc., I couldn't do any of them. And he was real good about moving in and doing it. Other times I have more time, and I say "Honey, I know that you've got 'this' coming up, so I'll take care of 'this' for a while." So we go back and forth, trading off, trying to decide who needs what and when. So it's an ongoing process.

During periods of inundation, student's spouses frequently express considerable concern over having to assume responsibility for almost the total range of problems involved with managing a family on a day to day basis, such as bringing in a partial income, cutting down on expenses and managing a tight budget, getting the student and the children to school, nursing illnesses, maintaining the home, doing the shopping and preparing the meals, and in general, keeping everyone satisfied. As with the student, many times the entire burden for the spouse

becomes simply too much, particularly when a number of problems converge at home such as illnesses, car troubles, money hassles, childcare problems, pregnancies and special occasions such as holidays. In such cases, because the student is neither in much of a position, or so inclined, to make "special circumstances" at school, more distant family members and relatives, and even friends, are called to fill in. Thus, during the four or five years of medical school, it is not uncommon for families of medical students to seek the help of "reinforcements" on many different occasions in order to simply keep the student in medical school, and all other attending problems of the family ameliorated.

Finally, in order to strike a balance, not only will the family make the necessary adjustment of exempting and then substituting for the student, but when situations arise wherein specific needs, activities, and interests simply cannot be met, the family will then typically "table" or reschedule such items until a later date. In general, attending medical school is looked upon as inherently involving considerable sacrifice. Thus, when conflicts in schedules emerge between the student and the family, it is almost taken for granted that many otherwise important things must be postponed until a more appropriate occasion.

Essentially, the problem facing the family is that of <u>scheduling</u> its own plans and activities so that they

conform to the convenience of the student's schedule. To this end, the "solution" to the problem is for the family to schedule itself so that its own activities are inversely related to those times during which the student is pre-occupied, both physically and social psychologically, with training. Obviously, to the degree the student's schedule can be anticipated, the more likely becomes the possibility of fitting the family back into the student's life. For instance, as discussed above, because the first two years of medical school are far more structured in terms of classes, exams, and labs, etc., the family is in a good position to schedule itself in anticipation of any upcoming breaks, pauses or vacations that the student can elect to utilize for purposes other than studying. However, inasmuch as the structure of training becomes progressively more elusive later on, and to the extent the student begins to think and behave that much more like a professional, the structure of training against which the family can schedule itself becomes not only less certain, but also less relevant. Thus, many of the plans and activities of the family that need to be tabled until later on are threatened with the prospect of being tabled indefinitely.

Interestingly, implicit in all of the adjustments that the family is required to make is a vital assumption about time that, as expressed by one student, "one of the things that makes it all worthwhile is that it soon will be over." In other words, implicit in the various accomodations that

the family will make in balancing its own needs and interests against the overriding priorities and demands of medical school, is a set of definite expectations that, first, an ultimate "pay-off" is forthcoming; and second, that eventual cessation is a promise. Both assumptions are pervasively embraced by everyone involved. Moreover, both serve as an obvious kind of buffer or hedge against the strain, workload, and sacrifices that that the family and the student must shoulder respectively. Indeed, as time goes by, whether the family is willing to continue making the necessary adjustments in order to strike a balance is very much contingent on the extent to which both the ultimate pay-off and the promise of cessation become closer realities, or remain as elusive, perpetually distant dreams.

Balancing as a Way of Family Life

In having to make the necessary adjustments to accomodate the unconditional commitment of the student to live up to the unremitting expectations and demands of medical school, an additional requirement of the family is that the process of actually making such adjustments must not itself create even further problems and pressures to be reckoned with. Rather, not only is the family expected to balance its own needs and activities in alignment with the overriding priorities and imperatives of medicine, but it is to do so in ways that are ongoingly unproblematic and

unburdensome. In this sense, both the student and the medical school anticipate that the family will function as a kind of enduring, self-regulating equilibrium. The family is not supposed to be a source of additional problems; it is expected to be a "given" that can be more or less assumed. This is for at least two reasons, both of which are implicit in the above discussion.

First, if the family defaults for whatever reason in either exempting and substituting for the student, or in tabling its own needs and activities into some kind of modest and convenient schedule, the student's situation - which already strains toward inundation - becomes unavoidably frustrated and crisis ridden. For example, as explained by a student whose family was unsuccessful at exempting and filling in:

> And I would come home feeling, wow, I really put in a hard day's work. And as far as my wife was concerned, I'd put in zero for her, and for the kids, and I just felt wronged myself. And when I was confronted with this attitude, I'd come home and the house would be a mess, and I thought, what the hell have you been doing, having coffee with the neighbors all day long.

But even more to the point, if the family does not take the necessary measures to strike a balance, then the student's position ultimately becomes untenable. As a student's spouse explained:

> If he wants medical school, fine, but help me also. And when I did say, "I really need help, come home I can't take it any more," he'd come home and he was like..."God damn, look what you're doing, you're sabotaging me,

and you can't handle your part of the bargain."

Interestingly, the typical response on the part of most students when they find themselves straining to maintain some schedule or pace in medical school, and yet are confronted with unanticipated pressures from the family, is to simply "bail out" of the family, at least temporarily. On a day to day basis, students will take refuge by studying in the library, labs, classrooms, or friends' apartments. If necessary, they will take a private room in hotels or dormatories. In other words, for reasons mentioned above, medical students will go to extreme lengths, if necessary, in order to stay on top of medical school. Exceptions to this tendency are very few. Thus, if the family is to maintain itself as a whole, it has no choice but to strike a balance because anything less will not work.

Secondly, the family is expected to maintain itself as a "given" not only because the problems and pressures created by failing to do so generate havoc. But, in addition, the family must exempt, substitute and minimize its claims on the student because, in terms of the extraordinary value, prestige, and importance attributed to the student's work and ultimate purpose in society - that of becoming a physician - the position of the family in comparison is inherently subordinate and subservient. The family is in no "position" to make any claims on the

student that compete or obstruct those of the medical school because of its own position; in terms of institutionalized authority, status and power, the position of the family is utterly inferior.

In contrast, the student's position is backed up by the entire tradition and institution of medicine, its honor, urgency, mystique, wealth and power. In this sense, any claims of the family that contest or hinder the student's mission in medicine is backed up only by whatever degree of audacity and boldness the family is able to muster on the basis of its own, meager resources. But when "push comes to shove," the degree of legitimation and authority of the student's position inevitably overrides that of the family on a day-by-day basis, except possibly in matters of life or death. And yet "matters of life and death" is precisely the ultimate, institutionalized justification for the family's subservience to the position of the student.

For these reasons, what is ideally expected of the family by both the medical school and the student is to maintain itself in a kind of an internally adjusting, self sustaining equilibrium. And, although this presents the family with some very difficult problems involving exempting, substituting and scheduling itself for the convenience of the student, most families go to great lengths to comply, not only because it has to in order to maintain order, but because this is what is socio-culturally and

institutionally expected of it.

In addition, however, the family also complies because implicit in its relationship with the student, as well as the student's relationship with the school, is, as mentioned above, a promise of eventual cessation of such problems and pressures, as well as an ultimate pay-off. And although most families have some difficulty in specifying even an approximate date for the arrival of both events, their significance plays no small role in bracing both the family and the student's commitment.

Medical Students as Spouses and Parents

The behavioral articulation of students' involvement in medical school with their identities as spouses and parents is achieved by virtue of the family exempting the student from engaging in many activities of family life, substituting for the student's absence, and scheduling its own needs, activities and goals at the convenience of the student's schedule and needs. All of this is frequently done matter of factly and without many problems, except those of a practical nature.

However, for a variety of reasons, the student's behavioral exemption from family life can come to be seen as incompatible with, or a breach of, their identities as spouses and parents, and then a great many problems of both a practical and a social psychological nature can surface. In such instances, the symbolic "grounds" for the

behavioral articulation of the student's involvement in medical school begin to dissolve, and engaging in the process of exemption, substitution and scheduling become issues of conflict and contention.

First, particularly for women students, usually from the very beginning, their identities as students are not seen, symbolically, by either themselves or their husbands, as "blended" with their identities as wives and mothers. In other words, their identities as students are not seen as either simultaneously fulfilling, or instrumentally relating to, their identities as wives and mothers. Thus, as one divorced student explained:

> As far as my husband thought, my role as a spouse and a medical student were completely mutually exclusive of one another. And I know that this is true of most women students generally because I've talked to some other women in my class who are still married, and it's been that. For women, it's alright to be good in your career, but you not only have to be a good wife, you have to be a super wife.

A single parent, woman medical student echoed the same feeling:

> You see, for a woman, you don't see being in medical school making you a good parent. When I look at it, I feel like I'm in medical school because of me, and that's selfish, because it takes away from being a good mother. I would never say that going to medical school is an integral part of being a parent. And in the same way that some women feel like they have to be super wives if they are also going to be students, I feel like I have to be a super parent. I mean being a parent has to be separate from being a medical student, and that I have to make up for this.

In the case of men students, their behavioral exemption from family life can also come to be seen as a "problem," but usually for different reasons. Foremost is the problem of sheer resentment on the part of students' wives. As one wife described:

> I felt very jealous of school, and I felt like John was constantly choosing school over my health and well-being. I remember one time when John and the two kids were all down with a high fever and sore throat, and I had slept like five hours in a period of three or four days. And I felt like, wow, I just can't take it. It was too much! And then John recovered, and then I felt like, ok, now I can sit back and be taken care of - I needed sleep - I was exhausted. But John had already missed a couple days of the clerkship, and so he couldn't take the time off to let me sleep even one day! And I felt like, here I had been giving help for several weeks, can't you give me one day. So I called John at the hospital, and I told him that I just couldn't take it, I need to get some sleep. And he said, "No, no I can't leave." So I said, ok, I cannot take it. If you don't come home, I'm going to take the kids and the car, and drive over a cliff! And I was! So then he came home, and he was very angry and said that I was trying to sabatoge his life.

Second, due to the feminist movement, many women are simply demanding that all responsibilities of home life must be shared equally, and they are demanding that their rights to careers, no matter in what field, must be given equal priority as their husbands' careers in medicine. Thus, as one male student lamented:

> I had all these demands at school, and I would come home and the only way that Mary would be willing to stay at home was if I would do more work at home. And I felt that that was totally impossible. I just had to get home and read and study, and she was

> demanding that I not do that, and that I help with the kids, and help with this, and I felt like she was very unreasonable.

However, whatever the reason, if individuals' identities as students come to be seen by themselves or by their families as incompatible, or in conflict, with their identities as spouses and parents, there are a number of general responses that students will initiate in order to ameliorate the problems that surface. Nevertheless, due to the demand structure of medical school, each of these responses introduce their own unique assortment of lingering problems.

In general, students will attempt to minimize the extent to which they require exemption from family life. To do this, students usually pursue two basic approaches to solving the problem. First, students decide to intentionally lower their academic standards and forego that extra level of involvement of doing research or studying that is necessary to get top academic marks. As one student noted:

> I know that if I hadn't had a family that I probably could have been in the top 10% of my class. I've got the ability to do that, but I have other priorities. I've hit a compromise. My academic standards are going to have to be a little bit lower so I can accomodate my family. And I've talked to other women who've said the same thing, that they are going to have to lower their academic standards, and even though they've been used to getting A's. And I've learned not to let it bother me too much. But it has showed: I didn't do too well on most of my exams.

As another student noted:

> Because of my family, and my involvement with my children, in comparison to other students, I'm not able to read all the journals on the side, I don't know all differentials for all the different lab values - I just don't know as much as many students. I'll go in and present a patient, and be basically unprepared in terms of the pathophysiology. I mean, if someone is going to quiz me about it, I'm not going to have the answers. And I accept that. Part of that is that I'm not going to be able to put as much energy into preparing a patient presentation as somebody else.

Second, students will make an earnest attempt to equalize their participation in the family. As one student described:

> Because both my wife and I have our own career, everything about the house and taking care of our son is divided equally. Whoever is home first cooks, whoever has a few minutes runs and does the laundry. Of course, at times it makes friction, but there are times we are both so busy that we get on each other's case.

Moreover, in order to prevent one's involvement in medical school from totally displacing, or indefinitely postponing, the opportunity to in fact bear children and raise a family, some women even chose to become pregnant while in training itself, and of course, the wives of male students do likewise. This, of course, is an extremely big decision, especially for women students, and also for those men who are committed to equally sharing the day to day responsibilities of raising their children. However, there is growing support, at least among students themselves, for those individuals who are daring enough to refuse to let

their involvement in medical school flood out their private and family lives. As one student noted:

> Most women are really supportive of those students who become pregnant. Most of us were really excited for them, and wishing we could do it too, and wishing them the best of luck. And I personally feel that the more people who are able to balance their motherhood and their studenthood, the better that looks for women. It's a big task. If X number of people in our class have gotten pregnant and gotten through school and maintained their marriages, then that's beautiful.

The unfortunate fact, however, is that it usually does not turn out that way. Students can attempt to minimize the extent to which they must exempt themselves from family life, or schedule their future lives more in terms of their own needs rather than their training schedules. And they can attempt to do this either by lowering their own academic standards and level of involvement in medical training, as well as equalizing their participation in family life. But doing so creates a number of weighty problems which, in turn, must also be resolved.

First, in electing either of the two options above, students open themselves up to the possibility of facing scathing criticism from the medical school, as well as criticism from other medical students. For instance, medical training reeks of a "Holier than Thou" attitude and, as in some religious orders, there is a great display among members as to who is the most righteous, the most committed, and the most dedicated. In these terms,

medicine is a most zealous profession, and there is a great deal of put down and mockery of the "old country doc" and others who are not up on the latest issues and developments, and who do not display one hundred percent commitment to the mission of medicine. Thus, for those students who dare to give equal priority to their involvements with their families, or who dare to settle for second best, or even average, in their performance as students, put themselves in the position of experiencing the "wrath of God." For instance, as one third-year student described the reactions she received toward her being pregnant:

> You know, you have no commitment to medicine, you're not really interested in doing this, you're diverting your energy. And that is in fact what the people in my OB clerkship said. I felt absolutely no support from them. And one person told me that I had better begin thinking real hard about having an abortion. And he said he didn't think that women should be in medicine, and that they are always going off and doing things like this.

In general, particularly in terms of screening new applicants, and in the priorities and schedules that are dictated to students, the message in medicine is clear: There is no room in medicine for people with split loyalties and conflicts of interest, or who are mediocre or satisfied with being anything else but the best.

A second problem, particularly for women, is that, because they have been categorically discriminated against in the past, there is great anxiety shared by women that

if they do not prove themselves to be as available for training as are men students, and as committed, then women in the future who apply to medical school will suffer again. Thus, for women to maintain an equal involvement in their families, or certainly to bear children while in medical training, heightens the intensity of that anxiety itself. The result, therefore, is that in maintaining an active involvement with their families as they feel they should, women in turn generally feel that they must perform at an even higher level in training than what is necessary. Thus, as they describe themselves, many women must become super human beings - super wives and mothers, and super students. Thus, as one woman noted:

> So you find these people getting up at six in the morning to cook their husbands breakfast, and rushing home to cook dinner and spend time with the kids, and then studying way into the night before they go to bed. So they try to be good as students, you know, 100%, and then they try to do the whole fantasy trip of being a housewife too. They <u>have</u> to become super human beings. And you see women complaining about this.

In much this same context, the final problem that students frequently experience in attempting to minimize their exemption from family life, which frequently requires them to minimize their involvement in medical training, is that rather than their lives becoming inundated on one level, <u>it becomes inundated on two levels.</u> And, because the student's position becomes a compromise by necessity in terms of both their involvement in training, and in

their families, the possibility of not finding a sense of satisfaction or fulfillment in either family life or medical training becomes that much greater. For instance, as one woman student noted, who felt great responsibility as a mother and as a wife:

> When I'm involved in training, the house goes to hell, my husband complains and his needs are not being met, the kids complain. And the experience of tending to a lot of pressure at school, and then coming home and finding a lot of pressure at home - I just feel like everywhere I turn, I am inadequate. I don't think anything has ever hit me as hard as that. But the thing is that you can't be super mom and super student. I've tried, and I find myself failing at both.

Or, as similarly expressed by the woman student who decided to get pregnant during her third year in training:

> Well, as you know I'm now pregnant. And as a result of my being in school, I don't spend as much time "being" pregnant, and thinking about it as I had hoped to do. And I've been really angry that school seems to take so much time, and that I don't have time to get the baby's room together, or exercise as much as I would want to, and that I'm just really pressed for time. And I don't know what that is going to do when the kid arrives.

