Understanding the disproportionate location of women physicians in lower status medical specialties necessitates knowing how women and men view the prestige hierarchy of specialties. Previous research on status ranking has been largely quantitative and based upon male respondents. Using narratives from face-to-face interviews with male and female resident physicians, this study finds that, although residents are fairly consistent in their rankings, women were more likely to resist the concept of a prestige hierarchy. In addition to explicit dimensions conferring prestige are implicit justifications grounded in the physician’s body. Specifically, high prestige is associated with active interventionist hands and “balls,” body parts that I argue are not gender neutral. The findings shift the focus from individual-level gender differences toward a gendered examination of the medical specialty hierarchy. The physicians interviewed here give voice to the silent, symbolic, embodied work of gender that shapes the structure of medical specialties into a ladder with a masculine top and a feminine bottom, regardless of whether male or female bodies occupy the rungs.

The concept of a prestige hierarchy of occupations is generally well documented (Blau and Duncan 1967). Most members of society agree that certain occupations deserve higher status and compensation because of their greater value to society, longer training periods, and difficult or complex skills (Davis and Moore 1945). Intra-occupational hierarchies exist as well. For example, in academia, physicists are generally accorded more respect, status, and compensation than, say, sociologists. Corporate lawyers are more esteemed than public defenders. And surgeons are “kings” in medicine, while pediatricians and psychiatrists vie for the bottom rungs of the ladder.

Feminist scholars, among others, have examined why women more often than men find themselves on the lowest rungs of occupational hierarchies. Research on general occupational sex segregation is voluminous (e.g., Bielby and Baron 1986; Jacobs 1989), and recently much attention has been paid to hierarchical or vertical segregation within occupations and occupational categories (Pavalko 1988; Reskin and Roos 1990; Williams 1989). The concentration of women in less rewarded subspecialties within specific occu-
Are females “ghettoized” in the medical profession? In “A Welcome to a Crowded Field: Where Will the New Female Physicians Fit In?” Judith Lorber (1987) argues that women will be tracked into lower status, lower prestige specialties and men will retain dominance in the occupational hierarchy. Currently, women physicians are underrepresented in surgery, the surgical subspecialties, anesthesiology, and radiology and overrepresented in pediatrics, obstetrics and gynecology, dermatology, psychiatry, and family practice (AMA 1994). But is their location due, as Lorber suggests, to tracking, discrimination, and constraint? In other words, are women grabbing the lowest rungs of the intra-occupational ladder because that is all that is available to them?

This article focuses on resident physicians’ perceptions of the specialty hierarchy in medicine. Testing hypotheses about gatekeeping and constraints that keep women out of the “top” specialties necessitates knowing how residents perceive the prestige hierarchy. Do they perceive a “top” and “bottom” and, if so, do they agree with the prestige differential? Why do some specialties deserve more status and income? What are the criteria for being on top? This article is based on face-to-face interviews with male and female resident physicians from a major research university. The residents were asked to describe the hierarchy and give reasons for their rankings.

What emerges from the narrative suggests a more complicated view of hierarchy than current formulations allow. Although resident’s descriptions of the hierarchy are fairly uniform, women in particular resist the idea of and justifications for a hierarchy based upon prestige. Furthermore, the narrative exposes a definite organization of medical specialties “along the lines of gender” (Acker 1992). The language reveals that medicine, independent of sex or gender as an individual category, is an institution demarcated by symbolic bodies, both masculine and feminine. The bodies, whether female or male, that occupy the highest prestige specialty are described as macho, action-oriented, physical, and technologically sophisticated. The bodies, whether male or female, that occupy the lower prestige specialties are described as passive, less physical, and affective. This article focuses primarily on the body of the physician; however, equally relevant is how the body of the patient factors into perceptions of the specialty hierarchy (Hinze 1997).

LITERATURE REVIEW

Early studies on specialty choice and status rankings were primarily conducted with male medical students, residents, or physicians. Howard Becker, Blanche Geer, Everett Hughes, and Anselm Strauss’s classic Boys in White: Student Culture in Medical School (1961) focused solely on the socialization of male medical students. Using qualitative methods, they used 140 criteria to assess specialties (from field notes) and 1,502 separate comments (from interviews). From this information, they developed twelve general categories of specialty choice criteria. Surprisingly, although the researchers had assumed that length of residency, money, and prestige would be key factors in considering specialties, the medical students studied were more interested (in descending order) in intellectual breadth, responsibility, special personal traits, manageability, comfortable patient relationship, and hours worked. Notably, only 2 percent of the fieldwork comments and 3 percent of the interview comments had to do with prestige of the specialty. Becker and his colleagues
concluded that professional colleagues use a different set of criteria than do laypersons, a notion supported by Andrew Abbot (1981) in his discussion of intraprofessional status.

Since Becker's study, the medical profession has changed dramatically. Most significant is the explosion of specialization. In 1875, the International Medical Congress listed 8 medical sections. Currently, there are 23 American boards that certify in 33 general areas and 50 subspecialty areas (ABMS 1990). Accordingly, the number of doctors who specialize has risen dramatically, spawning recent concerns about a paucity of primary care physicians. For example, one study documents a rise in the percentage of senior medical students interested in specialization from 64 percent to 85 percent between 1982 and 1992 (Xu, Rattner, Veloski, Hojat, Fields, and Barzansky 1995). Along with the increase in specialization came a dramatic influx of female medical students. In 1960, approximately 5 percent of medical students were female (Martin, Arnold, and Parker 1988); by 1993, almost 42 percent were female (Xu et al. 1995). A final change accompanying the increase in specialization and the influx of women is a widened gap in earnings between those at the top of the specialty prestige hierarchy and those at the bottom. The income gap differential between specialists and primary care physicians is due largely to the government's Medicare fee schedule, which reimburses excessively for procedures (Starr 1981). Thus surgeons averaged $255,200 per year in 1994 compared to $126,200 per year for pediatricians (AMA 1995–1996).

