Negotiating new roles, new moralities: Ukrainian women physicians at a post-socialist crossroad

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NEGOTIATING NEW ROLES,
NEW MORALITIES:
UKRAINIAN WOMEN PHYSICIANS
AT A POST-SOCIALIST CROSSROAD

by

Maryna Yevgenivna Bazylevych

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NEGOTIATING NEW ROLES,
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Abstract.

My dissertation discusses concepts of professionalism and morality as seen by women physicians in post-socialist Ukraine. As in many other post-socialist societies, Ukrainian women constitute the majority of the medical profession (over 70% of practicing physicians and 80% of medical students). Most of the existing literature explains this narrowly in materialist terms whereby low salary is viewed as determinant of low prestige and thus unattractiveness to men. I suggest that prestige is defined much broader in the local context. Based on ethnographic fieldwork in Central and Western Ukraine (2007-2008), I argue that the meanings of prestige carry both socialist and post-socialist rhetoric that create hybrid professional identities. Physicians actively negotiate their socialist upbringing and biomedical training with new venues for income (private clinics, pharmaceutical companies) and changing ideology of informal monetary exchanges. These biomedical developments reflect the broader situation of flux in post-socialist Ukraine, and significantly add to the professional repertoires of the biomedical professionals. I argue that female prevalence in the biomedical field offers a door to understanding complex transformative social processes where moral codes are being actively re-negotiated. I discuss the ways in which the continuities with the socialist past are expressed and how women are crafting new professional identities. Through a focus on marketization in the medical system that gives rise to new venues for income, this study investigates how women physicians use their cultural and social capital in new circumstances and how they negotiate changing ideas about professional respect, income, gender roles and moral obligation. What does it mean to be a good physician in post-socialist society today, and what does make women more likely candidates?
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Chapter I. Introduction.

Research Objectives.

In contrast to most industrialized societies, the medical profession in socialist Ukraine during the 20th century was highly feminized. Seventy percent of the practicing doctors with medical degrees in the Soviet Union were women (Korolev 1975:78). As post-socialist transformations currently unfold in Ukraine, they are triggering changes in the structure, prestige and income of various professional fields. Research has shown that Ukrainian women are disproportionately impoverished by the on-going economic transition (Zhurzhenko 2001), and their numbers in some previously feminized professions, such as finance and banking, are dropping as these professions become more lucrative (Einhorn 2000, Lokar 2000). In contrast to this, the number of women medical students in Ukraine is steadily growing, reaching nearly 80% of those enrolled (Ministry of Health 2008). Here, I investigate the reasons and implications of this phenomenon. My dissertation explores whether the increasing number of women in post-socialist medicine is the result of the increasing empowerment of Ukrainian women, or of women being pushed out of more lucrative jobs (in the finance and banking sectors), or of interrelations between local gender constructions and economic transformations, or of a complex interplay among all of these factors.

I reconsider the assumption that the medical profession in post-socialist societies does not offer a feasible avenue for good income and does not carry high prestige. The neo-Marxist perspective of medical work (Navarro 1977, Reskin & Roos 1990) imbues the economic processes with deterministic qualities. According to this perspective,
women enter the medical profession during times of economic instability when male competition decreases, in other words, as it becomes less lucrative to be a physician. However, my ethnographic fieldwork in central and Western Ukraine (2007-2008, 2004), suggests that men and women regard the medical profession as a desirable career choice and as one of few stable professions in the extremely unstable post-socialist world. While the official wages of Ukrainian physicians are not high, they often represent a fraction of their unofficial income, which also include patients’ informal payments and cooperation with pharmaceutical companies. These informal earnings cannot be considered merely a supplementary “tip,” for they often constitute the bulk of physicians’ actual incomes (Kornai & Eggleston 2001). My dissertation investigates how lucrative the medical profession is in relation to local economic standards. This approach will allow me to provide a more complete discussion of gender negotiations in the biomedical profession than the neo-Marxist perspective currently offers.

I argue that the meanings of prestige carry both socialist and post-socialist rhetoric that create hybrid professional identities. Elements of socialist morality are interwoven in the new market driven discourses, and this "braided" (Phillips 2008) code informs post-socialist biomedicine. Physicians actively negotiate their socialist upbringing and biomedical training with new venues for income (private clinics, pharmaceutical companies) and changing ideology of informal monetary exchanges. These biomedical developments reflect the broader situation of flux in post-socialist Ukraine, and significantly add to the possible repertoires for biomedical professionals. I argue that female prevalence in the biomedical field offers a door to understanding complex transformative social processes where moral codes are being actively re-
negotiated. This dissertation discusses the ways in which the continuities with the socialist past are expressed and how women are crafting new professional identities. What does it mean to be a good physician in post-socialist society today, and what makes women more likely candidates?

Research site.

This research is based on ethnographic fieldwork data collected in the central and western parts of Ukraine in 2007-2008. This project took place in central Ukraine with a focus on Kyiv, its capital city. The major administrative and educational center for Ukraine’s centralized healthcare system, Kyiv (population 2.6 million) is at the forefront of the country’s biomedical system. It is also one of the few sites for emerging private healthcare facilities and a testing ground for new health-related policies, for example, medical insurance. This central location has allowed me to keep a finger on the pulse of new developments in an actively changing field and gain better access to statistical information relevant to the medical profession.

To explore how gender constructions in biomedicine potentially differ between central and peripheral areas of the country, I have also conducted fieldtrips to the smaller city of Vinnytsia in a remoter part of central Ukraine. Vinnytsia is an appropriate secondary research site because it hosts one of the major medical universities in Ukraine, National Pirogov Memorial Medical University. Such access to the medical educational institutions in Vinnytsia (and in Kyiv) has increased the potential pool of both the older generation of physicians educated in the Soviet Union and their students, younger respondents trained in post-socialist Ukraine.
Research Methods.

I initiated my fieldwork research by conducting a series of open-ended interviews with a free-listing component, where my respondents were asked to select their own starting points that were the most salient to them. This allowed me to elucidate the categories they prioritized without the researcher’s bias. I collected over 150 semi-structured interviews, lasting anywhere from 45 minutes to four hours and longer. Most interviews were recorded digitally with the permission of the respondents. I usually took extensive notes upon completion of the interview session or participant observation event. All interactions were in Ukrainian or Russian, and translations are my own.

I observed work in state-run policlinics, inpatient hospital facilities, research hospitals, private clinics, and private doctors’ offices at the primary and secondary location sites (Kyiv – the capital of Ukraine; and Vinnytsia – a large peripheral town in central Ukraine). I also made regular visits to two healthcare facilities at the secondary site (one oblast level clinic and one private policlinic); and two facilities at the primary site (one city level large hospital; and one city level policlinic). I was able to see some of the daily routines of the physicians, observe their communication with other doctors, medical staff, patients, patients’ relatives, and with the visitors to the healthcare facilities. Some physicians allowed me to join them during their overnight shifts. They also introduced me to other healthcare professionals at their work places and in their social networks. This snow-balling technique is a limitation of this study, since the selection of respondents was not truly random. The project also incorporates an analysis of relevant press, major periodicals, and online readers’ discussions, as well as Ministry of Health reports and regulations.
Additionally, my ethnographic data include six life histories of key informants (physicians trained in the Soviet Union and those who decided on the medical career in post-socialist Ukraine, female and male). I was also able to conduct seven focus groups: two mixed groups with male and female physicians, two with only male physicians, and three with only female physicians.

I conducted regular extensive phone conversations and electronic correspondence with my respondents, potential respondents, and other people related to my research. Before an interview was conducted, I would arrange it via prior agreement usually over the phone, and sometimes via email. I have maintained contact with some of the respondents via electronic correspondence to continue share our insights on the research topic. Some of the evaluative procedures related to research design were carried out over email. Secondary data (local mass media, periodicals, and biomedical journals) were thoroughly investigated in the duration of fieldwork to understand the public discourse on gender roles and their contestations, as well as new developments in the Ukrainian biomedicine. Thus, my project incorporates an analysis of relevant press, major periodicals, and online readers’ discussions, as well as Ministry of Health reports and regulations.

Since my project focused on medical professionals and the changing ideas of professionalism and gender, I interviewed mostly healthcare providers. Attention to patients’ rationalizations was not a part of the research design, and is a limitation of this work. However, my circulation in the clinical settings, popular rumors, and mass media, all added to the interactive aspect to my study. I routinely encountered people who had made healthcare related decisions in the past several years and who commented on their
experiences. Healthcare became a prism through which transformations in Ukrainian medical field, local value systems and ideologies, society at large and international exchanges could be studied.

Research Design.

The research purpose of this study is to identify factors associated with women’s increasing involvement in the biomedical field in post-socialist Ukraine while the profession appears to have a relatively high prestige and potential for income. My objective is to describe and understand the relationship between social and economic domains (local gender norms, professional prestige, potential for income, socioeconomic status, family, etc.) and the decision to practice biomedicine among women who entered the practice in post-socialist Ukraine and those who began their careers in the Soviet Union, as compared to men. To this end, the following key questions will be addressed:

- How prestigious and lucrative is the biomedical profession according to local Ukrainian standards in post-socialist times?
- What changes are occurring in the biomedical domain in post-socialist Ukraine? What levels of income and prestige are associated with public clinics compared to the emerging private clinics? How do women participate in these developments compared to men?
- How do gendered ideas and relations vary in the biomedical profession in post-socialist Ukraine? What is the relationship between gender roles and professional choices of Ukrainian physicians?
What is the content of the “portfolio of stocks” (Ghodsee 2005) of those women physicians who were educated in post-socialist Ukraine as compared to those who received their degrees in the Soviet Union? How does it compare to men physicians’ “portfolio”? What kinds of education, experience, skills and networks enable women’s increasing involvement in biomedicine?

It is essential to explore the concept of prestige in specific locales to determine just how lucrative the biomedical profession is according to Ukrainian standards. I understand prestige as a combination of materialist and non-materialist motivations that guide people’s search for higher status (Hatch 1989). Many neo-Marxist studies of biomedicine conceptualize prestige quite narrowly as the material well-being reflected in physicians’ wages. Such an approach not only omits another material aspect – informal income – that may greatly contribute to physicians’ earnings, but also leaves out nonmaterial aspects of prestige, such as respect for providing an outstanding or crucial service to society, following local cultural norms in an excellent manner, etc. Yet, it is exactly the unstable post-socialist societies that are actively negotiating the concept of prestige and are trying to establish a balance between moral obligations and new consumer-oriented materialist values (Patico 2005). This dissertation undertakes the urgent task of investigating how the local understanding of prestige varies among male and female physicians, and how it is associated with women’s and men’s decision to work as a physician.

New post-socialist developments in biomedicine may influence the potential for income and prestige of the profession, and therefore impact professional decision-making among the Ukrainian women and men. One of the major changes is the emergence of
private healthcare institutions as potentially more lucrative workplaces (Kriachkova et al. 2006). I explore how prestigious these new clinics are compared to state-run facilities, what incomes different specialties within them carry, and in what ways both genders are involved in them. In addition, I explore other newly emerging biomedical avenues for income, such as official and unofficial payments from patients, cooperation with the pharmaceutical companies, personal long-term contracts with individuals and families, as well as migration of the Ukrainian physicians to the countries with former socialist allegiances (Mozambique, Angola, etc.) for temporary contracts. We have to explore how both genders are involved in these changes to understand gender politics within the profession.

It is vital to uncover the range of gender discourses that operate in the biomedical setting in Ukraine, since they may strongly influence employment patterns. This research asks: What kinds of jobs do people in Ukraine consider as appropriate for men and women? What is the range of issues they consider while deciding on their profession? Using a social-constructionist lens, I explore ways in which people use cultural logic, including gender constructions, in their interactions with broad economic processes (Burawoy & Verdery 1999).

Finally, I investigate the ways in which both genders prepare for their professional careers. According to Ghodsee’s (2005) theory, an individual’s “portfolio of stocks” of cultural capital contains education, connections, and relevant professional experience. It is vital to identify the contents of the Ukrainian women physicians’ “portfolio” as compared to men’s – what types of stocks of cultural capital they had during socialist years, and what changes occurred with post-socialist transformations.
In my original research design, I planned to compare physicians’ work in state-run healthcare facilities and newly emerging private clinics. Currently, the Ukrainian healthcare system is nationalized with private healthcare facilities comprising only 10% of the sector (Kriachkova 2006). Private clinics appear to provide services not readily available in state clinics, such as higher quality healthcare, more personal attention, more advanced treatment methods, and clear-cut fee schedules. Private clinics are also reported to serve a higher income stratum of the population (Handrig et al. 2005, Kriachkova et al. 2006). Thus, the existing literature suggests that private facilities may be more prestigious sites for biomedical employment than state-run institutions. This comparison could be telling in regards to gender dynamics. For example, are women actively constructing a new biomedical order in and out of state-run facilities, or simply filling in the positions in state-run clinics left by men? However, in the course of my fieldwork, my respondents promptly pointed out my mistake in separating public and private healthcare and physicians who work there. Instead, I found that the same individuals work in both spheres, state hospitals and private clinics of various kinds. It is also common, and indeed prevalent, to consult patients for an additional fee at the facilities run by the state. The division between private and public in today’s Ukraine is indeed very blurred. My respondents repeatedly pointed out that the same doctors combine their work in both spheres of the biomedical employment, unwilling to relinquish the security of state employment, but also seeking out new avenues for income and self-actualization.

Ukraine was until recently closed to outside investigation during the Soviet regime. In contrast to other post-socialist societies, Ukraine is still often referred to in the context of Russia even though these cultures have quite different sociopolitical situations,
identity issues, and cultural productions. Because there is virtually no anthropological
body of work on healthcare in post-socialist Ukraine, I draw from existing sources that
focus on other post-socialist societies, being careful to avoid inaccurate generalizations.
My study will be the first to remedy this dearth of information on Ukraine. Underlying
the differences in the direction of healthcare reforms between Ukraine and Russia is the
fact that the Ukrainian Ministry of Health, with notable enthusiasm, has until recently
been placing discussion of the European integration at the forefront of its agenda
(Polishchuk 2006). The Ukrainian case does not stand alone, but bears parallels other
post-socialist societies that have had similar EU-oriented political-economic reforms. In
my study, I investigate some of the changes in the healthcare system generated by
Ukraine’s recent pursuit of European Union membership. Ukraine’s political orientation
has recently changed with the election of a new President Victor Yanukovych, whose
program is diametrically opposite to the ones promoted by the ex-President Victor
Yushchenko. My dissertation considers how Ukrainians are responding to these changes,
and how such change influences the prestige of the medical profession and women’s
involvement in it.

The next chapter casts a wide net to describe the history of the biomedical
profession in Ukraine. I discuss the relationship between the biomedical profession,
gender, and the state in historical perspective, paying close attention to the history of
women in the profession. I address the establishment of the medical profession in the
course of the last two centuries, as well as changes and continuities brought about by
revolutions and the uprooting of regimes. In so doing, I pay special attention to female
biomedical professionals, their entrance into the field, and their roles in it. The first
chapter also delves into post-socialist changes in the medical field, and the broader context of women’s position in Ukrainian society.

Chapter three proceeds to discuss the concept of prestige among medical professionals, its development and ambivalence. I argue that the prestige of Ukrainian physicians is better understood as a multilayered and hybrid process negotiated in every social context.

Chapter four discusses one of the ubiquitous parts of post-socialist life, informal exchanges, focusing on the everyday life of Ukrainian physicians. The informal economy may be a means through which private citizens cover the gaps caused by the state’s retreat from public health protection, which may indicate one of the functional aspects of unofficial exchanges. Yet, this shadow economy tends to polarize and sometimes antagonize its stakeholders, physicians, patients, and administrations. In this chapter, I seek to uncover the scope and gradations of informal practices in biomedicine, and physicians’ understanding of their own involvement in this process.

Chapter five uses the groundwork outlined in previous chapters to expand the neo-Marxist perspective to explain the prevalence of women in medicine. In particular, I argue that some of the reasons so many women choose the medical profession are related to their choice of and culturally embedded beliefs about particular specialties, which in turn manifest a particular non-Western version of feminism. More specifically, the chapter describes how gendered concepts of beauty, cleanliness, motherhood, and erudition structure the practice of medicine in Ukraine. Paying attention to the micro- and macropolitics of women’s involvement in the biomedical field provides crucial knowledge about power and disadvantage within the newly forming capitalist system. At
the same time, my ethnographic evidence suggests that changes in the biomedical sphere that are associated with the introduction of new market ideas have been at least in part empowering for women professionals who have found new venues for investing their cultural capital.

Post-socialist societies have been described as plagued with moral disorder, corruption, uncertainty, fragmentation, and competing discourses on proper behavior and social justice (Lindquist 2006; Steinberg, Wanner 2008). In chapters six and seven, I focus on the ways in which Ukrainian physicians make sense of social change in their professional lives and society more broadly. I address the different ways in which they engage with change and act on it. Given my analysis of the post-socialist biomedical profession as a field that is undergoing profound transformations and is simultaneously transformative for its agents, I am particularly interested in the ways in which people may be able to convert their struggles and pains into forms of agency. I trace this on two levels: mundane everyday experiences and practices, and overarching discourses, as represented by my respondents. Thus, chapter six addresses physicians’ understanding of changes within the profession and quandaries about professional ethics shaped by the new market economy. The chapter seeks to answer: What do physicians view as good work, or professionalism? How do they enact it in everyday lives? In chapter seven, I move further to ask: What are physicians’ dreams and aspirations? What is right and wrong? How do they engage with the concept of morality? The final chapter delves into broader discussion of post-socialist disorder, governmentality and future. I address physicians’ understandings of overarching morality, social order, and relationships between citizens and the state.
My dissertation, therefore, embarks on a project of finding out why increasingly more women join the biomedical profession by exploring the changes that Ukrainian biomedicine is undergoing today, determining the ways in which these changes influence the prestige of the profession, and how both genders are involved in them.
Chapter II. Historical Excursion into the Medical Profession and Health Care in Ukraine.

Women’s Involvement in the Profession.

I. Introduction

Ever since Ukrainians adopted Christianity in the 9th century, Ukrainian land has been under the control of various world powers. The Mongol-Tatar occupation by Genghis Khan in 13th century lasted for nearly one hundred years, followed by three hundred years of rule by the Great Lithuanian Kingdom and the Rich Pospolyta (Polish Kingdom). Eastern Ukraine has also been under “the protection” of Poland and Turkey for nearly two hundred years, and Western Ukraine has been a part of the Austrian-Hungarian Empire and Romania. Finally, a large portion of Ukraine has been a part of the Russian Empire since the mid 17th century, after which Eastern and Central Ukraine joined Soviet Union in 1921. Western Ukraine was annexed after the World War II. Because of this stateless history, the Ukrainian medical profession worked within the frames of other empires and countries – Russian Empire, Poland, and Austro-Hungarian Empire (Pliushch 1970: 10). The contemporary Ukrainian health care system relies heavily on the Soviet model of socialist medicine. In this chapter, I discuss historical roots of the Ukrainian biomedical profession, focusing mainly on the years preceding the socialist revolution of 1917 in the Russian Empire, and Soviet Union. Because Ukraine has inherited and continues using a centralized Soviet health care model, it seems to be most appropriate to provide a historical account of women’s involvement in these state structures of biomedicine, as opposed to other medical traditions that were present in the territory of contemporary Ukraine in the course of history. In this chapter, I discuss the
relationship between the biomedical profession, gender, and the state in historical perspective.