Thus, in summary, students initiate a number of responses to ameliorate the problems that can surface from their having to exempt themselves from family life, and from expecting the family to substitute for them, and schedule itself in terms of the student's schedule in training. However, while each of these responses ameliorate certain problems, due to the demand structure of medical training, each response creates another assortment of lingering

problems. Accordingly, while students do find that they are able to achieve a behavioral articulation of their multiple lives, that articulation is continuously plagued with problems, whether of a practical or of a symbolic nature. Thus, the most central discovery of many medical students is that, no matter what ameliorative steps they take, inevitably they find themselves "damned if they do, and damned if they don't."

Chapter Five

Multiple Identities in Articulation: The Situational Dimension

Time "On" and "Time Out"

Identities have their own relatively distinct temporal careers, and individuals continuously grapple with the future in terms of scheduling the expression of certain identities over others. In this sense, participation in medical school involves a structured and highly scheduled status passage that provides clear markers as to when one's identity as a medical student must take precedence over other identities, as well as the date of possible pay-off when the realization of becoming a physician can then become a means for the realization, expression or support of other identities.

For instance, while the experience of being a student in medical school threatens to inundate one's life, flooding out and overwhelming all other competing identities and interests, the inundation itself tends to be scheduled and, thus, predictable. Students are aware of which clerkships are notorious for taxing all of one's time and energy, and which reputedly do not. They are also aware of, and prepare for, the reoccurring periods of examinations, such as mid-terms and finals, during which their absorption in studying becomes all-consuming and maximal.

Conversely, just as they can predict periods of inundation, students can also predict scheduled periods of slack time, vacations and respites from training. Indeed, during such periods, it is typical to find students feverishly attempting to catch up and compensate for much in their lives that they have had to temporarily abandon, postpone or neglect in the face of inundation with medical training. As one student described:

> There have been times, particularly after finals, when I was just incredibly hyped, and I didn't come down for three days. I couldn't sit still. I didn't want to delay anything for anybody, I just had to do it. If there was a movie that I hadn't been able to see, then I wanted to go now; some friends I wanted to see, let's go, no fucking around about it. In general, you always feel that there's a lot that you want to do, a lot of experiences that you want to take advantage of.

Similarly, another common tendency of students is to use periods of slack time to think through, and reposture themselves for, the changes that they will have to face brought about by new schedules or new clerkships, and also to think generally about their overall "game plans" in medical school and their future careers in medicine. As one student described:

> One important use of slack time that my husband and I use is preparing for the changes that we envision that are coming up, and that we'll have to get adjusted to. When you are in the middle of a clerkship, it's hard to think about what you want to do next year, and it's important to take that free time and think about it overall. Who has time to worry about when you're going to have your kids and how it's going

> to work out? You've got this patient, and you have reading to get done. So vacations are a nice piece of time to do some thinking.

However, as important and useful as respites and vacations may be, in relation to the amount of time that students are "on," medical training provides very little "time out." Simply, much of what students give up and postpone while in training cannot be recovered or compensated for simply on breaks. Thus, as discussed earlier, all students look forward to the day of graduation because that event holds for them a promise of cessation and an ultimate pay-off. Nevertheless, in many ways, both the promise and the pay-off, while immensely reassuring in the present, loom ominously precarious of ever being significantly realized in the future. Namely, students commonly note the possibility that, due to the nature of their internship, residency, area of specialization, and problems associated with establishing and sustaining a professional practice, many of the conditions in medical school that bring about the inundation of their private lives while in training, and the concomitant impact of such inundation on the student's relationship with others, are feared by some students and their spouses as holding a promise that offers merely an extension of their present predicament.

First, an important condition students note that may be largely unaffected by the pay-off of graduating is the

perpetuation of the high demand workload; there are always more people in need, endless pregnancies, emergencies, life and death situations to be faced, and one more hour out of every day that can be easily gobbled up in the fight against disease and misery. Moreover, although a 9 to 5 schedule is now a luxury that more physicians are reputedly able to enjoy, many do not, or they find themselves "on call" two or three times a week. In addition, students point out that, in actual practice, each physician's pace varies according to a myriad of uncertain situations and cases that they must be prepared to handle. The work demands an acute mind, steady hands, patience, an eye for subtle discoveries and deductions, and plenty of nerve in dealing with unimaginable calamity and risk. All of this, the uncertainty, responsiblity and pace, naturally yields a resolve, an anxiety, a preoccupation to always stay "on top of it," and to be continuously informed and prepared. Many students particularly emphasize the responsibility aspect of medical practice. As one student put it, "While in medical school, the school makes the demands that are relatively unnegotiable, but the thing is that the patients take the place of the medical school after one has graduated." However, the intriguing feature of responsibility over life and death situations, particularly as it progressively heightens students' involvement in medicine, is that the responsibility itself becomes such a positive motivating force.

As one fourth-year student explained:

> Responsibility becomes the great motivating force. And I'm just really getting used to it. When these patients come on the wards, I'm scared to death that they are going to die, unless I read about them and am really careful. And I've heard other people say those things, and for the first two years I didn't really feel that way. And the thing about this responsibility is that it is so much more of a positive kind of force, something that I morally want to respond to. And I feel like I am really digging down into the core of my insides or being. And I think that this is one of the reasons why a lot of people when they are interns just feel totally sucked in. But the suction is not negative, but positive. It feels good to be there.

Or, as another third-year student described it:

> ...this responsibility for your own patients and your own reading is much greater, and nobody is telling you to do this or that. You are learning because you need to have this information to help deal with your patients on a day to day basis. And this kind of responsibility greatly increases your involvement. I am thus much more motivated than I was before. When I was a first and second year student, I used to bitch a lot of having to put in so much time. And I'm putting so much more time in now and I'm not complaining about it. Except now I complain that I don't have enough time to deal with my patients. Now I would rather stay home on Saturday night and get reading done that I feel is important to me in terms of my patients.

Thus, the point is that, due to the increased responsibility, uncertainty, and the high demand workload, many students envision that their future practice of medicine is not an easily contained burden, amenable to being casually set aside at the end of each day. Rather, it is seen as a progressive invasion of all of one's life and

consciousness. Indeed, to be able to contain it requires a definite skill in itself, a skill in fact that students emphatically indicate is not taught in medical school, but must be developed in spite of it and on the basis of whatever personal resistance each future physician is able to generate and sustain.

And finally, many students note that, coupled with the unremitting workload and the inherent uncertainty and risk of the work, the physician's life, like that of the student, continues to strain toward inundation with the practice of medicine simply because the work can be tremendously fascinating and intellectually absorbing, and the combined social and economic rewards are among the highest one can receive. Moreover, the professional oath and responsibility that each physician assumes underlies a sworn commitment, a commitment in fact that is ongoingly evaluated by all other practicing physicians whose esteem and approval form the basis of each doctor's identity and validation. The result of all this is that students typically fear that the so called pay-off after graduation simply does not affect the conditions that bring about the inundation of their private life; indeed, the conditions not only persist, but appear to even gain in significance. To this extent, therefore, the degree to which the so called pay-off significantly affects or changes the student's relationships with others following graduation becomes similarly questionable. This becomes particularly

apparent with reference, again, to those students who also happen to be members of families by virtue of being spouses and parents.

The Pay-Off in Family Life

Given the observed likelihood of continued inundation with medicine in the indefinite future, students and their families begin to foresee that, in many dimensions of family life, the problems and processes that were faced by the family in medical school are simply not affected by the pay-off of graduation. For sure, graduation from medical school, or at least completion of internship, more or less guarantees the family a qualitative change in socio-economic circumstances. There is a great deal more money to spend, the family as a whole is accorded much more respect and status in the community, there are more opportunities for providing an education for the children, owning a nice home in a wholesome neighborhood, and for traveling and recreating.

However, in other significant dimensions of family life, students and their spouses see very little change. For instance, the differential between the new physician's position and that of the family, in terms of the former's prestige, authority and power, is in fact greatly increased rather than diminished. Indeed, in terms of the years and energy that have been invested, the student emerges as a super autonomous, highly revered, immensely

skilled professional, who has been trained and prepared to act with an immense sense of independence, authority and confidence. In recognition of this, society grants the physician the license to carry out the work of medicine according to the way physicians themselves think it should be conducted, including the privilege of evaluating their own performance, and of deciding how much remuneration their services should receive (Freidson, 1970).

On the other hand, the family's position, and particularly that of the spouse, does not undergo any fundamental change whatsoever. Indeed, in terms of the years and energy invested overall in getting the student through school, internship, residency and building a professional practice, the spouse's position possibly becomes even more dependent. This is particularly so in the sense that the only real evidence of the latter's investment is in terms of what the student ultimately becomes, as well as in sharing the portion of the pay-off that accrues thereof. But this is simply to recognize that, regardless of whatever the final, cumulative investment is, it is not a direct enrichment of the family in and of itself, but rather an indirect enrichment in terms of what side benefits the physician eventually brings home.

Finally, inasmuch as the differential between the physician's position and the family continues to exist in terms of relative importance, prestige and power, and to the extent the underlying conditions persist that promote

the inundation of the physician's life with medicine, the status of the family will continue to be relegated to that of having to balance its own needs and activities in relation to the overriding priorities and expectations of both the physician and the larger institution of medicine. As one physician's wife stated matter-of-factly:

> Not only is his own leisure repeatedly interrupted by the telephone and the demands of his patients, reasonable or unreasonable, but his wife and children are inevitably forced to some extent into the mold of the life's work that he has chosen...The home becomes an adjunct, to some degree, of the medical practice (Howe, 1954:15).

Accordingly, as the need for "give" persists over time, it is the family that will largely be required to make the necessary adjustments in terms of exempting, substituting, and scheduling its own needs and activities in conformity with the schedule and convenience of the physician. As another physician's wife wrote, "The mother of a doctor's children serves in a dual capacity. She is always mother; she is often a substitute father" (McCabe, 1954:32). Thus, the pay-off is frequently seen as in no way categorically affecting those expectations toward the family to function as a "given," an equilibrium that is assumed to adjust flexibly and unproblematically to the overriding priorities and needs claimed by the physician in the service of practicing medicine.

For these reasons, while the student and the family may receive a pay-off following graduation in terms of

certain well-earned socio-economic benefits, students and their spouses in many ways foresee that the actual conditions during training that necessitated the family's subservience in having to accomodate the claims of both the student and the medical school continue to persist relatively indefinitely. Thus the promise of cessation remains essentially that; a promise that is never forthcoming in a meaningful sense. And the necessity for balancing the needs and activities of the family at the convenience of the physician's practice of medicine comes to be seen as an end in itself, a way of family life.

Grappling with the Future

Given the prospect, whether real or imagined, of indefinite inundation by their careers with medicine, students early in their training become quite concerned over, and spend considerable time pondering, a number of decisions that must be faced in terms of articulating their professional lives with their private lives. In this sense, students' perceptions of their future careers in medicine feedback and impact on a number of decisions that they must make in the present regarding both their professional and their private lives. Moreover, the processes of symbolically rehearsing, and of sorting out alternative career plans with respect to one's private life, is a weighty business. As one third-year student noted:

> Thinking about the future is a major preoccupation. Sometimes when things get out of order in terms of things that I see happening to me, I get totally flipped out over it. Like, I can't pursue my other activities until I resolve the major question. The decisions have so many ramifications that you can't screw up.

Generally, students' concerns regarding their future professional careers pivot around three major problems, and the ways in which these problems are solved are greatly, if not overwhelmingly, influenced by the attitudes, values and goals that students hold toward their private lives. First, students must decide which specialization within medicine they should pursue. Now, obviously, making such a decision is influenced by the encouragement and recommendations of certain faculty members. On the basis of formal evaluations and informal kinds of reinforcement, students are informed by the faculty which areas among the various clerkships they seemed to show appreciable promise and aptitude. Such encouragement is part and parcel of the coaching and advising processes that are integral to the nature of professional socialization (Strauss, 1969). And students also become aware of which clerkship areas they personally find to be most intrinsically interesting and stimulating.

However, above and beyond these considerations, students' decisions regarding areas of specialization are greatly influened by their attitudes toward their private lives and, except for the most totally committed, students

select particular specializations in terms of a compromise between their professional and private lives in the future. For instance, as one third-year student explained:

> Now regarding a specialty, my choice is made almost entirely on its congruence with my lifestyle. For me it is very important to recognize that you have to compromise. You have to chose something that you're going to like, but also something that will fit your life goals; otherwise you're going to get yourself into hot water - you're going to end-up divorced, or something.

Or, as another third-year student described:

> For instance, my private life has very much influenced my choice of specialties. I'm thinking about going into anesthesiology. And one of the biggest reasons is that you can plan your private life, you can go to work at a certain time, and then come home and leave your work there. And you won't be bombarded at night with calls, or have to go out. But when I first went to medical school, I felt sure that I would go into family practice, and from there I went to internal medicine. But both specialties are just impossible - you get home and eat, and then go back to the hospital, and there's just too much daily disruption of your private life.

Second, students must decide which geographic area of the country they prefer to ultimately establish their professional practice. This decision invariably is based almost totally on students' attitudes toward their private life and, indeed, it probably accounts for the gross differential distribution of physicians throughout the United States (cf. Mechanic, 1968). Clearly, physicians' preferences as to where to practice are not based solely on professional decisions as to which areas of the country

are most in need of their services. Rather, almost in keeping with the sense of independence and autonomy that comes with being a professional, students' decisions as to where to practice are predominantly predicted on private considerations: Personal attachment to particular cities or towns, proximity to former families, relatives and friends, environments best suited for raising children, areas offering greatest prestige, economic rewards or opportunities, and so on.

Finally, students must decide how high in the profession of medicine they are willing to aspire. That is, given whatever opportunities are provided them, students must decide how much time, energy, resources, and personal investment and sacrifice they are willing to devote to medicine itself. As one fourth-year student observed:

> You have to make decisions as to how high in this profession you want to go. What kind of a doctor you want to be. You say, ok, I want to win a Nobel prize. Then, ok, you're going to have to put a lot of things on ice. On the other hand, if you want to be a family physician and work for Kaiser, then that isn't such a heavy commitment. For instance, and I could be wrong, but a lot of people who are not as compulsive as others are the ones that say that they want to go into family practice. But I know damn well that those people that just simply try to slide by know that they will not be the kind of physician to do heart surgery. And I think that a lot of people with this attitude and orientation to medical school are freed up to do a lot more outside things.

Or, as another student noted, "If you're going to be a high powered physician, surgeon, be in a good program and,

absolutely, if you're going to be an academic physician, you're going to have to continue to give your medical situation highest priority."

Now, obviously, many medical students, probably the bulk, are not interested in devoting the totality of their lives to their practice of medicine. Rather, what they look for, as in their selection of an area of specialization, is a compromise or trade-off between their professional and private lives. In terms of grappling with the future, such a compromise is a difficult and uncertain matter. Regardless of the decisions students make, there are still plenty of unknowns remaining, and the conditions that bring about the inundation of the student's life with medical school persist in one way or another in all medical specialities; certainly the high demand workload, the inherent uncertainty and risk of medical practice, the immense responsibility, and so on. Thus, as much as students may strive to carefully design their future professional lives in terms that are compatible with their private lives, uncertainty and anxiety persist. As one third-year, woman student noted:

> When I get really panicky, and wonder whether my life is going to stay like this - you know, am I going to have so little time and always feel so pressured, and wonder how we are going to survive with having children. But then I realize that I am now working about 80 hours a week. And when I think about establishing a practice that requires only 40 hours a week, if that can be done, then so much more seems possible. And having a family seems possible.

To the extent students attempt to plan their futures, but nevertheless continue to face a number of uncertainties and the threat of indefinite inundation with medicine, students hedge against the uncertainty itself with a sense of adamancy: Yes, much in the future cannot be controlled on the basis of decisions in the present; but regardless, one's life eventually can be brought under control in some way or some how if one is determined. Thus, there is a persistent attitude that, in one way or another, the future can and will be rendered according to one's own bidding. For instance, as one student emphasized regarding her upcoming residency:

> But regarding my residency, I see these people that are really consumed by it, and I have to say that this is troubling to me, and I'm having second thoughts. Maybe I should look for another specialty where you really get to go home at six or seven. For instance, I think that I would like to practice medicine about 30 hours a week; 30 hours where I would actually see patients, and then 10 hours where I would be able to read and study. But whatever my residency will be, I will contain and control it. I'm just not yet sure how that will be done, or what the residency will be yet. But I plan on having some control over my life again.

