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Abstract

The medical/surgical specialty of Obstetrics and Gynecology (OB/GYN) has undergone significant transformations over the last 40 years, particularly with regard to its gender composition, its generational cohorts, and its models of practice organization. All of these changes have had profound effects on its professional identity within and outside of medicine, as well as influencing the professional identity of individual OB/GYN physicians themselves. Little sociological research has paid attention to these changes in medicine; almost none has examined OB/GYN itself. This case study of OB/GYN, drawing from interviews with over 50 OB/GYN physicians spanning three generations and both genders, finds that looking at these transformations within OB/GYN illuminates changes in professional identity both within this specialty and in the larger profession of medicine. The historical schema of medical work-devotion, which demands that physicians prioritize their patients and profession above all other responsibilities, has diminishing influence within OB/GYN. By comparing the attitudes of physicians in Baby Boomer, Generation X, and Millennial cohorts and men and women toward this schema, it becomes clear that it is cohort replacement rather than feminization that is driving these changes in medical work-devotion and professional self-identity. The professional identity of OB/GYN as a whole has also changed radically over the last 40 years, as the field has shifted from being overwhelmingly male to being predominantly female among younger physicians. Examining gender in this high-status field upends expectations that occupational sex segregation always leads to sex stratification that disadvantages women, though men still experience areas of advantage in the field. Lastly, previous models of practice setting inadequately understand the true differences in the organization of medical work. Conceptualizing the practice of obstetrics as a coverage continuum—from physicians covering their own patients to shiftwork—makes the differences between practices much more clear. Placement on the coverage continuum drives differences in physician work-life balance, income models, work hours, physician-patient relationships, and the experience and satisfaction of physicians and patients.

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THE PROGRESS OF MEDICAL LABOR:
GENDER SHIFTS, GENERATIONAL DIFFERENCES, AND
THE COVERAGE CONTINUUM IN OBSTETRICS AND GYNECOLOGY

Claire B. Barshied

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THE PROGRESS OF MEDICAL LABOR:

GENDER SHIFTS, GENERATIONAL DIFFERENCES, AND THE COVERAGE
CONTINUUM IN OBSTETRICS AND GYNECOLOGY

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*Dedicated to Ben,
Who sustained this whole effort
And is partner in all my best work*

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Many friends have encouraged, prayed, prodded, and assisted to allow me to complete this research and present this dissertation. My debts to them are many, and I hope they are proud of what they have helped to accomplish.

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ABSTRACT

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Claire B. Barshied

Charles L. Bosk, Ph.D.

The medical/surgical specialty of Obstetrics and Gynecology (OB/GYN) has undergone significant transformations over the last 40 years, particularly with regard to its gender composition, its generational cohorts, and its models of practice organization. All of these changes have had profound effects on its professional identity within and outside of medicine, as well as influencing the professional identity of individual OB/GYN physicians themselves. Little sociological research has paid attention to these changes in medicine; almost none has examined OB/GYN itself. This case study of OB/GYN, drawing from interviews with over 50 OB/GYN physicians spanning three generations and both genders, finds that looking at these transformations within OB/GYN illuminates changes in professional identity both within this specialty and in the larger profession of medicine. The historical schema of medical work-devotion, which demands that physicians prioritize their patients and profession above all other responsibilities, has diminishing influence within OB/GYN. By comparing the attitudes of physicians in Baby Boomer, Generation X, and Millennial cohorts and men and women toward this schema, it becomes clear that it is cohort replacement rather than feminization that is driving these changes in medical work-devotion and professional self-identity. The professional identity of OB/GYN as a whole has also changed radically over the last 40 years, as the field has shifted from being

overwhelmingly male to being predominantly female among younger physicians. Examining gender in this high-status field upends expectations that occupational sex segregation always leads to sex stratification that disadvantages women, though men still experience areas of advantage in the field. Lastly, previous models of practice setting inadequately understand the true differences in the organization of medical work. Conceptualizing the practice of obstetrics as a coverage continuum—from physicians covering their own patients to shiftwork—makes the differences between practices much more clear. Placement on the coverage continuum drives differences in physician work-life balance, income models, work hours, physician-patient relationships, and the experience and satisfaction of physicians and patients.

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PREFACE

This dissertation presents research findings from a study of Obstetrician-Gynecologists (OB/GYNs) and the profession of Obstetrics and Gynecology in the United States. In accordance with the options for dissertation structure available in the Graduate Group in Sociology at the University of Pennsylvania, this work is presented as three separate papers; they are unified by their focus on OB/GYN and by drawing upon the same set of interviews, but they were written to be read individually. Thus, each chapter presents its own literature review, methods, results, and conclusions. The introduction and conclusions of the entire dissertation draw out themes common to all the papers and point out their broad significance.

INTRODUCTION

What do we mean when we talk about identity? The word connotes unity of concept, but its meanings are various. In mathematics, it means equality of expressions in an equation; expanding upon this idea as a metaphor, it can mean a close similarity or affinity between things. For individual persons, identity can mean how others recognize you, how you recognize or understand yourself, or a deeper, supposed meaning of who you “really” are, beyond your own and others’ perceptions. Groups also have identities in the same three ways, and sociologists tend to see “identity” either as self-concept or as that which distinguishes a person or group from others.

Professions have identities as well, both because they are groups of people and because there are socially recognized characteristics of professions that transcend the current members of the group and provide some sense of continuity over time. In social science research, “professional identity” has largely come to mean the self-concept of individuals as members of a profession, based on their attributes, beliefs, values, motives, and experiences (Slay and Smith 2011).

These papers are about professional identity and changes to it over time, using the case of Obstetrician/Gynecologists (OB/GYNs) in the United States over the last 40 years. The focus of analysis in each paper is different, but they all relate to one or more of the definitions of identity or professional identity. Professions are defined in part over their control over admission to their ranks: Who is allowed to be considered part of this profession? Who will be counted as a member of this group? This aspect of professional control leads to further questions: For group members old and new, how do they

understand the identity of their profession as its composition changes? How do they understand themselves as individual members of this profession—what is their own personal professional identity? How much similarity—metaphorical mathematical identity—is there in these self-concepts across individuals belonging to different sub-categories within the profession?

If new types of people are admitted, especially in large numbers, the external professional identity—the way that outsiders understand the identity of the profession—changes. OB/GYNs in the early 1970s were overwhelmingly male, and the presumption of a male physician shaped the social expectations of patients, nurses, and physicians and even the structure of medical practice and its demands upon practitioners. Since then, the profession has radically transformed: each year a higher proportion of women enter OB/GYN training programs, and women are rapidly coming to dominate the profession. Patients have come to expect and seek out female OB/GYNs to a greater degree than their male counterparts, and this demand imbalance—especially the perception of this demand imbalance—is changing the identity of the profession of OB/GYN. The medical specialty itself may still be bounded by its work content (the reproductive health care of women) and by its entrance requirements (completion of medical school and residency), but public perception of the person wearing the white coat in the office or the scrubs in the delivery room is increasingly female rather than male.

This perception of the professional identity has powerful effects within medicine, too, as male medical students are dissuaded from entering OB/GYN and male residents from pursuing general OB/GYN practice because their personal identities as men are increasingly incongruous with the professional (female) identity of general practice OB/GYN. As fewer men enter OB/GYN each year, it becomes more “weird” to be a male OB/GYN, and these male physicians must negotiate increasing stigma both from outsiders

who find their professional choices strange and from patients who express preferences for women. These changes are not unidirectional, though, and the complexities of gender, professional identity, and disadvantage are examined more fully in Chapter 2: Men in the Medical Sorority.

Gender is not the only large compositional change to occur in OB/GYN over the last four decades, however. The new physicians entering the profession are part of successive cohorts of workers: Baby Boomers, Generation X, and now Millennials. Researchers have argued that these cohorts have distinct approaches to work and work/life balance, and the approaches of the youngest workers in particular challenge ideas of work priority that have been key elements of the professional identity of older physicians. What are the self-concepts of professional identity among these three generations of OB/GYNs? What do physicians think it means to be a good OB/GYN? What is required of them? Chapter 1 unpacks these questions, and asks: If differences in these self-concepts of professional identity exist, are they more closely linked to physicians' gender or their generation?

Lastly, we turn to the actual work of OB/GYNs, especially those who practice obstetrics. Within the bounds of the specialty of OB/GYN—that its practitioners are medical or osteopathic doctors, that they have completed residencies in OB/GYN—there is remarkable diversity in the ways in which the doctors' work can be organized. Previous conceptions of these differences, according to typologies of medical practice from sociologists or the American Medical Association, do not adequately understand the key axis of variation that is associated with different work setting characteristics. I find that what really determines the work structure characteristics of OB/GYNs is their position along a continuum of patient coverage, which at one end requires that a single physician meet all of a given patient's medical needs, regardless of time of day or duration, and at

the other end structures medical practice as shiftwork, requiring no ongoing obligation to patients outside of their assigned hours. Placement along this continuum has profound implications for professional identity of individual physicians, as their location determines the possibilities for and burdens of relationships with their patients. These relationships are often central to the meaning that physicians derive from their work, and thus to their identity (self-concept) as physicians. The theory of this spectrum and its implications for physicians and patients is discussed more fully in Chapter 3: The Coverage Continuum.

The professional identity of OB/GYN and of individual OB/GYNs is changing. The organization of the medical work, the cohort replacement of physicians by generation, and the trends in gender composition all affect how outsiders see the profession of OB/GYN. These changes further affect how physicians understand the professional identity of OB/GYN as distinct from other medical specialties, and most profoundly, they deeply shape how individual OB/GYNs understand their own profession and their identity as professionals who are part of it. Paying attention to these changes illuminates the evolution of this specialty and the larger forces shaping it and, perhaps more importantly, makes sense of the meaning of medical work and professional identity for physicians.

CHAPTER 1: GENDER OR GENERATION?

In 1905, 96 percent of American medical school graduates were men. Over a half a century later, almost nothing had changed: 93 percent of all physicians and 89 percent of all medical students were male (Groves 2008; Boulis and Jacobs 2008). The story of the next few decades in American medicine, however, would be radically different. Beginning in the 1970s, women flooded into the medical profession, and, by 2013, women made up 33 percent of practicing physicians and 48 percent of medical school graduates in the United States (AAMC 2014). Among the various physician specialties, these changes are most acute in the practice of obstetrics and gynecology (OB/GYN). Over the last 40 years, the profession of OB/GYNs in the United States has undergone a dramatic transformation in its gender composition: it has swung from being almost wholly male to having overwhelmingly female incoming classes of residents.

During this same period, the structure of OB/GYN practice has also shifted, from solo practitioners toward group practices and employee positions, but its work remains demanding for physicians. Being an OB/GYN requires an lengthy, intense training period and long hours as a practitioner, and women physicians who want to become mothers must manage these demands during the window of years they have available for bearing and raising children. Moreover, physicians have long been described as having particularly strong norms around the priority of their work over their personal lives (Parsons 1951). How have women OB/GYNs responded to these norms, as they have moved into the specialty in large numbers?

Gender composition, however, is not the only significant shift that has occurred within the ranks of OB/GYNs over the last decades. Three different generations—popularly described as the Baby Boomers (born 1945-1964), Generation X (born 1965-1980), and Millennials (born 1981-2000) (Taylor 2014)—are now in the medical workforce. Commentators in medical journals have made much of differences in norms of work priority and work/life balance between these three groups (Johnson 2005; Cowan 2009; Blanchard 2012; Phelan 2010; Johnson 2005; Bickel and Brown 2005; Adams 2004), but little sociological attention has yet been paid to these claims. Yet there is an opportunity here: by interviewing OB/GYNs from different generations and both genders, we can discover whether norms about the priority due to one’s work—what Mary Blair-Loy called the “schema of devotion to work”—have been changing among a group of workers, OB/GYNs, of whom a very high degree of work devotion has historically been expected. Further, we can better understand whether any such shifts are more closely connected to cohort replacement by gender or by generation.

Literature Review

Work and Life

A certain amount of conflict between work and family, or work and private life more generally, is endemic to the human condition, at least for societies where “work” is physically removed from the space of home and family. This conflict has become much more visible in the United States, however, since the remarkable twentieth-century shift towards women—especially married women and mothers of small children—working outside of the home (Macunovitch 2010; Cohany and Sok 2007; Jacobs and Gerson 2004).

Where once the dominant labor market pattern was a man working full-time with a stay-at-home wife handling the family's domestic affairs, one is now more likely to find a dual-earning couple or a single working parent; these arrangements may maximize adults' labor force participation, but they minimize the resources available for childcare and household tasks. Since housework and caring for children still must be done by someone, families must develop ways to somehow fulfill these duties regardless of their time and resource constraints.

For those with professional careers, these pressures are even more acute. In the United States, the labor market has bifurcated over the last decades, into lower-wage hourly and part-time workers, who often report wanting to work more hours, and salaried professionals and managers, who tend to report feeling overworked and desiring to work less. At the high-income, professional end of this "time divide", workweeks have been getting longer, creating a further "time squeeze" on families with professional workers (Jacobs and Gerson 2004). Professional jobs are also often rigid in terms of the work schedule required by employers, and even where corporate policies for family leave or reduced hours are available, workers frequently report being wary of claiming them, for fear of the negative consequences on their salary or career advancement (Blair-Loy and Wharton 2004; Jacobs and Gerson 2004). Sociologists have often pointed to control over the content and evaluation of work as a defining characteristic of a "profession" (Freidson 1970), but in an era when much of that sovereignty has been stripped away by the alternate control structures of government and corporations (Light and Levine 1988; Hafferty and Light 1995), what probably unites the lived experience of being a professional across various fields today is not the sense of control over one's work, but of work's control over one's time and personal life.

Much sociological attention has been given to the gender differences in the effects of these time squeezes. Arlie Hochschild (1989) described the uneven distribution of household and childcare tasks between husbands and wives as a “stalled revolution,” meaning that though the women’s movement had opened doors to professional work for women, they remained responsible for most domestic work as well. These tasks amounted to a “second shift” of daily work required of women but not their spouses. In the years since then, men have become more likely to contribute to domestic tasks, but there remains a pervasive sense that conflict between work and family life remains more intense for women. Anne-Marie Slaughter, Dean of the Woodrow Wilson School at Princeton University and former senior State Department official, recently drew a flurry of attention to this gender difference by writing “Why Women Still Can’t Have It All” (2012), describing women’s difficulty in combining meaningful family life with powerful, demanding jobs. Indeed, researchers continue to find that women who work full-time still take on a greater share of household tasks and childcare (Jacobs and Gerson 2004; Drago 2009; Spain and Bianchi 1996) than their spouses, and these demands, often met through attempts to multi-task, lead to higher levels of perceived work-family conflict, negative emotions, and stress than those reported by men (Offer and Schneider 2011).

Professional women’s experience of work-family conflict is shaped by much more than their unequal share of domestic tasks, however. High-earning women, after all, often have the financial resources to hire someone to clean their houses or babysit their children. Sociologists have described an underlying clash of ideologies that animates the logistical struggles of balancing work and personal responsibilities. Mary Blair-Loy described two cultural schema—shared, publicly-available models for understanding the world—operating among the women business executives she interviewed. One, a schema of “work devotion”, legitimates long hours and priority given to work by viewing a person’s career

as “a calling or vocation that deserves single-minded allegiance and gives meaning and purpose to life” (Blair-Loy 2003:1-2). Through the lens of this work-devotion schema, work is not only a means to gain material resources, but an enactment of a person’s identity; a person’s success in work, then, is a validation of their own worth. Prioritizing the needs of an employer over other social goods (family needs, friendships, community service) thus makes sense within this perspective, justifying the long hours committed to a professional’s job. Even though not all professional workers embrace this work-devotion schema, it exerts a powerful influence on the expectations of employers and employees alike, acting as a standard of professional work that workers either proudly meet or of which they are cognizant of falling short (Blair-Loy 2001, 2003).

Conflict between the work-devotion schema and the second schema Blair-Loy described among executive women—that of “family devotion”—is the engine of many professional women’s work-family frustrations (2003). Sharon Hays (1996) also described this second schema as an ideal of “intensive mothering”. This ideal, like that of devotion to work, is culturally specific not only to our current period in history, but to particular segments—generally the more educated, often professional ones—of the population of American women; it is not a universal ideal of what it means to be a good mother. Yet this image of “appropriate childrearing” exerts a powerful pull on women. Hays found that, despite her informants’ demanding professional jobs, they felt like they—as mothers—should be their children’s central caregiver, and that this care-giving must be “child-centered, expert-guided, emotionally absorbing, labor-intensive, and financially expensive” in order to meet the needs of their children and properly fulfill their role (1996:8).

Blair-Loy described three cohorts of women among her interviewees—those born during World War II, early Baby Boomers, and later Baby Boomers—and found that their

generational position was connected to their experience of the work-devotion and family-devotion schemas (2001, 2003). Her first two cohorts found the schemas to be intractably in conflict, such that family and work had to be either singly chosen or sequenced, or else lead to tremendous contradiction and tension. Among the third cohort, the late Baby Boomers, she found some opportunity to redefine the family schema in ways that allowed them to be more fully committed to work without seeing themselves as bad mothers or spouses (Blair-Loy 2001, 2003).

Blair-Loy exclusively interviewed women, however, so she cannot weigh in on whether men's conceptions of these work-devotion and family-devotion schemas changed along with the generations, except in the ways their thoughts were refracted through their wives' interviews. Bringing in men's voices, as well as pulling the frame of reference forward in time to capture the experiences of much younger professional workers, allows us to better understand changes in more recent generations, as well as better parse the differences and similarities between the schema of expectations experienced by women and men.

A Greedy Profession

Physicians are a special case even when compared to other professional workers. The profession of medicine is much more explicit about making claims that its practitioners should be ruled by their devotion to work, and this devotion to work is framed as part of a deeper, self-denying service ethic oriented toward putting the patient's needs before those of the physician. Talcott Parsons (1951) first drew sociological attention to this service orientation by describing how physicians were committed to giving precedence to patients' well-being over physicians' monetary concerns, but

physicians' own admiration for colleagues that are always at the hospital and available reveals a professional ethic that also includes giving service to patients precedence over physicians' personal needs more generally (Gerber 1983). The way physicians describe their responsibilities in the language of ethics (AMA 2001) reflects a schema of work devotion that is framed in moral terms, with the nobility and virtue of the medical profession deriving from the sacrifice required to perform it.

Of course, Parsons has been roundly criticized for describing the rhetoric of the profession of medicine, rather than the reality of practitioners' behavior (Freidson 1970; McKinlay 1977). Yet the sense that practicing medicine is a "higher calling", one that legitimately deserves precedence over personal and family concerns, has persisted in the way physicians talk about their field since Parsons wrote. Like the more general schemas of devotion to work and devotion to family, it acts as a standard against which physicians measure their own and other physicians' professionalism. Just as the "greedy institutions" described by Coser (1974) "seek exclusive and undivided loyalty and...attempt to reduce the claims of competing roles and status positions on those they wish to encompass in their boundaries," medicine is a "greedy profession". Doctors are expected to give more.

The Hospital and the Home

All of these factors combine to mean that becoming and being a physician has a profound effect on the balance between work and life. Indeed, when compared with high school graduates, physicians report less satisfaction with their work-life balance, while other college-educated Americans report more (Shanafelt et al 2012). Yet for all of the intensity of this conflict for physicians, there has been little sociological attention paid to where exactly this conflict emerges or how it is endured or resolved. The only two

qualitative studies to exclusively focus on this tension in the lives of physicians are based on interviews and observations from the mid-1970s (Broadhead 1983; Gerber 1983). Since then, data from quality-of-life or physician-satisfaction surveys has appeared regularly in medical journals, but there was almost no sociological notice paid to this area until Boulis and Jacobs's work (2004), which will be discussed below.

One of the particular problems for physicians struggling to give time and energy to their lives outside of the hospital is that excellence as a physician is so often measured by the amount of time and energy spent inside the hospital. Both Bosk (1979) and Gerber (1983) describe how doctors value those who “sweat blood” and “bust their butts” during long days and weeks on the job, and those who try to curtail their hours are suspected of being less-dedicated physicians. This ethic is often indirectly articulated, leaving students and young physicians with a sense that they are always in danger of falling short of the dedication required to be a “good doctor,” unless they are spending every possible moment studying or in the hospital (Gerber 1983).

Specialty Choice: Looking for Lifestyle

The increasing influence of “lifestyle” preferences on specialty choice among young physicians has attracted a great deal of attention in medical journals in recent years (Dorsey et al 2005; Newton et al 2005; Lambert and Holmboe 2005). Many more editorials and opinion pieces have referred to these trends negatively, suggesting that they are evidence of weaker professional ethics among a younger generation of physicians and bode ill for the future of the profession (Johnson 2005; Cowan 2009; Blanchard 2012). Put in the frame of Blair-Loy, these commentators see younger, more recent generations of physicians as resisting a schema of medical work-devotion that was dominant among

earlier generations, and instead prioritizing their own individual, personal needs over the needs of patients and their work.

The precise meaning of “lifestyle” concerns among young physicians and researchers varies. Early work dichotomized specialties into “controllable lifestyle” and “non-controllable lifestyle” groups based on whether the researchers assessed that specialty to possess “control of work hours” (Schwartz et al 1989). Schwartz and his colleagues (1989) considered the controllable-lifestyle specialties to be anesthesiology, dermatology, emergency medicine, neurology, ophthalmology, otolaryngology, pathology, psychiatry, and radiology; the non-controllable-lifestyle specialties were then all that remained, especially the surgical and primary care specialties and obstetrics and gynecology (see also Newton et al 2005).

Generations and Change

One of the sociologically interesting aspects of this attention to “lifestyle” concerns is that the medical researchers and commentators who have written about it almost always describe it as part of an emerging generational divide between young physicians and their older counterparts. This “generational difference” description is present in the analysis of Gerber (1983) and Broadhead (1983), who conducted their research in the 1970s, Schwartz and colleagues (1989) more than a decade later, and a special issue of *Academic Medicine* on specialty choice in 2005 (Newton et al., Dorsey et al., Lambert and Holmboe). The repetition of this pattern—of younger physicians being dissatisfied with the lifestyles (or submission to medical work-devotion schema) of their mentors, and older physicians perceiving new graduates as being unwilling to work as hard as they did—may indicate that some part of this “trend” toward lifestyle concerns could be an artifact of the natural

history of a physician's career, with young doctors hoping for a more generous work-life balance, then submitting to work demands during their career, and finally expecting that same submission from the next generation as a mark of devotion.

At the same time, there have been measureable, significant increases in the priority students are assigning to “lifestyle” issues in their specialty choice, and the idea that there is a “generation gap” in medicine generates a lot of heat in medical journals' commentaries. Many of these physician-commentators take a decidedly negative view of the generational differences, comparing the self-focused, impatient, unprofessional attitudes of “Generation X” with the sacrificial, hard-working, gratification-delaying devotion to medicine of the “Baby Boomers” (Cowan 2009; Blanchard 2012; Phelan 2010; Johnson 2005). Surveys of physicians have found these ideas to be fairly widespread: 64 percent of physicians aged 50 to 65 say that doctors trained today are “less dedicated and hardworking” than those 20 to 30 years ago (Adams 2004).

Most of the medical commentators on generational change draw from the work of Janet Bickel and Ann Brown (2005), who apply a popular view of generational differences (Howe and Strauss 1998, 2000; Lancaster and Stillman 2002) to the problem of the declining attractiveness of academic medical careers to young physicians. Bickel and Brown describe four cohorts—the Silent Generation (born 1925-44), the Boomers (born 1945-62), Generation X (born 1963-81), and Millennials (born 1982-2000)—but focus on the differences between the Boomers and Generation X, who largely make up the senior faculty and mid-career practitioners today. According to their description, Boomers work hard out of loyalty, expect to stay in a job for a long time, respect authority and hierarchy, and see paying dues and self-sacrifice as virtues. In contrast, members of Generation X work hard “if balance allowed,” expect many job changes, question authority, and discount the value of paying dues and self-sacrifice (Bickel and Brown 2005: 206). They also point

to significant family differences between the groups: the parents of Generation X were both likely to be working outside of the home and divorce was about twice as prevalent than in the preceding generation, and many members of this later generation have had an “extended adolescence,” married later, or remained single. Perhaps theorizing somewhat beyond the scope of their evidence, they point to these changes as part of why “Generation X’ers are seeking a greater sense of family and are less likely to put jobs before family, friends, or other interests” (Bickel and Brown 2005:206).

Bickel and Brown suggest that these differences result in a mismatch of expectations regarding mentoring, faculty careers, and the “ideal worker,” leading to conflict among younger and older physicians and lower recruitment and retention rates in academic medicine. Many of these mismatches relate to differing expectations and goals regarding the balance between work and life: younger physicians resist the model of single-minded work devotion that the Boomers exalt (the traditional medical work-devotion schema), instead seeking a “multifaceted life” from the beginning of their careers, one that does not mean career success at the cost of family and personal health. To their Boomer supervisors and mentors, this approach can amount to being a “slacker” or “uncommitted to medicine” (Bickel and Brown 2005:207). As one Baby Boomer physician said of his younger colleagues, “Instead of a ‘profession,’ many now consider this as a ‘job’” (Cowan 2009: 326).

Despite the popularity of this explanation of differences among physician writers, there is little empirical work supporting their assertions with regard to generational differences among physicians. Sociologists have found evidence of generational effects elsewhere—Glen Elder (1974) described the influence of growing up during the Great Depression on cohorts of children, and subsequent work following his life course perspective has drawn attention to other ways that social changes affect the seemingly

personal choices of individuals. Thirty years later, Claudia Goldin (2004) used census data, surveys, and alumni records to describe the different family and career experiences and expectations of five cohorts of twentieth-century college-graduate women. Mary Blair-Loy (2001) also found evidence of generational effects in the work and family expectations of women finance executives who were born before and during the Baby Boom. Among physicians, though, there is yet little data to support the strength of the arguments of Bickel, Brown, and the commentators who have followed them that these perceived differences in work-life expectations reflect a real generational shift rather than a more constant tension between workers at different stages in their careers.

Women in White Coats

Of course, an alternate hypothesis from the “generational change” view is that the perceived differences in work-life expectations and demands of younger physicians have less to do with their generation, and more to do with their gender. As was discussed previously, the last 40 years have seen an influx of women into the profession of medicine, and some physician commentators who bemoan the “lifestyle” concerns of younger physicians suggest that the prominence of these concerns among new physicians is due to the higher proportion of women among them (Hall 2004; Johnson 2005).

Indeed, women physicians do appear to have struggles in their careers and between their practices and their private lives that are distinct from those of their male colleagues. Women report more exposure to gender discrimination and sexual harassment during training (Nora et al 2002), and are more likely to feel that female nurses offer them less cooperation than they do male physicians (Gjerberg and Kjolsrod

2001). Women physicians are also underrepresented among physician-administrators, full professors, and other positions of influence (Boulis and Jacobs 2008).¹

Becoming and being a physician also creates intense pressures on women's time. The period of training required of medical doctors is particularly long, and it and the demands of early practice or academic career establishment overlap almost perfectly with a woman's childbearing period (Bickel 2000). Women who become physicians have been less likely to marry, more likely to divorce, and less likely to have children than their male colleagues, though these differences have become smaller over time (Boulis and Jacobs 2008, Lorber 1984). Female physicians who do marry are overwhelmingly likely to be partnered with other professionals, including fellow doctors, meaning that they tend to have spouses who also work long hours away from home (Boulis and Jacobs 2008; Bickel 2000; Bowman et al. 2002). Even when they are married to other doctors, women physicians spend more time than their mates on household tasks (Bowman et al 2002; Frank et al 2000). Once physicians become parents, women spend significantly more weekly time on childcare than their husbands, and they reduce their work hours while male physician fathers increase theirs (Bowman et al. 2002; Boulis and Jacobs 2008; Grant et al. 1990; Weisman and Teitelbaum 1987). Women in dual-doctor marriages also report making more career sacrifices for their family than do other physician women or men (Sobecks et al. 1999; Hinze 2000).

Childbearing brings other challenges. During residency, female doctors often report experiencing disapproval and criticism from their superiors and fellow residents,

¹ The data on male and female physicians' earnings are mixed (Baker 1996; Ash et al 2004; Hoff 2004; Boulis and Jacobs 2004). One factor that unites the literature is that women physicians experience a wage penalty associated with motherhood (and sometimes marriage), both through women's reduced weekly hours and through reduced compensation for those hours (Baker 1996; Hinze 2000; Laine and Turner 2004; Ash et al 2004; Sasser 2005; Boulis 2004). Within OB/GYN, the most recent studies indicate a raw income gap of about 19 percent between male and female physicians. Differences in productivity and practice style explained about half of this gap in the 1990s and all of the gap by 2002, according to Reyes (2007b).

who express resentment about covering the pregnant resident's work while she is on maternity leave (Bowman et al. 2002; Wiebe 1997). Significant numbers of program directors admit discouraging pregnancy among residents because of its perceived effects on training programs and departmental workloads, and these attitudes appear to be significant stressors for pregnant residents (van Dis 2004). Residents (Gabbe et al. 2003) and practicing physicians take very short maternity leaves (Bowman et al. 2002), most likely due to the financial and practical difficulties of keeping their practice afloat without seeing patients or generating income. If physicians wait to have children until they have completed residency and any fellowships, and even more so if they wait until their practices are established, they are also at the tail end of their fertile years and may have difficulty conceiving and carrying a pregnancy to term (Bowman et al. 2002).

