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WEB PAPER

From calling to a scheduled vocation: Swedish male and female students' reflections on being a doctor

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Abstract

Background: All over the world an increasing number of women are entering medical schools. Soon women will constitute half of the physician workforce in Scandinavia. However, specialty segregation persists. Reports have shown different motives among male and female doctors to be, but the impact of gender, i.e. how ongoing social constructions of femininity and masculinity influence the development of professionalism, is not fully described.

Aim: The purpose of this study was to explore views and visions among second-year students at a Swedish Medical School, and to identify challenges for education and workforce planning.

Methods: After receiving research ethics board approval, all students participating in the course 'Professional development', including a task to write a free-text essay on the theme 'to be a doctor', were invited to share their essays for analysis. Of 138 (40% men) students in 2002, 104 (39% men) accepted. The texts were analysed according to grounded theory.

Results: Students held 'doctorship' to be an outstanding profession of commitment, authority and duty. Fears were exposed, especially among women, regarding how to fit demands of self-sacrifices and balancing a private life. Belonging to a new generation, they conceived gender equity as self-evident. Actual working conditions were met with disapproval, as did an all-embracing calling. A scheduled vocation was hoped for. They relied on the mass of women to implement change. Women's 'other' values, alluding to family orientation, were expected to alter working conditions and also give men more leisure time. Despite equity conviction, segregating gender patterns in students' representations, interactions with tutors and future prospects were disclosed.

Conclusions: Students' arguments raise challenges for medical educators and planners regarding professional values, medical socialization and specialty recruitment. The new generation requires a renewed Hippocratic Oath, gender-aware role models and practice sites. Swedish students' arguments are compared with current international literature.

Introduction

Students enter medical school with their own specific view of the ideal doctor. Historical portrayals, anecdotes, media icons and personal experiences certainly contribute to their preconceptions. Along with heroic images there might be impressions from critical reports. Doctors are scrutinized, do not command respect as before, and are sometimes described as victims rather than guardians of the healthcare system (Cohen 2002). For health planners, medical educators and administrators it is important to know how medical students harbour and deal with these different signals. A lot is known, but the impact of gender, for instance how ongoing social constructions of femininity and masculinity influence the development of professionalism, is still to be elucidated.

All over the world an increasing number of women enter medical schools. Numerous international reports display statistical data on persisting gender differences in specialist career choice (Baxter et al. 1996; Limacher et al. 1998; Boulis et al. 2001). Women currently appear in relation-orientated, humanistic specialties, such as family medicine, psychiatry, paediatrics, gerontology, men in autonomy-orientated and technical specialties such as surgery and anaesthesiology (Odborg et al. 1995; Buddeberg-Fischer et al. 2003).

Practice points

- Fresher students at medical school regard the 'doctor' as holding an outstanding position of commitment, authority and duty, but are anxious as to how to fit into the demands of self-sacrifice, superiority and balancing of a private life.
- They disapprove of the actual working conditions and hope for time limitations and scheduled periods of work.
- They do consider gender equity but rely on the mass of women to implement the change.
- There is a gendered hidden curriculum in medical socialization.
- Professional demands ought to be matched with the priorities of the 'new generation'.

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In the near future, women will constitute half of the physician workforce in Scandinavia, yet specialty segregation persists. There are reports of different motives and attitudes among male and female doctors to be (Hyppölä et al. 1998; Vaglum et al. 1999; Wiers-Jenssen & Aasland 1999; Niemi et al. 2003; Gude et al. 2005), but sparse information from Sweden. Knowledge of motivation and career goals of the next generation and eventual gender differences is asked for and important in recruitment programmes, and action to prevent segregation (Shields & Shields 2003).

In Sweden, medical school is very popular and admission standards are extremely high. However, we do not know which preclinical attitudes and aspirations predict professional behaviour or job satisfaction, or what is needed to level out shortage and segregation in certain specialties. Are students' depictions realistic, and do they match what is expected regarding professionalism and future challenges?

