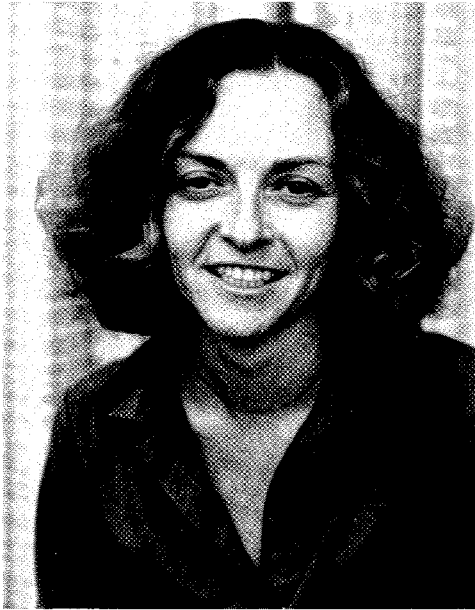


Pregnancy during residency: attitudes and policies



Johanna Shapiro, Ph.D.*

Residents are taught that pregnancy and childbirth are significant developmental events in the life cycle of any family. Yet, residency programs are silent on the subject of pregnancy in their own female residents, who are often treated on an ad hoc, crisis basis. The result is additional stress for both faculty and residents.

The present study sought to explore ways of dealing effectively and sensitively with the issue of pregnancy among residents. Basic goals were to identify existing departmental policies and provisions in the area of pregnancy and childbearing; to assess attitudes of faculty and residents toward pregnancy during residency and toward the feasibility and desirability of balancing family and career; and to elicit suggestions for policy changes.

To this end, a survey questionnaire was mailed to all faculty members and residents at a major university medical center, with an overall response rate of 35.3%.

Analysis of variance indicated that male respondents had a significantly more negative attitude toward pregnancy during residency than female respondents did ($p < .001$). Male respondents also felt that the general environment of a medical center was less favorable to the pregnant resident than female respondents did ($p < .03$). Further, male respondents reflected a significantly more negative attitude toward the feasibility and desirability of balancing family and career ($p < .04$). Finally, residents perceived the attitude of their own departments toward the pregnant resident as significantly more negative than faculty did ($p < .001$).

The problem

Residency programs often find themselves unprepared to deal on a regular basis with women residents who also want to be mothers. Women residents who become pregnant during their residency are treated on an ad hoc, crisis basis. The result may be additional stress for both faculty and residents, hastily constructed solutions, and at times inequities. Yet pregnancy and childbearing among residents cannot be ignored. During her time as a resident, a woman is often at the peak of her childbearing years. Simultaneously, having selected a field which is still largely dominated by males, she may feel in conflict about expression of her feminine identity.¹ The implicit message from a nonsupportive department that she is not expected to have children may reinforce her fear that to be a doctor she must deviate significantly from her sex and gender roles.² Thus, the conflicts and dilemmas of the pregnant resident may not be so much intrapsychic, as has at times been posited,³ but rather appropriate responses to negative environmental stimuli, in the form of colleagues' and supervisors' anxiety, hostility, and jealousy.⁴ There is widespread agreement that the wellbeing of women physicians is related to the types of solutions they find for the stresses of combining dual family and professional roles.^{5, 6, 7, 8}

The present study sought to explore further ways of dealing effectively and sensitively with the issue of pregnancy among women residents. The study specified four major objectives:

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1. To identify existing departmental policies in the area of pregnancy and childbearing;
2. To establish whether a need exists to develop specific policy in this area;
3. To assess the level of stress caused by pregnancy and balancing family and career during residency;
4. To assess attitudes of faculty and residents toward the pregnant resident and toward the balance of family and career.

Methodology

A survey questionnaire was mailed to all faculty and residents at a major state university-sponsored medical facility on the West Coast. Four months later a second mailing was sent to nonrespondents. Despite several informal mechanisms to promote completion of the survey, combining responses to first and second mailings, we obtained the following response rates: 44.2% for male faculty; 53.3% for women faculty; 30.1% for male residents; and 41.1% for women residents. Number of subjects cited in the results section refers to actual respondents and not the total number surveyed.