And so, while students' visions of the future feedback and influence many of the important decisions that they must make in the present, much that remains uncertain must be managed on the basis of sheer adamancy in favor of a change in the future; a future, however, that resists relinquishing its mirrored image of the present.

Chapter Six

Multiple Identities in Articulation

The Situational Dimension

A Situational Approach to Personal Change and Consistency

In analyzing the problem of personal change in adult life, Becker (1968) noted that, in what has now become a classic position in symbolic interactionism, individuals are continuously faced with having to choose from among a wide variety of situations, and in adjusting to any given one, the individual transforms himself in the process (see also Strauss, 1969).

> The person, as he moves in and out of a variety of social situations, learns the requirements of continuing in each situation and of success in it. If he has a strong desire to continue the ability to assess accurately what is required, and can deliver the required performance, the individual turns himself into the kind of person the situation demands (Becker, 1968:150).

Becker's important point, however, is that to account for personal transformation or change in adult life, all one needs to look at is the character of the situation that individuals respond to, the particular structure of demands, rewards, goals and expectations that the situation contains, rather than looking for attributes internal to an individual that may account for the supposed transformation. Or, as Becker (1968:150) explained:

> If we view situational adjustment as a major process of personal development, we must look to the character of the situation for the

> explanation of why people change as they do. We ask what there is in the situation that requires the person to act in a certain way or to hold certain beliefs. We do not ask what there is in him that requires the action or belief. All we need to know of the person is that for some reason or other he desires to continue his participation in the situation or to do well in it...Our further analysis must adjust itself to the character of the situation (Becker, 1968:150).

Interestingly, we have seen in the case of medical students a tendency to maintain a consistent line of activity and preoccupation with medical training in the face of innumerable situational alternatives. Particularly during periods of inundation, whether it be the situation of students' families, spouses, intimates or so on, students typically decline making the necessary adjustments called for by particular alternative situations of which they are virtually a member. The question therefore arises, if personal change in adult life can be explained by reference to the concept of situational adjustment, without reference to attributes internal to the person, can personal consistency across situations be explained in the same terms?

Becker's (1968) answer is that, no, personal consistency across situations must be explained by virtue of an individual's "commitment," which exposes a contradiction in Becker's thinking: If personal change can be explained without reference to attributes internal to an individual, why must personal consistency be explained by reference to an internal attribute such as "commitment?" Becker

suggests no answer. The position taken here is that the contradiction need not prevail: Both personal change and consistency can be explained by virtue of the notion of situational adjustment, without reference to attributes internal to individuals, particularly if the problem of what "is" a situation is reexamined.

Although Becker neglects to explicitly specify what he means by the concept "situation," an analysis of his use of the term reveals that situations seem to be organizationally and institutionally bounded; that is, situations are tied to "settings." Thus, as a given person moves through one setting to another, the person faces, as Becker (1968:153) would say, "a sequence of varied situations." Thus, "we say a person is committed when we observe him pursuing a consistent line of activity in a sequence of varied situations" (Becker, 1968:153). In this sense, Becker would suggest that the example of medical students feverishly absorbed in their study of medicine <u>while in the situation of their homes and families</u> can best be explained by reference to a presumed "commitment" that students hold toward their studies <u>while being outside the situation of medical training itself.</u> On this point, however, an obviously important question needs to be faced: While studying in the midst of their home and family life, are students actually <u>outside</u> the situation of medical training?

Without belaboring the point, the answer to the query

is as obvious as the query itself; no. To the extent that a social situation is understood as an organized, thematic line of interaction, frequently purposeful in nature, that calls for the performance of particular acts, and that is morally and normatively bounded with expectations - a definition that is ostensibly acceptable to most symbolic interactionists, including Becker himself - then there is no inherent or necessary relationship between settings and situations. Within any given setting, a potentially innumerable number of situations can emerge. Frequently the objects, boundaries and temporal features of a setting compliment, or are direct products of, or props for, a typical number of situations. But just as frequently, situations, or lines of activities between interactants, emerge within settings that are incongruous, foreign, novel, or even inappropriate to a setting itself.

To this extent, situations are not necessarily "situationally" bounded (to use the double meaning of the word, as Becker did); nor are they necessarily temporally bounded. Depending on the nature of the interaction, individuals can continue to carry out the performance called for by particular situations either in direct, face to face interaction with others; or they can continue to carry out a line of activity central to a situation itself, but that is temporally and spatially removed from an immediate, face to face interactional context. In this sense, to explain the example of students pursuing their

medical studies in the setting of their homes and families, or indeed, to explain the consistency of their behavior generally, requires one to merely note that students simply continue to respond to the demands and expectations held toward them by the medical training situation itself. In other words, there is no need to refer to internal attributes of individuals to explain personal consistency. As mentioned above, the label "obsessive-compulsive" most accurately describes the nature of the training situation rather than a personal attribute of medical students. Moreover, as was discussed in Chapter Three, the question of students' motives as to "why" they exhibit such perseverance and consistency in their efforts to manage the training situation is greatly variable; there are any number of intrinsic and extrinsic reasons, or "side bets," that may underlie each student's resolve. However, regardless of the varying nature of students' motives, the single most important "reason" for the consistency of students' behavior across time and space - a "reason" that is universally shared by all students - is the nature of the training situation that they collectively face; the demand structure of medical training requires a high order of consistency in students' behavior.

The overall training situation, therefore, that engages students in medical training not only calls out and defines a rather specific and unique identity - that of "student" during the first two years, and "student-

physician" during the clerkship years - it also establishes the conditions that promote a high order of consistency in individuals' behavior across time and space in the face of alternative situations. However, in spite of their immersion in medical training, as we have seen, students are also simultaneously participants in other situations, and they embrace many different identities other than that of being a medical student. Moreover, as also discussed above, such identities become articulated with and shape students' medical training itself; competing identities have a great influence on the level and quality of students' involvement in training, selection of areas of specialization and areas to eventually establish a professional practice, and a commitment to medical training and professional practice based on a number of extrinsic and private values.

Accordingly, in noting the pivotal importance of the process of "situational adjustment," what needs to be emphasized is that such adjustment is not a problem of students simply <u>adapting</u> to the requirements of situations; rather, such adjustment is much more of a creative process of students partially constructing the nature and significance of the medical school situation itself. In other words, situational adjustment needs to be understood as much more of a "role-taking" than a "role-playing" process (Turner, 1962). For instance, as Becker and Geer et al.'s (1961) research revealed, the most important or central

aspect of the medical school situation that students themselves create is a sequence of "student perspectives" on "how to make it" in medical training. Becker and Geer et al.'s (1961) research documented that, particularly during the first two years of training, students fashion a number of short term and provisional perspectives that they use to orient themselves to only specific aspects of the medical training situation; they begin concentrating on learning "only what the faculty wants us to know," rather than on "all that there is to know." Thus, they proceed to fashion their behavior as students by only selectively responding to all that the training situation potentially calls for; such selective involvement is accomplished on the basis of a pragmatic and provisional criteria of what is "really" important that students themselves introduce into the training situation. In other words, the nature of students' situational adjustment is a negotiated response to a situation that is part and parcel a product of their own making. Students' interjection of their own "student perspective" into the training situation changes the nature of the situation itself.

However, the perspectives that Becker and Geer et al. (1961) documented were only those that are grounded in, or extend from, students' perceptions and definitions of their situation in medical school on the basis of their specific identities as students only. In other words, as criticized in Chapter One (page 12-13), Becker

and Geer et al.'s analysis, as well as their twin analysis, Making the Grade (Becker and Geer et al., 1968), exhibits the same myopia of other interactionist analyses generally. The analysis, focused at the situational level, emphasized only the specific identity, and its accompanying perspective, that is seen to emerge within the training situation; and the identity itself is treated as largely unrelated to, and dissociated from, all other identities that individuals bring to a situation. However, given that students also collectively embrace other important identities, and that such identities become articulated with and influence students' situational adjustment to the training situation, there remain a number of other perspectives that extend from those identities themselves, and that serve along with the "student perspective" to creatively make up and shape the nature of the training situation and students' adjustment to it.

The Multiplicity of the Medical Training Situation

Just as individuals creatively assemble and transform the nature of the training situation by invoking a perspective into the situation itself that reflects their collectively shared identities as students, individuals also invoke a number of other perspectives, based on still other identities which they collectively embrace, that similarly transform and shape the nature of the training situation. What this implies is that, if we are to

understand the medical school "situation," and the nature of students' situational adjustment to it, what is required is a theoretical framework that reveals, and encourages us to look for, all of the multiple situations that indeed make up the total situation itself. In turn, what this calls for is an elaboration, or an augmentation, of the scope of the theoretical framework developed in Becker and Geer et al.'s (1961) Boys in White, particularly with respect to the following terms.

Most importantly, what needs to be included is an emphasis on the fact that many of the identities students collectively share are not entirely derived specifically from the training situation itself (as Becker and Geer et al. suggested was the case of the identity of "student"). Rather, many collectively shared identities are brought into the training situation from outside. Thus, just as Schatzman and Strauss (1966) argued that the nature of a profession is changed by virtue of professionals' identification with various public movements and ideologies that exist outside the profession itself, so too the nature of a professional socialization process is changed by virtue of participants' collective identification with various social movements and reference groups that exist outside the socialization process. Most noticeably, such identities provide the conditions for the emergence of entirely new group perspectives that reshape the situation of the professional socialization process itself.

Secondly, what needs to be emphasized is that such perspectives that derive from identities brought into the medical training situation orient students toward entirely different aspects, issues and interests in the training situation than does the student perspective. While, as Becker and Geer et al. (1961) noted, the student perspective pivots around the central concern of "how to make it" in medical school in terms of managing an overwhelming workload, and so on, other perspectives that students embrace orient them to completely different issues, and they result in different types of group activities and endeavors.

Research of the medical school "situation" revealed a number of perspectives, derived from identities students embrace from outside the medical school, that compliment the student perspective. For instance, there is a distinct "Black perspective" that is based on an ethnic identification among Black medical students. The perspective involves an orientation toward illness that competes with the traditional medical model: Rather than approaching the problem of disease as specific to individual patients, the Black perspective orients students to focus on diseases unique to an ethnic group that are the result of social and institutional conditions, such as racism, unemployment and poverty, and that are common problems of that group. As a result, students who share in the Black perspective are much less interested in esoteric and

complex kinds of diseases that call for heavy utilization of advanced medical technology and specialized knowledge. Rather, such students tend to be far more concerned about the common medical problems of hypertension, alcoholism, narcotics addiction, malnutrition, lead poisoning, sickle cell anemia, and so on, that affect Black communities in far greater proportion than other ethnic groups. The Black perspective also orients students to be more concerned with socio-economic change in society, and the application and greater availability of existing medical knowledge and services to remedy these problems, than the development of even greater, technologically sophisticated equipment, or research into diseases that are relatively rare.

The Black perspective becomes expressed in the emergence of a number of Black student organizations, such as the Black Caucus and the Black Student Health Association. And it serves to orient students not only toward a different approach to the problem of disease, but a unique orientation toward one another, inspiring a sense of comraderie and a strong sense of Black pride and responsibility.

In addition to the Black perspective, there are a number of other perspectives, such as the "Human Potential perspective" and the "Chicano perspective" that have emerged within the medical school situation, thereby shaping the nature of that situation itself. However,

rather than attempt to catalogue all of the various perspectives, and delineate the specific uniqueness of each, the following analysis will focus on an in-depth examination of one specific perspective that has emerged within, and shaped, the medical training situation, and that is derived from an identity that transcends the training situation itself.

The Women's Health Perspective

To the extent women are being accepted into medical school in ever increasing proportions, it comes as no surprise to discover the emergence of a distinct "women's health perspective" which orients women as students to rather different orders of experience and problems in medical training.[8] It must be emphasized, however, that not all women necessarily approach medical training on the basis of the women's health perspective, or that their orientation to training only partially reflects it, just as Becker and Geer et al. (1961) noted that all students do not necessarily share in, or embrace, the student perspective. However, the women's health perspective has been introduced within the training situation through students' identification with one another on the basis of their collectively shared identities as women. And, as Becker and Geer et al. (1961:36) also noted:

> We see group perspectives as arising when people see themselves as being in the same boat and when they have an opportunity to

> interact with reference to their problems. Under those conditions, people share their concerns and their provisional answers to questions about the meaning of events and how one should respond to them.

Moreover, the women's health perspective is derived not only from women students, or women working in health care capacities and organizations, but much more significantly, from women outside of medicine who are generally concerned with problems specific to women's health care, medical delivery services, and, indeed, women's liberation. As Ruzek (1975:1) explained;

> ...the impetus for the health movement has come from the larger women's movement...Throughout the world women are coming to view their bodies as their primary, essential selves. And they are coming to see control over their bodies as a crucial first step in gaining control over their lives.

Thus, in contrast to the student perspective, which Becker and Geer et al. (1961) argued was derived almost totally from individuals' mutual identification with one another as students <u>within</u> the training situation itself, the women's health perspective is largely derived from a distinct social movement outside of the training situation, yet introduced into it by women themselves by virtue of their identification with the larger women's movement. For this reason, the following perspective is presented not only with respect to the observations that were collected in direct interviews with women students, but also with reference to a number of published statements in the area that have been expressed by women from many

different social and occupational walks of life.

What is central about the women's health perspective as it has been introduced within the medical training situation is that it does not so much deal with, or prepare women for, the problem of "making it" in medical school in terms of managing an overwhelming workload, a high level of uncertainty, and so on; that orientation is basically provided by the student perspective that Becker and Geer et al. (1961) described, and that women share in by virtue of being students. Rather, the women's health perspective contributes to the situation of medical training by orienting and preparing women for "making it" in medical school with a special concern for, and involvement in, a certain number of issues, problems and concerns with medicine, health care, and medical training that are of central importance to women themselves, not only as women students, but as women in general societal terms. The more salient of these issues and problems of the women's health perspective are presented below, followed by an analysis of the impact the perspective has had in shaping women's orientation to medical training.

Parenthetically, it needs to be emphasized that, in a way similar to all perspectives or ideologies associated with any given social or political movement, the women's health perspective on many points is frequently polemical, argumentative in style, and biting in its criticism of certain groups and institutions. However, in presenting

the perspective below, no attempt is made to simultaneously critique or call the perspective into question, even though many of the issues discussed are very much open to dispute. Put another way, the objective here is to "take the role" of the women's health movement, present the perspective that has evolved from it, and delineate the impact the perspective has had in orienting many women students to medical school. In this sense, the following discussion should in no way be interpreted as an advocacy or an endorsement by the author of the perspective itself.

The central issues of the women's health perspective pivot around four interrelated themes. The first theme is that women, historically, have been denied, or have relinquished, the essential control over their bodily processes due to the "pathologizing" of those processes by the institution of medicine. As Ehrenreich and English (1973) analyzed, particularly at the turn of the century, the pervasive attitude of the medical profession toward women was that they were inherently "sick," and all natural bodily functions, particularly those related to reproduction, were authoritatively defined as illnesses. This included the processes of menstruation, pregnancy, childbirth, menopause, sexuality, and, indeed, the overall physical constitution of women themselves; women's bodies were seen as fundamentally frail, weak, unstable and vulnerable to, if not carriers of, disease. The result of this has been that the medical profession progressively

became the main seat of authority and responsibility over women's health care and, thus, routine events such as bodily examinations, diagnoses, deliveries of babies, contraception, and so on, became "medicalized," or "medical problems" (Illich, 1976; Zola, 1972). Indeed, the medical profession became the sole possessor of the skills and knowledge necessary to not only define women's illnesses in the first place, but to provide the treatment and the remedies for their care.

The second theme is that the historical tendency to define women's natural bodily processes as problems of "sickness" has been a product of the pervasive, institutionalized sexist attitudes against women, particularly as those attitudes have been incorporated into, and reflected by, the profession of medicine. Namely, the medical profession's orientation toward women's bodies as inherently "sick" is part and parcel of the cultural imagery of women as dependent, passive, emotional, intellectually inferior and weak. It is parallel to the ideology that has been used to justify the domination of women in the division of labor. And it is parallel to the same ideology that served historically to deny women their right to vote, to hold public office, or to be accepted into professional schools, including medicine. Sexist images of women in the medical world provided the ideological basis for the exaggerated "doctor knows best" attitude, and the typical condescension and arrogance of

physicians who assume that women are incapable of understanding their own physiology and reproductive system, or that most physical complaints by women are psychosomatic in nature (cf. The Boston Women's Health Book Collective, 1973).

