The Making of the “Women’s Physician” in American Obstetrics and Gynecology: Re-Forging an Occupational Identity and a Division of Labor*

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After struggling as a surgical specialty, obstetrics and gynecology initiated its “women’s physician” program in the 1970s. This program officially defined the mostly male obstetricians and gynecologists at that time as women’s primary care physicians. Using archival data, this article explains this development as a response to the specialty’s dishonored position within the medical division of labor. Whatever else it was intended to be, the women’s physician program, in its most developed form, aimed to galvanize the various interests within obstetrics and gynecology behind a strategy to restructure the medical division of labor serving women so that obstetricians and gynecologists controlled both the upstream positions responsible for their own case referrals and the downstream positions to which they referred their difficult cases. The article illustrates the importance of integrating insights from both macro-institutional and intra-occupational explanatory frameworks in accounting for significant developments in medicine.

After World War II, increasing numbers of U.S. physicians entered specialty practice. In 1940, only 24 percent of physicians were full-time specialists (Starr 1982:358–59). By the late 1960s, almost 90 percent of U.S. medical graduates entered specialty residencies (LeRoy and Lee 1977:145). As specialization increased, the ratio of primary care physicians to people in the population declined. There were 94 primary care physicians per 100,000 people in 1931; there were only 55 per 100,000 in 1974 (LeRoy and Lee 1977:146). Policymakers defined the primary care shortage as a serious problem and enacted innovative responses to correct it during the 1970s.

One of the more fascinating of these responses was that of obstetrics and gynecology (ob/gyn). After fighting to establish itself as a consultant/specialty, ob/gyn embraced the role of “the women’s physician” in the 1970s.1 In this new role, ob/gyns were to deliver comprehensive primary care to women for ob/gyn and non-ob/gyn conditions. They were to provide checkups and routine care, keep medical histories and, when appropriate, refer patients to other specialists. Historically, general practitioners provided primary care after finishing their internships. Medical specialists, after three or more additional years of residency training, defined primary care as ill suited to their hard-won expertise (see Halpern 1990:32–33). Why, then, did ob/gyns embrace the primary care role?

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While scholars have associated feminine values of caring and empathy with primary care (see Riska 2001, chapter 2), female ob/gyns did not play a significant role in either formulating or initiating ob/gyn’s women’s physician program during the 1970s. Historically, ob/gyn had discriminated against female physicians, defining work in ob/gyn as men’s work (see Willson 1972). During the 1970s, ob/gyn was still, like the rest of medicine, overwhelmingly male—only 7.1 percent of ob/gyns were women in 1970, compared to 7.7 percent for all physicians (figures from American Medical Association Council on Long Range Planning and Development, 1987:3548). While the numbers of women in ob/gyn increased during the 1970s—-reaching 12.3 percent in 1980—it was not until the 1990s that ob/gyn became disproportionately female. In the 1970s, female ob/gyns lacked the numbers, resources, and power to shape ob/gyn’s occupational policies and programs. Thus, male physicians developed ob/gyn’s initial women’s physician program.

This article employs a multi-level theoretical framework to explain this puzzling development. This framework integrates insights from theories of the U.S. medical profession’s institutional development, particularly the professional dominance and “countervailing powers” theories, with insights from an intra-occupational perspective drawing heavily from Everett C. Hughes’ essays (1971). The article shows that ob/gyn leaders initiated their women’s physician program in the 1970s in response to intense inter-specialty competition, dishonoring, and structural dependency. Whatever else it was intended to be, ob/gyn leaders used this program as a resource for changing the specialty’s dishonored position in the medical division of labor.

INSTITUTIONAL DEVELOPMENTS FUELING THE PRIMARY CARE CRISIS

Expressing the central theme of the professional dominance perspective, Magali Sarfatti Larson (1977) argues that physicians reshaped the U.S. health care system during the early twentieth century with a “professional project” aiming to create a monopoly market. This professional project defined physicians’ service as a commodity, standardized this commodity through the routinization of training, and won state backing to exclude competitors from the market (see, also, Starr 1982). This professional project legitimated physicians’ control over their work with an institutional logic asserting that, in order to produce the highest quality care, physicians’ work judgments had to be free from market and administrative controls. This logic favored, and presumed, fee-for-service, private practice (see Scott et al. 2000; Freidson 2001; Light 2004; Mechanic 2004). Scholars have singled out a number of factors in explaining this development, including technical efficacy (see Freidson [1970] 1988:21; Mechanic 2004:12–13; Scott et al. 2000:21–22), work organization that maximizes private responsibility and isolates physicians’ work processes from scrutiny (Freidson [1970] 1988), and physicians’ use of their cultural authority to block the development of “countervailing powers” in civil society and the state (Starr 1982, chapter 3; see, also, Hafferty and Light 1995; Light 2004).

While national governments elsewhere cultivated strong countervailing powers and mobilized them to counter physicians’ dominance, in the United States the federal government accommodated its policies to the interests of a medical profession committed to private, fee-for-service practice (Hafferty and Light 1995; Light 2004; Starr 1982). Donald W. Light (2004; see, also, Hafferty and Light 1995) has argued that this failure to develop strong countervailing powers is behind many of the current pathologies of the U.S. health care system. Indeed, this failure played a role in creating the primary care shortage of interest here.

In the post-World War II decades, as Paul Starr (1982) documents, the federal government committed itself to liberal activism with regard to medicine, in essence, restructuring the system with massive investments in hospital construction and medical research. Total national expenditures for medical research, for example, increased from 18 million dollars in 1941 to 181 million in 1951; average medical school income increased from 1.5 million at the end of the 1940s to 15 million by 1968–1969 (Starr 1982:342–43). This massive centralized investment occurred without centralized controls, as the federal government respected physician dominance over medical institutions (Light 2004; Scott et al. 2000; Starr 1982). Furthermore, because the National Institutes of Health distributed research funds to researchers through separate institutes, federal research investments encouraged specialization (Starr 1982; see, also, Hafferty and
Light 1995; Light 2004). Medical researchers met their labor demands not with general interns but with residents who had specialty training (Ginsberg et al. 1981:511–12; Hiestand 1984; LeRoy and Lee 1977:145–46). While the number of candidates for medical degrees (M.D.) increased 31 percent from 1950 to 1967, the number of residents training in specialties increased 311 percent (Fein and Weber 1971:54).