Questionnaires were five pages long, and considered both open-ended and closed-ended questions on departmental policies and procedures regarding pregnancy; and on attitudes of respondents toward pregnancy during residency and toward the balancing of family and medical career. Initially, questionnaires were pilot-tested by 10 residents to ensure clarity of items and to determine a reasonable time for completion of the form.

Subjects

Subjects consisted of 76 male faculty and 8 female faculty; and 143 male residents and 44 female residents. The mean age of male faculty was 41.2 years and of female faculty 41.8 years. The mean ages of male and female residents were 29.9 years and 30.1 years respectively.

Marital status. Of the male faculty ($N = 74$), the great majority were married, while among the female faculty ($N = 7$), larger numbers of single, divorced or separated women were found as compared to the male faculty. Among the residents, males ($N = 141$) tended to be married more often than did females ($N = 44$).

Children and plans for children. Of the male faculty ($N = 75$) 54 had children, while 24 had three or more children. The women faculty ($N = 7$) reported four having no children, although this may be an artifact of

their marital status. The resident group, as might be expected, reported somewhat lower numbers of children: 50 of the males ($N = 143$) and 16 of the females ($N = 44$) reported already having at least one child. Seventy-six males and 22 females planned on (more) children.

Breakdown by specialty. Among the faculty there was a fairly even distribution between primary care specialties (here operationalized to include internal medicine, family medicine, pediatrics, and ob/gyn) and other specialties (such as anesthesiology, dermatology, radiology, surgery, neurology, ophthalmology, etc). Psychiatry was somewhat overrepresented among women faculty. However, among the resident sample, respondents reflected a definite skew toward the primary care specialties, with 29 of 43 women and 87 of 143 men coming from primary care programs.

Year in residency. The resident sample spanned the spectrum of the residency years.

Analysis

Three scales were formulated from statements rated on a 5 point scale by respondents indicating a range of agreement or disagreement with the item. Scale items were determined in the following way: 1) A literature review on topics identified by the scales was conducted to generate potential items. 2) Pilot-testing of a pool of items was then carried out with 10 family medicine residents, who rated items as either reflecting a negative or a positive view. 3) Items on which all 10 residents agreed were included in the final versions of the scales.

The scales were respectively: a) The personal attitude toward pregnancy during residency scale. This scale consisted of 13 positive and negative items, such as pregnancy during residency can be a positive experience (+); female residents should postpone their families until after completion of their residency (-). b) The environmental attitude toward pregnancy during residency scale. This scale measured respondents' perceptions of the favorability or lack thereof in the general medical and social environment toward the pregnant resident. Aspects measured included attitude of other residents and departments, attitudes of patients, spouse and health care personnel, and the perceived availability of adequate childcare. The scale consisted of eight items. c) Attitudes toward the desirability and feasibility of balancing family and career.