In the past three decades research on specialty choice has also changed dramatically. The grounded theory approach employed by Becker and his colleagues has given way to more quantitative studies that tend to rely on a methodological paradigm (i.e., highly structured quantitative analyses of survey data utilizing closed-ended questions with forced choice items) that precludes the individual's own perceptions of specialty prestige (Anderson 1975; Lieu, Schroeder, and Altman 1989; Matteson and Smith 1977; McGrath and Zimet 1977a; 1977b; Zimet and Held 1975). Studies of medical students' specialty rankings (Bruhn and Parsons 1964; Matteson and Smith 1977; Kritzer and Zimet 1967; Zimet and Held 1975) and the public's specialty rankings (Rosoff and Leone 1989; 1991) rarely explore reasons for the rankings, and none rely upon open-ended explanations. Generally, surgery and internal medicine are ascribed the highest status while pediatrics, psychiatry, and family medicine hover near the bottom. Historically, few studies of specialty status examine gender differences largely because so few women were available for comparison. Recently, much attention has focused on women's greater interest in primary care specialties (Burkett and Gelula 1982; Bland, Meurer, and Maldonado 1995; Lieu et al. 1989; Xu et al. 1995), but explanations for gender differences in specialty choice vary. I will highlight three types of explanations here. One strand in the specialty choice literature, that I term the "social roles perspective," suggests that women choose specialties that are less time-consuming and demanding (but also less rewarded) because of family responsibilities (Marder, Kletke, Silberger, and Wilke 1988; Martin et al. 1988). In this vein, women's choices are seen as personal choices contingent on familial responsibilities. Another body of evidence supports the notion that specialty choices of women physicians are contingent on the desire for more active patient-participants and for less invasive, less technological, and more holistic approaches to medicine and patients (Hinze 1995). Studies in this vein, which I term the "cultural feminist perspective," emphasize the possibility of women's distinct values as determinants of choice (Davidson 1979; Kutner and Brogin 1990; Leserman 1981; Schobot, Cayley, and Eliason 1996). Finally, a more critical structural perspective, termed the "liberal feminist perspective," holds that women have experi-
enced tracking, discrimination, and constraints (Lorber 1984; Quadagno 1976). Women's "personal" choices are viewed as situated within a larger structural context where men subtly discourage or even actively prevent (through the system of informal sponsorship or sexist treatment and/or sexual harassment) women from pursuing the most coveted, highest prestige niches in the occupational hierarchy. Implicit in the liberal feminist perspective is the assumption that, all things being equal, women would want access to these specialties and that women view the hierarchy in terms similar to men's perspective. The purpose here is not so much to test these explanations against each other; that has been done elsewhere (Hinze 1995). Rather, I wish to explore how the hierarchy is perceived and to test the assumption that women and men physicians perceive the hierarchy in similar fashion.

Following Myra Marx Ferree (1985), I argue that scholars tend to think about the professions in ways that derive from men's experiences. Ferree notes that much of our research on professional work focuses on how individuals are motivated to acquire professional training and what structural impediments exist to professional credentialing for women and minorities. However, our understanding of professional work is not drawn from women's experiences or voices. Similarly, too often in the medical specialty choice literature, the assumption is that all residents, both male and female, internalize a prestige hierarchy and that all residents desire to be as high on this hierarchy as possible. In order to test such assumptions, it is important to have physician voices, both female and male, at the center. How they think about the specialty hierarchy may differ markedly from the perceptions of academic researchers, a point supported in Becker's work on medical students and Abbott's work on professionals. Furthermore, with the increased number of women in the medical profession, a qualitative assessment of the hierarchy and why it exists is timely.

DATA AND METHODS

Data are drawn from open-ended, face-to-face interviews conducted with a subsample of female and male resident physicians (N = 18) who were interviewed as part of a larger study (N = 405; 84 percent response rate) of physicians' specialty choices (Hinze 1995). The 405 respondents who participated in the larger study were asked about their willingness to be recontacted for follow-up interviews; 76 percent of respondents in the telephone interview (N = 308) said they would participate. Three criteria guided my selection of twenty respondents for the follow-up: gender, specialty, and degree to which the respondent engaged in the interview process. Prior to conducting the telephone survey with the full sample, interviewers were asked to evaluate the quality of each interview conducted. Respondents received a score from 0 to 4 depending upon how interested, enthusiastic, or thoughtful the respondent was about the issues explored. In selecting the subsample, the primary investigator (myself) set up three tiers of high scoring respondents representative by sex and specialty. If someone from position five in tier one (e.g., a male pediatrician) was unavailable or unwilling to be interviewed, then I would substitute someone from position five, tier two and so on. It is noteworthy that all of the respondents selected in tier one agreed to the lengthy face-to-face interviews. Eighteen interviews were successfully conducted; two fell victim to scheduling problems. Ten women (three surgeons, two obstetrician-gynecologists, and one each from psychiatry, pediatrics, dermatology, internal medicine, and anesthesiology) and eight men (two surgeons, two internal medicine physi-
FINDINGS

Hierarchy Description

Consensus

There are four notable findings with regard to the specialty rankings. First, residents were fairly consistent in their descriptions of the prestige hierarchy of medical specialties. The hierarchy or “ladder” they described consisted of anywhere between 4 and 10 levels or rungs with an average of about 6. Most resident physicians ranked surgeons as the most prestigious (level or rung 6), followed by internal medicine physicians (level 5), a “lump” that included anesthesiologists, radiologists, pathologists, and others (level 4), followed by obstetrician-gynecologists (level 3), then pediatricians (level 2), and finally psychiatrists at the bottom as the least prestigious (level 1). Residents were quicker to describe a top and bottom and tended to lump together specialties in the middle levels (especially level 4). Similar prestige rankings have been reported over time and across sites (Cassell 1998; Kutner and Brogin 1990; Matteson and Smith 1977; Merton, Bloom, and Rogoff 1956;
Zimet and Held 1975), indicating that the hierarchy described by Southern residents is fairly standard. Interestingly, there is not a perfect correspondence between income and prestige. Average incomes in 1994 were highest for (in descending order) surgery, radiology, anesthesiology, obstetrics-gynecology, pathology, internal medicine, psychiatry, pediatrics, and finally, family practice (AMA 1996).

Second, although residents were fairly consistent, there was some jockeying for position between surgeons and internists. Sixteen of the eighteen residents placed surgery at the top, two ranked internal medicine as highest or equal to surgery, and several commented on the rivalry between surgery and internal medicine for the top ranking. One female psychiatrist viewed internal medicine and surgery as vying for top dollar. As the following quote illustrates, whereas surgeons make more money and work harder, internal medicine physicians are considered more cerebral:

There's a big kind of a thing between medicine and surgery, you know? Like, the [internal] medicine people think that they're the cerebral people, and they think about things and they're the real doctors, and they're what the “M” in M.D. stands for. And the surgeons, they think that, “Well, we're the real bright people, and we have to work really hard, and we make more money.” And each of those thinks that they're the top specialty.

One female internist remarked that surgeons

obviously see themselves at the top of the pile and I think what they don’t realize is that a lot of medical people just laugh at them and shake their heads. And they let them continue to think they're at the top of the pile because they scream and yell and make a lot of noise and tell everyone how important they are, and no one wants to fight with them.

Indeed, the strength of surgery at Southern University may eclipse other departments. One female obstetrics and gynecology physician suggested that surgery is a “hugely strong department and it’s very nationally recognized. That’s why anesthesia's not very strong here, because they have to compete with surgery. So here, surgeons are kings. They’re the real men.” She suggested that in other programs with weaker surgery departments (relative to other surgery departments), anesthesiology may fare better in terms of prestige, perhaps a notch or two higher than other nonsurgical specialties.

Third, residents had a slight tendency to rank their own specialty higher than others ranked it. Although most residents placed radiology in the great “middle morass” (in the words of one resident, referring to what I’ve termed level 4 and including pathology and anesthesiology) of specialties, one male radiologist put his specialty on a par with surgical subspecialties. In addition, most physicians placed dermatologists in the internal medicine category since they do a year of internal medicine and really “subspecialize.” But some placed dermatologists below that great “middle morass,” perhaps only a step above psychiatrists or pediatricians. However, one female dermatology resident placed cardiothoracic surgery and neurosurgery at the top of the hierarchy and then said: “I'd personally perceive dermatology probably next [to] or even above the other subsurgical subspecialties.” She continued with internal medicine physicians, followed by radiology, obstetrics and gynecology, pediatrics, and finally, psychiatry.