II. Prerevolutionary Medical Profession.

Renner (2008) traces the formative years of the medical profession in the Russian empire to the 18th century. Unlike other scholars who either emphasize the significance of Western physicians commissioned to develop the medical profession in Russia, or focus on the unique quality of Russian physicians in their activist roles and preoccupation with public health, Renner conceives of the 18th century medical profession as transregional, socially mobile, and elite. In the course of the 18th century, the medical profession grew in numbers and in relation to civil and military patrons, highlighting the Tsarist modernizing project.

Starting with Peter the Great (1696-1725, years of rule), Russia recruited medical experts from the West together with other specialists. With time, the domestic population became increasingly involved in the medical profession. Physicians were recruited from impoverished clerical ranks (especially orthodox seminaries) or professional groups like pharmacists, barbers and physicians. Even serfs were sometimes admitted to the medical schools (Frieden 1975). A large proportion of the medical students, therefore, had humble social origins. This is one of the unique features of physicians from the Russian Empire, as compared to the West where physicians usually have come from higher status families. Medical students were also recruited among talented soldiers and students from various parts of the empire, especially Ukraine (approximately 15%). This heterogeneity of professionals was a strategy to integrate vast imperial territories. Renner (2008) argues
that physicians were appointed to strengthen the army and other pillars of the empire, and to keep an eye on dangerous diseases among the civilian population.

In particular, during the reign of Catherine the Great who succeeded Peter I, Russia focused on its modernization project\textsuperscript{iii}. What this means for medicine is that it was established not from the bottom up, but from the top down, without corresponding autonomous schools at first, or an established market for new medical services. Rather, these were popularized by the regime. Thus, Renner argues, the elite status of medical professionals meant association with the state (status depended on posts and ranks), and not independent income or institutions. While autonomy (expressed in the profession’s regulation of its members’ ethics, performance, and medical training) is a fundamental feature of the medical profession in the West, this has historically not been the case in the Russian Empire (Frieden 1977). The state, sponsoring all medical education, was the only grantor of medical licenses, and the main employer of graduating medical doctors.

Physicians social status began to increase with the period of Great Reforms and the abolition of serfdom in the Russian Empire (1861). Physicians served the empire, but in the process managed to garner privileges. Thus, physicians were eager to medicalize areas previously outside of the scope of doctors’ work, such as birth, childcare, nutrition, living and working conditions. However, in so doing physicians were willingly identifying and promoting the cause of the empire: ensuring the health of the tax-paying population and protecting the rulers from infections. Frieden (1975, 1981) has shown that Russian physicians supported a system of free medical care organized around \textit{zemstvo} self-governments as a convenient symbol of their status as scientists and humanitarians. Often, privileged Russians saw the state as a positive force, “the source of power and
position, and the protector of rights and immunities” (Frieden 1981). They also professed the humanitarian mission of medicine as opposed to capital accumulation as the target of their professional activities. Frieden (1975) quotes Professor V. I. Razumovskyi’s (Kazan Medical School) 1902 speech, which underscores this point:

> Medicine, pursuing its humanitarian goals, fulfills its mission only when medical care is available to all in need, regardless of station and social condition. No matter how far a country may advance in medical science, if that science be available to only a select few, that country cannot take pride in its medical progress.

It is therefore reasonable to question whether autonomy from the state should be considered a universal value cherished by professional groups worldwide. Physicians were not passive or apolitical. Instead, they emphasized their commitment to public health and service, which gave them more recognition from the state and the people (Frieden 1981).

Despite the opportunities that newly minted physicians from lower social stratas received from their state-endowed professional status, their relationships with the government were fraught with conflict. The educated elite, including physicians, was stimulated by the mid-19th century Great Reforms that followed the Crimean War (1853-1856). The most significant of these was the abolition of serfdom and the creation of *zemstvo* administrative divisions (institutions of local self-government) in the Russian Empire. *Zemstvos* supervised welfare functions, including hospitals, and provided a more independent institutional setting for physicians, where they had more control over professional decisions and less supervision by the Ministry of the Interior, the organ that they answered to. *Zemstvo* medicine consisted of rural clinics staffed by physicians and assisting staff who served particular districts and were reimbursed from local taxes.
Zemstvo doctors were responsible for controlling epidemics, statistics, vaccinations, check-ups of migrant workers, famine relief, as well as hygiene education projects (Frieden 1975). Historical evidence suggests that zemstvo physicians represented a new movement, which for the most part was sincerely striving to see positive social change and improve the life of the people. Yet, Frieden’s portrait of a progressive community of physicians has been questioned. Solomon and Hutchinson (1990), for example, discuss physicians’ promotion of zemstvo medicine as political rather than an enlightenment project or a commitment to community welfare. They argue that zemstvo physicians often rejected new biomedical knowledge and displayed backward territorial allegiances. They posit that these doctors fought bureaucracy in the capital not so much because of their commitment to public health, but with the goal to carve out a more prestigious social status for themselves and gain more power. Though Frieden (1975, 1981) disagrees, she acknowledges that physicians’ support of zemstvo medicine does not mean that they were aligning with the state completely. It only means that they saw it as a way to escape close supervision by authorities and have more freedom of action.

Physicians promoted hygiene education to prevent epidemic breakouts, and formed a professional organization, Pirogov Society, in 1888 (Frieden 1975) to further their humanitarian and professional mission. Epidemics ravaging the Russian Empire, and especially the cholera epidemic of the 1890s, were a key point of physicians’ renegotiation of their roles with the state (Frieden 1981). Physicians were strategically located throughout the provinces and had direct access to ailing populations. Not only did they possess expert knowledge, even if quite rudimentary by modern standards, but they also saw deficiencies in the state’s tackling of epidemics. The Ministry of the Interior
acted like medical police: it employed physical force. Violent quarantines led to poor sanitation. These factors met stark opposition by the ill (Solomon and Hutchinson 1990). The cholera epidemic allowed physicians to gain some leverage in their relationships with administrators. Physicians’ staking of their legitimacy claims after cholera epidemics provides interesting parallels with contemporary Ukraine. Will increasing mortality rates in Ukraine become a trigger for meaningful health care reforms today?

However, these initiatives came to an end after the 1900 repressions when the government started to focus on the independent professionals as a threat to autocratic power (Frieden 1981). Physicians who promoted reason and science appeared to threaten the monarchy, the social order and the church (Solomon and Hutchinson 1990). Therefore, the pre-revolutionary government was intent on continuing its centralized control of medicine via the civil police. Much as Schecter (1997b) argues for the Soviet medical profession, historians studying pre-revolutionary Russia conclude that physicians were not able to develop an independent corporate group like their colleagues abroad did. While Field (1957, 1967, 1988), Ryan (1990) and Schecter (1997b) argue, somewhat romantically, that pre-revolutionary physicians had a strong corporate professional identity and political power lost under socialism. Historical evidence does not support that. Many physicians felt disempowered by the Tsarist regime, and a significant number put their hopes into the socialist revolution. The socialist government gave physicians more freedom, and it promoted many public health projects consistent with the agenda of zemstvo physicians. Indeed, zemstvo medicine was “a landmark in the history of public health” (Frieden 1981). The Blshevik government also professed its dedication to science
and reason (Solomon and Hutchinson 1990), which resonated with many medical professionals.

Thus, the argument that physicians lost their professional autonomy in the Soviet Union is not the complete historical picture. In comparison to the position of the majority of physicians in the Russian Empire, excepting a very few privileged doctors employed by the nobility, physicians had more channels for expressing their agency in the Soviet Union. In order to understand the medical profession in socialist and post-socialist Ukraine, therefore, ethnographic evidence is essential to understand what agency entails and to examine it contextually.

The social history of the medical profession before the 1917 revolution, I argue, is crucial for understanding the social status of physicians in Soviet Union, as well as women’s increasing numbers in this field. Among especially telling continuities are physicians’ roots in the lower social strata, origins of the profession in state modernization projects as opposed to population demand, as well as physicians’ focus on public health as a way to acquire more power. Their status as salaried workers is key in understanding Soviet expectations for the medical doctors who had received their training free of charge. According to the Medical Statute of 1857 that legally governed medical practice (Frieden 1975), physicians were supposed to “treat the poor without charge, set an extremely low fee scale, and if a well-to-do patient so desired, they were allowed to augment their fee.” This premise of physicians’ obligation to society did not change significantly in the Soviet Union. Physicians were still expected to provide free care to all in exchange for their state-sponsored salary. Most of them also received military training and could be called for army duty at any time. Even the double-standard of setting low
fees, but expecting higher payments from the wealthier patients, was fully enforced in
Soviet times. It has been carried forward into post-socialist environment. This point will
be elaborated upon in Chapter IV discussing informal exchanges in Ukrainian health
care. These factors suggest that physicians’ relationship with the Soviet state, at least
before the Stalinist regime, was in some ways a continuation of their previous role in the
Tsarist Empire. Hutchinson (1990) confirms that the Bolsheviks were able to draw on a
number of fortunate circumstances, such as the continuously important role of the state
and the legacy of service to the population. The new regime was mainly perceived by the
main body of pre-revolutionary physicians as “far more ready than the tsarist government
to uphold the importance of modern technology and professional expertise” (Hutchinson
1990:203). Scientific knowledge, perceived by the Tsarist government as a threat,
became “a linchpin of physicians’ cooperation with the new regime… recognition of their
scientific abilities attracted physicians, whose professional identity gave them a sense of
social value and a claim to authority” (Frieden 1981:322). Physicians who did not have
professional autonomy in a Western sense, still defined themselves as professionals, as
they do today, and as my chapter on professionalism will demonstrate. Because of the
state affiliation of the profession, the free play of the market, crucial to the
professionalization in the West historically, has not been important in the context of the
Russian Empire, the Soviet Union, or post-socialist space. It is therefore important to
broaden our definition of professionalism to include more context-sensitive approaches.
This will be addressed in Chapter VI of this dissertation entitled “Professionalism, Ethics,
and Social Change.”
Another continuity between the pre-revolutionary medical profession and Soviet biomedicine is its increasing feminization. I will turn to this point after discussing the organization and foundational principles of Soviet health care, as well as the status and role of Soviet physicians.

III. Soviet Biomedicine and Its Professionals.

III.1. Soviet health care system.

The 1917 revolution in Russia coupled with civil war and World War I exacerbated poor health in the population with raging epidemics of typhus and cholera and with starvation. The new socialist government urgently faced the practical necessity to formulate a basic health policy, which was done in 1918 when the Commissariat of Health Protection [НарКомЗдрав] was founded (Field 1967:54). Public health was one of the main foci of the socialist revolutionary government, consistent with the ideology of equal access to resources, prioritizing the working class as a valuable labor resource in light of the dire epidemiologic situation in the country after the revolution. Lenin’s often cited proclamation “Either the lice will defeat socialism, or socialism will defeat the lice,” highlights the Bolshevik preoccupation with the health of the masses. Preventative medicine, especially the prophylaxis of infectious diseases, became key, including a special interest in burgeoning immunization techniques (Kravchenko, Saltykov 1967).

As early as 1919, the Commissariat of Public Health initiated a mass vaccination against smallpox, followed by a campaign against tuberculosis in the late 1930s (Torgunova 1967), diphtheria (1940), pertussis (1955), polio (1956), and measles and mumps (1970) (Brinton, Ladyzhensky 1992).
World War II also influenced the development of the medical profession. In particular, it contributed to what the Western social critique calls a fragmented view of the body (Gordon 1988, Lock 1993, Martin 1987). During the years the Soviet Union was fighting and recovering from war, biomedicine emphasized such specialties as surgery, orthopedics and urgent care, necessary for dealing with complex injuries and trauma that occurred on the battlefields. In these circumstances, the focus on anatomy was reinforced, leading to further segmentation of the medical field into multiple medical specializations. For many years, specialization was considered to be a measurement of the efficiency and development of health care (Ponomarenko 1998: 117). This interest in medical specialization coincided with international trends in medicine, developed during wartime. In addition, a biomedical approach was able to establish deep roots in the Soviet Union because it was consistent with communist ideology. As an atheistic state, government had zero tolerance for religion. The dominant discourse was that of evolution and science, which reinforced a biomedical approach with its segmented view of the body. It continues to dominate medical practice in Ukraine, although alternative healing techniques are gaining momentum, in part due to the current financial crisis in the biomedical health care system (Phillips 2004). In this connection, Wanner (2003) offers an interesting point that the current resurgence of religion in Ukraine is a healing strategy that “critiques … the moral code and social contract created under socialism” (2003:274), including a reliance on Marxism-Leninism, and its exclusionist dominance of scientific discourse as a source of answers to all philosophical existential questions.

The Bolshevik government employed a Marxist understanding of medicine as a part of a superstructure resting on a socioeconomic base. This base consists of the means
of production of commodities and their exchange. The scope of medical services thus depends on the development of productive forces in society and the nature of social relationships. According to a socialist understanding, the elimination of class struggle and private ownership will end exploitation and lead to an equitable health system serving the needs of the entire population, and not just a privileged few (Ashurkov 1961, Barsukov 1961, Field 1967). Much like contemporary critical medical anthropologists (Farmer 2003, Singer 1995), early Soviet administrators felt that only by uprooting capitalism and unequal access and distribution of resources, will it become possible to have a healthy population. Soviet health care ideology was rooted in Marxism-Leninism and an understanding of disease as a product of the social environment and class struggle (Ashurkov 1961, Barsukov 1961).

The socialist health care model is largely preserved in the Ukrainian health care system and it includes the following foundational principles: health care is the responsibility of the state; public health measures take place within the framework of a single plan; health care is provided without cost to the patient; it is controlled by a central authority; practice and theory act in unison; health care allocates priority of care to workers; and it emphasizes preventive care. (Cockerham 1999:30, Field 1967:43-48). Socialized health care therefore excludes private practice and instead employs physicians who provide their expert help to patients free-of-charge. All medical services are free with the exception of prescription medications for non-chronic conditions. A hierarchical system of health care facilities provides services to the population according to a single plan developed by a centralized authority – the Ministry of Health. The central government allocates a budget to local governments who finance the work of health care
facilities locally – hospitals and polyclinics. The general public is directed to specific outpatient facilities and hospitals depending on their catchment area (Cockerham 1999:31). There are also specialized health care facilities for certain critical industries, such as the Ministry of Transportation, the Army and other governmental units. Pursuit of knowledge for the sake of knowledge is not encouraged; instead the applicability of research is emphasized, especially research involving preventative measures.

Soviet health care had multiple problems, widely discussed in foreign publications. Because of its emphasis on the labor force in the interest of state, individual health and comfort were never prioritized. Health care was funded according to residual principle, from the budgetary funds left after financing heavy industry. Because of this, health care was chronically under-funded. In the 1960s, the share of the GDP spent on medical care was 6%, in the 1980s it barely reached 3%, and it fell to a disastrous 1% in 1993 in many post-Soviet states (Feshbach 1988), compared to 8% recommended by the World Health Organization. In addition, health care policy based on the centralized plan meant attention to quantity before quality. Thus, success was measured according to hard numbers, such as beds in the hospitals per 100,000 people and the number of physicians per capita (Cockerham 1999:31). Although the Soviet Union boasted the highest numbers in these measures worldwide, more qualitative indicators were systematically dismissed.

Despite the deficiencies of socialized health care, Soviet medicine achieved major improvements by the mid-1960s. Life expectancy increased from 40.4 years for males and 46.7 for females in 1938 to 64 for males and 72.1 for females in 1965 (Cockerham 1999:35). Great numbers of qualified medical staff were trained; hospitals, clinics, outpatient facilities were opened, and most of the infectious diseases were taken under
control through extensive preventative measures. The state also initiated accreditation procedures with the goal of the qualitative development of Soviet doctors (Burton 2005). This less known fact about Soviet health care policy demonstrates state interest in the standardization of professional norms, the implementation of rewards based on performance at work, the establishment of peer review and regulation, and quality control. In Stalinist fashion, however, accreditation was also utilized to uncover and punish the underachievers or otherwise unwanted cadres, and quickly became highly politicized (Burton 2005). All in all, the Soviet regime created a comprehensive system, a “blueprint for modernization” (Field 1967:202) that has been applicable in a number of developing countries. Socialized medicine has been one of the landmarks of the Soviet regime, acknowledged by domestic and foreign populations.

III.2. Soviet medical profession.

From its beginnings, the medical profession was envisioned as a particularly important locus for popularizing socialist ideas. Hutchinson and Solomon (1990) have shown that physicians served as patrons of such diverse fields of knowledge as biomedicine and positivist science, social hygiene, eugenics, sexuality and normalcy, as well as psychiatry and others, combining strong and mutually contradictory nurturist and naturalist philosophies. Biomedicine under the Soviet regime was more than health care. It was all-encompassing modernization project, related to empire building (Bernstein 2007; Healy 2009; Michaels 2000, 2003; Starks 2008). A 1961 Soviet Ministry of Health publication explained that Lenin’s approach to health care was “electrification plus elimination of disease,” which underscores a tight connection between progress and
medicine. The struggle for sanitary culture was equated with the struggle for socialism (Ashurkov 1961). All aspects of everyday life were subject to change in the early years of socialism, precisely with the goal of creating a new Soviet man and woman who would walk, talk, interact, eat, and sleep in a Soviet way. Bernstein (2007:7) notes in this regard that “language, hygiene, leisure, time management – all aspects of existence were subject to scrutiny and radical alteration in the battle for a new lifestyle.” In particular, Bernstein explores how sex became medicalized with the purpose of regulating Soviet everyday life. In Foucaultian sense, sex was transformed into discourse, wherein professional authorities built a frame within which people had to construct their sexualities. Adopting a discourse of science legitimized physicians’ authority in the new regime and allocated to them the role of expert. As the socialist world order was being constructed, social norms were experimented with and reconsidered. Sexual behavior debates were an important part of public discussions in the early socialist years, for they represented broader issues of the public and the private, state control and family regulation, enlightenment and progress. Bernstein suggests that medical professionals quickly claimed “the sex question,” as part of their jurisdiction, medicalizing sexuality with the purpose of carving out a niche for themselves in postrevolutionary social institutions. For Bolsheviks, medicine offered a language of modernity, and became the key to most questions that were previously understood as moral questions (Healey 2009). The government agreed to accept the authority of physicians in exchange for their help, and therefore transferred sexual matters from the individual to the collective via medicalization and the invention of social hygiene.
Although physicians were subjects of centralized state authority, they also were its pillars in the modernizing project, and especially the project of sanitary enlightenment (Bernstein 2007:102). They were indispensable. This allowed medical doctors a degree of status and decision-making power in the socialist state. In fact, physicians openly competed for influence with some of the party members who were testing their strength in publishing sexual education literature for the masses (Bernstein 2007:29). Semashko, the first Commissar of Health and the founder of the Soviet health care model, criticized party members without medical education who were trying to capture the audience with unscientific statements, and he did it via major newspapers, such as Izvestia. This demonstrates a degree of freedom that the expert status of physicians allowed. The early Soviet state also satisfied physicians’ long-standing desire to be free from supervision by the Ministry of Internal Affairs (Healey 2009). Education, prevention and prophylaxis are the foundational principles of the Soviet health care system, therefore sanitary literacy was envisioned as a way to raise awareness of matters of health, and the political consciousness of the population (Bernstein 2007:104). Soviet citizens received free care, but in return they had to agree to be “sanitary subjects.”