More generally, women physicians often experience role conflict between their identities as physicians and mothers in ways that are less salient for physician fathers. Robert Broadhead noted of medical students that “many students who are husbands and fathers see their identity and involvement in medical school as *being* a husband and father” (1983:43). This congruity of roles is not present for women: working hard in the hospital is not aligned with cultural ideas of being a good mother or wife—it represents a threat to those roles. Women have reported finding medical training and practice to be a “neutering” experience, rather than one that enhances their femininity (Broadhead 1983). Furthermore, being a good mother requires physical presence with children, to provide the “intensive mothering” needed to properly care for a child (Hays 1996). Unsurprisingly, women physicians report more role strain and stress surrounding marriage and childbearing than do male physicians (Bowman et al. 2002). Some women physicians find this strain too much to bear, and either choose not to marry or have children (Broadhead

1983; Conley 1998; Cassell 1998) or drop out of the workforce after they have children (Boulis 2004).

Methods

To investigate schema of medical work-devotion among OB/GYNs, I have conducted an interview study of 51 physicians, all of whom had or were completing a residency in OB/GYN. Respondents spanned the Baby Boomer, Generation X and Millennial generations and both genders: I spoke with 22 men (43 percent) and 29 women (57 percent), and physicians ranged in age from 26 to 69 at the time of the interview, with a mean age of 43 years (41 for women, 44 for men). (See Figure 1) I continued to contact and interview physicians until I reached a point of thematic saturation.

Figure 1: Respondents by Generation and Gender			
	Baby Boomers	Generation X	Millennials
Men	7	9	6
Women	8	12	9

Contacts for these interviews were made through snowball sampling, following personal connections to gain introductions over email, text, or in person to physicians.²

² While a representative sample, created through a random draw of names of active OB/GYNs and OB/GYN residents across the country would have provided greater confidence in making generalizable conclusions, I quickly found that getting access to very busy physicians only worked when there was a personal introduction through peer relationships. I had no success being able to interview physicians because of recommendations from their patients; I suspect a request coming through that channel made physicians feel guarded against a breach of their professional distance and less inclined to give me their time. Instead, I found that being introduced to physicians by their friends, family, or coworkers made physicians feel more comfortable talking openly with me.

By working through networks with links across the country, I was able to speak with physicians on the West Coast and in the Southwest, Midwest, Deep South, Mid-Atlantic, and Northeast regions of the United States. Most physicians worked in mid-to large cities, though I also spoke with a few small-town doctors. Some interviews were in person, in the doctors' lounges of hospital Labor and Delivery wards while physicians were on call, but most of the interviews were conducted over the phone. With permission, I recorded and transcribed all interviews. I received approval from the Institutional Review Board at the University of Pennsylvania for this study, and all physicians' names and identifying details have been changed to protect their privacy.

My interviews with the physicians were semi-structured; I asked all of them about the same areas of their personal experience—the choice to go into medicine and OB/GYN in particular, their experiences as a man or woman in training and practice, their choices about practice setting, the interactions between their work and private lives, their concerns and plans for the future—but I attempted to let the physicians lead the conversations as much as possible. I wanted to hear their thoughts in their own words, reflecting what they saw as most pertinent to their individual experiences, and then I followed up on repeated phrases and key themes to work inductively toward a theoretical understanding of categories, patterns and relationships, as described by a grounded theory approach to data analysis (Glaser and Strauss 1967).

Results

The Medical Work-Devotion Schema Among OB/GYNs

Doctors did not describe the medical work-devotion schema as an abstract standard of professionalism. They talked about this ideal as embodied in real individuals who they knew personally, describing physicians with a high level of expertise, skill, and clinical judgment who were “ironmen”, “machines”, and “able to take the pain” of working tremendously long hours. These labels were used as terms of praise, exalting physicians who put the overwhelming priority of their lives on devotion to their work—usually described as “putting their patients first”—and specifically admiring the amount of time these physicians spent being physically present in the hospital. Very few doctors described themselves in these terms; the labels were reserved for physicians they admired, who almost always were members of the generation prior to their own. When OB/GYNs did describe themselves as members of this group of committed physicians, they said they were “dinosaurs” or “old-school”. By this, the physicians did not mean that they were out-of-date clinicians, but that they held themselves to different (higher) standards of care and priority for patients, standards that they felt were no longer esteemed by younger physicians. They saw themselves as belonging to a different era.

The schema of medical work-devotion described a “hero-standard” of doctoring, and it was clearly gendered. In order to spend so much time in the hospital and give wholehearted priority to patient care, someone else has to be taking care of your personal responsibilities, especially if you have children. Thus the “hero-standard” assumes either an at-home spouse handling housework and childcare or requires that there be no dependents at all. Only male doctors, or female doctors explicitly described as being “like men” in their lack of family responsibilities, were said to be fulfilling this ideal.

Among Baby Boomers

Based on the sociological literature and the gendered nature of the hero-standard, one would expect strong gender differences in physicians' responses to it. Indeed, among Baby Boomer OB/GYNs, this gendered pattern was clearly present. Only one female Baby Boomer OB/GYN closely approximated the standard in her work orientation, which she acknowledged by saying that around the hospital, people think she is "a little different" for her high level of physical and mental stamina and for maintaining the same level of energy as she nears retirement that she had when she began her practice. Other clinicians described her as "a machine." Yet even she reflected deep reservations about the hero-standard and the priority it demanded on the hospital over home life:

Dr. May (female, Baby Boomer): Well, lots of people told me not to go into OB. Lots of people told me I couldn't have a family. Lots of people told me I would be divorced. Lots of people told me I can't do it. But....some people said, you can do it all. Some of the woman doctors talked about how you could do it all.

Um, there's been plenty of divorces! [laughing] Plenty of people, I think, have let that happen. But it depends on what you see as important. My children know that my work is important, but they know they are more important. Plenty of doctors, with lots of patients, are always, always--they lived in the hospital [and that led to their family problems].

This parsing of the hero-standard of medical work-devotion—that the work ethic demand is valid, while the time demand of always being in the hospital is rejected as destructive—was the closest any of the women Baby Boomer OB/GYNs came to endorsing this work-devotion schema.

Since none of the female Baby Boomer OB/GYNs in this study had stay-at-home spouses, the "male" aspects of the hero-standard were problematic for women physicians from the very beginning of their careers. Two doctors reported leaving the first private practices they joined because the other physicians in them, who were either men or

childless women, demanded a level of time commitment and work priority that they felt was incompatible with being mothers.

Dr. Bratten (female, Baby Boomer): I ended up going into a practice after I finished [residency] where we all covered our own patients five days a week, 24 hours a day. A lot of the other people I trained with—especially the women—went to practices where there was someone different on call every night through the whole practice. So they never had that 24 hours a day, five days a week kind of a thing. And I think that was a more—those are the people that are still practicing, really. But I liked the idea of taking care of my own patients. And knowing that I was going to care for them, and probably deliver them....So, in retrospect, it probably wasn't the best choice for me, as far as the track just to enter.

...Neither of the women [already in the group] had any children. So... I think the practice had remained, sort of, cover-your-own-patients, because it was men, who, you know, weren't as—didn't see any real need, I guess, to have coverage all the time. And the two women who were already in the practice didn't have any children. So they were, kind of, more like—not like 'men', you know what I mean! [laughing] But they didn't have children to come home to, you know. So that they were very resistant to covering. And I think the practice still is that way, they still don't cover each other during the week. They still all cover themselves. And they would not change that for anything when I was there. They really liked it that way.

It was pretty unsustainable with children.

Even for the women who were able to make their jobs compatible with their family responsibilities, they had to explicitly let go of the hero-standard of medical work.

Dr. Driscoll (female, Baby Boomer): When I was just out of training and trying to really build a practice, I [came] in more on my off-hours. Partly to build a practice and get myself in the community, partly because I didn't have kids yet, and I was married but...my husband's awesome and really understanding....So I would come in more for my patients when I was younger, and it gets to be a little bit prohibitive as you get more things in life to deal with.

I think it [became prohibitive] when the kids were born. It just—you know, that was such a huge draw, to split my time up. Although it was hard, it wasn't hard in the sense that I chose my job over my kids, but it was like, at least when I trained, there was a *commitment* [expected of you as a physician, that it would be your top priority]...My husband [said], "Being a doctor isn't what you *do*, it's who you *are*." And so that sense of commitment makes it—it's hard. It's hard when I have to miss deliveries. It still is. I wish it could work out, but you know, obviously logistically I'm with the kids, I can't—it's kind of a compromise I'm not really willing to make.

Other women found the hero-standard to be ridiculous from the start, and something they defined themselves in opposition to from early in their careers. One physician, Dr. Grunwald, had her first child in residency. Her daughter became grievously ill at four months old, and she recalled a struggle with her supervising physician, who felt that her sole priority should be on her work.

Dr. Grunwald (female, Baby Boomer): And then we moved in with my parents for three months 'cause we had ICU nurses around the clock for three months, and I did take off an entire month that she was on the respirator, and I called up my chairman and I'm

like, "I need an official leave of absence," and he's like, "What are you talking about?" I'm like, "well, my daughter was admitted to the hospital three days ago and...it's pneumonia and they're intubating her now as we speak."

And he's like, "Well, when will you be back?" I'm not kidding, like without [skipping a beat]—and I'm on a payphone.

And I'm like, "I don't know, it depends if she lives or dies." And he's like, "Well, what do you mean?" I go, "Well, I guess if she dies, I'll come back like a week afterwards, and if she lives, I'll come back as soon as she's off the respirator."

And he goes, "I'm gonna hold you to that."

...I already hated him. So it just made me—I mean, that's just ridiculous....[Later, he gave me lowered marks for my third year evaluation.] And I said, "Well, what was this devaluation for?" And he's like, "Well, you took a month off last year." And I'm like, "My daughter was dying. Do you think I wouldn't have rather come to work and done the nine calls?"

In contrast, none of the male Baby Boomer OB/GYNs reported such conflicts with the ideal of the devoted physician, at least early in their careers. All but one of the male Baby Boomers married and had children, and these physicians all had wives who took primary responsibility for the household and childcare responsibilities. One physician, Dr. Biondi, really strongly identified with the hero-standard of medical devotion, and it was through the schema of work devotion that he evaluated his life's meaning.

Dr. Biondi (male, Baby Boomer): I had a fabulous career. I got full professorship at the university, and I ended up—I could've had a lot more publications, but I ended up with like 37 publications, almost 40. I worked full-time as a perinatologist as well as the medical director. [But] what we see in all the people now is that they don't want to do what I did, have the kind of lifestyle that I had.

And what happened is that the people that were born, particularly my era—I have a view of the Depression and of the World War...and lots of things happened to my father, who lost everything [in the Depression]...I was always insecure and one of the reasons I was afraid to stop practicing was I was worried about the money, but believe it or not, I saved so much money that [*laughing*] I don't ever need to work...

But it wasn't about money at all for me, never was. It was always about the patients, and in our training we were imbued with the idea that they came first....

What happened, you know, because I've really thought about this and I've observed, it is that as in intern, I was on call every third night. Every third night and as a resident every fourth night, and never once did [my wife] ever say to me, "Oh you're on call again, or oh, you have to leave," or—never once in my entire 40-something-year career did she ever raise the issue. So she and I were born in the same—had the same kind of ethic around what the work meant.

And I what happened to me eventually is that the group you know that I hired, [*laughing*] that I drove relentlessly, you know they wanted a different lifestyle. And the women joining, they had families, and I couldn't understand it because here was a practice that had a lot of time off built into it, a lot of money and very satisfying kind of—but they wanted basically a different kind of practice, you know?

The question comes up for me and probably what you're thinking about is – and sometimes I think because maybe I should have you know not been so driven for patient care or ambitious writing papers or being a leader like I was, and maybe I should've been able to contribute more to my family, and I don't know whether my sons suffered or not about that – I was a loving father. I was very generous. They had everything that they could ever hope for from me, but they struggled with psychological issues...Both my wife and I had familial depression, and it's like they also got it...

I know this. I helped thousands of women. I did procedures that people don't—I put membranes back in so many women and they had babies. I had a technique, you know, and I did this for 20 years, and I would stay with those women—I didn't get paid for that. At 5 o'clock in the afternoon I'd go to drive home and they came, losing their pregnancy [and instead I would turn around and stay with the patients]. I knew what to do and I did it and I was so esteemed in the community because I developed procedures out of all that experience with high-risk women, so I know that. And I, you know, live with that.

Here, Dr. Biondi's reflections offer key insights into the schema of medical work-devotion. The schema encompasses the standards expected of physicians and the honor that derives from fulfilling them: Dr. Biondi is proud of his career because he feels like he met that hero-standard, and listening carefully to how he explains his pride illuminates the contours of it. First, his acceptance of the schema began during residency, when the idea that the patients are to “come first” was communicated as a clear expectation. What that norm meant is that he worked long, often irregular hours and that he did so without complaint, because it was right that his schedule be dictated by patients' needs rather than his preferences or his income. He stayed with the women even after their procedure was done, because that is what being a good doctor meant to him.

Second, the hero-standard involves clinical excellence. That clinical skill—reflected in Dr. Biondi's discussion of his successful procedures—is often measured by physicians both in the affection of grateful patients and in colleague recognition, through leadership in his perinatology group. As an academic physician and a clinical innovator, Dr. Biondi received the further accolades of publication and full professorship, and what he describes as the esteem of the community: all of these sources of praise serve to recognize and honor his devotion to his patients. Dr. Biondi, more than any other physician in the study, experienced the fullness of the schema of medical work-devotion: he believed in the standard, he fulfilled its requirements, and he received the honor due to him as a result.

Dr. Biondi's description of his career also illuminates some of the gender and generation dynamics swirling around the schema of medical work-devotion. As the oldest

physician in the study, Dr. Biondi was born right on the edge of the generational divide between Baby Boomers and their predecessors, the Silent Generation; in many ways, his firm commitment to the hero-standard of medical devotion—he used the term “ironman” with no reservations or qualifications—is more characteristic of his elders. Coming from a family that had memories of scarcity and hardship in the Depression, his dedication to work and to seeking financial security became a clear priority for his life; because of his success in both, he evaluates his career as “fabulous”.

His ability to give such priority to his patients and his work—to be on call every third or fourth night, to come in when there were emergencies—was enabled by his wife, who took care of his household and children and accepted this division of labor as natural and right. They “shared the same ethic around what the work meant,” meaning, they agreed that his work was more important than their personal or family time, and also that domestic work was not his responsibility. Though he does not articulate this here, without his wife’s support, he would not have been able to have this dedicated career.

Dr. Biondi also noticed and was extremely frustrated by gender and generational shifts regarding this schema of medical work-devotion. The younger physicians he hired—especially, in his view, the women—had different priorities for their work and family life in ways that were bewildering to him. In his view, the setup of his practice was ideal: it was highly remunerative and highly honored, the two axes of meaning that measured his career. His fellow physicians’ insistence on a third axis—time—was something he struggled to accept. Even the idea of measuring time in the hospital versus time at home perplexed him, because one of the main ways that he conceptualized “putting patients first” was by generously giving them his time.

Dr. Biondi’s comments also illustrate the tensions created by the medical work-devotion schema with regard to family relationships. Initially, he shares the view of

separate spheres common to many men of his generation, presuming his wife's responsibility for domestic care that facilitates his work devotion. This presumption of a gendered division of labor is clearest when he notes that the women he hired into his practice, who wanted a different lifestyle, "had families." Obviously, he and most of his male colleagues "had families," too, but what he really means is that they were *mothers*, and that women with children were unwilling to work according to his (male or childless) standard of medical work-devotion.

But Dr. Biondi also reflects with ambivalence about the effect on his own family of his dedication to the schema of medical work-devotion. Thinking of his sons and their struggles to establish themselves as independent adults, he wonders if being a more involved father could have ameliorated some of their difficulties. Even as he questions the demands of the schema for priority over his family, though, he shifts his focus to what he "knows"—that his dedication has resulted in work that was valuable and valued. Instead of undermining his allegiance to the schema, he reifies it, then finishes with a declaration of the meaning of his life and identity as drawn from it.

What was most interesting about talking to the other male Baby Boomer OB/GYNs was that, even if they began their practices being socialized toward an ideal of a devoted hero-physician, many of them became disillusioned with that standard and the schema of work devotion it represented. Over the course of their careers, three of these men reported moving away from lives oriented around a work priority—in two of these cases, the shift required a dramatic career change—a finding not suggested by the previous sociological literature. Unlike their female counterparts, male Baby Boomer OB/GYNs did not make this shift when they became parents; instead, their disillusionment often emerged decades into their careers, when the effects of their work devotion became apparent in their own health or in the lives of their family members.

Dr. Meier (male, Baby Boomer): [In the practice I joined] what totally frustrated me was that it turned out they were working harder than, and I was working harder with them, than any of my peers were working, and it was harder than I worked in residency, if you can even believe that.

...They're maniacs, they're...crazy people. They were working hard and...I was expected to catch up. [But] I had slightly different goals and wanted to be home for dinner...Friday night dinner. My wife converted to Judaism, and it was a point to me to...walk my walk, and do what was important, and there was not a place in their world for that....My marriage didn't survive that process, and I became a single parent... So the whole notion of being managing partner [of an infertility practice] and being a single parent and doing those things that needed to be done was getting a little intense, and so in terms of balance I had no balance. No that's not true; in terms of your question about a balance in life, I had lots of balance I just had no life. So I ultimately decided I couldn't do that, and that's when I moved into the notion of, "How can I pursue this issue of my calling and my issue of my need to balance my life at the same time?" And that's when I went to the managed care side and started to do some other things.

...My daughter turned 14 and said, I really need to come live with you...and you begin to sense that you're needed elsewhere, you begin to sense that your heart and your soul have to be elsewhere, you begin to sense that your energy level and your focus has to be more balanced. So I developed a balance in my life out of self-preservation in a sense. I didn't demand it, I was perfectly happy being an old-style doc, but I'm much happier now that I'm not.

Dr. Merton (male, Baby Boomer): My wife and I have been married for almost 37 years, and we have three kids and we have six grandchildren with another one on the way, and I tried to balance all of that during that time when I was on call five out of seven nights, and it was just starting to wear me out. So by my early 50's, mid 50's, I said, this is not – I'm not gonna live very long if I keep doing this.

I ended up getting some counsel from just a clinical psychologist that someone had recommended, 'cause I was having trouble sleeping and it just wasn't good... So I met with this guy—and his questions to me were, "You're not very happy in what you're doing; what is it that's keeping you from making a change?" And so I thought about it for a week or two, and essentially it was fear and greed. And I'm not a really greedy person. My whole group tried to maximize income all the time and you know, it's fine to be paid a lot for doing stuff where you really are rescuing people—moms and babies—from disasters, and it was financially rewarding, but I just thought, "Gosh, I'm sort of locked in the golden handcuffs here and I'm afraid of what will happen if I change, if I do something different."

...You're just tired, and you're worn out. And there was a period of time actually seven or eight years ago, where I got tired of working all day long, being on call all night long, and then being told I had to work the whole next day in clinic. I said, I can't do that anymore.

And I was just – now of course, the default mode is that nobody works after being on call overnight, but it was really difficult to get some of my colleagues to even contemplate doing it differently. They were just – they would try to pretend like, "Yeah, we're working hard, but it's just part of what we do, and then you can be gone for two weeks." And I say, well, I don't like working like a maniac and feeling terrible for the next six days.

...And I was actually—I liked working. I mean, I liked being busy, but being on-call overnight five out of seven nights? Was crazy. I mean I actually, at certain points, felt like I was losing my mind and I wrote this rambling letter to these senior colleagues who had hired me and said, "You guys are crazy!" I mean, this is not sustainable.

Dr. Merton and Dr. Meier both began their careers as physicians working under the schema of medical work-devotion and continued to do so for years, but unlike Dr. Biondi, whose devotion to the hero-standard strengthened over time, they saw increasing

gaps between its demands and its promises as their careers progressed. Dr. Meier experienced this primarily as preventing him from being with the family who needed him, and Dr. Merton saw it instead as incompatible with his physical and mental health. Both of them ended up making large career changes to break out of the schema of medical work-devotion.

The schema and the hero-standard may have become unsustainable to them, but it did not cease to be something they admired. Their work demands were “crazy”, and in the words of both of them, the colleagues who worked like that were “maniacs,” but even the word “maniacs” conveys some of the residual ambivalence they had about letting go of the schema and the hero-standard. In saying their colleagues were maniacs rather than neurotic or schizophrenic, they emphasized their colleagues’ intense energy, still geared toward a rational and valuable direction. They saw their colleagues as crazy, but in an admirable kind of way.

Among Generation X

When we shift focus to Generation X, this sharply gendered pattern of engagement with the hero standard of medical devotion disappears. Though women still bear unequal burdens regarding childbearing, gender no longer predicts individual physicians’ acceptance of a work-devotion schema. There is much more diversity in both the structure of jobs and in the arrangement of household and childcare responsibilities among these physicians and their spouses, such that physicians’ approaches to the work-devotion or family-devotion schemas described by Blair-Loy reflect individual choices and opportunities much more than broad categories.

One female OB/GYN, a married mother of two, describes herself as more “old

school” in her work ethic and her approach to patient care. Reflecting a nuanced embrace of the medical work-devotion schema, Dr. Martin describes the very intense workload her practice carries with pride:

Dr. Martin (female, Gen X): Not everyone can – we’ve had people come and go from our group because they can’t handle it. Not in any way. It was just, like, they don’t want to work that hard. Our way is not for everybody, and I understand the appeal of this Q8 [call every eighth day]. Sure, on days that I’m getting killed and I’m here, and I haven’t seen my family for four days, you know, I’m mentally and physically exhausted. It’s hard, and that’s even Q4 [call every fourth day].

Yet she emphasizes that she chooses to practice this way—sharing call only among four doctors, rather than a larger number—because, “I love what we do, because I love being close to my patients, I want them to know all the doctors. I don’t want to cross cover with four other doctors and do Q8 [take call every eighth day], because I feel like that takes away so much from our practice and what it is.” She takes pride in the priority she puts on her patients, consistent with the schema of medical work-devotion schema, but her reasoning is different from that of Dr. Biondi: rather than that such work devotion being necessary to be a good doctor, it is animated by her individual preference for one work arrangement out of many possibilities.

Prioritizing patient care over personal time creates difficult tradeoffs for parents, however. Because of the intensity of her particular work demands, it is impossible for Dr. Martin to be an “intensive mother,” and she points this out: “I can’t balance it all. I have to completely let go. I think I’ve dropped my kids off three times to kindergarten. I would not recognize their kindergarten teachers if I passed them in the street. Like, I’m not involved that way, but in a sense, I’m okay doing that.” The reason that she can be “okay” is that her husband is a highly involved stay-at-home dad, who manages all household responsibilities and childcare. This solution that works very well for them, but would have been nearly unthinkable among Baby Boomer physicians. Yet among Generation X OB/GYNs in this study, several female doctors had husbands who had been stay-at-home

fathers for all or much of their children's early lives, and many more had live-in help from other close family members, such as mothers or sisters.

Other women wrestled more with the balance between their devotion to work and their devotion to their families, especially if they had less support at home from their spouse and extended family. Several mentioned either turning down offers to head groups or departments or not pursuing opportunities for research because they did not want to give up more time with their children. There remain gendered aspects to these decisions, especially about aspects of work that could be considered "extra". As one female OB/GYN married to another physician put it:

Dr. Becker (female, Gen X): He works and that's okay, but the kids kind of still expect, even if the mom is a physician and the dad is a physician, they still expect the mom to be there and do everything. So it's kind of hard that way to share both those roles. I think the guy gets off with that a lot easier. I think that's why they can take on bigger responsibilities and become department heads and all that, because it's easier to justify it whereas it's harder for a woman. There's less time with the kids, and then if the kids don't turn out well it's her fault because she wasn't there.

Among men, there was also remarkable diversity in the way they set up their practices and family lives. Though such arrangements have been declining for decades, one male physician, Dr. Hasan, set up a solo practice in a large city, where his wife manages the practice's office and billing. Dr. Hasan is committed to spending extended time with each of his patients in the office and personally delivering their babies. He emphasizes the importance of working very hard, yet—despite his very traditional practice setting—describes the reasoning behind his choices not in terms of putting the patient's needs first, but because it is his personal choice to not be rushed, by trying to meet a hospital- or supervisor-imposed productivity demand. Dr. Hasan's practice is essentially concierge medicine, offering "VIP" treatment to a much smaller number of patients who pay large fees in cash or have very generous insurance coverage for maternity care. Unlike solo practitioners of the past, however, even though he must be on call 24/7, his practice is arranged to support his family life, rather than the other way around:

Dr. Hasan (male, Gen X): But right now if I wasn't in the labor room...I would have been taking my kids to the ballet class myself. So go there and, you know, [take] the computer in my hand and do things while waiting outside in the ballet class or the tennis class.

...We do breakfast together, and put their clothes, take them to school. And then I go see patients. Or if that day I'm at home then I go back and do my work and get to pick them up from school and do the homework. But my wife does tons of work. She's both. She works from home, because everything's computerized.

This version of solo practice reflects the social changes that have occurred in the roles of men and women, especially parents, and reshaped physicians' perceptions of their professional priorities. Here Dr. Hasan describes that it would be usual for him to take his kids to ballet class and school and do homework with them, which were responsibilities that fell to wives among the Baby Boomer physicians interviewed. Furthermore, managing clinical responsibilities in such a way as to facilitate ballet class transportation—even the idea that medical work-devotion could accommodate such an arrangement—would be totally incongruous for a male physician of an earlier generation.

Other Generation X physicians—both men and women—had clear priorities on their work lives and ascribed more fully to the traditional medical-devotion schema. These physicians did not have children; they were either single or in partnered homosexual relationships. Most of these physicians had already firmly decided against having children, but the couple of them who were still considering it expressed high levels of anxiety about whether they could be good parents, given the importance of their work to them and the demands it made on their time.

Dr. Richerot (female, Gen X): Honestly, it's scary. It's very daunting to me. And [my partner] very much wants children, and I, while I like the idea—but honestly, it's like...How do you do that? Who takes care of them? ...

I think if I didn't have such a demanding schedule, I might feel very different. But it's weird to think that your family, procreation, etc.—everything is subject, secondary to your job.

Among Millennials

Millennial OB/GYN physicians demonstrated the same absence of a clear gender-

linked pattern regarding their attachment to the schema of medical work-devotion, but as a group they described norms of work priority that were very much in contrast to both those of Baby Boomers and even to those of Generation X physicians. Many physician commentators have decried this shift as a diminishment of work ethic or professionalism, and many of the Generation X and Baby Boomer OB/GYNs in this study also pointed out a negative difference between the way they perceived Millennials to approach their commitment to their work in comparison with their own generations.

In their own words, this contrast was not as harsh as their critics have charged: Millennials still spoke of working hard and wanting to practice excellent medicine. However, Millennials of both genders did describe approaching their work-related decisions in ways that were different from their predecessors. Dr. Ashton, a male resident intending to go into general OB/GYN practice, summarized his thoughts on the kind of practice he is hoping to have:

Dr. Ashton (male, Millennial): I knew it was one of those fields that has a less optimal work-life balance, or at least a tougher schedule. At the same time, I think not just for OB/GYN but I think for a lot of specialties, there are getting to be more and more options of work-life balance so that not everybody in the same field has the same kind of schedule. ...So I think things are getting a lot more customizable, so you can kind of adjust your schedule and have other options for lifestyle.

... I'm definitely hoping that [my work hours] will decrease. I think it's just a matter of after residency finding a group and a work style that works with your personal goals...So I think you can sacrifice some of your paycheck if you're willing to—or if you're willing to sacrifice some of your paycheck, I think it is possible to find a group where hours are more divided among the group and less intense for each person. So that's something that I'm probably hoping for....My goal, I guess, would be to try to keep my work weeks around 50 hours a week.

What is most remarkable about Dr. Ashton's comments is not that he hopes to find a job that is less time-demanding than residency; what is remarkable is that he describes the priority of his job search and early professional career as being on finding a work environment that fits his lifestyle. Earlier generations described their early professional concerns as building up a private practice by working intensely hard to establish a good reputation and a strong referral base; often this meant that physicians expected their first

years of practice to involve going above and beyond requirements, as Dr. Driscoll described above. This shift away from work demands being animated by a schema of medical devotion to arrangements prioritizing personal time and limiting work hours is a clear marker of a distinct approach among Millennials to establishing work-life balance.