At the Medical School of the University of Umeå, Sweden, the 'Professional development' (PD) course runs like a thread through all 11 terms of the medical course. One aim is to develop communication skills, another to enhance empathy and self-awareness in humanistic and ethical aspects of medical life. Students are encouraged to consider how, for instance, sex, gender, class and culture affect medical endeavours. Courses with corresponding aims are under development in medical schools in different parts of the world (Hafferty 2002; Thistlethwaite & Ewart 2003; Sivalingam 2004).

As a part of the PD agenda all the students in their third preclinical term consider the theme 'to be a doctor'. To gain input for reflection there are different assignments: Students are scheduled to shadow physicians from different specialties during a working day. They interview a doctor, whom they can choose themselves according to interest, and are encouraged to read current articles on what it is like to be a doctor. The course is completed with a critical development task: to write and submit an essay of 2–4 typewritten pages with free-text reflections on 'to be a doctor', to be discussed in tutor-conducted group sessions afterwards. They are encouraged to develop the following themes: How do you depict 'being a doctor'? How do you imagine yourself in the doctor's role? What about the prospects of a future life as a doctor? Is gender of importance?

The purpose of this study was to explore second-year medical students' views on what it is to be a doctor—from a gender perspective—and to identify challenges in medical education and workforce planning.

Method

Participants

After having completed the third term, all students from two different courses, spring and autumn 2002, were asked to share their essays for analysis. They were informed that the purpose was to scrutinize their reflections on the physician's profession, working conditions and gender issues. Participation was voluntary. All 138 students of the year group were invited, 55 (40%) men and 83 (60%) women; 104 students (75% of the total number) accepted to participate and be quoted anonymously, i.e. 104 essays from 41 (39%) men and 63 (61%) women constitute the data.

The mean age was 24 years, with a range of 21–39 for women and 20–40 for men. Dropouts did not differ significantly regarding age or gender. Some 7% were first- or second-generation immigrants.

Data

The essays were 2–4 machine-typed pages. Students' names were replaced with codes: W for women, M for men. Students from spring 2002 were given numbers 1–59 and those from autumn 101–145.

Analysis

Analysis was exploratory in nature and proceeded according to grounded theory (Strauss & Corbin 1998). To keep an open mind in coding, and prevent premature closure and bias from preconceptions, the 104 essays were coded by the two authors independently. First open codes, key words, expressions and emerging ideas were noted in the margin. After the open coding procedure the researchers met to discuss and compare the codes, and by consensus group them in preliminary categories. Then data were reread in a selective coding process, discussed and reanalysed until overriding concepts were condensed and saturated from a variety of aspects, and a core category emerged.

A gender perspective was applied, implying a search for variety and patterns of similarities and differences within and between the male and female students' scripts, for instance in what they emphasized as important, and what they feared and hoped for. Gender is referred to as the constantly ongoing construction of what is considered 'male' and 'female', in expectations, attitudes and manners based on sociocultural norms and power (West & Zimmerman 1987).

For the reader to follow, key words of the analysis are presented as subheadings for each subcategory. Verbatim quotes are enclosed in quotation marks or as indented quotes and followed by the student's secret code.

The Ethical Board of the University of Umeå approved the study.

Results

The core category 'from calling to scheduled vocation' embraced the students' expectations, considerations and prospects regarding their future as doctors; presented below in the subcategories 'Something to be', 'How will I fit in?', 'We are a New Generation!'

'Something to be'

In almost all reports (92 of 104) there were expressions conveying a conventional, accepted image of the optimal doctor: 'we all know what a doctor is and should be' (W119). Recurring statements from both male and female students were; *outstanding, a calling, authority* and *demanding duties*.