Nowhere was it as obvious as in the Soviet advancement of biomedicine in non-European parts of the country. Michaels (2000, 2003) provides an in-depth account of Soviet modernization of the Central Asian steppe, and specifically Kazakhstan. The expansion of biomedical services, she points out, served to keep the workers healthy, but also to forge a pan-Soviet identity based in European traditions with a focus on positivist science. A medical professional’s mission was more than dispensing health care, it was to popularize ideas of social hygiene rooted in a socialist outlook. The program linked a
Kazakh way of life as the foundation for disease. It condemned Kazakh religious practices, the Kazakh nomadic lifestyle and Kazakh family roles. These were viewed as remnants of a patriarchal, semi-capitalist world order, incompatible with the future of socialist civilization. Physicians were therefore entangled in associating the local culture with disease and medicalizing progress itself. In particular religion was the target of sanitation education all over the Soviet Union. Religious practices were deemed to be “the opiate for the masses,” after Marx. They distracted from socialist building and created dangerous loyalties. It also did not fit into the evolutionary positivist outlook. Medical doctors were instrumental in warning the population about the dangers of religion: kissing crosses and drinking water from common vessels spread germs; circumcision exposed infants to infection; fasting caused intestinal disorders; and religious fervor led to psychosis (Michaels 2000). Physicians were fundamentally important in building the groundwork for the popularization of socialism. By demonstrating positive health outcomes, they validated the regime in the eyes of its citizens, especially those in the far corners of the empire. Thus, their contribution has been not only medicalization through coercion, but also and even more significantly – indoctrination into a Soviet lifestyle and framework of thinking.

Bernstein (2007), Healy (2009) and Engelstein (1992) have shown how physicians actively engaged with discourses on sexuality and normalcy staking their expert role in a relationship with the state in order to achieve a degree of professional power. Michaels (2000, 2003) has demonstrated how important medical doctors were for the Soviet modernization project in non-European parts of the empire and in the European countryside. Starks (2008) revealed how physicians shaped the everyday lives
of Soviet citizens and helped to create and discipline the Soviet body. While Soviet physicians had to work within a strict framework imposed by the state, they exercised significant political roles. This is important to keep in mind while proceeding to the next section, in which I discuss the professional status of medical doctors in the Soviet Union.

III.3. Soviet physician: a professional or a bureaucrat?

It is important to discuss Mark Field’s contributions to the understanding of the role and status of Soviet medical professionals. His works (1957, 1967, 1988, 1991) have been extremely influential in Western social sciences. Indeed, Field’s access to Soviet publications, archives and respondents is remarkable for its time, and his scholarship is pioneering. Today we are able to contribute ever more fine-grained analyses with the help of in-depth ethnographic data collected over prolonged periods of time, as opposed to brief heavily supervised visits during the Soviet period or a narrow scope of research subjects, for example only dissidents and immigrants, which Field had to do in his research. We are now able to secure a wider scope of respondents. Field’s conceptualization of Soviet and post-Soviet health care professionals has evolved over the decades of his academic career. Yet, the main message has remained constant: Soviet physicians have become apolitical, docile and inert employees of the state, rather than a self-conscious, independent and vocal corporate entity (1957:45).

Field considers pre-revolutionary doctors to have been dedicated, aware and a strong group, even if not always held by formal association ties. In particular, Field is fond of *zemstvo* medicine, described earlier in this chapter. Not accidentally, he begins his monograph with the luminary Russian writer’s Chekhov’s account of his work as a
zemstvo physician. He idealizes pre-revolutionary medicine as independent from the state, selfless and humanitarian, “organized, self-governing, a social group or social force” (1957:54), despite the contrary evidence presented by Frieden (1981) and Hutchinson (1990). Reliance on writings of some of these physicians, no matter how masterful and talented, is an unlikely source for objective information. Field views the dissolution of the Pirogov Society of Russian Physicians and the Pan-Russian Union of the Professional Association of Physicians, shortly after the 1917 Revolution, as the death of the profession. In so doing, he not only dismisses evidence of weaknesses in the pre-revolutionary autonomy of medical doctors, recorded by historians like Hutchinson, but also somewhat overemphasizes their beneficence. Indeed, Hutchinson and Frieden both note that physicians sought out zemstvo appointments often precisely in order to achieve better financial status. He also frames professionalism in terms of autonomy from the state, and thus dismisses newly formed socialist trade unions [МедСанТруд] and other forms of organizing as potentially empowering and professionally satisfying for their members. Because of physicians’ dependence on the state and the preponderance of communist party members among health care administrators, Field (1957:58) suggests calling Soviet doctors a group of “expert officials,” instead of “professionals.” Here is what he has to say in his 1991 publication:

The ideal, born in the nineteenth century, of the educated professional working independently and employed only by the patient, governed by a strong consciousness and an accepted code of professional ethics, a person dedicated to service to others, a member of a highly respected and politically powerful and articulate constituency, has to a large extent disappeared in the Soviet Union.

In his 1967 volume, Field (1967:51) writes that Bolsheviks inherited a system “that not only was politically corrupt, economically bankrupt, and militarily on the verge
of collapse, but also was endangered by a shortage of medical personnel, supplies, and facilities.” Despite his realization of the ruinous conditions in the country and in the medical profession, it is surprising to read the rather romanticized image of pre-revolutionary physicians that Field juxtaposes with a bleak image of Soviet physicians. While Frieden (1981) and Balzer (1996) argue that many physicians found socialist promises attractive, Field (1991:46) believes that pre-revolutionary physicians “were concerned that they would be placed under the control of ignorant or unqualified, but politically acceptable, subordinates in the medical field.” Indeed, vast evidence exists that this is exactly the type of administrative control that pre-revolutionary physicians were subject to in their земства where they were subordinate to internal police. It is also precisely the земство physicians that Field glorifies as anti-socialist, who, in Field’s own words, had humanitarian public health goals in mind. If anything, this ethos of service could only strengthen the doctors’ interest in socialism. Furthermore, Field’s scholarship is a product of its time and as such employs Cold War biases. One of the remarkable examples of this is Field’s (1967:204) discussion of the applicability of the Soviet health care model in underdeveloped countries as well as the export of Soviet physicians to underdoctored parts of the world as “disturbing.” While acknowledging achievements of the Soviet organization of public health, Field finds its replication in other parts of the world “disturbing” not because of its inefficiency or danger to the population, but due to political considerations.

Field (1957, 1991) discusses fraudulent trials that accused famous physicians of betrayal and sabotage during the Stalinist regime as an example of the absence of collegiality among Soviet physicians. In so doing, he conflates the desire for collegiality
with the objective availability of channels to act on this desire during the violent Stalinist period. The socialist experience cannot be reduced to Stalinism, since it was only one epoch in Soviet history, though a significant one, and was discredited upon Stalin’s death.

In chapters VI and VII, I will discuss Lindquist’s (2006) contributions to understanding human agency not only as a will to act, but also as an availability of material channels where plans and desires can be enacted. Her conceptualization of agency can be applied for a better understanding of professional decision-making and Soviet biomedical practice, particularly during Stalinism. In contrast to viewing physicians as bureaucrats, Rivkin-Fish (2005) has shown that Russian physicians today emphasize their separation from the state bureaucracy and capitalize on their clinical roles. Similarly, my ethnographic evidence will highlight the significance of collegiality and clinical knowledge in Ukrainian physicians’ conceptualization of socialist morality and their critique of the new market morality.

Contrary to Field, Balzer (1996) suggests that the consciousness of professional identity and attempts to assert a role as a specialist have never vanished in the Soviet Union. The absence of new professional associations in post-socialist states, according to him, is not a sign of the Soviet deprofessionalisation, but is an evidence of an economy that undermines the social and economic status of professional specialists and the stunted development of civic society. Professionals do not seek to be absolutely independent from the state, for it is the state legal system that is supposed to enforce their basic rights and freedoms. Instead, they seek to be autonomous while being able to rely on the state and utilize its power. Balzer argues (1996:302) that in civic society, the key is the relationship (ideally, partnership) with the state where conflicts over boundaries between
private and public spheres are kept within limits and where the state performs mediating roles. Independent associations that have no relationship with the state produce corporatism and disillusionment.

In his later scholarship (1988, 1991), Field acknowledges that the term profession has multiple meanings, including demarcation of expert knowledge and excellence, occupation more broadly, pursuit of knowledge and discovery, and solidarity between colleagues that stem from performing the same work. Yet, he does not explore these categories further, once again returning to a sociological understanding of profession “as a socially and legally recognized association and an interest group” (1988:43). The only channel for expressing physicians’ agency in a Soviet and post-Soviet context, in Field’s view, is control over the patients (Field 1991:49). He argues that physicians are corrupted by the power of medicalization that the state has endowed them with, and they use it indiscriminately against their patients. This includes indifference, formalism, cruelty, and extortion of under-the-table payments (Field 1991). So influential is Field’s work, that many Western scholars who write about physicians in the former Soviet Union argue that Soviet doctors’ medical knowledge and skills were rudimentary by Western standards (Barr et al 1996, Schecter 1997). These scholars suggest that simply because physicians did not have a free-standing professional organization independent from the state, there was no quality control in the field. Yet, in a highly hierarchical and centralized system, control was a big part of everyday medical practice, and internal accreditation certifications were implemented after the World War II precisely to ensure quality control within the profession (Burton 2005). This dissertation will discuss the ways in which
post-socialist physicians see their training and practice in comparison to their Western colleagues.

Many anthropologists have shown (Andaya 2009, Ledeneva 1998, Rivkin-Fish 2005) that an informal economy in socialist and post-socialist health care has much deeper meaning than physicians’ alleged lack of morals. I delve into the issue of informal exchanges and moral economy in Chapter IV. At this point, it will suffice to say that informal exchanges could be considered as an act of resistance to discredited state regulations, a demonstration of the negotiating power of patients who gain more influence upon making an informal payment, and also an indication that physicians and patients work together, even though informally, to achieve desired health results. Analysis of these personalized ways of seeking medical services will shed more light onto the re-negotiation of rights and responsibilities of patients, doctors, and the state in post-socialist space. In his most current scholarship, Field (1991) concedes that the biomedical profession is not completely powerless, but rather hybrid: it is powerless before the state, and too powerful in relation to the patient. This dissertation will provide rich ethnographic data stemming from analysis of physicians’ daily routine that will offer new avenues for understanding the role and status of Soviet and post-Soviet physicians. It is my intention to contribute a more fine-grained analysis of the concept of profession and professionalism than current sociological studies focusing on post-socialist space offer.

This next section turns to the historic situation of women’s involvement in the Ukrainian medical profession. I trace women’s roles in providing medical services
shortly before the Revolution and during the Soviet period in order to contextualize the current increasing numbers of women in the Ukrainian biomedical field.

IV. Women in health care.


The Bolshevik revolution of 1917 brought an abrupt end to the Tsarist regime in the Russian Empire, however the country was far from unified. World War I and years of civil unrest introduced multiple political discourses that threatened the legitimacy of the Bolshevik state. The task of the new government was to gain control not only of major resources and means of communication, but also over discourse. The Bolshevik task was not simply a “seizure of power,” but a “seizure of meaning” (Bonnell 1997:1).

Marxist ideology guided all aspects of the Bolshevik regime, among these, gender relations. The revolutionary state believed that by changing the mode of production and bringing all members of the socialist society into the labor force, it would be possible to create a single Soviet culture. Through participation in productive labor, the population had an opportunity to turn from a feudal order to modern socialism along the lines of unilineal social evolution (Hirsch 2005: 8). Regarding gender, Marxist ideology was based on the premise that women had to be involved in the revolution and had to be emancipated through their participation in wage labor in order to become true citizens of the socialist state (Kollontai 1923). Peasant and illiterate women constituted the majority of the country’s female population, and baba was an unlikely builder of modernity – of socialism. Baba is a term signifying an illiterate, superstitious, small-minded, irrational and overly emotional female figure, usually a peasant (Wood 1997). Women were the
target of new policies even more so than men, since men, having served in the army and traditionally involved in public life, were usually more exposed to the outside world. In contrast, *baba* was perceived to be a survival of the old world-order, “a *baba* thus could not remain a *baba* and still be a comrade” (Attwood 1997: 17). She marked “behaviors and attitudes which were not considered sufficiently revolutionary and dedicated to the cause of building a new order” (Attwood 1997: 17).

On one hand women were misogynistically viewed as a raw material from which the revolutionaries could mold desired civilized citizens. On the other hand, women were mothers responsible for future generations of Soviet citizens. Bolsheviks thought to redirect the loyalties of women away from their families, kin and church and into the state and into social production (Wood 1997:15). They drew from August Bebel’s “Women under Socialism,” Friedrich Engels’s “Origins of the Family,” and GSDs (German Social Democrats) Clara Zetkin and Lily Braun’s writings to set a goal of “liberating women from domestic slavery” (Attwood 1997: 27). Lenin and his wife Nadezhda Krupskaia spoke of housework as “degrading” and “stultifying,” and denounced “patriarchal immobility” and “personal dependence” (Attwood 1997: 29). We have since learned that if gender policies aimed at securing women’s rights and bringing about a greater equality of the sexes diverged from material considerations of the Soviet government, that is, consistent economic development and growth, they were often sacrificed (Dodge 1966). Indeed, Soviet gender policies were often contradictory. They emphasized women’s liberation from domestic slavery and their economic potential, yet women’s roles as mothers and wives were rarely questioned. Instead, these roles were solidified by the legislature proclaiming women’s special physical and psychological
needs that stem from their reproductive roles. Despite this, however, socialist gender
dreaming created frames circumscribing women’s new space in socialist society.

The Bolshevik vision of women’s liberation is not to be confused with feminism
as the term is used in the Western world. In a Soviet context, organizations had to walk
the tight rope of uniting women for furthering various public issues, while at the same
time not turning them into their own “class,” thus channeling their enthusiasm away from
Proletarian interests (Attwood 1997:30). Feminism was labeled a bourgeois movement,
and antipathy to this term can be noted in Ukrainian society even today (Pavlychko
1996).

Bolshevik’s socialist government initiated the creation of a new gendered space,
intended in opposition to the pre-revolutionary conceptions of gender roles. The old
mentality was not acceptable in the radically new state-building. It is not surprising that
even today the word “pre-revolutionary” in Russian and Ukrainian languages is used
widely to signify backwardness. Women were urged to get involved in social production,
albeit on state terms.

As the first decade of the socialist project came to an end, Stalin’s regime
changed many aspects of the early Bolsheviks’ ideas. The New Economic Policy that
gave a relative degree of freedom to private businesses and farms was replaced by crash
collectivization and industrialization (Fitzpatrick 1999). Women were encouraged to
participate in these projects as collective farm workers and industrial workers. A
ubiquitous image of the male industrial worker and the female collective farm worker
immediately comes to mind as one of the most widely popularized icons of Soviet living.
An image of *kolkhoznitsa* (a collective farm worker) became a dominant theme of
political propaganda (Bonnell 1997:101), as the need to actively recruit peasants into collective farms became more pressing. Collectivization was a highly unpopular policy, accompanied by forcible extraction of land, equipment, and houses. In Ukraine in particular, collectivization met intense resistance, and arguably led to the 1932-1933 *Holodomor* (Ukrainian for famine) (Bilinsky 1994, Mace and Heretz 1990, Wheatercroft 2004). Political propaganda was a very important means of conjuring new and more attractive meanings of being a part of the socialist state. Modernizing the under-developed peasant countryside through collectivization was a Soviet state priority. I have already mentioned the role of physicians in spreading the socialist imperial project to the distant corners of the Soviet state. One of Lenin’s most famous slogans was “electrification of the entire country” – by which he meant that even the smallest house in the remotest village had to have an electric light bulb (Bekman Chadaga 2007). The light-bulb became a symbol of progress. In a direct and figurative sense, it brought enlightenment to the citizenry. In the same vein, the tractor became another symbol of modernization for the Soviet countryside. It symbolized progress brought about by the socialist collectivization of farmers. The image of *kolkhoznitsa* successfully operating the tractor is abundant in the political art of the time. In this way, women are shown to symbolically have departed from their peasant roots and arrived to a new state of being in a collectivized modern countryside indistinct from urban space. Given the stereotyped perception of peasant women as uniquely backwards, female “domestication” of the tractor was a bold message pointing to progress and the imagined advantages of socialism.
The early Soviet government conceptualized child rearing as a burden, and intended to take it away from women’s shoulders by providing public collective care in kindergartens and schools. In this way, women would be on track for liberation from domestic slavery, while children could receive a better chance of becoming progressive members of the new socialist society. Despite these egalitarian ideas that indeed provided women a degree of freedom from their traditional domestic duties, they also did not envision men as true partners in child-rearing. Father figures were important, and children outside of wedlock were strongly frowned upon. However, a broad social welfare network helping women with child-rearing did not extend to men, who were not eligible to the state benefits available to women in this area. During World War II (1940-1945), the importance of a maternal role for women began to be re-emphasized by the Soviet government. This invocation of a pre-revolutionary theme, namely motherhood, corresponded with the re-opening of Orthodox churches to draw on religious faith during war time. This brief episode of spiritual freedom during Stalin’s regime was a surprising and radical departure from the intense condemnation of religion. With the end of the war, however, the former intolerance of religion returned. Yet, women’s roles as primary caretakers for their children, for elderly and sick family members, became even more solidly rooted.

Victory over fascism in World War II resulted in a powerful celebration of the Soviet way of life. It was a crucial unifying factor for creating a common reference point for identifying with Soviet culture and Soviet citizenship. Post-war rebuilding was exhilarating for the citizens, and health care in particular experienced significant progress. Women did not withdraw into the domestic sphere as in the West. They were
able to capitalize on some of the early socialist ideas and continue to carve out more
lucrative niches for themselves. Women formed over half of the professional and semi-
professional labor force in the Soviet Union, and constituted 30% of all engineers
compared to 1% in the US in the mid-60s. Soviet women comprised close to 75% of
physicians, compared to 7% in the US at the time (Dodge 1966). We now know that
despite this impressive involvement of the Soviet woman in the Soviet economy, she also
constituted a disproportionate group in lower and intermediate professional levels, as
opposed to supervisory, management, and scholarly positions. However, women’s
numbers among the directors and chief physicians of health care facilities were still
impressive, nearing 57% (Dodge 1966:244). It is important to acknowledge that
motivated women had impressive opportunities to develop and utilize their talents.

In the early 1960s, the demand for female labor increased due to the stabilization
of the economy and the exhaustion of manpower from rural areas (Lapidus 1978). The
expanding economy and the deficit of males created a favorable environment for
women’s massive entry into the professional workforce in various roles, including the
health care field. Lapidus explains this in terms of the economic requirements of Stalinist
development policies and economic pressures. She points out that these expectations may
also have been guided by other motivations, but her historical account of women and
work in the Soviet Union is not designed as an ethnographic inquiry. My dissertation will
provide a window to understanding some of the internal motivations of contemporary
women in joining the health care field in increasing numbers.

I now turn to a discussion of women’s involvement in the biomedical profession
in the Soviet Union and in the years preceding the socialist Revolution.

