Feminism and Profit in American Hospitals: The Corporate Construction of Women's Health Centers

Jan E. Thomas and Mary K. Zimmerman

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FEMINISM AND PROFIT IN AMERICAN HOSPITALS The Corporate Construction of Women's Health Centers

JAN E. THOMAS
Kenyon College

MARY K. ZIMMERMAN
University of Kansas

This article provides a critical analysis of the evolution and impact of hospital-sponsored women's health centers. Using original data gathered from interviews, participant observation, and content analysis of documents and brochures, the authors describe the development of four models of hospital-sponsored women's health centers and illustrate three specific mechanisms of the co-optation process. They show how many elements of feminist health care were used for the purpose of marketing and revenue production rather than for empowering women and transforming the delivery of care. Following Stratigaki's notion of negative countereffect, the authors show how the key feminist concepts of women-centered care and empowerment ended up contradicting their original meaning and purpose. Rather than being the subject of care, women became the object of treatment and revenue production.

Keywords: *women's health; feminism; co-optation; empowerment; profit*

Hospital-sponsored women's health centers (HWHCs) have helped define health services for American women since the early 1980s and have mainstreamed women's health into the U.S. health care system. According to the American Hospital Association's 2003 data (Sheila Cochran, personal communication), almost one-half of U.S. hospitals have some type of women's health center. Advocates believe their gender-specific approach has raised the visibility of women's medical issues well beyond the narrow confines of reproductive health. Critics, on the other

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hand, view them as co-opting and diluting the changes proposed by earlier feminist activists. Given their prevalence, it is surprising that HWHCs have received relatively little research attention. Several authors have traced their development and commented on their relationship to the earlier feminist women's health movement (Kay 1989; Morgen 2002). Beyond this, there has been no detailed, systematic analysis of their evolution or impact. Our research looks at the development of HWHC models in the 1980s and their transformation over 20 years.

Today, the term "women's health center" typically refers to a particular package of services and programs offered by hospitals or their doctors. Services may include reproductive care, diagnostic tests, educational programs, primary care, spa and appearance services, and referrals to affiliated providers and clinics. The goal is to "capture the woman patient," and the target market is the insured, middle-income woman with disposable income (Looker 1993; Morgen 2002). Begun in the 1980s, HWHCs were developed primarily as a marketing vehicle to bring women's health care dollars into the hospital system. The original concept of women's health centers, however, was a product of both the consumers' health movement and the women's health movement of the 1960s and early 1970s. Early grassroots feminist women's health centers (FWHCs) were developed by and for women as an alternative to the mainstream health care system (Looker 1993; Ruzek 1978; Weisman, Curbow, and Khoury 1995).

FWHCs reflected their roots in the "radical" Left in both services and structure with an emphasis on self-help and participatory democracy (Thomas 1995). Services were women centered—women cared for other women, women were the subject of care, and women were partners and active participants in their health care. While services originally centered on contraception and gynecology (and in some cases, abortion), education focused on women's bodies and health beyond reproductive issues. The goals of these FWHCs included (1) demystifying medical processes, (2) empowering women through education and support, (3) providing services that were women centered and accessible to a variety of women, and (4) advocating for women and women's health issues (Fee 1983; Ruzek 1978; Thomas 1999; Zimmerman 1987). Approximately 50 such centers existed in 1976 (Ruzek 1978).

By the 1980s, some 3,600 facilities called themselves "women's health centers" (Weisman, Curbow, and Khoury 1995). It is important to note that 80 percent of the centers founded after 1985 were part of hospitals or corporate health care systems. In this article, we show how many of the elements of feminist health care pioneered by the early FWHCs have been

co-opted by HWHCs and used for the purposes of marketing and revenue production rather than for transforming the way health care is delivered. Far from the empowerment envisioned by the feminist women's health movement, current critics see HWHCs colluding with popular culture and media images to manipulate women and exploit their bodies and health (Davis-Floyd 2004; Ratcliff 2002; Sullivan 2001; Weitz 2002; Wolf 1991).

What is missing from critics' accounts, however, is a systematic analysis of the mechanisms through which this shift from empowerment to a co-opted, market-driven model took place. Using case examples and qualitative interviews with hospital executives from HWHC staff, we provide such an analysis here. We show how women have moved from subjects of care to become objects of treatment and revenue production and how the intent of early feminist centers was dramatically contradicted in the process. Drawing on a wide variety of historical and case material, we highlight three specific mechanisms through which the co-optation of the grassroots women's health care model occurred.

Co-optation of Women's Health

Social scientists have given minimal attention to HWHCs, with Weisman's (1998) historical account of women's health care being a key exception. Moreover, conceptual analysis of what has happened to feminist women's health has failed to move much beyond the basic 1980s notion of co-optation as nonfeminist mainstream health care providers' taking feminist ideas and making them their own (Morgen 1986; Ruzek 1980; Whatley and Worcester 1989; Zimmerman 1987). Neither the specific dynamics of co-optation nor the changing political and economic health care environment have been adequately explored. Changes during the past 25 years suggest that developments in women's health may best be studied in terms of a political organization intersecting with the marketplace (see Loe 1999). The development of HWHCs provides an important opportunity to focus on co-optation as part of this process.