These research investments did not break the medical profession’s tenacious grip over the numbers admitted to medical school—the entrée port into the physicians’ labor market. The number of students entering medical school did not increase substantially above general population increases, even as opportunities for post-graduate residency and fellowship training increased (Starr 1982). Indeed, the ratio of physicians to population, even in the face of a serious physician shortage, changed little from the end of World War II until federal policies were enacted, beginning in 1963, to increase physician supply (Starr 1982:35). Medical school graduates, who in the past entered quickly into general practice, entered residencies supported by research and training grants. This development fueled the primary care crisis (Starr 1982:337–38). As we argue below, ob/gyn leaders, through their women’s physician program, attempted to appropriate this crisis as a resource in pursuit of their own occupational ends.

RE-EMBRACING EVERETT C. HUGHES’ OCCUPATIONAL PERSPECTIVE

While useful for understanding how the primary care crisis developed, the macro-institutional perspectives cannot really explain why ob/gyn embraced a primary care role. There is good reason for this. At the institutional level, the medical profession must represent itself ideally—as a unified, standardized commodity (Larson 1977). Organized medicine, as represented by the American Medical Association, speaks with one voice, as if all physicians held a common identity and set of interests. However, institutionalists realize that professional reality in medicine no longer conforms to this ideal (see Scott et al. 2000). Frederick W. Hafferty and Donald W. Light (1995), for example, refer to this ideal as “medicine’s public façade of internal equanimity” (p. 136). With increasing specialization, a complex division of labor with splintered occupational ideologies, identities, and interests has largely replaced organized medicine as a unified profession (see Ginzberg et al. 1981:525–26; Hafferty and Light 1995; Light 2004; Scott et al. 2000:185–86; Zola and Miller 1971). Thus, we must supplement our theorizing at the institutional level with theorizing about developments at this splintered intra-occupational level to better understand developments like ob/gyn’s initiation of its women’s physician program (Zetka 2003, 2008; see, also, Berman 2006). To do this, medical sociology would do well to re-embrace Everett C. Hughes’ (1971) occupational sociology. The historical analysis of ob/gyn’s embrace of the primary care role presented below draws from the basic tenets of Hughes’ occupational perspective.

Hughes encourages us, first, to specify the definitional frames within which occupational groups assign meaning and significance to their work tasks, and from which they develop their senses of identity and worth (1971, chapters 28, 30, 33). These definitional frames are referred to here and elsewhere as core-skill definitional frames (see Zetka 2001, 2008; Zetka and Walsh 1994). They orient action and provide the foundation for each medical speciality’s distinctive occupational program. In medicine’s splintered intra-occupational division of labor, many core-skill definitional frames coexist, compete, and contradict one another (Hughes 1971:295–98; see, also, Bucher and Straus 1961; Bucher [1962] 1972; Bucher 1988).

Hughes also encourages us to recognize that the programs emanating from occupational groups’ core-skill definitional frames unfold in complex divisions of labor (1971, chapters 30, 35). Macro-institutional developments, like those fueling the primary care shortage discussed above, partially structure these divisions of labor, providing both constraints and opportunities. Occupational groups also pursue the programs emanating from their core-skill definitional frames within these divisions of labor in the face of significant others who themselves have vested interests in their outcomes. Indeed, such programs are often directed toward these significant others in sometimes subtle, and sometimes not so subtle, ways. For Hughes, understanding these interactions and relationships at the inter- and intra-occupational level are critical to understanding...
how occupational groups mobilize themselves and act collectively.

**PROFESSIONAL DIVISIONS OF LABOR AND THEIR COORDINATION AND CONTROL DYNAMICS**

The professional division of labor within which these occupational programs unfold contain a structural contradiction. At the most basic level, the professional division of labor consists of two types of workers: (1) generalists who screen workflow, handle routine cases, and refer complex cases to others, and (2) consultant/specialists who limit their workload to complex cases requiring a level of expertise beyond that possessed by generalists. While research suggests that structural positions that control the work flow of many task units gain power and status (see Hickson et al. 1971; Wallace, Griffin, and Rubin 1989), generalist positions in professional divisions of labor often are devalued. Professionals view the work of the specialist as important, skilled, even heroic, and that of the gatekeeper/generalist as routine. However, since generalists control market access (see Hafferty and Light 1995:136–37; Hughes 1971:382–83), positional power and status honor stand inversely to one another. This, as discussed in the case narrative presented below, can be problematic.

Historically, because of the institutional developments discussed above, the U.S. medical division of labor has lacked effective structures for regulating specialty developments and relationships (see De Santis 1980; Gritzer 1982; Stevens 1971). Over time, normative scripts have emerged to direct workflow between generalists/gatekeepers and specialists. These scripts define which specialist should get which case, when they should get it, and why. They carry moral authority over the market spaces they regulate (see Zetka 2001, 2003).

Securing specialized turf in this division of labor usually required that those in gatekeeper positions accepted specialists’ core-skill definitions and “turf logics” as legitimate scripts for processing cases. Turf logics are the arguments specialists use to persuade others in the division of labor that their core-skills, rather than those of competitors, are most critical for servicing a particular market. Turf logics define the skills of the specialists they favor as superior to others. They direct gatekeepers to send relevant cases to these specialists (see Zetka 2008). Gatekeepers/generalists have used these normative scripts to perform screening functions. Specialists typically have worked downstream and have received their new cases from these gatekeepers. They have stood structurally in a dependency relationship with them.

Having one’s core-skill definition and turf logic incorporated into a legitimated script for directing workflow within this division of labor has been problematic, for this development restricts market opportunities for others within the profession (Stevens 1971; Zetka 2003). Ob/gyn belongs to the first wave of surgical specialties achieving independence from general surgery. Ob/gyn’s traditional core-skill definition challenged surgeons’ control over pelvic turf by promising superior treatment outcomes. With a formidable competitor antagonized, ob/gyn had to deliver the superior outcomes it promised to secure its legitimacy. To understand ob/gyn’s women’s physician program, we must first understand the core-skill definition and turf logic ob/gyn used historically to justify its turf claims. We must then extend our focus outward to the medical division of labor and examine how important groups, acting within its web of institutionally-structured opportunities and constraints, responded to ob/gyn’s claims.