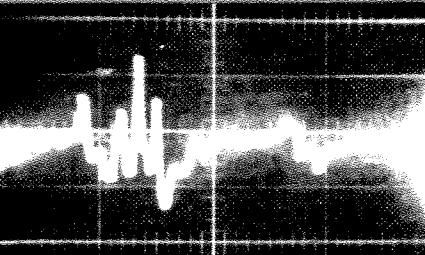
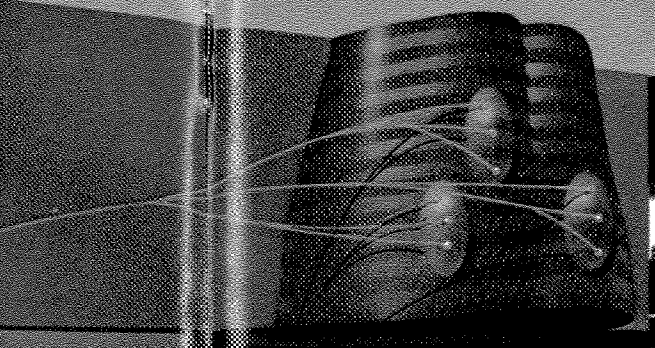
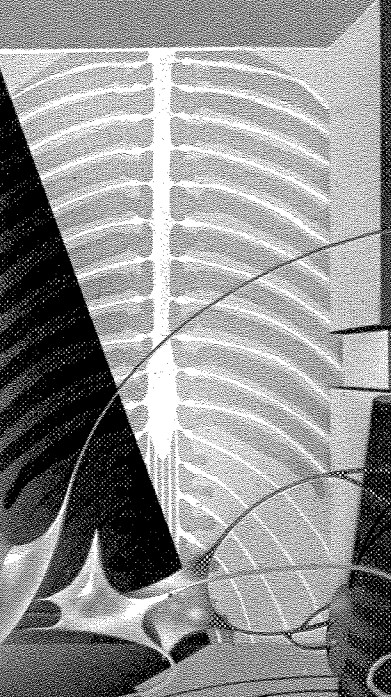
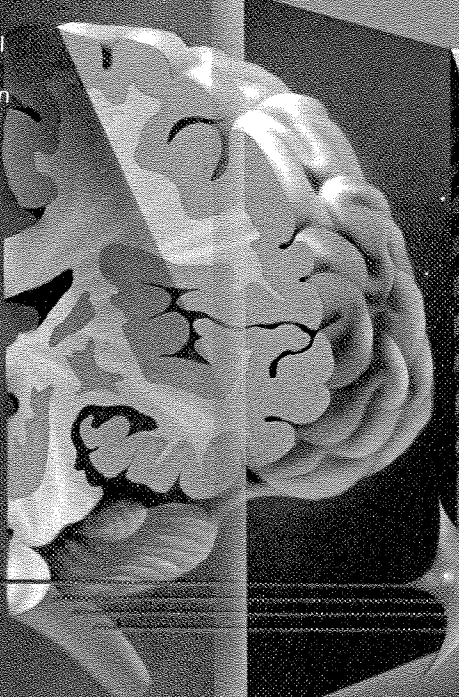
This scale, consisting of 10 items, measured the respondent's own personal view of combining family and career as a practicing physician—eg., I feel a child of my

SKELETAL MUSCLE SPASM

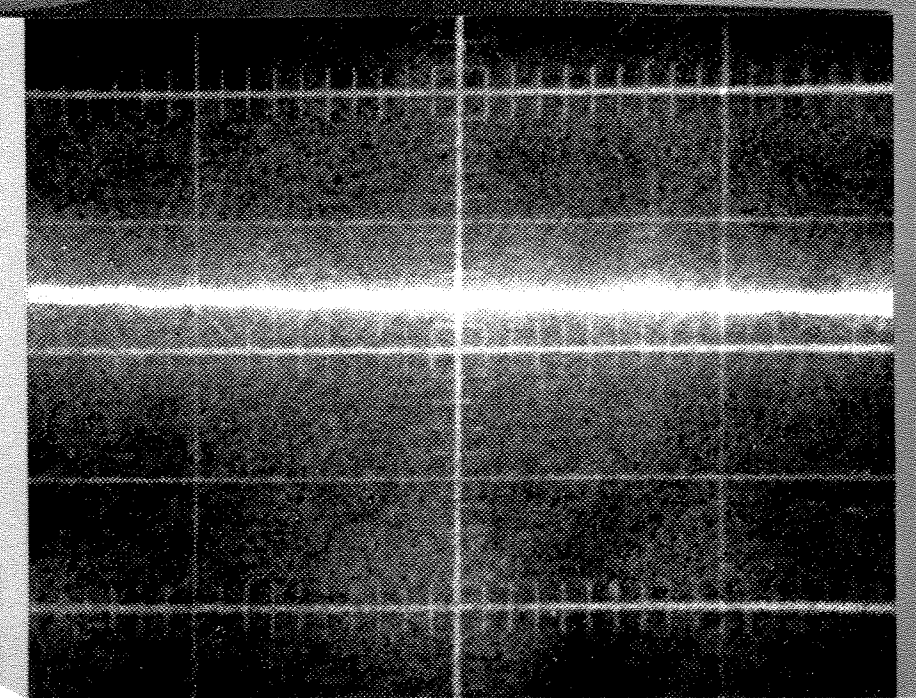
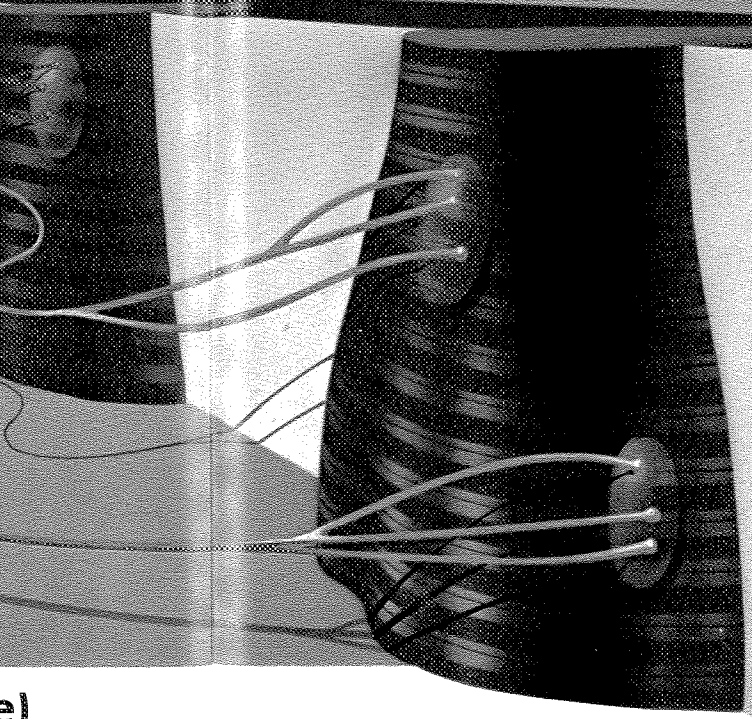
Actions and counteractions