The term "co-optation" is often used in the social movements' literature to describe the process through which agitators are absorbed into the structures they have been struggling against (Ferree and Hess 2000; Piven and Cloward 1971). But the term may also be used to describe the appropriation or dilution of the ideological principles and practices of movements. The recent work of Stratigaki (2004, 1-2) defines co-optation as occurring when "the [feminist] goals of . . . proposals are undermined by shifting the meanings of the original concepts to fit into the prevailing

political and economic priorities . . . resulting in the loss of their potential for changing gender relations." Stratigaki's focus on economic imperatives helps us better understand the development and present practices of HWHCs because prevailing priorities in health care have shifted so dramatically toward profitability. What HWHCs offer, and what many women seek, is in reality not women-centered but rather hospital-centered (read profit-driven) care. Childbirth epitomizes this (see Davis-Floyd 2004). To attract clients, hospital birth centers in the 1990s began to feature what two decades earlier were alternative practices, for example, nontraditional labor and delivery equipment such as large balls, water tubs, birthing chairs and a homelike décor. More recently, the focus has been on convenience and hotel amenities such as gourmet meals, wine, and luxury bed linens. Yet at the same time, there have been few changes in traditional hierarchies or the generous use of medical technology and drugs. The majority of births in HWHCs are still at odds with grassroots feminist health care practices.

Even more important for our analysis of co-optation, Stratigaki (2004) points out that agendas for changing the status quo—such as women-centered care—are not rejected as a result of co-optation; rather, their initial meaning is transformed so that they are used for a different purpose than originally intended. In contemporary HWHCs, the meaning of "women-centered care" has shifted from its original implication that women should have decision-making power to a model in which women are pampered and attended to by experts and hospitals with the latest technology available. Following Stratigaki, we argue that as concepts from the feminist model of care were co-opted by hospitals, their meaning gradually shifted "from an objective with feminist potential . . . to a market-oriented objective." These concepts were then "used to promote goals that contradict the original meaning of the concepts" (Stratigaki 2004, 31). In the context of their new meaning, they were stripped of their potential for transforming women's health care.

In this article, we examine the origins of the HWHC concept and its manifestation into four primary models: programs, pavilions, centers, and medi-spas. We provide case studies of each model and illustrate how various concepts of feminist care were appropriated by the hospitals and used as marketing tools. In addition, we detail three specific mechanisms of the co-optation processes: (1) the redefinition of the meaning of "women-centered" services, (2) the transformation of empowerment, and (3) the shift in locus of control. We conclude with a discussion of how these notions might apply in other settings.

METHOD

To answer our research questions, we used a historical, qualitative analysis of three sources: (1) in-depth interviews with hospital administrators and medical directors representing five hospitals with women's health centers, (2) participant observation in three additional women's health centers, and (3) written documents and brochures from these and other women's health centers. These data were collected first independently and later jointly by the authors. They represent multiple time periods between 1982 and 2002 in selected U.S. metropolitan areas in geographic locations available to the authors in four Midwestern and Western states. To supplement our analysis, we drew on articles from marketing and business publications representing the same time period.

Interview Data

Our data set includes 19 individual interviews with hospital administrators and medical directors. In 1988, we examined all hospitals in one large metropolitan area and found six hospitals that advertised women's health services. Four of these met standard criteria for a "program," "center," or "pavilion" model HWHC (defined in the next section). Thirteen interviews were conducted in 1988 and 1989 at these four hospitals (identified here by pseudonyms). Those interviewed included two hospital CEOs, two chief operating officers, two marketing managers, two directors of ambulatory services, two medical directors, two women's health center administrators, and one hospital community relations director. A follow-up study was conducted of these four hospitals in 1997. We found only one of the original four women's health centers still in existence. An additional hospital (not part of the original study) had added a women's health center. We interviewed the administrators of each of these two hospitals. Finally, in 2002, we studied a new, physician-owned women's health center in one metropolitan area and interviewed the administrator and medical director.

A single interview guide was used for all interviews. Since many interviewees were upper-level executives, we decided to take notes rather than to tape record. We thought this approach would be less threatening and would increase participation. In fact, all those asked agreed to participate and chose their own offices for the interview location. They were told that the purpose was a study of hospital innovation focusing on women's health services.

Participant Observation

At three sites, we had the additional opportunity to conduct observations during a longer period of time. The first author helped establish the country's first hospital-based women's center in Chicago in 1982 and collected data during that time. She collected similar data at several new HWHCs in the Denver area in the mid to late 1980s. The second author conducted observations at a Kansas City HWHC in 2001 and 2002.

Documents and Print Media

We also collected written materials documenting the development of specific HWHCs in three metropolitan areas between 1982 and 2002. We reviewed trade journals, newspapers, and popular print media from the 1980s and 1990s.[1] These sources provide important documentation for how the HWHCs were framing their views of women's health care. In the 1980s and 1990s, newspapers, business journals, and women's magazines ran articles on emerging trends in women's health care and "cutting edge" HWHCs. In 1986, *Ms. Magazine* summarized many of the early trends in women's health care and profiled some HWHCs in a story titled "One-Stop Health Care for Women" (Jacobs 1986). In 1999, CNN.com posted a story titled "Magazine Selects Top Women's Health Centers," which featured *Health Magazine*'s five top women's health centers. Using medical, business, and popular culture sources to identify model HWHCs, we were able to track their development. It was difficult to trace some of the earliest centers due to hospital mergers and acquisitions, so much of this research was essentially detective work. Since the 1990s, a major industry has developed in marketing women's health care. Publications, conference proceedings, and consultants' Web pages were very useful for tracing more recent women's health services trends.