Fourth, residents often gave more detail to an intraspecialty hierarchy. For residents whose specialties contained several subspecialties, “ranking” subspecialties becomes the
focus because the internal hierarchy was more familiar than a comparison of one’s own specialty to more distant specialties. Consider the words of a surgeon:

I’d say surgical subspecialties are at the top like cardiac surgeons, neurosurgeons, then vascular surgeons maybe. Then I’d say the other, general surgeons are probably just a tier below that, you could put transplant surgeons, otolaryngologists, other subspecialties. Then down from there I’d say invasive subspecialties in medicine like cardiology, GI [gastrointestinal], pulmonary. And then you get down to the, you know, run of the mill internists, et cetera, I would say ob/gyn would probably be above internists, probably, then I’d say, hovering down at the bottom, unfortunately, pediatricians, psychiatrists, and stuff like that.

Notice his reference to 7 categories of surgeons and 4 categories of internal medicine physicians, but the further he gets away from his own specialty, the less detail he gives. In fact, he neglected to mention pathology, radiology, and dermatology. When prompted, he located them, but he seemed less sure the further “away” specialties were on the prestige scale. The finding that residents make finer distinctions in specialties or subspecialties nearest them is consistent with the literature on social class distinctions.

Resistance

Four of the ten women and one of the eight men interviewed made comments revealing their resistance to the concept of a prestige hierarchy. For example, one female obstetrician-gynecologist asked, “Who defines prestigious?” She prefaced her comments on the hierarchy by arguing that medical students pick up on the prestige hierarchy very early, so clearly one exists, but “that doesn’t make it right. I mean, that’s a hierarchy based on the majority’s opinion or the most outspoken people’s opinion, from the people who set the standards, the people in power.” She struggles with the hierarchy and possible hypotheses or explanations for women’s place in it, arguing that men set up this “hierarchy” and “women are going into fields because they choose to, and tough shit, and we just don’t happen to care that we’re not high on their hierarchy” (emphasis added).

One female psychiatrist acknowledged that “psychiatry is totally at the bottom. People consider psychiatrists as, like, not really docs.” However, she argued that the value system is male and “women in medicine tend not to buy into that as much.” She said men are concerned about “how much money you make, and what kind of car you drive, and what kinds of women will sleep with you” whereas “women tend to think about things differently” and value, as she does, “time for myself and to feel like my work itself is rewarding.” She asserted that just because women are different “doesn’t necessarily mean we’re inferior.” The only man critical of the prestige hierarchy was an obstetrician-gynecologist who, while ranking psychiatrists at the bottom of the hierarchy, remarked: “I think society probably should value psychiatrists the most, because much of what is wrong with us is psychological.” Another female obstetrician claimed:

Psychiatry . . . always ends up being ranked down lower because it’s not a classic medicine that you’re taught. . . . I think they should not be at the bottom. . . . I’ve seen just too many unusual cases here at Southern that psychiatrists made the biggest difference—postpartum depression, trauma after pregnancy loss—where everything I could do, nothing could accomplish what a psychiatrist could accomplish.
Although resistant voices are few, their emergence is surprising. I did not expect respondents to challenge the hierarchy I so matter-of-factly asked them to describe. However, finding a gender difference among the resisters is not altogether surprising. The 405 residents who participated in the larger study were asked how important prestige of a specialty was to their choice; 58 percent of the women reported it was not at all important compared to 40 percent of the men (p ≤ .01). The gender difference in the quantitative study parallels the narrative comments because women are less likely to see prestige as important for their choice of a specialty and are less likely to validate the concept of a prestige hierarchy.

The resisters bring up two important questions. First, are women more likely to resist because they see the hierarchy as male-defined or because they tend to be lowest in the hierarchy? In the interviews conducted here, women toward the middle or top of the hierarchy (i.e., the three surgeons, one anesthesiologist and one internist) did not resist. Rather, like the men at the top, they went to great lengths to describe why they were more “valuable” and deserved higher status. This suggests that status defines resistance more than gender. Only one man in the “lower status” specialties resisted the hierarchy and prestige differentials. If status defines resistance, then lower status men should resist, too. This is not a quantitative study and the resistant voices are few, but it seems plausible that, independent of gender, status predicts resistance, and independent of status, gender predicts resistance. But these variables are not independent. Since women tend to be located in lower status specialties, they are doubly marginalized and most resistant—along gender and status lines. Status tempers resistance for higher status women (women are more likely to resist a male-defined hierarchy but their position in the hierarchy keeps them from it), and gender tempers resistance for lower status men (lower status residents are more likely to resist but maleness causes them to buy into it). Interestingly, the only man who resisted the hierarchy is an obstetrician and one who, in his own words, “likes working with women” and throughout his life “always had better friends that were women than [were] men.”

The second important question is: What is the resistance based upon? The comments explored here reveal resistance to the concept of a prestige hierarchy and the lower status of certain specialties within it. The narrative explored in the next two sections suggests that the resistance is based largely upon resistance to the high value attached to interventionist specialties. However, respondents also resist the value placed upon the “macho” nature of higher level specialties and the consequent pressure for those women choosing high status specialties to adopt male personae (while at the same time preserving outward femininity).

In summary, residents were fairly consistent in their rankings, although there was a slight tendency to overrank one’s own specialty and to be more familiar with intraspecialty rankings than interspecialty rankings. Finally, the women interviewees were more likely to challenge the concept of a prestige hierarchy, and their resistance may be interpreted variously through a gender lens (resisting a male-defined hierarchy) and a status lens (resisting their subordination on the prestige hierarchy). The following section examines the types of explanations given for the prestige hierarchy as defined above.

**Explanations**

Some residents initially claimed that certain specialties were more prestigious because practitioners in those specialties earned more money, an observation that begs the ques-
Gender and the Body of Medicine or at Least some Body Parts

Hence, respondents who gave “money” as an explanation were prompted to reflect upon why they thought certain specialties earned more. A couple of residents resisted explanations. For example, when asked why some specialists earned more than others, one woman psychiatrist replied: “I’m a really bad person to ask ‘cause I don’t really care about those things. I mean, it’s just not part of my value system.” However, most residents argued that specialty prestige is not only about earnings; indeed, many high earning specialties (e.g., radiology) are lower in prestige than specialties where incomes are often less (e.g., internal medicine).

What defines specialty prestige? In general, the explanations focused on the extent to which the *training* is rigorous and tough (longer hours and more years) and the extent to which residents learned concrete, measurable *skills*, especially those that resulted in heroic measures. Thus, the dimensions conferring prestige are time, effort, and skills.