Actions associated with spasm

Normally, presynaptic inhibition of impulses to motoneurons prevents the continuous contraction of skeletal muscles. When this regulatory mechanism is overloaded, however, it cannot cope with the excessive number of impulses directed at the motoneurons and muscles go into spasm. This bombardment of impulses may come from the brain stem reticular formation or the spinal cord—or both. Whichever the source of the impulses, adjunctive Valium (diazepam/Roche) has demonstrated its ability to relieve the spasm-pain-spasm cycle. This has long been known. Now evidence is emerging that Valium may have skeletal muscle relaxant activity not only at the brain and spinal levels but possibly at a third site—the muscle itself.



Electromyographic evidence of muscle spasm in a patient before administration of diazepam*



35 minutes after I.M. diazepam 10 mg, muscles are completely relaxed*

Counteractions associated with Valium® (diazepam/Roche)

In the reticular formation

Animal experiments have shown a reduction in the rate of neuron firing in the brain stem reticular formation after administration of Valium.^{1,2} This system, therefore, may be a major site of Valium action.

In the spinal cord

The ability of Valium to diminish skeletal muscle spasm may also be due to its action at the spinal level. Both animal and human experimental evidence indicates that Valium appears to improve the efficiency of presynaptic inhibition in the spinal cord.³⁻⁶

In the muscle itself

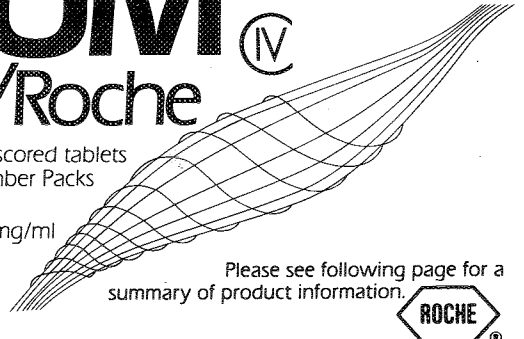
In both animal⁷ and human⁸ studies, Valium has been shown to have a direct effect on the muscle itself. Diazepam, administered to 15 spastic patients with neurological lesions, reduced the amplitude of the compound action potential of direct muscle response as well as the isometric twitch tension. From this, it was postulated that Valium may affect the contractile properties of muscle and possibly

the electrical properties of muscle membrane. Recent *in vitro* studies demonstrated that diazepam decreases tension in rapidly stimulated muscle and increases the rate of loss of calcium (needed for efficient coupling of action potential to muscle contraction) in the skeletal muscle of frogs. While these studies imply three possible sites of Valium (diazepam/Roche) activity, conclusive proof of the sites of action of Valium will require further research.