Moreover, due to the ingrained sexism embedded in the medical profession's orientation, the medical services provided have been in fact directly detrimental to the health of women in two major respects. The tendency to define women's complaints as psychosomatic has meant that many real, organic problems have been glossed over through the prescription of psycho-active drugs, thus the problems themselves never received appropriate treatment. And medical definition of women's natural bodily processes as problems of illness have created a whole assortment of iatrogenic diseases due to unnecessary or inappropriate treatment procedures (cf. Rosenbaum, 1977).

The third pivotal theme of the women's health perspective is that, given that women's "illnesses" are part and parcel a creation of the sexist attitudes against them, a new understanding of women's health problems is required. Many of the issues of the women's health perspective specifically take up the reexamination of the nature of women's illnesses, and such a re-examination has revealed entirely new attitudes toward matters such as contraception, menstruation and menopause, pregnancy and childbirth, the appropriate uses and abuses of surgery and drugs, and

problems of sexuality and mental health (cf. Ruzek, 1975). The most significant conceptual advance has been the dissocation between women's bodily processes and definitions of those processes as either "sick" or potentially "dangerous." Childbirth in particular, a "problem" that physicians have both traditionally defined and claimed complete authority over, is increasingly being seen as an extraordinarily natural process. Women are striving to not only educate themselves in all aspects of the process itself - an education that physicians have notoriously and contemptuously withheld from women patients - but there is also a growing movement to take the childbirth experience out of the hands of the medical profession (cf. Arms, 1975). As Ruzek (1975:28) noted, many groups have "...been advocating participation of women and their relatives in the childbirth experience, and questioning the routine use of anesthesia and episiotomy and separating mothers and babies." Others have advocated natural childbirth at home, and reinstitutionalizing the use of lay midwives, and even the use of one's own family members to assist in the birth process.

The women's health perspective involves a very critical eye toward the use of surgery and drugs to remedy many "problems." Individuals have documented the alarming amount of needless hysterectomies and mastectomies that have been performed, and the negligence in the approach of

physicians symptomatically treating women's problems through the use of tranquilizers. Finally, the women's health perspective has led women to inspect the abuses women have received in being used as unwilling guinea pigs in medical experimentation, particularly involving relatively untested drugs and contraceptive devices.

In general, the thrust of the women's health perspective has been to provide women a totally new and critical orientation toward their own health problems, a sense of responsibility to gain knowledge and control over both the facts and the medically perpetuated myths concerning those problems, and a militancy to demand from the medical profession either an enlightened reform in the quality of medical services, or a threat to strip the profession itself of its traditional monopoly over treating women's health processes.

The final pivotal theme of the women's health perspective is that, in order for women to secure the rights and knowledge necessary to control their own bodies and selves, the problem of sexism in all major institutions, particularly medicine, must be eliminated through a re-structuring of those institutions themselves, as well as in the emergence of new health delivery services.

As already noted, women are increasingly advocating the use of midwives in childbirth, and resituating the childbirth experience from hospitals to homes and other "natural" environments. Moreover, women have collectively

brought about the emergence of alternative women's clinics staffed by both professional and lay women personnel. The women's health perspective has also oriented women toward creating self-help programs "where women learn to rely on themselves and each other for routine examinations and health care" (Ruzek, 1975:48).

There have also been a number of changes brought about within the profession of medicine itself. Women have become critical of the nature of routine treatment; the condescension and mystique of the traditional physician-patient interaction is increasingly being challenged, and women are conceptualizing problems such as "How to treat your doctor" (Blackman, 1972). Women and others have brought about massive changes in "informed consent" procedures, both in medical treatment and experimentation, and physicians are now expected to provide in clear and comprehensible language the nature of all medical treatments that are used, and a summary of all possible risks. In general, the medical profession is finding itself increasingly on the defensive in dealing with women, and this has been a humbling experience. As Ruzek (1975) noted, the medical profession itself has had to come around to acknowledging many of the problems in medical care that women have revealed.

In terms of medical organizations, the women's health perspective, as well as the larger women's liberation movement, has served as an impetus for the increasing

influx of women into the medical profession and allied medical fields. Women have become sensitive to the need for greater numbers of women physicians who are more likely to represent their interests, both in terms of the politics of health care, as well as in delivering medical services. However, as the Boston Women's Health Book Collective (1973:269) cautioned, "Lots of changes are coming, and women's clinics and health centers will probably be part of them, but for most of us for a long time doctors and hospitals as they are now will be part of our lives." The women's health perspective is as much concerned with the reorganization of medical services as with criticizing the present system. Thus, many of the changes in medical services that have already emerged because of the perspective itself are more than likely simply the beginning of what may very well be a minor revolution in medical thought and practice in the coming years.

The Impact of the Women's Health Perspective in Medical Training

A general discussion of the overall impact that the women's health perspective, and the larger women's movement, appears to have had, and is continuing to have, on the many different institutions, occupations, and legal and social arrangements within particularly the United States would require an analysis far too great to be offered here. The women's health perspective itself has

brought about the emergence of new forms of health clinics, new definitions of health and illness, new life styles, entirely new areas and problems of medical and social research, hundreds of articles and books, and much needed legal reform in terms of women's rights to medical treatment, availability and quality of services, and the use of women in medical experimentation (cf. Ruzek, 1975; Olesen, 1976; The Boston Women's Health Book Collective, 1973). In view of the immensity of the impact, for our purposes, the specific area of consequence of the women's health perspective to be examined here concerns the more salient changes it has introduced in the nature of the orientation that women students bring into the medical training situation. Although even this examination itself cannot pretend to be exhaustive of all the changes that the women's health perspective has introduced in this single area, there are at least five major dimensions of the impact that appear to significantly influence the orientation of women students generally to training.

First, the rather extensive reexamination and reconceptualization of the nature of women's medical "problems," integral to the women's health perspective, has generated a critical eye on the part of women students toward the way such problems are dealt with and presented in medical training. For instance, in terms of matters such as pregnancy and childbirth, which traditionally have been approached as problems of sickness by the medical

establishment, women students are now more quick to openly dispute and challenge the disease model as it is presented in traditional terms. Such occasions frequently occur during the classroom years of training, and thus as one student noted, "Some women that are big on home births have come down hard on professors who are too hospital oriented, and these kinds of debates occur in the classroom all the time." In general, as one student noted:

> Women have brought women's issues into focus for medical students. At times when there were few women in medical school, issues of body image and images of women were not seriously called into question and re-examined by medical students. And women coming in have changed the attitudes toward obstetrics and gynecology, and they are starting to make a dent in how people treat female patients, and how to approach the female body and the female approach to things.

Overall, however, what needs to be emphasized is that all of the issues that have been called into question, challenged and reconceptualized within the larger women's health perspective are now issues that women students feel free and confident to call professors on; these issues are now fair game for debate, and women students know that the orthodox medical establishment must not only face up to the questions that they are raising, but it must also change itself in the process of so doing.

Second, in alerting women to the vast misconceptions, utter fallacies, and gross abusiveness that characterizes so much of the "science" of orthodox medicine, the women's health perspective has also alerted women to the

connection between the development of that "science" with the more general and pervasive state of sexist ideology against women that pervades all of the dominant political, economic, religious and educational philosophies and institutions in western civilization. As Ehrenreich and English (1968:5) noted:

> Medical science has been one of the most powerful sources of sexist ideology in our culture. Justifications for sexual discrimination - in education, in jobs, in public life - must ultimately rest on the one thing that differentiates women from men - their bodies. Theories of male superiority ultimately rest in biology... Medicine's prime contribution to sexist ideology has been to describe women as sick, and as potentially sickening to men.

Thus, not only has the women's health perspective significantly shaped women's orientation to training in terms of sensitizing them to the pervasive amount of medical misinformation regarding women's health problems, but to also the pervasive amount of sexism inherent in medical training, treatment procedures and medical thought. In general, women describe not only their sensitivity to the problem of sexism in training, but also their vociferous reactions to it. In particular, women students express sensitivity toward sexism in medical training as it is conveyed toward women as students, and women as patients.

In terms of women as patients, almost all students interviewed noted the tendency for women students to react vehemently to the sexist images of women patients

typically conveyed in instructional presentations. As one woman student expressed:

> However, in the classroom years, women patients are almost always presented as "crocks." It used to be that whenever a patient would come in with symptoms that turned out to be emotional problems, those would always, always, always be women patients. But women now boo and hiss like hell in classes if a professor says or alludes to women inappropriately.

Thus, as another women explained:

> From my own experience, the way male physicians talk about female problems and female parts, the kind of joking that used to go on in anatomy about female breasts and vaginas, the slides that we've been shown to "wake people up" in lectures - all that stuff of women as an object has had to change because women who are in the process of training are not going to stand for that.

In terms of women as students, women note that the sexism toward them can be subtle. But the important thing that women emphasize is that, whether obvious or subtle, the fact of being a woman, in and of itself, is never a neutral attribute. As one woman explained:

> I have been in clerkships where I have been the only woman, and sometimes I get congratulated for doing well in a bunch of men, and then I've been in other clerkships where all these men thought that I was just awful just because I was a woman. So being a woman is either an advantage or a disadvantage, but it is never really a neutral situation. You are always aware of its effect in one way or another.

In these respects, an example of overt sexism are instances of women students receiving differential training in comparison to that of men students. For instance, as Lopate (1968:21) described the experience of "a woman

who was the first graduate of a well-known medical school before World War I...":

> When she got into clinical medicine and the class had a patient with, for example, genito-urinary diseases, she was asked to leave and go to the library for the period. Such restrictions were frequent at that time, but common sense has since triumphed over delicacy, and women medical students are now expected to learn the full curriculum.

True, women students are now expected to learn the full curriculum, but even to this day the expectation may not be totally honored in certain cases by the faculty. As one woman described a situation that involved herself and four other women students:

> Usually you pair up in groups for some clerkships, and for several of mine it just happened that four of my friends who were all women made up the entire clerkship group. But the problem that came up in that situation is that the doctors who were teaching us, the preceptors, were kind of overwhelmed by being faced with five women. So, for instance, we were never, never taught how to do rectal exams. We were supposed to be taught in surgery, and the surgeon was completely freaked out at the idea of taking five women into see a patient and teaching them how to do a rectal exam. And so he said that we would learn that in general medicine. And we kept saying that this is clearly spelled out for surgery, and he just chose to ignore it. And so, when we got to general, this guy said, "Well, you should have learned it in surgery." So they never did teach us how to do a rectal - it was just completely evaded by the faculty.

In contrast to overt sexism, women students note that subtle kinds of sexist actions toward them by faculty members are much more insidious and difficult to call into question. As one woman student described:

> The ways in which sexist messages are conveyed are really subtle and insidious. Like, in a group of people, the men will tend to speak and address only the other men in the group. And when men speak up, the group seems much more interested. And then, when we get our student evaluations there are certain things said like, they'll say that I'm "cheerful" - and that's the kind of word that they'll feel free to use for a woman, but you would never see that word used for a man. And I have another friend, and her evaluation said that she was "well mannered!" (laughs) She had good manners and was polite! These are the kinds of Pollyanna kinds of evaluations that women frequently get.

Lopate (1968:16-17) noted that, up until and including most of the twentieth century, "The majority of women physicians have purposely tried to merge their identity and interests with those of the male segment of the profession." We have seen that, due to the advent of the women's health perspective, women are not only opposed to the idea of "being made into men," but they now adamantly insist, some quite vociferously, that their identities as women be regarded as equal to that of men, and that all traces of sexism be eliminated from medical training. Obviously, the battle against sexism is still being waged, both quietly and openly, and the position that women are attempting to carve out for themselves gains its ideological and substantive strength from the women's health perspective itself, as well as the larger women's liberation movement.

Third, the introduction of the women's health perspective into the training situation has strengthened women's orientation to protecting and enhancing the status

and position of women as students. By this I mean that, as just described, not only are women now prepared to openly repudiate sexist attitudes and action toward them by faculty members, but women are also very conscious of the necessity for them to set a very high example of performance in training in order to assure the continuance of opportunities in the future for other women applicants to medical training. The reciprocal of this is that women are also very conscious of how far they should attempt to "bend the rules" in order to bring the situation of medical training into a relationship that is more accomodating to women's needs and values, and yet at the same time not jeopardize the status of other women by intimating that women cannot handle the present training situation. In this sense, women find themselves walking a very thin edge: The women's health perspective has strengthened women's attitudes toward themselves, and has provided the ideological rationale for women to rightly push for institutional reform in medical school. Yet, they do not want their advocacy of reform to be used against them as an insinuation that such reform is needed because women are unable to measure up to the rigors of present training policies. Thus women find themselves in a dilemma.

On the one hand, there is a tendency to avoid pushing for any special considerations. As one student noted:

> There is a real strong pressure for women not to ask for special consideration. For instance, there have been a couple of times

> that I have been tempted to take a leave of absence, or even drop out of school, because the pressure was too much for me to take. But that is a pretty big pressure because I would be damning a lot of women, and they would be the ones to pay the price for that. And, you know, when I was interviewed for admission, I was told that a lot of women have dropped out of medical school to have children, and thus I was going to be discriminated against because of that. So women generally, and particularly women with families, really have to make the same sacrifices as anybody else. We're not going to get any special consideration because we are women, or have families, or anything.

On the other hand, the women's health perspective inspires women, both individually and collectively, to push for "special circumstances," or for general institutional reform. Yet both circumstances open women up to either the anxiety of undermining the position of women generally, or, indeed, the charge by men that women are not cut out for the rigors of medical training. As one third-year woman student expressed, after she had made the decision to become pregnant while in the midst of medical training:

> I basically think that having a baby isn't a real cool thing to do while in training. And when I was in OB clerkship, I really worked hard to make sure that I was doing everything else that people were doing. And at times I was really worried about how I might be screwing up the situation for other women.

In this same vein, many women are not simply interested in bending a few unspoken rules or asking for special consideration in individual cases. Rather, the motivation inspired by the women's health perspective, to protect and enhance the status of women students, has given them reason

to push for overall reform in training policies. For instance, Crawford's (1972:583) article in The New Physician sparked a great deal of controversy when she suggested that "...getting young women into medicine is only the beginning. Once there they need programs responsive to their special needs or they will not stay." The overall recommendations that Crawford advocated included:

1. Reevaluating the need for a 75 to 90 hour work week while in training.
2. Reduction of the overall time required for medical training.
3. Opportunities for part-time and half-time training programs.
4. Internships with regularly scheduled hours, including part-time internships.
5. New types of medical practices.
6. Provisions for child care services for women students and maternity leaves without penalties.

In conclusion, Crawford (1972:585) asserted:

> It is a simple fact of life that women have babies and medical women are no different. Special provisions must be made for the woman who does not postpone childbearing until all her education and training have been completed. She should not be made to feel guilty about having a child during her training and should be allowed a reasonable time for maternity leave without penalty.

Recommendations such as Crawford's (1972) reflect many of the pivotal themes of the women's health perspective as it is applied to the medical training situation, particularly in the sense that women's needs not only must be reexamined in an attitude completely divorced from the

traditional sexist mentality, but that women's issues are inherently valid, legitimate and viable as grounds for re-evaluating training policies. Crawford is not suggesting that, due to the inherent inferiority and inadequacy of women, training policies should be revamped. Rather, given that women are equal to men, and as inherently capable, medical training must be reorganized to support students' interests as women. However, as much as Crawford's recommendations were clearly based on the intention of strengthening and enhancing the status of women in medicine - a concern integral to the women's health perspective - those recommendations themselves can be used by others as indicative of a number of reasons why women may not be appropriately suited for medical training (cf. Daley's [1973] reply to Crawford).

Thus, while the women's health perspective orients women to a responsibility and a consciousness on their part to protect and strengthen the status of women as students, women are experiencing a dilemma in how that should be accomplished: Clearly, women attempt to fulfill the mandate of the perspective by maintaining a high level of excellence in their performance as students within the existing structure of medical training. But whether they are protecting or undermining the position of women by either campaigning for general reform in training based on women's interests, or arranging their training schedules to accomodate their own personal desires to bear children

and raise families - both options eminently justified by the women's health perspective - remains questionable and, as yet, unresolvable. In general, however, women remain optimistic. As one third-year woman student noted, who also was a single parent:

> I think as more and more women get into medical school, it is going to become more and more responsive to the needs of students generally. I think of the women students that I know that have kids, they can't do what the single students do in terms of putting in the hours. You know, I know single men that would stay a whole week in a hospital and not go home one night. But when you have children, and you feel like you have a right to have children, then you say, look, I won't do that. So I think that women who end up doing well in medicine and end up refusing to do those kinds of things, will demonstrate that things can be done differently. So I think as far as clerkships go, women will, and are, making a big difference because they are unwilling to be pushed around as much.