Another place this different approach to the medical work-devotion schema emerges among Millennials is in their willingness to join practice arrangements that older generations often spoke of with disdain, especially hospital- or health care consortium employee positions, as with the Kaiser Permanente group in the western United States. Older doctors often speak of these employee positions as trading away professional autonomy, something they value as key to the meaning of their work as physicians, but Millennials seemed much more positive toward these jobs. Dr. Sydney, a female OB/GYN in early practice in one such position, reflects on her decision to join such a practice:

Dr. Sydney (female, Millennial): [In my practice of eight women] everybody's married. So everybody has a pretty big emphasis on family, and want this to be a sustainable lifestyle. So I think a lot of what we talk about is, with regards to scheduling and call schedules and clinic schedules and OR [operating room] schedules is coming up with ways to make it so that when you're at work, you're at work, but then when you're at home, like, you get to be at home.

Trying to make sure that those are, like, relatively clearly delineated, I guess. I think to some degree, everybody wouldn't mind working a little bit less, but I think everybody also wants to get paid. So you kinda have to balance. I think what I'm seeing is people trying to balance, like, income requirements with trying to limit how much time their practice takes up....

I really didn't want to have the business burden that I felt like [private practice] was going to place on me. It was one of the big things. Like, I didn't want to have to be responsible for, like, paying my nurses' salaries, paying my malpractice, paying my office staff, paying my rent, doing all that kind of stuff. In a very clear way, I just didn't feel like I was prepared to do that.

Dr. Sydney views the freedom from the “business burden” of private practice as a benefit of her practice arrangement, and she does not view her employee status as a threat to her professional identity. Instead, the focus of her negotiations at work centers on ensuring a sustainable lifestyle rather than protecting her autonomy.

Dr. Sydney describes a group practice structured around making OB/GYN work controllable and predictable for the physicians, rather than around providing a certain

style of medical care or encouraging the kind of heroic standard of work devotion that was esteemed among earlier generations. It is not that Baby Boomer and Generation X OB/GYNs did not also seek strategies to minimize the demands of their work; the differences is that Millennial physicians tend to strongly prioritize these strategies over other aspects of the organization of their practices, reflecting that their norms of work devotion have shifted considerably from their elder colleagues.

Additionally, the comments of both Dr. Sydney and Dr. Ashton point to where they see a central tension in their work arrangements. Unlike the OB/GYNs of the earlier generations, who often struggled with the medical work-devotion schema's expectations of what is required to be a "good doctor" and their personal needs and responsibilities, Millennial physicians described their main tradeoff as between money and time. Also unlike earlier generations, Millennial OB/GYNs of both genders reported their willingness to "sacrifice some of [their] paycheck" in order to have jobs that had more circumscribed hours.

Consistent with other research describing the optimism of Millennial workers, these physicians saw it as within their power to have work arrangements that met their expectations for balancing work and their private lives.

Dr. Minami (female, Millennial): I think there's a lot of flexibility within this field to be able to do all kinds of different things and I think...you can make of it what you want depending on how you want your life to be and how much money you want to make and what's important to you. There's so many different things you could do. So many ways you could span.

Elsewhere, Dr. Minami described her desires for her career:

Dr. Minami (female, Millennial): I always thought I wanted to do private practice, but speaking with the attendings here who've been doing this for years and years and have families it seems sub-optimal to have to be doing—especially obstetrics—forever. You have to wake up all the time and everything is disrupted and you don't get to tuck your kids in at night and you have to, like, FaceTime it on the phone. It just seems like that would be exhausting after a while. So I'm thinking of ways that maybe I could do what I want in the future without having to sacrifice quite so much.

Again, we see here a clear difference in orientation toward the schema of medical work-devotion: before beginning her independent practice, Dr. Minami wants to find a path that does not require so much sacrifice of her personal and family time. Such a desire is completely reasonable and rational, but it reflects an assumption on her part that being a good doctor does not *require* such a sacrifice.

Several Millennial physicians acknowledged that work demands are lessened for them now, and they appreciated it. Many of them reported having children during residency training, and they were particularly glad for the opportunity to combine work and family life more satisfactorily:

Dr. Lapin (male, Millennial): My responsibility to be with [my kids and my wife]. You know, I don't see the point in working so hard that your family doesn't see you. Just like I want to devote time and energy to my patients, I think I should be devoting time and energy to my kids, my family.

I mean I think it's definitely different than things, you know, 30, 40 years ago, 'cause I think at that time medicine was just an all-encompassing devotion that you didn't have time for those things. And I think with the Bell Commission and with the [duty hour restrictions], I'm still able to work very hard but still have a life, right? I think that's very different then the way it used to be and I'm very grateful for that. You know, obviously, I can't be there for everything and I do miss things, I will miss things, but I don't feel like my life and my family have been robbed from me.

Here Dr. Lapin articulates a new schema of medical work-devotion. Instead of the view that primary allegiance and priority is owed to patients, he sees his family and his patients as having more equal claims on his time and energy. Furthermore, rather than admiring “ironmen” who were previously so devoted to medicine, he sees that approach as “robbing” him of his life and his family; he is looking for a career where his work role is circumscribed to protect his family life.

Conclusions

“Generations” are always imperfect social dividers, but this study finds that the broad groupings of Baby Boomers (born 1945-1964), Generation Xers (born 1965-1980),

and Millennials (born 1981-2000) align with meaningful differences between the cohorts in regard to their acceptance of the schema of medical work-devotion. Though gender differences in the acceptance of and compliance with this medical work-devotion schema were strongly predicted from the sociological literature about other professions and about generations prior to and including Baby Boomers, this gender difference was found only among our oldest generation. Gender, operating primarily through expectations laid on parents, became a less salient predictor of response to the schema over time.

Both male and female Baby Boomer OB/GYNs aspired to the hero-standard of the medical work-devotion schema. To their disappointment, however, female Baby Boomers found early in their careers that they could not or would not fulfill it, especially after they became mothers. Male Baby Boomer physicians had less initial trouble with the work standard created by the schema, and several of them drew profound meaning from evaluating their lives and careers against its hero-standard of priority for patients and commitments of time and energy to the hospital. Other men began their careers working in accordance with this standard, but came to struggle with or reject it years later.

Among Generation X OB/GYNs and Millennial physicians, there were no gender patterns regarding their acceptance of the schema of medical work-devotion. For Generation X physicians, there was much individual variation in the degree to which the schema shapes their own expectations for work, as some female physicians are supported by stay-at-home spouses, and some male doctors arrange work to protect family time. For two-career families, women still tend to bear greater household and childcare burdens, forcing a compromise with the work demands of the schema, but both men and women expressed admiration of “old-school” physicians and the hero-standard they embodied.

Millennials did not describe either adherence to or rejection of the schema of medical work-devotion: instead, it did not seem to press on them at all. For the

Millennials, their idea of what it means to be a good doctor did not include the expectation that their work take overwhelming priority over the rest of their personal lives or that it require extremely long hours in the hospital. Instead, Millennials generally seemed to feel that they could tailor their work environments to meet their desires for work/life balance and personal or family time; they saw the main tradeoff required as one between money and time, and they expressed willingness to trade away some income for more circumscribed workhours.

So: Gender or Generation? The strongest patterns by far are by generation, but this is still hugely a gender story. These generational shifts are largely about changes in gender norms between cohorts, working in tandem with changes in the structure of medicine that have diminished the rewards of the medical work-devotion schema and allowed for more diversity of practice patterns. In many ways, this is a gender success story: it is more possible—though still not painless—to be a female OB/GYN and have a satisfactory work/life balance than before. For Millennials particularly, it is easier now to find a fit between the moral schema one aspires to embody and the actual structure of one's life and practice. Men, too, benefit from this openness: they have more options to determine as an individual how much priority to give their patients and their practice.

The Millennials are dedicated physicians, and they describe being determined to provide good medical care to their patients. However, there is a profound difference in the way they understand the core articles of faith that underlie their concepts of the ideals of being a physician and the duties owed to their patients and their practices. This remarkable shift bears some additional comment.

The work desires, expectations, and practices of American Millennials have been described as distinct from those of earlier generations across many workplace environments (Taylor 2014; Zemke et al. 2013). In many ways, Millennial physicians are

merely keeping in line with their peers in business and other occupations. But medicine is also different: its rigorous selection criteria and its long socialization in training have in the past meant that the norms of medicine and medical work-devotion have been stronger than those of other professions. It would be possible to imagine that this socialization would override generational orientations to work, and that Millennial physicians exiting residency would look more like their attending physicians and less like their peers regarding work/life balance desires.

But something else has happened in medicine in the last 15 years. First in 2003, and then again in 2011, the Accreditation Council for Graduate Medical Education (ACGME) established work hour restrictions for residents, generally limiting them to 80-hour workweeks and only 24-hour call shifts (12-hour shifts for first-year interns). These restrictions were put in place to prevent resident exhaustion and protect patient safety, though several studies have found no improvement in patient outcomes after the work hour restrictions were implemented (Patel et al 2014; Rajaram et al. 2014).

What the restrictions certainly have done, as reflected in these interviews, is completely reorient the socialization process of medical residency training. Instead of new physicians enacting the patient priority and long hours expected of the medical work-devotion schema, their training is shaped by the clock: they are required to account for all their hours to ensure that they are not violating the rules (though many of them lie around the edges), and programs certification depends on clean reports from their trainees (Szymczak and Bosk 2012; Szymczak et al. 2010).³ These work hour restrictions may have

³ In a study of residents' work patterns under the first (2003) iteration of the ACGME work hours rules, Szymczak et al. (2010) found that internal medicine and general surgery residents did not exhibit eroded professionalism as a result of the rules, saying that they observed residents staying late to finish patient care tasks and did not blindly follow duty hour rules. Their conception of "professionalism" differs from the medical work-devotion schema, though: just like Szymczak et al. found, residents in this study reported sometimes staying later than required to finish tasks and working hard to provide good patient care. But the schema of medical work-devotion goes far beyond this level of "professionalism": it requires that doctors give priority to patients and medicine over all other commitments, and the new work hour restrictions have

little effect on patient outcomes, but they have effectively delegitimized the idea that medicine rightfully can demand unlimited time and priority from its physicians. New Millennial doctors are socialized to standards that emphasize the bounding of commitments to patients and to the hospital: being a good doctor now means getting your work done during your shift.

These patterns are important to understand for several reasons. First, changes in the priorities physicians have for their work lives lead to changes in the jobs they seek and take, which in turn changes the structure of medical care available to patients. The replacement of Baby Boomer physicians by Millennial physicians will change the shape of American health care, as more OB/GYNs seek positions of shared responsibility, shiftwork, and salary rather than commitment to individual patients, regardless of day or night. Second, the weakened or expanded schema of medical work-devotion among Millennial physicians also makes them more open to practice settings and structures than were disparaged by older physicians. These practice structures are much more family-friendly, allowing physicians greater scope for creating a satisfactory work-life balance and, perhaps, broadening the pool of medical students willing to consider a career as OB/GYN providers.

Third, sociologists have not paid much attention yet to the popular press claims about generational differences between Baby Boomers, Generation X, and Millennials, but this research suggests that there may be significant differences buried in the popular conceptions, and these social trends are worthy of exploration and understanding. The Millennials in this study really were different, and that difference is yet to be fully conceptualized or understood. Lastly, though it is always significant to understand the

flipped this norm around by institutionalizing the idea that physicians work hours (and thus, their commitment of time and priority to patients) should have limits.

way gender binds and divides individuals, it is also important to understand where experiences are not deeply gendered, or where they cease to be gendered. This kind of understanding helps us clarify the meaning of social categories on the experience of individuals, and also can help us mark social progress where it may occur.

By its very nature as an interview study, this research has limitations. Physicians were recruited through social networks, so the sample cannot be said to be statistically representative in any way. Though I hoped to mitigate this by using snowballs to recruit colleagues of initial contacts and by approaching doctors who happened to be around when I was on hospital wards, there could be dimensions of bias that are hidden in this sample. Likewise, having only 51 physicians in the interview sample could mean that further dimensions of the schema of medical work-devotion remain yet to be discovered and theorized.

CHAPTER 2: MEN IN THE MEDICAL SORORITY

Since the mass movement of women into the labor force in the mid- to late-twentieth century, sociologists have given a great deal of attention to the distribution of men and women across and within occupations. They have particularly focused upon two patterns: occupational sex segregation—the tendency of men and women to have different occupations—and the clustering of women in certain jobs within occupations, usually those with lower status or less remuneration (Reskin and Roos 1990; Blackburn and Jarman 2006). The reason these two characteristics have been so interesting is because of a surprising dynamic common to both of them: despite profound changes in social attitudes about women’s capabilities, federal prohibition of sex discrimination in hiring, and the lowering of formal barriers to women’s entry into male-dominated occupations over the last four decades, these patterns have not changed that much (Reskin and Hartmann 1986, Reskin 1993, Jacobs 1989). This persistence is perplexing to researchers who generally assume that there are no inborn, biological differences between the sexes relevant to occupational suitability; furthermore, the persistence of occupational sex segregation is concerning, since researchers have viewed sex segregation either as a cause or a direct measure of social stratification between the sexes.

Sex stratification matters because it privileges men above women, constraining the opportunities of women and diminishing the dignity accorded to them by treating women and women’s contributions to society as less valuable than those of men. Almost all research on occupational sex segregation has interpreted it as part of this social process: the occupations in which women cluster (and which become known as female-dominated

or “typically” female) are seen as less valued in society because they are on average less well-paid than male occupations, contributing to the wage gap between men and women (Reskin 1988; Hegewisch et al 2010; Hegewisch and Hartmann 2014). And when occupations are integrated, women tend to cluster in the lower-paid and lower-status jobs within those fields, further exacerbating the wage gap and leaving women underrepresented in positions of authority (Reskin 1988; Reskin and Roos 1990). Where women do manage to make substantial inroads into male-dominated occupations, researchers have posited that occurs only after a drop in men’s desire for that occupation, due to diminished relative wages, status, or autonomy, leaving employers to fill jobs men no longer want with willing but less-desired women (Reskin and Roos 1990, 1992). Even in female-dominated fields, researchers describe that the few males present are advantaged and often groomed for leadership, in what has been described as the “glass escalator” for men compared the “glass ceiling” that prevents women from advancing (Williams 1992, 2013). Regardless of the situation of the occupation—segregated, integrating, resegregating—researchers seem to find that the effect is that men go up and women stay down.

Yet the close linkage drawn by many researchers between sex segregation and sex stratification—treating them as causally related if not actually the same phenomenon—obscures some of the causes of occupational segregation and job clustering and can lead to a misunderstanding of the gender power dynamics affecting occupational choices. This study uses the case of obstetrician-gynecologists (OB/GYNs) in the United States to illuminate some of these gender dynamics. From interviews with more than 50 male and female physicians who trained in OB/GYN over the last 40 years, a different, more complicated picture emerges: for OB/GYNs, being a male practicing today can be both a benefit and a liability, and the balance between the two shifts over the course of a

physician's career. Moreover, closely examining the case of male OB/GYNs illuminates some of the ways that imperfect knowledge of a field—particularly, uncertainty over the demand for one's services—can lead to compounding, self-reinforcing effects on the occupation's gender composition. This process is underway but not yet complete in OB/GYN, though it has already radically changed the opportunity structure for men in the field. Because trends in the gender composition of OB/GYN are set in motion years before, through medical schools and residency programs, it is clear that OB/GYN will become a highly gender-segregated, female-dominated field in the coming decades. The meaning of this for the physicians in this high-status field—their own sense of who is advantaged and disadvantaged by this change—challenges our notions of the connection between sex segregation and sex stratification.

Literature Review

A Specialty for Women

Obstetrics and gynecology (OB/GYN), the medical-surgical specialty that cares for women's reproductive health in the United States, is a field that very recently was highly segregated and male-dominated. In the early 1970s, only 3 percent of practicing OB/GYNs in the United States were female (Bluestone 1978; Scully 1980). Women made up only about 10 percent of all physicians at the time, and were clustered in a few specialties—pediatrics, public health, and psychiatry—but were almost entirely absent from surgical specialties (Bluestone 1978; Boulis and Jacobs 2008). Women's relative underrepresentation in OB/GYN was not an accident: in 1972, a physician in a leading OB/GYN journal bemoaned the low recruitment success of OB/GYN relative to other

specialties, saying that 15 percent of residency spots were left unfilled and at least half of residents were graduates of international medical schools (IMGs)—a group typically considered to be of much lower status than graduates of U.S. medical schools. He advised a change:

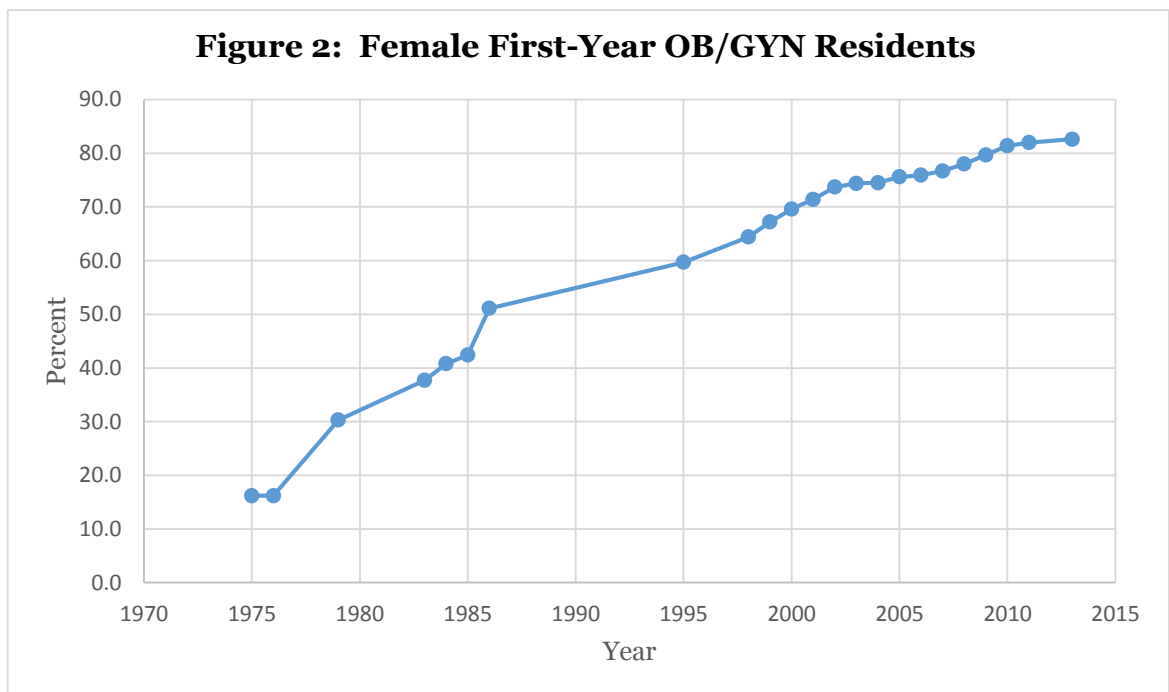
Few women have been accepted in obstetric-gynecologic residencies despite the fact that they are as capable and well prepared as their fellow male students....The rationale used to exclude them has been that obstetrics-gynecology is too demanding physically for women and that their education would be wasted because they would get married, have children and discontinue practice. These ideas have been supported by the American Board of Obstetrics and Gynecology, which has been reluctant to approve part-time or training interrupted by pregnancy-leave which is essential for women. As a consequence, an important source of highly qualified residents particularly suited to careers in obstetrics-gynecology has been excluded. (Willson 1972)

Aside from the unintentionally comic objection that OB/GYN is too physically demanding for women—despite the fact that it was women who actually labored and gave birth to all those babies the male OB/GYNs were “catching”—the intense sexism described here formed the animus for institutional policies that kept women from entering OB/GYN training programs. Following both the expansion of medical school seats in the 1970s (Cooper 2003) and the enforcement of Title IX prohibition on gender discrimination in education, these formal barriers weakened and soon approximately 9 percent annually of the large number of women graduating from medical school were able to gain residency posts in OB/GYN (Fenner 2004).

The strength of this historical opposition to women OB/GYNs makes what came next more surprising. There has been a rapid integration of this specialty: currently, 51.8 percent of active OB/GYNs are female (AAMC 2014). This shift in gender composition began in earnest in the 1980s, and since the 1990s, each year a higher percentage of women have been first-year residents in OB/GYN (see Figure 2).⁴ By 2013, 82.6 percent of all current OB/GYN residents were female (AAMC 2014), and many programs have

⁴ Data compiled from AAMC, Hayashi and McIntyre-Seltman 1987, and Seltzer 1999.

entirely female cohorts. Medical students call the field a “sorority” due to its female-heavy gender composition. As it is today, the average age of practicing male OB/GYNs is 10 years older than the average female OB/GYN (Rayburn et al. 2011a), and as the older cohorts of physicians retire over the next 20 years, the specialty will swing to become overwhelmingly female in composition. OB/GYN is not integrating: it is resegregating.



Feminization: Advancing Equality or Reshuffling Inequality?

Because of the durability of the large-scale patterns of occupational sex segregation in the American labor market, sociologists have paid careful attention to the few places where women have made significant inroads into male-dominated occupations, looking for ways to understand why integration happens in some fields but not others. Reskin and Roos (1990, 1992) and their collaborators advanced a theory of “queueing” to explain this

movement, finding a pattern across 14 case studies of women gaining access to occupations only after the fields have lost attractiveness to men. This reduced occupational desirability to men arose as a reaction to relative declines in earnings, autonomy, entrepreneurial opportunities, or availability of full-time work, or a shift in the content of work from male-labelled tasks to female-labelled tasks (Roos and Reskin 1992). Faced with labor shortages due to reduced willingness of men to accept such jobs, or by an expansion in demand for such jobs beyond what the male labor force would supply, employers resort to hiring women. Catanzarite and Strober (1993) described similar dynamics as part of their “relative attractiveness” theory, in which men choose to stay in the occupations most attractive to them, leaving only less desirable occupations open to women.

Additionally, where women do make inroads into male-dominated occupations, many researchers have pointed to persisting job or task segregation within the occupations. What looks like integration from an occupational level turns out to be “ghettoization”, where women are clustered in the lowest-paying, lowest-status jobs or specialties within an occupation (Bielby and Baron 1986, Reskin and Roos 1992). Even as occupations feminize, men retain their hold on the most desirable jobs or specialties within it.

Underlying all these social processes, according to researchers, is a nearly universal tendency to regard women and women’s work as less valuable than that of men. Thus, according to “devaluation theory”, women workers are considered less desirable relative to men and placed in the bottom of applicant queues, and occupations that substantially feminize go on to lose status and have diminishing relative wages, *because* it is primarily women who fill their positions (Reskin 1988, 1993; Jacobs and Blair-Loy 1996; Catanzarite 2003; England et al. 2007a, 2007b). When women press to enter male-

dominated occupations, men resist through exclusion, open harassment, and restricting women's advancement; where women succeed, it is only because the occupation is no longer desirable to men or because they are hemmed into low-status corners of the occupation (Reskin 1988). Thus, even though women's entry into male-dominated occupations may seem like the advance of gender equality, these gains are largely illusory: the system of sex stratification remains intact (Reskin 1988; Roos and Reskin 1992).

Two main forms of evidence support these theories: case studies of feminizing occupations (Reskin and Roos 1990; Strober and Arnold 1987) and macro-level analyses of the links between occupational sex composition and wage levels or wage returns to education across national economies (England et al. 1994; Jacobs and Steinberg 1990; Sorensen 1994). Despite the strengths of these studies, though, there are reasons to be cautious about interpreting them as evidence of devaluation theory as expressed in the "queueing" or "relative attractiveness" views. These views of occupational feminization imply predictions about how wages and sex composition will change over time: longitudinal research has found some evidence of increasing feminization being related to subsequent reductions in relative wages, but there has been little to no support for the "queueing" prediction that relative wage reductions would lead to increased feminization (England et al. 2007a, 2007b).⁵ England et al. (2007a) found, using fixed-effects models to account for unobserved characteristics of occupations, that their results were "inconsistent with the view that employers prefer men in all occupations, one of the assumptions used to generate predictions in the queueing view." Other case studies of

⁵ England et al. contrast "devaluation theory" with the "queueing" perspective, saying that devaluation theory predicts that increasing female representation in a field leads to relative wage declines, while queueing predicts that relative wage declines lead to increasing female representation. While I agree that those are separate dynamics of feminization, "queueing" seems to me to be an outworking of the same fundamental devaluation of women and their work that "devaluation theory" posits (and apparently seems so to Barbara Reskin, who developed the "queueing" concept and argues as well for devaluation theory—see Reskin 1988, 1990, and 1992).

court reporting (Jacobsen 2007) and computer work (Wright and Jacobs 1994) also find no evidence of declines in relative earnings for men predating feminization, and Wright and Jacobs also find that the entrance of women per se does not prompt the exit of current male workers.

The entrance of women may not cause current male workers to leave, but there is some evidence that men hesitate to *enter* female-dominated occupations. Applying Schilling's dynamic model of segregation (1971) to male preferences for seeking doctoral degrees by the sex composition of fellow recipients, England et al. (2007b) found that there was a "tipping point" for male entry into a field: once women comprised 24 percent of a discipline's doctoral recipients, men became increasingly less likely to enter the field. They separated out effects of salary changes and found that there was no link between salary declines and feminization (as "queueing" would predict), but that "feminization in and of itself deters the future entry of men above and beyond what is required by competition" (England et al. 2007b:35). Due to the nature of their investigation—using data on doctoral degrees by sex and assistant professor salaries—they were not able to determine *why* men were deterred from entering female-dominated fields.

We must be cautious about inferring status or desirability of occupations or jobs in the absence of specific measures of those concepts. Pay differences are easily assessed; differences in prestige or status are no less real but are certainly more subjective. Retrospectively assessing change in status or prestige over time is particularly difficult: merely stating that an occupation exhibited a status decline before feminization, based on individuals' memories or evidence of challenges to the field, risks treating the purported effect—an increasing proportion of women in an occupation—as evidence of the cause, declining status or desirability. The closest measure of the status of occupations is prestige, and the evidence on the links between occupational sex segregation and prestige

is mixed at best (Warren et al. 1998). One Swedish study that assessed occupational prestige according to the Treiman's scale and sex composition found evidence that contradicted the expectation of devaluation theory: it was gender-mixed occupations (41-60 percent female) that were most prestigious, rather than male-dominated ones. Women did, however, experience lower wage-returns to their occupation's prestige than did men (Magnussen 2009). Especially when assessing horizontal segregation⁶ by the relative status of sub-fields within occupations, we must take care: when it is reported that men cluster in the more "prestigious" or "high-status" areas of an occupation, who is determining the status rankings?

In sum, the "queueing" theory of changes in sex segregation has strong internal coherence, especially as it builds off of the devaluation perspective, but there has been little confirming evidence of its pattern outside of case studies from the 1970s. Devaluation theory broadly has quite strong evidentiary support, especially as regards wages, and could provide a theoretical explanation for why men decline to enter occupations after they "tip" towards female composition, but is considerably weaker in making sense of status or prestige in occupations. Both of these perspectives assume and predict that even when there are changes in the sex composition of occupations, women will remain disadvantaged and devalued: the sexes will remain stratified, and women will be on the bottom.

With regards to OB/GYN, there is some suggestion of status declines preceding the widespread entry of women into the profession. According to Willson (1972) above, OB/GYN residency spots were going unfilled in the early 1970s, and half of the residents filling the rest were international medical school graduates (IMGs), a potential indication

⁶ "Horizontal" segregation refers to the separation of workers into different jobs or occupations; "vertical" segregation is the separation of workers into hierarchies of supervision or authority (bosses to employees within an organization, or department chairs to staff physicians) (Blackburn and Jarman 2006).

of diminished desirability by the (overwhelmingly male) graduates of U.S. medical schools. A comprehensive analysis of the relationship between specialty status and the trends in resident composition by percentage IMG and female is beyond the scope of this paper,⁷ so for this analysis, the relationship between the relative prestige of OB/GYN and its propensity to feminize remains an open question.

The Experience of Minority Men

If you go on Labor and Delivery (L&D) wards in many big American hospitals, one of the first things you will likely notice is that you have entered an entirely female world. All the patients are women, all the nurses are women, and nearly all the visible physicians are women. Since L&D wards in teaching hospitals are typically staffed with residents working under the oversight of an attending physician, and since so many resident classes are entirely female, it is likely that the only male medical staff member you may find may be a bored anesthesia resident. For the male residents who enter this working environment, their training experience is unavoidably shaped by being members of an extreme minority.

Sociological literature offers us several expectations regarding the working experiences of small minorities. One of the most influential views of gender minorities is that of Kanter (1977), who described female executives at a large, male-dominated corporation as “tokens”, representative of their category (“women”) rather than independent individuals. Kanter focused little upon processes of gender discrimination in

⁷ I intend to pursue this analysis of the “queueing” theory as regards the feminization of specialties in the 1970s and 1980s separately. IMGs are a significant part—25 percent—of the overall U.S. physician workforce (AMA 2015); their mere presence in a specialty is not necessarily evidence of a status decline, as the U.S. medical training is highly prized across the world. However, investigating trends in the proportion of IMGs in specialty residencies and the subsequent feminization of those specialties could help illuminate the historical status and “desirability” of various fields.

hiring that resulted in so few women; she examined the interactional effects of being one of a small minority—less than 15 percent of the larger group—and asserted that some characteristic aspects of these interactions shape the performance of women at work in ways that make them seem more “typically female,” largely to their detriment. Kanter theorized that the three interactional effects she described—heightened visibility, contrast with the dominant group, and assimilation into stereotypes held by the majority group—would be true of all such minorities; she argued that it was the proportional representation that mattered, and that token groups (whether males amongst females, blacks amongst whites, etc.) would all have similar problems.