'Outstanding' alluded to both the practice and the practitioner. The contents of 'the world's best occupation' were: vast options to choose among, stimulating, varying, challenging,

developing, and always meaningful. The expectations of the practitioner's character were outstanding, too:

> Oops, not just anyone could be a doctor. You have to be self-sacrificing, ambitious, controlled, accountable, kind-hearted and correct regarding decisions. (W2)

The 'calling' was commented on by most of the women (52 of 63). One man compared the commitment to a medieval code of behaviour, while women saw it as shared compassion to help humanity, making it 'impossible to become a doctor unless you burn for it' (W124). Altruism was emphasized in expressions such as helping others, doing good, and being needed. The reflections circled around a 'lifestyle', a lifelong enterprise implying personal sacrifices:

> Traditionally it is a profession of vast personal sacrifices regarding your private life. Overtime work is implied in the choice of being a doctor. (W138)

The authority of the profession was considered stable; 'doctor' was a respected title, trusted and seldom questioned. The thought of this future status inspired pride with the feeling of being judged and considered good enough. One female student confessed that the thought of her future position made her sometimes shiver with excitement at night, thinking: 'Just imagine the possibilities, the whole world at my feet' (W40).

At the same time many students (47 of 104) discussed power and hierarchy and feared the risk of being put on a pedestal. An exceptional position implied segregation from other near workmates. Students mentioned observing that doctors and nurses neither had tea nor lunch together. Status might induce arrogance and make doctors consider themselves better and more dignified than others, 'they were aloof and kind of posh' (W32). One young man even wanted to issue a 'megalomania warning' (M6). To be considered 'Ubermensch' (M137), 'superman' (M20) or even 'God, with power over life and death' (W52) imposed demands impossible to live up to.

In fact everyone (104) described highly demanding duties, such as heavy responsibilities, long working hours, many nights on duty, readiness for service, and a never-ending learning commitment:

> Doctors stay overtime on wards not always due to their sense of duty, but also for their own ambitions for professional development. It could be due to an interesting case or something else to learn from. (M8)

Demanding duties and working conditions did not always impress, but were described with both humour 'they seem more glamorous than they are' (W126), and scorn 'as if the doctor were a machine, able to work without pausing' (W39). One student was astonished on hearing about a senior surgeon, who 'boasted of not having eaten dinner with his family for the last seven years' (W32).

'How will I fit in?'

The students defined themselves as having '*absurd ambitions*' (W51). They wondered how they would react to demands of excellence, authority and commitment and how they would be able to deal with them. 'How shall I, an ordinary person, be able to shoulder this prospect, manage the calling, and at the same time live an ordinary life?' (W49). They were already treated as special, in public and at medical school. This was flattering and desired, but implied expectations that might be hard to live up to:

> When you say you're a med student you're always met by admiration or interest: 'oh my, how exciting!' or 'I say!' People are never indifferent; it is never just a neutral 'okay'. (W34)

They were prepared to do their best and accepted the thought of lifelong learning, but feared that they might turn out to be big-headed know-alls. High repute in combination with their own ambitions could lure them to be climbers, only evaluating performance. One young man overtly expressed that the highly demanding school mentality and the 'talk of medical students as elite, or worse, the crème de la crème, must come to an end' (M128). Also they considered the consequences: isolation, segregation and hierarchy:

> Med school is such a huge part of my life . . . what if I have already adopted a pattern that will stay with me for the rest of my life? (W123)
>
> We're socialized into this role. WE belong to the club. The study rate is so intensive that you only have time to see other med students. We have a special course in professional development and . . . isn't there a risk that we are infused with 'between us' and 'them'? (M139)

To shoulder the *doctor's identity* was something female students (35/63) found problematic for the future. They worried that self-sacrifice might border on self-effacement. Therefore they discussed whether to see doctorship as an identity or a job, whether they were 'to *be* a doctor, or to work as one' (W41).