Fourth, the impact of the women's health perspective on women's orientation to training is revealed in the many informal, ad hoc, and formal kinds of meetings, organizations and caucuses that women ongoingly organize within the medical situation. As one student reported:

> There have always been a women's caucus in my classes, particularly during the first two years. And they kept notes on things that bothered them more than anyone else. And these groups have been involved in protesting things outside of the medical school, such as rallies for a child-care center on campus, legislation regarding the suspension of monies for abortions, the Bakke decision, and others.

Moreover, women profit from these meetings not only in terms of an opportunity to share their own problems with

one another, and to bring women's issues of concern into focus, but such meetings are also frequently very functionally related to training; i.e., women speak of the several occasions when they have invited female residents in to counsel them on what to expect on the wards, conferences with various deans to discuss policies toward women, planning strategies for various social and political campaigns both within and outside the university, and so on. In general, the women's health perspective, as well as the larger women's liberation movement, has engendered in women a much greater appreciation and respect for the experience of comraderie and the pleasure of being together. For instance, as one woman student described:

> One morning I went to surgery and there were two women surgeons and I was the medical student. And when we were scrubbing, these people talked about their children and their families, and they discussed just really human issues - we didn't talk about sports or about the stock market which is the general thing that men talk about. And this was just a much warmer and comfortable atmosphere for me.

Finally, due to the women's health perspective, women have increasingly begun to see themselves as introducing an alternative to the traditional model of physician-patient interaction. To begin with, women claim that their orientation toward patients and illness is generally more humanized and personal than that of men students and physicians. As one student noted:

> I think that women have also brought in a different emotional level. Women tend to be more expressive of their emotions, they cry and laugh more easily, and I think that these things have tended to humanize the process a little bit. Women are just a bit more open about their feelings toward things. There is less of this old traditional "detached concern" bit, and the cold aloofness - being able to cry with the patient and empathize with the patient.

One important tangential indication of this is the greater tendency of women to react to dehumanized and degrading treatment accorded patients. As the former student continued to say:

> Women have also booed and hissed to things that they viewed as being insensitive to patients. I think women have been much more vocal about that; just more sensitive to basic human treatment.

Specifically, women see themselves as being not only more humanistically oriented toward the whole person, and more sensitive about the quality of the relationship between the physician and the patient, but they also see themselves as much less aggressive in their overall demeanor. In fact, one woman commented that such a demeanor may even be rubbing off on men students:

> I think also that men are learning that non-aggressiveness has its place. I have a lot of women friends that are pretty low-keyed with their patients, and I think they are presenting a different model. A lot of men are into being show-offs, and they are very aggressive in letting the attending physician see how good they are being real flashy.

Obviously, whether women in the future will succeed in institutionalizing an alternative to the traditional

physician-patient model remains to be seen. Many voices, both inside and outside of medicine, have called for more humanistic, personal kinds of treatment, more gentleness and tenderness, more concern for the whole person, and more affective-expressive involvement. Women suggest that the advent of modern medicine, being dominated by men, has brought with it a highly depersonalized attitude toward patients, with only minimal concern for, or knowledge of, the patient as a person. The advent of the women's health perspective brings with it a specifically humanized orientation, not only toward women, but toward people in general. The introduction of this perspective into medical training has introduced a heightened concern for humanistic regard for others. And women see this attitude as not only appropriate for the way in which they themselves feel they should be treated as students, but also as a model for the way patients should be treated as well.

Identities, Situations and Social Worlds

As we have seen, situations that individuals find themselves in call out and define particular identities that are specific to situations themselves. Moreover, some situations, such as participation in medical school, tend to be not only highly demanding, but also highly specialized and truncated in terms of the specific identities that they call out in individuals. However, to the extent that students are also simultaneously participants

in other situations, competing identities that individuals are committed to can serve to dialectically feed back into and partially redefine the nature of situations themselves. Thus, articulation of multiple identities within specific situations invokes a dialectic process of situations defining identities, and identities redefining situations.

In addition, competing identities that individuals embrace can serve to not only redefine situations but, indeed, define altogether new situations. In this sense, the medical school setting flourishes with a colorful abundance of unique and varied "social worlds" and "scenes" that medical students, and other members of the university community, collectively fashion and participate in by virtue of other identities and interests they hold in common (Strauss, 1977; Irwin, 1977). Such "situations" constitute, as Strauss (1977:4) explained, "universes of discourse" that pivot around particular activities; "... the basic social processes of communication signifies an enormous, unlimited and ceaseless proliferation of functioning groups, which are not necessarily clearly boundaried or tightly organized." Which is to recognize that, besides the "student culture" in medical school, there are a number of alternative cultures that become expressed in the form of innumerable social worlds. Such social worlds can be heuristically categorized into those making up an outdoor culture, an athletic culture, and a free-form intellectual culture.

The medical student community is populated by many individuals who identify themselves with interests in the outdoors, wilderness areas and nature. Such identities provide the conditions within the medical school setting for the emergence of what can be called "outdoor exchanges;" individuals participating in a particular social world by organizing outdoor excursions and various recreational trips. In some schools, such exchanges can become formalized into a permanent organization, as in the school researched in this study. Such an organization takes upon itself the job of organizing outdoor trips, providing rental equipment, and offering special classes in first aid and wilderness medicine. The activities organized by such an exchange reveal the plethora of social worlds that many medical students identify with and opt to participate in. For instance, the specific above-mentioned exchange caters to individuals who identify themselves as rock climbers, surfers, rafters, snow skiers, hikers and mountain climbers, and snow campers.

In terms of the athletic culture, students identify themselves with a number of social worlds of sport and, thus, the medical school becomes a setting wherein many of those social worlds emerge. Many medical students identify themselves as racquetball, squash, tennis and basketball players, joggers and karate enthusiasts, and body builders. Groups and tournaments are organized, such as those held by the squash club, the track club, and the

karate club. For some students, commitment to a particular sport no doubt runs as deeply as their commitment to medical training, and one's reputation as a basketball player, karate expert, or so on, can be as important to one's overall identity as that of being a medical student.

Finally, students' identification with various social worlds provides the conditions for the emergence of a free-form intellectual culture that becomes expressed in a mini-university within the medical university itself. Classes, workshops and conferences in all different intellectual and substantive areas are organized. For instance, due to many students' identification with what can be called the "human potential movement," there is currently great interest in classes and workshops focused around such topics as "Developing and Experiencing the Whole Person," "Intensive Human Energies Workshop," "Women's Exercise and Body Awareness," "Yoga and Meditation," and "Shiatsu Massage and Eastern Medicine." In addition, there are classes organized in painting, stained-glass, pottery, calligraphy, and tap dance.

Social worlds within the medical school setting swirl and coalesce around these types of intellectual, athletic, and outdoor interests, giving rise to entirely new situations. Such worlds consist of universes of discourse and interaction, but the conditions that make such communication and interaction possible are students' identification of one another as highly diverse and multifaceted beings,

Chapter Seven

Conclusion

What has been developed above is a theoretical perspective on how individuals in everyday life articulate their multiple identities in terms of relating them to one another, symbolically, as well as relating them to one another in behavior, within situations and across time. The substantive focus of the research has been explicitly delimited to the experiences of individuals involved in a formal, professional socialization process, namely medical students and their significant others. A summary of the basic, interrelated themes of the perspective, particularly as they were developed with respect to the experience of medical students, is presented below in conclusion.

Articulation as an imperative social process: Individuals are continuously in the process of embracing, presenting and fashioning multiple identities and that, due to the exigencies of social interaction and social organization, the articulation of those multiple identities is an imperative process, as well as an ongoing one. In terms of gaining admission to medical school, prospective students articulate their multiple selves in such a way as to create the impression that becoming a medical student is the single most important identity to which they aspire. Applicants thus attempt to create an image of their

personhood wherein all accompanying identities and personal attributes flow into, and appear to be subservient to, the overriding identity of their becoming medical students. In other contexts, however, students see their professional socialization, and their identities as medical students, as supportive of, and a vehicle for, the fulfillment and expression of still other identities. Thus students ongoingly articulate their professional socialization so that it becomes a means for realizing, and preparing for, multiple identities and alternative goals themselves.

The symbolic dimension: Multiple identities are articulated with one another, symbolically, in terms of the convergence and divergence of assumptions, definitions, attitudes and values that exist between the perspectives of different identities, as well as in terms of the hierarchy of social value that is symbolically assigned between identities. While, for any given person, the specific meanings that make up a relationship, or a symbolic calculus, between identities is problematic, there are a number of distinct forms that any given symbolic calculus can take. For some medical students, mostly those who are men, husbands and fathers, such identities are seen as essentially "blended" with one another, so that the student's involvement in medical school becomes a simultaneous fulfillment or expression of all of the remaining identities. For others, the relationship between their

identities as medical students is seen as "instrumentally" related to other primary identities which they embrace; i.e., being a medical student becomes a means of expressing or achieving other, relatively separate identities. Finally, the symbolic calculus between being a medical student and certain other primary identities is felt by many to be ongoingly "problematic." Particularly for women, and for students who see themselves as adults, many find that the symbolic articulation of these identities is ongoingly troublesome and unresolvable, which leads to a number of problems in students' lives, such as feelings of being stigmatized, sexually neutered, or infantilized.

The behavioral dimension: Multiple identities are articulated with one another, behaviorally, in terms of the ways in which individuals negotiate, with themselves and others, the allocation of the time, energy, interests and resources necessary for the expression of one identity, or identities, over others. For individuals in medical school, the behavioral articulation of their lives exists as an immense problem because the largely unnegotiable demands of medical school tend to inundate their private lives, threatening to flood out the possibility of expressing and fulfilling competing identities. Thus medical students, in their relationships with significant others such as friends, spouses and families, find themselves requiring exemption from such relationships, as well as for others to

substitute for them, and to schedule their lives and activities into conformity with the training schedule. Reciprocally, as involvement and intensity with medical school increases, students attempt to control and minimize all competing demands on their lives. If such a tendency on the part of the student is interpreted by others as incompatible with, or a symbolic breach of, their relationship with the student, then the symbolic "grounds" dissolve for negotiating the behavioral articulation of the student's involvement in medical school. Thus, engaging in the processes of exemption, substitution and scheduling become issues of conflict and contention.

The temporal dimension: Identities have their own, relatively distinct temporal careers, and individuals continuously grapple with the future in terms of scheduling the expression of certain identities over others. In this sense, participation in medical school involves a structured and highly scheduled status passage that provides clear markers as to when one's identity as a medical student must take precedence over other identities, as well as the date of possible pay-off when the realization of becoming a physician can then become a means for the realization, expression and support of other identities. However, as training evolves, many students begin to envision that, due to the nature of their internship, residency, area of specialization, and the problems

associated with establishing a professional practice, the inundation of their lives with medicine threatens to carry over following graduation. Thus, in terms of minimizing such an event, students' visions of the future, particularly as it appears to affect their private lives, feeds back upon and influences many of the important decisions that they must make in the present regarding their objectives in training and commitment to medicine.

The situational dimension: Situations in which individuals find themselves call out and define particular identities that are specific to situations themselves. Moreover, some situations, such as participation in medical school, tend to be highly specialized and truncated in terms of the specific identities that they call out in individuals. However, competing identities to which individuals are committed can serve to dialectically feed back into and redefine situations themselves. In this sense, students' adjustment to the medical training situation is not merely an adaptation; situational adjustment is much more of a creative process of students partially constructing the training situation itself by interjecting their own perspectives into it. Moreover, such perspectives are grounded in identities that students embrace which are derived from groups and relationships outside of the training situation. Thus, articulation of multiple identities within specific situations involves a dialectic

process of situations defining identities, identities redefining situations, and, indeed, identities defining altogether new situations.

In closing, it should be further emphasized that the value and usefulness of a theoretical perspective, such as the one developed above, is revealed not only in terms of what it enables one to observe, describe and explain with respect to a single substantive area, but also in terms of the perspective's generalizability and usefulness in being applied to altogether different areas themselves. Accordingly, perhaps it would also be worthwhile, both for purposes of summary and conclusion, to discuss a number of different substantive areas that the above perspective might fruitfully be applied to, as well as to note some of the more central, analytic questions, issues and problems that would quickly emerge through such an application.

First, in the area of professional socialization, there are a number of different substantive types of formal socialization processes, some which have already been frequently investigated and others which deserve greater attention, that the above perspective would be helpful in researching. In applying the perspective, a number of initial questions and problems would become immediately important. For example, in reviewing the existing research and theory on any given socialization process, to what extent are individuals analyzed, while in the process of

socialization itself, as persons rather than as simply students. In other words, to what extent do existing analyses reveal the ways in which the process of fashioning an identity of a professional in one area affect, or is itself affected by, individuals' identities and relationships with others in different aspects of their lives? Almost inevitably, as discussed in Chapter One, most analyses depict a highly fractured and hollow image of individuals, and focus on the socialization process itself as if it existed totally independent of other socialization processes, and different institutional and interactional contexts. In addition, to what extent do such analyses reveal, or fail to reveal, the ways in which individuals themselves collaboratively assemble the nature and significance of any given socialization process, both in terms of the training situation(s), and the particular relevances, concerns and priorities that they bring to training, and thereby shape it accordingly. A direct research application of the above perspective to any given professional socialization process would immediately bring into focus these kinds of questions and issues, and it would lead the researcher to discover the array of meanings, perspectives and provisional adjustments that individuals hold or make toward any given socialization process in which they are participant.

In this sense, the structural conditions of any given socialization process may be very different from those

associated with medical training; e.g., the socialization process may only minimally inundate, or problematically tax, students' private lives. Yet, to the extent that such students are in the process of fashioning a new identity, the necessity of articulating it, symbolically, behaviorally, temporally and situationally with the remainder of their private lives and relationships with others remains an imperative, generic process.

Turning to research on the nature of professional practice, rather than professional socialization, application of the above perspective would lead the researcher to investigate the relationship between the ways in which individuals conduct themselves, professionally, as that is affected by, and affects, their nonprofessional and private lives. Such research would explore the meanings that individuals hold toward their professional practice in terms of it being either a business, or a means of support for other ends, such as private ambition, family life, personal status-seeking, religious commitment, and so on. The perspective would lead the researcher to explore the ways in which individuals' identities as professionals articulate with various social, political and economic situations within which they participate, and how their involvement in such situations dialectically feeds back into, and influences, their professional practice, commitment, and perspective.

Another substantive area that would profit from

application of the above perspective is that of middle and late life transitions or transformations. As Strauss (1969) noted some time ago, much of what is thought of as human development in middle and late life is actually a "transformation" that individuals undergo in adapting to new social situations, whether those be occupational, marital, or so on. Such transformations involve not only taking on new identities, and their accompanying philosophies, as well as possible changes in one's geographic location and economic status; such transformations also frequently involve a rather complete review and reconfiguration of one's entire life. In other words, such transformations, such as the loss of a spouse, job, or one's health, frequently call into question and make problematic, all of the symbolic calculi that underlie the articulation of one's gestalt as a person. The above perspective on multiple identities and their articulation becomes immediately useful in research bearing on such transformations. It would lead the investigator to research not only the problems which individuals face in taking on new identities and living up to the many structural and interactional contingencies that may come into play in so doing; but also the problem associated with articulating a new identity with the remainder of one's personal life and relationships with others.

For example, there are many individuals who undergo various philosophic, political and religious kinds of

conversions. As discussed above, frequently such conversions make problematic all of the prior relationships that a person may be a part of. Specifically, there are many people who are currently undergoing religious conversions, as with the followers of Reverend Moon and the Unification Life Church (see Rice, 1976), and other Hindu-based faiths, who are required, or choose, to disaffiliate themselves from their parents and former friends (see Damrell, 1977). Many take on new names of themselves which signify not only a "rebirth," but also a symbolic "death" of one's former self and biography. Or, as Balch and Taylor (1976) noted, such conversions frequently involve "walking out the door of your life." In these respects, much has been written about the different types of cults and social movements with which individuals elect to identify with. However, there is a very conspicuous lacunae of research, guided by a perspective similar to the one developed above, that reveals the ways in which conversion experiences set up the apparent necessity for a rather total reworking of one's life and relationships with others, and the processes through which that reworking and renegotiation of a new self, and relationships with others, is achieved, however problematically.