While our research is limited because we do not have a random sample of health care markets across the country, the HWHCs we studied represent diverse geographical locations.

MODELING WOMEN'S HEALTH: PROGRAMS, CENTERS, PAVILIONS, AND MEDI-SPAS

Women were recognized as a major health market in the early 1980s. The first HWHC, Women's Health Resources, was opened in 1982 by Illinois Masonic Medical Center. The director, a woman's health advocate,

worked to incorporate many of the concepts of feminist care into the center. Billed as "an alternative within the system," the freestanding facility was located in an apartment building across the street from the main hospital. The center's services included a resource center and library, educational programs, workshops, and a female internal medicine physician. Consistent with a feminist model of care, an early goal of the center was to move thinking about women's health beyond reproduction. Within two years, the all-female staff had grown to include a second internal medicine physician, a nurse practitioner, a psychiatrist, an OB/GYN, an education coordinator, and a nutritionist (Center targets women's health needs 1984). "One-stop shopping" was the term coined to describe this type of center—primary care, specialists, education, and mental health all in one location.

Women's Health Resources also sought to empower women to be participants in their own care. Women weighed themselves, could read their charts, and were given 20- to 30-minute appointments for routine care. Providers conversed with patients fully clothed and seated on the same level. Other procedures—such as Saturday and evening hours, child care, prompt return and explanation of lab results, and prices quoted in advance—served as "symbols of respect" for patients (Rynne 1985a, 63-64; 1985b, 15; 1989).

Women's Health Resources exemplifies a model of a comprehensive women's health center. During the first decade of HWHCs, three primary models appeared: programs, pavilions, and centers. More recently, a fourth model has developed, the medi-spa. We will describe each of these with case studies, keeping in mind that many variations of these models exist.

Women's Health Programs

Developing a women's health program requires the least effort on the part of the hospital. Essentially a women's center without walls, existing services (such as obstetrics, gynecology, mammography) are typically repackaged under a new name and logo, which serve as an organizational umbrella. No dedicated space is added, just promotional brochures, education and information, and referral to hospital physicians (Rynne 1985a, 1989). Metro Hospital explained this repackaging model in its 1985 newsletter: "[Metro] has one of the most complete groups of services for women in the . . . area. So, we've consolidated them into The Women's Center." Metro's HWHC services included their birth unit and outpatient

surgery department. A separate phone number for the center called The Women's Line was installed as the point of access.

One critical element of the feminist model of care was women caring for women. Metro lacked women OB/GYN physicians, however, and both the CEO and vice-president for patient services voluntarily defended (in independent interviews) their all-male obstetrics and gynecology staff as, in the words of the CEO, "suitable for women." The vice-president also commented that "OB men can do good breast exams." It was the CEO's opinion that it was "stupid to have women MDs to attend women."

Other hospitals developed more extensive versions of the program model. City Medical Center's women's health center repackaged existing services with a dedicated space for a resource library and health screenings. City's HWHC opened in 1987 on the first floor of an office building one block from the main hospital. Educational programs and a newsletter were designed to increase community awareness of the program, and a library was established to make up-to-date information available (interview with chief operating officer). The library offered medical searches with up to 30 pages of photocopies, a bibliography of additional resources, and addresses of related organizations.

Within the feminist model, health care is designed and provided by women, for women. City's HWHC was designed, however, with input from a prominent local (male) gynecologist, primarily to funnel patients to hospital inpatient units (obstetrics and gynecology and neonatal) as well as to the physician's private practice. The hospital chief operating officer was clear about targeting an "upscale women's market." In many ways, the services were simply a means to an end, namely, increasing hospital and specialist referrals.

The City brochure adopted FWHC language, stating that the center represented a "holistic, preventive approach to women's health care." Rejecting women's health as simply reproductive issues, the brochure also stated, "women want more information about their bodies, knowing a woman's body is much more than a reproductive system." However, City HWHC scrupulously avoided services that would threaten or upset local physicians. Significantly, there were to be no doctors on staff. Clinical services included nutritional counseling and psychotherapy but were otherwise mainly detection oriented (mammography, osteoporosis bone scans, blood pressure, weight, cholesterol). In contrast to the feminist movement agenda of establishing an alternative way to deliver health care, City's women's health services were described by the medical director as "additive" to mainstream care and specifically intended not to compete with physicians.

The program model focused mainly on offering information about women's health issues. City's brochure vaguely referenced woman-centered care by claiming an "attitude" of respect, partnership, self-care skills, and personalized care. Yet program model centers often limited women's empowerment due to the selectivity of the information offered, the absence of female physicians, the targeting of insured women, and the lack of real change in the way women were treated in health care encounters. Their priority was marketing physician and hospital services (Rynne 1989).

Women's Health Pavilions

A second model developed in the 1980s—women's health pavilions—added specialized inpatient programs to the basic features of the program model (repackaging existing services plus education).