References: 1. Przybyla AC, Wang SC: *J Pharmacol Exp Ther* 163:439-447, 1968. 2. Tseng TC, Wang SC: *J Pharmacol Exp Ther* 178:350-360, 1971. 3. Stratten WP, Barnes CD: *Neuropharmacology* 10:685-696, 1971. 4. Schmidt RF, Vogel ME, Zimmermann M: *Arch Exp Pathol Pharmacol* 258:69-82, 1967. 5. Murayama S, Uemura H, Suzuki T: *Jpn J Pharmacol* 22 (Suppl): 79, 1972. 6. Verrier M, MacLeod S, Ashby P: *Can J Neurol Sci* 2:179-184, Aug 1975. 7. De Groof RC, Bianchi CP, Narayan S: *Eur J Pharmacol* 66:193-199, 1980. 8. Verrier M, Ashby P, MacLeod S: *Am J Phys Med* 55:184-191, 1976. 9. Fowiks EW, Strickland DA, Peirson GA: *Am J Phys Med* 44:9-19, 1965.

Adjunctive
VALIUM®
diazepam/Roche

- 2-mg, 5-mg, 10-mg scored tablets
- Tel-E-Dose® Reverse-Number Packs
- 2-ml Tel-E-Ject® ready-to-use disposable syringes } 5 mg/ml
- 2-ml ampuls, 10-ml vials }



Please see following page for a summary of product information.



*Adapted from Fowiks EW, et al.⁹

Adjunctive
VALIUM®
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome. *Oral form* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion. The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs. Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam/Roche), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated). The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; re-administer if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures

available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug. Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam/Roche) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualized for maximum beneficial effect.

ORAL—Adults: Anxiety disorders, relief of symptoms of anxiety, 2 to 10 mg *b.i.d.* to *q.i.d.*; acute alcohol withdrawal, 10 mg *t.i.d.* or *q.i.d.* in first 24 hours, then 5 mg *t.i.d.* or *q.i.d.*, as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg *t.i.d.* or *q.i.d.*; adjunctively in convulsive disorders, 2 to 10 mg *b.i.d.* to *q.i.d.* *Geriatric or debilitated patients:* 2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg *t.i.d.* or *q.i.d.* initially, increasing as needed and tolerated (not for use under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcoholic withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children, administer I.V. slowly; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available. Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied: ORAL: Scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500.* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25† and in boxes containing 10 strips of 10.†

INJECTABLE: Ampuls, 2 ml, boxes of 10;† Vials, 10 ml, boxes of 1;† Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00710

†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110



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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Pregnancy (continued)

own would give me better insight into my patient's families (+); a physician with children is less likely to deliver adequate care than one without children (-). The three scales were analyzed by a two-way analysis of variance, examining the variables of sex, group, and sex by group.

Results

Personal attitudes toward pregnancy scale. Both male and female respondents had a somewhat positive personal attitude toward pregnancy during residency. When comparing the resident group to the faculty group, faculty tended to have a slightly more positive attitude, but this difference was not significant, indicating that professional role alone was not a predictor of personal attitude. However, a significant effect due to sex ($F = 14.5$; $p < .001$) was found. Males had a significantly more negative attitude towards pregnancy during residency than females did.

Perception of environmental attitude toward pregnancy. Again, both male and female respondents perceived the environment as somewhat positive to positive. When results for this scale were examined, a main effect was discovered due to sex but not to group. Male respondents tended to have a significantly more negative perception of the environment than did females ($F = 5.0$; $p < .03$). Faculty also had a slightly more negative perception of the environment than did residents, but the differences between the two groups was non-significant. However, when questioned as to whether they felt an attitude favorable toward the pregnant resident existed, specifically in their own department, faculty had a significantly more positive perception of departmental support for the pregnant resident than residents themselves did ($X^2 = 11.8$; $p < .001$).