Recent scholarship (David 2007, Frieden 1981) questions the common assumption that the feminization of the biomedical profession has been a result of the alleged low status of the health care field in the Soviet Union. For instance, Schecter argues that women were able to join the field in increasing numbers because it became less lucrative and attractive for men. In contrast, David (2007) demonstrates that rather than a product of the Soviet regime, the feminization process was initiated well before 1917. The St. Petersburg Women’s Medical Institute systematically graduated women physicians from 1897 onward (Ryan 1990). Frieden (1981) shows that the number of female physicians had been consistently growing, from 409 in 1889 to over 1,590 by 1910. Ryan also suggests that during World War I, the numbers of women doctors nearly doubled, from 2,322 in 1914 to 4,000 in 1917. David (2007) further demonstrates that while in 1914 females made up only 9.7% of all doctors in the Russian Empire, by 1926 their numbers had grown to 39%. Between 1912 and 1923, more female than male doctors graduated each year from medical studies. This growth therefore cannot be attributed to the 1917 Revolution since it began much earlier. In addition, the civil wars and unrest that blanketed the former imperial territories prevented consistent policy making from taking place that would usher women en masse into the profession. David (2007) argues that the feminization of the medical profession was an outgrowth of World War I and the resultant loss of male physicians, as well as the progressive attitudes among academic physicians of late Imperial Russia. David’s analysis provides valuable evidence for understanding the continuing feminization of the medical profession.
throughout the 20th and 21st centuries, particularly since women’s numbers among medical doctors also increased dramatically during and after World War II.

Women’s participation in Soviet medicine was consistent with the proletarianization of the profession and socialist ideology that required every citizen to participate in social production. A special effort was made to recruit medical students from working class families in order to transform biomedical care from a pre-revolutionary bourgeois circle to “specialists instead of encyclopaedists” (Popov 2001). According to Riska (2001), women entered the field as labor resources, driven by the industrialization and collectivization of other parts of the labor pool. Women were also driven by a state-sponsored women’s emancipation project (Watson 1994). Lapidus (1978) notes extensive opportunities for women in scientific and technical training that facilitated their entry into medicine and engineering on an unprecedented scale. She also points out that because the state could dictate the terms of employment, it was able to create favorable conditions for women’s work, such as child care benefits. However, I understand these factors as facilitating women’s entrance into the professions, rather than the sole causative determinants of this process.

In fact, in the Soviet Union, there was never a policy that would create special privileges for women who wished to enter medical schools. Women were admitted to medical schools based on high school grades and entrance exams. Entrance to medical school could be facilitated by gaining prior working experience [Rus. трудовой стаж], usually as a nurse’s aid in a hospital, or attending of special preparatory courses. Sometimes, prospective medical students from working class families could enroll in special departments without competing in the general pool of applicants [Rus. рабфак].
In addition, soldiers who fought in World War II, received special privileges during the admission process. Early educational posters and enlightenment literature portray male and not female physicians as icons of science and of progress, fighting superstitious religious practices (Bernstein 2007:107,124). Health care was not visualized as a female profession, yet the numbers of women physicians continued to grow exponentially: 51% in 1937, 61% in 1940, peaking at 77% in post-war years (1950), and then averaging 70% in the 1980s (Ryan 1990). According to my respondents, women physicians who received their training during World War II served as inspiring role models for many. Indeed, human loss after World War II was close to 45 million (16% of the population expected by 1950) (Field 1967:72). Women in particular found it favorable to join the medical profession. Thus, the proportion of women in health services increased from 76% to 83% and in educational institutions from 58% to 73% during World War II.

Ryan credits this growth to the broader background of Soviet policies, namely political ideology, centralized economic planning and industrialization. He posits that since engineering institutes were more popular in Soviet times, medical institutes were somewhat easier to enter. This factor drew more women. In addition, the remuneration of physicians was relatively low, and women, allegedly, had a positive mindset towards a caring profession that also allowed them to be a part of a technical intelligentsia or what Ryan calls “workers by brain” [Rus. работники умственного труда]. I explore this point in more detail in Chapter VI, contextualizing it in ethnographic data. Rapid industrialization pushed everyone into labor force, and, Ryan argues, the medical profession seemed like a good choice for women. These pragmatic considerations were also supported by an official ideology that embraced egalitarian principles.
While theories explaining the exhilaration of women’s participation in the medical field may explain the economic factors at the time, they leave out culturally embedded local processes that, without a doubt, influenced women’s choice.

Scholars who explore feminization of the biomedical field in other countries (Finland, Norway, Sweden and Denmark with 50%, 33%, 39% and 33% of female physicians respectively in 2002) have linked it to the position of the medical profession as a “welfare state occupation” (Riska 2001: 65, 71). Women are concentrated in the area of public health and primary care, two areas especially regulated by the state and thus easy to enter. Some scholars argue that the large number of women physicians in Soviet and Scandinavian countries indicate a global trend to the feminization of the medical profession (Harden 2001: 182, Reskin & Roos 1990) with the aforementioned countries being the first to undergo this restructuring due to internal peculiarities of ideology and the labor market.

Another trend that follows feminization is the creation of a dual labor market with clear gender segregation in medical specialties (Harden 2001: 182). In the early 1970s women constituted around 30% of surgeons in the Soviet Union, while otherwise dominating the fields of pediatrics, obstetrics and gynecology, cardio rheumatology, and endocrinology at around 90% (Riska 2001: 81). Gender statistics by specialty that I was able to collect in one of the Ukrainian towns in 2005 demonstrate a similar gender distribution, with men dominating surgery at 93%, anesthesiology 83.3%, and orthopedics 100%. In my dissertation, I refrain from considering these masculanized specialties, that universally carry the highest social status as well as the highest formal
and informal incomes, as such. I address the issue of the prestige of various medical specialties, based on ethnographic evidence.

Although women were a minority among academicians (only about 20%), they represented 53% of chief doctors and other heads of health care facilities in the 1970s (Ryan 1990). Ryan sides with Riska and Harden to argue that women’s heavy concentration in primary care signifies a substantial barrier to egalitarianism. Theirs is a subservient role in the biomedical profession. He does not provide an interpretation for the high number of women in health care administration positions. While Field (1967:110,118) does not delve into this, he nevertheless mentions women’s great contribution to the development of the Soviet health care network, stating that without their participation, impressive increases in the health care coverage of the Soviet population (24.3 patients per physician in 1963, the highest ratio in the world) would never have happened.

My dissertation builds on a critical interpretive perspective (Cassell 2000, Rivkin-Fish 2005) to provide a more culturally embedded understanding of the micro-level processes involved in women’s decision to practice medicine. For instance, Harden (2001) argues that the main reason for gender segregation by specialty lies in a traditionalist patriarchal culture that flourished in the Soviet Union despite the official politics of gender equality. Although each woman was expected to work, the choice of job was limited by family priorities, the major task of each woman being child-rearing and caring for the family (Mashika 1989, Tolkunova 1980). The soviet state clearly expressed this woman’s task through its legislature, generously providing women with paid maternity leaves, restricting workloads for women during active motherhood
(pregnancy, birth, breast-feeding, caring for small children), and circumscribing gender-appropriate jobs in accordance with “psycho-physiological peculiarities of the female organism and women’s social role as mothers” (Tolkunova 1980: 14). Harden suggests that “women’s choices were (re)produced by a gender discourse rooted in essentialist notions about women’s character and role as reproducers and their resulting suitability for certain forms of employment” (2001:189). She argues that the material and ideological role of women in reproduction directly impacts their choice of labor, including medical specialization. Field (1967) similarly associates the high number of women in medicine with their domestic duties. Medical work in primary care or narrow specialties of non-surgical and non-emergency character allow women to have flexible schedules with plenty of hours to devote to household work.

I explore these ideas in contemporary Ukrainian society in order to contribute a micro-analysis of female physicians’ experiences that shape their professional and personal choices, in addition to a macro-analysis of wider political economic circumstances that determine the position of women in the medical profession. In chapter III, I will provide rich ethnographic data that complicate the association of primary care with a lack of prestige, as well as gender division by specialty. I also challenge the association of the feminization of the biomedical profession with disempowerment and the low prestige of this group.

In Ukraine, feminization of the medical profession continues, and my ethnographic data will provide the missing pieces of the puzzle to complete our understanding of women’s participation in biomedicine.

According to a 2008 Ministry of Health statistic, there are 119,541 working women physicians and 76,014 working men physicians in Ukraine (61% and 39% respectively). The number of women entering the medical universities is continuing to grow from 39% in 1957, 48% in 1962, 53% in 1982, 59% in 1992, 68% in 2003, and finally 70% in 2007 (data of Ministry of Health of Ukraine). This demonstrates the pattern of growing numbers of women in medicine. My interview with an official of the State Department of Cadres Politics, Medical Cadres and the State Service confirmed that the recognized trend in the biomedical profession is the increasing numbers of women, or as the official put it “decreasing numbers of men in the profession.”

Women’s connection to medicine goes further back in time than their participation in organized biomedicine, all the way to 11th century Kyivan Rus’ in the historical record. From the 9th to the 13th centuries, Kyivan Rus’ was the nucleus from which Ukraine and Russia emerged. It has been shown that women in Kyivan Rus’, including commoners and nobility, possessed a relatively large scope of freedom. They had the right to property and inheritance, and the right to take their complaints to court. Women also had relatively broad rights in terms of family and community (Kryvoshiy 2004).

From the 10th to 12th centuries, Kyiv was the cultural center of East Europe. The borders of this first Ukrainian state stretched from the Finnish Bay to the Sea of Azov.
Kyiv had political, military, and cultural relationships with East and West, and thus literature in Slavic, Greek, Latin, Syrian and Arabic was present. Medicinal scholarly works used at the time were those of Hippocrates, Asclepiad, Celsius, Avicenna, Razes, and others. Monks were the predominant class that provided medical treatment, however various male and female folk healers were also extremely important, notably in everyday life of commoners (Pliushch 1970)\textsuperscript{vii}.

Although there are records of peasant women who were successful healers and usually inherited the craft from their parents, more accounts exist about women from higher social classes practicing medicine (Konopelko and Holiachenko 2002, Pliushch 1970). For example, Eufrosyniya the daughter of a Chernigiv prince and Princess Anna Vsevolodivna who opened a secular school in Kyiv that among other things taught medicine. The earliest known scientist-physician in Ukraine was a woman – Eupraksiya-Zoya (1108-1172), daughter of Prince Mstyslav Volodymyrovych and granddaughter of Volodymyr Monomakh. She was educated at the royal court and provided services to her servants and to the surrounding villages. She was married to Byzantine Tsar Ioan Komnen and continued her medical education in Constantinople. Eupraksiya wrote a medical tract “Alimma,” addressing issues of pathology, diagnosis, general hygiene, hygiene of women and children, food hygiene, private hygiene, and the treatment of various diseases. The ancient roots of women in healing roles are not unique to Ukraine. For instance, Martin (1987) reports how male biomedical professionals have usurped reproduction care and pushed out female midwife practitioners who were once the main authority in this field.
The Ukrainian tradition of female folk healers continues today. In my dissertation, some female respondents have commented on their interest in healing as a natural extension of centuries-old female roles in caring. In a more obvious way, we see historical continuities in babky – granny whisperers [бабки-шептухи]. Babky are elderly women who possess traditional knowledge and skills to perform healing rituals imbued with religious symbolism. The atheist Soviet government strictly prohibited alternative systems of medical knowledge, since they were viewed as remnants of false consciousness that drew people away from a productive construction of socialism. In the face of the dilapidated health care network in contemporary Ukraine, babky increasingly return into public arena as providers of medical help. Phillips (2004) argues that this return to non-biomedical ways of healing in part reflects Ukraine’s revitalization of spirituality. Phillips’s concept of healing acquires a double meaning: the direct notion of improving one’s health condition, and the figurative meaning of healing the Ukrainian society. She says,

In today’s trying times … Ukrainian babky carry out gendered performances that accord them a measure of prestige and power; complement and replace the system of state medicine; act as psychotherapists; and specialize in psychosocial ailments to simultaneously heal persons and communities (Phillips 2004:25-26).

Bernstein (2007:122) and Michaels (2003) document opposition between folk healers and biomedical doctors in the first decades of the Soviet Union. In medical education posters, folk healers were commonly portrayed as female, especially in the European part of the Soviet Union. They were often placed in discursive opposition to male doctors of biomedicine. The former were portrayed as uneducated, dangerous and superstitious. The latter were the embodiment of progress and rationality. Treatment by babky was portrayed as backwards and dangerous, potentially leading to anything from
infertility to death. Going to a babka was not only a bad choice, but also showed lack of social responsibility, since individual health did not belong to an individual. It ultimately belonged to society and the socialist future. A long-standing association of women with healing roles in society may have influenced the growing numbers of women biomedical practitioners. In chapter V, I will offer a detailed consideration of this point.

IV.4. Women’s position in contemporary Ukrainian society.

Since Ukraine gained its independence in 1991, women have been introduced to new and often competing gender discourses. New gendered spaces are being constructed and negotiated in a state, currently torn between visions of European Union membership and a familiar affiliation with the less democratic Russia. In chapter V, I will address gender discourses in Ukraine that reflect the opposition to old socialist ideals, as well as continuities. I will discuss how they are shaping women’s participation in the biomedical profession today.

Given the rich history of women’s involvement in social production, where exactly do most women stand today in Ukrainian society? According to the international human development index and the gender-related development index (HDI and GDI)\textsuperscript{viii}, Ukraine is in the 24\textsuperscript{th} place among 155 countries. Ukraine scores relatively high on the gender-related development index due to a higher life expectancy for women (73.8 years compared to 62.7 years for men in 2007); high literacy rates (next to 100%), as well as the combined educational enrollment (93.2% of women as compared to 87% of men were involved in various educational facilities in 2007). These indicators demonstrate women’s continuing and increasing involvement in the sphere of intellectual labor, which
follows the socialist modernization project as well as post-industrial emphasis on non-material production, and is also consistent with increasing numbers of women working as medical doctors. If we look at the estimated earned income, the number for women (5,249$ per annum) is significantly lower than for men (8,854$). Similarly, women’s participation in politics is abysmal. Ukraine ranks 114th in the number of women members of parliament\textsuperscript{ix}. In Ukraine, women constitute only 8% of those in politics, as compared to almost 20% European average, excluding Nordic countries where participation is even higher. In 2008, women also held only 4% of ministerial seats in the government\textsuperscript{x}. Women are, however, better represented among senior officials and managers at almost 40%, and constitute 64% among professional and technical workers. Because of this low percentage of women in governmental bodies and women’s lower income as compared to men, Ukraine ranks low, 86\textsuperscript{th} out of 109 countries in the gender empowerment measure (GEM). The gender empowerment measure reveals whether women take an active part in economic and political life. It tracks the share of seats in parliament held by women, of female legislators, senior officials and managers, and of female professional and technical workers. It also includes the gender disparity in earned income, reflecting economic independence. Differing from the GDI, the GEM exposes inequality in opportunities in selected areas\textsuperscript{xi}.

Though these statistics look gloomy, it is important to note that these categories are dichotomous. They do not take into consideration informal or quasi-formal incomes, which may influence the estimated earned income, that an overwhelming number of Ukrainians make. Though women are under-represented in official politics, they may exert significant influence in the political process via their participation in other public
arenas: journalism and media, administrative positions that sometimes serve as “a neck that manipulates the official head” (Ukrainian stable phrase), as well as civic organizations. Thus, Ukrainian women dominate civic organizations at 68%, and this niche is an important locus of personal, local, state-level and transnational transformation. Phillips (2008) argues that although women activists’ stories are not those of dazzling success, they achieve a sense of empowerment and personal achievement, as well as collective social healing. Women activists in Ukraine may have found a way for empowerment, even if it is “pragmatic” or “community” feminism (Bohachevska-Chomiak 1988).

In January 2006, a new law regulating equal rights and opportunities for men and women was adopted in Ukraine. According to the law, equal rights of women and men are understood as the absence of gender-based limitations or privileges. Equality is conceptualized as equal legal rights for women and men, as well as equal opportunities for acting on these rights. Overall, the new gender law does not differ much from Soviet regulations. In particular, the law continues to make special provisions for women due to their reproductive functions (Article 24). This includes the creation of favorable conditions that allow women to combine work and motherhood, such as paid leaves and benefits for pregnant women and mothers, breaks from work for breast-feeding, guarantees of continuing employment during child-bearing. The special provisions also encompass establishment of special norms regulating women’s work in dangerous or harmful conditions, as well as women’s lifting and moving weights over a specific mass limit. At the same time, the law tackles new issues silent in the Soviet law, such as sexual harassment. It outlines specific actions that constitute verbal and physical sexual
harassment, particularly at work, and corresponding legal responses. The law specifically states that it does not consider special provisions for women’s reproductive needs as discrimination against men (Article 6). It also broadens the rights of men in their care-taking roles, in comparison to the Soviet law. Adoption of the new gender law in and of itself does not testify to the increased public discussion of gender issues. It may have been adopted due to pressure of international organizations and Ukraine’s recent interest in joining the European Union before the election of the current President Victor Yanukovych. Yet, it sheds some light into the broadening space for multiple gender discourses in Ukraine.

My dissertation will focus particularly on the everyday experiences of Ukrainian women physicians in order to go beyond the statistics and reflect upon other measurements of success or disappointments. I will analyze the biomedical field in order to assess the degree of disadvantage and opportunity that it provides to both genders. I now turn to a brief exploration of the Ukrainian health care system today, its main features and challenges. I intend to paint a general portrait of contemporary health care in broad brushstrokes, contextualizing and elaborating on various points throughout my dissertation.

V. Ukrainian Health Care System.

The fall of the Communist system and the reorientation of the Newly Independent States to a free market economy and private ownership has triggered extensive transformations in society that affect all areas of life. The health care system is one of the very few fields in which structural changes have not been initiated. In its current form at
least, Ukrainian health care is an “island of socialism in a sea of capitalism” (Ninnetto 2005). Newly independent Ukrainian government continues promising free health care according to a long-standing socialist ideology that proclaims health as a fundamental human right. For multiple reasons that will be addressed in this dissertation, the introduction of market principles into the health care system is problematic first and foremost ideologically. Belief in the principle of “social solidarity” (Sheiman 2000), according to which everyone deserves equal medical care, is deeply rooted among Ukrainians. Through an analysis of the medical profession, I will comment on the struggles to preserve a Soviet health care model in a market economy, and the choices that are being made by patients, doctors, medical institutions and government in this sphere.

Ukraine is currently experiencing mortality crisis with average life expectancy at 75 years for a female and 63 years for a male in the population, an average 12 years less than in Western European countries (CIA factbook). Ukraine’s population has fallen by five million since independence in 1991, with fertility rates one of the lowest in Europe. Deaths from cardiovascular diseases have increased by 40%, and communicable diseases are also on the rise (Lekhan et al. 2004, WHO in Ukraine statistics). The country’s socioeconomic crisis has created an environment where health problems flourish. Health indicators have been deteriorating. The rates of the infectious diseases, HIV/AIDS, tuberculosis, STDs, mental disorders and drug abuse, infant illnesses and mortality, inborn disabilities, birth pathologies, gynecological diseases, and other disabilities are on the rise. The new social order caused a polarization of incomes and an economic crisis. People’s access to medical care and the material resources necessary for taking good care
of their health have dramatically diminished. In the context of skyrocketing prices for pharmaceuticals, medical supplies, equipment, and energy, “free” and “accessible” health care is essentially substituted by the informal fee-for-service system.