One final substantive problem that might profit from being researched through application of the perspective developed above is that of "inundation" itself, or "inundating circumstances," as discussed in Chapter Four. Such

circumstances include the lives of individuals that pivot centrally around a fervant "mission" in life, whether in medicine, music, art, politics, academia, business or religion. The concept also includes the lives of individuals who experience an irrevocable and catastrophic misfortune, such as great material loss, or loss of physical abilities. And, it includes the experience of those individuals whose lives become caught up in some kind of overwhelming "societal reaction," whether that be due to being labeled as a celebrity or symbolic leader (Klapp, 1964), or a criminal (Lemert, 1967).

Following the perspective as developed above, research into such circumstances would reveal not only the conditions that give rise to such experiences, and the symbolic and interactional problems that extend from them, but also the processes through which individuals attempt to ongoingly articulate, sustain and manage the remainder of their personal lives and relationships with others.

In all of the four, above-mentioned substantive areas, research into the multiplicity of individual's lives and relationships with others is needed and deserving of greater attention. This particular study has been, in part, an attempt to discover and develop a theoretical perspective on the basis of which future research in these areas, and others, can proceed. The perspective, as developed with respect to the specific situation of students in medical training, would draw researchers' attention in other

substantive areas to not only the fact that individuals simultaneously articulate multiple identities in any given situation, but that such articulation is a manifold process involving symbolic, behavioral, temporal and situational dimensions. The perspective would also draw researchers' attentions to further discovering the different kinds of social psychological and interactional processes that individuals themselves use to achieve articulation in terms of each of the various dimensions, as well as to discover the different types of social structural conditions within which the process of articulation occurs.

Chapter Eight
Methodology

Introduction

Beginning with the advent of Glaser and Strauss' (1967) The Discovery of Grounded Theory, and the overall emergence of ethnomethodology (Garfinkel, 1967; Douglas, 1970; Filmer and Phillipson et al., 1972), the problem of social science methodology has been thrown into an entirely new perspective. By methodology, what is at issue now is not only a careful disclosure of the means through which sociologists attempt to verify their theories and hypotheses, but a disclosure of the means through which theories and hypotheses are developed in the first place. The contribution of ethnomethodology has been to bring into focus the problem of how do sociologists, both lay and professional, go about the business of theorizing; i.e., what are the processes of interpretation that both professional and lay sociologists use to "make sense" of any given situation, and what are the procedures and (ethno)methods they use to make that sense sensible to themselves and others. The main contribution of Glaser and Strauss' grounded theory is that it provides the beginnings of an explicit analytic procedure for generating theory in the process of research itself; i.e., it is an attempt to formalize a process of theorizing that is traceable, documented and demystified.

Accordingly, by methodology, I am concerned here with specifying the procedures and methods utilized in this

research that eventually yielded the theoretical perspective developed above on multiple identities and their articulation. Or, by methodology, as Phillipson (1972:79) explained, I am concerned with specifying

> ...the processes by which a sociologist generates an abstract view of a situation. The processes of observation, selection, interpretation and abstraction constitute the sociologists' methods of constructing his "theory." In this sense, methodology comprises how the sociologist decides what social phenomena are relevant to his descriptive project at hand, and how he deals with these in developing his account or theory. Methodology, therefore, includes all the processes by which a theory is constructed (emphasis in the original).

In order to describe "all of the processes by which a theory is constituted," perhaps the appropriate place to begin is at the beginning.

In an important sense, I began the research, late in 1974, long before discovering what was the research problem itself. Thus, I began the research without a clearly defined theoretical problem, or a carefully delimited and representative sample, or a research design. Instead, I began with only an initial substantive interest in "private life," a number of rather abstract, philosophic assumptions about the nature of persons, society and social reality, as contained within symbolic interactionism, and a number of relatively formalized "analytic procedures" for generating theory within a process of research itself. The aforementioned analytic procedures were partially derived from Glaser and Strauss' (1967)

The Discovery of Grounded Theory, and also partially derived from the training I had received directly from Barney Glaser and Leonard Schatzman on analysis of qualitative data. The more important of these analytic procedures are discussed below, particularly as they served as a framework for guiding the research process itself, and also in terms of eventually selecting a sample, collecting, coding and analyzing data, and finally generating and testing out a theoretical perspective. First, however, I will discuss the initial interests and assumptions that led me to begin the research in the first place.

Initial Research Interests and Assumptions

My most immediate interest in studying the private lives of medical students originated from the fact that I lived during the entire period of graduate training in a married, medical student community. Thus, in terms of convenience, feasibility and economy for doing a dissertation project, my private residence provided a natural and accessible setting for doing research. Indeed, if one is interested in doing fieldwork and participant observation, the opportunity to actually "live with" your research subjects is an opportunity of immense value and importance (see Gans, 1962).

But, just as importantly, my interest in private life stemmed from my interests in studying "everyday life," particularly as these interests were heightened by the

particular training and orientation I was receiving in sociology, that being "cognitive" or "interpretive" sociology (see Wilson, 1970; Bruyn, 1966). This particular sociological orientation pivots around a number of interrelated, ontological assumptions concerning the nature of society and social reality. Moreover, in doing the research, from start to finish, these assumptions underlied not only what I saw, but how I generally carried out the research itself (this will be more clearly spelled out in the next section). The more important of these assumptions are the following:

1. The social world is an ongoing social construction. It has no existence apart from the continual human activity that produces it, and thinks of it, and this leads to still further productions and achievements.

2. All individuals are sociologists; there are just lay and professional sociologists (Zimmerman and Pollner, 1970). Interpretation and theorizing are processes in everyday life. Schutz's (1964) "wide awake, grown-up man" fashions his behavior on constructs and conceptions of what "is." Or, as Kenneth Burke (1954) noted, all people are "critics," whether lay or professional. They can explain their own behavior, and others, via any number of vocabularies of motive. Motive imputation, avowal and explanation are the province of no special type of intellectual craftsman.

3. The meaning of social behavior is not found within individuals in terms of, say, needs, attitudes, personalities or motives (cf. Mills, 1940). Nor is meaning given to behavior in terms of abstract and impinging norms, rules, roles, etc. (cf. Foote, 1951). Rather, meaning of behavior is to be found in the context of behavior itself. It is given in terms of the way interactants themselves symbolically act and respond toward one another, as well as toward

objects (Blumer, 1969).

4. The meaning of social behavior is continuously emerging. That is, to the extent meaning is found in interaction with self and others, it is not static but processual. Meaning is ongoingly built up, assigned, reassigned, and transformed in terms of the interactions of people themselves.

5. To the extent that all objects and events of social reality are ongoing human achievements, all objects themselves are appropriate topics or problems of research. All of the "unquestioned, but questionable background," as Schutz (1964) would say, is a sociological topic. This makes the everyday reality of both professional and lay sociologists "available" as a problem of research. Thus, even the most ordinary, mundane, ostensibly apparent, taken-for-granted situations become immensely fascinating, problematic, and phenomena in their own right: How is any given object, event or meaning socially constructed in any given situation?

6. Finally, to the extent all persons are sociologists, and that social reality is an ongoing human achievement, emerging out of the interpretations and interactions of individuals themselves, the appropriate sociological problem is "how" is social reality, and any specific social object, achieved by persons themselves.

It was by virtue of these assumptions, integral to a cognitive sociology, that I became interested in the private lives of medical students. Put simply, I had been trained to see "everyday life" as a phenomenon; and what could be more everyday than private life?

Interestingly, I became intrigued in medical students' private lives because, from all ostensible and cursory appearances, their private lives were so boring. The student community within which I lived was utterly dull and lifeless, populated by people who appeared to lead

extraordinarily quiet and subdued lives (this initial impression quickly faded once the research began). So here was my chance to put my sociology to the "test" - what kind of a phenomenon is this? Nothing seems to ever happen! So much for everyday life.

And then I began to realize, nothing ever seems to happen because, at least for medical students with families and children, their private lives appeared to be on "ice;" students and their families appeared to be in a "holding pattern," circling the medical school, patiently waiting for a respite from training, or coping with the rigorous demands of medical school. And this generated my first, major research question (as discussed in Chapter Four): How are individuals able to assemble and maintain a private and family life when it is inundated with an overdetermining and largely unnegotiable focus? Thus, a beginning question, a beginning for the research itself.

With this question in mind - not yet knowing whether inundation was a "real" problem for medical students themselves - I began the research. Certainly, at this point, I did not know that I was, or would be, studying the problem of multiple identities and their articulation; the awareness of this on my part did not come until several months later. In this sense, because I began the research without a specific hypothesis, or a preexisting research design, I began organizing the research itself on the basis of a number of analytic procedures for generating

theory in the process of research itself. The essentials of this type of empirical analysis, and the research design that evolve out of it, is discussed below (see also Bruyn, 1966; Schatzman and Strauss, 1973).

Procedures of an Analytic Research Design

The research reported above was carried out on the basis of three, central analytic procedures. The initial phase of the research, roughly one and a half years, was conducted on the basis of the procedures of "substantive sampling" and "open theoretical coding."

Because the research was not controlled from the very beginning by a preexisting theoretical or conventional research design, the logic that guided the initial collection of data was, by necessity, derived from the observed and unfolding characteristics of the substantive problem itself; i.e., the private lives of medical students. This logic of sampling can be referred to as "substantive sampling." Unlike statistical or random sampling, which refers to the collection of data for quantitative ordering, in various ways, of people, places, attitudes and activities, substantive sampling refers to a conceptual ordering and comparison of the same items, primarily in the form of descriptions and classifications. Obviously, such a procedure is fundamentally in the service of exploration and discovery in research rather than verification and control. As such, I became very much concerned with

discovering, substantively, the different kinds of private and personal circumstances and arrangements of medical students, other than the fact that they were students. I began noting and comparing the great variety of medical students, as well as the variety of private circumstances in which students found themselves; women versus men students, Chicano versus Black versus Chinese versus White Anglo students, single students versus married, students who were wives, husbands, mothers, fathers, single parents, women students who were pregnant while in training, older versus younger students, and all combinations thereof, and so on. Much of this initial, substantive sampling was carried out through firsthand observation and informal interviewing with scores of medical students and their spouses. I then began to assemble a comparative sample of medical students for formal interviewing who were situated in, and represented, different types of personal circumstances. In all, I interviewed forty medical students, and many of their spouses, each representing one or more of the different substantive categories listed above (see Appendix A for a copy of the interview guides).

I utilized several different procedures for finding medical students who were willing to be formally interviewed. First, I asked medical students with whom I had become friends if they would be interested in participating in my reserach, the substance of which I then carefully

explained to them (see Appendix B for a discussion of the procedure I used in obtaining an "informed consent" from all research subjects). Inevitably, these students were eager to cooperate. Following each interview, particularly if it had been an interesting dialogue and the respondent expressed pleasure in having participated (which usually happened), I then asked the student if he or she knew of other students who might be agreeable to being interviewed, and who might provide data bearing on a personal circumstance or private situation that I had not yet investigated. In this sense, many of my respondents referred me to still other respondents. In some cases, students volunteered to contact prospective respondents for me, explain to them the nature of the research, and ascertain their willingness to be interviewed. In other cases, students gave me the names and addresses of other students and told me to contact them, using the former students' name as a reference.

For those students who personally became directly involved in helping me find additional respondents, I gave them xeroxed copies of a formal, one page description of the research project to pass on to prospective respondents. Following this procedure, many medical students later contacted me and said that they had spoken with a given student or students and that, in turn, it would be appropriate for me to follow-up and personally contact them for the purpose of scheduling an interview

appointment.

For those students who gave me the names and addresses of other prospective respondents, and who said that I could use their names as a reference, I composed a formal letter indicating my referral source which I then mailed to the students recommended. I followed up this letter a week later with a telephone call or, in some cases, students called me first. Following this telephone conversation, many students expressed an interest in the study and, indeed, many said they thought it was important research. Most students quickly agreed to an interview. Some students declined to be interviewed, or were somewhat ambivalent. In either case, in no way did I ever attempt to talk a student into agreement; I simply described the research, requested the student's participation, and let the conversation stand on that basis.

Generally, the interviews were extremely absorbing, quickly passed and productive. Medical students are noted for their brightness. They found discussing their private lives rewarding, as most people probably would, simply because it is a topic that is seldom discussed in depth with others, and yet it is of maximum importance to any given person. Moreover, most medical students were generally quite candid in disclosing even the most private aspects of their private lives and relationships with others; their problems, worries, frustrations, disappointments, hopes, and so on. In another important sense,

medical students responded as helpfully and eagerly as they did simply because, for many of them, sustaining a fulfilling, private life while in medical school is a very real challenge, to say the least. Thus, to be interviewed in depth concerning such a very personal issue provided medical students with an opportunity to seriously reflect on their present situations, and to understand those situations in even greater detail.

The substance of both the formal and informal interviewing focused on two different general problems. First, besides what data I was able to gather through published research concerning the nature of professional socialization, I interviewed students concerning the nature of their involvement in medical school; what were the demands placed on their lives, collectively, and what were their schedules, routines, and assorted problems of being medical students. Second, I interviewed students in terms of the meaning of their professional socialization as it related to other aspects of their personal and private lives. For instance, I queried students on how becoming a professional relates to, as they saw it, being a woman, man, single-parent, Chicano, adult, mother, father and so on.

Simultaneous with the collection of interview data, I initiated the procedure of "open theoretical coding." Such a procedure refers to the process of theoretically analyzing and notating the full range (but not amount) of events, problems, processes, characteristics, contexts and

subtleties of the substantive problem being researched. Because collection of the initial substantive sample was not guided by a certain number of predetermined or pre-selected theoretical codes and concepts, open coding involved the process of applying, in a very flexible way, all existing theoretical codes, vocabularies and concepts that were found to be useful in theoretically rendering the data. In other words, in open coding, the language of existing theory became available as a potpourri of ideational counters, foils, catalysts and levers that were used to conceptually "dissect" the given problem. In the present study, the procedure of open coding initially resulted in the generation of a virtual hodgepodge of codes and concepts, some from here, some from there, sitting side by side.

Eventually, however, open theoretical coding, and careful comparison of codes to one another, resulted in the emergence of more central, transcending codes and concepts. For example, in coding the data on students' descriptions of the nature of the professional socialization process in medical school, there were a number of codes used to index various salient features of the process itself. Much of the data referred to the "unnegotiable" aspects of the training, the "highly structured" and "unshareable" aspects of students' involvement, the "high social value," the "uncertainty" and "risk," and the "unremitting workload." All of these theoretical codes, and

many others, were used frequently in open coding, and they served to dimensionalize the professional socialization process itself.

Ultimately, the code "inundating" was used to index data bearing on students' complaints to the extent that their private lives were being flooded out and tyrannized by training itself. Through comparison and reflection on the code "inundation" with all other codes dealing with professional socialization, I began to see two important connections. One, inundation, in some way, shape or form, was a collective problem of all students, as discussed in Chapter Four. Second, inundation was a transcending concept because it subsumed all of the other important codes; i.e., students' lives were inundated at times because of the "unremitting workload," the "inherent uncertainty," "risk," the "unnegotiable aspects of training," and so on.

Finally, two central codes emerged through open coding, that of "inundation" and "articulation." The former code conceptually transcended the larger class of codes that dimensionalized the features of the professional socialization process. The latter code conceptually transcended the larger class of codes that dimensionalized the ways in which students saw their professional socialization relate to their other primary identities, relationships with others, management of time and resources, and their adjustment to different situations. In other words,

the concept, articulation, subsumed the codes of "symbolic calculi," "enblendment," "problematic calculi," "balancing," "exempting," "scheduling," "substituting," "pay-off," "situational adjustment," and so on. It subsumed the symbolic, behavioral, temporal and situational dimensions of the relationship between students' professional socialization and the remainder of their private lives.

Given this stage of the research process, as the conceptual framework began to emerge, grounded in innumerable observations, descriptions, interview data, codes and notations from the field, the procedures of substantive sampling and open theoretical coding were displaced by the procedure of "theoretical sampling" (Glaser and Strauss, 1967). In other words, future data were collected and analyzed with an eye toward further discovering and developing the properties, dimensions, and problems of the central concepts that emerged and "cored out" of extensive open coding and substantive sampling. This involved a concerted effort to seek out data that bore on and revealed the range of properties, dimensions and characteristics of the emerging theoretical perspective itself.