Historically, the term "pavilion" refers to a type of hospital architecture that emphasizes space, light, ventilation, and separate wards for various departments (Sloane and Sloane 2003). Hospitals manifested these ideas in the 1980s through renovating and renaming their obstetrical and gynecological areas to make them more appealing to women (Rynne 1985a). In some cases, additional women's services were added, but the pavilion model typically focused on existing inpatient services for women such as breast and reproductive care and cosmetic surgery. Pavilion rooms were decorated in soft décor such as mauve and gray. Fluffy robes or bed jackets, stylish hospital gowns, and other "feminine touches" were introduced to make the environment more women friendly. The Women's Pavilion at Saints Hospital in Denver illustrated these design principles: "The Women's Pavilion . . . has been specially designed. Soft tones of mauve and teal are used throughout, and the carpeting, wall and window coverings and other amenities in the rooms are coordinated to create an environment which is attractive, warm and comfortable" (brochure).

Catering specifically to business and professional women, hospitals sometimes included computer terminals, on-call masseuse and manicurist services, and special meals (Jacobs 1986; Longe 1987). As in other hospital settings, pavilions also offered champagne and lobster dinners or special gift baskets for parents and newborns (Stephens 1989).

Saints Hospital, in Denver, opened its women's health pavilion in 1984. A full-page ad in the *Denver Post* on June 17, 1984, set the tone for the new services: "The beautiful spectrum of womanhood. Each passage presents the wonder of a new age . . . the need to make enlightened personal decisions. Health care decisions that require competent, compassionate

medical care. Now, in a dedicated area of Denver's leading hospital, The Women's Pavilion brings together the physicians, the staff, the resources, the technology for health concerns that belong uniquely to women. For the times you need information, reassurance, a check-up. For the times you need prompt, responsive treatment. And for the mother and baby times."

This suggests that the hospital had designed services to help women make enlightened health care decisions at all stages of life. However, at the bottom of the ad was a list of available services—"mammography, infertility, reconstructive surgery, premenstrual syndrome, birthing and total maternity care, gynecology, ultrasound, breast surgery, mother/newborn care, newborn intensive care, high-risk mothers, classes in infant care, parenting and other topics for women of all ages"—that focused mainly on reproductive care as well as technology (detection, intervention) rather than comprehensive primary care and prevention. Pavilions offered comfort and convenience yet typically did not attempt to change the actual content of medical care for women.

The development of the pavilion concept signaled a shift away from women's decision making and control over their bodies to their comfort, reflecting what Noonan (2000) has termed "the mauving of medicine." While affluent women seeking care may have appreciated the new décor and free gifts, this model did little to empower them, nor did it increase access, demystify, demedicalize, or in any other way change health care delivery.

Women's Health Centers

The women's health center, pioneered by Women's Health Resources in Chicago, was the most comprehensive model with the greatest potential to integrate feminist principles of care. Comprehensive women's health centers included features of the program model with the addition of primary care—usually outpatient, delivered by women professionals with referral to hospital-affiliated specialists. The center model ideally included education and information, a mini laboratory, diagnostic facilities (mammography, ultrasound, bone densitometry, EKG, etc.), and a multidisciplinary staff with mental health, nutrition, primary care, obstetrics and gynecology, and specialists by referral (Rynne 1985a, 1985b, 1989).

Redeemer Hospital's HWHC, opened in 1987, exemplified this trend. Located next to the hospital, it featured a female family physician, psychological counseling, wellness/fitness programs, nutritional counseling, diagnostic services (mammography and osteoporosis evaluation), information and a resource center with an information phone line, support groups, an

annual conference, a quarterly newsletter, and a wide variety of ongoing classes.

According to the CEO, the original idea for the center came from the hospital's marketing and planning department. Rather than start with a resource center (program model), the hospital board and administration wanted more. In the CEO's words, "we didn't want a sham [but rather] a one-stop shop." He emphasized his preference for the center rather than program model: "[I] didn't want to do something that was not different or unique. . . . The critical part is physician-directed services." This comment underscores the key difference between this model and the others and also the most challenging aspect of the center model: integrating physicians into new or existing women's health services. The comprehensive HWHC concept focused on primary care rather than obstetrics and gynecology. As Redeemer's chief operating officer noted, "[The center] is to provide a physician's office directed to women. . . . [We] don't want an OB/GYN office. Men and women are different, and the approach to disease should be different."

By extending the women's health concept from educational and health screening to actual medical treatment, this model comes closer to the feminist agenda of actually changing health care delivery. The length of appointments and scheduling flexibility illustrate attention to making women the subject of care. The center's brochure promoted a flexible scheduling policy, stating that "the Center is prepared to schedule an appointment . . . during the early morning, late evening or on the weekend." Feminist goals of health care reform are also reflected in Redeemer's attempt to enhance participatory doctor-patient communication. According to the brochure, "We schedule and give all our attention to just one patient at a time and we allow for a minimum 40-45 minute examination for each patient—at no extra charge."

While referencing feminist ideas, administrators were careful to separate themselves from feminism. According to Redeemer's director of marketing, "The [center] is not a feminist group in any stretch, but there is a sense of [women] taking more responsibility in their health."