Feasibility and desirability of balancing family and career. Both male and female respondents agreed that it was fairly difficult to balance family and career. Analysis of this scale indicated that there was a main effect due to sex, but not to group. Males had a more negative attitude than did females toward combining family and career in their own lives ($F = 4.2$; $p < .04$). No significant difference was found between faculty and residents, although the mean for the faculty group was higher (indicating a more positive attitude) than it was for the resident group. Results for all three scales are summarized in Table I.

Official policy. Among faculty, four of seven women responding believed their department did not have any official policy toward pregnancy during residency and the rest did not know. Thirty-five (of 74) of the male

TABLE I A Comparison of Subject's Attitudes and Perceptions of Pregnancy During Residency and Family and Career Balance by Sex (Male vs. Female) and by Group (Faculty vs. Resident)

Scale 1: Personal Attitude Toward Pregnancy During Residency					
		N	Mean	F Value	P <
Sex	Male	216	2.37	14.5	.001
	Female	52	3.29		
Group	Resident	186	2.88	1.3	N.S.
	Faculty	82	3.25		

Scale 2: Perception of Environmental Attitude Toward Pregnant Resident					
		N	Mean	F Value	P <
Sex	Male	216	4.30	5.0	.03
	Female	52	3.60		
Group	Resident	186	3.27	2.8	N.S.
	Faculty	82	3.93		

Scale 3: Perceived Difficulty of Balancing Family and Career					
		N	Mean	F Value	P <
Sex	Male	216	3.06	4.2	.04
	Female	52	3.43		
Group	Resident	186	3.08	2.4	N.S.
	Faculty	82	3.86		

faculty respondents agreed with them, while 33 checked "Don't know." Twenty female resident respondents ($N = 44$) also believed their department had no formal policy, and 23 did not know; while 33 male residents ($N = 139$) expressed the same belief, with 101 simply not knowing. Apparently most subjects did not know whether or not a policy existed.

Existing departmental provisions. When asked to state what provisions the department made for a pregnant resident, regardless of official policy, the largest number of both male and female faculty (2 and 17 respectively) believed simply that residents got "some time off." While 24 male residents ($N = 74$) agreed with this statement, only three women residents ($N = 31$) concurred; this difference between male and female residents was significant at the .05 level (2-tailed p test). By contrast, 10 women residents and 19 male residents believed that their department had no provisions whatsoever for dealing with the pregnant resident. Only one woman faculty member and six male faculty members believed this to be true. Comparing residents and faculty, significantly more residents than faculty believed their departments had no provisions for dealing with the pregnant resident ($p < .05$; 2-tailed test).

Pregnancy (continued)

Policy suggestions. When queried as to what provisions they would like to see made by their departments for the pregnant resident, however, faculty and resident responses were surprisingly similar. Most faculty and residents agreed with the statement that pregnant residents should receive no special treatment. When asked whether they favored flexible scheduling for the pregnant resident, 6 of 8 women faculty and 57 of 75 male faculty agreed; as did 39 of the women residents ($N = 44$) and 115 of the men residents ($N = 142$).

However, whereas 6 of the 8 women faculty agreed that the pregnant resident should receive support and encouragement from her department, only 44 of the 75 male faculty agreed with this. Thirty-three women residents ($N = 44$) and 87 male residents ($N = 142$) thought this would be a good idea, with women residents significantly more in favor of this idea than were their male counterparts ($p < .05$; 2-tailed test).

Only 7 female residents endorsed the suggestion that the pregnant resident receive some kind of financial aid. Similarly, only 17 of 142 male residents; one of eight female faculty members; and four of 74 male faculty members supported the concept of financial aid for the pregnant resident. However, residents as a group did favor this idea significantly more often than did the faculty ($p < .05$; 2-tailed test).

Only 16 of 44 female residents felt that special counseling for the pregnant resident was necessary. Fifty-seven of 142 male residents felt special counseling was necessary. Four female faculty supported this proposal, as did 31 of 75 male faculty respondents.

Finally, faculty and residents alike agreed that a support group for pregnant residents would not be useful.

When women residents in particular were asked to describe additional provisions which might be beneficial to the pregnant resident, most frequently mentioned were individual negotiation with the department and a specified amount of leave (ranging from 1–12 months), plus the option of a part-time residency (9, 10).