> If you say 'to be' it has a tendency to extend to much more than a job, to comprise your whole personality. At the same time it reduces your personality to what you achieve at work and nothing else. I think I am so much more than a med student. (W54)

Men on the other hand did not express worries about the identification part, nor did they perceive the calling as being so intrusive as women did:

> It's a job and nothing but a job, a good way to grow and improve and at the same time hopefully do good for others. (M116)

Regarding duties and readiness for service, they associated this with how it would interfere with their *private life*. The students had thoughts of vast and diverse working options as a major advantage of the profession. They were therefore astonished by the fact that almost all doctors they had asked initially said that their specialty choice was a *matter of coincidence*. It was due to details around the first employment, or if there 'happened' to be a trainee vacancy. The students, however, noticed more behind the coincidental chances. Male students pointed to the importance of a confirming reception in the

ward, while women noted non-confirming examples in the medical milieu, when referring to the doctors interviewed:

> Finally, it was mere coincidence. It happens easily that the small details are decisive in the end. As a dead-scared trainee you starve for acknowledgement and in that state a slap on the back is enough, or someone saying you did a good job there—or simply a good atmosphere in the ward. (M104)
>
> She wanted to be a surgeon but after a period of being locum in the surgical ward she decided to quit that career specialty, due to the bad reception she experienced on the ward. (W132)

Although seniors minimized their own specialty choice to a coincidence, they gave *straightforward gendered advice* to students. Male students were encouraged to stick to what they aspired for, not to bother about work burdens, and to let family interests come second: 'Choose according to your interests and don't mind duty hours' (M1, M144). Female students were, directly or indirectly, recommended to choose a specialty, and also a partner, compatible with family life: 'Put a lot of consideration into choosing specialty, and even more into choosing a partner' (W54). One female student overheard a male senior talking to a new trainee on the ward:

> You're going to have fun here and learn a lot, but if you have a wife or a fiancée—forget it. Here almost all of us have at least one divorce behind us. (W52)

Still, there were indications that among the students both men (20 of 41) and women (46 of 63) had a future family in mind. Men in general were confident: 'I have good hopes of being able to combine ferociously interesting work with a family life, and to have the time and strength to take part in my family life the way I want to' (M17). Women in general were troubled:

> I am interested in surgery, but not at any price. Still, if I refrain it would be to avoid, and not to fight back against, discrimination. (W44)

'We are a new generation!'

Students disagreed with doctors' pretentiousness and strivings for power. They were also disillusioned over the working climate, and all expressed great hopes for a change. They saw themselves as a *new generation*, with other attitudes to quality of life and work morality: 'We're not as greedy—neither for work, nor for money!' When proclaiming their different attitudes they often added an annotation regarding a possible gain, for themselves and for patients:

> I am convinced that persons of our generation do not look at themselves or the profession in the same way as the older generation. That is probably a good thing for both the doctor and the patient. (M130)

They seemed convinced that they shared the same definition of *quality of life*, namely an interesting, financially rewarding job, plus a rich and full private life, implying fewer working hours:

> The older generation may be satisfied with the stimulation and status of the profession per se, that's okay, but for me, work comes second. My philosophy has always been that you work to have options in meaningful time off. (M115)

The students took *gender equality* for granted and believed that today's unfair wage differences and segregated specialties would 'fade away' in their generation, as they were all on an equal footing and had the same chances. When exploring this transition further, it was that the *mass of women doctors would make a difference*. So, although they assumed that young men and women shared the same values concerning quality of life and all had equal opportunities, they preserved the opinion that *women had other values* than men. 'Other' alluded to family orientation, and they expected women to fight for better conditions to balance work and family. Of the 46 women discussing family 27 problematized the dilemma in having to choose between *family* and *work:*

> I don't want not to be able to spend time with my children when they're little. At the same time I would like to choose an interesting specialty. So I hope I'm going to be interested in a specialty with not too many duty hours and inconvenient working hours. Still, it's sad that as a woman I'm forced to make this choice. (W4)

Only a couple of men faced this choice. Fourteen of the 20 men commenting on family were sure they would be able to have both *work* and *family* in their future (quote M17 above). The men's problem lay in how to make sure of their leisure time for hobbies and 'eventual family'. A male conviction was that if women too just focused on and pursued what they wanted, this would be a gain for all:

> I hope many women in my generation will make demands that counteract too much overtime work and that they will become better at negotiating their salaries. That would help to level out wages. (M17)

However, due to different claims on women and men in general, and in medical school, they could see that prospects were already different from the start:

> If I were to generalize about masculinity and femininity, a woman wants so much and is therefore easily distracted by different undertakings. And moreover she has difficulties in liberating herself from caretaking, such as the calling, and finds it difficult to say no. Guys on the other hand focus on one thing at a time, which helps them to gain a position faster. (M116)

Students also pointed to *the resource a family could be*. Some referred to interviews with women physicians (4) and a few men (2); family engagement was described as a way to avoid burnout and marrying the job. One male student referring to a male interviewee said:

> His opinion was that having children early in his career was a way to learn to appreciate time out of the hospital before it was too late. Too late? The staff was said to be quick as lightning to exploit newly graduated doctors' eagerness to work. Thereby it

> easily happened that you grew into a lifestyle where work took up too much time and space—a lifestyle difficult to change once established—especially when you think of the money you make by working hard. (M136)

Very few female students (3/63) and no male took up the option of taking part in trade union work to demand better working conditions or keep up salaries. Some (9/104) mentioned and hoped that the *scarcity of doctors on the labour market* would make them attractive on the labour market and thereby give them chances to pick and choose.

> I am very satisfied with my choice of profession and I think that the day I settle down and have a family I suppose that even a 10% duty will be possible. There is a scarcity of doctors nowadays, for Christ's sake! (W117)

There was a wishful prospect, expressed by a woman, that men and women in the future could be split into many different specialties where they 'all could have time to eat dinner with their families, at least once in a while' (W50).

Discussion

Method and participants

Are these findings, from Swedish third-term students' essays, trustworthy and transferable? First, 25% of the students asked did not want to produce their essays for research. This might be due to deviant as well as sparse views on the topic. However, we consider 75% an acceptable participation rate for capturing the discourse of the students.

As this was a task in medical school, students might have left out ideas they thought incorrect for medical teachers to read. Still, it was not an exam with right or wrong answers. They had been encouraged to write and reflect upon whatever they themselves found most striking.

The high proportion of women students in the third-term courses in 2002 (60%)—and among the participants—correspond well to a general trend in medical schools all over the world (Bickel 2000; Burton 2004).

In Sweden, as well as in other countries, medical students are similarly recruited from the middle or upper class, from intellectual families with relatives that are doctors (Neittaanmaki et al. 1993; Vaglum et al. 1999; Niemi et al. 2003; Greenhalgh et al. 2004). Most of these students were brought up in Sweden, where almost as many women as men (80%) are out in the labour market, where parents have the opportunity to share paid parental leave, and where there is a well-developed day-care system for all pre-school children. This might have had an impact on their attitudes regarding gender issues and family planning.

Participants in this study were high-scoring young persons, knowledgeable in studies but beginners at medical school. Nevertheless, we consider their reports to be reflections grounded on their views on medical professionalism as seen in a medical school context, and therefore challenging in terms of the renewal of medical education and practice.

Professional values

Students were not specifically asked about medical professionalism but they reflected on this theme. For instance, 'Something to be' contained an arsenal of attitudes and expectations concerning the doctor's competence, authority and commitment towards patients that fit well with the general consensus on professionalism (Swick 2000; Arnold 2002; Blank 2002). Altruism, in the sense of doing good and helping others, was indisputable, as were also the continuous learning aspirations. Many studies show that beginners often start off being very altruistic and idealistic (Bellas et al. 2000; Branch 2000; Hajek et al. 2000). But the students had problems in figuring out how to embrace obligations and authority, to be treated as special and still stay ordinary. The students seemed unaware of the current discussion on the subject of doctors having lost privilege and status (Swick 2000; Coulehan & Williams 2001; Diaz & Stamp 2004). Finding some doctors sophisticated and arrogant, they feared superiority. They had humble attitudes and preferred to imagine themselves on a more equal level with workmates, colleagues and patients. Considerations regarding the salient ethical issue of power and respect for others are also reported by other researchers (Robins et al. 2002).