The argument developed in the historical narrative presented below is this: In the face of ob/gyn’s historic failure to legitimate its traditional core-skill definition, ob/gyn leaders initiated their women’s physician program as a tool for restructuring the medical division of labor and ob/gyn’s position within it. With this tool, ob/gyn leaders aimed to secure better access to ob/gyn’s coveted market turf. Ob/gyn leaders, thus, appropriated the primary care crisis fueled by a medical care system structured by both a logic of professional dominance and weak “countervailing powers” so as to serve their own occupational ends. The information used below to support this argument was collected from medical and ob/gyn specialty journals, including editorials, presidential addresses, commentaries, letters to the editor, and published study results (on methodology, see Zetka 2008).

**OB/GYN’S HISTORIC CORE-SKILL DEFINITION AND TURF LOGIC**

Ob/gyn formed in 1930 as a specialty combining obstetrics and gynecology. Ob/gyn allied itself to a new order of medicine that opposed the traditional division of labor between
medicine and surgery. This new order based its divisions not on specific task skills but on comprehensive care in diagnosing and treating anatomical regions. Ob/gyns claimed superior expertise to care for all aspects of women’s reproductive and sexual lives (Hodgkinson 1961; Sturgis 1957). They embraced a broad skill set, including diagnosis, endocrinology, medicine, surgery, and later even psychological counseling (Beecham 1969; Mengert 1959; Reid 1961; see, also, Zetka 2008). Ob/gyn’s core-skill definition held that ob/gyn’s comprehensive knowledge of women’s gynecological and reproductive organs made their skills in diagnosing and treating these organs superior to other physicians.

The foil in ob/gyn’s core-skill definition—that which ob/gyn defined itself against—was typified as “the mechanical surgeon,” a one-dimensional cutter rather than a true doctor (see Perdue 1952:77). Such a surgeon diagnosed through the open incision, subjecting patients to surgical trauma unnecessarily (see Ellison and Thornton 1955; Perdue 1952). In contrast, ob/gyns, with their broad comprehensive knowledge, claimed to be better able to diagnose accurately the true nature of patients’ gynecological and reproductive troubles. Whether the problem proved to be medical or surgical, the greater diagnostic skill, afforded through ob/gyn’s comprehensive understanding of the pathology of female genital and reproductive systems, enabled better treatment outcomes (Beecham 1969; Bloss 1950; Sturgis 1957). While ob/gyns performed surgery, surgery was but one of their many treatment options. And, rather than simply remove organs from the pelvis, ob/gyn’s procedures aimed, whenever possible, to preserve organ functioning (Riva 1965:645). The anticipated successes promised in ob/gyn’s core-skill definitional frame—improvements in diagnostic accuracy, reductions in unnecessary surgeries, and better preservation of organ functioning—were to establish and secure its turf jurisdiction.

OB/GYN’S TURF LOGIC AND MEDICINE’S INTRA-OCCUPATIONAL DIVISION OF LABOR

As documented below, ob/gyn’s experience in winning legitimacy as a consultant/specialty was dismal. This experience contrasted starkly with that of other specialties. For example, urology and otolaryngology, like ob/gyn, claimed jurisdiction over all functions involved in servicing their anatomical regions. Each specialty mastered endoscopic technologies early on that combined diagnostic and treatment functions. These technologies enabled each specialty to claim impressive improvements in its diagnostic and surgical outcomes. Once these specialties became associated with their endoscopic technologies, surgical competitors, without endoscopic experience, could not easily encroach upon their turf.

While ob/gyn tried various endoscopic technologies, none became widely embraced, or particularly successful until fiberoptic laparoscopy in the 1970s. It was not until the late 1970s, in fact, that this technology began to improve results. For the period of interest, ob/gyn shared the diagnostic, medical, and surgical techniques used by others and, as recognized in commentary (Mengert 1959; Taylor 1958), this made ob/gyn’s turf vulnerable to encroachment.

During the period of focus, ob/gyn had failed to achieve the diagnostic and treatment successes anticipated in its core-skill definition (see Zetka 2008) and, according to its own commentary (discussed below), ob/gyn’s reputation in the medical division of labor had tarnished considerably. The failure to improve diagnostic and treatment outcomes threatened ob/gyn’s hold on its surgical turf. The poor reputation resulting from this failure blocked the referrals coveted in ob/gyn’s consultant/specialty role, and it hindered recruitment efforts as well. By the 1970s, commentators were questioning ob/gyn’s survival as a specialty.

“BABY CATCHERS”

Ob/gyn made considerable progress in obstetrics after 1930. Maternal and infant mortality showed impressive continuing declines, as did morbidity, obstetric injuries, and complications. Despite its accomplishments, however, obstetrics was dishonored in the medical division of labor (Bloss 1950; Simard 1957). Ob/gyns accomplished their improvements as much through public health campaigns as from any innovation they developed. Ob/gyns also took advantage of innovations in other fields that they had no hand in developing themselves. Basic obstetric deliveries, in fact, held little mystery for physicians. All were trained to perform them, and, historically, family practitioners and general surgeons did so early in their careers. Because the hours were long and unpredictable, and because the process was
both routine and stressful, most abandoned this work as soon as possible (see Brewer 1953; Simard 1957). As one very frank ob/gyn commentary suggested (Brewer 1953), obstetricians established their independence only because surgeons did not generally value deliveries and no one else wanted to claim this turf as their own.