Discussion

One of the most striking findings of this study were the sex differences which emerged in terms of all three scales. On the whole, men—whether faculty members or residents—appeared to have an attitude toward pregnancy during residency which was significantly more negative than that of women respondents. Similarly, they also perceived the medical environment as more hostile toward the pregnant resident than did the women them-

selves. Finally, their views of balancing family and career were significantly more negative than were those of women in either group. In a profession still so clearly dominated by men both in terms of numbers and influence, this is a disturbing finding indeed.

The group differences which emerged from the study are also worthy of mention. While most faculty members believed their department had a positive attitude toward the pregnant resident, most residents believed just the opposite. This discrepancy indicates at least the need for increased communication between residents and faculty about departmental positions on issues of importance such as pregnancy during residency.

Discussion of policy recommendation. Among faculty and residents, considerable confusion appeared to exist as to whether any formal departmental policies existed concerning pregnancy during residency. The vast majority of all respondents believed that no such policies existed. In terms of what provisions could be made for the pregnant resident within the department, again confusion reigned. The largest number of faculty and male residents reported vaguely that the pregnant resident could simply get "some time off." Interestingly, almost a third of the women residents and a quarter of the male residents believed their departments made no provisions whatever for the pregnant resident.

In terms of policy suggestions, thinking of both faculty and residents was again somewhat vague and surprisingly conservative. Most faculty members and residents agreed that there should be some special provisions for the pregnant resident, and specifically, the vast majority of respondents in both groups also supported the idea of flexible scheduling (11). Women faculty members and women residents tended to favor the idea that the pregnant resident receive support and encouragement from her department more than men in both groups did, although the majority of men were also in favor of this statement.

The great majority of respondents in both groups rejected the idea of financial support for the pregnant resident. Similarly, there did not seem to be much support either for counseling or support group services for the pregnant resident.

This research was supported in part by the American Medical Women's Association Professional Resources Research Center through a grant from the Program to Increase Participation of Women and Minorities in Educational Research of the National Institute of Education, DHHS. Statistical analysis of the data was performed by Dr. Eleanor Saltzer, Director of Nursing Research, University of California, Irvine Medical Center.

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Four-letter words to avoid

In my book of porn the most sordid of phrases, the most demeaning of words, is the expression "part time." It is used too often by the woman physician. She has, in this culture, all the jobs that other women assume: caring for children, choosing their schools and getting them there, transporting youngsters to dental and dancing appointments, keeping the family social calendar, and tending to hundreds of other details of household management. She is usually a capable, energetic, and well-organized person. She performs her supertasks with apparent ease, but they take a great deal of her time.

The woman physician is a well-educated, highly skilled specialist, having had exactly the same training as her male counterpart. Yet, in the eyes of her colleagues and social contacts, "part time" signifies a less than complete ability to do the work for which she is trained. And it does not support her own self-esteem.

She is still a woman in a man's world. Her professional status is determined at almost every point in her career by a male chief and male colleagues. His expectations and those

of her patients are measured by her own image and other women MDs'.

Most physicians—who are men—know that their colleagues take days



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off for seminars or golf and time off for haircuts and personal needs. There are physicians who work a 40-hour work week consisting of two consecutive days in the emergency room, and they earn a good salary. The other five days are theirs to fly a plane, play soccer, build an addition to the house, or spend days at bench crafts. Their self-esteem remains unimpaired. As a matter of fact, their regimen even enhances

their status. They are the Renaissance men; they have versatility and a pool of talents that supplements their ability to practice medicine. *Medical Economics* is replete with articles on "The physician and his trip around the world," "The physician and his investments," "The doctor and his collectibles."

If the woman physician takes a segment of her week out for hobbies or family, she is said to work part-time. She is accused of not giving her complete interest to the profession.

Though she has the same training and the same staff appointment, yet her salary is appreciably lower. Often this is a matter of lower expectations. Thumbing through any journal ads that come to the medical office, we find the prevailing image of the doctor as a white-coated male. The bedside physician is a man, the laboratory consultant in front of the electrocardiograph is a male physician. The media give the impression that it's the male physician who is dependable and available.

The younger woman physician is the one who finds herself in dilemmas that affect her status, leading to