Hiring a female physician for the HWHC sparked strong resistance to the center from the hospital's physicians in the late 1980s. The existing OB/GYNs on the hospital staff (all male) believed she would take patients away from them. The lavish offices provided by the hospital for the center only increased the hostility. The physicians perceived the hospital as embarking on a project that would compete directly with them. The hospital CEO did not agree that women would so readily switch doctors, but he recognized the perceived threat. According to him, "all the doctors

were concerned. We still hear grumbling. [But] women already have doctors, and you can't take patients away from the hospital's doctors."

Redeemer's financial goals ultimately fell short. By failing to anticipate the hostile reaction of physicians, the hospital created the conditions for the center's failure.

In deference to medical staff concerns, hospital officials decided to avoid directly marketing the center's physician services. This created an untenable contradiction. The center's concept depended on a woman's physician providing services and generating new patients for its clinical services, yet it could not promote these services and find its new patient base. Reflecting on the problems, the CEO noted,

> The center is losing money because these physician services are not well developed. The center could have been better if a female internist could have transferred an established practice. This would be the ideal for establishing clinical services. The center's philosophy requires training physicians in a new way. We probably haven't thought big enough. We probably should have spent more money on our physician, but we would have had to absorb great losses at the beginning.

Redeemer had made a financial commitment to providing medical services that in part reflected the feminist model of care. As evidenced in the CEO's comments above, Redeemer had also accepted some feminist concepts of care, that is, the notion of longer doctor visits and a more egalitarian and participatory style of doctor-patient relations. These innovations failed, however, to gain the support of other medical staff, and thus the hospital could neither financially nor politically sustain the center. After some five years, Redeemer's HWHC closed.

As the examples of Redeemer and Women's Health Resources (described earlier) illustrate, in its ideal form, the center model contains many dimensions found in the feminist model of care including primary care services delivered by women, a multidisciplinary or holistic approach, and longer appointment times to allow women to participate more fully in their care. While political advocacy was not part of this model and care was still focused on mainstream medical practices, other elements of feminist care were less diluted in this model than in others.

Adding Retail And Spas To Women's Health Models

Many variations of the program, pavilion, and center models of women's health services flourished in the 1980s, but continual competition in the 1990s led hospitals to seek new ways to attract more female

patients and generate additional sources of revenue. HWHCs opening during and after the 1990s faced a very different set of challenges than the FWHCs in the 1960s and 1970s or the early hospital women's health centers in the 1980s. By the late 1990s, there were almost twice as many women physicians as there were a decade earlier (www.ama-assn.org/ama/pub/article/171-195.html), yet managed care requirements to see more patients in less time made it virtually impossible for doctors, male or female, to incorporate a feminist model of care. Declining reimbursements from insurance companies and the government also increased pressure on hospitals for higher profitability services. For HWHCs, this meant less emphasis on education and more on high-revenue product lines, targeting an increasingly selective clientele.

In line with these changes and the increasing commodification of women's health (Kay 1989), retail services and specialized boutiques were added to many HWHCs. For example, lactation supplies, baby gifts, birth announcements, diapers, and parenting books all generated revenue for obstetrical programs. Other hospitals went beyond boutiques to develop retail centers.

Combining medical services and alternative therapies in a spa-like environment created a new niche, the medi-spa model HWHC. Beauty, luxury, and retail products are important components of this model. Redefining beauty products as health products created vast new sales possibilities for plastic and cosmetic surgery (Sullivan 2001) and dermatology. At the medi-spa, "a woman can have her hair styled, a pedicure, a massage, and her Pap smear in the same setting" (Noonan 2000, 34). Noting an interesting reversal in trends, Noonan (2000, 34) points out that women's health centers "previously incorporated massage and other alternative treatments into their health care settings. The medi-spa does the opposite, introducing health care into the wellness setting." In one Midwestern city, The Women's Wellness Institute represents this newer type of model.

Women's Wellness was developed by a group of female physicians and a hospital in 2001. According to one of the founding physicians, the concept was to create a center that blended the Mayo Clinic (medical care), the Cooper Institute (fitness), and Canyon Ranch (spa). A newspaper article described the institute as "more like a chic spa than a doctor's office. The calm, Zen-like tone is apparent immediately. Mosaic tile in Tuscan colors covers the foyer floor. A neoclassical dome arches above the room. Spa music sets the mood" (Jaffe 2002).

Guided by the results of a patient survey, the intent was to create a place for body, mind, and spirit (Jaffe 2002). The hospital provided osteoporosis screening, mammography, vascular health assessments, nutritional

counseling, women's rehabilitation services, and spiritual wellness counseling. A group of female OB/GYNs, a female urologist, a gastroenterologist, and three general surgeons (one female) offered medical care. Other tenants leased space in the facility offering facials, hair removal, vein removal, chiropractic care, acupuncture and massage, diabetes support and education, and cosmetic surgery education with referral to a plastic surgeon.

The institute combined several of the trends shaping models of women's health care in the early 2000s. A partnership with the hospital allowed the center to provide a range of diagnostic services to appeal to women and generate revenue. The spa-like atmosphere and aesthetic services illustrated the emphasis on beauty, and the holistic services, such as massage and nutritional counseling, catered to a stressed professional woman who wants one-stop shopping. Spa and aesthetic services allowed hospitals to tap into the growing self-pay market, thus bypassing insurance companies and payment schedules.