Researchers testing Kanter’s views about male tokens in female-dominated occupations have largely disagreed with her. Instead of finding that men who worked in female-typical occupations were left out of social networks, viewed as less competent, or paid less (all of which have occurred to women in male-dominated occupations), men experienced a number of benefits. Men experienced preferential hiring, positive associations with male supervisors, and were often “tracked” into areas of their occupation that were considered more appropriate for men—areas that frequently had higher status and promotion opportunities (Williams 1992; Maume 1999; Hultin 2003; Fløge and Merrill 1986). Williams (1992, 2013) described token men as experiencing a “glass escalator” effect when working in female-dominated occupations: her respondents said they felt favored by their colleagues and supervisors, as well as gaining hiring and promotion advantages. Advantages in promotion lead to “vertical” segregation within female-dominated occupations, with men clustered in managerial roles (Hultin 2003). Not all research has found this effect for male tokens, though: Snyder and Green (2008) found “horizontal” segregation rather than “vertical” segregation in female-dominated nursing. Men gravitated towards areas of practice that seemed more “masculine” to them,

leading to gender-based segregation within the field (also see Heikes 1991). Male tokens in female-dominated occupations also experienced negative effects of their position, largely in criticism, suspicion, or derogation of their masculinity from individuals outside their occupation (Zimmer 1988; Heikes 1991; Allan 1993).

Methods

To investigate the nature of changes in sex composition and gender advantage in contemporary OB/GYN, I conducted a case study of this specialty and its gender dynamics. I reviewed articles, editorials, and commentaries on the gender changes in OB/GYN from the archives of major academic medical and specialty journals over the last 40 years with data from the Association of American Medical Colleges (AAMC) and other sources on residency trends by gender. Public commentaries and research articles only provide one dimension of this story, however. To understand the attitudes and experiences of individual OB/GYNs with regard to their own gender and the effect of gender in their specialty, I conducted interviews with 51 physicians, all of whom had or were completing a residency in OB/GYN. I spoke with 22 men (43 percent) and 29 women (57 percent), and physicians ranged in age from 26 to 69 at the time of the interview, with a mean age of 43 years (41 for women, 44 for men).

Contacts for these interviews were made through snowball sampling, following personal connections to gain introductions over email, text, or in person to physicians.⁸

⁸ While a representative sample, created through a random draw of names of active OB/GYNs and OB/GYN residents across the country would have provided greater confidence in making generalizable conclusions, I quickly found that getting access to very busy physicians only worked when there was a personal introduction through peer relationships. I had no success being able to interview physicians because of recommendations from their patients; I suspect a request coming through that channel made physicians feel guarded against a breach of their professional distance and less inclined to give me their time. Instead, I found that being introduced to physicians by their friends, family, or coworkers made physicians feel more comfortable talking openly with me.

By working through networks with links across the country, I was able to speak with physicians on the West Coast and in the Southwest, Midwest, Deep South, Mid-Atlantic, and Northeast regions of the United States. Most physicians worked in mid-to large cities, though I also spoke with a few small-town doctors. The majority of physicians (34) were general OB/GYNs; the rest had or were pursuing sub-specialty training in addition to their training in general obstetrics and gynecology. Seventeen interviews were in person, in the doctors' lounges of the L&D wards of hospitals while physicians were on call, and the rest of the interviews were conducted over the phone. With permission, I recorded and transcribed all interviews. I received approval from the Institutional Review Board at the University of Pennsylvania for this study, and all physicians' names and identifying details have been changed to protect their privacy.

My interviews with the physicians were semi-structured; I asked all of them about the same areas of their personal experience—the choice to go into medicine and OB/GYN in particular, their experiences as a man or woman in training and practice, their choices about practice setting, the interactions between their work and private lives, their concerns and plans for the future—but I attempted to let the physicians lead the conversations as much as possible. I wanted to hear their thoughts in their own words, reflecting what they saw as most pertinent to their individual experiences, and then I followed up on repeated phrases and key themes to work inductively toward a theoretical understanding of categories, patterns and relationships, as described by a grounded theory approach to data analysis (Glaser and Strauss 1967).

Results

Unopposed Entry?

The first and most surprising thing to emerge from the interviews was that—despite the strong sexism reflected in the American Board of Obstetrics and Gynecology’s (ABOG) resistance to female residents in the 1960s and early 1970s—the oldest female physicians did not report much if any gender discrimination in the course of their residency training. Dr. Taylor, who entered her residency in 1979, described her OB/GYN residency in a way that was typical of other same-age women in the study:

Dr. Jean Taylor: I was our third female resident....So I certainly wasn’t the first one, but the first of a very few, the second one in our residency to have a baby during residency. And I never really felt like I wasn’t welcome there at all....When we made rounds with the staff, it wouldn’t be unusual for [the patients] to call me back at the end and ask for the bedpan or something like that. But no—not too much [different treatment] from the physicians. We were—we obviously worked every bit as hard and still do. No, I don’t think we had any real problem with our staff at all, either OB/GYN or other people in the hospital.

Asked if they thought there was a reason why so few women had entered OB/GYN in the years prior to them, they also did not point to institutional or personal gender discrimination in residency programs. Instead, they pointed to the low numbers of women graduating from medical school and said that the intense lifestyle required by OB/GYN practice probably deterred earlier women.

They did not feel the same way about their exposure to surgery during their medical education. Dr. Driscoll described a typical experience for senior female physicians:

Dr. Gayle Driscoll (female, senior): Well, there was definitely a little bit more of an opposition to women in surgical specialties when I was training. And actually, before I went to medical school I was doing some surgical assisting in a community hospital...and that was really ripe with disgusting sexist comments....I’ll never forget one of the old doctors, when he found out that I wanted to go to medical school, said, “Why would you do that? Any woman in medicine is either totally fat or ugly as sin,” or some ridiculous comment like that....Even when I went to medical school, they were sort of looking at women like, “You better not be taking a seat that some man could have occupied.”

Asked about such experiences in her OB/GYN residency at a prestigious academic hospital, she said, “No, no, I never felt it there. Like discrimination, or looking down upon me or something? No. I never felt that at [my residency hospital]. I mean, in the world, yeah, a little bit...but it wasn’t huge in my personal life.” Many women in the study mentioned

This lack of structured resistance to women entering OB/GYN is unexpected, and there are several possible explanations for it. First, it is possible that the women I interviewed were simply lucky; the experiences of other women may have been much more difficult. Second, even my oldest female respondents were entering a specialty that at least some women had joined before; perhaps the most intense resistance was felt by those lone pioneer women a generation before them. Certainly, though, virulently sexist resistance to women remained characteristic of general surgery and its subspecialties for decades later (Cassell 2000; Conley 1999); why was it different in OB/GYN? Given the history of OB/GYN—that its claims to professional authority over women’s reproductive care were established largely by driving female midwives out of practice (Wertz and Wertz 1989; Leavitt 1988; Ehrenreich and English 1973) and that feminist critics of OB/GYN at the time described it as the headquarters of global patriarchy (Daly 1978, Scully 1980, Pringle 1998)—one might expect even greater resistance to women in OB/GYN than in other fields.

Asked about resistance to women, Dr. Bratten points to one of the central features of the current gender dynamics in OB/GYN.

Dr. Mary Bratten (female, senior): Definitely it had already started changing from predominantly male to predominantly female right about the time that I was training. But I don’t really recall any particularly negative reputation [about OB/GYN]. Before that, there wasn’t a whole lot of choice [of practitioner], because there weren’t that many women in medical school. So I think that probably just with the admissions [to residency], they knew that that was going to be the way it was going to be. And a lot of women at that point in time wanted female OB/GYNs, too, whereas a lot of the older women thought it was weird to go to a female gynecologist, because they had always been to a man. And then the younger

women coming up all wanted female gynecologists. I think it was really hard, even when I started, for men to start a practice, because so many women wanted to go to women....Everyone, I think, sort of saw the writing on the wall. [laughing] Really, I never had any negative experiences with other physicians or faculty, or—it was all very positive.

Dr. Bratten's assessment—that there was little resistance to women who gained entry into OB/GYN residencies because of perceptible patient demand for female OB/GYN practitioners—both clarifies and further deepens the mystery of the difference in women's experiences between surgery and OB/GYN. Unlike in surgery, where there was little gender-specific market demand, at least some potential OB/GYN patients actively preferred to see women providers but had been denied that opportunity.⁹ Following much of the literature on male resistance to women entering a male-dominated profession, though, one would still expect to see more effort to protect market share on the part of men in the specialty. After all, given the patient demand for female practitioners, increasing the number of female OB/GYNs meant opening the field to direct competitors for male OB/GYNs' current patients.

Women in Demand

Every respondent asked about gender dynamics remarked on the asymmetrical demand from patients for female OB/GYN practitioners. For mid-career and especially senior physicians (those who graduated from med school before or during the 1980s), this was one of the most prominent changes in their field over the course of their careers.

Dr. Jean Taylor (female, senior): [I began practicing in the 1980s with] one male partner. He was very fair to me as far as starting out in practice. I remember we tried to do

⁹ There are more avenues for research regarding this comparison between OB/GYN and general surgery and its subspecialties. One of the most often repeated explanations of why women have made so little inroads into surgery is that the "lifestyle" is terrible and incompatible with having a family (for women). Obviously, at least in the 1970s, this was also true of OB/GYN, yet it rapidly began to feminize. In future work, I intend to investigate more deeply what the relative status of the two fields has been over the last several decades: if surgery was considered the highest prestige, best-paid area in medicine—an anecdotal information suggests this was so—then its desirability to men may be a key reason why men resisted women gaining access to the specialty, using means of formal discrimination and informal harassment.

our own deliveries during the day...and then nights we took call for each other. But at that point in time, there was—a lot of my draw was being a female. On that side of town, I was the only one at that point in time, and I got busy very quickly, and so there was a lot of patients who weren't crazy about me turning them over to a male. That's why they had come to me.

Dr. David Meier (male, senior): There were still more male OB/GYNs than female OB/GYNs so it wasn't that weird yet [when I started practice in the early 1980s], and I was a specialist, I wasn't just—so I can't say that those issues became prominent in that point in time. It was perfectly fine, it was perfectly comfortable. I was comfortable with the female OB/GYN docs. I was a little jealous of my same-age partner who had joined the practice and I hadn't seen since the elementary school—we'd gone to kindergarten together, and I had known her forever, and yet she was...for a guy I was really popular, but she was even *more* popular because at that point and time she was a smart, cute—smart, good doctor woman. I was very jealous of that and I don't think it's—I knew she wasn't a better doctor than I was, but I did know that there was a demand for her services.

Dr. Robert Kahn (male, senior): [My practice] stayed the same, until just a couple years ago. Probably about the time I turned 65, the number of OBs [obstetrical patients] started to drop off. So we've added young, new partners, and they're female, and a lot of the new OBs prefer to go to them.... A lot of my practice has aged with me. There's a lot of my patients that have never seen a female doctor. In part, I probably have fared better than some guys who joined us 15 or 20 years ago. I'm busier than they are. It's just that I am still seeing patients that I saw my first week in practice.

Dr. Frank Biondi (male, senior): And the males who are older have seen a tremendous decline in their OB practices....I know a bunch of practices where the male doctors who are in their fifties and sixties—unless it's one of those practices where it's like a hospital practice where everybody gets patients assigned to them irrespective of a gender—a lot of these males—call 'em dinosaurs, you know—their practices are falling and fewer men are going into the field. I think that it's a trend that is—first of all, I think it is a trend that is not alterable. I don't believe that either from the patient perspective that gender necessarily always is a determining factor in either women's acceptance or quality of care. I have known men—and I would put myself in that category—who are sensitive and caring and gave their heart and soul for their patients and the patients loved them, patients are all women patients and patients love them and it didn't matter about the age of the patient.

Dr. Lisa Tennant (female, mid): I think it's great. I think patients really sometimes have a strong preference for a female provider. I don't personally have a strong preference for a female provider and I don't think it takes having a baby to deliver a baby or having a uterus to treat—I don't necessarily think that, but I think patients like it. I think females do have naturally some empathy and sympathy and make good providers for that in certain specialties.

Dr. Abby Garfield (female, mid): And so I was the first female to join [our group private practice]....I mean usually the first few years in private practice you're working late, you know, just doing a lot of extra stuff around town to try to drum up business. But you know for me, I mean, I walked into a totally busy practice from day one. I mean that was obviously really nice for me. You know my partners are kind of half, "Gosh that's not fair, why do all the new patients want to see her?" versus, "Wow, this is really nice! You know, we don't have to subsidize your income because you're actually earning it yourself."

...But when I [started practicing] there were maybe 3 or 4 other female OB/GYNs in town and they were all much older. I mean it's so easy to build up a really full practice. I mean, that's been my main practice struggle in private practice has been to get some sort of control over this out-of-control schedule. That you no matter you know what I say, there are always more people added on to the schedule, and we are always here super-late. And there's you know just always a full waiting room of people waiting. It's a good problem to have, if there's a problem to have. But that's you know been the constant challenge over the last 10 years is to try to get some sort of control over how busy we are.

Regardless of when they began their medical careers, no female respondents reported any difficulty drawing enough patients to sustain their general OB/GYN practices, and many, like Dr. Garfield and Dr. Taylor, described clear benefits of being women physicians. Also like Dr. Taylor, many of them reported struggling with an excess of demand for their services, which both created scheduling problems and frustration on the part of their male partners and colleagues, who had noticeably fewer patients seeking them. Senior male physicians reported no problems establishing their own practices, but like Dr. Kahn and Dr. Biondi mention, they all noticed with irritation or resignation that patient demand for male physicians has noticeably declined in recent years. For the most part, this did not affect the careers of older physicians, who had established, long-term patients and referral networks; as Dr. Kahn says, they tend to do more gynecologic practice, on patients who have aged with them and are now menopausal or post-menopausal. But they drew fewer new, young obstetric patients, and observed younger male physicians having even more difficulty in doing so.

Having this lived experience of asymmetric demand—either as a benefit (for women) or a frustration (for men) made a deep impact on mid-career and senior physicians. Many of them reported that they saw this as an increasing trend, rather than something that has already reached its equilibrium, and they had very negative outlooks on the future of men in general OB/GYN practice.

Dr. Karen Simon (female, senior): And the guys who go into OB at this point, I mean they're a dying breed, you know. They're just there are not many men who go into just obstetrics....It's not a field for men anymore, it really isn't. Why do I think that has come about? Because we women got to go to medical school finally, and women prefer to see women, I mean really, pretty much, yeah. And then a lot of the men are good. I've [worked with many and] a lot of the men are quite good but it's just not—there are just not a lot of them left.

Dr. Anna Martin (female, mid): A guy would be crazy to be a generalist, I would think....Most aren't generalists, because women aren't going to want to go. It just makes more sense. A woman is going to know a woman. I am a much better OB because I have a kid. I almost don't think I would go to an OB who doesn't have a kid, because I feel like my entire—everything about [the way I approached my practice] changed completely [after

giving birth].

Dr. Martin Fell (male, senior): They're told that it's harder for them when they're starting out. And it is. I see the young guys who are starting out their practices—it takes them longer to get established. And I think men aren't used to being the underdogs in a discipline, so they find disciplines where they're not gonna be the underdogs. I mean, that's the reality of it. I think when I was starting off, I could—I could sense that it was taking a little bit longer....I mean, I think that some guys do struggle with it a little bit more. And I think it's harder nowadays for some of those guys.

Dr. Michael Haberlin (male, mid): That is still in my mind now....I don't think of it as reverse discrimination; it's just, out in the public, a lot of young women prefer female doctors. And that's just the way it is; there's nothing I can do about it, not at all....I do think I probably do have to work harder. I think that is a bit of a negative, as far as I'm a young, white, male OB/GYN. And so I do have to work harder to get new patients. But like I said, I don't—no one's really is at fault or anything like that, it's just kind of how society is now.

Several junior or mid-career men mentioned being warned off going into general OB/GYN practice (consistent with Schnuth et al. 2003), and mid-career and senior physicians of both sexes described speaking frankly to male medical students and residents about their assessments of their constricted career prospects.

Dr. Mark Phillips (male, junior): Yeah, I definitely remember hearing people say that [I shouldn't go into general OB/GYN]. Not a lot, really, but I definitely remember hearing that from a couple of folks along the way that were older or maybe they were faculty...expressing concern that as a male OB/GYN starting a practice or joining a practice out of training, you might have a harder time building your practice.

Dr. Max Fisher (male, mid): I think they're just concerned that if a male person goes into OB/GYN, that they'll be limited, that they're going to have less options for their career choice in the future. I think it's more of a warning to those physicians that they may not be as desired in certain areas. If they're going out into the rural community and it's an underserved area then it's not a big deal. If they plan to go to an already-saturated city they're just not...most existing practices don't want a male who's going to take a lot longer to fill their practice and a lot longer to become profitable when they can hire a female who will instantly fill. Because when the patient calls they're going to ask for a female and if they hear it's a male, they're just not going to be as interested. I think that's the main thing is warning that they're limiting...they may be limiting their potential.

I think it's definitely a legitimate concern, [having seen] from residents that have graduated which job opportunities they were getting and where they ended up is just...it's not all-or-nothing, but it's certainly a trend. There's definitely that bias; it's a fact that when a patient calls a practice...I know that the female physicians, even if they're not even known, [the patients] hear the word female or male and...they say, "Doctor I really wanted to see a female." [Women] fill their practices and they build practices much, much quicker.

It is important to note what the key aspect of the warning to young male would-be general OB/GYNs: it is not that they will be unable to get a job, or that they will not be able to be esteemed among their colleagues. It is that their "potential" will be limited by their inability to draw a full practice's worth of patients right away in their careers. This

concern is largely about money: older physicians warn younger men that they will make less money than their female colleagues because they will have fewer patients, and men are less desirable as hires to existing group practices because it takes them longer to become profitable, as is reflected in Dr. Fisher's and Dr. Garfield's statements above.

In fact, this perception of demand for female OB/GYNs paired with the increasing proportion of female OB/GYNs graduating from residency has led to the development of all-female OB/GYN practices. Many practices are marketed to patients as all-female as an advertising strategy, as evidenced by the Virginia practice "All Female OBGYN LLC" and dozens of others accessible through a simple internet search. Hiring discrimination clearly exists in this realm, though here the discrimination runs in the direction opposite from the historical medical preference: men are removed from contention from jobs, and women are advantaged. There have been a few suits claiming violation of federal anti-discrimination laws either in hiring or termination (Lewin 2001), but the courts have yet to determine whether sex discrimination in hiring of OB/GYNs constitutes unlawful discrimination or is a bona fide occupational qualification (BFOQ), and thus an exception (Waldman 2004). On internet discussion groups about medical jobs and careers, there are many further assertions that men also offered less money for starting generalist OB/GYN jobs in private practice groups, also because it is presumed that they will take longer to have profitable practices (StudentDoctor.net 2009). Though they point to no sources of compensation data that confirm this fear about reduced compensation, the perception of it appears widespread across medical student and resident forums.

Perceptions and Reality

This information pathway makes for a very strong feedback effect from perceived

demand onto the development of the supply of male OB/GYNs, due to information lags inherent in the structure of medical training. First, medical students make their choices about which specialty to pursue (and for which residency programs to apply) 4 to 8 years before the point when they would be actually seeking a job in OB/GYN or a related subspecialty: this means would-be OB/GYNs choose their employment track long before they have any close exposure to the actual market for them as physicians. Second, there appear to be limited trustworthy resources upon which medical students and residents draw to make broadly-informed decisions about specialty choice. The internet provides many discussion forums sharing a mix of insider knowledge and biased anecdotes and stereotypes; in addition to those sources, there are bland official sites from the AAMC and various specialty organizations that provide salary averages and very general descriptions of specialties' work and practice settings. Physician recruiting companies also often list job openings online, hoping to draw doctors to use their services.

From my interviews, however, it seems that students and residents get almost all their information on specialties from the physicians they see on their clerkship or residency rotations. This myopic approach is perhaps understandable, given that both medical students and residents are intended to learn about specialties and sub-specialties by doing their work, but it also means that the opinions of physicians closest to residents and med students will have outsized effects on their picture of the medical market.

OB/GYN leaders have tried to counter this echo chamber effect through deliberate efforts to recruit men. After 2004, a year in which only 65 percent of OB/GYN residency positions were filled by graduates of U.S. medical schools, and 7 percent of spots went completely unfilled, the Association of Professors of Gynecology and Obstetrics (APGO) and the American Congress of Obstetricians and Gynecologists (ACOG) developed a recruitment task force to spur interest in their specialty. In order to remedy the sense that

“in our attempt to attract women to the field in the 1980s and 1990s, we had inadvertently sent the message to male medical students that there no longer was a place for them in obstetrics and gynecology,” APGO developed a “recruitment playbook” with explicit strategies for encouraging male medical students to pursue careers in OB/GYN (Bienstock and Laube 2005). To faculty, residents, and nurses working with male medical students, the playbook noted that:

- Physicians overestimate the impact of provider gender on patients’ comfort with their care
- Males are openly discouraged from choosing Ob-Gyn more often than women
- Most patients, however, do not rate provider gender as highly important
- Physicians may unwittingly sabotage male students’ experiences because of their belief that women prefer female physicians (Erickson et al. 2005)

To spread their message of welcome to male students, the playbook advised that male attending physicians try to be positive role models and that department chairs and nursing leaders distribute “fact sheets summarizing literature regarding the impact of provider gender on patients’ comfort with their care” (Erickson et al. 2005). Perhaps unsurprisingly, these efforts have not changed trajectories of declining male entry into OB/GYN.

Part of APGO’s underwhelming efforts to counter the idea that patients do not want male providers was emphasizing survey studies that purport to show that patients do not really prefer that OB/GYNs be female above all other characteristics. Howell et al. (2002) found that only 34 percent of their sample of women preferred female physicians, while 7 percent preferred male OB/GYNs. But Howell et al. used a small convenience sample (67 postpartum patients in one hospital), which seems highly likely to be skewed by timing of the study, if not by the non-representativeness of the sample. These women had just experienced what was likely the most profound obstetric event of their lives; they were likely in a much different emotional place with regard to their OB/GYNs than when

they were choosing a physician for a Pap smear or a pregnancy test. Likewise, Plunkett et al. (2002) concluded from their convenience sample of postpartum and post-gynecologic-surgical patients that only 25 percent of respondents listed gender among their top 3 important factors in physician choice, so it was not of “primary importance”. When asked directly, 52.8 percent of their sample said they preferred to see a female physician. Other research using data from the 1990s found comparable results: about 40 percent of sampled women prefer a female OB/GYN and 10 percent prefer a male, while 50 percent want a “good” doctor (Chandler 2000). To be fair, though, even with the limitations of these studies, it seems clear that patient preferences for female providers are neither absolute nor universal.

Male medical students often have more than just the word of older physicians to go on regarding experiences of gender discrimination in OB/GYN, however. On their clerkship rotations through OB/GYN, many students have the experience of having patients refuse to allow them to be present or participate in an examination or a procedure, and this is more likely to happen to male students than females (O’Flynn and Rymer 2002). The experience of being asked to leave examinations has a double effect on male medical students: first, they have fewer opportunities to learn and practice how to perform pelvic and breast exams (Powell et al. 2006), and second, male students have a tendency to presume that they are being excluded because they are male versus being excluded merely because they are medical students: that is, male students’ perceptions of their own clinical deficits and of the degree of preference for female providers tend to be exaggerated (Emmons et al. 2004).¹⁰ Regardless of how well-founded their concerns are, male

¹⁰ More specifically, Emmons (et al. 2004) found that 78 percent of male medical students felt their gender adversely affected them on their OB/GYN clerkship, while 67% of female medical students reported feeling that their gender had a positive effect. Students who perceived a positive gender effect reported higher involvement with procedures, but all groups performed adequate numbers of clinical elements to meet the clerkship standards.

students are much more likely to perceive aspects of gender discrimination on their OB/GYN clerkships, and that perception has an effect on their interest in pursuing OB/GYN as a career (Nora et al. 2002).

Routes for Men

Given such discouragement, it is perhaps surprising that any men pursue OB/GYN as a specialty. Yet many still do, even if their numbers are smaller each year, and those that choose to enter OB/GYN residency programs do so largely for the same reasons that women give: they love the work. Across all my interviews, physicians of both genders said that it was the content of OB/GYN, specifically the mix of surgery and procedural work with office-based primary care and long-term patient relationships that drew them into the field.

Dr. Diana Porter (female, resident): I wanted to do primary care, and then I fell in love with surgery during the surgical rotation....[But] one of the reasons I struggled with surgery was they were very much like, "Oh, we'll leave the medicine to the medicine people," and I really loved medicine.

Dr. Helena Sydney (female, junior): I just really like being in the OR, and I like the sort of tactile process in doing cases and the start and the end. I just really like that. I like it more than just managing medications. So I felt like OB gave me a little bit of the longitudinal relationships, with some elements of managing medications and patient relationship and all that stuff, but it also gave me the opportunity to do surgical procedures, which is what I really wanted.

Dr. Nate Ashton (male, resident): [Thinking of what drew me to OB/GYN,] probably the main things were it was one of the only specialties I found where you could do both primary care and a good amount of surgery. So you could do a lot of good clinic stuff, but you could also get a lot of good surgery and procedures. It was one of the few specialties that's really pretty well balanced that way.

Dr. James Wayne (male, resident): It was sort of like love at first sight. In the first week of the rotation I was on a clinic block where I bounced between different offices, and different subspecialties within OB/GYN, and immediately got taken with the variety of it, and based from the practice perspective of the skills that you need and the things you get to do, but also and more importantly, for the things you get to help people with. It felt sort of limitless, whereas most other medicine felt like you had to sort of pick your area of one part of the body that you really were going to specialize in, in order to make your way.

Dr. Micah Chang (male, junior): [I starting thinking of OB/GYN] probably in my senior year in medical school. Most people, I think, would say that for women's health, most women would prefer a woman provider, and also everybody knows about the litigation, the

malpractice around obstetrics, and the hours. All of those things are kind of general knowledge for medical students, but practically speaking it didn't seem like a practical specialty to pursue, and I kind of always just left it to the side. The problem was I always enjoyed it when I had a rotation in it, and a lot of the people I looked up to as attendings and senior residents were OB/GYNs. At the very end, that's where you have to submit and finalize all your applications for choosing a specialty program. Two months before the deadline I kind of had a crisis, and didn't know what I wanted. I tried doing an OB/GYN rotation, one more time...So I did it again, and loved it, and I thought, you know, I might as well make an emotional decision with what I felt like I loved. I never looked back. I believe it is what I was meant to do.

Dr. Daniel Krieg (male, resident): OB/GYN wasn't on my radar at all. I was going into surgery. I really wanted to do something surgical so I joined elective surgery interest groups and did some shadowing in different surgical subspecialties, and I think the thing that made up my mind was that surgeons often don't really have like long-lasting relationships with their patients. So, you know, for most surgeons it's like there's a problem and then their patient's gone, or it's like they see them once a year to say hello and follow-up on like some things—I didn't find the relationships as strong. But in OB/GYN you get all the surgeries and you also get these really intense relationships with people that are pretty long-lasting, so that's what attracted me to it.

Dr. Ari Nahum (male, resident): I went into it with an open mind. I loved every single part of it because there was surgery, there were emergencies! There were babies! There were baby emergencies! Just a little bit of everything.

Despite the appeal of the variety of practice within OB/GYN, many men who begin residency programs are channeled toward subspecialization within the field. The four main subspecialties—maternal-fetal medicine (MFM, or perinatology), reproductive endocrinology (REI), gynecologic oncology (GYN-ONC), and urogynecology (URO-GYN, or reconstructive pelvic surgery)—each requires additional training in fellowship programs lasting 3-4 years beyond the OB/GYN residency. Fellows earn modestly higher salaries than residents¹¹, but given then high debt levels many residents are carrying from college, medical school, and often residency, deferring the start of their practice for further training requires a significant financial sacrifice at the time (Lu et al. 2004; Gerber and Lo Sasso 2006). Once in practice, though, OB/GYN subspecialists have both higher incomes and a more controllable lifestyle than generalists, though they lose the diversity of practice that initially draws many doctors to OB/GYN.¹²

¹¹ See University of Pittsburg Medical Center for a typical scale: <http://www.upmc.com/careers/GME/Pages/benefits.aspx>, accessed 3/5/16.

¹² MFM physicians essentially practice only obstetrics, and many base their practices around consultant ultrasound evaluation of pregnancies rather than taking on their own patients. URO-GYN is entirely

Typically, young male OB/GYN residents are advised to seek subspecialty training to protect themselves against the perceived lower demand for their generalist services.