Today, Ukraine continues to use the state-sponsored and centralized Soviet health care model mandated by the Ministry of Health. The constitution of Ukraine appoints legal responsibility for ensuring free and universally accessible health care to the state (Constitution of Ukraine 1996. Article 49). Health services are organized under the Ministry of Health hierarchically: republic, oblast, raion, and feldsher station (basic medical help), plus sanitary-epidemiological stations responsible for basic public health surveillance activities, such as the control of infectious diseases and immunization (Farmer et al. 1993:324). The centralized governmental body controls, administers and plans health services for the entire country. It allocates the funds to each local government that then finances its corresponding health care facilities (Cockerham 1999:30, 31). In Ukraine, these include hospitals, specialized hospitals, outpatient polyclinics, emergency health care units and stations for blood transfusions, maternity and child care services, special prophylactic medical services (e.g. leprosarium) as well as medical prophylactic and rehabilitation facilities (Ponomarenko 1998:112).

The Ukrainian health care system is state-owned and financed through the state budget. Budget funds are capable of meeting only a small part of its needs. Only about 10% of health care facilities are privatized, mostly in the field of dentistry. Many state-run dental clinics have a self-funded system with free treatment provided only to pensioners, the disabled, Chornobyl victims and children. The Ukrainian health care system has inherited systemic problems which have been magnified in the post-socialist
years of general economic and political crisis (Ponomarenko 1999). Currently, only about 4% of the Ukrainian GDP is spent annually on health care (Bezrukov 2003), compared to the 8% recommended by the World Health Organization. Because of this, formal and informal out-of-pocket payments are high, and according to the World Bank, they equal the same amount as formal expenditures. This situation means that lower income groups experience significant difficulties in accessing health care. Ukraine inherited an extensive hospital infrastructure and staffing system, which is expensive and consumes over 70% of the budget. The number of hospital beds and the average stay in Ukrainian hospitals are much higher than in Western countries. Critics have suggested that an emphasis on public health, primary health care providers and ambulatory care, instead of hospitalization, might be a solution to some of the problems. Another thorny issue is the fragmented nature of public health financing. Budgets are formed from the funds of local and national governments, as well as national institutions funded by the state budget (e.g. the Academy of Medical Sciences)\textsuperscript{xiii}. Most health care facilities’ users, doctors, and the wider public agree that the system in its present shape and form is inefficient.

Informal payments for medical services are ubiquitous, but because of their shadowy nature, they are not well-researched. Patients may incur any of the following informal costs: purchase of medications and supplies; payments to the physician or the surgery team; payments to nurses or sanitary workers; and miscellaneous fees to speed up access to scarce resources and services (Thompson and Witter 2000:172). Health care administrators, physicians and patients alike shout in headlines from the pages of newspapers and on television screens, and privately on interview tapes, that health care
is not accessible to all, does not always offer high quality services, and lacks advanced technology, medications and supplies.

There are many discussions about the introduction of a National Medical Insurance program, however, this program is not developed yet, and there are many concerns about its suitability for the Ukrainian market of medical care. Over the years, various draft laws have been prepared and submitted to Parliament, but not adopted. Ex-President Victor Yushchenko’s administration developed a “road-map” of health care development (Surzhik 2006). The general direction of reforms is towards decentralization of the system, inviting private capital, implementing open market principles in the health care system, and generally aligning Ukrainian medical care with European Union standards. Because health care is sponsored by the state, it is especially influenced by the political instability permeating the country. In the past five years, at least four Ministers of Health have tried their hand at running the biomedical field. None of them have made much headway (Bobrov 2006). In neighboring Russia, a compulsory medical insurance system was adopted in 1993. It was designed with a goal to improve the financing of health care and gradually to implement reforms that would prioritize primary health care providers as opposed to excessive hospitalization and specialization (Schecter 1997c, Twigg 1997). The insurance system is supposed to be funded from payroll taxes or contributions from the central government for those who are not able to pay (elderly, children, homeless, unemployed). Yet, the application of the insurance policy has met numerous obstacles, the most significant of which is the lack of funding, given enormous numbers of people who are underemployed or unemployed, as well as inexperienced insurance companies who have been handed too much responsibility without nearly
sufficient experience or guidelines (Schecter 1997c). Twigg (1997) argues that the negative elements of the Soviet health care model persist in Russia, while the most positive principle of universal and equitable access to basic care has suffered tremendously due to the implementation of compulsory medical insurance. On one hand, Ukrainian stake-holders in the health care system look up to Russia, eager to move reforms from a moribund state. On the other hand, they are apprehensive and critical of the ways in which the insurance system has been working in Russia. It gives them an even stronger incentive to continue with the current system, relying on personalized networks to achieve desirable health results.

In these disorderly and dysfunctional circumstances, it is not surprising that the population has developed a distrust of authority, including a biomedical one. People in need of medical help often strive to develop personalized techniques to ensure the best health outcomes, such as establishing personal relationships with a network of physicians (Rivkin-Fish 2005; Temkina et al. 2008). As the former main sanitary inspector of Ukraine, Mykola Prodanchuk, stated during the roundtable discussion with immunology and infectious diseases specialists, “Unfortunately, Ukraine faces a tremendous crisis of distrust to authority and its institutions, including the Ministry of Health” (Skrypnyk 2008: 10(689)).

Medical doctors continue to be gate-keepers in dispensing important benefits provided by the state. Adriana Petryna (2002) demonstrates this in her discussion of “biological citizenship” – an aftermath of the Chornobyl accident. It is a new relationship between state and people, mediated by medical doctors, whereby citizens find it beneficial to construct their identities as ill people – sufferers of various health
conditions caused by the Chornobyl accident. Securing the official status of sufferer guarantees state welfare assistance, since the Ukrainian state places a high emphasis on the Chornobyl accident, a crucial moment in Ukrainian national history, and regards individuals who helped to bring the nuclear radiation explosion under control as heroes (Wanner 1998). Petryna views the Chornobyl accident and the corresponding construction of a “biological citizenship” as a “political economy of radiation illness” (Petryna 2003:563). Yet, physicians’ work has undergone significant changes in the post-socialist years. Physicians no longer have to rely solely on their connection to the state authority to garner prestige and status. Often, physicians try to disassociate themselves from anything and everything political, and function as independent clinicians to the degree that it is possible. They create personalized networks and arrangements with their colleagues, administrators, and patients. In this way, they participate in maintaining a double-system in Ukrainian health care: officially, the system continues to be universally accessible, but in reality it is dominated by personalized networks, making free access problematic and unpredictable. In so doing, physicians are often able to achieve significant status, material as well as non-material respect, and even fame. While these pragmatic considerations may be successful on an individual level, they do not create space for positive and definitive social change. Doctors’ affiliation with state power structures continues to be as contradictory and problematic as it has always been throughout the history of the biomedical profession in Ukraine. I will address this uneasy relationship throughout my dissertation.
VI. Conclusions.

This chapter has delineated the historical background for understanding changes in the Ukrainian biomedical profession and women’s roles in it. Given historical evidence, I have argued that the key for understanding the roles and status of Ukrainian medical doctors and the position of the biomedical profession is an exploration of the relationships between medical professionals and the state. The state has heavily regulated biomedicine in Ukraine, and physicians have variously deployed biomedical discourses in order to secure a more lucrative niche for themselves as well as to obtain legitimacy and respect as experts. Some of the continuities in the role of the state stretch from the pre-revolutionary Russian Empire to post-socialist Ukraine. While specific state control levers have differed in various historical periods, the governments nevertheless have remained in active discussion of the roles and expectations of biomedical professionals as elsewhere in the world.

This is not, however, to say that the medical profession has been depersonalized or lacks a relatively high social status. In this chapter, I have provided historical accounts of various political projects in which medical doctors participated with at least the partial goal of negotiating a higher social position individually, as well as collectively.

I have also provided evidence against the popular view that associates the feminization of the medical profession with a Soviet policy that allegedly depopularized this field. Feminization of the profession began before the 1917 revolution, and evidence links it to various effects of the wars. Similarly, the Soviet medical profession gained the highest numbers of women after World War II. This fact gives us reason to deeply
explore not only the demographic and economic factors in the feminization process, but also cultural expectations and gender roles. Thus, I have discussed the potential significance of essentialized understandings of women’s special abilities in care-taking, translated into the official labor market due to a range of favorable macro-factors. The micro-analysis of women’s and men’s choices in regards to their professional lives will be key in this dissertation.

Finally, this chapter has suggested looking into the disappointing standard statistics of female empowerment in Ukraine, not as exclusive evidence of women’s disadvantage in the new economy, but as only one of a number of factors. Through my exploration of the current state of the health care system in Ukraine and post-socialist changes, I have attempted to set the background for understanding various ways in which women and men choose to act upon their professional goals and plans. This chapter provides background for a further discussion of prestige in the biomedical profession, the exploration of everyday exchanges in the biomedical realm, changing ideas about professionalism, the role of the state and morality, as well as multiple ways in which gender shapes the medical profession in millennial Ukraine.
Chapter III. Prestige concept reconsidered. Hybridity of prestige in post-socialist biomedical profession.

I. Introduction.

This chapter re-considers the applicability of the concept of prestige by focusing on a post-socialist context as the site of particularly rapid social change and re-negotiation of social relationships. Studies focusing on prestige and social status systems have not been in vogue in the anthropological discipline in the recent decades. An extensive database search reveals early classics (Malinowski 1926; Leach 1965; Veblen 1973) and a handful of works dating to 1980s (Goode 1978; Bourdieu 1984; Turner 1984; Goldman 1988), with the main corpus of literature based in sociology. Although many studies engage with these concepts indirectly, there are not many ethnographically based works that put the concept of prestige at the center of their discussion. Post-modernist and post-structuralist approaches critique positivist anthropology for its claims of objectivity and eagerness to derive cross-cultural laws and universals; post-modernist anthropology points out significant limitations and inescapable subjectivity of any systematic research that strives to neatly categorize every cultural phenomenon. It seems, however, that this critique has labeled some anthropological concepts as unforgivably old-fashioned and unable to offer new theoretical insights. Theories of prestige and social status are such examples of unpopular concepts in anthropology.

In this chapter, I attempt to infuse discussion of prestige with new energy. I propose to bring our attention to the post-socialist context – a site of particularly rapid social change and re-negotiation of social relationships (Buyandelgeriyn 2008; Steinberg
and Wanner 2008) and especially productive ground for re-considering the applicability of the concept of prestige.

This dissertation focuses on the feminization of post-socialist medicine to discuss it as a potential site of women’s empowerment and challenge the association of feminization of the medical profession with its lack of social status. I reconsider the assumption in most of the social scholarship addressing this issue that the biomedical profession was not prestigious during the Soviet regime and is even less prestigious in East Europe and post-Soviet states today (Navarro 1977; Field 1988; Schecter 1992; Hafferty and McKinlay 1993; Riska 2001). The state retains considerable decision-making power in healthcare organization, delivery, and financing in majority of post-socialist states. This is true even in states where attempts have been made to introduce national health insurance programs, like in Russia (Rivkin-Fish 2005). Perhaps, it is this continuing involvement of the state that leads scholars to view the biomedical profession as a “welfare state occupation” with a service-job status rather than a prestigious social production field (Lorber 1993; Riska 2001). My ethnographic data suggest that this strictly materialist explanation is too narrow. Some of the more recent ethnographically based works on post-socialist biomedicine (Harden 2001; Rivkin-Fish 2005) acknowledge the new angles that social construction of prestige takes, and I would like to delve into this process in more depth. What about myriad of social, political, and economic changes that have left healthcare in a state of constant flux? What about the ever-present informal economy in biomedicine (Groedeland, Koshechkina et al. 1998; Ledeneva 1998; Thompson and Witter 2000; Kriachkova 2006; Polischuk 2006)? Finally, how should we account for the non-material aspects of prestige (Hatch 1989)?
This chapter focuses on local understandings of professional prestige among physicians themselves. How do physicians understand the interplay of these factors in formation of their professional status? Which factors do they see as contributing to their social position? What has attracted and continues to attract physicians into the biomedical profession? My goal is therefore gaining an emic point of view about status and honor and its intersection with varying kinds of medical work. Although discussion of the relationship between doctors and patients in the production of prestige would benefit this article, it was not the focus of my research. This interactive aspect of prestige formation is therefore not included in this article.

II. Theories of prestige.

In his work on theories of social honor, Elvin Hatch (Hatch 1989) insightfully points out that more often than not the idea of prestige is assumed to be “self-evident” and is left unanalyzed. This opens the doors to a baggage of assumptions in regards to people’s motivation to participate in a given hierarchy. The most common assumption often accompanying studies of prestige is the premise that material well-being and social status are isomorphic. People are assumed to value material comfort over any other motivations, and they are assumed to respect and bestow honor on those who belong to higher socio-economic statuses. Although many social theorists, heavily influenced by Bourdieu, have broadened their understanding of social status to go beyond the economic capital, it has not been the case for many scholars who write about post-socialist healthcare. These assumptions are especially true of literature focusing on policy relevance (Schecter 1997), as well as laymen understanding of prestige found in
journalistic work. Critics of these materialist assumptions have pointed out that influential codes of meaning, such as religion or other types of social hierarchy historically based in non-material cultural ideas (e.g. caste system), often serve as the driving forces for higher ranks (Dumont 1970).

Bourdieu’s (Bourdieu 1984) concept of capital offers us an analytical bridge between materialist and non-materialist approaches to understanding prestige. For Bourdieu, economic capital is a resource that allows an individual to garner social distinction and cultural capital. Economic capital includes material goods, property and finances. Cultural capital has to do with an individual’s education, skills, and experience. Social or political capital refers to an individual’s access to social networks, connections, and positions of power (Ghodsee 2005). The ultimate motivation is therefore not the wealth in and of itself, but achieving exclusiveness, a distinction from inferior classes (Hatch 1989). Bourdieu also detects symbolic capital, by which he understands not only education and skills, but cultural authorization of power from a dominant position (Bourdieu and Wacquant 1992; Radhakrishnan 2009). This cultural authorization perceives the power of a dominant group as natural and therefore not exerting coercive power, a process that Bourdieu calls misrecognition. Since social status of physicians is so greatly contested and renegotiated in post-socialist context, I refrain from using symbolic capital as conceptual lens in this article. Instead, I prefer to work with smaller building blocks – the concepts of cultural capital, economic capital, and social capital to gradually build a more complete picture of prestige of the biomedical profession in Ukraine as it is understood by physicians themselves.
Following Hatch’s (Hatch 1989) discussion of non-materialist approaches to prestige, I distinguish calculating prestige seeker theory, ludic approach, and self-identity theories. All these theories allow more space for motivations other than economic ones. The calculating prestige theory views the search for status as a calculating process whereby an individual accrues prestige by presenting an outstanding performance of the socially approved activities or qualities. The ultimate goal is therefore maximization of the social honor (Goode 1978). Ludic approach discounts the calculating effect, and instead focuses on the idea of “playful spirit” and competition. It suggests that people are striving for social honor for the love of the game itself (Huizinga 1955). Self-identity theory, unlike the previous approaches, emphasizes the inward focus of the agent, whereby an individual derives personal fulfillment by being excellent in the social spheres that are regarded as valuable and meritorious (Barkow, Akiwowo et al. 1975; Goldman 1988).

In the sections to follow, I will use these theories of social honor as a platform for developing a renewed theoretical framework that is more firmly based in the current globalized exchange of ideas and goods than what has been previously offered, grounding my insights in the ethnographic context of post-socialist biomedical profession.

III. The hybridity of post-socialist biomedicine and its prestige.

I define prestige as a social distinction that people derive from a combination of materialist and non-materialist pursuits. I focus on doctors’ conceptualizations of prestige of their profession, as opposed to public perceptions of this field. Yet, accrual of prestige
is an interactive process, and evaluations of patients and public at large play significant role in physicians’ understanding of their social status. Physicians’ narratives reflect this interactive aspect, even though methodologically I did not include specific formulations of biomedical prestige by the general population due to the scope of my research project.

Many scholars have discussed the re-negotiation of the balance between moral obligations and new consumer-oriented materialist values in post-socialist societies (Caldwell 2004; Patico 2005; Wanner 2007; Patico 2008; Zigon 2008). The concept of prestige is actively changing due to the influences of competing discourses that carry both socialist and new post-socialist rationalities. I borrow Maciniak’s (Marciniak 2009) definition of hybridity as a potent metaphor describing the encounter of “material and emotional architecture that mixes enduring socialist realities with the welcome arrival of western goods, images, and new models of desirable identities.” A desire to partake in the conspicuous consumption and new freedoms is layered with attempts to reaffirm a new meaningful identity, develop national culture, and mitigate fear of being considered a “second” or “third” world citizens (Marciniak 2009). The hybrid nature of the current biomedical profession is a salient theme running through the narratives of the Ukrainian medical doctors. This chapter discusses the ways in which the post-socialist biomedical profession is hybrid: it combines socialist and new market ideologies that inform everyday practice.

At first glance, it is tempting to evaluate the prestige of the biomedical profession as low, given the public discontent with the system and low official remuneration. However, such analysis is too superficial, as it presumes the primacy of materialist motivations and does not account for new venues for biomedical income. Deeper
conversations and focus group discussions with those working in the biomedical field provide a more complete context. Although many respondents tend to think of low salary as denoting low status, they understand it as a socio-political problem rather than a low professional prestige per se. My physician informants speak about the status of their profession in such terms as “unclear” and “double standard” – illustrating multiplicity of meanings of prestige. Prestige for them is a broader notion, with those aspects regulated by the state most often under fire by the public (institutional, structural problems), but work that depend on physicians themselves (biomedical knowledge, clinical practice) building their professional status. One of my respondents, Myroslav, an established male psychotherapist argues that public discontent is directed more at the healthcare system as a whole and at physicians only secondarily, in their role as representatives of the system rather than knowledgeable experts:

Politicians are provoking negative attitude towards physicians among the patients. It is a socio-political problem. Something is not fully thought-through in our healthcare system. It is not undergoing the necessary reforms. Primary healthcare providers serve as a valve for letting out steam. The patients throw tantrums because nobody else would listen - only the physician. One can complain at the physician… The population does not understand today’s healthcare system, what it should do, what the society should do for it, and on what terms…

In the following sections, I turn to an in-depth discussion of the various angles of prestige that illustrate hybridity of the biomedical profession in the post-socialist context. These categories emerged from narrative analysis of the interviews and field notes, and constitute themes that my respondents deemed most salient in their everyday practice.
IV. Prestige and the association of the healthcare system with the state.