The institute also exemplified contemporary dilemmas facing the women's health movement. Providing comprehensive medical services, education, and women-focused research along with more holistic care is consistent with the goals of the earlier, more feminist-oriented centers. There was, however, nothing in this new model that challenged existing beauty norms and much that encouraged the medicalization of appearance. It reinforced the notion of beauty as a central criterion for evaluating women, contradicting earlier feminist principles of empowerment. The luxurious setting targeted women with time and money, not the uninsured or medically underserved. While the Women's Wellness Institute was run by female OB/GYNs and offered many medical services, it should be noted that medi-spas are often run by plastic surgeons and/or dermatologists, are focused only on beauty treatments, and are not affiliated with hospitals. This represents a further co-optation and commodification of the ideals of feminist care.

CLIMATE AND CONTEXT

FWHCs began as part of a social movement to empower women and change the way health care was delivered. Economic trends in U.S. health care soon created conditions that, with the help of marketing experts and entrepreneurs, carried the women's health center concept into the mainstream. Recognizing women as the main users and brokers of health care, hospitals set out to capture them. All three HWHC models developed during the 1980s were considered loss leaders, that is, low-profit services

that would generate hospital revenues indirectly through physician referrals, outpatient services, and inpatient care. But the economic benefits of HWHCs (particularly the center models) often failed to justify the costs, and many HWHCs were closed or scaled back.

Women's Health Resources, the first model of one-stop shopping, went through periods of expansion in the late 1980s but by the end of the 1990s had downsized, closed its satellite offices, and moved into an office suite on the third floor of the hospital's physicians' office building. Other 1980s HWHCs remained competitive through the 1990s. City's women's health program (no doctors), continued to offer mammography, mastectomy aftercare, osteoporosis evaluations, and nutritional counseling. While they dropped their education programs, they added services more closely related to appearance and beauty: a medically supervised weight loss program (female physician) and vein treatment.

Services that would allow centers to sustain themselves occupied HWHCs in the new millennium. New centers continued to be built with lavish attention to detail and comfort. Private foundation funding helped some HWHCs, such as the Cleveland Clinic (Avon) and Columbia Women's Health Center (Proctor & Gamble), expand and develop. Other hospitals developed membership programs (LeFleur and Taylor 1996). For a one-time or annual fee, members might receive newsletters, unlimited access to the health resource center, discounts on educational programs, early notification of new programs, and a special gift for joining. Some centers operated a tiered membership program. A minimum fee might include a newsletter and a free gift, while a larger fee includes these benefits plus discounts in the hospital gift shop or for special events (Ireland 2005). Membership programs created financial barriers for less affluent women, thus rejecting the feminist concept of making services available to all women.

Continuing pressures to attract new patients led some hospitals to open facilities in the 1990s, after not doing so during the 1980s. Avoiding tension with physicians, most of these centers adopted the program or pavilion rather than the center model. Fearing they might be missing an important target market, one Kansas City–area hospital opened a new women's health center in 1996. According to the director,

> The reason for the center was primarily marketing. We thought we could be missing out on who was a potential user, so we decided to take the 'deciding for the family' approach and market to them. [We] did not want to compete with the medical staff, but we wanted a centralized location that was attractive to women. . . . We really wanted an ambulatory care center with the luxury services that women were wanting.

This quote shows how complete the co-optation of feminist concepts had become. Priorities shifted so dramatically toward revenue that there was nothing left to challenge or change the way care was delivered. Women no longer want to be empowered to care for themselves; they want to be pampered.

INDICATORS OF CO-OPTATION

FWHCs pioneered a model of care that challenged the patriarchal and hierarchal medical model of care. Working from outside the mainstream system, they pressured doctors and hospitals to treat women with respect and encouraged women to be active participants in their own care. As hospitals began to recognize the importance of women as health care consumers, many of the concepts advanced by the feminist model of care were appropriated and became institutionalized within the mainstream HWHCs. Many aspects of feminist care were no longer viewed as alternative but came to be expected aspects of mainstream women's health care. Table 1 summarizes some of the key differences between these two models.

The challenge posed by the FWHC became diluted and then ultimately co-opted by imperatives in the market-driven mainstream health care system. Our goal was to illustrate this process by showing how the hospitals' use of feminist concepts promoted goals that contradicted their original meaning and purpose. There are three significant indicators of this process: (1) the redefinition of the meaning of "women-centered" services, (2) the transformation of empowerment, and (3) the shift in locus of control. We will briefly discuss each of these.

Women-Centered Care or Revenue Production

A key marker of co-optation was the shift in the focus from women-centered to revenue-centered services. FWHCs were motivated by a vision of women-centered care, "a style of practice based on principles of feminism and empowerment" (Shelley 1999, 11). Positioning women as experts about what health care decisions are right for them, comprehensive education focuses on giving a woman the full range of information with which she can make informed choices and take care of herself. Medical services focus on primary, preventive care—keeping women healthy and out of the doctors' offices. Women-centered care is also holistic, recognizing that physical health is affected by social, psychological, environmental, and economic factors. Women-centered care has the potential to