Ob/gyn commentators spoke of obstetrics’ image as being that of a “humble art” involving the work of “skilled laborers” (see Simard 1957). Others looked upon obstetricians as “baby catchers” overseeing a natural process. This role lacked the glory associated with, say, saving lives through surgical intervention, or with relieving misery medically after a successful, complex diagnosis. One ob/gyn commentary made this point well:

Obstetrics . . . still remains, in the minds of many, a poor relation of medicine and surgery. Sometimes a good friend will repeat the sally: “If your son is intelligent, let him be a physician; if he is clever, let him be a surgeon; if he is neither, let him be an accoucheur [obstetrician]!” (Simard 1957:1163)

“WOMB SNATCHERS”

Surgical residencies traditionally trained residents to perform all tasks necessary to treat patients’ surgical problems regardless of which organ systems were involved. Attaining this level of skill required that all surgical specialists undergo training in general surgery, usually for one year or more. Ob/gyn, however, split obstetrics and gynecology into two 18-month stints. Thus, a typical ob/gyn had no general surgery training, and no more than 18 months of total training in gynecological surgery, far less than other surgical specialists. Ob/gyn leaders held that, because of impressive developments in anesthesia, blood and electrolyte monitoring, aseptic and antisepctic techniques, etc., any ob/gyn resident during a relatively short stint could learn to perform gynecological surgeries effectively (Mengert 1949: 207–208). This position presumed that ob/gyns needed only basic proficiency to manage cases on their own, so long as a viable referral system existed that could match quickly the demands of the more difficult cases to more accomplished surgeons with requisite skills. One commentator explains it in this way:

The type of surgeon visualized by this school will be a relatively standardized product, capable of carrying out effectively the accepted procedures in the area in which he has been trained and indoctrinated with the ideal that he must not undertake procedures beyond his capabilities. This school proposes to solve the problem of surgical care through organization and the interrelationship of one surgeon with another, rather than by what it believes to be the futile task of attaining and maintaining versatility and virtuosity in a sufficient number of ‘ideal surgeons.’ (Taylor 1965:36)

However, as its treatment outcomes paled in comparison to others, many began to challenge the viability of ob/gyn’s alternative approach. The general belief voiced in numerous ob/gyn commentaries was that gynecological surgery’s glory years were behind it (see Brunschwig 1968; Mengert 1959; Willson 1972). Ob/gyn’s surgical record continued to draw consternation well into the 1970s. Ob/gyns, for example, were responsible for most of the ureteral injuries and genito-urinary fistulas treated by urologists on referral (see Symmonds 1976). In studies of second opinions for elective surgeries, moreover, ob/gyns had higher rates of non-agreement between physicians providing initial and second opinions than other specialties (McCarthy and Finkel 1980). One commentator (Barter 1975) went so far as to state that “the specialty of Ob-Gyn as a surgical entity may be doomed to indistinction and to ultimate death” (p. 814).

General surgeons held a low opinion of ob/gyn’s surgical abilities, and this opinion spread throughout the medical division of labor (Hodgkinson 1968; Mengert 1959). General surgeons refused to cede to ob/gyn’s jurisdiction over the uterus and ovaries. General surgeons performed the majority of gynecological surgery in the United States long after ob/gyn incorporated. General surgeons, who trained long and hard in surgical residencies, felt they were far more competent in performing operations on the gynecological organs through the abdominal incision than were ob/gyns (see Taylor 1965). Apparently many gatekeeping physicians agreed, since the bulk of the gynecological cases general surgeons treated came to them in this way.5

RECRUITMENT INTO A DISHONORED SPECIALTY

Ob/gyn leaders realized that the specialty’s future lay in its ability to attract talent. Improving the quality of the ob/gyn recruit be-
came a preoccupation. Yet efforts here were stymied. Why would successful medical graduates enter ob/gyn when others generally viewed this specialty as a routinized field, a view reinforced with a barrage of demeaning nicknames like “glorified midwives” (Willson 1972) and “baby catchers and uterus snatchers” (Tyson 1973)? Top medical students, in fact, were not attracted to this field. Ob/gyn drew its residents from the bottom third of the academic barrel (Tyson 1971; Willson 1962, 1972).

This situation was not acceptable to ob/gyn’s leaders and efforts were made to improve it. At the 1953 American Gynecological Society (AGS) meeting, Dr. Howard C. Taylor, Jr. presented a statement critical of the caliber of graduates choosing ob/gyn. The AGS then appointed a committee, chaired by Taylor, to study the issue. The Taylor committee surveyed eighty ob/gyn departments and reported findings to the AGS in 1954 that documented Taylor’s claims. These results led to more committees and further efforts (see Barnes 1971).

However, even with these efforts, neither the numbers entering ob/gyn residencies, nor the residents’ academic quality, improved greatly during the period of focus. A 1971 commentary proclaimed such efforts “pathetic failures” (Lund 1971:464).

**DISHONOR AND ITS OUTCOMES**

Figure 1 illustrates case-flow relationships in the medical division of labor. The simple relationship depicted in row A illustrates the ideal relationship coveted by surgical specialties. Only one arrow depicts case flow from the primary care screeners to the specialty. Here, screeners accept as legitimate the specialty’s normative scripts for processing cases. They refer such cases to the specialist and do not contemplate other options. The specialty’s core skill definition has cognitive and moral authority over this space in the division of labor.

The relationships depicted in row B in Figure 1 illustrate the case-flow relationships ob/gyns experienced in the postwar period in their role as surgical consultants/specialists.
Dual arrows depict case flow from primary care screeners: one to ob/gyns, one to general surgeons. Screeners, in essence, had a choice as to where they sent cases. Ob/gyns failed to legitimate their normative scripts for processing their cases, and the competition ob/gyns experienced with general surgeons shifted power to screeners. This situation made ob/gyn’s case flow vulnerable. A second arrow in row B extends from ob/gyn to other surgical specialists, depicting ob/gyn’s dependency upon others to manage their surgical complications. This dependency opened up ob/gyn to external criticism. This criticism fed back to the screeners and reinforced ob/gyn’s difficulties in receiving referrals. The dual dependency did not bode well for ob/gyn’s fate.

In fact, it is reasonable to expect failure, even death, as the likely fate of a specialty that (1) fails to establish superior work outcomes, (2) fails to secure control over its market turf, (3) fails to improve its reputation and status in the division of labor from which it draws referrals, and (4) fails to attract recruits. Compared to specialties such as urology and otolaryngology, ob/gyn performed very poorly in all areas, producing the very difficult, perhaps unworkable, case flow relationships depicted in row B. Yet ob/gyn did not die.

The institutional system characterized by professional dominance and weak countervailing powers discussed above actually abetted ob/gyn’s survival. This system, by encouraging specialization (Ginsberg et al. 1981:511–12; Hiestand 1984), created a rather large structural vacancy for primary care services (see Abbott 1988, chapter 4). Unintentionally, this structural vacancy became a “mop-up” market open to those physicians inclined to move into it. This development provided opportunity and protection to those experiencing increasing competition. Since this space was not a downstream position in the medical division of labor, its occupants were not dependent upon referrals. Whether they were honored or dishonored in the medical division of labor made little difference. This space was one demanding more physicians. Without official guidance, many ob/gyns moved to this mop-up space and provided primary care to women, long before federal legislation favored primary care specialties (Gardner 1966).