One of the ways in which the biomedical profession displays its hybridity is by drawing prestige from its association with the state sphere in contradictory ways. Because the healthcare system is mostly state-run – only about 10% of facilities are privately owned (Kriachkova 2006) – physicians feel that it is within the government’s power to ease the contradictions in the system. Whether through implementation of the national health insurance system or by other means, doctors desired to have recognition of their work expressed in official income. They reasoned that low salary was an invitation for the general population to view this group as not deserving and morally corrupt. Different doctors in different hospitals, situated in both of my research sites, referred to the same story, trying to emphasize this double standard. The story alleges that when Lenin was signing the wage scales directive, he rejected the suggested amount of medical doctors’ salaries saying: “Good physicians will always be able to feed themselves and their families, and bad physicians – well, we do not need them!” On one hand, earning unofficial income was deemed wrong, but on the other hand, physicians were expected to earn additional income informally. Many physicians framed their quandaries in terms of rights and responsibilities, feeling that they were entitled to protection of the state to straighten out the system, even if they no longer had trust that it would ever be accomplished. Alina, a female pediatrician who combined work in the state pediatric clinic and a homeopathic practice, captured the desire for clearing up these unspoken expectations in biomedicine and establishing more clear rules of the game:

… Our Soviet and post-Soviet lives are governed by double morality. Things are not expressed out loud…: “You won’t drop dead, you’ll find the way to earn money” (in regards to physicians’ informal incomes). I also heard disdainful slurs: “Don’t you (physicians) even complain that people don’t give you enough (under
the table).” But we don’t always get paid under the table! … Current attitude to physicians is special – it is like an eructation of the Soviet system. Not a good attitude – as if we (physicians) always owe something…

This uneasy marriage with the state, whereby medical doctors resent and even hate it, but at the same time expect its protection, has beautifully unfolded during 2007 pre-term parliamentary election campaign. The slogans of the party “Block Volodymyra Lytvyna” made news in the medical community when the party leader announced his intention to upgrade the official contract between physicians and the state to that of “держслужбовець” [state official]. This position is currently held by administrators at certain levels of state agencies, including judiciary, police, local governments, etc., and includes a competitive salary, lucrative retirement plan, as well as a whole range of other coveted entitlements. Though physicians often ridiculed the state and emphatically expressed their disrespect to politicians, many of them desired the association with the state body because of the entitlements it carried. These entitlements could open access not only to additional economic capital, but also symbolic capital, since official acknowledgement of the medical work as meritorious would create more recognition of their work. The socialist rhetoric of the state’s responsibility to provide for its citizens employed by Volodymyr Lytvyn was most certainly a political move to capture otherwise untapped electorate. It nevertheless illuminated the space that some socialist codes of morality continue to hold in post-socialist Ukraine.

Prestige stemming from association with the state can also be traced in official titles awarded by the state to exemplary institutions, such as schools and hospitals. A university or hospital may receive a title “national” upon specialized certification process that involves achieving a list of accomplishments and well-oiled administrative
connections. Such status is prestigious and desirable. It institutionalizes the superiority of this facility over other comparable facilities, which in its turn attracts additional bonuses, clientele, and public exposure. Such elite status stems from the state, but the advantages associated with attaining it are broader than simply being a champion in the competition reminiscent of socialist times. Rather, being a “national” hospital means being the first in line for more funding, including private donors, new biotechnologies, and increasing fee schedules, which together allow for continuing accrual of economic and social capital (financial benefits and participation in elite networks). Although association with the state alone does not carry high prestige and symbolic capital, it opens the doors to other processes, more engaged with market relations, which allow for additional accumulation of capital, and are therefore desirable. Awards fashioned by the socialist regime gain additional connotations in post-socialist context, where socialist infrastructures still retain their value, but new market developments continue to gain prominence.

Higher education is deemed as a sign of higher status, or cultural capital in Bourdieu’s words (Bourdieu 1984), even if it does not directly translate into increased income in the Ukrainian context. Being educated aligns with the Soviet ethics of knowledge and rationality, and also with the Western model of the supremacy of science and technological advancement. Altered in the disorderly post-socialist fashion, Ukrainian higher education is notoriously corrupt. Students not only can pass exams with an envelope of cash handed over to the instructor, but sometimes they are able to go as far as “purchasing” a diploma as a sign of added status. Nadia, a female respondent in her 40s reminisces about the symbolic value of higher education that her parents inculcated in her:
My father really wanted for me to have a higher education. It was his panacea. When I finished the pre-med program I wanted to start working as a nurse, but he would beg me to continue studying: “Nadia, apply to the university!” He kept asking me to do that, any university, any program would do.

Post-doctoral positions in medical research are similarly imbued with hybrid prestige. On the one hand, they are more of an investment in cultural capital than economic capital, since post-socialist uncertainty often makes it hard to count on educational pursuits to garner an increased income. On the other hand, the title of the medical professor or “Кандидат Наук” [Candidate] boosts the physician’s position in symbolic way, and it also increases the clientele and promotes invitations to provide professional consultations in other medical facilities, including private clinics. Valentyna, who is a female pediatrician in her 30s, discussed in our interview her hope to trade her current position in a policlinic for a post-doc position in one of Kyiv’s medical centers. She explained that this position would be beneficial because it would make her work hours more predictable, which would give her more time with the family; it would make her more able to attract new clients and new job opportunities; and it would also mean a social space of “a respectable individual under any government,” in her words. Here, the respondents’ motivation is not simply material returns, but also the promise of stability in social status and personal family life.

These rationalizations of prestige demonstrate that non-monetary facets, such as official title and educational status, are all legitimate constituents of biomedical prestige. Their relation to the maximization of profit is not clear, illustrating that non-materialist motivations also have a place in physicians’ participation in the messy post-socialist healthcare system.
V. Prestige and intelligence.

Belonging to the intellectual elite circle confers cultural capital to the biomedical profession in both socialist and neo-liberal contexts. In the socialist bloc countries, biomedical work did not carry high official salary, and blue-collar workers were often paid higher salaries than physicians. However, my respondents were unanimous in their understanding that medical profession was one of the most prestigious. It allowed not only for significant cultural capital, but also social capital (participation in ubiquitous informal networks), which in its turn could lead to increased economic capital.

Admission to medical school was difficult, and my interlocutors often framed their career narratives in terms of how many years it took them to gain admission to medical school. They were proud if they were admitted on the first try, and expressed their determination to continue working in healthcare despite the difficult conditions precisely because it took so many of them a lot of effort to get admitted and successfully graduate. In a socialist society where the general population was equally poor, being a physician meant belonging to intelligentsia and carried significant social recognition. Today, new social classes are emerging, and the social hierarchy is not always based on intellect. What constitutes cultural capital is not universally agreed on. What some people may view as meritorious, others might see as useless in the changing post-socialist environment.

Often, it is precisely the social classes that were stigmatized in the Soviet Union that are now in position to earn higher incomes, such as those involved in commerce, finance, and even construction and various spa services. The overwhelming feeling among physicians is the new imbalance between their intellectual identity and the everyday experience of low official financial evaluation of their work while they witness the inflated incomes of
their newly rich patients. The changing social fabric sifts through the profession making its prestige uneven. The increasing gap between the rich and the poor layers of the population makes this unevenness very visible. While the medical profession continues to be associated with somewhat an elite status, its current impoverished position challenges the social position of these newly poor. Still, the majority of my respondents were proud of their profession and placed it unequivocally above the trades of the newly rich.

Tetiana, a female physician who combines her biomedical work with a small commercial enterprise selling expensive leather goods at the local market, felt ashamed of her business and longed for the day she would not have to rely on it for her income:

> You know, we have a small business (with her husband). I am usually ashamed to say that I sell at the market, but I feel proud to say that I work at the emergency hospital… When people ask me where I work, I would never say that I sell at the market, though I see that some talk about it as if it were an achievement. I had to go into this business because there was time in my life when I needed additional income. But it was not from the heart… This job (emergency hospital) – I like; despite sometimes barely dragging my feet back home after the shift. I am eligible for an early retirement … but until my feet carry me, I’ll continue working.

The biomedical profession also garners prestige through its association with cross-cultural views of healers as honorable members of society performing socially useful jobs. One of my respondents somewhat sheepishly suggested that doctors were the most intellectual, respectable, and necessary profession in any society at any historical point. This notion agrees with both the calculating prestige seeker and ludic theories of social honor that highlight human desire to maximize their social position, and their joy of achieving excellence through competition with others. During one of my interviews, Valeria who works in the capital diabetes clinic pointed at her medical scrubs and said, “This uniform (pointing to her physician’s uniform collar) is worth of something… There is no crown… but a crown is not what’s important (about monetary recognition).”
The symbolic facet of the biomedical prestige also draws on the international status of this profession. Ukrainian physicians are acutely aware of their colleagues’ high status and lucrative income in the Western countries, and although their own incomes usually cannot compare to them, they feel an affinity with this global community of intellectual elites and even superiority of their own medical skills and knowledge, which will be discussed later. Parts of the Soviet discourse that position physicians within intelligentsia are thus enmeshed in the international status of the profession.

VI. Biomedical prestige and new market developments.

The influence of international discourses on the status of the biomedical profession is not limited by the cultural capital alone. Fluctuation of professional prestige as a broader corollary of new market developments is a salient topic in my interlocutors’ narratives. The dynamics in the hierarchy of medical specialties illuminates these changes especially well. If surgery and obstetrics/gynecology specialties have been deemed more prestigious than other specialties in socialist medicine, today we also see the increased status of such marketable professions as dentistry, psychology, pharmacology, and reproductive health. Embedded in global markets, Ukrainian biomedicine is influenced by the international pharmaceutical industry and biotechnologies burgeoning into post-socialist states. New categories of prestigious jobs are emerging. These jobs are connected to international capital and allow for relatively higher incomes that stem from working with new biotechnologies and pharmaceutical products. Svitlana, a female reproductive specialist in her late 30s, runs a new reproductive medicine center in a town in central Ukraine. She is very proud of the achievements of the center and her personal
career. This is unusual, since Ukrainian physicians, and especially women, often use self-effacing techniques when asked about their careers. The word “career” does not sit well with majority of my respondents, most likely, because most of them make their professional choices in the environment where little personal choice is available and little power of making independent decisions according to one’s convictions or desires exist. The concept of career, in their view, does not capture the experiences that surround their professional pursuits. Svitlana’s comfort with the idea of career demonstrates her engagement with new discourses introduced by marketization:

Prestigious fields in medicine develop parallel to broader economic processes. I believe, dentistry, psychology and pharmacology are popular here, just like anywhere else in the world. Previously, obstetrics, gynecology and surgery were the most prestigious. Today, in my view, other specialties are at the forefront. Reproductive technologies are a prestigious and interesting field.

Yet, other respondents are quick to identify these newly popular specialties as commercial projects rather than real medicine. This clash of classic medical specialties and newly developing biomedical sectors is especially visible in the discourses surrounding work of pharmaceutical representatives in Ukraine. Work as a pharmaceutical representative is probably the most common secondary job for many physicians. The responsibilities of this position entail introducing certain group of pharmaceutical products to the biomedical community of specific region, which includes door to door marketing where representatives describe the products to physicians and pharmacies, introduce new research in the field, distribute articles, advertising materials, and product samples. In Ukraine, unlike the Western countries, only professionals with medical degrees can hold such jobs. The advantage of being a pharmaceutical representative is a relatively high pay (roughly three to five times higher than the medical
doctor’s official salary; on average $500 per month for representatives) and flexible work schedule, which allows physicians to combine both their clinical and pharmaceutical work. The system of bonuses that often includes transportation (company car), travel to seminars and conferences to the internationally acclaimed resorts, etc. is also attractive to many. Since there are no current laws in place regulating possible conflicts of interest, such work is fully legal. Fed by international capital, work for the pharmaceutical companies links physicians to the ‘progressive’ Western world.

Yet, legitimacy of these newly emerging classes is being challenged by old elites within the biomedical profession. The relationships between pharmaceutical representatives and physicians are not always peaceful. Many resent the fact that representatives are paid higher salaries for their marketing work, while their clinical knowledge is not acknowledged properly. Physicians often view their jobs as significantly more responsible and challenging. This is how a young female neurologist Iryna characterized pharmaceutical representatives:

This is not a medical profession. It is marketing. Pharmaceutical representatives are an annoyance. Some are more or less OK – they give us information and leave. But others keep talking on and on. We (physicians) simply try to avoid them.

A young physician Liudmyla who combined her work in the policlinic with work for a pharmaceutical company confirmed her marginalized status in the biomedical circles despite her higher salary, which stemmed from her involvement in the non-clinical enterprise:

We (representatives) work with physicians and pharmacies. The main difficulty lies not in having to be on the go all day visiting different offices, but in the negative attitudes towards us. Physicians growl at us. We are buffers for their negativity. By the end of the day, I don’t even feel my legs from all the walking…
This new and financially lucrative field of pharmaceutical work open to physicians underscores my argument that materialist motivations alone cannot account for physicians’ participation in the medical hierarchies. Prestige, in this context, is not directly commensurate with pay, but is enmeshed in historical and cultural constructions that deem some activities meritorious and others not. Many representatives are thus hesitant to leave their jobs in state healthcare, despite the low official pay, and continue to view them as their main employment. They describe their pharmaceutical work as secondary, temporary position to supplement family income, an easily dispensable job. Hardly anyone describe it as a planned first choice career; rather, they view it as a means to an end, a quick fix for material needs. As Anna, a successful pharmaceutical product manager and former anesthesiologist, put it, work in the pharmaceutical industry is “seduction by money.”

Vasylysa is a female internal medicine specialist who took on a pharmaceutical representative job while she was on a child care leave (available for up to six years in special circumstances with guaranteed return to previous work place in the state system from her main job in the oncology clinic. She identified her current pharmaceutical work as a job rather than a medical work per se:

This is a job, not a medical specialty. I am still struggling to understand – how did it happen? I spent in total eight years in the medical school, and I hate to toss away all these years of training. It was very difficult for me to decide to take this job of a pharmaceutical representative. I spent too many years, too much health, and money to get my medical degree. Med school was really hard; I think it is the most difficult learning process of all out there. I am hesitant to cross it all completely out of my life (and move to pharmaceutical work full time). Because of this prior investment in medicine, we (physicians) are now trying to make the best of it. This job is a necessity; we are just trying to find possible ways to make the ends meet.
Another female doctor Oksana, who left medicine to stay at home with her newborn child, pointed out the moral quandaries that physicians go through when they are faced with decision to stay in clinical medicine with a poor official salary, or move to a less respectable but better paid pharmaceutical field. She described her friend who continued to refuse to leave her job as pediatrician despite the fact that it took a lot of her time and energy without sufficient financial return, which she could have otherwise invested in making a successful career in the pharmaceutical industry instead of doing it only part-time:

I directly confronted her (her friend): “What have you seen in your life except for work? You have never even been to the Black Sea!” I tell her, we need to go places while we are still young. Life will pass us by, and we won’t see anything with the work like ours’ (medical work). Darn it, I just want to go skiing to the Carpathians for once in my life! So many times I would tell her (her friend): “You are so communicable and smart. You can pull off even the product manager position. You can do it. But she refuses! She clings to her medical job (pediatrics), even though it has given her nothing but bruises!”

This informant argues that since work in pediatrics does not allow her friend sufficient material return it had little to offer and questioned her decision to stay. Clearly, this clinical medical profession offers significant satisfaction to her friend, since she sticks to it despite all odds. I had a chance to interview her friend for this study as well, and this single female pediatrician in her early 30s confirmed that she could not imagine herself not doing clinical medicine. She said it was like an “addiction” that she could not shake off. She loved her medical job and used the pharmaceutical work only as a way to support herself financially. She also found that some of the communication techniques she learned at the seminars offered by the pharmaceutical companies were useful to her personally. They boosted her self-confidence and taught her more about presenting herself to other people, patients, and colleagues.
In a way, pharmaceutical jobs serve as an economic capital that can be transformed into physicians’ cultural capital. The pharmaceutical representatives use the resources offered by their companies (economic and symbolic) to enhance their social position while maintaining clinical medical positions that continue to be deemed more professionally prestigious despite low official pay. Olena, who combines her clinical work as a gynecologist with teaching at the medical school, emphasizes this point by arguing that pharmaceutical jobs are a viable option for young specialists to gain an outside experience and save up capital for future investment into clinical biomedical work, including their own private practice:

Smart students (with good heads and hands) can achieve high positions in the pharmaceutical industry. They can go into this field temporary, for 5 years or so, and meanwhile earn their primary capital. They can re-confirm their medical licenses later and build their private medical practice. These companies offer high salaries, training abroad and plenty of other interesting opportunities for self-development. I think it is a viable option especially for recent medical graduates. It gives them a good start, since today the competition in the biomedical field is very harsh, and your connections can only get you that far. Today, you need to continue proving your professional worth lifelong.

The hybridity of the post-socialist medical profession comes to light once again. While newly marketable biomedical jobs offer higher income and lucrative opportunities for travel and development, they do not always offer high status and respect. The association of pharmaceutical industry with commerce figures prominently in legitimacy claims of the clinical physicians. The social position of pharmaceutical representatives reflects re-negotiation of the value system in post-socialist context. The neo-liberal lure of money is mixed with a socialist moral code that regards commercial work as parasitic. The legitimacy of clinical medical knowledge that continues to be prominent today in the biomedical field finds re-affirmation not only in the socialist discourse of the supremacy
of pure science and objective knowledge untainted by money, but also in newly accessible information about the high international status of the practicing physicians and the heroic ethos of clinical medicine, which are not offered by the pharmaceutical industry.

These legitimacy stakes should also be understood as post-socialist physicians’ positioning of their skills and knowledge at the same level or above that of their international colleagues despite the latter’s high pay and former’s impoverishment. Many Ukrainian physicians interviewed for this study base their professional pride and dignity on the fact that they are able to work and excel even under the most unfavorable circumstances: they save lives armed with just their heads and stethoscopes, while their well-paid foreign colleagues, allegedly, are not able to accomplish even a fraction of that without relying on their expensive technology. Valentyn, who has spent several years working in Israel with Western-trained doctors, is adamant about the advantages of Soviet and now Ukrainian education:

Their (Western) healthcare system is primitive. In Israel, physicians use American biomedical approach. Our Soviet physician is two steps ahead of them in the game. Our physician is smarter, and can do anything. Western knowledge is limited, it is too narrow… Despite our current crippled situation in healthcare, our specialists’ training and knowledge are above those of a Western doctor. They do not have clinical thinking. For example, if you broke your leg and there were no appropriate materials to fix your wound, a Western physician would be totally lost; he would not know what to do. But it would not be an issue for our doctors.

Joining broader social debates about the future of Ukrainian sovereignty in the European Union context, Ukrainian physicians express their anxieties about the changing geopolitics and global distribution of authority and power by discursively positioning themselves as elites among their international colleagues.
VII. Two ends of the prestige spectrum: surgery and pediatrics.

What emerges from the ethnographic evidence is the fact that biomedical prestige is not a uniform notion, but is commensurate with specialty and position. The multiplicity of meanings attached to the concept of prestige is vibrantly shown in the division of power among biomedical specialties. Discourses on the hierarchy of medical specialties illuminate not only the power dynamics within the profession, but are also critical commentaries on the politics and economics of the healthcare system, gender, formation of new social classes, and the influence of new geo-politics. In this section, I discuss the two ends of the prestige spectrum, focusing on surgery and gynecology on one hand, and pediatrics on the other hand to illustrate these processes.

Surgery and gynecology/obstetrics were often regarded as the most desirable medical specialties by my respondents. While these specialties carry the most potential for official and unofficial incomes, I argue that this privileged position can be best explained not only by potential for materialist gain, but by the convergence of several codes that signified prestige in socialist context and are currently claiming legitimacy in the new Ukraine. The continuity of prestige can be explained by the inherent nature of surgical specialties, when visible change in the patients’ health occurs as a result of the treatment, and the fear and respect people feel towards someone who dares to cross the boundaries of the bodily integrity, the so-called heroic epos of surgery. Also, in the Soviet context, surgeons enjoyed prestige associated with the domination of objectified scientific rationality over any other mode of morality, and a legacy of honor from their involvement in the World War Two. Their status is now infused with additional charge derived from the global development of new biotechnologies and their association with
the peak of modern civilization. Thus, prestige of the surgical specialties includes both materialist and non-materialist aspects.