Dr. Robert Kahn (male, senior): Most general OB-GYNs are female now. The men that go into it tend to go into a subspecialty, like oncology or maternal/fetal medicine. Mostly, it's because the women know that there'll be enough patients without going and getting an advanced subspecialty. And I think they guys recognize that unless they've got an advanced subspecialty, they may not have enough business to be very successful.

Dr. Martin Fell (male, senior): And most of the guys go into fellowships just because they feel like they need to do something else that makes them stand out more.

Dr. Ari Nahum (male, resident): One of my attendings said, "Hey, you should go to subspecialty, you'll get a constant stream of patients in, because a lot more women are trying to get [general OB/GYN] doctors that are female."

Dr. Mark Phillips (male, junior): I really banked on doing a fellowship, so I never really spent too much time thinking about that....A lot of time even in something like OB/GYN, where I guess a lot of patients would prefer to see a female for whatever reason, by the time you get to this [subspecialty] stage, I find that the patient doesn't really care so much about gender anymore, and they just want to go to the best doctor or the nicest, or...in our case, where the best pregnancy rates are, etc. So it's less about gender once you get to the subspecialty level.

Because doctors perceived that physician gender mattered less to subspecialty patients, they thought (and were often told) that seeking subspecialist training made men more marketable than they otherwise would be. This combination of factors—the eventual financial and lifestyle rewards of subspecialty practice, men's perception of barriers to them in generalist practice, the opportunities of fellowship training—is resulting in a disproportionately high number of men entering OB/GYN subspecialties. In recent years, men have been 50 percent more likely to subspecialize than their female co-residents (Reyes 2007a).

The decision calculus about subspecializing is often different for women. As discussed above, they are appealing hires directly from residency into generalist practice, and women also often have family obligations that curtail their ability and willingness to

gynecologic surgery, and REI is exclusively lab- and office-based, as it is focused upon infertility treatments but refers patients to other OB/GYNs for the management of their pregnancies. GYN-ONC does include both surgery and medicine (chemotherapy), but does not practice obstetrics.

spend yet more years in training.

Dr. Christina Mikkonen (female, mid): I can give you an example. One of the residents here would make an outstanding subspecialist. She's smart. She's professional. She would really [be great], but it's three extra years of training. And she has four kids together with her husband, and so she can't do this because she doesn't have enough support and she needs to start working to support the family.

Gerber and Lo Sasso (2006) point out that there are trends toward specialization for both men and women in OB/GYN, but the trend is smaller for women; paired with the reduced numbers of men entering OB/GYN residencies, this results in a strong clustering effect of newly-trained male physicians in OB/GYN subspecialties. Indeed, even among my unrepresentative sample, significantly more men had or were pursuing subspecialty training: 62 percent of men versus 38 percent of women had opted for that career path.

Because subspecialties require more training and pay better, the concentration of men in them relative to the rest of the specialty suggests that, like in other occupations, men are disproportionately found in the areas of highest status or prestige. None of my male respondents offered on their own that they chose to specialize in order to join a higher-status or less female-dominated niche of the field, and when asked directly if those factors influenced their choice to subspecialize, male respondents gave different answers. Dr. Noah Berg (male, resident) said, "No, no, no—that's mainly me thinking about my personal future. What I want to do with my life, less about [being with] more men or women." Another male subspecialist was more equivocal:

Dr. Mark Phillips (male, junior): Well, maybe. Not a significant role, but yeah. I definitely remember thinking at some point, the thought of having a chance to have more of a sort of equal number of guys, or more guys to be around, or more guys to work with would be nice, at some point. And in fellowship, sort of the higher you go up the ladder, the more subspecialized you get, the more the gender ratio sort of equalizes...It's fun in different ways.

Regardless of their conscious motivations for pursuing subspecialty training, though, the effect is very similar to what Williams (1992) describes as the "glass escalator": in encouraging men to pursue these subfields, men were "tracked" into better paying and

more prestigious specialties” (257). What is novel about male OB/GYNs’ experiences, though, compared to those Williams describes, is that men are encouraged away from general OB/GYN practice not because being an OB/GYN is seen as incongruent with masculine identity—recall that nearly 50 percent of actively practicing OB/GYNs are still men, and they are still surgeons—but out of fear of discrimination and diminished career and income prospects.

The Benefits of Being Male

Being encouraged to subspecialize by more senior physicians cuts both ways for male OB/GYN residents: it is a response to a source of disadvantage (the perception of diminished job prospects due to higher demand for female generalist OB/GYNs), but its effect is to lead to a pattern of gender advantage (men willing to go into OB/GYN become clustered in subspecialties). In other areas, being one of the few males in OB/GYN seems to bring distinct advantages.

Men may have disadvantages in starting positions for generalist OB/GYNs, but in an earlier market—the one for spots in residency programs—many physicians reported that being male made them much more desirable to programs.

Dr. Daniel Krieg (male, resident): Going into OB/GYN everyone was like, “Oh, you’re a guy, it’s going to be great!” Like, most of OB/GYN is women, so you’re going to be able to go wherever you want because everyone wants guys in their program and basically it’s like affirmative action for a residency program, because all the programs are mostly women. And historically OB/GYN was a very male-dominated field, like all the leaders in the field, all of the old-time trainers were all men, and now there’s a swing to much more female providers. So I had everyone telling me that. And honestly I felt that on the interview trail, very much so. Like my interviewers telling me, ‘Oh, you’re a guy. You’re going to be set.’ So sure, that was nice to hear.

Dr. Micah Change (male, junior): So the preponderance of residents now are women. So for men, that’s been awesome, because it means that we’re—you know, all programs want a balance. So we are kind of given this advantage now, that is kind of a turn, and now we’re the ones that are sought after for our gender. We definitely aren’t complaining, and it’s kind of nice to be that novel, different one. For me, it’s been a really good experience.

Additional evidence also supports this idea that men benefit from positive discrimination in residency selection. A study of resident application qualifications found that men and women had similar scores on the medical licensing exam, but that male applicants were less likely to have received honors in their medicine and OB/GYN clerkships (Brandt et al. 2013). The researchers interpreted this as greater interest in OB/GYN on the part of women students, but it is equally likely that the scarcity of male OB/GYN applicants meant that the bar for their acceptance was set lower.

Several female physicians also noted this preference, without complaint: Dr. Christine Sun (female, mid) mentioned that, “our residency program director tries really hard to have as many guys in the program as possible, and the most we get is, like, two guys out of a class of nine. And we’re usually happy to [have even that many].” In addition to wanting men for “diversity”, there is also a suggestion—never directly spoken—that male residents symbolize program status. As Dr. Cynthia Becker (female, mid) remembered of her residency, “It was probably one-third guys to two-thirds girls, and in some classes 50-50. We were really academic, and our chairman insisted on having males.”

Consistent with the critiques of Kanter’s (1977) theory of gender-neutral tokenism (Zimmer 1988; Williams 1992), male residents seemed to generally derive benefits from their scarcity at work. Several of them reported feeling like things were better for them than for female residents:

Dr. Ari Nahum (male, resident): I just know that watching all my co-residents, I can tell you that being a guy makes it just a little bit easier, especially in the most challenging environment, which is L&D, which is mostly all women. I think we have *one* guy who works there and he’s a tech...I mean all the L&D nurses, some of them having been doing this for like 35 or 40 years. Although all of them are really nice, when new people come in, especially other women, the new residents that are women...will have a harder time to establish their—I don’t want to say dominance, but establish themselves as coworkers. For the guys, it’s been way easier....So as a male, I haven’t really had any issues. I think it’s actually easier for men in this field, at least in residency, to make it through as long as you’re kind.

Dr. Andrew Lee (male, junior): During residency itself, I think it helped being a male, because, you know, first the relationship with other residents. I think on average, ok, sometimes females have difficulties dealing with other females, and sometimes it's good to just have someone that maybe has a little different perspective. So sometimes, in the personal relationships among residents, it helps in that regard.

In terms of the relationship with faculty, do I think I got more special treatment because of being a male? Maybe. Possibly. You know, I like to think that maybe it's because of my performance, but I would definitely say that maybe some older female OB/GYN attendings—I mean, I know a few that really saw me as like a son figure. So maybe they were a little bit easier on me or, you know, they gave me a little bit more attention....I know that a couple of [my co-residents] always say, "Oh yeah, you know Andrew would get the special treatment because he's a guy." So I heard that probably at least 10 times...And I could definitely see that sometimes I would get preferential treatment...but obviously you have to be competent and know what you're doing. But I think with all things being equal sometimes they were a little bit easier, I think, on me.

Lest we be tempted to think that Dr. Lee's statement about females having trouble getting along with each merely reflects a personal, sexist view, it must be noted that this benefit of having male residents and physicians was mentioned, unprompted, in at least a third of the interviews. Both men and women reported preferring a "healthy mix" or a "balance" of genders at work, and they wished that more men would go in to OB/GYN.

Female residents tended to agree about the beneficial treatment given to male residents, too. As described by both research about the sometimes-strained relationships between female doctors and female nurses (Gjerberg and Kjolsrod 2001; Galvin et al. 2015) and studies of male tokens (Heikes 1991; Floge and Merrill 1986), some female residents reported more positive interactions between males and other medical staff:

Dr. Kelly Nehare (female, resident): I think they actually get a bonus. Because the working environment for them is so much nicer. Like, nurses love them—you know, it's bad that, like, women don't want to be bossed by other women, especially women that are younger than them, because residents tend to be young and nurses tend to be older, so that never works well. So the boys have an easier time working, and the patients also—even though there are so many women in medicine now, they still assume when women walk in and you're young and you're their doctor, they still think that you're the resident, whereas with men, they'll say, "Oh, Doctor So-and-So!"...I don't know. I think there's actually—there're bonuses for them in OB/GYN. I don't think they're suffering.

Dr. Diana Porter (female, resident): I think if you talk to any single female in my program, they'll say that the men get away with a lot more than the female residents. They'll do more surgeries. They're able to get out of more call. I think if you break down the numbers in my class of who's done the most hysterectomies and major cases, John has done the most by far. A lot of it's just luck. He always happens to—it's an ongoing joke that he's in the right place at the right time. So maybe if he wasn't a boy, and he just happened to be where he was he would still have similar numbers, but it's pretty crazy actually.

Not all female residents suspected that their male colleagues received better treatment, but none of them thought that their token status was a drawback for the male residents with regard to their colleagues:

Dr. Isabel Minami (female, resident): I think they like it! [laughing] I don't know. Maybe it's just the personalities of the two we have left, but I think they enjoy it.

Dr. Kristen Marks (female, resident): So, it's funny. One of our guys is married and he's expecting a kid, but I feel like he just loves attention from women, 'cause he's perfectly happy. One of the other residents, who is one of my favorite people—I love him. He's an amazing doctor, he's an amazing resident. He's just so sweet and earnest and just fits in really well. And then the one who's in my class is kind of like our pet. We just think he's like a cartoon character and hilarious. So I think it's probably pretty fun to be a guy in a female-dominated field. You're like—you're like this specimen that everybody pays attention to.

Furthermore, as was noted in some of the research on gender preferences for OB/GYNs mentioned above, a minority of women seem to prefer to see a man for their reproductive health care. For some of their male providers, this means that their token status is an advantage in drawing those patients. Asked how he feels about being a male in a female-dominated occupation, Dr. Adam Hasan (male, mid) said, "It's fantastic. Because when you're the exception to the rule, you tend to shine more. It's great for business for me." The same processes and expectations that make male general OB/GYNs devalued in some domains also make them special:

Dr. James Wayne (male, resident): I think it's been great. I actually think it's part novelty value, and part—I think there are certain patients that just really prefer male OB/GYNs...It's something that I really like, because being a man that's invested in women's health...I think it makes me really excited to be part of that. I think that my enthusiasm for things—I don't want to generalize, but I think my enthusiasm as a man is probably more than it would be if I went into this as a woman. Part of what draws me to it is that it's special to be a man who's working on women's health issues.

In sum, unlike Kanter's predictions of negative effects from "tokenism", male OB/GYNs generally benefitted from the increased attention and differentiation they experienced, at least in residency placement and in interpersonal interactions with nurses, supervising physicians, and co-residents.

Gender and the Gynecologic Exam

Still, even if male resident “tokens” experienced positive interactions with fellow medical staff, they still had to navigate interactions with female patients, who, as described above, often interpreted the distinctiveness of male OB/GYN trainees in a much more negative light. Just as in medical school, male residents were often refused by patients, though the physicians who were undaunted enough to proceed into OB/GYN generally took this much less personally than do medical students generally.

Dr. Daniel Krieg (male, resident): Every once in a while you just get a woman who says they prefer a female provider, whether it’s because they’re Muslim or whether they just want to, but that’s not a big deal to me. It happens very infrequently, and I just say, “Fine.”

Dr. James Wayne (male, resident): Really, the only time that’s an issue is with very specific patient populations, and very specific backgrounds, which is mostly South Asian women who are of Muslim religion. It’s like such a narrow subset now, that I just don’t encounter it too often.

Dr. Micah Chang (male, resident): If they don’t want me to do it because of my gender, I have never been offended by that, and I think that’s been a good thing for me. I know a lot of other male providers who kind of take it personally. They’re offended, like, “Why? I’m good enough.” And I hear [that] feeling exists for a lot of the men, and they think it’s a kind of reverse discrimination. For one, gosh, you know, we’ve been discriminating against women for millennia. OK? No big deal. We still get a lot of advantages in this world from being a man, so I think we should give them that one little thing.

The multiplicity of audiences of male OB/GYNs reflects a complexity of gender interactions that is not really reflected in the sociological literature about “tokenism” or “glass escalators”: for men, depending on the context and the category of person they are interacting with in their work role, the meaning of their gender shifts. Sometimes being male means receiving benefits—being prized as a “token” male resident or having favorable hiring discrimination—and other times it means having their work devalued and rejected.

Even the meaning of being male while giving gynecologic exams—one of the most sensitive parts of OB/GYN practice, in which physicians must touch the genitals of female patients—can vary from being taboo (as for many Muslim women) to being a positive

characteristic. Several male respondents said that they had been told that men often were more “gentle” in pelvic exams than female OB/GYNs, or that men took more care with their patients because they could not presume to understand their experiences.

Dr. Jacob Lapin (male, resident): When I was a med school student and I was rotating with a male OB/GYN, I had to ask all the patients—‘cause I was interested in the field—I said, “Why do you come to a man?” ‘Cause I couldn’t figure out—I didn’t think I would have much of a future in the field. And they all said, we choose to come to a man. You know, they said, “Well, this particular doctor is gentler, is kinder, he’s not as rough, more sensitive with us.” And you know, so they choose to go to a man. And I thought, “All right, maybe I do have a future in this.”

Dr. Mark Haberlin (male, mid): It makes sense in my head [that young women would prefer female OB/GYNs, because] it’s a very personal examination [and there’s] a lot of anxiety with a lot of young women, and I go out of my way to kind of ease that. And frankly, I think that—I’m not bashful, I’ll tell them to tell your friends, you know, explain that I am a [good doctor]. My big shtick is communication, because a lot of what I do is just listening, and so I tell people, if you like me—and I think you do—tell your friends. It’s how I grease the wheel. I gotta drum up business somehow.

Dr. Daniel Krieg (male, resident): Obviously, I could never fully understand what any of these women are going through. You know there’s no way that I can relate to the bodily stuff that’s going on in a way a woman can. I don’t know how much I’ve processed that aspect of things yet....I think there’s a little bit of, like, mysticism to the whole thing, [and] I have more respect for it because I’m like, you know, I could never even imagine. I don’t know if I consider it a loss or a negative, but it’s something worth mentioning.

And I often joke about it on the labor floor, you know: “They tell me this hurts!” like I kind of poke fun at it sometimes. But I’ve heard that men are often more gentle with their exams, because women [OB/GYN’s] are just like, “They’ve made their bed.” So they are a little bit less [sympathetic to patients], and men are a little bit more worried about giving off the wrong impression or something.

Clearly, there is no way to evaluate whether men are more gentle in their pelvic exams without actual research comparing patient experiences, but this idea of sensitivity to women born out of a *lack* of shared bodily experience was widespread among male respondents. And as was noted above, a small percentage of women do actively prefer male OB/GYNs. But one of the most fascinating details here—and one that goes greatly against the expectations of the sociological literature—is that men are differentiating themselves from female physicians not by appealing to traits considered “masculine”, such as decisiveness, stamina, or work dedication, but by claiming that they are more sensitive, gentle, and kind. In a way that are claiming to be more “feminine” than female OB/GYNs, some of whom were described by male physicians as “rough”, “brutal”, and “uncaring.”

Another area of vulnerability for men is what Dr. Krieg called “giving off the wrong impression.” Because male OB/GYNs are touching women’s genitals when they perform exams, the situation could be easily interpreted in sexual terms. Indeed, there are many public cases where male OB/GYNs have been accused of molesting their patients (e.g. Ross et al. 2014). Male OB/GYNs who do not want to sexually abuse their patients must work extra hard to define their encounter with patients as professional and clinical, minimizing the role of their gender as much as possible. Joan Emerson (1970) wrote about the effort required to create and sustain this definition of the situation in gynecologic exams more than four decades ago, pointing out elements of the “performance” and of the roles of doctors, nurses (who act as chaperones for male physicians’ exams), and patients.

Immersed in the medical world where the scene constitutes a routine, the staff assume the responsibility for a credible performance. The staff take part in gynecological examinations many times a day, while the patient is a fleeting visitor. More deeply convinced of the reality themselves, the staff are willing to convince skeptical patients. The physician guides the patient through the precarious scene in a contained manner: taking the initiative, controlling the encounter, keeping the patient in line, defining the situation by his reaction, and giving cues that “this is done” and “other people go through this all the time.”

Not only must people continue to believe that “this is a gynecological examination” but also that “this is a gynecological examination going right.” The major definition to be sustained for this purpose is “this is a medical situation” (not a party, sexual assault, psychological experiment, or anything else). If it is a medical situation, then it follows that “no one is embarrassed” and “no one is thinking in sexual terms.” (Emerson 1970: 77-8)

Because Emerson was writing in 1970, she merely presumed that all gynecologists are male; she does not address the fact that the gender of the physician is what makes the definition of the situation in a gynecologic exam so precarious.¹³ Though of course it is possible for a female OB/GYN to molest her patient, this likelihood seems so remote to both the physician and the patient that very little interaction work needs to be directed against such an interpretation.

¹³ Emerson’s lone comment about physician gender comes at the end of her essay, when she discusses that the major safeguard of the reality of the exam is that challenge to its interactional definition occurs only outside of the exam. Her example is: “The patient may establish a momentary ‘fellow-woman aura’ as she quietly voices her distaste for the procedure to the nurse... ‘I wish all gynecologists were women.’ Why? ‘They understand because they’ve been through it themselves.’” (Emerson 1970:90)

Especially for male OB/GYNs now, though, they must be particularly careful not to trigger alternate, especially sexual, definitions of the situation in gynecologic exams. Moreover, questions about men's motivations now spill out of the exam situation itself into broader questioning of any man's motivation for entering OB/GYN.

Dr. Micah Chang (male, junior): I get this question a lot. Why do you do this as a man? Why would you want to do this? I tell them, if you—I know what they are referring to. They're referring to genital exams, and I know what they mean. And I say, "Ok." I'll get to the bottom of the question. "If you wanted to see that all day for your personal entertainment, you wouldn't do this. I don't think people that are that way go into this profession," and usually they kind of get the point. Is it a conflict? No, it's not a conflict, because I'm providing women's health. I have to do this exam for their health. If they request not to, I will do everything I can to accommodate that, and most of them understand that if it comes down to it, and there's no other choice, then fine. So it's really hardly a big deal.

Despite what Dr. Chang says at the end, it seems like it *is* rather a big deal, in the sense that it is at the very least unsettling to men to be questioned about their motives and suspected of perverse intentions in their profession. Not only male OB/GYNs perceive this tension regarding their gender; female residents also pick up on the public perception of male OB/GYNs:

Dr. Kristen Marks (female, resident): At the same time, I think it's probably really hard to be in a specialty where everyone thinks it's really weird that you're in that specialty. 'Cause I don't—the reasons I wanted to go into OB have nothing to do with being female, although I do care about women's health. You can care about women's health and not be a woman. But there's still this perception from the outside that it's really weird to want to be an OB if you're a guy. So I can't imagine going into a field where you're gonna get all this scrutiny from the outside.

The experience of male OB/GYNs fits very neatly alongside what Williams (1992) found about men in female-dominated occupations, where they often had to defend themselves to "outsiders" who had negative stereotypes about them, especially as regards their sexual interests. Unlike the men in many of the occupations Williams studied, however, advancing in the field either by subspecializing or seeking academic or professional leadership positions does nothing to alleviate the interactional complexity of the exam; all practicing OB/GYNs and subspecialists still do pelvic exams as part of their

practice. These interactional demands—the frustration of being seen as “weird”, the need to scrupulously define clinical boundaries in examinations—must simply be endured.

The Further Benefits of Being Male

Despite all the aforementioned challenges—and especially in contrast to the perception of challenges communicated to medical students and young residents—males in OB/GYN are doing quite well. Overall, men earn significantly higher salaries than women: in 2014, men averaged \$256,000 in income to women’s \$229,000 (Peckham 2014). While these raw averages could be skewed by men’s higher representation in subspecialties and relative advancement in their careers, accounting for these factors does not remove the wage gap. In fact, the starting salaries of men and women in general OB/GYN practice are different, in contrast to the fears of young male medical students and residents: using data from New York State from 1999-2008, male generalist OB/GYNs started at \$203,789 on average while women started at \$182,047 (Lo Sasso et al. 2011).

Given all the concern over the poor job prospects of men in generalist practice, how can these wage gaps be understood? First and most simply, the problems of new male OB/GYNs seem to be overstated. Undoubtedly there are many jobs that discriminate against males in hiring, but the market for OB/GYNs still seems to have enough opportunities that men are not being overwhelmingly disadvantaged.

Second, a large literature attempts to make sense of wage gaps in medicine, which seem to have more complicated mechanisms than the straight salary differences found in business: in medicine, some employees are salaried, some are solo practitioners and thus small business owners, some are in partnerships, and others are in groups, which may

offer any possible combination of direct billing, salary, productivity models, or profit-sharing. Since insurers reimburse equally to men and women for procedures, research into income gaps has focused on productivity (in hours, patients, or procedures) and characteristics of salaried positions, but men and women are unequally distributed across the various forms of practice setting. Previous research on earnings in medicine has found links between women's marital and motherhood status, work hours, and income, suggesting that after marrying and especially after having children, women reduce their work hours (and thus income) voluntarily (Sasser 2005). Other studies find that, among physicians married to physicians, the wives tend to work less and do "family", while the husbands work more and do "career" (Hinze 2000). Still others find that, even after specialty, hours, experience, and achievement are accounted for, a gender pay gap still exists (Laine and Turner 2004; Hoff 2004).

In OB/GYN, the most recent research suggests that the unexplained gender gap in salary (Kelly and Pereles 1995) among young OB/GYNs has closed (Reyes 2007a, 2007b). Female OB/GYNs were about 85-90 percent as productive as male physicians, with the difference being accountable to maternity leaves and fewer weekly hours, patients, and procedures (Reyes 2007a). Women were much more likely than men to be in salaried positions, and the gender gap in procedures, especially surgeries, grew from 1990 to 2002. Together all these factors fully account for salary differences in young physicians up until the early 2000s. They are also suggestive of labor market changes in which, as women became more numerically dominant in the field of OB/GYN, they were able to develop practice patterns that reduced some of their work intensity, but at the cost of some of their income (Reyes 2007b). Lo Sasso et al. (2011) hazard that this is also what underlies the difference in starting salaries: they suspect that their survey data is capturing unmeasured differences in flexibility and family-friendly work arrangements that women are

disproportionately favoring, now that they have enough numerical heft to prompt employers to offer them.

Men are also much more likely to be the heads of OB/GYN departments than women. Hofler et al. (2015, 2016) found that even though OB/GYN has the largest proportion of women faculty (54 percent) and department chairs (20 percent) compared with other specialties, the representation in academic leadership positions still lags behind women's representation in the field. One exception to this was in residency program director positions, where women were over-represented, but which Hofler et al. associated with clinician-educator faculty tracks that may not lead to major departmental leadership positions (e.g., department chair, vice-chair) (2016).

Several women reflected on this overrepresentation of men in leadership positions, attributing it not to discrimination but, ambivalently, to their own and their colleagues' choices:

Dr. Lisa Tennant (female, mid): I think there's no doubt there's a difference in the men and the women in the field. There's a big difference. Maybe with the exception of the rare female in our specialty...who are attendings who are not married and have no children. I think otherwise for most women, there's a big difference between yourself and the males you work with. In our practice right now, 5 of the 10 of us are female. And, it's very odd—we're all right on time for work, but we're not early.

We all at least use one of our days as a flexible day, where we work through lunch to try to start our workday later or finish our workday earlier. Some of the men do that too, but none of us are on like, you know, medical boards or spending extra time to earn extra money by being expert witnesses. Not that I have enough experience to do that, but the point is even the older females who have children a little bit older, they also are not doing those things.

I don't know, as our generation gets older and we're the more-senior partners, I don't know *how* it will work because right now all the senior partners are males and they are very—they do a lot of volunteer work for medical boards, and they serve as presidents of different committees. I don't know how that will *work*, and maybe I'll change my mind as I get older, but I don't foresee that being me for a long time or maybe ever.

Dr. Vivienne Wilson (female, mid): The one place where it has not shifted, and I think I still see trouble is in the subspecialties and in the chairmen and directors of departments and stuff. That troubles me. I think it's the same thing that me and my buddies—like, I feel like we really push it to a point. You know what I mean? A lot of times I will have this nagging voice in the back of my head, 'cause I don't really do [research]—I consider myself faculty. We're all faculty. I *could* do research [but I don't]. You know what I mean?

But that's like that last little layer of, "I could have gone into a fellowship." I was exhausted by the time I finished. I could in theory, but I just can't. I'm just too tired. The reality is that I think I chose appropriately, because I really like general OB/GYN. I like

being able to do go to the OR and do a hysterectomy. I think I'm in the right place, but it worries me a little bit. I think that the one thing that's true is that it is hard for—it's not impossible, but I think that it's hard for women when you're really trying to get that extra level. We are all doing pretty well and stuff, but I do feel like a lot of times, we feel like we've just barely got things balanced and [then] that one extra little thing...happens and everything falls apart. So I worry about that. I don't know how to fix it.

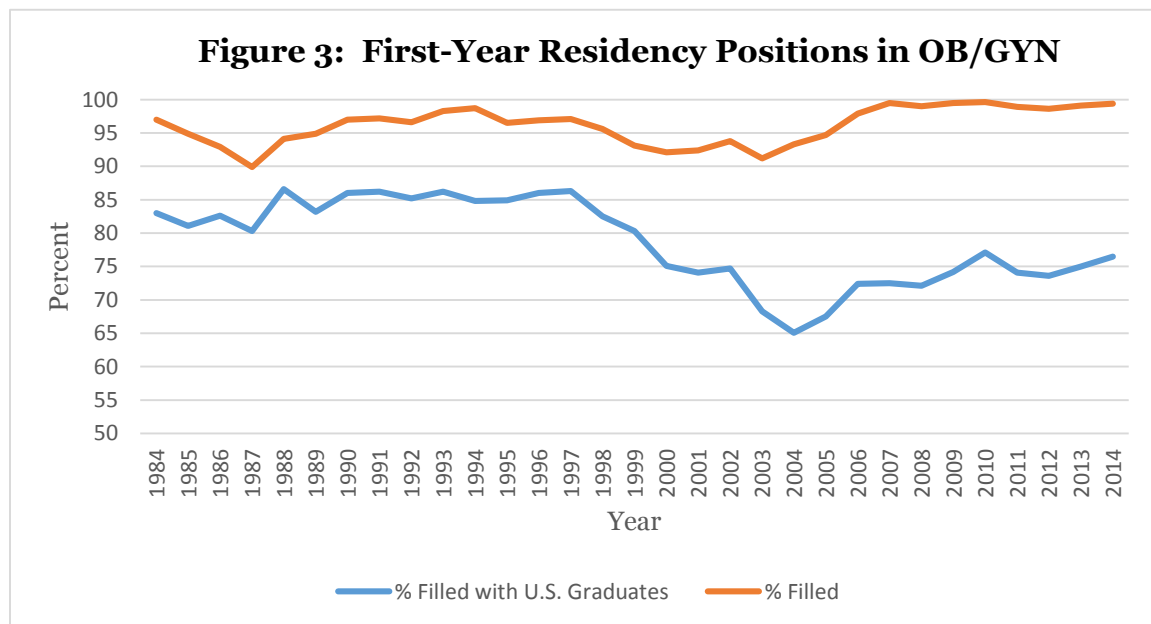
These female physicians have identified a key tension in OB/GYN and many other areas of medicine: women have gained access to this profession through the removal of discriminatory barriers to entry. They have earned the right to be counted as full members of their field, and their increasing numbers have begun to shape practice arrangements in ways that allow them to balance their work and family roles more satisfactorily. But those victories still do not mean parity with men in leadership or pay. These differences are maintained not because of overt discrimination—I found no evidence of personal discrimination against women in hiring or advancement—but because women and men maximize their personal satisfaction in different ways, and those choices lead to different career paths and income trajectories.