TABLE 1: Key Dimensions

Dimension	*Feminist Model*	*Hospital Model*
Control	Women owned and operated	Corporate owned and operated
Targeted clients	All women	Insured women, discretionary income
Focus of services	Women centered	Revenue producing
	Woman as subject	Woman as object
	Women caring for women	Referrals to doctors
	Primary care beyond just reproduction	OB/GYN, reproductive, cosmetic/appearance
	Comprehensive educational resources	Selective educational resources
	Prevention	Detection
	Woman as expert	Provider as expert
		Product lines
		Spa—retail
Definition of "empowerment"	Informed, active, decision making through comprehensive education and support	Choose among existing services, providers, treatments
	Change in power dynamics	Power dynamics unchanged
Model	Holistic, prevention	Biomedical, detection, intervention
	Self-help	Technology
	Demystify and demedicalize care	Medicalization of women's lives
Goals for social change	Alternative to mainstream care, change system	Additive to mainstream care
	Political advocacy	

transform the way health care is delivered by shifting away from reliance solely on the biomedical model, by shifting power dynamics to give women more authority and control in health care encounters, and by putting women's needs and desires at the center of health care delivery.

HWHCs were motivated primarily by a desire and need to attract women and increase revenues. While some hospitals and marketing analysts claimed that the boom in women's health centers drew on feminist principles and insights, the primary driver was "financial practicalities" (Toufexis 1987). The hospital administrators interviewed for this study, our own participation working in an HWHC, and the brochures and literature from various HWHCs, conferences, and industry trade journals all bear this out. In this model, women were the objects of marketing strategies and revenue production. Models of HWHCs developed originally around repackaging existing services and focused on obstetrics and gynecology, with 85 percent of HWHCs providing obstetrics in 1989 (Harness and Kraus 1989). In the second and third decades of HWHCs, attention to the bottom line, increased competition, and declining reimbursement rates led hospitals to reduce educational services (which were at the core of feminist care) and develop more and more self-pay services such as spa treatments, aesthetic services, and cosmetic surgery.

Few hospitals developed the full complement of primary care services at the heart of the feminist model of care. Marketing surveys of the 1980s had consistently shown that women wanted comprehensive, holistic, primary care, yet Weisman found that only 12 percent of all "women's health centers" delivered primary care (1998, 164). Instead, hospitals tended to make referrals to existing doctors' practices, leaving mainstream medical practices in place.

The feminist concept of women-centered care was appropriated by HWHCs in a way such that the original meaning of the concept was fit into prevailing economic priorities. Women-centered care was co-opted from an active state to a passive one. Far from enhancing control over health decisions, in HWHCs, women-centered care seemed to be primarily defined by making women feel comfortable through décor, amenities, having access to the latest technology, and one-stop shopping (convenience).

The Transformation of Empowerment

Empowerment was the cornerstone of feminist health care. It has been a basic feminist strategy since the development of consciousness-raising groups in the late 1960s. In the feminist model, empowerment is a process

(Merzel 1994, 410) through which one gathers information, makes choices, and receives support in a dignified and respectful environment. Empowerment challenges basic power relations (Bookman and Morgen 1988, 4) and provides a means of resisting the passive and dehumanizing role assigned to patients in the health care system. The locus of control shifts from provider to client (Thomas 2000, 143).

HWHCs have also appropriated these goals as part of their discourse. Yet while patients may be given information, they do not necessarily become agents of control. Elements of empowerment are strikingly different in FWHCs and HWHCs. For example, educational materials at FWHCs included mainstream medical information plus self-help and alternative treatments. Information was given to women during exams or procedures, and women were often encouraged to participate in their exams (for example, through a cervical self-exam), thus giving women more autonomy and control. The materials we saw at the HWHCs tended to be exclusively from mainstream medical sources, including pharmaceutical companies. If this was not true when a center opened, it became increasingly true over time, as in the case of Women's Health Resources.

Empowerment also came from breaking down systematic barriers to care and personalizing care. FWHCs were located in older homes or smaller office buildings in easily accessible parts of town. Staff and providers were referred to by first names and did not wear lab coats. Appointment times ranged from 15 to 60 minutes to allow time for questions. Staff members often went out into the community to offer programs to those who might not normally access the health care system (Thomas 2000). HWHCs did offer community programs but generally in their own space, thus encouraging women to come to the hospital. HWHCs also made efforts to deinstitutionalize the look of their facilities and make them more welcoming. However, the essential power dynamics between providers and patients remained largely unchanged.

Finally, FWHCs were based on the idea that empowerment occurs when women are treated as though they can make choices that are right for them and are supported in those choices. Women are empowered at HWHCs to make choices about their health care, but these choices are typically limited to services available through the hospital and its programs. Empowerment within this altered context of meaning is more about being allowed to make choices than about genuine autonomy and control.

The term "empowerment" was appropriated by HWHCs and was removed from its feminist roots to become a market-oriented tool. The term tapped into women's growing interest in health care, but it was used

to promote the goal of bringing women into the mainstream medical system, thus contradicting its original purpose and depoliticizing the concept. Education and information were limited to approved materials. Services became an end to themselves rather than a transformative experience. Power dynamics remained essentially unchanged. Empowering women meant simply encouraging women to participate in mainstream medical care, not to challenge it.

Locus of Control

The third indicator of the co-optation process is the shift from women-controlled to provider- or corporate-controlled care. In the feminist model, traditional power hierarchies between providers and patients are broken down, and instead they become partners. HWHCs appropriated the language of partnership, but medical hierarchies and control remained largely unchanged. As our interviews and data showed, hospitals ultimately saw women's services as adding to rather than changing mainstream care.