At the other end of the spectrum, pediatric and adult policlinic service and emergency care are perceived by the Ukrainian public, and physicians themselves, as least prestigious. The common disadvantage of these jobs is a combination of small opportunity for informal income and highly mobile nature of work (responding to emergency calls and making house visits). The monetary compensation of these specialties was the bleakest of all positions. Yet, do these specialties carry such little prestige? I offer a more detailed discussion of pediatric work as an example.

At the first glance, position in the pediatric policlinic appears to be demanding with little financial rewards. Indeed, several healthcare administrators – both in the capital and in the periphery – discussed the growing scarcity of pediatrics practitioners. Valeria – an accomplished female physician in her 50s, who combines her clinical pediatric work with administrative position in the policlinic – discusses why this specialty draws in only a particular type of person, who is becoming a rare breed in neo-liberal society:

The work of a pediatrician in the policlinic is a very hard piece of bread… Work with little children and their worried parents is very difficult and responsible, and the material return is limited… Many physicians in our policlinic have to take double workloads, because we do not have enough pediatricians, even though by law we cannot work double shifts and we are not reimbursed for it. Yet, somebody has to do this job, we work with people!

Children represent a special class of clients. My respondents report that informal money-making in pediatrics differs from that in the adult healthcare. It appears to be less acceptable to participate in such informal exchanges, making pediatrics less lucrative. The informal exchange industry in the post-socialist context is not an unruly enterprise
devoid of logic. It has an internal rationality and morality, as unlikely as this sounds. Respondents have an elaborate understanding of which types of exchanges were considered right and which types were wrong. Children stand on the end of the spectrum that often made them less likely candidates for informal exchanges. State healthcare facilities working with children tended to have slightly better financial support, especially in bigger cities, which also decreased the field for informal exchanges.

Yet, is the position of pediatricians indeed so powerless? The re-negotiation of social relationships and redistribution of power in post-socialist societies creates new types of partnerships between patients and physicians. Many patients today, empowered by sizable capital, both financial and informational, are attempting to forge different directionalities of influence. This newly emerging middle class is quite capable of differentiating between the quality of the services on the market, and often forges private agreements with pediatricians of their choice for an informal fee. If the patient and physician decide to work together, physician leaves her or his telephone number with the patient, and essentially agrees to be on call whenever the patient needs medical help, advice, or assistance in a search for consultations with other specialists. This practice is reported to be quite common, with services ranging from 20-30 (USD $4) hryvnia per visit in peripheral towns to 100-150 (USD $19) in the capital. A pediatrician is just a phone call away. These arrangements significantly boost the incomes of pediatricians who are willing to participate, but they also boost their fulfillment of professional identity and feeling accomplished and in demand. Olena, a pediatrician in a state clinic, emphasized her feeling of accomplishment stemming from her private clients:

I have patients who ask me to consult for them regularly. When a physician has good reputation, the word gets out and you start to get phone calls and visits from
people from far and wide. They ask if I would agree to be their private consultant for additional pay, because they want high quality help and regular contact with the same doctor. Sometimes, I consult for an entire family, and not just a child. I know some of my patients from diapers to eighteen years old, and I can help them with a wide spectrum of medical problems.

Thus, little patients, as the object of competing morality discourses, may influence the work of pediatricians in multiple ways: on one hand regulating the sphere of the appropriate unofficial maneuvers, while on the other hand empowering the doctors by establishing new types of partnerships with their clients.

The variation of the concept of prestige between and within different specialties once again points to multiplicity of prestige’s meanings. While material returns are understandably an important aspect of prestige, non-material factors also come into play. Many respondents pointed out that professional accomplishments, personal determination, and energy can make any specialty prestigious and financially lucrative. A more philosophical view is based on the idea of self-realization, i.e., achieving a desirable balance of material and non-material comfort from work in any type of medical specialty. Oleg, an anesthesiologist and intensive care specialist in a prestigious Kyiv children’s clinic, attests to this view:

If a person is talented, you can see it. If a person has character, he or she will achieve his or her goals… I believe that one can always find a way out of a bad situation. Everything depends on his or her determination and desire… Despair… It is difficult to live with such attitude in your head… Even a fool can eat a candy out of silver platter… In order to achieve something – one must pay some effort. If something did not work out, try something else!

Several other respondents, men in their late 30s, went so far as to say that it would be ideal if their medical profession could be just their hobby while they earned money via financial investments or other business ventures unrelated to medical work. Along the same lines, some women physicians spoke of being grateful to their non-physician
husbands who were able to make enough money for the two of them, while they were simply able to enjoy fulfillment from their professional identity without worrying how to squeeze the money from a suitable patient.

These narratives support Hatch’s (Hatch 1989) argument for applicability of self-identity approach in research of social honor. Post-socialist physicians actively search for new meanings and new ways to strike a balance between their moral and material needs, “the underlying motivation is to achieve a sense of personal accomplishment or fulfillment, and the individual does so by engaging in activities or exhibiting qualities that are defined by the society as meritorious” (Hatch 1989). While the approval of others is very important for life satisfaction, as our discussion of physicians’ relations with the state and entitlement discourses demonstrate, self-identity approach is useful in its emphasis on the ability of people to derive significant satisfaction and motivation even if their position within hierarchies is not the highest. People can feel fulfilled by being recognized for their excellent work in socially needed field. Prestige, therefore, does not have to revolve exclusively around maximization of both materialist and non-materialist values. It is important to acknowledge that prestige is produced not only through economic capital and cultural capital like education and qualifications, but is also co-produced in encounters between patients and doctors, and is highly individualized. I now turn to discussion of this process of personalization in accrual of prestige in post-socialist biomedical profession.
VIII. Personalization as a step in prestige forming process.

Given rich ethnographic evidence of post-socialist renegotiation of values and corresponding hierarchies of social classes, I argue that prestige in the post-socialist biomedical profession should be understood as a process, and not an endowment commensurable with the medical degree. Prestige quandaries illustrate such social phenomena as formation of a new social contract between physicians and patients, renegotiation of their rights and responsibilities in the context of reorganization of social classes. Prestige in the biomedical profession is more achieved in post-socialist societies than it is in the developed nations where biomedicine is the leading healing system. Western medical school graduates can count on a lucrative position and high social status upon successfully completed studies. In this sense, there is a certain ascribed status to the biomedical profession in the West, the link between cultural capital, and following it, economic capital is clear cut. In post-socialist Ukraine, there is no direct link between successful biomedical education and income. Financial and social statuses are more achieved. There is no universal prestige that the biomedical profession offers in post-socialist context; instead each physician needs to actively negotiate it through her or his everyday practices. As one of my respondents concisely put it: “Respect has to be earned, it is not a given. If you deserve respect, then you’ll feel it, if you really helped a person.”

In her analysis of the Russian post-socialist healthcare system, Rivkin-Fish (Rivkin-Fish 2005) centers her argument on the idea of personalization. She argues that individualization of responsibilities and rights ignores structural problems and undermines potential for collective action in achieving the systemic change. In her ethnography, physicians employ personalizing techniques to reassert their medical
authority when they were lacking other forms of influence, disempowered by the system that reduced them to bureaucratic positions, and feeling impoverished in comparison to their newly rich patients. I argue that personalization techniques can also have a productive role in the post-socialist healthcare. While personalization indeed does not produce any systemic changes, it allows participants in the existing, albeit dilapidated, system to make the best of their experiences and even garner a new degree of prestige. While many patients continue to distrust healthcare institutions, they are able to establish private relationships with specific individuals within these institutions. By establishing personal relationships with physicians, patients and physicians come to better understanding of their new social relationships. While official salaries are low, physicians without secondary jobs more often than not depend on their informal incomes, and in order to invite them they need to display professional qualities that would draw in the clients. Although this process is unofficial, it has become quite socially accepted given the years of double standards discussed in this article. This informant, a female internal medicine specialist in the policlinic, reasoned that she always had to work hard in order to earn the reputation before it would start working for her:

In order to earn this authority, a physician must give 100 percent to every patient regardless of his or her social status. It does not matter to me whose child is in my office – first of all he is my patient, and I treat him as my own child. I try to help and understand the problem, because what goes around comes around.

Personalization via informal networks becomes a source of social capital that can often translate into economic capital. While informal networks were also commonplace during Soviet regime, they were not nearly so monetized and pronounced as today in the open market economy. In the process of accruing social capital, many physicians display the non-materialist work ethics in order to accumulate meritorious reputation and win
over clients with fat wallets – those, who could become suppliers of their unofficial economic capital.

**IX. Conclusion.**

In this article, I attempted to flesh out the competing discourses that inform prestige of the biomedical profession in a post-socialist context. My ethnographic data show that prestige is not uniform and even. It is clumpy and individualized, and it is hybrid: it contains materialist and non-materialist aspects stemming from both socialist and new neo-liberal globalized discourses.

In staking their legitimacy claims, physicians employed both socialist and neo-liberal rationalizations, demanding state entitlements on one hand, and participating in new biomedical markets on the other hand. While newly marketable biomedical jobs offer higher income and lucrative opportunities for travel and development, they do not always offer high status and respect. Thus, the association of pharmaceutical industry with commerce decreases the social status of those physicians who work as pharmaceutical representatives. In this situation, higher economic capital does not translate into higher symbolic capital. Legitimacy of clinical medical knowledge continues to be prominent today in the biomedical field, finding re-affirmation not only in the socialist discourse of the supremacy of pure science and objective knowledge untainted by money, but also in the newly accessible information about the high international status of practicing physicians and the heroic ethos of clinical medicine, which are not offered in the pharmaceutical industry. On the other hand, joining broader social debates about the future of Ukrainian sovereignty in the European Union context,
Ukrainian physicians express their anxieties about the changing geopolitics and global distribution of authority and power by discursively positioning themselves at the same or higher professional level among their international colleagues.

In evaluating the attractiveness of the biomedical profession, prestige concept emerges as a nuanced process rather than static notion, underlying the ambiguity of post-socialist physicians’ status. Both materialist and non-materialist motivations guide physicians’ participation in the biomedical profession. Since post-socialist changes bring market-based relations to the forefront, it is tempting to ascribe analytical primacy to the materialist considerations of maximization of profit and newly accessible consumption. However, more careful examination reveals that physicians’ search for economic capital reflects not only a desire for physical comfort, but just as importantly desire for re-negotiated social status when relationships between social classes change. Physicians are eager to reposition themselves in a way that would allow them to retain the status of respectable experts that they enjoyed in the socialist context, but also that would allow them to gain new dimensions of prestige as economically free professionals. The layered nature of discourses that combine concerns for monetary remunerations with quandaries about dignity and morality attest to this new hybrid notion of prestige.
Chapter IV: Moral Economy and Informal Exchanges in the Ukrainian Healthcare System.

I. Introduction.

Healthcare in Ukraine is notorious for the informal economy that essentially undergirds the system. Like in many other post-socialist societies, popular opinion and mass media have crowned healthcare as one of the most corrupt sectors of economy in Ukraine. Kyiv International Sociology Institute (KISI) suggests that half of the Ukrainian population considers healthcare to be one of the most corrupt social institution, on par with the education, law enforcement and judiciary systems (Fylypenko 2008). The popular image of post-socialist physicians envisions them as greedy, aggressive, deceitful, and insatiably hungry for money. Doctors’ reputation is controversial, so much so that they often prefer not to disclose what they do for a living when in a circle of new acquaintances. Laymen tend to believe that it is moral flaws within the professionals themselves that need to be fixed, and that punishing the wrong-doers is the key. This paper investigates how these so-called offenders understand their own participation in the informal economy. In contrast to popular media-promoted image of morally corrupt healthcare professionals and officials, this paper seeks to analyze deeper meanings of the informal economy in which they are implicated. Based on the ethnographic fieldwork research conducted in Central and Western Ukraine in 2007 and 2008, I attempt to answer the following questions.

What is the scope of informal practices in Ukrainian medical sphere today? How do physicians understand and explain their involvement? What are their stakes in the
game? What are the gradations of the informal exchanges and what are their interactions with the concept of morality? What functions do informal exchanges currently play in the Ukrainian healthcare system? What explanatory model for the analysis of perpetuation of informal practices in healthcare and beyond might we suggest?

I take a cue from Ledeneva (2006:17) and define informal practices as “conflicting, fluid, and complex interaction between formal rules and informal norms.” Some informal practices take place outside of the formal economy (such as paying physicians for their services in their free time), and others penetrate formal economy (such as embezzlement of state budget, misuse of hospital resources, etc.) This understanding of informal practices helps avoid thinking of this unofficial economy in dichotomous terms. Private and public realms are intertwined in post-socialist context, and the ethnographic evidence presented in this chapter will testify to this.

In the section to follow, I provide a brief overview of the Ukrainian healthcare system, its organization, challenges and everyday practices. I then proceed to outline theoretical terms and definitions that will guide my discussion of informal practices.

II. Theoretical considerations.

Informal practices are not universally understood as a negative phenomenon by social scientists. For this reason, I avoid using the term “corruption” in my analysis of informal exchanges in healthcare. Anthropological scholarship criticizes the common definition of “corruption” as “the abuse of public office for private gain” (World Bank 2002), pointing out that the boundaries between public and private are often not clear-cut, and institutional variables are far from fixed and unproblematic (Haller, Shore 2005).
Conceptualizing informal exchanges as corruption also reduces the problem to the issue of personal moral flaws, such as greed of officials, and fails to acknowledge situations when corruption is systematic and structural. Haller and Shore (2005:2) succinctly describe this as focusing on “the individual apples rather than the barrel that contains them.” Finally, the international policy that prioritizes transparency, good governance, and liberalization itself has come under anthropological critique (Sanders and West 2003, Sampson 2005). Multiple studies in various parts of the globe have reported local suspicion of the international interventions that profess fighting against corruption, hardly differentiating the latter from informal local practices and criminalizing both (Bastian 2003, McCarthy Brown 2003, Kendall 2003). These authors question agendas of various transnational groups that espouse such policies (like the WTO), pointing out that power remains at least “somewhat opaque” (Sanders and West 2003), and at most protecting the interests of a privileged few. Zinn (2005:240) explains this latter scenario, “the liberal bourgeois public/private distinction… allows for public equality and private inequality… and works to mask implicit forms of privilege, be they of class, gender, or ethnicity.”

Instead of focusing on corruption, this research views relationships between public officials and individuals in post-colonial and post-socialist cultures as being deeply influenced by non-formal value systems, such as rules of kinship or friendship (Zerilli 2005, Lovell 2005). Often, there is a traceable utility in such economy, especially in the areas where state recedes, leaving various sectors unattended and largely abandoned, either de jure or de facto (Dunn 2008, Lindquist 2006). In her work on post-socialist Russia, Ledeneva (2006) argues that the main feature of post-socialist informal economy is its double-edged nature. On one hand, informal practices are a handicap: they
privilege a chosen few, undermine development and open-market principles, and create obstacles to the rule of law. Informal practices occur in the context of power relationships that “marginalize, stratify and exclude” (Zerilli 2005), and often its participants have little choice about whether or not to engage in them for fear of losing access to their “social rights.” On the other hand, informal practices may act as a resource: they cater to wider needs of economy, they are competitive, and are implicitly endorsed by the state. Huntington (1968) suggests, for example, that informal economy “provides immediate, specific, and concrete benefits to groups which might otherwise be thoroughly alienated from a society… It might be functional to the maintenance of a political system in the way that reform is. Corruption itself may be a substitute for reform and both corruption and reform may be substitutes for revolution.” This paper will engage this understanding of informal practices in their “paradoxical role” (Ledeneva 2006:21) as simultaneously impeding, but also advancing healthcare institution in Ukraine.

Informal exchanges in Ukrainian healthcare appear to be guided by a set of principles, albeit not universally agreed upon. I am reluctant to call informal practices a system, even though payments for various services are somewhat systematic and vary by geographic location, prestige of the clinic and difficulty of the procedure. Information about the prices and the right people or ways to transfer payments is shared by the word of mouth, often among patients sharing the same hospital ward. Yet, negotiations about treatment are personalized – physicians and patients come to decision about the way in which the patients wish to receive their treatment individually (Rivkin-Fish 2005b). For this reason, I will discuss the guiding principles of these informal exchanges, as opposed to the system of informal exchanges. In this, I agree with Ledeneva’s (2006)
understanding of informal games as practices, rather than rules. The term “rules” presupposes predictability and consistency, while life in post-socialist space is anything but that. This formulation acknowledges that informal practices are fluid, changing, often conflicting, and people are constantly navigating between formal rules and informal norms (Ledeneva 2006:17). In my research, I focus on agents’ understanding of their involvement in informal games, rather than social institutions that are sites to these exchanges. I examine informal practices in an attempt to draw parallels between personalized logics of various stake-holders in Ukrainian medicine, while not oversimplifying or over-generalizing their experiences.

Despite popular conspiracy theories, healthcare is not an organized mafia, and there is no single pyramidal scheme to it. Comaroff and Comaroff (2003:287) argue that such occult cosmologies appear in the situations of uncertainty and ambiguity, when people seek out vital information, but it is not available to them either due to power imbalance or mistrust of the official sources of the information, “conspiracy… has come to fill the explanatory void, the epistemic black hole, that is increasingly said to have been left behind the unsettling of moral communities, by the so-called crisis of representation, by the erosion of received modernist connections between means and ends, subject and objects, ways and means.” Agreeing with Feldman-Savelsberg et al (2000:170) and Butt (2005), I argue that popular beliefs in conspiratorial plots on the part of local and international power structures emerge not only in response to political disempowerment and disillusionment as a symbolic resistance to oppression. Rather, it reflects local awareness of lack of the rule of law. In my discussion of informal economy in Ukrainian healthcare, I show how physicians and patients tap into the authority of
healthcare institutions (Pinto 2004) and question their legitimacy. Their actions are triggered by disjuncture between the official discourse of the state that emphasizes democratization and transparency, and their lived experience of corruption and lack of respect to order on the part of the law-makers and authorities themselves (Butt 2005: 418).

Furthermore, I understand informal exchange as an interactive process where patients and physicians construct the informal practice together. Though for different reasons, both parties participate by subverting formal rules and perpetuating the status quo. I will first briefly describe the alleged scope of informal exchanges in Ukrainian healthcare and proceed to discussion of physicians’ understanding of their involvement. Although they are not the only stake-holders in medicine who determine the rules of the game, they play an important role, and this chapter will examine their repertoire.