According to one resident, surgery is highest on the prestige hierarchy because: “You put so many hours, so many years into it, so there’s a big time commitment. Delaying gratification . . . gosh, it took them that long to learn [those skills], they must be smart!” Later, she claimed that the “end result, what people see,” is important to surgery’s prestige. “It’s like, ‘Ah, you saved our little girl with that heart.’”

Implicit in much of the narrative is a subtext that provides a richly detailed, in-depth view of how specialty prestige is organized in the minds of the residents. Specifically, what is striking is the extent to which prestige is not easily categorized by money, lifestyle, or skill level. In fact, only a few of the residents gave such standard responses, and even then they elaborated upon other, less easily categorizable reasons for prestige. Clearly, there was something more important to their sense of why some specialties were “worth more” than others. The residents often talked at length about the body of the physician, or parts of the physician’s body, and how that body was engaged with the patient’s body. What emerges is the body as an organizing framework for explanations about the prestige hierarchy. Furthermore, the body is not gender neutral. After detailing how the body of the physician matters for specialty prestige, I will address how gender figures into this conceptual framework.

**Body Part I: The Hands**

Several residents placed surgery and the surgical subspecialties at the top of the hierarchy because the surgeon’s hands touch, enter, or probe the human body. The hands are not just any hands, they are active hands. The more somatic intervention, the more prestigious the specialty. This finding is consistent with Stephen M. Shortell’s (1974) study in which physicians, medical students, and patients accorded higher status to physicians who fell into Szasz Hollender’s activity-passivity model, where patients are essentially passive and physicians have control over patient outcomes. Consider the following:

I’m not here to sit on the sidelines. I don’t know what God wants me to do, but I’m here to do something, not to stand still. It is to move, it is to be active, it is to do something, to participate . . . and medicine is to save someone’s life, relieve the pain, somehow change the course of that human’s life and hopefully to make it better. And with that comes responsibility . . . Surgery demands an action, demands a simulation of information, demands a translation into manual, usually manual, physical actions, which I like. I like using my hands, I like touching things, I like doing things, and you translate
taking information and coming to a conclusion and then performing the act and watch-
ing, participating in the recovery of a patient. . . That’s what I like about surgery, it is
an active subspecialty of medicine whereas a lot of others are passive.

A female surgeon, when asked why she chose surgery, said, “I like working with my
hands.” She also emphasized the extent to which the specialty is action-oriented, dynamic,
and challenging both “medically and technically.” For her, the prestige of the specialty is
linked to the manual skills of the specialty as well as to the extent to which surgeons “out-
work” other specialists and “sacrifice” more. The anthropologist Joan Cassell (1998)
args that some specialties are more embodied than others and that having “good hands”
is seen as fundamental to being a surgeon. Furthermore, she suggests: “The extent of
embodiment seems roughly parallel to the prestige system among doctors: psychiatrists
are on the lowest rung, while at the other end surgeons loftily disdain the less embodied
specialties” (p. 33).

Nonsurgeons also ranked surgery as the most prestigious because of their ability to
“know” what is going on inside the body and to “fix” it with their hands. An internal med-
icine resident acknowledged that those in his specialty are less experienced than surgeons
with the body. He added, “We feel a belly, you know, and there’s something going on
there. We don’t really know what it is. We don’t know how to operate on people so we
don’t know.” The implication is that the deeper one enters the body, the more one knows
about the patient’s condition. Because of the surgeon’s hands-on, interventionist experi-
ence with the body, internists must often rely on their judgment. The same physician said,
“We call them [the surgeons] and they feel: ‘Oh, it’s nothing, why did you call me?’ Just
’cause they’ve felt a lot more [of] what we call acute abdomens, they know when some-
body needs to be opened up and looked at.”

One pathologist placed surgeons above internal medicine physicians because surgeons
“are in a position to physically save lives, and they’re sort of frequently in that position. . .
Medicine people kinda hem and haw around. They think about it, they deliberate about it,
they mess around with it, then they call the surgeon and the surgeon fixes it, you know?”

An obstetrician—gynecology resident argued that surgery is more valued: because sur-
geons take a life right into their own hands. Medicine people, god knows, the way they
change their medicines around. Scares me to death. But it’s not perceived as much as
taking someone’s life into their hands because they’re never cut open, you know. I
mean, all you’re doing is changing medicine. That’s not a big deal. (emphasis added)

Again, the hands figure prominently. Surgeons hold life in their hands and the actual
movements of their hands can dramatically alter someone’s life. Also, as one resident sug-
gested, the harder certain body parts are to get at, the more prestigious the specialty or
subspecialty. In the following quote, a female obstetrician-gynecologist recognizes that
working on basic organs that most of us never get to see raises the prestige of some spe-
cialties and subspecialties: “Oh, neurosurgery! Works on a brain. I mean, that’s even more
mysterious. Not only do you never see the surgeon, you don’t even see the brain. I mean,
it’s such a fantastical thing.” Clearly, physicians who touch or feel our most hidden, distant
organs (namely, the heart and brain) have status in the eyes of other physicians and the
public. Also, notice the comment “never see the surgeon.” She argued that surgeons are
distant and, hence, godlike to the patients. It is difficult to get an appointment with the sur-
geon; even when a patient does, the surgeon rarely talks at length, and the major work with the patient is done while the patient is sleeping. According to this resident, such distance makes them “unseen magical workers” with enormous power.

According to another obstetrician-gynecologist, psychiatry is at the bottom of the prestige hierarchy because “it’s sitting down, talking. . . . Psychiatrists just sit there and they take your money and you lie there and talk, and that’s what most people’s perceptions are,” whereas surgeons save lives and bring about dramatic outcomes and are perceived as “fixing things.” She said, it is “very sad” because “reimbursement is set up for taking care of it, fixing it, that sort of thing, but not for preventing it. And so then we have the lower class and the upper class doctor. . . . It’s not fair.” She gave the example of surgeons amputating a leg when more aggressive preventive medicine might have arrested the vascular disease from going as far as it did in the first place. “If that [smoking] had been changed umpteen years ago, then you wouldn’t be the surgeon taking the gangrenous leg off.”

Using one’s hands to bring about dramatic outcomes is financially rewarded. Active physician bodies are more valued than bodies that are considered passive or inactive, such as psychiatrists (who just sit down and talk) and pediatricians. One male surgeon claimed:

Pediatricians, they are morons. I’ll say that right now into the tape. I know pediatricians. They are morons, they are worse than internists. They are the prime example of inactivity in medicine. I mean, they sit around all day with their little teddy bears and stuff like this on their stethoscopes. . . . And basically, I mean, you’ve probably heard that pediatricians are the children of medicine. I mean, if you think like a child, act like a child, behave like a child, you go into pediatrics because you feel comfortable with children. If you are an active, assertive, hands-on type of individual, that usually goes into surgery, you feel very uncomfortable around children because children are, the entropy is maximum and the surgeon hates entropy. The surgeon likes order and children are disordered. Surgeons are the big boys on the block, the parents who spank the children. (emphasis added)

A great deal is revealed in this quote, but note especially the surgeon’s emphasis on inactivity and the association of inactivity with low status to the point of being child-like (and deserving of a spanking given, of course, by an active surgeon). Internists (residents in internal medicine) are also perceived as inactive by this surgeon, consistent with the notion of “hemming and hawing around” offered by the pathologist (quoted earlier) to account for the lower prestige of internal medicine physicians relative to surgeons.