Conclusions

Evaluating Devaluation

As predicted by Reskin and Roos's (1990) theory of gender "queueing" to explain why some occupations feminize while others do not, it may be the case that status declines in OB/GYN in the years before women gained widespread entry to medical school made it easier for women to enter the specialty. As described by Willson (1972) and discussed above, OB/GYN programs in the early 1970s were not filling, and many of their spots were being taken by graduates of non-U.S. medical schools, which is suggestive of diminished appeal to male U.S. medical students.

But Reskin and Roos tend to underappreciate the ways that the status or desirability of occupations can shift. Through the 1980s, the desirability of OB/GYN residencies as assessed by the percentages of spots filled by graduates of U.S. medical schools and filled overall increased, perhaps reflected the new pool of women desiring those places, peaking in 1988 when 86.6 percent of OB/GYN residency spots were filled by U.S. graduates (see Figure 3).¹⁴ From there, the desirability of OB/GYN takes a sharp decline, and by 2003-2004, only two-thirds of residency positions are filled by U.S. graduates and nearly 9% of seats are left empty. Even if “queueing” theory’s predictions of status declines preceding women’s entry cannot account for the status shifts following feminization, perhaps devaluation theory more broadly can. As women enter OB/GYN, their desire for residency positions increases demand for them until the market reaches equilibrium (near 1988); further feminization beyond that point then reduces demand for residency positions from men (who find the now female-dominated profession unappealing either because they devalue women’s work or because they see a “female”



¹⁴ Data from APGO, in Pradhan 2014.

field as lower status and thus less desirable) leading to its nadir in 2003-2004.

The devaluation perspective also falls short here, though. Recall from Figure 2 that the proportion of women going in to OB/GYN has increased every year: the trend is smooth and unbroken. Yet since 2004, both the percentages of U.S. graduates in positions and the total positions filled have steadily increased. Even as the field of residents has nearly completely feminized, it has grown *more* desirable, and in 2014, 76.5 percent of residency spots were filled by U.S. graduates, and 99.4 percent of the spots were filled overall.¹⁵

In addition to predicting that feminized occupations will come to have lowered status (as understood by “desirability”), the devaluation perspective also predicts that, because women’s work is devalued, it will also come to have lower pay. Somewhat consistent with this expectation, compensation accounted for inflation for OB/GYNs has been relatively flat in the last three decades (Studer-Ellis et al. 2000; ACOG 2004; Rayburn et al. 2011b). But again, this long trend masks a number of shifts in pay that do not fit with a devaluation perspective. OB/GYN faculty salaries, which are largely tied to their clinical practice, increased from 1988-1993, then turned sharply down so that by 1988 they were not keeping up with inflation. Private practice salaries in the following period, from 1995-2003, were also down, and OB/GYNs’ real income declined 6-7 percent, adjusted for inflation (Studer-Ellis et al. 2000; Rayburn et al. 2011b). Since 2001, however, there has been a reversal of this downward trend, and salaries have been increasing for faculty OB/GYNs at very slightly over the level of inflation. Especially for faculty generalist OB/GYNs, this trend is consistent with other generalists in core teaching departments (Rayburn et al. 2011b). Thus, there is no evidence that salaries of OB/GYNs

¹⁵ This complete filling of residency positions has occurred despite the total number of graduates of allopathic U.S. medical schools remaining fairly consistent around 16,000 per year since the early 1980s (HRSA 2008).

have declined along with their increasing proportion of female physicians, nor has OB/GYN experienced different compensation trends relative to other medical specialties that were not rapidly feminizing.

Thus, the changes in the desirability/status and compensation of OB/GYN do not fit with predictions of “queueing” or the devaluation theory more broadly. It seems more likely that these shifting trends are responses to changes in health care reimbursements, which contracted sharply in the 1990s as price competition from payers drove down public and private reimbursement rates (Rayburn et al. 2011), and the malpractice “crisis” of the 1990s and early 2000s (Mello et al. 2004; Mello et al. 2005; Benedetti et al. 2006). Both of these factors—which affected male and female physicians equally—made OB/GYN less appealing until the mid-2000s. Since then, it seems likely that shifts in practice patterns and expanded possibilities of practice settings have lessened the “lifestyle” burden of OB/GYNs, something that appeals to both men and women in recent residency classes, making the specialty more desirable overall. None of these changes are primarily responses to shifts in gender composition.

Still more generally, talking about “women’s work” as low status when discussing OB/GYN mischaracterizes the place it has in the American work structure. Physicians, including OB/GYNs, have all the social markers of high status: they consistently top prestige rankings (The Harris Poll 2014), have very high levels of education, and typically have incomes in the top 1 percent of earners. Compared with other medical specialties, its earnings are about halfway through the distribution, consistent with its practice mix of low-paying primary care and high-paying surgical and procedural care. If this medical specialty is to be considered an occupational ghetto, it must be a very classy ghetto indeed.

OB/GYN may be utterly resegregating by gender—and unless trends in the percentage of male applicants rapidly reverse, it will be resegregated in the next 10-15

years—but that sex segregation does not seem associated with sex stratification. If anything, women’s dominance in OB/GYN undermines a broader system of sex stratification privileging men, because it gives women a hold over a high-status occupation where patient demand values women and women’s work more highly than that of men.

Tipping, Information Gaps, and the Perception of Marketability

Another way of understanding the relationship between devaluation theory and changes in gender composition in occupations is by borrowing Schelling’s (1971) model of “tipping” to describe how progressively more men are unwilling to enter occupations as they become more heavily female, a dynamic that reinforces itself until segregation is achieved. As discussed above, England et al. (2007) apply this model to the sex composition of fields of doctoral degree recipients, finding that, though the large-scale entry of women into doctoral programs explains most of the change in sex composition, there is indeed a predictive effect of the percent women receiving degrees in a field on the subsequent likelihood of males doing so. By means of explanation, the researchers offer that “this finding suggests that the nonpecuniary stigma for men of being in a field that is ‘too female’ is the major part of what men try to avoid” (England et al. 2007).

Returning to Schelling’s original model, though, he is careful to note that “inferences about individual motives can usually not be drawn from aggregate patterns” (1971: 143). England et al. (2007) presume that men are directly and negatively responding to women’s increased representation in a field, but because their research is focused at the aggregate level, there is no evidence that the pattern is the same as the mechanism.

Instead, from this case study, an alternate possibility presents itself, at least as

regards OB/GYN. Because mid-career and senior physicians have experienced a strong shift in the demand for female practitioners over the course of their careers, they advise young male medical students not to pursue generalist OB/GYN practice. Whether their assessments of the future career prospects of male OB/GYNs are accurate or not—and this case study suggests that they are exaggerated—their perception of these diminished prospects is what matters, for this is what is communicated to younger men. Male medical students are not exposed directly to the market for male OB/GYNs until 4 to 8 years after the point when they make their specialty decisions, and that time lag means that they are influenced much more by the opinions of the physicians who train them than they are by broader assessments of demand. Moreover, male medical students experience patient refusals often, and they tend to overestimate the degree to which they are refused for being a man versus refused for being a medical student (Nora et al. 2002). A good example of this disconnect is the widespread belief among students and residents that men will be offered lower starting salaries than women in generalist OB/GYN practice, despite the fact that the opposite appears to be true (Lo Sasso et al. 2011).

This effect of this process of dissuading male medical students becomes self-reinforcing, because as fewer men enter residency programs and even fewer enter generalist practice to train the next cohort of medical students and residents, the conviction that “it’s not a field for men anymore” only grows stronger. Many of my male respondents mentioned struggling with whether to believe these messages and seek another specialty; none of them mentioned being discouraged about entering a specialty that had so many women. A robust test of this theory of “marketability perception” versus devaluation theory/gender bias would examine medical student attitudes and beliefs about OB/GYN and sources of information as they progress through their clerkships and choose specialties; for now, it is enough to note that perceptions of male “marketability”

as communicated to medical students can have the same negative and compounding effects that the “tipping” metaphor describes, and this theory has the additional advantage of specifying the mechanism—warnings and advice from more senior physicians—that perpetuates the cycle. This perspective also locates the primary feedback loop pressing forward the process of resegregation not in diminished male demand for a “less-desirable” medical specialty, nor in their desire to avoid working in a female-dominated occupation. Instead, what seems to really be the engine of resegregation is men’s fear of discrimination against them in the workforce and their perception of the likelihood of it increasing in the future.

Advantages for the Disadvantaged

As discussed above, the feminization and resegregation of OB/GYN does not fit the expectations of diminished status, pay, and opportunities described by the devaluation perspective. Sex segregation in OB/GYN seems to operate in society generally as a means of advancing women rather than perpetuating sex stratification, and the only explicit—and possibly illegal—gender discrimination I found was against men, in advertisements for jobs with women-only OB/GYN practices.

This does not mean, however, that gender inequality favoring men does not appear within the profession of OB/GYN. Consistent with the “glass escalator” descriptions of the experiences of token males in female-dominated professions (Williams 1992) and in contrast to the original expectations of “tokens” described by Kanter (1977), men experienced advantages in residency acceptances and interactional benefits from nurses, attending doctors, and co-residents. Rather than receiving favoritism from male supervisors, though, it was always women who were described as “going easy” on male

residents, suggesting that this favored status has more to do with sexual dynamics and less to do with replicating a gender hierarchy. Practicing physicians also felt that being a highly visible, highly differentiated male OB/GYN was good for their business, as they drew women who preferred to see a man, though, in a fascinating turn, they located the center of their difference in their “feminine”, rather than “masculine” qualities. All of these factors favoring men may indeed be real, but none of them seem particularly significant; they are pleasant for the male “tokens”, especially during residency, but do not seem to be strong enough to have much impact on sex stratification within the OB/GYN workforce.

More problematic from that perspective is the clustering of men in subspecialties, their higher pay, and their overrepresentation in leadership. These difference are challenging to theorize, because they do not seem to be the results of discrimination, and yet the result clearly is inequality. What do we make of this? On the one hand, it is the same story, told again, of men keeping control of the most desirable, most rewarding, most powerful positions. On the other hand, many women choose generalist practice because they like its work variety and patient relationships, because they are welcomed there, and because it offers a way to enter practice and begin earning enough to support their families (and climb out of their educational debt) at an age when they are most likely to have young children. They choose practice arrangements that offer ways to limit their workhours and be more flexible; they opt not to pursue yet more work on committees or in conducting research, so they can enjoy their families and be as present as possible at home (see Pearse et al. 2001; Benedetti et al. 2004). In interviews with these women, they do not talk about their home responsibilities as an oppressive burden they unequally bear; they *want* to be home enough to see their kids, to go to a preschool event, to celebrate a birthday. Their choices as individuals lead to aggregate inequalities, but it is hard not to view these possibilities as progress. These options for combining work and family were largely absent

from OB/GYN decades ago; then, women who managed to enter the profession had to make much deeper sacrifices of their work or their family. These patterns of gender difference are inequality. They are also freedom.

Weighing Gender Across the Career, Predicting the Future

In sum, gender operates in different ways at different times in the careers of OB/GYNs. As medical students, men are discriminated against by patients and discouraged from entering OB/GYN, especially with the intention of pursuing generalist practice. In residency, men experience boons from their rarity and their sex: they have an easier time getting residency positions, and they generally receive positive treatment, if not favoritism, from nurses, attending physicians, and other residents. In early career, women are on top: they are much more desired by patients and find building a practice comes much more easily to them. But by mid- and late-career, men are advantaged again, as their higher earnings from longer work hours and careers, more income-generating practice patterns, and specialty training bear fruit, and they also are more likely to be in positions of leadership and power.

Looking towards the future, I can speculate about the continued effect of some of these trends. First, I suspect that the proportion of female residents will continue to rise, but slow; I doubt men will entirely cease to enter the profession, but their percentage may become very small (less than 10 percent). Second, as men become so rare among young practicing OB/GYNs, especially in generalist practice, almost all women initiating care with an OB/GYN as teens or young adults will be seen by a woman; as this becomes what is the norm, having men treat women for routine OB/GYN care will be seen as increasingly abnormal. Especially because of the interaction effort required for gynecologic exams to

be seen as routine medical events, male physicians will have an even harder time making it seem “normal” for them to take on this role. The stigma of it being “weird” to have a male general OB/GYN may spread so much that almost all remaining men in the field subspecialize, which would be a loss for the men who would be excellent in this profession, and for the women who would be their coworkers and patients.

Limitations and Future Directions

This study’s main limitations are that there are always more trails to go down, more avenues to research and explore. The interview sample was not representative of all OB/GYNs in the United States, nor could any interview sample in a small study ever be; thus, there may be large areas of the experience of gender in OB/GYN that I am missing entirely.

One direction for future research is illuminating the effect of specialty desirability, as operationalized in the percentage of residency spots filled and filled by U.S. medical graduates, on the subsequent likelihood for specialties to feminize, as the “queueing” theory would predict. Conducting a comprehensive analysis across all specialties could allow for a robust test of this theory, but it was beyond the scope of this paper.

Additionally, it would be particularly interesting to compare the experiences of women in general surgery training programs over the last 3 decades with those of the women in OB/GYN. Is it true that women experienced much more discrimination and maltreatment in surgery than in OB/GYN? What can explain the differences in response by these male-dominated specialties to the inroads of women? If differences in prestige or desirability between the two specialties are part of the answer, the residency match data mentioned above could help clarify that relationship. And how do the experiences of men

in OB/GYN compare to those of women in urology? Learning the answers to these questions could clarify the process by which women entered some specialties more easily than others and the areas which trigger gender conflict over changes in sex composition, thus shedding more light on the gender dynamics that underlie current patterns and trends in occupational sex segregation.

CHAPTER 3: THE COVERAGE CONTINUUM

Recently, sociologists of medicine have been most concerned with health care inputs and outcomes—disparities in access or treatment, costs, general improvements or declines in mortality or quality of life—and these factors are important for assessing the function of medicine in contemporary society. They are not the only aspects of medicine that are vital, however. The practice of medicine—what doctors actually do when they are at work—is also a site of social and personal meaning for both physicians and their patients.

Physicians themselves have been better at paying attention to some aspects of doctors' work: there is a large literature on physician “career satisfaction” and “burnout”, which is often treated as its opposite, in journals and trade publications across the medical spectrum (Bettes et al. 2004; Kravitz et al. 2003; Leigh et al. 2009; Rivzi et al. 2012; Scheurer et al. 2009; Weinstein 2008). Many of these studies have an odd flatness about them, though: they tend to use taken-for-granted categories of separating practice characteristics (e.g., academic versus private practice, community versus teaching hospital, privately-insured versus Medicaid patients) and measure the correlation between these characteristics and “career satisfaction”. This approach can be useful for identifying areas that are perennial problems for physicians, such as medical liability concerns and government or insurer control over practice (Becker et al. 2006; Mechanic 2003), but they tend to assume that many characteristics of the practice setting would affect all physicians in the same way.

Especially in Obstetrics and Gynecology (OB/GYN), the typical typology of medical practice characteristics—academic versus private practice, solo versus group model—obscures the real axis of differentiation between practices. For physicians who practice obstetrics, the most significant differences lie along a spectrum of how responsible a single physician is for caring for an individual patient’s labor and delivery, which I call the “coverage continuum”. This spectrum runs from complete responsibility for a single patient—meaning, a commitment to attend her labor and delivery whatever time of day or night it occurs—to pure shiftwork, in which a physician cares for whoever is in the hospital during his or her shift, but has no obligations to patients beyond that set time period.

It is physician practice location along this coverage continuum that drives the observable differences in work hours and work-life balance among OB/GYNs. In turn, location on the coverage continuum also determines the patient relationships available to physicians and the emotional burden physicians must bear for their patients: these are sources both of cost and profound meaning to physicians, and their location along this spectrum necessarily implies tradeoffs between relationship burdens and benefits. Moreover, a physician practice’s location on the coverage continuum determines aspects of patients’ experiences, too: their relationships with their physicians are shaped, their level of choice over provider practice orientations are expanded or reduced, and even the medical management of their labors and deliveries are affected by their physician’s location on the coverage continuum. For physicians and patients, their satisfaction—with their career or with their obstetric care—depends on the fit between their personal sources of meaning and the practice characteristics that result from the physician’s location on the coverage continuum.

Literature Review

Until about 1970, sociological analysis of medical practice largely followed a functionalist approach, as researchers searched to understand and explicate the role of physicians and their profession within society and to analyze the physician-patient relationship in terms of individual social roles (Parsons 1951). Researchers did survey differences in practice organization, but they tended to focus primarily on understanding relationships among medical personnel, comparing professional competence between solo and group practitioners, and clarifying the tensions between colleague-based professional control and physician autonomy (Weinerman 1966).

One of the few sociologists to attempt a broader understanding of the shape of medical practice as it actually occurs was Eliot Freidson, who discussed the “empirical types of practice organization” as part of the everyday work settings of physicians (1970a).

He described four empirical types:

- 1) Solo Practices
- 2) Associations
- 3) Small Legal Partnerships
- 4) Group Practices

In Freidson’s taxonomy, the key variation is in two dimensions: level of autonomy and billing organization. By “autonomy”, Freidson and other mid-century sociologists meant the power and warrant given physicians to make clinical decisions according to their best judgment alone. “Autonomy” in this meaning was a treasured value of American physicians at the time, and the American Medical Association (AMA) undertook great efforts to protect this ideal from encroachment by the development of medical insurance companies, salaried physician positions, or capitation payment systems (Freidson 1970a). Specifically, the AMA opposed any movement away from a fee-for-service model of physician compensation, saying that interference upon physician autonomy from “third

parties” lowered the dignity of the profession and left doctors open to pressure by administrators to lower the standards of practice. In their view, it was physician autonomy that protected the essential, responsible aspects of the physician-patient relationship, and the quality of medical practice itself was threatened by any diminishment of physician autonomy (Freidson 1970a).

Solo practices, where one physician operated his own practice, were the most autonomous of the arrangements, though Freidson noted that the platonic ideal of physician autonomy was, in practice, rather less than independent. He described solo practices as “inherently unstable”, tending to fall under the control either of patients (on whom the physician was dependent for recurring business) or colleagues (on whom the physician was dependent for referrals) (Freidson 1970a:92). Since solo practitioners were responsible for caring for their patients at all times, they also had a problem arranging coverage for their patients during times when they would be unavailable; merely asking another physician to do it voluntarily risked that their patients would be “stolen” by another practice. From this need was born the association, in which 2 or 3 physicians would join together to share an office and staff and would cover each other when needed. They kept their billing separate, however, essentially operating solo practices together.

From the association to the small legal partnership, there was a large leap: partners were legally bound together, sharing both profits and overhead expenses. Freidson noted that the division of profits was often contentious in these arrangements, as physicians rarely brought in exactly the same billings under fee-for-service models, but in addition to arranging coverage, partnerships also allowed for longer-term financial security for physicians. Younger doctors, who otherwise had to work hard for years to attract new patients and build a practice, found instead that they drew new patients much

more quickly; older physicians nearing retirement earned a share of junior partners' billings, even as their own billings decreased.

As more physicians joined a group, Freidson noted that its internal structure changed, taking on more of the technical characteristics of bureaucracies: their organization became more hierarchical, the division of labor became clearer, and they needed more systematic rules and procedures. Freidson saw these as characteristics of a "group practice," where the emphasis shifted from physician autonomy and independence to "groupness" and interdependence, typically when there were 5 or more physicians (1970a; Wolinsky (1992), based on AMA censuses, suggested it was more often at upwards of 7 physicians).

For Freidson and some of the sociologists who followed him, this taxonomy shed light on two areas of concern: first, as physician practices moved from solo to large groups, the level of social control over physicians practice decisions increased, which also meant that their "autonomy" decreased (Wolinsky 1992). Freidson and Mann (1971) found separately that diminished physician autonomy was associated with lowered physician satisfaction; additionally, patients seemed less satisfied by group practice models, preferring the personal connection of a solo practitioner (Freidson 1961). Second, and somewhat inversely, as practice models grew larger, medical care seemed to increase in quality, perhaps due to the greater technological resources available to groups, as well as the benefits of consultation and supervision of physicians (Freidson 1970a; Freidson and Mann 1971).

After the early 1970s, however, discussions of the details of physician practice settings faded from the sociological literature, in part due to Freidson himself. His 1970 book *Professional Dominance: The Social Structure of Medical Care* shifted from evaluating medical care largely in its own terms to critically analyzing its professional

claims as means of enacting social control and reifying its own special professional position. His argument that medical professional power was more self-interested than patient-oriented marked a turn in sociological approaches to medicine, and following its publication, sociologists of medicine primarily focused upon analyses of professional claims, power, and contradictions (Freidson 1970b).

As a result of this turn—as valuable as it has been—sociologists have since paid little attention to the structure of actual medical practice in its ordinary settings. Portions of those practices are examined—overtreatment patterns in billing codes, prejudice in physician-patient interactions—but what physicians are actually doing while they are at work and how it is organized has been relatively ignored.

Physicians themselves have continued to take note of practice setting and the organization of medical practice, largely through the AMA and its surveys of physicians. Their assessments, however, remain rather static: they may count each year how many physicians are in solo, single-specialty or multi-specialty group practice and chart those trends year by year, but they tend to take for granted that the meaning of those categories for physician and patient experiences is known and does not change over time (Kane and Emmons 2013). Especially for physicians who have responsibilities to care for patients outside of business hours, such as OB/GYNs who practice obstetrics, these categories seem to miss what makes their jobs different. Physicians divide up responsibility for these off-hour work requirements in a broad range of ways, even within a category such as “single-specialty physician-owned group practice”, and taking a closer look at how physicians actually do their work may bring us closer to understanding their varied experiences and the significance of those differences for physicians and patients.

Methods

To investigate what physician work patterns look like in their ordinary settings, I conducted an interview study of 51 OB/GYNs, from residents to retirees, men and women. All physicians had or were completing a residency program in OB/GYN at the time of the interview, and eight had also gone on to pursue sub-specialty training. Physician respondents were located by means of snowball sampling, using personal networks across the country to achieve dispersion along age and gender lines. These in-depth, semi-structured interviews typically lasted 45 to 60 minutes, and they took place in person at hospitals or over the phone. Physicians were asked about their practice setting and structure, their work history, their motivation for entering practice, and their areas of frustration and satisfaction. I listened for emerging themes and then followed up on repeated phrases and key concepts to work inductively toward a theoretical understanding of categories, patterns and relationships, as described by a grounded theory approach to data analysis (Glaser and Strauss 1967). With permission, I recorded and transcribed all interviews. I received approval from the Institutional Review Board at the University of Pennsylvania for this study, and all physicians' names and identifying details have been changed to protect their privacy.

The sample of physicians was remarkably diverse across a number of dimensions. Physicians were located on the West Coast and in the Southwest, Midwest, Deep South, Mid-Atlantic, and Northeast regions of the United States. Slightly less than half (43 percent, 22 physicians) were men and the rest women, and a mean age of 43 years (ranging from 26 to 69 years) at the time of the interview. Most physicians worked in mid-to large cities, though I also spoke with a few small-town doctors. Two-thirds of the physicians were married, and the rest divided between single, partnered, and divorced; five OB/GYNs

were gay (four men, one woman). Ten percent of the study physicians were born outside the United States.

Reflecting the reality of OB/GYN practice in the United States, the physicians' practice structures were also notably diverse. Three physicians currently worked in public health settings; one was a health care consultant. Two were directly employed by hospitals—one as hospitalist, one as an employee of a large healthcare consortium—and 5 were in solo practice. Eight were in academic positions, and another 13 were in positions that blurred the lines between academic and private practice, which will be discussed below. Current residents made up 14 of the OB/GYNs. And for the physicians in private practice or a hybrid private/faculty practice, the sizes of their practice groups ranged from 1 (solo practitioner) to 20 doctors.

Results

Taxing the Taxonomies

The currently available taxonomies, whether following Freidson or the AMA, are inadequate for understanding the actual practice structure of OB/GYNs. For example, take the case of a solo practitioner in private practice, the prototypical American physician and seemingly the most straightforward of practice arrangements:

Dr. Hanke: I'm part of a multi-specialty group....There's two other OB/GYNs, there's surgeons, internal medicine doctors, and rheumatologists, and there's, I think, between 20 and 30 physicians total in a group. We're not—none of us are really associated business-wise, we just all kind of belong to this group which just sort of run the business side of our practice. I'm physically in a clinic by myself. I share call with the other two OB/GYNs, but outside of that, we don't really have much—we're not financially related in any way....

So there's a total of six OB/GYNs at the hospital, and three of them belong to the same group that I do. Again, kind of take "group" loosely in that we're not—I have my own clinic, each of them has their own individual clinic as well. Basically, during the week, Monday through Thursday, each doctor just rotates one in every six. And so as far as the weekend, the weekends are kind of split between the two groups, and then among that splitting we just rotate as well....

Like, if I'm not on call, but one of my patients come to them to deliver, the on-call doctor will call me and ask, you know, if I would prefer them to take care of the patient or if I would like to take care of the patient. And usually, if we're in town, we'll take care of our own patients.

So how should this practice be categorized? In terms of how the patient understands the arrangement, it is a solo practice: she visits an office ("clinic") where only one physician works, and that physician meets the patient for all prenatal appointments. When labor begins, she goes to the hospital, expecting her physician to come attend her birth, unless it is during his previously scheduled vacation. The physician sees things much the same way: he delivers almost all of his patients who give birth during the week, and typically comes in on the weekend or at night as well. In the previous year, he had about 250 patients give birth, and he personally attended all but 6 to 8 of those deliveries.

According to the AMA categories, however, he is part of a multi-specialty group practice, in which physicians in the group share billing and business arrangements, with varying levels of practice interrelationship (Kane and Emmons 2013). Such a multispecialty practice can either be physician-owned and contract its services with one or more area hospitals, or it can be itself owned by a hospital or hospital consortium, thus making its physicians indirect employees of the hospital system. Considering this physician's practice to be part of a multi-specialty group practice may make sense for tracking the process of billing or comparing the relative efficacy of such bureaucratic arrangements for getting insurer reimbursements, but it makes no sense in terms of understanding what this physician's everyday work looks like: he is alone in his own clinic, he is primarily responsible for all of his patients' deliveries around the clock, he is in charge of marketing his own services and attracting a patient base.

Similarly, Freidson might have looked at this arrangement and seen it as an example of an association, where some physicians—here, the other two OB/GYNs in his large multispecialty group—join together to share some of the business requirements and

cover each other during call periods and vacations. In terms of daily work arrangements, this understanding hits closer to the mark, but Freidson's description of the autonomy of physicians in solo practice or an association does not square with being an employee of a large multispecialty group practice, whether physician-owned or hospital-owned.

Nor is this example unusual. Other OB/GYNs in the study described being part of small group practices of 3-6 physicians, which operated like the small, tight-knit partnerships Freidson described: they cared for their patients as a collective, maintained their own call and vacation schedules, and shared the overhead expenses of their office space. Yet due to the high malpractice premiums demanded by insurers in their large cities, they were unable to be in independent private practice. Instead, these physicians are on staff at hospitals with medical students and residents (in a "faculty practice" at teaching hospitals) and had titles of Assistant Professor of Clinical Education or Faculty Attending (Block et al. 2015). In exchange for supervising residents and students according to a schedule that rotated through the dozens of attending physicians, these OB/GYNs received a nominal salary and malpractice insurance coverage through the hospital—at greatly reduced rates, due to the risk-sharing among a large pool of physicians and the negotiating power of the hospital.

Are these physicians in academic or private practice? They teach residents and medical students by example as they care for their own patients (to whom they refer as their "private" patients) as well as oversee resident care for hospital clinic patients, who are often on Medicaid or uninsured. Some of these physicians are deeply committed to these teaching responsibilities; others discharge them with as minimal effort as possible to ensure the standard of care is maintained. They generally are involved in little to no academic research. Many hospital systems describe these jobs as being part of a "clinical educator" track within academic institutions: physicians in these roles sometimes may

take on departmental responsibilities directing residency programs or medical student clerkships, but they rarely are promoted to department chair or vice-chair positions (Hofer et al 2013).

Indicative of the difficulties in drawing boundaries around physician practice settings, 13 to 17 of the physicians in this study could be considered to have these hybrid academic-private practice jobs, depending on how one assesses the balance of their responsibilities. Among them, some of the physicians were in tight-knit groups with close co-management of private patients, some practiced alone, and others had coverage and office arrangements like physicians in associations. Yet most of them are actually employees of hospitals, via large multi- or single-specialty physician practice groups that collect their insurance reimbursements and then pay the physicians their salary and portions of their billings, minus a 10-11 percent “dean’s tax” that goes back to the hospitals, according to arcane and sometimes indecipherable schedules. Where do they fit, according to Freidson’s or the AMA’s taxonomies?