THE WOMEN’S PHYSICIAN PROGRAM REVISITED

Ob/gyn’s failure to win legitimation for its core-skill definition conditioned its responses to policy initiatives. In general, academic ob/gyns desired more support for their residency programs and research; community practitioners wanted better access to their surgical markets. Ob/gyn leaders championing the women’s physician program, in essence, appropriated the primary care initiatives to serve the market interests of both segments of the specialty.

ACADEMIC INTERESTS AND OB/GYN’S WOMEN’S PHYSICIAN PROGRAM

By the 1970s health policymakers had recognized the decline in the numbers of primary care practitioners as a serious problem. The 1976 Health Professions Educational Assistance Act, renewing earlier legislation providing capitation grants to medical schools, stipulated that medical schools should insure that by 1980 50 percent of their graduates were entering primary care (Ginzberg 1986:3; LeRoy and Lee 1977). Ob/gyn leaders realized that their number of residency programs, their number of residents, and their research funds all hinged upon the specialty’s recognition as a primary care provider (McElin 1977). In 1972, the American College of Obstetricians and Gynecologists produced a policy statement proclaiming that ob/gyns should be equipped to serve as primary care physicians. In 1979, the American College of Obstetricians and Gynecologists sponsored a “task force committee” to study the issue, and in 1980 it formally defined ob/gyns as both consultants and women’s primary care physicians.

Ob/gyn leaders directed several large studies documenting ob/gyns’ contributions to primary care. Lo and behold, such studies found that ob/gyns spent much of their time providing routine periodic services to well women: cancer screenings, physicals, and medical histories. Ob/gyns also were found to treat non-ob/gyn conditions and served as entry ports to the medical system, making referrals to other specialists (Raney et al. 1976; Willson and Burkons 1976a, 1976b). In a large representative study, 40 percent of practicing ob/gyns reported that half or more of their patients came to them for primary care (Yankauer et al. 1971). A survey of 1,000 ob/gyn patients in
Michigan found that 44 percent had no primary care physician and 86 percent only saw their ob/gyns for regular checkups (Burkons and Willson 1975). A study conducted by the Medical Foundation of Massachusetts found that ob/gyns gave more hours to primary care than internists (Wechsler, Dorsey, and Bovey 1978).

Ob/gyn leaders proffered a demand-driven explanation for these patterns. Their explanation favored, and drew heavily from, the definitional frame of conservative obstetricians, who had contributed actively to ob/gyn commentary since the founding of the specialty. According to the conservative obstetricians’ definitional frame, a special bond existed between a woman and her ob/gyn. This bond developed naturally during first pregnancy, with the ob/gyn at the young mother’s bedside during one of her most intimate life experiences. Here, the ob/gyn gained the mother’s trust and devotion (see Craig 1959). Afterwards, the ob/gyn nurtured this “special relationship” through periodic examinations throughout the woman’s reproductive years. The ob/gyn, in this definitional frame, was the true woman’s physician because of this bond and, according to one commentary, “the true woman’s physician [was] actually, other than her husband, the most intimate man in her life” (Burman 1968:393). Women preferred to see their ob/gyns for routine care, according to this frame, because they learned to trust them over an extended period. It was just natural that women chose to rely upon their ob/gyns for medical guidance and referrals (Ranney 1976:287).^6^  

Influential health planners did not buy ob/gyn’s claims, however (Pearson 1975). Ob/gyn was not listed in 1971 legislation linking medical school scholarships to the promise of practicing primary care in needy areas. After intense lobbying, The Department of Health, Education, and Welfare recognized ob/gyn as a primary care specialty in 1974. However, ob/gyn was removed from the list of primary care specialties in the 1976 Health Professions Education Assistance Act (McElin 1977; Pearse and Trabin 1977). The stickler in ob/gyn’s efforts to have its primary care role recognized by policy makers was Dr. Robert Knouss, heading the Federal Bureau of Health Manpower Committee. Dr. Knouss, an internist, did not accept the practice data supporting ob/gyn’s primary care role as evidence that ob/gyn was a true primary care specialty. He demanded data indicating that a primary care emphasis played a prominent role in the training of ob/gyns (Pearse 1980). Ob/gyn’s leadership was hard pressed to provide this.

Many within the discipline felt that the ob/gyn residency poorly trained ob/gyns for primary care (Dunn 1993; Willson and Burkons 1976b). Efforts were made to address this shortcoming. On the basis of findings from a series of studies he conducted with David Burkons, Dr. J. Robert Willson proposed reforms for residency training to better prepare ob/gyns as primary care providers in his presidential address before a joint meeting of the American Gynecological Society and the American Association of Obstetricians and Gynecologists in 1974. Willson, drawing from a number of earlier proposals, argued for expanding the length of general training to four years to provide better training in primary care and counseling, including weekly stints in outpatient clinics and more training in general and internal medicine (Willson and Burkons 1976b).

The fourth year requirement that Willson and others proposed was reinstated in 1976. In addition, the American Board of Obstetrics and Gynecology recommended in its 1979, 1980, and 1981 statements regarding residency training that ob/gyn residencies provide “a significant portion of graduate education in a broadly oriented approach to patient care” (quoted in Dunn 1993:1053). These statements, however, did not come with real requirements, and they were not repeated after 1981 when the Reagan Administration ended federal funding for enrollment increases. Then, the advantages that academic medicine reaped from being officially recognized as a primary care specialty evaporated (see Dunn 1993).

THE INTERESTS OF SURGICAL GYNECOLOGISTS AND OB/GYN’S WOMEN’S PHYSICIAN PROGRAM

Traditionally, ob/gyn trained its residents to become surgically-oriented consultants/specialists. Most ob/gyns embraced the surgical role as at least part of their occupational identity; some considered themselves as primarily surgeons and worked throughout their careers to establish exclusive surgical practices. And, while practicing obstetrics and providing primary care services enabled most ob/gyns to establish busy practices and good incomes, these
were not the practices for which they were trained. Many commentators defined primary care work as boring and addressed the issue of the resulting alienation inherent to such a role (Willson 1972; Willson and Burkons 1976b; see, also, Halpern 1990). Some ob/gyn leaders felt that something had to be done to reconcile the consultant/specialty role emphasized in residency training with the primary care role most ob/gyns played out of necessity (Willson and Burkons 1976b).