For instance, in terms of the dimension of "symbolic articulation," I had already collected and coded data bearing on "problematic calculi," particularly as it related to problems expressed by women medical students. For the purpose of theoretical sampling, however, I needed to return to the field and interview several more women

students specifically on the problem of problematic articulation itself. Doing so revealed, comparatively speaking, the array of meanings that women students themselves expressed in terms of the problems they encountered, particularly symbolically and situationally, in being both women and medical students. In an important sense, in returning to the field for the purposes of theoretical sampling, I attempted to gather more rich and comparative data bearing on every concept and problem of the theoretical perspective that had emerged. In doing so, I revealed to the students being interviewed the specific problem or concept being investigated. In this way, the validity of each particular theoretical point or assertion was directly put to the "test" in terms of its relevance, recognizability, and congruence with respect to students' own experience and reactions to the analysis.

The theoretical perspective, therefore, by virtue of the procedure of theoretical sampling, became both progressively more developed and verified within the research process itself. Eventually, sufficient data had been gathered on the variety of meanings, interpretations and responses that students expressed toward any given aspect of the theory that I virtually could not locate any major exceptions, or exceptions that could not be immediately elaborated into the perspective. At this time, in fall, 1977, I ceased theoretical sampling, sorted my notes and memos into the framework of the perspective itself, and

proceeded to write up the first draft of the research.

Memoing and Sorting

Throughout the research project, I was writing very detailed and copious memos or notes on the analysis itself, particularly in terms of conceptually developing the meaning of the codes which had been applied to the data, and in comparing the codes to one another. Essentially, following the style developed by Schatzman and Strauss (1973), three different types of memos were written. First, there were observational memos which consisted of descriptive reflections on the lives of medical students, as well as descriptive observations of events and happenings that I had observed firsthand in the medical student community. Observational memos were fundamentally descriptive in nature, primarily in the service of substantive sampling, as described above. For instance, the following is an example of an observational memo, written early in the analysis, bearing on an interview with one student and his wife as they discussed a number of apparent "threats" to their family life while in medical school:

> 7. Threats to spouse and student. (Cont., see memos 2, 3, and 4): Student in Family A alludes to constant concern about proving self toward profs and faculty. His reference group is school. Spouse's reference point however is other spouses, as evidenced by her expression of self-consciousness and embarrassment, and competition with other housewives who "keep their houses so neat, and who appear to always be so together."

> She felt any time she stepped outside she should put on a pleasing face and demeanor. She was surprised because people always commented on how "together" she always seemed (A,II:1).

Note that each memo was numbered and given a brief title for easy reference. The symbols at the end of some memos, such as the one above, indexed the memo with a specific set of data; for instance, this memo was indexed with data derived from an interview with Student A, second interview, page one.

In addition to observational memos, methodological memos were also compiled. Such memos consisted of a series of directives as to emerging problems and issues in the research that I needed to attend to in the immediate future. In a sense, methodological memos represented a built-in monitoring process of the research itself, supplying me with reminders as to things to do, people to contact, new questions to ask during upcoming interviews, and so on. For example, the following is one such methodological memo:

> 26. Substantive focus: It's becoming apparent that the problem of this study is structural inundation, but the focus is on "students in an intensive training program," especially medical, dental, pharmacy and bio-medical sciences. Thus, I must begin making comparisons in terms of the different structural conditions or imperatives of the various programs themselves: Obviously these differences substantively give rise to many different kinds of adaptive responses. Differences in options, electives, leaves of absence, policies on dropping courses, taking incompletes, scheduling, timing. While each program may tend toward inundation in its own way (indeed, even soc. graduates, in a very loose structure, complain of it),

> the possibility of inundation is varied within each program in terms of the latter's flexibility, and varying properties of intensity, tempo, negotiability, duration, etc.

Finally, theoretical memos were also compiled, which consisted of memos bearing on, and conceptually elaborating, the emerging theoretical framework. In an important sense, these memos were used to examine in greater detail the theoretical codes themselves which had been applied to the interview data. For instance, the code "exemption" was used frequently in notating students' descriptions of some of the constraints placed on their relationship with others by virtue of their involvement with training. Careful examination of the protocols with reference to the construct "exemption" revealed that there were, in fact, many different types of exemption. The theoretical memo below represented one of the first memos specifically focused on conceptually elaborating, or "thinking through," the code "exemption":

> 49. Exemption:dimensions: (see also memo 47) Student F spoke of a number of different types of exemption. At least three different dimensions exist: Physical, psychological and social. Logical elaboration of the combinations could indicate possible problems - physical exemption, but not psychological, vice versa, etc. Student F obtained social exemption from having to help the family move from one apartment to another, but she had to gain physical exemption in order to really secure it.

In terms of evolution of this study, the continuous writing and compilation of memos served a number of important functions. First, as a process, memoing served as

a vehicle for the progressive collection of ideas and concepts which eventually became organized into the theoretical framework of the study. In this sense, the writing up of the research began at precisely the same time as the research project itself. Ideas, thoughts, flashes of insight, reflections, questions and hypotheses were continuously committed to paper, elaborated upon, critiqued and compared with one another. Conceptual development of certain passages, transition sentences, and key paragraphs were also worked out in memos, particularly as such statements, concepts and organizing schemes "came to mind" unexpectedly, night or day. This progessive build-up and collection of concepts and analyses in the form of hundreds of memos, varying in length from mere sentences to several, detailed paragraphs, ultimately yielded every major problem, process, issue, topic, discussion, critique and construct presented in the complete research manuscript. In other words, writing up the first draft of the research amounted to <u>rewriting</u> in clear, concise language what had already been conceptually specified, organized and elaborated upon in the memos themselves.

A second function which memoing served was to provide a means of theoretical analysis and writing that complimented, or did not interfere with, the natural, subliminal processes of intellectual thought and personal pacing. By this I mean that memoing was a maximally efficient, convenient and nonthreatening process for writing and

analysis. Memoing provided a method for recording thoughts and ideas that emerged unexpectedly and at any time. It was an informal, reflexive, introspective process; or, put another way, memoing became an extension of, and a means of cultivating and recording, the internal, intellectual dialogue that I attempted to establish with myself in terms of pondering, both intentionally and preconsciously, various aspects of the research problem. Indeed, memoing frequently served as a reinforcement to such subliminal intellectual work because, as such thought found a means of expression, I became that much more aware of its importance and that much more prepared to pace myself in terms of providing the time and patience necessary for such thinking to run its own natural course, without being forced.

Finally, writing analytic memos permitted me to share with others the research in progress, regardless of the particular stage in which, or how far along, the analysis was. Such sharing of memos with colleagues and the dissertation committee was exceedingly helpful because it enabled me to disclose, and keep others informed of, the progress of the research, the specific problems and issues that were being worked out at any given moment, as well as evolution of the entire analysis from beginning to end. In other words, memos provided a means through which I could "keep in touch" with significant others, and thus avoid the situation, frequently experienced by graduate students,

of finding myself lost in the research project, or estranged from a meaningful dialogue with others due to an inability to provide them with a documentation of what has happened in the research, or a statement as to what (new) direction I seemed to be headed. Finding myself in such a predicament would have also severely limited the possibility of meaningful input by others into the research analysis itself.

Memoing permitted a high level of sharing for two reasons. First, memo writing is, by definition, rather rough and crude in style, punctuation and choice of words; grammatical rules are suspended in service of hacking out conceptual outlines, ideas and hunches. The objective in memoing is not to be neat and correct, but conceptually open, searching and creative. Thus, I found myself much more inclined to share with others simply because such memos are meant to be considered <u>without</u> reference to the traditional canons of academic scholarship, but <u>with</u> reference to the specific objective of furthering the conceptual and analytic development of the research.

Second, memoing is continuously in service of taking intellectual risks and flings, all in the name of discovery and creativity. Thus, memos provided me with the opportunity to be sometimes right and sometimes wrong. But either way, memoing gave me the opportunity to experiment without fear of penalty, to try ideas out, and to write and share my writing within a nonjudgmental and nonthreatening atmosphere. In this sense, I felt much more

inclined to share my work in progress with others because the intellectual "stakes" were minimized, and the exchange with faculty and colleagues was intended to strengthen and collaboratively improve the analysis, rather than judgementally evaluate it as even a near-finished product.

Eventually, having compiled memos for over two years, sufficient memos had been written and compared with one another to yield the overall theoretical framework of the analysis. In other words, as memos were compiled, the conceptual development of the analysis became progressively more elaborated, built-up and specified. For example, late in the memoing process, a number of very abstract memos were written that pulled together and synthesized a number of other memos which focused on various dimensions of the process of articulation. These memos eventually were used to write one, long memo which stated the entire theoretical framework of the dissertation, as presented in Chapter One (page 16-21). Given this stage in the analysis, in addition to the process of memoing, I proceeded to <u>sort</u> all of the memos, from beginning to end, in terms of the various points of the larger, overall theoretical framework.

For example, memos dealing with inundation were sorted into the pile indexed the "behavioral dimension." Memos dealing with time were sorted into the pile dealing with the "temporal dimension." Once all of the memos had been sorted into all of the general piles, which roughly corresponded to all of the chapter headings (see the Table of

Contents), I then proceeded to do internal sorts of the memos in each major section. In terms of internal sorting, careful and patient examination of each memo eventuated in my recognizing the necessary and logically consistent subsections of each chapter, and thus the memos in each major section were subdivided accordingly (again, see the Table of Contents). Sorting of the memos was, therefore, a very important process in and of itself. Sorting forced logical placement of each memo into the overall framework of the analysis, and it forced logical division of memos in each section into subcategories. In addition, sorting served another important function.

Sorting all of the memos revealed which subsections of the theoretical framework still suffered from the lack of either too little data, or too few memos. Many sections were rich in both, others required considerable more work. Some of this work required more interviewing, or more careful examination of existing data, or writing important transition sentences, and so on. Thus, sorting of memos revealed exactly how much more research and conceptual work was required before I could begin writing the first draft of the manuscript. And, as the memos sat in neatly separate and organized piles all over my desk and living room, they served to assure me that the bulk of the conceptualization and writing of the research manuscript was already accomplished.

Methodological Conclusion

By virtue of following the analytic procedures of substantive sampling, open theoretical coding and theoretical sampling, this research yielded a theoretical perspective on multiple identities and their articulation. The nature of students' involvement in medical school, or the nature of the professional socialization process, became the social structural "backdrop" of the perspective. The social psychological and interactional process of articulation became the ways in which students and their significant others were seen to interpret, assemble and sustain their own private lives in the face of students' participation in medical school. The research process itself evolved on the basis of a simultaneous process of collecting, coding and analysis of data.

As an additional summary, perhaps it would be worthwhile to formally specify the "criteria of proof," briefly alluded to above, that was held toward the research during the entire process. First, I was very concerned with producing a "grounded" theoretical analysis; that is, in keeping with Glaser and Strauss (1967), the eventual theoretical perspective had to evolve out of a process of research itself, rather than being specified through an abstract, logical kind of analysis, prior to research itself. Plus, by "grounded," the analysis had to correspond to Schutz's (1964) postulate of "subjective interpretation:" The research had to be infused with the first

order meanings and interpretations of the subjects being researched.

Second, the research had to conform to Schutz's (1964) postulate of "logical consistency:" The eventual theoretical perspective had to evidence an internal, logical symmetry and succinctness.

Third, the research findings had to conform to another postulate of Schutz (1964), that of "recognizability." The theoretical perspective, as developed, had to evidence face validity, and be understandable and sensible to the subjects of the research itself. As discussed above, an endeavor was made to continuously test out the findings of the study by disclosing to the research subjects themselves the essentials of the research, and to obtain their reactions and impressions.

Finally, the research had to be "reflexive." It was incumbent upon me to reveal the assumptions and procedures used to conduct the research and to develop the perspective.

Footnotes

1. A single exception to this is Davis and Olesen's (1972) short study on "identity problems in the status transition of coed to student nurse." Davis and Olesen analyzed a number of "identity stresses" between individuals' identities as student-nurses and essentially two other identities, those of "adult" and "eligible female." As such, Davis and Olesen's study, while revealing in its insight, was nonetheless limited particularly since the research omitted analysis of a number of other important identities that students embrace. Moreover, Davis and Olesen (1972:21) suggested that the identity stresses mentioned could be unique to nursing, although "...it would be premature to conclude that analogous phenomena are not to be found in other professional fields as well."

   In these respects, the study offered here is intended to offer an examination, in an altogether different substantive area, of the generalizability of some of Davis and Olesen's findings, as well as to provide a more complete analysis that focuses on how emerging professional identities relate to a much larger array of competing roles and identities.

2. An exception to this is the literature on "role-conflict." Particularly structural sociologists have examined the problem of individuals finding themselves in situations wherein they face a conflicting number of role demands. The most classic analysis is Goode's (1960) A Theory of Role Strain.

   However, in the same way structuralists argue that individuals act in terms of roles that exist transcendental to individuals, and that largely prescribe appropriate ways of behaving,rather than roles being lines of action that individuals themselves creatively fashion in situations on the basis of communication and interaction with others, structuralists typically analyze certain types of role conflicts as producing certain types of predictable consequences. Their analyses, therefore, remain largely focused at the level of preexisting roles and social structures as shaping behavior, rather than on the social psychological and interactional processes of how individuals themselves articulate multiple roles and identities, and how individuals' subsequent behaviors are a consequence of a process of articulation itself.

Structuralists have developed, therefore, no theory of identity articulation because such an analysis would require them to shift their theoretical focus from the assumption that social structure and roles determine behavior, to the assumption that behavior is a consequence of individuals' interaction and communication with themselves and others.

3. A further discussion and illustration of this problem is offered in Chapter Six (page 130-131) with reference to Becker and Geer et al.'s (1961;1968) research.

4. Glaser and Strauss' (1971) study of Status Passages offers an analysis of the ways in which individuals articulate multiple status passages, rather than identities. Their theory of articulation frequently intersects with the present study in a number of important ways, although the major dimensions of articulating multiple status passages are altogether different, theoretically, than the dimensions examined here that are involved in the articulation of multiple identities.

5. There have been a number of studies on normalization processes in different substantive contexts (cf., Davis, 1963; Lemert, 1967; Yarrow and Schwartz et al., 1955).

6. I am stating a generalization here and, as with all generalizations throughout this study, there are exceptions. Instances of students having difficulty in symbolically articulating their lives as students, spouses and parents, etc., are discussed in the section of this chapter on "problematic articulation."

7. The most recent study available on the number of medical students who are married is Crocker (1974). This study, based on a national survey, reported that in 1971, 47 percent of all medical students were married. The distribution of married students according to year in training was as follows:

Freshmen	35%
Sophomore	41
Junior	51
Senior	65

8. As an orientation, the women's health perspective, as well as any other perspective, is potentially

available to all students, and undoubtedly many students who do not share the identity that underlies a perspective are nevertheless sympathetic and supportive of the perspective itself.

Appendix A

First Interview Guide

Introduction: Purpose - substantive and theoretical
Assurances - confidentiality
"Key" of respondents' names
No mention of apartment complex
Permission to tape - How analyzed relevance and irrelevance of questions

Biographical Facts

Date:
Composition, Age and Ethnicity of Family:

Formal Education:

City of Residence prior to university entrance:
Occupation:

Religious Affiliation:

I. Coming to Medical/Dental/Professional School:

1. Describe the events in your lives before you came to school. Alternate plans or goals, occupations.

2. Describe the events that led to your application to school.

3. After being accepted, were there any misgivings about going?

4. What are your feelings now about your original reasons for coming? Your original misgivings?

Appendix A continued

II. Being in School:

5. Describe a typical work/school day and evening. Differing schedules/responsibilities/housework/ childcare/meals:

6. Typical weekend:

7. Favorite pastime activities for yourself/family:

8. Relationship with fellow students and families of fellow students:

9. Relationship with relatives/parents/old friends:

10. Relationship with school/faculty/degree of support.

III. Leaving School

Entrants: What are your plans after leaving? How, if any, do you expect this experience will affect your family relationships?

Veterans: In what ways have the relationships within the family changed since coming to school?

Have you noticed your typical changes in other families?

What are your future plans?

To a prospective student, what advice would you offer him/her with respect to family relationships?