In summary, surgery is perceived by surgeons and nonsurgeons alike as a hands-on, active subspecialty where the goal is to “fix” a broken body. Surgeons hold life in their hands and use their hands to save lives. Since results are less dramatic or heroic, physicians who practice preventive medicine, engage a person in talk therapy, or are “inactive,” such as pediatricians and internists, are viewed as less prestigious.

In addition to the emphasis on hands-on, somatic intervention, the resident physicians studied here repeatedly evoked the image of “balls” as important for specialty prestige. As the next section reveals, in addition to having aggressive, highly skilled hands, the highest prestige specialists, whether male or female, have enlarged “balls.”
Body Part II: The “Balls”

Many residents, whether male or female, recognize and clearly state the importance of the toughness factor, sometimes referred to as the presence and size of one’s testes. When asked why the prestige hierarchy exists as it does, one female anesthesiology resident argued:

Some of it has to do with how hard you slave. The reason, I think, that psych residents are looked down upon is because, whether or not this is true, people perceive them as rolling in at nine o’clock and rolling out at five and, you know, taking calls. My friend who is a psych resident at UCLA took [a] call once every ten nights. And so, it’s, you know, “You don’t work as hard as I do; therefore, you are not worth as much.” I think that comes in. Same with radiologists. . . . They don’t put in the hours that other trainees do. Puts them lower down.

In contrast, according to this resident, surgeons are just brutalized. There’s just no way around it. They’re brutalized for four years. And without being genderish about it, I think it’s just—you know, it’s like, “My balls are bigger than yours” because I’m here every night of the week,” that kind of deal. (emphasis added)

One female obstetrician-gynecologists claimed: “Surgeons are kings. They’re the real men. They have the biggest testicles.” When pushed as to what she meant by having “the biggest testicles,” she elaborated on the concept of toughness, seeing it as connected to “people who work harder”:

When I come off a service where I’ve been workin’ really hard, I feel like the toughest person. I am so tough; I am so superior to you because I work longer hours than you; I have stayed awake more days in a row than you will ever stay awake, you know: I am so cool . . . that’s exactly what it is. So I think it’s—god, that’s such a good question. I think it’s imposed on us by the people in this field. I don’t think it’s as important to pediatricians to be big macho people.

The same resident also identified an intraspecialty hierarchy along the lines of balls or toughness within obstetrics and gynecology. She asked if I knew any “gyn-onc docs” (gynecological oncologists) and then stated:

These guys are so macho. Dr. X, do you know her? . . . I always talk about how her testicles are bigger than anybody else’s in the department. I mean, she is so macho. This woman is so tough. And she walks; she’s tough; and she sits like this, you know. She’s tough. And she went through six million years of training in one of the hardest training programs in the country, no doubt. She is an incredible surgeon and she’s incredibly intelligent. And why is she so damn macho? Because she worked so hard for so long; because she doesn’t actually save lives. She just prolongs them for a little while. That’s what oncology surgeons do. But she does big, huge, major surgeries that I would never dare to touch. Well, that makes her much more macho than I am because she’s not scared of anything, you know?

One dermatologist said, “In my eyes, I’ve got a lot of respect for them [surgeons]. . . less ‘cause of how much they get paid, but because of how much work they put into it. And
they’ve been through a lot, I mean. The guys get harassed emotionally in the surgical profession” (emphasis added). For this resident and several others, it was not just the long hours but the extent of the harassment during medical training. One female psychiatrist viewed the more macho specialties as those that not only worked the most hours, but also “suffered.” When asked why some specialties are seen as more prestigious than others, she responded, “I think it’s the macho thing. I mean, people perceive that surgeons and otolaryngologists and—people like that—must be suffering a lot and so, you know, what they achieve must be good.”

She continued:

It isn’t just working hard—surgeons work an eighty-hour week and people are abusing them all the time and they can’t complain or even talk about how hard it is because then someone thinks they are weak or have a bad attitude. Whereas peds, you can work the same number of hours but you’re playing with kids, you’re having the fun, your coworkers are commiserating with you over the hours: “Oh, you’re post-call. You must be tired.” You know? Whereas in surgery, “Oh, you’re post-call. Well, you know, that’s just part of the life, you know? Stop whining.” (emphasis added)

One female pediatrician elaborated: “Talk about delayed gratification, you know. They go through more years than just about anybody. It’s very grueling. It is grueling. It is really grueling.”

A male surgeon, reflecting on why so few women are in the highest prestige specialty, argued:

Surgery is . . . compared to the military. And, a lot of women don’t feel comfortable in the military. And if you don’t feel comfortable in the military, you are not going to feel comfortable in a surgical . . . and again, this, you are going to say this is chauvinistic . . . but . . . there is something . . . I think it is socialization, that it is alright for males to, like the kids in the playground, you know, the kids fight, the boys are able to fight and you know, scuff ‘em up and throw mud at each other and they are best buddies afterwards. Well, girls can’t do that. . . . It’s not as acceptable for women to spar, but for men it is.

Militaristic images were evoked repeatedly in descriptions of surgery. This resident’s comments are revealing in light of Judy Wajcam’s (1991, p. 3) observation: “The cultural stereotype of science as inextricably linked with masculinity is also crucial in explaining the small number of women in science. If science is seen as an activity appropriate for men, then it is hardly surprising that girls usually do not want to develop the skills and behaviors considered necessary for success.” Whether the surgeon’s words reveal a deeply entrenched stereotype (“women don’t feel comfortable in the military”) or not, the reality is that he perceives the discipline as inappropriate for women.

According to one female resident, “this is still a male-oriented profession. And I know that my testosterone level has gone up remarkably—really! Not my actual blood test, my psychological testosterone level is elevated—from the day I hit medical school until now, nine years later. So, I mean, there’s a certain amount of macho.”

A woman can symbolically grow balls and her “psychological” testosterone level rises during the harsh medical training. Hence, women can compete with men as long as they are perceived as macho and tough. However, as the words of one female surgeon reveal,
the costs can be high. She explained: “I think I’ve changed probably for the worst these last twelve months because you work so hard and you get the shit beat out of you on a daily basis and they want you to be a man and act like a man and then when you do, it’s like you have some big personality disorder . . . you are not feminine anymore.” The resident began to cry but continued:

The goal was never to be perceived as a bitch or something, uh, or to beat up on men and to be some big, I didn’t want to be a man, I didn’t want to be like real tough and have to chew people out and play hardball with them, that wasn’t the goal. . . . [crying harder now] You know, if this is what, you know, if everyone hates working with me then it wasn’t worth it at all.

Toughness, being macho, having balls, suffering—together these contribute to the prestige of surgical specialties. Women can be perceived as macho as men but, as the above resident indicated, there are consequences. Furthermore, as the following quotes reveal, women who choose tough specialties play the macho role but must also emphasize their femininity, at least in physical appearance.