These third-term students also focused on job satisfaction, workload and feelings. The main obstacles for them were demanding duties on call and long working hours, and how these obligations would match with a good quality of life. The scarcity of doctors in the labour market was not looked upon as a threat to the quality of healthcare. On the contrary, they considered personal gains, giving them opportunities to 'pick and choose' a job. They did not see it as an incentive to work more hours, rather the opposite; by being attractive in the labour market, they thought they could negotiate part-time duties and a good life outside work. The students' reasoning here contradicts altruism, and can even be interpreted as individualism and lack of social responsibility, recognized as 'malaises of modernity' (Eckenfels 1997). In current literature the newcomers' stance is sometimes considered as evidence of a moral decline in altruism and commitment to service and duty (Hafferty 2002). Worried voices have requested a restoration of the Hippocratic Oath (Swick 2000; Diaz & Stamp 2004). It is claimed that doctorship must again be emphasized as a true calling and not just a beleaguered occupation (Cohen 2002). The results in our study show the importance of raising gender issues in discussions on the calling.

Gender issues in medical socialization

It is generally apprehended that men and women have the same prerequisites and possibilities for becoming capable physicians. Our findings, that male and female students have very similar attitudes to what is required of a good doctor, are supported in studies from different parts of the world (Buddeberg-Fischer et al. 2003; Odborg et al. 1995; Todisco et al. 1995).

Professional values are not merely a question of upbringing but are also fostered, created and re-created in medical

socialization (Coulehan & Williams 2001; Wilkes & Raven 2002). Apart from the formal curriculum there is a hidden curriculum (Hafferty 1998), inhibiting rather than facilitating moral reasoning (Patenaude et al. 2003). From our findings we wish to emphasize the *gendered* hidden curricula.

According to Hirdman there are two main strands of logic in the gender system of societal structures, a horizontal separation of men and women, and a vertical, women being subordinate to men (Hirdman 2004). The system is continuously under negotiation—often unconsciously—on the personal, the symbolic and structural level. The interviewees, as well as the students in this study, demonstrated how they were upholding, but also trying to change, the conditions of the gender system. The students' prospects in terms of duties and specialty choice are examples of this.

Students presented gendered ideals of Supermen and Nightingales. The old icon of a doctor is male, based on Hippocrates and surgeons. Men are depicted as skilled, decisive and effective. According to the cultural idealization of femininity, women are expected to be relation-oriented (West 1984; West & Zimmermann 1987), and like Florence Nightingale to put the interests of others first, at work as well as in family settings. These expectations obviously persist and are imposed on the new generation.

Beginners imagined medicine to be an arena of numerous working options, 'all the chances in the world'. The gendered fences and barriers were masked. Presentations of specialty choice as a matter of coincidence covered the subtle messages and the supportive or discouraging hints on the ward. The young were expected and prepared to shoulder huge burdens and autonomy. Nevertheless, they expected quality of life also to include leisure, relaxation and family. Women, although young and childless, were expected to be family oriented and were given few options to balance their future life, except in specialties with a low workload and part-time work.

Boulis et al. (2001), too, have shown that students pick up explicit and implicit advice that maintains gender segregated career options. To keep on defining family issues as a question of women's personalities and preferences is, according to Carr et al., a disservice bordering on discrimination (Carr et al. 2003). There were thoughts about private life and family among both the young men and women in our study. But, already the young women were supposed to shoulder future family care, which put them in a dilemma as to when to embrace the calling, and to identify and adapt to a medical career.