By many accounts, HWHCs have produced more medicalization rather than less (Reissman 1983; Worcester and Whatley 1988; Zimmerman and Hill 2000). This expansion is another example of how HWHCs have moved away from feminist principles. Early feminists called for women to be active participants in health care, and in fact, they have. This agency, however, now takes place within a much different health care environment. Current federal policies structure health care as a capitalist market, and contemporary HWHCs advertise and sell women's health with invasive technological products. Thus, women's active participation now serves to increase rather than decrease medical control over their lives. The overmedicalization promoted by HWHCs not only has co-opted feminism but has created a negative countereffect.

Women's agency is an important consideration in assessing the locus of control in health care models. FWHCs were started by women who wanted information in the interest of greater control. Hospital models have been shaped in large part by focus groups and surveys designed to gauge what women want in health care. In the 1980s, women's health advocates wanted active participation in health decisions but also compassionate and respectful care, health information, female providers, pleasant surroundings, and convenience. HWHCs, in contrast, have tended to focus on information, surroundings, and convenience, paying less attention to the way care is delivered and by whom.

Women today no longer challenge the health care system as they did in the 1960s and 1970s. Radical feminist ideology has been replaced with the idea that cesarean sections on demand and cosmetic surgery are feminist choices. Women have embraced their roles as consumers in the health care marketplace even though, overall, fewer women have access to it. Nonetheless, affluent women seek and choose attractive facilities and providers knowledgeable about gender-specific medicine who treat them with respect (Looker and Stichler 2001). At first glance, this appears to demonstrate the success of the feminist model. But a more careful analysis shows just how dramatically the feminist model has been co-opted. Many of the elements of medicalized care that early feminists fought against are now redefined as women-centered care. Most important, the incentives and prospects for feminist change have diminished. As Stratigaki (2004) warned, once the challenging ideas have been neutralized by co-optation, mobilizing for change becomes difficult.

CONCLUSION

Most original FWHCs did not survive, yet the feminist model of care they pioneered has led to significant changes for women's health care. HWHCs represent one of these changes. They have helped increase awareness of women's health issues and created new options for well-insured women (an increasingly small proportion of all women). At the same time, HWHCs reveal the continuing commodification of health care (Sloane and Sloane 2003, 116). Reflecting on the first few years of HWHCs, Bonnie Kay (1989) noted that they limited women's choices to those that generated revenue, were only interested in paying or insured patients, and used information for marketing rather than social change. As she stated, commodification in women's health "perpetuates a health policy that serves the few at the expense of everyone else" (p. 374). More than 25 years later, we find that these trends have only intensified. Moreover, commodification and the process of co-optation it contributes to have produced the negative countereffect Stratigaki (2004) warns of: women's health, delivered through HWHCs, looks in many respects like the health care that 1960s and 1970s feminist activists worked to avoid. Studies of the original FWHCs (Iannello 1992; Morgen 1986; Thomas 1999) have looked at how political ideals play out when financial survival is at stake. Most original FWHCs found that efficiency often took priority over programs when revenues ran short, thus leading to changes in structure and

service. Other research, such as Loe's (1999), looks at the tensions between profits and politics in contemporary feminist businesses. Research is needed to assess these struggles in relation to the dynamics of maintaining ideological commitment in the context of economic survival within a market economy.

The processes described here are not limited to the case of women's health centers and could certainly be applied to other situations in which the driving force of change is revenue production rather than gender equity. Rothschild and Ollilainen (1999), comparing egalitarian workplaces with businesses utilizing Total Quality Management techniques, found that concepts of empowerment were similarly co-opted; the language used was the same, but their practices were quite different. The stated goal of redistributing power between workers and management was diluted by the overriding purpose of increasing profits. Stratigaki's (2004) work shows that even when gender equity concepts are initially important, priorities may shift as economic demands change. When profits are the motivation, strategies that challenge existing structures are quickly diluted and change ultimately becomes illusory. Thus, in our study, the changes in HWHCs were primarily about style or form rather than substance.

The development and transformation of HWHCs raises questions of how feminist change can be accomplished in profit-centered systems. In general, our study suggests that change in such a system is likely to be superficial rather than substantive. In the context of current U.S. health care reform efforts, it is unlikely that this situation will change. The profit motive would have to be substantially reduced, and operational goals shifted from financial outcomes to health outcomes, before real feminist changes could be expected.

NOTE

1. Journals that followed trends in health care, including *Hospitals, Profiles in Healthcare Marketing, Health Care Strategic Management,* and the *Ireland Report* (specifically targeted to managers and directors of women's health centers and services), were reviewed to help identify model women's health centers and programs. Examples of the popular print media we examined include *Ms. Magazine, Working Woman,* and local newspapers.

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Jan E. Thomas is an associate professor of sociology at Kenyon College. She spent many years working in women's health care and is interested in women's health activism outside the mainstream system. Her current work focuses on maternity care in the United States and Sweden.

Mary K. Zimmerman is a professor in the Department of Sociology and the School of Medicine at the University of Kansas, where she studies gender, medicine, and health care. Her recent work involves comparative health systems and global care work. She is the author of Passage through Abortion *and* Global Dimensions of Gender and Carework.