One male surgeon described the female “chairman” [sic] of a surgery program as “a competent surgeon, an impressive woman.” He continued, “She started off as, yeah, everyone called her a bitch, she’s a bitch, but attractive, dresses well, professional, is competent, and her surgical skills were good, above average I think, at least average or maybe a little better than average” (emphasis added). He insisted, “If you are a female in a profession, you maintain your femininity but you assert yourself as a professional. . . . You will be respected and you will advance yourself” (emphasis added). One female surgeon claimed that the only women she knew in surgery were “not very warm and were not feminine.” She added:

And I think I have maintained my femininity over the seven years, really, pretty well. Post-call or like when I’m extremely tired then, like now, what the hell . . . I didn’t put eye shadow on this morning because I knew it would be a long hard day and I’m not going home until tomorrow night, but if I’m, like, going home in the evening, if I’m getting up and going home, then I like to wear nice things. I wore scrubs in today because I figure, like, why bother. But I have my skirt that I wore up there like yesterday, actually, two days ago, . . . I wore my skirt and my hose and these are my . . . I mean, I wear girl shoes, I mean, a lot of these women in surgery are pretty unfeminine, the great majority of them are not very feminine. If I’ve been any kind of role model, sometimes I think it would be to be more of a feminine role model, a feminine surgeon role model, but then like I say, the thing that worries me is maybe I’m this hard-ass that everyone hates working with.

In her study of women physicians, Cassell (1998) finds that women surgeons are an oxymoron for many in the medical profession. According to one woman surgeon, male surgeons viewed female surgeons as “not women” (i.e., they were lesbians or dogs) or as not surgeons (i.e., they were incompetent). Male mentors in two different cases advised women surgeons to wear lipstick, which Cassell interprets as “embodied refutation of not-woman status” (p. 42). The men and women quoted above focus on the importance of women maintaining feminine bodies and suggest that women actively shape their bodies (by dressing well, wearing eyeshadow and “girl” shoes) to fit the embodied expectations.
This is not unlike the observation that women athletes in masculinized sports must emphasize their femininity (e.g., runner Florence Griffith Joyner) and men athletes in feminized sports must emphasize their masculinity (e.g., figure skater Elvis Stojko). But for women physicians in masculine specialties, the pressure to “be tough” while looking feminine is contradictory and can be a difficult balancing act, one that men are not expected to perform.

In summary, the highest prestige specialties are perceived as filled by those who have slaved and suffered and consequently have the largest balls. That is, one’s balls grow larger through training. Women as well as men can have balls, but the costs of acquiring them are high; women may be perceived as too tough and must work extra hard to preserve their feminine gender identity or, to echo the surgeon quoted above, they will not be accepted.

Residents’ beliefs about the existence of and explanation for a prestige hierarchy are complex. In general, most carry a similar mental map of the hierarchy, although lower status women are most likely to resist it. Moreover, for most residents, certain specialties (e.g., surgery) deserve higher status but the explanations residents gave for deserving that status are not as clearly organized around standard sociological concepts of prestige as we might expect. In addition to time, effort, and skills, residents invoked the concept of activity, especially as related to the physician’s hands and the concept of balls, which symbolize toughness and the ability to survive grueling schedules. In the next section, I explore the relationship between gender and residents’ perceptions of what makes a specialty prestigious.

DISCUSSION

Past research on occupational sex segregation in medicine has focused almost exclusively on where individual men and women are located in prestige hierarchies and neglected the extent to which the hierarchies themselves are socially and culturally constructed in gendered ways. It is not enough to ask how women are kept out or, in the words of Karen Miller-Loessi (1992), ghettoized; rather, we must examine the cultural meanings embedded within the existing structure or hierarchy of specialties. The narratives presented here reveal that residents’ perceptions of a prestige hierarchy in medicine, of why some specialties are “worth more,” are grounded in symbolic body parts that are gender linked. After reviewing how gender figures into the “body of medicine” as described by residents, I conclude by arguing that the images of specialties are not gender neutral and discuss how they may influence women’s location in the specialty hierarchy.

Hands

Women as healers have been central across time and place, within families, and at various institutional levels (Perrone, Stockel, and Krueger 1989). Throughout history, women have “laid hands” upon the laboring, sick, and dying or dead. Only as medicine professionalized did this role fall to men, or more accurately, to male physicians (Ehrenreich and English 1973; Morantz-Sanchez 1985; Starr 1983). However, as women have entered medicine in increasing numbers, they have continued to locate in specialties that are least likely to be associated with the kinds of invasive, hands-on activity that is, according to the residents, what confers prestige. For example, women are overrepresented in psychiatry and pediatrics, which residents perceive as “inactive” specialties where nothing is “fixed,” and they are underrepresented in the most “active” (and prestigious) specialties such as
surgery, the surgical subspecialties, and invasive internal medicine specialties. Certainly, pediatricians and psychiatrists use their hands, but using hands merely to diagnose or soothe the body or catch a baby is not considered high status. The hands must intervene, they must probe, manipulate or cut the body open, often assisted by sophisticated technologies. Implicit in much of the narrative is that the more technology, especially technology that intervenes, the more prestigious the specialty.

The "active hands" invoked by resident physicians are not gender neutral. The classical Western dualism of male activity and female passivity pervades the social world (Hochschild 1983). While much work deconstructs such hierarchical oppositions (Collins 1990), others' work (Bordo 1993) recognizes that those dualisms are embedded in this culture and shape the way we think, in this case, about the prestige of specialties and why some physicians are worth more than others. The historian Christopher Lawrence examines how corporeal images of physicians were employed to enhance the prestige of physicians, especially those engaged in active, interventionist, hands-on medicine that was seen as "inappropriate" for women. Lawrence (1998, p. 194) quotes an anonymous author from 1845 who wrote, "No man can know much of Anatomy, who is too finical or too lady-like to soil his delicate fingers."

Feminist critiques of the scientific revolution of the sixteenth and seventeenth centuries highlight how science emerged based on masculine projects of reason and objectivity (Wajcam 1991). Wajcam (1991, p. 5) writes that the critiques "characterized the conceptual dichotomizing central to scientific thought and to Western philosophy in general as distinctly masculine. Culture vs. nature, mind vs. body, reason vs. emotion, objectivity vs. subjectivity, public vs. private." In each dichotomy, the former dominates the latter, and the latter is systematically associated with the feminine. In a similar vein, practitioners of Western biomedicine invoke dualistic metaphors that reveal underlying social meanings: activity vs. passivity, fixing vs. maintaining, hands-on vs. hands-off, invasive vs. noninvasive, technological vs. personal care—and in each, the former dominates the latter, and the latter is associated with the feminine. The dualism inherent in the residents' narratives is important if we accept, as Evelyn F. Keller (1992) argues, the power of language and the extent to which language, in which beliefs are encoded, has the force to shape what men and women think, believe, and do. Furthermore, the narratives reveal the power that body images have for conveying status and prestige and the extent to which women and men attempt to conform to the appropriate embodied images, a process that may be below the level of language. Our knowledge of what it means to be a man or woman in a particular social setting is embodied, wordless, and transmitted, according to the philosopher Moira Gatens (1996), from the images, symbols, and beliefs encoded in both tangible and imaginary bodies.