Dr. J. Robert Willson’s proposals for incorporating the primary care role into the specialty, and his associated proposals for reforming residency training discussed above, spoke to this contradiction. Willson was an academic ob/gyn who held a keen interest in reforming residency training. He held high offices in ob/gyn’s elite associations throughout his career. Willson, for example, was elected President of the American College of Obstetricians and Gynecologists in 1970. He presented his famous presidential address in 1974, where he spelled out the features of his version of the women’s physician program before a joint annual meeting of the American Gynecological Society and the American Association of Obstetricians and Gynecologists.

Recently, Neil Fligstein (2001) has championed a “social skills” framework for analyzing how significant actors create and modify institutional fields. Elizabeth Popp Berman’s (forthcoming) recent work employs Fligstein’s social skills framework effectively to account for the mobilization of a network of occupational actors across federal government and university positions in support of a standardized “institutional patent agreement.” Willson was the type of leader that the social skills framework singles out for intensive analysis. Willson defined his version of the women’s physician program as hegemonic, serving the interests of all of ob/gyn’s diverse constituencies. He attempted to use his position and its resources to mobilize these constituencies in support of the program.

Willson fully recognized ob/gyns’ dishonored position within the medical division of labor and spoke for the interests of the surgically-oriented ob/gyns. Willson’s women’s physician program, while responding to federal initiatives designed to alleviate the primary care shortage, also contained an occupational agenda. Willson’s program ultimately aimed to restructure the medical division of labor serving women so that ob/gyns controlled both the upstream positions responsible for their own case referrals and the downstream positions to which they referred cases. Willson’s program was consistent with the views of ob/gyn’s academic leadership, and it incorporated into a coherent structure a variety of innovations championed and implemented within ob/gyn, such as subspecialties and the use of paraprofessional physicians’ assistants.

Here, we examine the logic behind Willson’s program and how this logic linked to the interests of surgical ob/gyns. While the major features of the program were accepted, Willson’s program generated opposition. The focus here is on the program’s logic and how it spoke to ob/gyn’s surgically-oriented rank and file. The contentious processes that this program set in motion will be examined in future papers.

**THE NEW DIVISION OF LABOR WITHIN OB/GYN**

A key pillar in Willson’s program, a pillar widely accepted within ob/gyn’s leadership, involved tracking ob/gyns into generalist and subspecialist roles. General ob/gyns would make up perhaps 90 percent of all ob/gyns. They would provide primary care, general obstetrics, and perform surgical procedures, such as hysterectomies and cesarean sections. The advocacy of primary care for the role was new, at least officially. The surgical content of the role, as Willson envisioned, would not change. Ob/gyn subspecialists in reproductive endocrinology, maternal-fetal medicine, and gynecological oncology would make up a small proportion of ob/gyns. They would be tracked for special training during residency and would undergo additional fellowship training for subspecialty certification. Through the creation of referral systems, subspecialists would serve as consultants to general ob/gyns on their complex cases (see Burkons and Willson 1975).

Willson’s proposal was controversial. Early commentaries tended to see Willson as splitting the ob/gyn role into two parts: the ob/gyn subspecialist as a true consultant/specialist, and essentially an ob/gyn general practitioner overwhelmed by primary care. Since only about 10 percent of ob/gyns would serve as subspecialists, some saw this as demeaning. One critic proclaimed that most ob/gyns were dissatisfied with a primary care role that underutilized their skills (Hester 1975). For such
critics, ob/gyn was, is, and always should be a consultant/specialty. The solution to the primary care shortage for women was not to saddle ob/gyns with this role but to train others for it.

But this was precisely Willson’s goal for routine primary care. Willson’s aim was to restore the general ob/gyn to a consultant/specialty role. However, because of the expansion of ob/gyn residencies, this could not be done by simply abandoning the general services most ob/gyns provided, for doing so would so reduce the ob/gyn market that drastic cuts to residency programs would be inevitable (see Burkons and Willson 1975). Willson aimed not to displace but to preserve the traditional role.

Willson articulated his own vision:

... a role for obstetrician-gynecologists of the future which relieved them of most of the routine care of normal women in order that they might add interesting and challenging medical responsibilities to the specific diagnostic, therapeutic, and surgical services they now supply.

We believe the major question generated by our suggestion was whether acceptance of a role of primary physician for women might represent a giant step toward transforming obstetrician-gynecologists from specialists to general practitioners. Nothing could have been further from our minds. (Willson and Burkons 1976a:631)

PLACING “WOMEN’S HEALTH CARE SPECIALISTS” IN THE SCREENING/GATEKEEPING ROLE

The lynchpin in Willson’s system was the use of paraprofessional “women’s health care specialists” (WHCS) for routine primary care, a position also supported by presidents of the American College of Obstetricians and Gynecologists in their inaugural addresses in 1971 and 1973 (see Ostergard, Gunning, and Marshall 1975). These women’s health care specialists would hold the status of nurse and assistants in ob/gyn practices, under the authority of the ob/gyns employing them. The women’s health care specialists would provide periodic checkups, medical histories, consultations for minor problems and complaints, advice and counseling on routine health matters, etc. In addition, the women’s health care specialists would screen cases, referring those cases that might require expert diagnosis and/or surgery to the general ob/gyns employing them. The general ob/gyns would become managers of the women’s health care specialists. The purpose of the women’s health care specialists in Willson’s system was to minimize the alienation ob/gyns allegedly experienced in routine primary care, freeing them to concentrate on their more complex and interesting cases (Burkons and Willson 1975; Willson and Burkons 1976a, 1976b).

Row C of Figure 1 specifies case-flow relationships in Willson’s reorganized division of labor. Ob/gyns’ downstream, referral-dependent relationship with screeners changes fundamentally from that depicted in row B, since the general ob/gyn now employs, controls, and regulates the women’s health care specialists serving in this position. This is represented in row C by the lower (control) arrow moving from the general ob/gyn to the women’s health care specialists. While screening cases, the women’s health care specialists do not have the choice of sending them to other specialists without permission. This system enables general ob/gyns to do structurally what they could not do normatively within the medical division of labor: establish market closure over cases requiring gynecological surgery.