It is predicted that the entry of women into medicine will lead to a decline in full-time equivalents of physician services and also to a decline in applicants for surgical training posts (Burton 2004). Reed & Buddeberg-Fischer (2001) argue that as it is in specialty choices that the significant gender differences are displayed, which indicates that obstacles for equal career goals are due to rigidity in career structures, and that gender discrimination acts synergistically with domestic responsibilities and parenting. Therefore, there is a risk of gender blindness if we uncritically rely on old ideals and the oath of a calling, when facing a new generation of parenting doctors.

Will a new generation automatically alter conditions?

Both male and female students in our study found the calling 'old-fashioned'. They looked forward to scheduled, realistic working hours. Being part of a new generation they depicted quality of life as a combination of purposeful work *and* a rich/creative private life. Among them, the potential for change relied on women's enlarging proportion of the workforce; the mass of women would in itself imply better working conditions. Is that so?

According to Kanter's theory of group dynamics, when women constitute half or more of a given population in a given setting, their interactions with their male peers will be more balanced and their position better able to influence their colleagues' attitudes and behaviour (Kanter 1977). However, many investigations on the topic disclose that structural factors might have greater importance than gender alone in predicting professional attitudes and career choices (Dufort & Maheux 1995; Baxter et al. 1996; Batenburg et al. 1999). The fear of women's entry causing deteriorating working conditions, through women being less demanding for fair salaries and working hours, was only indirectly touched upon, by expressions such as 'women must get better in claiming wages', perhaps because these students were still at the beginning of their medical school course and had not faced the actual gaps in salaries.

There are trends indicating a shift. It was recently demonstrated that parenting, not gender, had most impact on workforce involvement among young physicians (Jacobson et al. 2004). Wendel found that reasons for *not* choosing surgery were the same for both men and women: residency lifestyle, practice lifestyle and length of training (Wendel et al. 2003). If, and when, men and women share domestic duties and parenting equally, this will counteract gender-dichotomized expectations and therefore segregation, and allow reasonable working options for all doctors. However, there is still a long way to go before the gender system has collapsed. Swedish students in their mid-twenties still show that they have internalized different prospects: men expect a highly interesting job *and* more time for hobbies, relaxation and family, women more often face the contradiction in being expected to choose between work and family commitments.

Future challenges

Patients want doctors of both sexes who are knowledgeable, technically skilled and have humane attitudes (Boulis et al. 2001). The obstacles to more women choosing prestigious careers and the increasing segregation in specialties (Bright et al. 1998; Niemi et al. 2003) must be actively counteracted. This must begin in medical school. Role models of both genders comprise one important issue. Efforts to implement and explore gender awareness among teachers and students is another effort to enlighten and deconstruct actual barriers in the medical social structure (Hamberg & Johansson 2006; Risberg et al. 2006).

A worldwide challenge for workforce planners in improving gender equality and productivity implies providing training and practice settings that are more manageable in balancing

work and parenting for both men and women (Buddeberg-Fischer et al. 2002; Gjerberg 2003; Burton 2004; Kato et al. 2004), and that also support mentoring.

With good aims to restore morality and devotion to medicine, we must avoid keeping up prejudice and maintaining segregation. As Dumelow et al. discuss, 'currently doctors seem to be fitting in with the system rather than the system adapting to a changing workforce and enabling doctors to have fulfilling professional and personal lives' (Dumelow et al. 2000). In a society of gender equity, family issues should no longer be addressed as women's 'other' values, but as shared issues. This also means that highly technical and former so called high-workload specialties must face the working condition claims of the new generation (Bickel 2001).

Striving to re-establish the 'calling' part of the Hippocratic Oath may turn into control, concentration of power and a backlash on equality endeavours, and become an obstacle for change (Niemi et al. 2003). Professional socialization requires constant matching of professional demands with students' own priorities and personal resources. There is a lot to be won and less to be lost in meeting the claims of the new generation, not to see them as amoral but as having increased social responsibility. Medical students are a creative force in the renewal of medical practice.

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