"Balls"

While the relationship between the hands/activity terminology and gender may be somewhat subtle, the relationship between balls or testes and gender is anything but subtle. Perceptions of toughness and masculinity pervade resident explanations for the prestige hierarchy. As noted by the residents, women can be tough and have balls, but requiring that women "grow them" to compete in the top specialties is problematic for three reasons. First, as Sandra Harding (1986) and others have argued, conceptually, the problem becomes women (their socialization, aspirations, and values), and the larger question, of
how medicine as an institution could be reshaped to accommodate women, is ignored. In
other words, if women are confined to lower prestige, less tough specialties, it is their fault
for lacking testicles. If only they had more balls or were less passive, then they, too, could
be surgeons. As Gatens (1996, p. 71) notes, “It is beside the point to ‘grant’ equal access to
women and others excluded from the traditional body politic, since this amounts to ‘grant-
ing’ access to the body politic and the public sphere in terms of an individual’s ability to
emulate those powers and capacities that have, in a context of male/masculine privilege,
been deemed valuable by that sphere.” Moreover, the presence of women with masculine
hands and balls does not change the value system, which is still male defined. Women can
successfully adapt but by doing so they become symbolic men and leave the larger struc-
ture intact.

A second problem with requiring women to grow balls and devalue noninterventionist
medicine is that for women to survive in the highest prestige specialty and subspecialties
asks them to “exchange major aspects of their gender identity for a masculine version
without prescribing a similar ‘degendering’ process for men” (Wajcam 1991, p. 2). As ear-
lier quotes reveal, the “degendering” can be painful. Women must act like men to survive,
but then they fear, as the woman surgeon confided, that everyone hates them for it.
The third and final problem with requiring a certain level of toughness and macho in
order to compete in surgery is that, as Wajcam (1991) notes in her work on technology,
institutional structures are founded upon the division of labor in larger society in which
men are expected to work hard in the public sphere and women are still expected, whether
employed or not, to carry the lion’s share of the private sphere. Being “tough” because one
has endured a long residency with an intense call schedule is more easily attained by
those—men—who have less responsibility for the home.

In summary, the bodies, whether female or male, that occupy the top of the hierarchy
are hands-on, active, and tough. The bodies, whether male or female, that occupy the
lower rungs of the ladder, are perceived as passive, emotional, and soft. The prestige hier-
archy is not a gender-neutral concept; as resident perceptions reveal, it is infused with gen-
der. Although there may be a conflation (in the minds of both the public and physicians) of
these symbolic, gendered body parts with physiologically based attributes, the narrative
makes clear that biological women can make it to the top despite the unsuitability of their
bodies; presumably, biological men can and do adapt to the femininity associated with the
bottom of the hierarchy.

**CONCLUSION**

Research on women’s location or underrepresentation in scientific and technological fields
has recently undergone a massive shift, from studies focused on sexual difference (or, as
some scholars have insisted, the lack thereof) to how masculine and feminine meanings
are constructed (Keller 1992; Wajcam 1991). Initial research on women’s occupational
choices utilized gender as an explanatory variable, an individual-level characteristic that
reflects the psychosocial development of individual men and women. The focus in such
research might have been on the values or social roles of women that eliminated them
from the competitive world of surgery and the surgical subspecialties and, increasingly,
more technologically sophisticated (and highly remunerated) specialties like radiology
and anesthesiology. Alternatively, more explicitly feminist analyses, particularly from a
liberal feminist perspective, have analyzed how women’s choices were constrained by
men in positions of power or by stereotypes about women that caused them to be tracked into lower level specialties presumed to be more compatible.

More recently, as Keller’s (1992, p. 16) work on women and science reveals, gender has come to be seen as a “cultural structure organizing social (and sexual) relations between men and women.” The final step in this progression away from individuals as gendered is to view gender as “the basis of a sexual division of cognitive and emotional labor that brackets women, their work, and the values associated with that work from culturally normative delineations of categories intended as ‘human’: objectivity, morality, citizenship, power, often even, ‘human nature’ itself” (Keller 1992, p. 17). Keller views gender and gender norms as “silent organizers of the mental and discursive maps of the social and natural worlds we simultaneously inhabit and construct—even of those worlds that women never enter.” She calls this “the symbolic work of gender” and argues that “it remains silent precisely to the extent that norms associated with masculine culture are taken as universal” (p. 17).

The narratives presented here shifts our focus from the tastes, similarities, and differences of individuals, from passive women and mean men, toward the structure of the gendered prestige hierarchy itself with a cultural top characterized by masculine images and symbols. My findings are consistent with Joan Acker’s (1990) work on gendered organizations, revealing that organizational structures are not gender neutral. Rather, images of men’s bodies and masculinity pervade organizational processes and hierarchies; such images, according to Acker, marginalize women and contribute to gender segregation. Acker argues that women’s bodies cannot be adapted to hegemonic masculinity; to function at the top of male hierarchies requires that women render irrelevant everything that makes them women. My findings suggest that women’s bodies can adapt but not without significant work and costs.

If, in residents’ minds, activity (cutting, fixing, probing, doing) is juxtaposed to passivity (listening, talking, waiting, emotion work), and toughness, as symbolized by having balls and denoted by surviving grueling schedules, is juxtaposed to softness, and if the former in each case is more esteemed and associated with masculinity, then we see a sexual division of labor where bodies at the bottom of the prestige hierarchy, whether male or female, are devalued by association with feminized work. Along similar lines, Rosabeth Moss Kanter’s (1977) classic work on men and women in the corporation reveals a masculine ethic of rationality and reason identified in image of managers. The traits assumed to belong to men are elevated: being tough, setting aside personal, emotional considerations, and exhibiting cognitive superiority. According to Kanter (1977, p. 46), “While organizations were being defined as sex-neutral machines, masculine principles were dominating their authority structures.”

Attempts to understand women’s disproportionate location on the bottom rungs of the occupational prestige ladder have been largely quantitative, expert defined, and male defined. While the earliest sociological studies on specialty choice used a grounded theory approach, more recent studies have been quantitative and more often from a medical perspective. The few studies by sociologists, particularly liberal feminists, have brought us closer to understanding the persistence of sex segregation among physicians but have at their core male-centered assumptions, namely, that women see the prestige hierarchy in ways similar to men. The voices heard here, while admittedly few and from a training program that may not be particularly representative of national medical education programs, expose the silent, symbolic work of gender and suggest resistance. Does the resistance
lend support to the cultural feminist perspective that women’s values differ from men’s? Perhaps, but the cultural feminist perspective does not allow for variation (only some women resisted) and ignores the extent to which differences might be a reaction to perceived structural barriers.