GENERALISTS AND SUBSPECIALISTS WITHIN OB/GYN

The dependency relationship between general ob/gyns and other surgical specialists also changes in row C. While general ob/gyns must still seek referral for their difficult surgical cases, the latter become, in the Willson system, ob/gyn subspecialists, who share residency training, identification, and allegiance with general ob/gyns. This keeps knowledge, recognition, and consternation regarding general ob/gyns’ surgical skills in house. It enables ob/gyn’s alternative surgical model to operate covertly, without damaging ob/gyn’s reputation within the medical division of labor. The common bond cementing this relationship is demonstrated in the model by the double-headed control arrow beneath the arrow representing case flow in row C.

Subspecialties were established in ob/gyn during the 1970s. Afterwards, subspecialists in gynecological oncology, reproductive endocrinology, and maternal/fetal medicine stood downstream from general ob/gyns to service their complex, troubling cases. Gynecological oncologists, with two additional years of surgically-oriented fellowship training after residency, usually assisted on surgical complica-
tions. They had the requisite skills to repair bowels, ureters, etc., thereby keeping ob/gyn’s surgical complications out of the hands of competitors outside the specialty.

Thus, under the banner of the women’s physician program, the system Willson and other ob/gyn leaders envisioned addressed the interests of the surgically-oriented ob/gyn. Willson’s system removed the upstream positions supplying ob/gyns with referrals, and the downstream positions correcting ob/gyns’ surgical mistakes, from the general medical division of labor. Willson’s system placed these positions under the sole control and purview of ob/gyns. Whatever else it was intended to do, Willson’s system was designed to reduce ob/gyns’ dependence upon other physicians. Willson’s reorganized division of labor was to help ob/gyns secure better access to their surgical markets than when they were dependent in a medical division of labor that dishonored them.

THEORETICAL DISCUSSION

Ironically, American physicians’ successful professional project set in motion forces in the post-World War II decades that undermined the project’s signal creation—the physician as an idealized commodity. State investment in health care, coupled with the absence of strong countervailing powers, fueled rapid specialization and the primary care crisis of focus. As more physicians specialized, the commonalities thought to unite, and “standardize;” physicians weakened. The ideal of the solo, multi-skilled practitioner was replaced by a complex, splintered, intra-occupational division of labor. While medical sociologists have recognized this, our theoretical frameworks have not adjusted well to this change.

This article works within Everett C. Hughes’ (1971) general theoretical framework to address why ob/gyn initiated the women’s physician program during the 1970s, a program that, in essence, redefined the specialty as a primary care provider to women in response to policy initiatives. Ob/gyn’s historic struggle to legitimate its core-skill definition greatly influenced its women’s physician program. Ob/gyn defined itself as a comprehensive organ specialty. Its turf logic held that ob/gyns would produce better results, because of their broad focus and training, than would others treating women’s genital and reproductive systems. General surgeons, in fact, held a central position in ob/gyn’s definitional frame; they became a foil to what ob/gyns claimed to be. Ob/gyn’s history was a struggle to claim their surgical turf from general surgeons, and to make good on the claim. For much of the post-war era, however, ob/gyn failed to do so.

This failure affected ob/gyn’s quest to establish itself as a true surgically-oriented consultant/specialty. Gatekeepers had the option of referring their suspected gynecological surgical cases to either ob/gyns or general surgeons. These gatekeepers chose general surgeons frequently. Ob/gyns never completely won legitimation as a proper consultant/specialty as a result. This historical context shaped ob/gyn’s women’s physician program. Savvy ob/gyn leaders structured their women’s physician program to free the specialty from its disadvantaged and dishonored position within medicine by recasting a new division of labor for women who they themselves defined and could better control. Understanding the historical context within which this struggle unfolded also enables us to understand better the actual influences of macro-institutional and gender variables on this and related outcomes.

OB/GYNS’ STRUGGLE FOR LEGITIMATION AND THE INSTITUTIONAL FIELD

Ob/gyn’s historic struggle to legitimate its core-skill definition unfolded within a macro-institutional structure characterized generally by professional dominance and weak countervailing powers. The larger system influenced this struggle in two ways. First, this structure generated a mop-up market space open to those willing to provide basic primary care in the early postwar period. This market space allowed ob/gyns to prosper, even in practices with increasingly low surgical content. Second, federal policies initiated to alleviate the systemic shortage of primary care physicians in the 1970s created a resource for ob/gyns to appropriate in their struggle. Skillful ob/gyn leaders such as Willson articulated programs specifying a central role for ob/gyns in primary care that, at the same time, addressed the specialty’s pressing occupational concerns. The state’s primary care initiatives became a kind of legitimating cloak for these programs, masking their more basic occupational designs. The U.S. health care system’s weak regulatory powers at the inter-specialty level have functioned generally to encourage this type of
development. We should look for it in the implementation of every policy initiative in health care, whether the initiative concerns increasing the physician supply, integrating women into the profession, or negotiating managed care. Distinctive specialties react strategically to such initiatives in ways reflecting their particular definitional frames, market interests, and place within the existing intra-occupational division of labor.

**OB/GYNS’ STRUGGLE FOR LEGITIMATION AND GENDER**

Understanding ob/gyn’s historic struggle to legitimate its core-skill definition also gives us insight into how gender dynamics can work in the medical division of labor. Ob/gyn’s women’s physician program was a bit of a paradox. On the one hand, its rhetoric did suggest a type of medical orientation that Elianne Riska (2001) and others have linked to feminine gender, that of holistic, comprehensive health care provided by physicians in tune with their patients’ personal histories, troubles, and needs. However, a male leadership created the 1970s program, as it responded to a threat from male surgeons. This program appealed to male rank and file ob/gyns desiring a larger role as surgeons. The program’s rhetoric was also sexist. It spoke of women as being childlike in their relationship with ob/gyns; it presumed as natural the gender roles of male-dominated society; and it defined ob/gyn’s function as adjusting women to these roles.