The categories that are part of these taxonomies do not map well onto the real practice arrangements of physicians, and even when they do, the categories do not mean the same things for all practices. Being a member of a single-specialty group practice can either mean functioning as a part of a large, somewhat bureaucratic organization with formal rules for clinical practice, or it be more like mere accounting structure, with little impact on the workday division of responsibilities.

The inadequacies of these conceptualizations are particularly visible when considering an area of medical practice such as obstetrics, where patient care responsibilities occur around the clock and require night, weekend, and vacation coverage. There is tremendous variation in the ways these off-hours responsibilities are divided up among different OB/GYN practices, and these differences do not line up with existing

categories of practice setting. Yet it is these differences that actually drive much of the variation in the ordinary work lives of physicians practicing obstetrics. A better taxonomy—one that has explanatory power for understanding differences between physician and even patient experiences—would be centered around the organization of patient care responsibilities.

The Coverage Continuum

Differences in obstetrical providers' practice structures are best understood as locations along a spectrum of responsibility to individual patients, which I call the coverage continuum. At one end, physicians are completely responsible for attending to the medical needs of a single patient, regardless of the time of day or duration of the episode. In obstetrics, this would describe an OB/GYN who was committed to attending a patient's labor and delivery, whenever it occurred: the physician is personally and completely responsible for "covering" his or her own patient's care. At the other end of the continuum, physicians are shift workers: they provide medical care for those they see in a clinic or hospital during set hours, then pass their care off to the oncoming physician. In obstetrics, this practice is carried out by OB/GYN hospitalists or "laborists", who work as employees of hospitals providing care to patients in Labor and Delivery (L&D) wards (McCue et al. 2016). They have no ongoing relationships with individual patients; at the end of their shifts, they sign out to the next hospitalist, and none of the patients are "theirs". In the center of the continuum are practices where physicians "cross-cover" to varying degrees: they have primary links to their "own" patients and generally see them for most office visits and scheduled procedures, but use call schedules and swaps to take care of each other's patients in the hospital or for urgent office care.

Here, I evaluate the coverage continuum primarily in terms of OB/GYNs who provide obstetric services. Not all clinically active OB/GYNs provide obstetric care, either because they limit their practice to general gynecology or subspecialize into gynecologic oncology (GYN ONC), urogynecology (UROGYN, also known as reconstructive pelvic surgery), or minimally-invasive gynecologic surgery (MIS).¹⁶ Even though the vast majority of gynecologic care occurs during regular clinic hours or is a scheduled hospital procedure, the effects of practice placement along the coverage continuum still matter for these physicians. There are aspects of gynecologic care that are urgent, whether it is a suspected ectopic pregnancy or the deteriorating condition of a gynecologic cancer patient, and the degree to which an individual physician is responsible for coming to the hospital to personally manage a patient still effects aspects of the physician's and patients' expectations and experiences.

Figure 4: The Coverage Continuum



This model is a continuum rather than a set of discrete categories because physician practices are located along this spectrum by degrees. Even solo practitioners in OB/GYN, like the physician quoted above, employ some level of cross-coverage when they are on vacation or in case of illness. Similarly, among group practices that cross-cover, the

¹⁶ Other OB/GYNs work in public health, hospital administration, or other related medical jobs, but are not responsible for direct patient care, which is the focus of the coverage continuum.

degree to which they do so varies from covering their own patients during the week and having cross-coverage on the weekends to near-shiftwork, when one physician remains in the hospital to deliver all of the practice's obstetric patients during a specific amount of time.

Another reason this conceptual model is a continuum is that many physicians described shifting back and forth along this axis over the course of their careers, even while in the same job. Here, one OB/GYN describes some of the reasons this could occur:

Dr. Green: [My practice] was always changing. First, I was in a three-person group, but we only covered on the weekends 'cause the other two doctors said, "Why would anyone want to come to me and get covered by you?" So then they all had children, 'cause none of them had children, and by the time they had children then they got it, and we were, like, in an every fourth or every fifth [night call] rotation.

At one point we became every three, and I said to these two women—one had, like, a 3-year-old and a 5-year-old and the other had a newborn, and I said, "I can't be on every third night. I can do every third night after 10:30, I can do every third weekend. I cannot be missing every third night from 6:00 to 10:30." ...And then we got a fourth person, and it was fine.

At one time it was seven [physicians], then we broke up and it was three and four and that's when I was panicking about the three. I think at the end it was five or six. More than six gets really unruly and four is really too small, because when you add maternity leaves and vacations it really gets hectic. I mean, ideally five, six is perfect and more than that it's too impersonal....

So if it was not my day on-call, but I was [in the office near the hospital], then I would run across the street and do the delivery, and sometimes I would have the covering doctor come do my office hours....We have always covered with [full-time academic physicians] here with no issue, and now that [a new hospital consortium] took over, they said they didn't want that to be the case so we just lost our coverage group.

So now we've covering with a group of purely private doctors, so that's been completely psychologically horrifying, even though those doctors are very nice and it's fine, but it's just, like, ridiculous....

It's making me come in for more deliveries....It's a control thing. The patients didn't know—like, on my first visit, I tell all my patients who I cover with. Well, that all changed.

This physician's comments illuminate some of the problems with prior means of conceptualizing practice structure and the usefulness of the coverage continuum. As Dr. Green sees it, her practice changed a number of times throughout her 30-year career, despite the fact that the AMA or Freidson would describe her practice setting as consistent. Early in her practice, she and her colleagues covered their own patients' deliveries during business hours and weeknights, even when it meant leaving their clinics to do so. This commitment to covering her own patients became too burdensome for her work-life

balance after she had children; with her colleagues' consent, the practice shifted along the continuum toward more cross-coverage during the workweeks.

Also, Dr. Green's patients were being cross-covered by at least two separate groups of physicians at different times. Early in her career, only the two other doctors in her association attended her patients; more recently, her patients were also being covered by a second group practice of faculty attending physicians at her hospital. This placed her even further along the continuum toward shiftwork, as it increased the number of hours per week that other physicians were responsible for delivering her patients. At the time of the interview, her practice had shifted along the continuum yet again, as her coverage group changed and she felt obligated to cover more of her own patients by coming in personally to deliver them. A model that makes sense of the organization of OB/GYN practice needs to be able to account for these dynamic changes over time.

Practice Characteristics

Each of Dr. Green's movements along the coverage continuum has implications for how she spends her time and energy at work, the length and predictability of her work hours, and her work-life balance generally. Many of these linkages show up in her comments: first, maintaining commitment to covering one's own patients as much as possible—to being closer to that end of the continuum—requires a high number of hours in the hospital and clinic. In her earliest practice organization, having cross-coverage only on weekends meant that she spent a tremendous amount of weekday and weeknight time going to the hospital. Second, these hours were also unpredictable, as babies may be ready to come any hour of the day, and each labor for each woman has an unpredictable duration. Third, this effectively meant that she was on call for all periods for which she

did not have specific cross-coverage: any time of day or night during the week, she could be called to drop whatever she was doing and head into the hospital.

Unsurprisingly, this way of organizing obstetric care has profound effects on the work-life balance of OB/GYNs. As Dr. Green discovered after she had children, it is particularly difficult for parents: the responsibilities of childcare cannot be dropped with a moment's notice unless another caregiver is instantly available, and many parents—especially mothers—described struggling with the feeling of wanting more time with their children. Dr. Drake, who still delivers 70-85 percent of her patients personally, recalled that she used to make even more of an effort to be there:

Dr. Drake: So I would come in more for my patients when I was younger, and it gets to be a little bit prohibitive as you get more things in life to deal with. I think it was when the kids were born. It just—you know, that was such a huge draw, to split my time up....It's hard when I have to miss deliveries. It still is. I wish it could work out, but you know, obviously logistically, I'm with the kids—it's kind of a compromise I'm not really willing to make [to spend less time with them].

Dr. Green's colleagues largely had the same experience when they became mothers; the whole group shifted their care organization down the spectrum, towards increased cross-coverage, which made their work hours more predictable and more limited, and also limited their call responsibilities to scheduled periods (see Figure 5).

Two physicians in this study did report satisfaction with their work-life balance, despite being committed to covering their own patients nearly absolutely. Both of these physicians chose to accept very few or no insurance plans, and this meant that they were out-of-network providers for almost all patients. Effectively, they were providing concierge medicine: they charged much higher fees for prenatal care and delivery, and patients paid in cash. This billing practice allowed these physicians to limit the number of patients they accepted at one time, which, in turn, spread out the times they were called in the middle of the night to attend deliveries. Thus, they were able to still earn acceptable

**Figure 5:
Practice
Characteristics**

	Coverage Continuum		
	Covering Own Patients	Cross-Covering	Shiftwork
Practice Structure	Solo, Association, or Small Group Partnership	Small or Large Partnership, Employee of Large Group or Hospital	Employee of Large Group or Hospital
Work-Life Balance	Awful, unless taking cash-only patients	Mixed, depending on schedule	Good
Predictable Hours	No	Yes, usually	Yes
Amount of Work Hours	Varies weekly; can be extremely high	Mixed, depending on size of group	Fixed
Call	Always on call	Call on arranged schedule	Never on call
Billing	Eat-what-you-kill/productivity model	Shared receipts or productivity model	Salary

incomes yet protect their work-life balance. In exchange, like Freidson’s patient-dependent solo practitioners, they were heavily reliant upon building and maintaining positive reputations with wealthy women, who were the only patients who could afford their fees and who also expected exceptional, personal service in return.

These two physicians’ billing structure is a variant of a larger approach to physician payment employed by many OB/GYNs who cover their own patients. It is generally called a “productivity” model or, in the vernacular, “eat what you kill.” According to this compensation arrangement, physicians earn only what has been paid for their specific services, less their responsibility for shared overhead expenses such as office staff or space. For solo practitioners, this is the obvious arrangement, but it also is used by associations and some partnerships. It tends to be linked with and reinforce the practice of covering one’s own patients in two ways: first, where physicians attend their own patients all or

nearly all the time, there is little motivation to share that income with other physicians not involved in that patient's care. Physicians vary in how full their obstetric practices are and how many babies they deliver annually; the "productivity" model rewards physicians who work harder with more money. Second, it strongly disincentivizes having another physician deliver one's own patient, because that physician will be able to charge for the cost of the delivery itself, leaving the original physician only able to bill for prenatal care.

Moving along the continuum, as physicians are involved in more cross-coverage, productivity models become more complicated to administer. When regular coverage schedules make it likely that an OB/GYN's patient will be delivered by another physician, practices make set arrangements for what portion of the delivery fee goes to the original physician versus the delivering physician. This arrangement is not without its problems, however, since it promotes competition for patients among physicians in the same practice.

Wary of the ways that productivity models can affect practice culture, some groups instead share their receipts, distributing the net income for the whole practice evenly or according to physicians' full time equivalent (FTE) workload. Dr. Tanner describes her reasoning for joining a 10-person practice like this, and also describes the linkages between her shared-receipts model and their cross-coverage arrangement:

Dr. Tanner: It's very much a team setup. We share patients. There's no productivity model...so everyone is more team oriented. So you really are—when you're on call, unless there's someone you're really especially attached to—that's the only night of the 10 nights that [you come in], but it's really busy when you're there....

Almost all of [my friends] from residency joined a productivity-based model. It's just a really...kind of malignant environment, as the transition from training where you pitch in to take care of patients and treat them as they need to be treated. Instead there's the situation where people are waiting in clinic to be seen because their doctor's gone over to the hospital, or they're waiting at the hospital to push or to be taken care of in an emergency because their doctor's not there. ...

I think it just creates a lot of competition within practices and you end up not having the right person do a surgery.

Dr. Tanner felt that her shared-receipts, team model of obstetric care, with its firm expectations of physicians delivering patients only when it was their turn to be on call, gave her patients better medical care. Patients with specific medical needs, such as for infertility treatment or robotically-assisted gynecologic surgery, were easily referred to the physicians within the practice with most experiences in those areas, since the original physician knew that they lost no revenue by doing so.

The more expansive the cross-coverage schedule for physicians, the more they could improve their work-life balance. Having periods of call that were defined far in advance, and the knowledge that one would not be required at the hospital except during those periods, made it much easier for OB/GYNs to arrange childcare when necessary, limit their work hours, and have consistent time for their families or personal life.

Dr. Seldon: There are other groups nearby [where] you deliver your own patients all the time, no matter what. I just didn't want that, because I felt like that was going to be too much of a burden on my family, for me to be on call all the time, at any point in time, for anybody. I don't know how people deal with that.

Dr. Teppen: I think the ability to make schedules and do things differently in terms of how you cover the office and how you cover the hospital, in your groups—I think that makes it better in terms of quality-of-life issues.

Dr. Fann: We do it by the clock. So the way our practice more or less works is that we each take a weekday...Weekends are Friday, Saturday, Sunday, and [I take call] every fourth weekend....As it is, I don't deliver half of the patients I end up seeing in their prenatal course, just because I'm not on call all the time. And those patients are fine. I mean, they do okay. I mean, every now and then, they're disappointed. And I'd love to be there, but I also want to have a life....I could never be a solo private practitioner, which is what some people do try to be. And I just think that's not really reasonable to either the physician or their patients, to be honest. So you have to have some kind of balance.

Such cross-covering arrangements can transform the inherent unpredictability of childbirth into predictable work schedules, making it much easier for physicians to meet family and personal needs. The closer such cross-covering practices were to shiftwork on the continuum, the more satisfied study physicians were with their work-life balance.

It also bears mentioning that physicians use the word “call” in slightly different ways to describe their work responsibilities. Physicians who always deliver their own

patients are, in one sense, always on call: like Dr. Seldon describes above, they can be summoned to the hospital at any time. This type of being “on call” can be done from the clinic or home, however; it requires responsibility only for one’s *own* patients. For groups that cross-cover, being “on call” for the group means that you are responsible for taking care of all of the *group’s* patients in labor during your call period. Depending on the group’s location of the coverage continuum, this can mean supervising patients in labor and calling in the primary physician for the actual moment of birth, or it can mean personally handling all of the group’s patient deliveries. Physicians can be on call at home, if the group is smaller or has fewer obstetric patients; they keep in touch with nursing staff via phone and text. For groups like Dr. Tanner’s team practice, though, being the “on-call” physician requires being physically present in the hospital for the duration of the call period, both because the group is large enough that it is almost certain to have at least one patient in labor and also because all of the groups’ deliveries will be handled by that on-call physician.¹⁷

Dr. Tanner’s practice, in which an OB/GYN stays in the hospital for a fixed time to deliver all patients for his or her group, is located close to shiftwork on the coverage continuum. The lone difference is that, unlike in pure shiftwork, Dr. Tanner and her partners see “their” patients for their prenatal and postnatal visits and, even when they do not personally deliver them, coordinate their care with their partners.

Pure shift workers in OB/GYN are known as obstetric hospitalists or laborists, and such positions have been on the rise in OB/GYN and now are present in 40 percent of U.S. hospitals (Rosenstein et al. 2015). Instead of having “their” patients, shift workers provide

¹⁷ In-hospital call is also generally required when physicians have call obligations directly to the hospital, as Dr. Hanke describes, to provide emergency or hospital-clinic coverage. Similarly, physicians with clinical appointments in teaching hospitals must generally supervise OB/GYN residents in person during their obligatory call periods.

medical care to anyone who presents themselves on L&D during their shift, and they have no prior or ongoing relationships to the patients. They are employed by large physician groups or hospitals, and rather than being paid according to the number of patients they see or deliveries they manage, they receive salaries associated with hourly wages. Hospitalists can be used by hospitals to provide continuous OB/GYN staff or by large groups, who want to contract out undesirable shifts such as nights or holidays.

In contrast to OB/GYNs who follow their own patients, hospitalists have defined, predictable work hours and no call responsibilities outside of their in-hospital shifts. They also report much better work-life balance as a result. Dr. Seton, a hospitalist in a large urban facility, describes what she likes about her work arrangement:

Dr. Seton: It's basically labor and delivery, whoever happens to come in, 'cause we always have a couple of C-sections scheduled. We have an indigent population, but we also have people from all over the world. So it's very interesting. And then we also have transports from other hospitals that come in who have medical problems or preterm labor or something like that. So it's quite an acute place....

Certainly, it doesn't pay as much as other jobs [in private practice], but we have a lot of flexibility, like when we want to work and when we don't want to work. I have to work a certain number of shifts per month, and, the good part is [that] I can take off all the time when I want. So that was very important when I was raising my children that I had a schedule. When the kids were young I really didn't work nights hardly at all.

Hospitalist jobs like Dr. Seton's have been gaining popularity, especially among younger physicians who are more eager to find positions that allow them to bound their work commitments, and who are willing to trade some potential income and the autonomy of self-employment for a better "lifestyle" (Olson et al. 2012).

Physicians' location on the coverage continuum explains differences in physicians' work life organization much more fully than other taxonomic approaches. As Figure 5 illustrates, the three broad areas of the coverage continuum do not line up with the practice setting categories of the AMA or Freidson's four practice structures. Among the OB/GYNs in this study, I found physicians in solo practice, associations, and small group partnerships who primarily covered their own patients. No physicians in this study

covered their own patients absolutely; even for the solo practitioners, they arranged some kind of cross-coverage for very important personal events or vacations. The degree of that cross-coverage, however, was linked much more strongly with other aspects of physicians' work life than their official practice structure.

Moving along the coverage continuum toward physicians who primarily organized their work through cross-coverage, OB/GYNs reported having improved work-life balance, more predictable and generally more limited work hours, along with financial arrangements that shared income more collectively. At the far end of the continuum, hospitalists who do shiftwork conduct the same procedures as other OB/GYNs, but their work lives looked were much more circumscribed. Their hours were predictable, fixed, and easily arranged; they had no responsibilities outside of their required shifts; they describe their work-life balances as very good. They may not earn as much as is possible in private-practice arrangements, but their salaries were guaranteed by their hospital or group systems, rather than being dependent upon changeable insurance reimbursements. In sum, knowing how OB/GYNs organize their responsibility for round-the-clock, individual patient care—knowing where they are located on the coverage continuum—illustrates more about their work lives than previous taxonomic approaches.

Physician-Patient Relationships and Physician Satisfaction

The coverage continuum not only illuminates differences in physicians' work lives, however. OB/GYNs' placement along this continuum also has profound implications for their relationships with their patients and, in turn, their satisfaction with their work and their careers (see Figure 6). Movement along the continuum implies not only different benefits, but tradeoffs of gains and losses.

**Figure 6:
Physician-Patient
Relationships**

	Coverage Continuum		
	Covering Own Patients	Cross-Covering	Shiftwork
Physician Relationships with Patients	Close, long-term	Mixed	None
Ongoing Emotional Burden of Responsibility	High	Medium	Low

Most OB/GYNs are drawn to this specialty because of its unique mix of surgery and medicine, of hospital procedures and primary care. For many physicians in this study, the crux of the appeal was the possibility of combining work that they enjoyed—surgery, office procedures—with the long-term patient relationships that can be part of medicine and primary care. Other surgical specialties do not facilitate these relationships, because patients do not continue to see their surgeons after their acute issue is resolved, but OB/GYNs repeatedly described these relationships as what motivated them to enter the field.

Dr. Wells: The ideal situation is to be a general OB/GYN who has a patient that you've had since they were 18, early 20s, and you're with them for decades as you practice, and as you go through their life...you are walking them through all the different things you can walk a patient through. The idea of being able to have that longitudinal relationship with someone that changes and goes through all of these things sounded ideal. It's what attracted me to that specialty in the first place.

Dr. Teppen: And we take care of women from—we always say from menarche to menopause and beyond. You see young women, and now it's oftentimes young women who are the children I've delivered, and watch them grow up and have their families.

These patient relationships have two dimensions: the longitudinal aspect of physician-patient relationships that span decades, and the shorter-term aspects that cover the duration of a pregnancy, from early prenatal visits through childbirth and postpartum care. Physicians who covered their own patients had the strongest relationships with patients in both dimensions. For Dr. Kern, who has been practicing this way for 40 years,

these patient relationships were crucial to his work satisfaction and his identity as a physician:

Dr. Kern: I always came in and delivered my own. And I still do. Why? I like what I do. I get to know my patients, and I think they are putting their trust in me. I should do what I can to be the deliverer. I'm an anachronism, I'm an old dinosaur. It's a little extra, but to me, it's worth it. For me, being satisfied with what I do, it's partly related to doing it the way I want to....

I am still seeing patients that I saw my first week in practice. We've delivered the children, we've done surgery on some of them, we've seen some of them go through losses, divorces, and tough times, and some really good times, too. It's kind of like a family reunion when they come in for a yearly checkup. We check up on their family, they catch up on yours. They know who my kids are.

Dr. Kern also distinguishes his practice from those that employ more cross-coverage, as well. Though cross-covering groups could still develop long-lasting relationships with patients even if a patient's primary doctor did not come in for a birth, he did not see it that way:

Dr. Kern: You don't develop as personal a relationship with a patient. There's a lot of large groups that rotate patients, so they are seen by whichever doctor happens to see them that day, and neither gets to know the other quite so well....

You get to the point where you know what things are important, and it really is just that patient-physician relationship...This is a pretty darn stimulating job to do, and I absolutely love seeing my patients coming back in, because they are like extended family. There's a lot of personal satisfaction, at least in the way I do it. If I just had to see any woman that walked into the office, whether I'd ever seen them before or whether my partners had seen them before, that would not be nearly as gratifying. It's still that relationship that's kind of the ground place on which medical care and trust is established.

I trust my patients a lot more than anybody else in the group, because I've known these people for 40 years. I know a lot about them, I know some of them will call, and if they call, they've got a problem, because they never bother you....It's a gift to me, too, because they're friends.

As Dr. Kern describes here, when these relationships build over the course of a career, they become something much deeper than the exchange between a service provider and a client or customer: bearing witness to patients' major life events over time creates a bond of trust that runs in both directions.

Residents still contemplating what kind of practice to pursue often waffle in their plans over the implications of different locations on the coverage continuum for patient relationships.

Dr. Mina: I struggle with that. I really love the idea of private practice because I think the greatest joys I've had on Labor and Delivery are when I get that continuity. I get

to see the same patients, and you get surprised that you see them on the labor floor and you actually get to deliver them—it's amazing. I love that continuity....

It's so hard because I see all the different kinds of groups that come through this hospital and there are very different types. Like, there are some groups that are huge, and there's, like, over 10 providers, and I sort of don't like the idea of that. I mean, it sounds great in terms of your hours. Like, you'd only be on call every 7 to 10 days—which sounds great. But how often do you get to deliver your own patients? What's the point of seeing someone nine months through pregnancy and then you don't get to deliver them? That just sounds really crappy to me.

The continuity of care that Dr. Mina describes—seeing a patient through all her prenatal visits and childbirth —was mentioned by many physicians as crucial to their concept of good medical care as well as their own professional satisfaction. Physicians described enjoying the “story” of pregnancy with patients, as they tracked them through the beginning and middle of their pregnancies and deeply enjoyed being part of the “end” by actually delivering their own patients.

For some doctors, these patient relationships were so important that they left jobs where they lacked that source of satisfaction. Asked how deliberate she was about choosing the level of patient coverage in her current practice, Dr. Macher explained:

Dr. Macher: [I was] *very*, very conscious about what I was going into. After residency, I actually left for a year and I was a hospitalist. I had the *best* lifestyle possible with a decent income. I absolutely hated it.

No continuity of care. I did not deliver a patient I saw in the clinic, and I didn't see patients I delivered. I had no idea who I was going to meet tomorrow. I had no idea about, you know, how my patients did. It was really sad. I love continuity of care. I would like to see my patient back and back and over and over and over. I want to deliver all her kids and see her kids growing....

I really do love my patients....It's just a completely different level of bonding because you see a patient and not only as a random person you see today for 10 minutes and are never going to see again, you see them growing from late teenage years to their thirties, getting married, and [you] bond on so many levels.

Other doctors realized how significant patient relationships were for their professional fulfillment when the content of their job shifted away from clinical responsibilities. Dr. Bahti received good news—a promotion to chairman of his department, in recognition of his scholarship and clinical care—but he found that losing his relationships with patients stripped away a major source of his satisfaction.

Dr. Bahti: I had this loss from patient contact and, you know, I got depressed, actually. I stayed in the job as chairman and I had a depression that lasted about a year, and

it was very traumatic for my family....My wife and I separated for a while and so it was a very hard time, and I wanted to go back to my practice, just the private practice.

Back in private practice, where he had more patient contact and could resume building relationships, Dr. Bahti went on to have a long and satisfying career.

Dr. Bahti was aware, however, that those patient relationships came at a cost to his personal life.

Dr. Bahti: My philosophy was that the patient owned me when I was on call. That was my contract. And the difference now, you know, as I see it, is that self-interest comes first. Their own lifestyle, their own families come first and I don't know, you know, what I sacrificed. I may never know, too, but I had no regrets as far as what I did for the patient, and I think that they loved having me as their assigned doctor and knew that they were getting superb care.

As these doctors indicate, there is a difficult tradeoff at the heart of the coverage continuum: greater commitment to covering your own patients leads to deeper and more meaningful physician-patient relationships, but at the cost of long hours and poor work-life balance. Essentially, deep patient relationships come at the cost of personal relationships. At the other end of the continuum, shiftwork arrangements protect private time and personal relationships, but they remove the possibility of long-term physician-patient relationships or even continuity of care. Since these patient relationships are so central to the professional satisfaction of many physicians, this tradeoff can be quite painful.

Dr. Seton, the OB/GYN hospitalist who chose a job that made her life manageable while raising her daughters, experienced this loss when she left private practice for her shiftwork position:

Dr. Seton: I think what I miss—I mean, I *very* much miss it—is the long-term relationship you have with patients. I mean, that is quite wonderful, and I don't have that anymore, and I mourned this for quite some time....So I don't have a lot of long-term relationships with patients. I mean, I did for 15 years and you're always carrying them home with you and—you know, and part of that is very—it's nice.

At the same time that Dr. Seton truly misses—even grieves—those relationships with patients, though, she also points out another cost that those relationships have for

physicians: one is “always carrying them home with you.” There is an emotional burden of concern for patients that are “yours”, and it increases along the coverage continuum as a practice becomes more organized to cover one’s own patients. Such doctors reported wondering about whether hypertensive patients were resting at home or taking their medications; on the other end of the spectrum, shift workers were freed from worrying about individual patients after their shift ended. As Dr. Seton put it, “You know, I had taken care of everybody for so long, I just didn’t feel like being responsible for anything anymore.”

The emotional burden of close patient relationships is the cost that must be born to enjoy the benefits of that connection. Each point along the coverage continuum demands a tradeoff between emotional freedom and patient responsibility, between close patient relationships and controllable work hours. Moreover, the weight of these tradeoffs—whether they seem “worth it”—can shift over time, even over hours.

Dr. Deacon: You have peaks and valleys. You have a bad break-up with a patient and things don’t go well, and you’re like, “I really gave it my all, and I can’t believe that they’re transferring their care,” and that’s really—it’s upsetting. Because you really gave them a lot of your time and energy.

Then sometimes you have the most awesome beautiful vaginal delivery and you’re like, oh my god. I can’t believe I got this patient who was such a complicated case to this point and delivered her baby and everybody’s happy.

Yesterday, one of my patients came in and brought her baby, and I was just hugging her baby so tight. It was just, like, a precious baby. She had a miscarriage at 20 weeks with her last pregnancy and didn’t know why. I was, “Ok, this is how it’s gonna be.” And you know, really, maybe I helped and maybe I didn’t. But I put her in the right direction, and then she had a baby full term and she came to see me yesterday and she was so happy—the baby is so big and so healthy. She was like, “Dr. Deacon, I love you so much! Thank you so much!” And she’s a grown woman! She wasn’t saying that in this, like, weird kind of adoration, like stalker-kind of a thing. Just like—and it was mutual. I was like, “Oh my god, I’m just so happy that we have a beautiful healthy baby and this is all we ever wanted, right?” And it was great. I was like, “Ok. This is why I do what I do.”

Then I keep moving along until the next incident and you’re like, “Damn! Why do I do this for a living? This is so stupid. It takes away from my friends and my family and I’ve got wrinkles and cellulite, and I can’t believe I do this for a living...”

It ebbs and flows, but I don’t think any of us get truly burned out. That continuity of care—you can’t replace it. When I hear how the structure of medicine is changing—it’s the one thing that drives obstetricians to continue doing what they’re doing, is that doctor-patient relationship and taking a patient through to a beautiful healthy delivery. And then letting them out into the world being parents. And it’s great.

As Dr. Deacon's comments illustrate, there are constant tensions around the tradeoffs that follow from each location on the coverage continuum. What helps physicians like Dr. Duncan sustain themselves through that tension, though, is being connected to what gives them personal meaning as a doctor. For her, it is a doctor-patient relationship carrying through difficulty to culminate in a healthy baby's birth; if she were a shift worker just meeting that patient on L&D, a healthy delivery would still be good, but it would be stripped of much of the meaning that having the deeper patient relationship gives it.