Do masculine images of activity and toughness that pervade descriptions of higher status specialties contribute to women’s ghettoization in the medical specialty hierarchy? Such a conclusion is problematic if we take seriously women’s own words, such as those of the obstetrician-gynecologist: “Women are going into fields because they choose to, and tough shit, and we just don’t happen to care that we’re not high on their hierarchy” (emphasis added). This individual clearly resists what ghettoization implies: that structural forces (and individuals in higher level positions) conspire to keep some individuals (i.e., women) out of higher status worlds. However, the same person evoked gendered images (“her testicles are bigger than anybody else’s . . . she is so macho”) that may function as symbolic barriers. Furthermore, it is possible that some women actively construct symbolic barriers as a guard against entry into marginalized specialties that are rife with pitfalls to avoid, such as grueling, militaristic training schedules.

The structural-agency divide is deep and dates back to Karl Marx’s (1852) classic observation that men make their own history but not under circumstances of their own choosing. Structuralist theories, such as those posited by liberal feminists who argue that the informal system of sponsorship and sexist treatment effectively keep women out of more prestigious specialties, tend to minimize the role of human agency. As H. Giroux (1983, p. 108) notes, “Too often they ignore the complex ways in which people mediate and respond to the interface between their own lived experiences and structures of domination and constraint.” However, cultural theories, such as the feminist theory that posits that women hold different values, are flawed as well. Jay MacLeod (1995, p. 148) asserts, “Culturalist theories . . . too often fail to contextualize attitudes and behavior as responses to objective structures.” The present narratives offer a way over the structure-agency divide, at least for the issue of gender and specialty choice.

Based on the respondents’ voices, I propose an alternative liberal feminist perspective that allows for more agency. Whereas the traditional liberal feminist perspective emphasizes a male-dominated structure that, either indirectly through an informal system of sponsorship or more directly through sexist treatment, effectively keeps females out of the more prestigious medical specialties, my research suggests two “twists.” First, the voices recorded here did not support the notion that male gatekeepers prevent women’s entrance into desirable, high status specialties; rather, the narrative indicates a range of embodied masculine images and symbols embedded in those specialties—a much subtler structural barrier. Furthermore, while women emphasized that they did what they wanted and no one “kept them” from anything, their own words suggest that the images encoded in the highest status specialties might be inconsistent with their own sense of self and body. Future studies might benefit from tending closely to perceptions of the embodied hierarchy and how women and men view their place within it.

The second twist to the liberal feminist perspective lies in the active resistance of hierarchical interpretations of medical specialties. Recall the argument by one resident that the value system is male and that women “tend not to buy into that as much.” This suggests not only a recognition of the maleness of the system but also an active rejection of it, rather than a passive acquiescence to a male-dominated structure. Utilizing a small sample from an admittedly atypical training institution does not justify sweeping generalizations.
(And keep in mind that only four of the ten women interviewed resisted the concept of a prestige hierarchy.) However, it is possible that resistant attitudes reveal oppositional behavior in the specialty choices of women, behavior rooted in a critique of the gendered ideology undergirding the medical specialty hierarchy. Rather than submitting to a dominant gender ideology by being forced into more feminine specialties, women struggled against the gendered structure of medical specialties but chose feminine specialties anyway as an "in your face" move. (One resident that I interviewed informally before beginning my research described how horrified her peers were when she turned down an extremely high status specialty—neurosurgery—for the lower status specialty of obstetrics-gynecology because, to paraphrase, she loved the daily miracle of birth. In fact, she admitted that she had trouble accepting her own choice of a "girl" specialty because, as one of the best and brightest, she could have done anything she wanted.)

I would argue, following MacLeod (1995, pp. 21-22), that studies focused on resistance (which was not the intent of this study) are key to understanding "the ongoing, active experiences of individuals while simultaneously perceiving in oppositional attitudes and practices a response to structures of constraint and domination." Women's location in lower status specialties may not be simply a result of the power of the gendered images encoded in the hierarchy that weigh on the choices of women. Rather, women may valorize or rescue what has been devalued as an act of resistance. Future research on specialty choice would do well to focus on the use of embodied metaphors and the presence of resistance in its varied forms. While these narratives capture resistance, it emerged during the data analysis and did not allow me to address openly the range of oppositional attitudes and practices.

In conclusion, these findings shift the focus from individual-level gender differences toward a gendered examination of the medical specialty hierarchy. Through their words, these women and men give voice to the silent, symbolic, embodied work of gender that shapes the structure of the medical specialties into a ladder with a masculine top and feminine bottom, regardless of whether female or male bodies occupy the rungs.

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NOTES

1. Some recent evidence suggests that the trend toward specialization is tapering off as more physicians are encouraged to become primary care doctors. Specifically, Xu and colleagues (1995) report an increase in the percentage of medical students interested in primary care careers, from 14.6 percent in 1992 to 22.8 percent in 1994. However, they note that interest in primary care falls well short of the stated goal of the Association of American Medical Colleges that half of all graduates should choose generalist careers.

2. Articles written by medical professionals and published in medical journals tend to invoke (their research did not always support) the social roles perspective. In fact, two of the specialties with the most controllable lifestyles are radiology and anesthesiology; women are underrepresented in both (AMA 1994).
3. As far as I know, my study is the only one designed to test empirically the cultural feminist perspective against the liberal feminist and social roles perspectives. The hypotheses were developed by drawing some of the "classic" (albeit nonmedical) cultural feminist works, such as Gilligan's *In a Different Voice* (1982), Belenky, Clinchy, Goldberger, and Tavule's *Women's Ways of Knowing* (1986), and Ruddick's *Maternal Thinking* (1989).

4. According to scholars of Western biomedicine, the current trend in psychiatry toward biochemical approaches has been prompted, in part, by the higher prestige attached to bodily manipulation than to psychoanalysis (Gaines 1992).

5. I am indebted to a *TSQ* reviewer for pushing me to think about the variety of forms inherent in resistance.

6. The residents' words suggest that patient perceptions of what doctors do is important to how doctors think about what they do. A few studies reveal that lay perceptions differ from professional perceptions (Matteson and Smith 1977; Rosoff and Leone 1991); I'm not aware of any studies that examine the influence of lay perceptions on professional perceptions.

7. It is interesting that the brain generates prestige only if a surgeon invades it. Manipulating brain processes through drugs (as a psychiatrist might) does not boost the prestige ranking of that specialty.

8. Moving farther back in the causal chain, the sociologist or public health worker might point out that if income inequalities were minimized, or tobacco companies reigned in, we would see less smoking to begin with.

9. The status of obstetrician-gynecologists is often contested because they are viewed as passive baby catchers by some (namely, surgeons), although they do perform surgeries. Cassell (1998) uncovers this tension in her work as well. Although the American College of Surgeons and the Association of Women Surgeons include obstetrician-gynecologists, she opted to exclude them from her study of women surgeons because their training is different and because most surgeons view them as "different."

10. Because the body was associated with the feminine as medicine evolved and as surgical skills and knowledge grew in the nineteenth century, the profession worked to cultivate its masculine image by emphasizing its active, hands-on heroic work of fixing the body (Lawrence 1998).

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