This peculiar women’s physician program was not insignificant to the later struggles of female physicians, however. Ob/gyn leaders rapidly increased the proportion of women accepted into ob/gyn residencies during the 1980s and 1990s. Ob/gyn commentators singled out women medical graduates’ alleged preference for a primary care orientation as one of their attractive features (see Hayashi and McIntyre-Seltman 1987). As their numbers rose in later decades, women activists within ob/gyn could draw upon the women’s physician ideal introduced in the 1970s, strip it of its sexist rhetoric and intent, and then use it to legitimate the more feminist agendas developing in medicine during the 1990s (on these agendas, see Riska 2001, chapter 8). This article addresses how and why male ob/gyns carried this peculiar resource into ob/gyn’s occupational culture in the first place. The historical processes involved in the appropriation of this program to serve a more feminist-oriented agenda should be explored in future work. It may well be the case, generally, that intra-occupational struggles and developments, like those documented above for ob/gyn, often create, quite unintentionally, significant resources for supporting such movements.

**CONCLUSION**

When we begin our analyses of health care system developments with the basic recognition that “the doctor” of the medical profession of the past has been replaced with a splintered occupational division of labor, new insights may be forthcoming. This article suggests that, at a fundamental level, this splintered medical division of labor may contain a serious yet largely unrecognized structural contradiction. To achieve high status and prestige, medical graduates must specialize. In specializing, however, they must enter into dependency relationships with generalists, who play a screening/gatekeeping role vital to their market access. When confronted by viable competitors in the medical division of labor, this market access can become jeopardized, as in the case of post-war ob/gyns. This simple structural contradiction may well lie at the root of many of the pathologies and paradoxes of the contemporary health care system. Consider how an appreciation of this structural contradiction may allow us to address two paradoxes.

**Paradox 1**

_How did a health care system, famous for its extraordinary levels of professional dominance in the early decades after World War II, so quickly become threatened by managed care and the specter of market controls during the 1980s and 1990s?_ While scholars have proffered many explanations for this development, the status/dependency contradiction discussed here may well be the most robust. Perhaps the natural tendency in systems of pure professional dominance is to increase specialization, and the resources supporting it, thereby creating a chronic shortage of devalued screening/gatekeeping positions. An unintended consequence of this shortage is a system quite vulnerable to rationalization and external control by third parties. When the profession itself delegates the screening/gatekeeping role to other less prestigious occupations outside the profession—a likely occurrence when everybody specializes—those in the screening/gatekeep-
ing role become much less capable of resisting routinization and rationalization. Those in the screening/gatekeeping roles, for instance, cannot employ the classic professional logic discussed by Eliot Freidson (2001) to defend their autonomy and control. Then, as Hafferty and Light (1995:136–37) suggest, external agents are in position to control specialists, not by dictating work contents, but by controlling patient access through their control over the screening/gatekeeping positions. Ironically, systems with well developed countervailing powers may not be so vulnerable to this contradiction, since they are less likely to develop severe imbalances between generalist and specialist roles. Strong countervailing powers may protect such professional systems from their natural tendency to overspecialize. The impact of this structural contradiction within different types of systems should be further developed theoretically and further explored empirically.

Paradox 2

Why do specialists, investing extra years and resources in residency training, willfully embrace primary care roles? This paper addresses this paradox in examining the case of the women’s physician program ob/gyn leaders initiated in the 1970s. This response may have little to do with gender. Rather, the move to the primary care position, as in the case of ob/gyn, may well be a market strategy designed to gain, or retake, control over positions regulating a specialty’s access to valued markets. Organized medicine’s contemporary movement to increase greatly the number of primary care physicians—a move sponsored by the American Medical Association and the American Association of Medical Colleges—may well have a similar motivation, after a failed but threatening bout with managed care in the 1990s. Retaking the screening/gatekeeping positions within the medical division of labor may well be necessary for securing professional dominance in the future. While all of this is speculative, it does suggest the potential importance of the theoretical framework employed here in generating insight into contemporary, as well as historical, developments.

NOTES

1. The “women’s physician” concept became popularized with Burman’s 1968 article titled, “The Gynecologist—The Woman’s Physician.” Other commentators used different labels for the same role, such as “the primary physician to women” or women’s “principal physician.” This article refers to ob/gyn leaders’ campaign to win official legitimation for their claim to be primary care physicians to women as the “women’s physician program.”

2. The actual percentages used to indicate numbers in the specialties depend on the source used. The American Medical Association data bank categorizes physicians into specialties on the basis of physicians’ self-reports. Sources restricting their categories to only board-certified physicians report fewer absolute numbers and smaller percentages.

3. A third category might include auxiliary workers, who provide services for those in either the screener or specialist roles. Halpern (1992) provides the best account of these types of roles and how they relate to others in the medical division of labor.

4. As Freidson ([1970] 1988:93) and others have long noted, the power of the individual in the “feeder/gatekeeper” role to control work flow within a local network of specialists has declined. This does not suggest, however, that those in surgical specialties are no longer dependent upon physicians working upstream from them for initially diagnosing a surgical condition. This categorical dependency has not changed fundamentally for elective surgery. Patients with recurring stomach pain do not typically make appointments with surgeons on their own to have their gallbladders removed; those with severe headaches do not contact neurosurgeons prior to an initial diagnosis from a non-surgeon. Once patients have been diagnosed, they are much more likely than in the past to shop around, consult their lay networks, etc. The self-referred category does not typically mean self-diagnosed.

5. Surgeons were much less likely than ob/gyns to serve in a primary care capacity in the medical division of labor. They worked downstream from those serving in screening/gatekeeping roles and received the bulk of their cases from referrals, including their ob/gyn cases.

6. As is evident in its rhetoric, ob/gyn’s women’s physician program presumed a patriarchal relationship between young females and their male ob/gyns. This rhetoric accepted women’s traditional roles in male-
dominated society. The patient thought to demand ob/gyns’ primary care services was not a feminist but a rather traditional woman. Some commentaries sympathetic to this definitional frame even seemed to equate women’s health and well-being to the state of their genital and reproductive organs (see Burman 1968). For these reasons, it is very doubtful that feminism generally, or the feminist health care center movement of the 1970s in particular, had much of an impact upon ob/gyn’s women’s physician program.

7. A JHSB reviewer suggested this possibility on an earlier draft of the manuscript.

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