It is not that there is a perfect location on the coverage continuum that leads to physician satisfaction; instead, physician satisfaction derives from the fit between an individual OB/GYN's continuum location and his or her own personal sources of meaning. Doctors in this study who entered practices that did not line up with their sources of meaning either left them for other jobs (as did Dr. Macher, who missed patient relationships when a hospitalist), grew burnt out or depressed (as did Dr. Bahti), or left OB/GYN practice entirely. In this study, the two physicians who stopped practicing OB/GYN did so because they could not meet the needs of their families while working long, unpredictable hours covering their own patients. For various reasons, more circumscribed cross-covering and shiftwork arrangements were not available to them, so they left for nonclinical medical positions where they could use their skills while still being the parents they wanted to be. Individual physicians found satisfaction and deep meaning in their work at places all along the coverage continuum; again, it is not the location of the practice along the continuum but the fit between location physicians' sources of meaning that lead to satisfaction and staying in the field.

Patient-Physician Relationships and Patient Satisfaction

Physician satisfaction is not the only outcome of importance, however. Patient satisfaction has come to take on a much more visible role in health care in recent years, as portions of service payments have become tied to patient satisfaction scores. Even beyond the data from patient surveys, however, the experiences of patients matter. In OB/GYN, patient word of mouth is a primary recruitment tool for practices drawing new patients, and women often bring their families into the hospital systems where they deliver for additional medical care, making their experiences valuable to hospital administrators as well. More importantly, though, the experiences of pregnant and birthing women matter because they are profound events in the lives of women and their families, and whether those experiences are ecstatic, traumatic, or both, their feelings about their medical care casts a long shadow on their early motherhood.

Figure 7: Patient-Physician Relationships

	Coverage Continuum		
	Covering Own Patients	Cross-Covering	Shiftwork
Patient Relationship with Physician	Confidant	Acquaintance	Stranger
Patient Choice of Physician Practice Orientation	High	Mixed, depending on alignment of group physicians	None
Labor and Delivery Management	Often active management of labor and delivery to meet other obligations → more interventions	Mixed	No competing obligations → fewer interventions

In this study, I did not interview patients directly, but physicians reported effects of varying levels of coverage on patient experiences. I look forward to future work that

will corroborate and expand upon what these physicians describe, and here I present how physicians understand patient experiences to be shaped by practice location on the coverage

First, as is probably perceptible from doctors' discussion of their own feelings about close relationships with patients, patients whose doctors made great efforts to attend them personally felt very positively about those relationships. Like the women Dr. Kern describes above, who know his children, such patients were described as having intimate, trusting relationships with their physicians; their doctors were their confidants. Dr. Hallen, a solo practitioner who delivers all of his own patients, described the way his patients experience that relationship:

Dr. Hallen: They know me. If you choose to stay at our practice, that means you like me because there's no other person there. So when you like your doctor, the doctor doesn't have to do much. They just want to see your bald head and they're very happy with that. But I think psychologically you need that. And this is why I don't have 10 [doctors] in my office.

Dr. Hallen suggests that patients benefit psychologically from seeing the physician they have chosen and truly like, and Dr. Vass, who also primarily covers his own patients, suggests that this is especially important for women going through labor and childbirth for the first time.

Dr. Vass: If somebody were in labor, a patient you've never met before—I don't know, I just think for a first-time mom it's real important [to know the doctor attending her], because you see them 13-15 times during the pregnancy and weekly towards the end. So you get to know the patient, they get to know you. There's a trust relationship there. You kind of develop some rapport there, and that way when they come into labor, you know them, they know you pretty well. If someone were to come in to a setting and have never met that provider before, I think it would be a little awkward, especially with a first-time mom.

Dr. Hallen's and Dr. Vass's perspectives were echoed by many other physicians who covered their own patients; they saw their consistent presence with their patients as part of the medical treatment itself. Women in labor are vulnerable, and to the extent that they are with people they know and trust rather than unknown strangers, as would be the case

for shift workers, the psychological and even physiological aspects of labor and delivery can be improved (Hodnett et al. 2013; Sauls 2002).

Additionally, many such physicians felt uncomfortable with the idea of handing off patients to other doctors who would not know the patient's medical history or who might approach the medical management of childbirth very differently. Physicians were concerned about this both with regard to shift workers and also among cross-covering arrangements, where patients may have met the other covering doctors once, but see them as nothing more than acquaintances.

Dr. Wells: [There's] what I call the standard structure group practices, where when you're a patient you go to that practice, and you'll have a visit with Doctor A, Doctor B, Doctor C, and you might if you're lucky get to meet all the members of the practice in the course of your pregnancy. Then good luck who you get on the day you're actually in the hospital! People could be wildly different in how they approach labor, their tolerance for labor, their threshold for doing C-sections, their belief in certain things, their knowledge about surgical techniques, their knowledge about troubleshooting emergencies. Now that I've seen the difference, that's a really wacky idea to me that that's how most places expect patients to be treated....

I spent a lot of time thinking about all these issues, but in particular from the patients' perspective: what happens when you lose control over your relationship with your doctor? A phenomenon that I see a lot, that probably plays out across the country and is a very disturbing one, is that you might have someone you really like in the practice. You might win the lottery of having that person be there when you come in, and that person might leave at 5:00 PM and be replaced by the person you really don't want to see. The next thing you know you're being whisked off for a C-section you didn't think was coming.

I don't want to characterize too black and white, because the world of C-sections is a very complex thing. But there's a lot of, sort of, laxity about labor management that I think comes from protecting one's lifestyle, and I think when you're coming on shift at 5:00 PM, and you have a choice between being in the hospital with some patient who's not really yours more than anyone else's, and you're faced with this idea of a C-section at 7:00 PM and going home, versus hours of effort and maybe a C-section at midnight [and so people do the C-section early] to be able to go home if you're not still managing them.

Here Dr. Wells brings up two issues of concern to patients: first, that there is variation between physicians in the way they would clinically manage the same situation, and second, that physicians might treat "their" patients differently than other patients they cross-cover or see during their shift.

Dr. Wells describes patients as somewhat aware of these possibilities, in the sense that they may have a physician in their OB/GYN practice group that they "don't want to see,"

though the degree to which this aversion is dependent upon personality characteristics versus suspicions about clinical variation is not clear.

One doctor acknowledged this idea of differential treatment for “his” patients, as he discussed how he cross-covers for a separate group to earn additional income:

Dr. Lewis: When I come in for the other group, every patient that walks in when I’m covering will be completely new to me. I don’t practice with them. I basically just take one of the doctors’ call, because he didn’t want to do them anymore, and he’s just paying me on the side....I mean it’s completely different than if it was one of my patients right now going into labor. I definitely would not—the word is not, like, not *care*, it’s not like that—but more like, maybe...designate more work to residents to take care of them. It wouldn’t be the same. I’d definitely give more personal attention to my own patients.

But if I were dealing with the situation where it’s my group and, you know, this is my partner’s patient, I think that would be a little bit different. And maybe I’m giving more personal attention. But...let’s say I’ve been with this patient all night in labor and now I’m finished covering? And would I feel bad about punting it off to the next colleague? No, it wouldn’t matter. It wouldn’t matter.

Here Dr. Lewis effectively confirms the sliding shift of committed physician attention based on the coverage continuum: for *his* patients, he gives lots of personal effort; if he had group or partners’ patients, he would give moderate effort; for shiftwork patients, he gives the least effort.

From the patient perspective, then, it seems that choosing a physician more committed to covering his or her own patients maximizes the patients’ power to have a physician whose philosophy of childbirth management best matches their own. When being cared for by a practice that cross-covers, the degree of influence the patient has is entirely dependent on the level of coordination and willing cooperation between the physicians in the cross-covering group. Some of the physician practices in this study had very high levels of such cooperation, either by sharing strong norms about labor and delivery management or by sharing strong norms about consulting and deferring to the primary physician. Other practices, however, reported variable approaches among cross-covering physicians, leaving patients open to the kind of negative surprises Dr. Wells

describes. Patients being treated by hospitalists working shifts, of course, have no influences whatsoever over their physician's practice orientation.

Patients who are concerned about having influence over the practice orientation of their physician may prefer to seek out physicians who try to maximize the degree to which they cover their own patients. Such efforts are, perhaps, most likely among patients who are suspicious of overtreatment in childbirth and motivated to seek a physician with a high priority on vaginal or unmedicated deliveries. Ironically, though, this is an area where patients' perspectives may substantively diverge from reality. Studies have found that OB/GYN hospitalist practices have lower rates of cesarean section and higher rates of vaginal birth after cesarean (VBAC) compared with private practices, a finding that goes against the expectation of some physicians and patients who anticipate poorer care in shiftwork models (Rosenstein et al 2015; Nijagal et al. 2015). Part of this difference is possibly due to the removal of incentive to "actively manage" labor and delivery for hospitalists' patients: since the hospitalists have no possibility of leaving their shift early to go home if a labor is accelerated or a C-section occurs sooner, they are more likely to wait and let labor proceed naturally. Similarly, since they lack any financial incentive to be present for a birth—as they receive the same salary either way—there is no benefit in trying to encourage a woman to deliver before their shift ends. Also unlike many physicians who cross-cover and almost all physicians who trying to cover their own patients, hospitalists are on the labor ward for patients' whole labor, rather than just coming in at the last moment to physically catch the baby (and the fee).

Some physicians who cover their own patients confirmed that they engage in efforts to manage patients' labors and deliveries to improve their own schedule. Part of these efforts were necessitated by the dual responsibilities physicians had to take care of their office patients at the same time as they kept track of their laboring patients; no one

can be in two places at once. Leaving an entire clinic full of women to be rescheduled to go to the hospital for a long labor does sometimes have to occur, but it may lead the unhappy office patients to look for a new OB/GYN.

Dr. Hanke: My entire life is about *timing*, that's what I tell people....The majority of patients that I have do require some sort of [management], either me breaking their bag of waters or me giving them medicine to augment their labor and make their contractions stronger, more intense, more regular. So those things—the things I can control, I control. And the things I can't, I mean that happens sometimes. I've had to leave in the middle of dinner and things like that, and it's just the way it is. But the things I can control, I do make sure to control....

I do inductions of labor just for patients' schedules and for my schedule....I am very strict and diligent about making sure that I'm delivering them [after] 39 weeks [in accordance with new guidelines], but I do a fair amount of inductions...I actually have a pretty good vaginal delivery rate and not an excessively high cesarean-section rate. I think we do pretty good....

For instance, I went to deliver a baby this morning, and I have another girl up there right now whose water just broke. She has an epidural in place. I told the nurse who's taking over for her to go and start her Pitocin [to augment labor]—gently. Since then, I have come home, I'm gonna walk in, shower, change clothes. And the wife and I have a meeting to go to, and then I'll probably call the hospital, see how things are going, maybe get lunch with my wife and then be at the clinic this afternoon. So I'll go back and hopefully have a baby before 5:00 PM.

But if not, well, if not, I'll tell them, "Ok, let's slow down the Pit." I'll go on home, get my kids bathed, put in bed, I'll go back and deliver after they're asleep. So like I said, it's just, you know—and again, if something catastrophic happens, I have to leave, and that's just how it is. And my wife understands that, and I understand that.

The time-shifting of labor described here is invisible to patients; they see their physician, with whom they have a close relationship, coming to be there for the moment they give birth. It is unlikely that many patients who chose to go to such a practice think much about the possibility that the physiologic course of their labor may be manipulated to make their physician's daily schedule go more smoothly. The patient is making a tradeoff here, too, albeit unwittingly: in choosing a provider who maximizes the potential personal relationship of committing to deliver her, she may be trading away her opportunity to have her labor proceed without unindicated medical interventions.

Conclusions

Conceptualizing obstetric physician practices along a coverage continuum, from always covering one's own patients to shiftwork, makes tremendous improvements over prior models in terms of explaining variation in the organization of medical work, the experiences of physicians in their everyday work settings, and the tradeoffs that both physicians and patients make between sources of satisfaction and areas of control. This area of medical practice has been long neglected and undertheorized by medical sociologists, which has led to longstanding misunderstandings of the nature of variation in medical work settings and obscured real differences in practice organizations and physician satisfaction.

Within the medical literature, there has been enormous attention paid to specialty choice, but almost no attention paid to choice of practice setting. Moreover, because “practice setting” has typically been understood in the same outdated typologies discussed above, what little career counseling is available often muddles the real differences in the organization of everyday work and the sources of satisfaction between settings. This research contributes to filling this gap, as by better understanding what makes physician practices different, doctors can find a better match between their own personal sources of meaning and the options for accessing them in a given job.

Job satisfaction, burnout, and physician discontent have received a great deal of attention in the last two decades. These concerns have been particularly pointed within OB/GYN, as this specialty is often near the bottom of career satisfaction rankings and near the top of burnout lists (Kravitz et al. 2003; Becker et al. 2006). But this research still conceptualizes OB/GYN practices in the taxonomic categories that obscure their differences; using the coverage continuum to better understand the differences between

obstetric practices may illuminate sources of meaning and discontent than have been previously obscured or misunderstood. In particular, studies of career satisfaction among OB/GYNs have tended to compare different settings (e.g., academic versus private practice in Bell et al. 2006) or parse elements of work associated broadly with dissatisfaction (e.g. heavy workloads, little personal control in Bettes et al. 2003), but none of them have examined anything like fit between practice organization and personal sources of meaning.

Paying attention to the coverage continuum and the differences in practice organization is particularly important now. In recent years, economic pressures and regulatory changes have pressured physicians to agglomerate into ever-larger groups or sell their practices directly to hospitals or medical consortia; at the same time, younger generations of physicians have prioritized “lifestyle” and work-life balance to a much greater degree than their forebears (Kane and Emmons 2013; DiVenere 2011; Dorsey et al. 2005; Newton et al. 2005; Lambert and Holmboe 2005). Further encouraging these generational differences, restrictions on residency duty hours have created a working culture among recent residents that expects limited hours within medical practice; they have been socialized to see medicine as a job that can be clocked in and out of without compromising their vision of professionalism. All of these factors have pressed in the same direction, toward models with increasing degrees of cross-coverage and shiftwork. In many ways, this is good news for OB/GYNs: some of their perennial complaints—poor work-life balance and long hours—can now be mitigated through changing practice arrangements. Younger physicians are much more likely to seek practices on the shiftwork side of the continuum.

This research on the coverage continuum should give these young physicians some pause as they search out their early jobs, however. Though positions in large groups with

infrequent call responsibilities or as hospitalists with set schedules undoubtedly improve work-life balance and likely overall satisfaction with personal lives, there is a key tradeoff made: the patient relationships that form such a huge part of many OB/GYNs' sense of professional and personal meaning are compromised as one moves along the continuum toward shiftwork. OB/GYNs who work shifts or have large cross-coverage groups end up seeing the same patients for routine checkups but caring for strangers on L&D; they may be doing the same number of procedures in total, but losing the connection between patients in the clinic and in the hospital strips away much of the meaning of the social experience of birth. Instead, relationship development is left to the clinic alone, and though it could be possible to achieve closeness in that situation, it seems much less likely. None of the physicians in this study said they chose to be OB/GYNs because they loved doing Pap smears.

Again, though, in this study satisfaction was not associated with finding the ideal point along the coverage continuum: physicians' satisfaction came from a fit between their location on the continuum and their values. For some physicians, patient relationships and continuity of care were of the highest importance; others found requirements to cover their own patients to be overwhelming, and they sought positions on the continuum that restricted patient demands on them, usually to free them to meet their family needs. Other physicians found joy in the clinical excellence they felt they had as hospitalists who were true experts in labor and delivery. Many more physicians sought a balance of all the factors: some ability to control hours and schedule through cross-coverage, some flexibility to deliver their own patients and develop close patient relationships when possible.

The coverage continuum also illuminates important aspects of patient experiences. Future research is needed to investigate these patient experiences directly, but physician

here offer thought-provoking perspectives on the tradeoffs patients are sometimes unwittingly making regarding their care. Physicians who primarily cover their own patients describe relationships with them that are intimate and significant—they see their patients as treating them as confidants. As practices employ increasing amounts of cross-coverage, the patients’ relationships with their physicians shift toward being acquaintances, with some interaction but much less intimacy. And for hospitalists working shifts, both the physicians and patients are strangers to one another.

At the same time, one of the few points of control that patients have over their obstetric care is their choice of a medical provider: choosing a physician that covers his or her own patients allows a pregnant woman much more agency in attempting a match between her desired childbirth experience and the obstetric philosophy of her provider. Patients in cross-covering practices can have highly variable experiences depending on who they draw in the hospital, and patients seeing shift workers have no ability to influence their provider’s care orientation at all. It would seem natural, then, for women to be drawn to practices that are closer to covering their own patients.

One of the ironies for patients, however, is that physicians who cover their own patients have such temporal challenges in doing so that they may resort to manipulating the labors and deliveries of their patients in order to meet all their competing demands. It seems very unlikely that patients are aware of this possibility, or even that when it comes to pass that they are apprised of the reasoning behind their labor interventions or the risks that attend them. In fact, women concerned about achieving a vaginal delivery may find they are better supported by hospitalists than by physicians who are committed to attending their delivery, but who may be absent for all but the moment of birth.

This paper explores the coverage continuum with regard to OB/GYNs who practice obstetrics, but it is applicable beyond this medical specialty. There are whole medical

fields with little variety in practice models, where specialists essentially all occupy one place on the spectrum; for instance, radiologists and emergency medicine physicians are all shift workers. Other fields, such as oncology, have more diversity of levels of individual patient responsibility outside business hours. For all of them, though, their place on the coverage continuum—the level of responsibility one physician has to meet the needs of one individual patient at all times—explains some of the possibilities and limitations of physician-patient relationships and work-life balance for physicians. Conceptualizing these sources of frustration and satisfaction as tradeoffs due to position along the coverage continuum may be more useful for understanding physician experiences than simply counting work hours or call shifts.

This research is limited by its foundation as an interview study of one medical subfield; broader future research could expand its questions beyond OB/GYN to interrogate whether indeed other specialties experience such tradeoffs of meaning, relationship, and time. Moreover, the interviews from which this work draws were gathered by nonrandom sampling: future research employing random samples, perhaps using survey instruments to future investigate links between the coverage continuum and physician satisfaction, could offer more conclusive evidence regarding the durability of this novel theory.

CONCLUSIONS

The professional identity of Obstetrics and Gynecology is changing and has been for some time in the view of outsiders, fellow physicians, and OB/GYNs themselves. Some of these changes are responses to macro-level, exogenous factors: rises in malpractice litigation and the increases in liability coverage premiums required to insure against lawsuits, shifting economic incentives and legislation that press forward some forms of health care organization and undermine others. But OB/GYNs' professional identity, to themselves and to the outside world, is tied much more closely with three meso-level changes discussed in these three papers: the gender shift from a male- to a female-dominated occupation, the effects of cohort replacement as Baby Boomers retire and Millennials enter the medical workforce, and the evolution away from practice arrangements based on covering one's own patients and toward ones that more closely resemble shiftwork.

These changes have radically altered the public and the medical community's perceptions of the profession of OB/GYN. As female OB/GYNs become more common, they have become normative to many female patients. This public expectation that OB/GYNs be women has deeply transformed the professional group-identity of OB/GYN physicians themselves. The gender dynamics within the profession have become much more complicated, as young male students feel discriminated against or out of place in an occupation where the expected physician is female. Similarly, male OB/GYN residents are

encouraged to subspecialize to become more marketable and protect against uncertain demand for their services.

Those patterns are driven by external perceptions or expectations of the identity of the OB/GYN professional; within the specialty, physicians generally believe that the gender of the physician matters very little—if at all—in the provision of good medical care. As one female OB/GYN put it, “I don’t really care if my patients are delivered by a man or a woman. My patients care, but I don’t care.” Within the confines of the specialty, where patient demand has less influence on professional status (as in training programs and in departmental leadership), men indeed appear advantaged relative to women. Yet they must still negotiate stigma from outsiders who view their professional identity as suspect, and the tensions between being male and being an OB/GYN are only likely to grow as they become a steadily smaller share of physicians in practice.

Other changes to professional identity have been driven less by responses to external expectations than by differences in the orientation of new physicians themselves. Millennial doctors as a cohort do not recognize the medical work-devotion schema so embedded in the professional self-concept of earlier generations; they do not report feeling obligated to attempt to meet a hero-standard of priority for patients and hospital time. Instead, their assumption is that seeking balance between work and home by protecting their personal time is a positive step in their professional development. They see self-care and family responsibilities as demands on their time that are just as valid as patient care, and they seek practice arrangements that they think will be sustainable for them over the long haul. These generational differences in professional identity have been strongly abetted by the changes in socialization during residency, as work hour restrictions have delegitimized older norms of professional duty and the identity that flows from fulfilling it.

Along with the macro-level economic, corporate, and policy influences that have pressed physicians toward larger practice groups and employee positions, these generational shifts in professional identity have diminished physician resistance to practice structure changes and encouraged the trends toward large group, salaried, and hospitalist physician practices. The same priorities that some Generation X and almost all Millennial physicians have on work/life balance and limited or predictable work hours make cross-covering in large groups and shiftwork practice structures much more appealing; there is a trend over time away from the end of the coverage continuum where physicians cover their own patients and toward practice structures more like shiftwork.

These predictable work arrangements allow for much better work/life balance, but they undermine or eliminate the opportunities for long-lasting, emotionally deep relationships with patients, and these relationships are often key elements in the professional identity of OB/GYNs who cover their own patients more often. These relationships are sites of particular meaning to physicians and where they draw great satisfaction; moving along the coverage continuum towards heavy cross-covering and shiftwork trades away this site of fulfillment and professional identity for another conception of professional identity—one based around successfully fulfilling multiple social roles (parent, spouse, child, friend, doctor) simultaneously, rather than privileging medicine and patient care.

Tracing the evolving professional identity of OB/GYNs through the profession's changes in gender composition, generational replacement, and practice organization provides a window into the broader changes in medicine, the workforce, and the meaning of work over the last 40 years. OB/GYNs are not unique in many of these aspects; they may often have exaggerated experiences, but the heightened nature of them (for instance, the dramatic gender shift) serve to illuminate the same forces at work in other fields where

the changes have been slower or more modest. Similarly, the generational differences between physician cohorts are likely to be noticeable in all specialties within medicine, though the strength of the shift in priority for work/life balance over medical work-devotion is likely more visible in fields like OB/GYN or general surgery, where working hard, long, unpredictable hours had previously been evidence of superior devotion and medical excellence. The coverage continuum also describes medical practice outside of OB/GYN as well, though often whole specialties occupy single locations on it (as do emergency medicine and radiology, which are always shiftwork). The trends that have made cross-coverage and shiftwork more appealing in OB/GYN operate there, too, as specialties that have more of those structural elements become more popular. All of these social shifts are part of broader generational trends away from finding meaning and identity from conforming to external standards of work-devotion and toward finding meaning from conforming one's work to internally-derived conceptions of one's personal identity.

Limitations and Future Directions

There is much more to investigate about these changes in OB/GYN, in medicine, and in work. Because much of the qualitative data gathered here draws from 51 interviews, the data is rich in depth but not in breadth: I made efforts to be as inclusive and diverse as possible in the snowball sampling that was necessary to gain access to informants, but these 51 physicians were not randomly selected and cannot be considered representative of their whole specialty in a statistical way. This study is also limited because it draws from research on one sub-field within medicine; comparing the experiences of multiple

medical specialties would provide powerful evidence supporting claims about generational shifts in medical work-devotion and the meaning of gender in specialties that are integrating or resegregating.

In particular, I see several avenues of future research that could help illuminate the theoretical and empirical findings presented here. To determine whether the generational shifts in allegiance to the schema medical-work devotion are indeed widely present, it would be helpful to interview physicians in at least two more specialties. For the best comparison, I would choose specialties with traditionally high expectations of medical work-devotion (such as general surgery) and with potentially lower expectations (such as pediatrics).

Interviewing men and women in these two specialties would also provide an opportunity to advance the examination of the gender transformation within medicine. Pediatrics is dominated by women, just like OB/GYN, but the presence of women in its field has been long-standing and has not had the dramatic reversal of gender segregation that OB/GYN has experienced. In contrast, general surgery and its subspecialties has been traditionally male-dominated and remain so today, though the numbers of women entering are slowly increasing. Comparing general surgery, pediatrics, and OB/GYN could illuminate the experiences of gender minority physicians in different circumstances, both for current trainees and for physicians reflecting on their experiences entering the field in the 1970s and early 1980s. What are the similarities and differences for gender minorities in these specialties, and how have those experiences changed over time?

Unlike general surgery and most aspects of general practice pediatrics, OB/GYN's field of medical expertise can be much more personal and sensitive, as it often deals with sexual health and sexual problems. For this reason, gender concordance between physicians and patients could be more important in OB/GYN, both to practitioners and

patients. Comparing the perceptions of demand for male physicians and the experiences of them in OB/GYN to the experiences of women in a specialty that often cares for male sexual health and dysfunction—urology—could therefore illuminate the ways in which gendered expectations of physicians mirror each other or are uneven. Are the concerns of patients and physicians in gender discordant situations similar in these two fields?

Regarding the coverage continuum, it would be useful to test the extent to which it offers explanatory power beyond OB/GYN. Returning to potential comparisons with pediatrics and general surgery, I hope to learn how medical work is organized in those fields and how responsibility for individual patients is assigned. General surgery has historically had much shorter time horizons for patient relationships, as the surgical follow-up appointment—if it happens—is often the terminus of the physician-patient encounter. How do surgeons conceptualize their responsibility for individual patients, and what do those relationships mean to them? In contrast, a large part of pediatric practice has traditionally been the maintenance of patient relationships, even in the absence of health problems or concerns. In times of health or when there are no acute, after-hours medical needs, this may work perfectly fine within a framework of set physician office hours; what does the physician-patient relationship look like when there are after-hours or emergent needs? How do pediatricians understand their responsibility to their patients then? And if these three specialties offer three distinct ways of viewing physician responsibilities to patients, are those differences part of what draws medical students to choose one specialty over another?

Significance

Finally, why should sociologists care about the experiences of physicians? There are no patterns of persistent, overwhelming injustice here; physicians certainly face problems, but they are on the winning side of the bifurcations of the contemporary American workforce. They have tremendous resources in education and training; they earn many multiples of the median U.S. income; they are widely esteemed and have high prestige. Most of the tradeoffs examined here are the result of choices that they make more or less freely. What is sociologically important about them?

First, physicians matter because they are people, and their sources of meaning and frustration, of satisfaction and burnout, are no less and no more important than those of other groups. Moreover, to the extent that many of these patterns of generation, gender, and work organization affect the lives of physicians—and I think they do very much—better understanding the contours of these social forces helps physicians make sense of their own experiences and challenges. Ultimately, this understanding could help physicians more clearly recognize the sources of strain in their lives, practices, and specialty and take steps to ameliorate them.

Second, physicians matter because their individual choices about work affect the structure of health care in the United States, its availability, and the lives of patients. Younger generations entering medical practice without a sense that their lives are owed to medicine leads to physicians taking more circumscribed jobs, working fewer hours, and sometimes leaving medicine earlier in their careers. All of these choices affect the structure of medicine, because they affect the patterns of work organization that become dominant, and its availability, since the long training period of physicians makes the pool of physician labor less responsive to unmet patient demand. If doctors are less available,

patients have less opportunity to be seen by a physician, resulting either in health care gaps or in shifts toward the use of non-physician medical providers.

Similarly, the choices of women to enter medical school and to seek training as OB/GYNs have radically changed the landscape of available physicians for women patients. Women patients have been very pleased with their expanded choices, and women who want to become physicians have benefitted by the opportunities to do so. At the same time, as integration of some medical fields has tipped into resegregation, this new gender imbalance has dissuaded many men from entering a specialty where they might contribute a great deal. It is just as problematic for men to feel shut out of an occupation as it is for women to be so denied.

The choices of OB/GYNs regarding how to structure their medical work and patient responsibility—where to locate themselves on the coverage continuum—also matter for individual physicians, for medical care structure and availability, and for patients. As physicians tend over time to be offered and to choose jobs with more cross-coverage or shiftwork schedules, the content of physician obstetric care changes, especially regarding the expectations of patient relationships. Women patients increasingly are told they cannot expect their own doctor to be present for their delivery, and they may often have never met the person in charge of their parturient medical care. Such practice arrangements necessarily affect patient experiences for good and for ill: patients may receive better, more attuned, more expert, more patient-centered care from a shift worker, or they may be traumatized by conflicts with an unpleasant physician they would never have wanted to see. These choices about the coverage continuum also affect the satisfaction of physicians, as they force them to trade off some sources of meaning—close, long-term patient relationships—to have more access to others, such as family time and work/life balance.

Finally, the experiences of OB/GYNs reflect the broader experiences of physicians as medicine as a whole undergoes continuing gender transformation, generational cohort replacement, and changes in practice organization. These factors have influence beyond medicine, too, as the same social forces are at work in the larger American workforce with varying degrees of influence depending on its sector. Understanding these changes as thoroughly as possible, and connecting these changes to the experiences, frustrations, and satisfactions of professional workers, is crucial for understanding how the workforce operates today and where it may be going in the future.

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