To a spouse of a prospective student, what advice would you offer him or her?

Appendix A continued

Second Guide for Open Ended Interviewing

1. When you think of yourself in terms of "who am I," what identities do you embrace other than that of being a medical student? (sample for contradictions or surprises)

2. In view of all of these identities, discuss the process of presenting yourself to the medical school in order to gain admission.

3. (For spouses/parents) As a (husband/wife/parent) do you see your involvement in medical school as a simultaneous fulfillment of your role as a (husband/wife/parent), or as a rather independent activity?

4. What are some of the difficulties of being both a medical student and----------a single person
   spouse woman
   parent
   family member
   ethnicity
   (sample for differences between feminists and traditional)

5. Except for short periods of time, have you been a student most of your life? (If yes) do you see becoming a physician as an avenue of achieving total adulthood, socially?

   (a) (If yes) Do you think having been a student this long has denied or delayed you in having the wherewithal to live your life as you think an adult should?

   (b) (If no) Did you have an occupation or begin raising a family prior to enrolling in medical school?

   (If yes) Do you think that enrolling in medical school makes a student feel "as if" they have been regressed back into some earlier stage of life, say post-adolescence?

   Do you think that enrolling in medical school in some ways denies or circumscribes the wherewithal that most people expect in order to live as adults?

6. (For married students or family members) Would you say that, in order to manage medical school, in terms of

Appendix A continued

energy, schedules, work load, and priorites, that your relationship toward your (spouse/family) must become secondary or subservient of your primary objective - to successfully get through medical school? Sample for elaboration.

(If so) Due to internship and residency, and the problems associated with establishing a practice, do you think that this subservience of the (marriage/family) will significantly change in the future? Elaboration.

8. How do you think, if any, the appearance and presence of (women/minorities) have changed the situation of medical training - medical practice?

9. (Single students) In what ways, if any, does being in medical school affect your social/sexual life as a (man/woman)?

10. (Single students) In what ways, if any, does being in a medical school setting provide opportunities for expression of one's social/sexual identity?

11. In becoming a medical student, have you had to abandon previous interests or identities that you previously embraced?

12. In periods of slack time during classes, between quarters, or on vacations, what do you do with your time?

13. During slack time and vacations, is there a tendency to pack into one's free time all the other experiences that one foregoes while in training?

14. What do you want to do with your life other than practice medicine? How do you see becoming a physician supportive of these endeavors.

15. How are your decisions or plans regarding internship affected by your attitude toward your private life and interests? - your selection of specialties?
- your selection of a future area in the country to establish a practice?

Appendix B

Achieving Informed Consent

Throughout the course of the study, in terms of conducting both informal and formal interviews, every effort was made to obtain an "informed consent" from the research subjects to, in fact, be research subjects. This always included a detailed disclosure as to the nature of the research, objectives, and even the theory underlying the questions.

For those individuals who consented to formal interviewing, I additionally received from them a signed statement regarding their consent (a copy of this consent form is found on the following page).

Finally, in keeping with the requirements of the University of California, I submitted my research proposal for review by the Committee on Human Research. The proposed research was approved, as well as the methods I used in gaining informed consent from all research participants.

Appendix B continued

Consent to Act as a Research Subject

Study on the meaning of professional socialization in the private lives of medical students, University of California, San Francisco, California.

Study Number: 930810-01

Mr. Robert Broadhead, a graduate student in sociology, UCSF, has explained the study to me. He can be reached at 665-4494.

I understand that the purpose of this study is to explore the meaning and impact of professional socialization as it affects the private lives of medical students.

I also understand that the interview is confidential and that every precaution will be taken to safeguard the anonymity and trust of those who consent to participate. I further understand that I can withdraw at any time without penalty and definitely without jeopardy to my professional employment or standing as a student.

I understand that there will be no benefits to me personally, but it is possible that the information sought will positively benefit future medical students by providing greater insight into the problems and processes of professional socialization itself.

Signature_____

Date_____

References

Andelin, Helen B.
1963 Fascinating Womanhood. Santa Barbara, Ca.: Pacific Press.

Arms, Suzanne
1975 Immaculate Deception: A New Look at Women and Childbirth in America. Boston: Houghton Mifflin.

Balch, Robert and Taylor, David
1976 "Walking out the door of your life: becoming a member of a contemporary UFO cult," paper presented at the meetings of the Pacific Sociological Association, March.

Becker, Howard S.
1968 "Personal change in adult life," in Bernice L. Neugarten (ed.) Middle Age and Aging. Chicago: University of Chicago Press.
1968a "The Self and adult socialization," in Edward Norbeck, Douglas Price-Williams and William M. McCord (eds.) The Study of Personality. New York: Holt, Rinehart and Winston, Inc.

Becker, Howard S.; Geer, Blanche; Hughes, Everett C. and Strauss, Anselm L.
1961 Boys in White: Student Culture in Medical School. Chicago: University of Chicago Press.

Becker, Howard S.; Geer, Blanche and Hughes, Everett C.
1968 Making the Grade: The Academic Side of College Life. New York: John Wiley and Sons, Inc.

Berger, Peter L. and Luckman, Thomas
1967 The Social Construction of Reality. Garden City, N.Y.: Doubleday and Co., Inc.

Blackman, Rosemary
1972 "How to treat your doctor," Vogue, Nov. 15: 115-120.

Bloom, Samuel W.
1963 "The process of becoming a physician," The Annals of the American Academy of Political and Social Sciences 346 (March): 77-87.

Blumer, Herbert
1956 "Sociological analysis and the variable," American Sociological Review 21 (December): 683-690.
1967 "Society as symbolic interaction," in Jerome G. Manis and Bernard N. Meltzer (eds.) Symbolic Interaction. Boston: Allyn and Bacon.
1969 Symbolic Interactionism. Englewood Cliffs, N.J.: Prentice-Hall, Inc.

Bolton, Charles D.
1963 "Is sociology as behavioral science?" Pacific Sociological Review 6 (Spring):3-9

Boston Women's Health Book Collective
1973 Our Bodies, Our Selves. New York: Simon and Schuster.
Broadhead, Robert S.
1974 "Notes on the sociology of the absurd: an under-socialized conception of man," Pacific Sociological Review 17 (January): 36-45.
Bruhn, J.G. and du Plessis, A.
1966 "Wives of medical students: their attitudes and adjustments," Journal of Medical Education 41: 381-385.
Bruyn, Severyn T.
1966 The Human Perspective in Sociology. Englewood Cliffs, N.J.: Prentice-Hall, Inc.
Buckley, Walter
1967 Sociology and Modern Systems Theory. Englewood Cliffs, N.J.: Prentice-Hall, Inc.
Burke, Kenneth
1954 Permanence and Change. Indianapolis: The Bobbs-Merrill Co.
Christe, Richard and Merton, Robert K.
1958 "Procedures for the sociological study of the values climate of medical students," Journal of Medical Education 3, pt. 2: 125-153.
Coombs, Robert H. and Vincent, Clark E.
1971 Psychological Aspects of Medical Training. Springfield, Illinois: C.C. Thomas.
Cory, Donald Webster and Leroy, John P.
1963 The Homosexual and His Society. New York: Citadel Press.
Crawford, Carolyn S.
1972 "Today's women in medicine," The New Physician 21 (October): 580-585.
Crocker, Anna R.
1974 How Medical Students Finance Their Education. Washington, D.C.: U.S. Government Printing Office.
Daley, Timothy M.
1973 "Women in medicine: an exchange," The New Physician 22 (September): 548.
Damrell, Joseph
1977 Seeking Spiritual Meaning: The World of Vedanta. Beverly Hills: Sage Publications.
Davis, Fred and Olesen, Virginia
1972 "Initiation into a woman's profession: identity problems in the status transition of coed to student nurse," in Fred Davis, Illness, Interaction and the Self. Belmont, CA.: Wadsworth Publishing Co.
Douglas, Jack D.
1970 Understanding Everyday Life. Chicago: Aldine.
Dr. X
1965 Intern. New York: Harper and Row.

Eagle, J.R. and Smith, B.M.
1968 "Stress of the medical student wife," Journal of Medical Education 43: 840-845.
Ehrenreich, Barbara
1973 Witches, Midwives and Nurses. Old Westbury, N.Y.: The Feminist Press.
Ehrenreich, Barbara and English, Deirde
1973 Complaints and Disorders: The Sexual Politics of Sickness. Old Westbury, N.Y.: The Feminist Press.
Epstein, Cynthia Fuchs
1971 Woman's Place. Berkeley: University of California Press.
Eron, Leonard D.
1955 "Effects of medical education on medical students," Journal of Medical Education 10: 559-566.
Filmer, Paul; Phillipson, Michael; Silverman, David; Walsh, David.
1972 New Directions in Sociological Theory. Cambridge, Mass.: The MIT Press.
Foote, Nelson N.
1951 "Identification as the basis of a theory of motivation," American Sociological Review 16 (February): 14-21.
Fredrick, Marcel A. and Mundy, P.
1976 The Making of a Physician. Chicago: Loyola University Press.
Freidson, Eliot
1970 Professional Dominance. New York: Atherton Press.
Gans, Herbert J.
1962 The Urban Villagers. New York: The Free Press.
Garfinkel, Harold
1967 Studies in Ethnomethodology. Englewood Cliffs, N.J.: Prentice-Hall.
Glaser, Barney G. and Strauss, Anselm L.
1964 "Awareness contexts and situated interaction," American Sociological Review 29 (October): 669-679.
1967 The Discovery of Grounded Theory. Chicago: Aldine.
1971 Status Passages. Chicago: Aldine.
Goffman, Erving
1963 Stigma. Englewood Cliffs, N.J.: Prentice-Hall.
1967 "Embarrassment and social organization," in Erving Goffman, Interaction Ritual. Garden City, N.J.: Doubleday and Co., Inc.
Goode, William J.
1960 "A theory of role strain," American Sociological Review 25 (August): 483-496.
Gross, Edward and Stone, Gregory P.
1970 "Embarrassment and the analysis of role requirements," in Gregory P. Stone and Harvey A. Farberman (eds.) Social Psychology through Symbolic Interaction. Waltham, Mass.:Xerox College Publishing.

Hayes-Bautista, David Emmett
1974 Becoming Chicano: A "Dis-assimilation" Theory of Transformation of Ethnic Identity. Unpublished Ph.D. dissertation: University of California, San Francisco.

Howe, Henry F.
1954 "Family and community relations," in Joseph Garland (ed.) The Physician and his Practice. Boston: Little, Brown and Co.

Illich, Ivan D.
1976 Medical Nemesis: The Expropriation of Health. N.Y.: Pantheon Press.

Irwin, John
1977 Scenes. Beverly Hills: Sage Publishing.

James, William
1910 Psychology. New York: Henry Holt and Co.

Kiev, Ari
1968 Magic, Faith and Medicine. New York: The Free Press of Glencoe.

Klapp, Orrin
1964 Symbolic Leaders. Chicago: Aldine.
1969 Collective Search for Identity. N.Y.: Holt, Rinehart and Winston, Inc.

Laing, R.D.
1959 The Divided Self. Baltimore, Maryland: Penguin Books.

Lemert, Edwin M.
1967 Human Deviance, Social Problems and Social Control. Englewood Cliffs, N.J.: Prentice-Hall, Inc.

Lindesmith, Alfred R.; Strauss, Anselm L. and Denzin, Norman K.
1975 Social Psychology. Hinsdale, Illinois: The Dryden Press.

Lofland, John
1966 Doomsday Cult: A Study of Conversion, Proselytization and Maintenance of Faith. Englewood Cliffs, N.J.: Prentice-Hall, Inc.

Lopate, Carol
1968 Women in Medicine. Baltimore, Maryland: The John Hopkins Press.

Lovell, John P.
1964 The professional socialization of the West Point Cadet," in Morris Janowitz (ed.) The New Military. New York: Russell Sage.

Lum, Carolyn
1975 "The fascinating womanhood counter-movement: a theoretical formulation," paper presented at the Pacific Sociological Association meetings, Victoria, B.C.

McCabe, Kathryn L.
1954 "The doctor's wife," in Joseph Garland (ed.) The Physician and his Practice. Botson: Little, Brown and Co.

Mead, George Herbert
1934 Mind, Self and Society. Chicago: University of Chicago Press.
Mechanic, David
1968 Medical Sociology, New York: The Free Press.
Merton, Robert K.; Reader, George; Kendall, Patricia
1957 The Student-Physician. Cambridge, Mass.: Harvard University Press.
Mills, C. Wright
1940 "Situated actions and vocabularies of motive," American Sociological Review 5 (December): 904-913.
Neugarten, Bernice L.; Moore, Joan W.; Lowe, John C.
1968 "Age norms, age constraints and adult socialization," in Bernice L. Neugarten (ed.) Middle Age and Aging. Chicago: University of Chicago Press.
Olesen, Virginia
1976 Women and their Health. U.S. Dept. of Health, Education and Welfare: National Technical Information Service.
Olesen, Virginia and Whittaker, Elvi W.
1968 The Silent Dialogue, San Francisco: Jossey-Bass.
Parson, Talcott
1951 The Social System. Glencoe, Illinois: The Free Press.
Perlow, Arlina D. and Mullins, Stella C.
1976 "Marital satisfaction as perceived by the medical student's spouse," Journal of Medical Education 51:726-734.
Rice, Berkeley
1976 "Messiah from Korea: Honor thy Father Moon," Psychology Today 9 (January): 36-47.
Rosenbaum, Marsha
1977 "Women's distinct health problems," unpublished paper, Graduate Program in Sociology: University of California, San Francisco.
Ruzek, Sheryl K.
1975 Women and Health Care. Evanston, Illinois: Program on Women, Northwestern University.
Schatzman, Leonard and Strauss, Anselm L.
1966 "A sociology of psychiatry: a perspective and organizing foci," Social Problems 14 (Summer): 3-17.
1973 Field Research. Englewood Cliffs, N.J.: Prentice-Hall.
Schutz, Alfred
1962 Collected Papers. The Hague: Martinus Nijhoff.
1964 Collected Papers. The Hague: Martinus Nijhoff.
Scott, Marvin B.
1970 "Functional analysis: a statement of problems," in Gregory P. Stone and Harvey A. Farberman (eds.) Social Psychology through Symbolic Interaction. Waltham, Mass.: Xerox College Publishing.

Shibutani, Tamotsu
1961 Society and Personality. Englewood Cliffs, N.J.: Prentice-Hall, Inc.
1967 "Reference groups as perspectives," in Jerome G. Manis and Bernard N. Meltzer (eds.) Symbolic Interaction. Boston: Allyn and Bacon.

Stone, Gregory P.
1970 "Appearance and the self," in Gregory P. Stone and Harvey A. Farberman (eds.) Social Psychology through Symbolic Interaction. Waltham, Mass.: Xerox College Publishing.

Strauss, Anselm L.
1969 Mirrors and Masks. San Francisco: The Sociology Press.
1977 "Social Worlds," paper presented at the Society for the Study of Symbolic Interaction meetings, San Francisco, CA.

Strauss, Anselm L.; Schatzman, Leonard; Bucher,Rue; Erhich, D.; Sabshin, Melvin.
1964 Psychiatric Ideologies and Institutions. New York: The Free Press.

Travisano, Richard V.
1970 "Alternation and conversion as qualitatively different transformations," in Gregory P. Stone and Harvey A. Farberman (eds.) Social Psychology through Symbolic Interaction. Waltham, Mass.: Xerox College Publishing.

Tringo, John L.
1970 "The hierarchy of preference toward disability groups," Journal of Special Education 4 (Summer): 295-306.

Truman, Stanley R.
1951 The Doctor: His Career, His Business, His Human Relations. Baltimore: Williams and Wilkins Co.

Turner, Ralph
1962 "Role-taking: process versus conformity," in Arnold M. Rose (ed.) Human Behavior and Social Processes: An Interactionist Approach. Boston: Houghton Mifflin.

Warkov, Seymour and Zelan, Joseph
1965 Lawyers in the Making. Chicago: Aldine.

Wilson, Thomas P.
1970 "Conceptions of interaction and forms of sociological explanation," American Sociological Review 35 (August): 697-710.

Wrong, Dennis
1961 "The oversocialized conception of man in modern sociology," American Sociological Review 26 (April): 183-193.

Yarrow, Marian; Schwartz, Charlotte; Murphy, Marriet; Deary, Leila
1955 "The psychological meaning of mental illness in the family," Journal of Social Issues 21 (Spring): 12-24.