III. Informal practices in Ukrainian healthcare.

A blossoming informal economy is a problem not unique to Ukraine or the even post-socialist space (Haller & Shore 2005, Roitman 2005), though such problems as corruption, state capture, shadow economy, underdeveloped private sector and incomplete institutional transformation are common in post-Soviet countries (Ledeneva 2006, Kornai 2001). According to scholars who focus on shadow economy (Ledeneva 2006), informal practices are usually perpetuated by the following structural inconsistencies: a legal framework that does not function coherently; people bound to violate at least some of the formal rules due to economy operating in such a way that makes following the rule of law impossible; punishment based on criteria developed
outside of the legal domain because informal practices are pervasive; and finally
punishment being selective and based on informal unwritten rules testifying to deficiency
of the formal law. In the same vein, Lovell (2005) explains endemic shadow transactions
in post-socialist and post-colonial states as a result of blurred distinction between private
and public, few legal restraints in unleashing free market forces, and multiple
opportunities to take advantage of public property. These factors are true for Ukraine, and
they create a cycle of informal exchanges in many economic spheres. In the healthcare
sector – notably. Although most Ukrainians today are disillusioned about the state and its
endless political games, when it comes to healthcare, physicians and other medical staff
are the easiest targets, as opposed to challenging state arrangements that are in place.

The commonly perceived image of a Ukrainian physician today is someone
grounded in material pursuits, cynical, and unsympathetic. Public opinion polls indicate
that in 2004 as many as 75% of the population expressed dissatisfaction with the work of
healthcare (Polishchuk 2005). Mass media often accuse Ukrainian physicians of low
professionalism, immorality, and bribe-taking. The headlines in popular press speak for
themselves: “Diagnosis. Ukrainian Medicine Demands Money and Does not Give
Anything in Return” [Диагноз. Украинская Медицина Требует Денег и Уже Ничего
не Предлагает Взамен], “How Much does Health Cost” [Почем Здоровье?], “Medicine
is Powerless Here” [Медицина тут безсильна], “Money under the Table is Mandatory”
[Класти в Кишеню Обов’язково], “Honesty Analysis” [Аналіз на Чесність], and
“Tested on Humans” [Випробувано на Українцях]. Scandalous stories zero in on
medical mistakes: physicians who disable patients who have refused to pay under the
table, infants killed by neglect during birth, and a wide range of other small and large sins.

Seventy two percent of Ukrainians maintain that they express their gratitude to physicians not by “thank you” alone (civic organization “Opora” survey 2008, cited in Koniushok 2008). Over 20% believed that they would receive better care if they paid money, 24% paid out of belief that otherwise they would face conflict with the physician, and 7% did so because everyone else seemed to be doing it. The survey argues that most people do not even imagine going to the doctor’s office without money, thus confirming that free healthcare exists mostly on paper rather than in reality. Not surprisingly, since only 2, 5 hryvniaxx (0.3 USD) per day are allocated by the Ministry of Health budget for each patient (Koniushok 2008). This money is barely enough to buy a loaf of bread. Yet, state financing of the healthcare sector has been increasing each year, and grew by four times in the past six years (Saley 2008). At the same time, Ukrainians’ consumption of pharmaceutical substances grew three times, and in 2007 Ukrainians purchased over two billion dollars (USD) worth of drugs while the mortality rates continued to rise (Saley 2008). Many experts argue from the lines of professional medical publications that no matter how much money is invested into healthcare; its efficiency will not increase due to the problems with the system itself (Akhmetshyn 2008). As expert put it, “We should stop pretending to be another North Korea. Ukraine has a market economy, and healthcare is not free of charge. Quite the opposite, it is expensive and inefficient. No matter how much money we pour in, there will be no result, neither in seven years, nor in seventy seven years” (Pashkovor 2008). The author proceeds with the suggestion to move the infamous Article 49 proclaiming universally free and accessible healthcare coverage
out of the Ukrainian Constitution and into the Museum of Medicine, underlining the inconsistency that the idea of free medicine has with the reality of people’s everyday experiences.

Indeed, the majority of my physician respondents confirm that informal payments are desired and often expected. Several of them accepted money from patients in my presence without any sign of concern or hesitation. Valentyna, a female ophthalmologist in a regional children’s clinic kept very busy and talked to me while seeing her patients. On a cold winter morning, a tiny building of the clinic was bursting with visitors. At any moment, her office had at least five people in, including the nurse, doctors from neighboring offices, patients, and their families. In the midst of all this hustle and bustle, crisp bills were placed into the pockets of her white physician’s uniform (robe) by the patients’ parents. While she murmured something to the effect that you should not have, the doctor did not make any attempt to scold the patient or return the money. While I did not feel comfortable asking about the amount, the important fact is that money was transferred in the very end of the check-up, as patients were leaving the office. This detail of the payment’s timing proved to be very important in physicians’ conceptualization of their professionalism and distinction between bribe and gratitude. The onlookers carried on with their work, without acknowledging what they had witnessed in any way.

Physicians receive honorariums for consultations and serving as primary providers; issuing sick leave authorizations and other medical paperwork; prescriptions; and cooperation with pharmaceutical companies and drugstores (receiving a certain percentage, usually 10%, from the cost of the medications purchased by the patients
through their prescriptions). An established physician may expect to make about 1,400 hryvnia (175 USD) per month in official salary, while a beginner about 700 hryvnia (88 USD) (Martynets 2008). At the same time, physicians working in a peripheral town hospital told me that they make six to seven times as much informally. Average informal prices for medical services in Kyiv range from 10 USD for polyclinic consultation, 5 USD for sick leave paperwork, 4 USD for nurse’s service, 2 USD for the sanitary worker’s (nurse’s assistant) service, to 40 USD for hospitalization and over 50 USD for non-surgical treatment per day. These prices tend to be significantly lower in the peripheral towns, where, allegedly, a daily cost of non-surgical treatment without the cost of medications can be as low as 3-5 USD. Invasive procedures, such as surgeries, are expensive, and range from 100 USD in the periphery to thousands in prestigious research institutes. The average cost of delivering an infant is approximately 300-500 USD in Kyiv, while in the periphery 100 USD also seems to work most of the time, unless the delivering physician is the head of the unit, which increases the price to 300 USDxxii. Head physicians and other administrators have additional sources of income: renting out the facility’s space to pharmacies, stores or private offices; payments for hiring new employees (2,000 USD and more for narrow specialties); kick-backs for budgetary purchases [тендерні] of medications, supplies, food, maintenance, etc. The higher the rank is, the higher the stakes are. Top rank officials are often involved in manipulations of state budget and state bulk purchases (Matynets 2008, Bondarenko 2008).

There are different ways in which the actual informal exchange takes place. Often, money is transferred in the infamous envelopes tucked into the pockets of physicians’ white uniforms. Sometimes, the middlemen do the job. Some expensive
procedures allegedly require more formalized agreements. The amount is written on a piece of paper, and a patient nods if he or she agrees. The note is then destroyed. A young anesthesiology resident named Ihor, shared with me some tricks of the trade that his senior colleagues taught him:

There are different options. For instance, one anesthesiologist told me that if after surgery the patients’ relatives hand him 50 hryvnia, he tells them “I did 400 USD worth of work, but I will only ask you to pay 200 hryvnia (25 USD).” My mentor allowed me to take new patients if we shared money in half. When he introduced me to the patients, he would say “Here is the doctor who will be treating you. Please, do not forget to cover the costs with him later.”

Inna, a general practitioner in one of Kyiv emergency hospitals shared her techniques and techniques of her colleagues:

Usually, people tuck money into my pocket. I generally never tell the price. I say “our healthcare is free of charge.” Every physician has her method. Some name the price, others do not. I know some who say “Whatever you consider appropriate,” and others “Whatever you think your health is worth.”

Because the informal economy is so ever-present in Ukrainian medicine, it is difficult for the outsiders, and sometimes even insiders, to navigate it. The frustrations are not only because one usually has to pay or is afraid not to pay, but also because there are no guarantees, no reassurances or accountability. This disjuncture fuels conflicts among the participants of the system. Rivkin-Fish (2005a) explains this seeming animosity in Russian context as an expression of personalizing strategies that both physicians and patients are applying in their clinical activities. Instead of forging corporate identity and uniting to make positive structural changes in the system, she claims, physicians and patients cast mutual accusations and assign responsibility for the unsatisfactory situation upon each other. I discuss how the image of the unscrupulous physician is constructed by tracking changes in physicians’ understanding of their professionalism.
IV. In search for Decent Income. Hybrid narratives of Ukrainian physicians.

IV. 1. What is a decent income?

In the context of rapidly crumbling healthcare sector, the idea of professionalism upheld by physicians is also changing. It is becoming increasingly acceptable to be involved in informal exchanges. While physicians’ official salary is barely 200 USD per month, many of them earn a comfortable living through informal payments (Grodeland et al. 1998, Ledeneva 1998, Polishchuk 2005, Thompson & Witter 2000), employment in private facilities, and collaboration with pharmaceutical companies (Musiy 2006). These informal earnings cannot be considered a mere “tip,” for they often constitute the bulk of physicians’ actual incomes (Kornai & Eggleston 2001). Rivkin-Fish (2005a) argues that informal exchanges in Soviet healthcare served as a personalizing technique and were based on the ideology of moral obligation rather than personal enrichment; while post-socialist physicians consider decent income as a criterion of their professional success. She says, “money is important for its symbolic no less than its material power,” underlying the salience of monetary unofficial remuneration in marking professional success and status of physicians (2005b:53). Ledeneva (2006) likewise agrees, that blat (“the use of personal networks for obtaining goods and services in short supply and for circumventing formal procedures”) has been monetized in post-socialist space. Consider this joke popular in Ukrainian medical circles as just one such illustration:

A patient brings “gratitude” to his physician. He begins to pull out various things from his big gift bag: a whole pineapple, bananas, a can of red caviar, a can of black caviar, expensive cognac, Swiss chocolates, imported salami… The doctor is staring at the smorgasbord in disbelief, finally he disdainfully utters, “Patient [хворий]! Who gave you the right to spend my money?!”
I use the attribute “decent” purposefully to demonstrate the conviction widely shared by physicians that they deserve to be paid well for the good work that they do. “Decent” does not only mean large in size, or comfortable income, but also income that is respectable, that reflects a higher than average position in the society. This is exactly what Ukrainian physicians want – money, certainly, but also recognition for their work, something that not all of them currently have. A popular critic of Ukrainian healthcare – Oleg Bobrov offers a controversial commentary on this monetization of informal exchanges in healthcare. A practicing surgeon himself, Bobrov combines his prolific career of a cardiac surgeon with that of a writer, a social critic, and a politician. He publishes essays in the medical press and has recently attempted to engage broader audience with a book. Rather than purchasing his book, which is not widely available in bookstores, physicians whom I met have been circulating home-made crude copies of his works. Bobrov’s works question the idea of the benevolent physician. Bobrov promotes the idea of an empowered physician, a front man of intellectual elite recognized as such in material and discursive terms:

Financial abyss is the deepest. One can be falling into it his entire life… Few in today’s medicine provide free services [Rus. бессеребряники]. These are either from rich families who already have it all, or are hopeless dim-wits unable to move around [Rus. химичить] due to hopeless rigidity of their brains and character. Finally, some of them may indeed be honest and principled who refuse to trade in their “doctor’s consciousness.” Therefore, they prefer to starve … wear old clothes, and be despised by their wives and children who consider them, the heads of their households, miserable losers. They roam the hallways of their hospitals as a live and formidable example for the new medical generation – here is what awaits you if you are planning to go through life as an honest Aibolit (a hero physician from children’s books).
Iryna, a young neurologist in a peripheral clinic views her small official salary (about 700 hryvnia or less than 100 USD per month) as a sign that taking money informally is totally acceptable:

A person that receives 500 hryvnia salary will not work as if he were paid 2,000 hryvnia. This is for sure. If I received 3,000 hryvnia per month, I would not worry about left (informal) money, because it would be too dangerous. However, my current 700 hryvnia salary justifies everything. We have this joke in the hospital that with such salary physician should do nothing, and even should cause a little harm.

Myroslav, a medical student who is about to start his residency in psychiatry, believes that informal income is not only necessary, but is also a significant boost for the quality of care and professionalism of physicians. Having paid, patients will expect results and will hold the doctor up to a certain standard:

I think there are very few physicians who would be so outrageous to take money and not give anything back. It is exactly the money that is the factor causing physicians to work extra hard. And this is quite right. Otherwise, how would physicians sustain themselves? I would like everyone to know that we (physicians) will first and foremost do what we need to do in order to help them, but we would like to have something in return for this. I would like people to know this, instead of starting with demands.

Furthermore, not accepting money from appropriate patients, or accepting small amount, is considered to be not only silly, but also uncollegial. Not only is the physician viewed as a bad specialist who is unable to put his or her knowledge to practical use, but also as someone who violates corporate code of biomedical specialists who work hard to establish the image of respectable professionals deserving of solid remuneration for their services. Ihor, anesthesiology resident in a provincial hospital, told me about these dynamics at his workplace:

Everybody (physicians) must support each other, we should not step on each other’s feet [Ukr. обламувати]. If one anesthesiologist takes 100 dollars, the other one might refuse 50 hryvnia for the same work, while yet another one might
take it. The idea is not to lower the price. If we work together, we decide, say 200 hryvnia, and none should agree to work for less.

For Rivkin-Fish, monetary exchanges are simply an extension of pre-existing patterns of “accessing healthcare through unofficial channels of personal relations” (2005b: 51). Central to this conceptualization is the importance of trust in biomedical exchanges between physicians and patients. In Russia, where national health insurance has already been put in place, there are official channels through which patients can access improved health services. In practice, however, many patients do not trust that simply by paying more money to the hospital they will necessarily receive better care. Similar to the situation in Ukraine, distrust towards state institutions is also present. Patients feel more comfortable striking personal relationships with physicians and paying them informally. Such direct exchanges, even if they occur through a mediator, ensure more accountability than paying officially. Rivkin-Fish (2005b:49) goes even further to suggest that “while official transformations that aim to discipline the patient and charge him certain fees for medical services are viewed by public as unjust and unethical, private exchanges are constituted as moral, and important forms of exchange.” For her, personal agreements between physicians and patients supersede institutional framework of healthcare, for they enable both parties to share a degree of trust when the patient pays the doctor personally and monetarily. Such view of patients as willing participants of the informal exchanges is definitely true for Ukraine as well; however this is far from commonly accepted view. While many patients feel comfortable putting money for their healthcare directly into the doctor’s pockets, many others resent this and they do not indicate that they feel they receive more accountability in return. For them, the option of paying officially without having to look for personal connections to get the desired result
appears to be most viable. Similarly, while many physicians enjoyed the feeling of being recognized and sought after, just as many reported feeling burdened by having to give their personal phone numbers to patients who wanted to see them regularly. They felt that the directionality of power was changing not in their favor, and did not want to be at their patients’ beck and call. Like some of the patients, these physicians seriously entertained the idea of how simple their lives would be, only if they could put official and decent prices on their work. Yet, it is possible that because there are still relatively few private clinics and no national health insurance mechanism, these respondents have an idealized image of what healthcare would look like if the rules of the game were out in the open and recognized officially. It is possible that more disappointments would follow, not unlike severe underfunding stemming from unemployment and underemployment, described by Rivkin-Fish, Schecter, and Twigg in Russia.

IV. 2. Playing with morality.

Though accepting money unofficially from patients is becoming quite common, this game is not without its principles. First and foremost, physicians understand that there must be appropriate sources of informal payments. Taking money left and right without any self-discipline [Ukr. брати від балди] is not condoned and in fact frowned upon. Most physicians avoid taking money (or feel bad when they do) from obviously marginalized patients, whom one might call “deserving poor” – poor not through any fault of their own (such as elderly or poor families with children). It is also highly reprihensible to take money from patients who are likely to pass away. The way in which money is given also seems to be important in this respect. Similar to Rivkin-Fish’s
findings (2005b:60), my physician respondents wanted to receive informal payments as an acknowledgement of their skills and respect from the patients, and not be “cynically paid off,” creating new obligations. Retaining humanity while conducting money-making activities is a salient quality that Ukrainian physicians view as professionalism. Angela, a female pediatrician practicing in Kyiv, was clear that medicine should not turn into a business:

People who become physicians for money’s sake should not have the right to practice. On the other hand, they should be materially protected and provided for (by the state). This stick has two ends: medicine is not a business, but it is not right to say that we should work at the expense of our own nerves, brain, energy, and health, and receive nothing in return… People are trying to sell their hands and brains in the best way possible, this is the right formulation, I think.

This male anesthesiologist working in the Intensive Care Unit in a prestigious Kyiv hospital, believes that the physician who is looking for the money before anything else, is not a physician:

He should not think how much a patient is going to pay him. He should first think how to help him correctly. If you are looking at your patient and thinking about what he is going to give you, you are not a physician. I understand that it is difficult to live today financially, but it is wrong to say “my service costs this much.” If your patients wants, he will pay you himself without your nudging, and you will enjoy it more because it comes from his heart. Only people who came into medicine with clear thoughts and good heart should be here.

Related to this ideal of retaining humanity while receiving adequate income, is the view expressed by many that loss of morality is in part loss of professionalism. Often, the ideas of moral behavior are infused with spiritual rhetoric or beliefs like karmic retribution. Many physicians shared this expression with me, “we all walk under one God.” It reflects their belief that even a shadow economy should have a human face.

Some of my respondents have argued that often times sticking to the rules too closely can be violent, and breaking the law – humane, citing such example as allowing a patient in
pain to cut the emergency room waiting line, and emphasizing empathy and ability to relate over the literal rules (Hrymych 2008). An outsider might note that this human face is not shown to all patients, but is conditional and depends on personal relations, and the understanding of who is a deserving patient, among other things. Olena, a young physician who combines her work in emergency hospital with the job in one of Kyiv branches of an Indian pharmaceutical company specializing in cancer medications, recounted this story:

My friend’s father was a surgeon in a small town. He used to say that if he did not make 100 dollars a day, it was a day he lived in vain. And this was not now. But he was punished later. I believe in this, maybe, that is why I don’t ask my patients for money. What goes around, comes around. He died a very painful death. I know their family very well, they are all very ill. His wife and their daughter also have serious health problems.

Almost superstitiously, doctors told me stories of similar karmic retributions. In one peripheral town, a reputable surgeon was going through final stages of cancer, having previously lost his wife and son-in-law to the same disease. The only cancer-free member of his family, his daughter, now remarried with two sons, was advised by many of her friends to move out from their posh suburban house that they believed was built with cursed money of her father’s patients. This interaction between the ideas of morality and professionalism demonstrates the attempt to build a new social order and re-negotiate the roles of physicians and patients. The narratives of what it means to be a professional in the field of biomedicine in Ukraine today offer us a window into the chaotic post-socialist life where fascination with money and material prosperity are intertwined with quandaries about the common good, just access to resources, and figuring out a hierarchy between humanity and monetary pursuits. Thus, expression “we all walk under one God” also has another version – “we all walk under one God and one Prosecutor” [Укр. ми всі
ходимо під Богом і прокурором]. The latter version emphasizes both materialist and non-materialist aspects of post-socialist professionalism.

IV. 3. Bribe and Gratitude [Ukr. хабар та подяка].

The attempt to marry materialist appetites and morality also finds reflection in physicians’ distinction between the concept of bribe and gratitude. A bribe is understood as informal payment for services that are illegal or that otherwise violate the scope of the physicians’ professional responsibilities. Gratitude, on the other hand, rewards physicians for work that falls within spectrum of their regular responsibilities. Gratitude is understood as a gift that patient gives to physician for the services that the physician normally conducts at work, and that are not outside of the acceptable range. Thus, paying for a physician’s additional attention or consultation can be considered as gratitude, but extending a sick leave document without actual illness is a bribe.

Additionally, the temporal dimension mentioned earlier, is of paramount importance. Gratitude cannot be a pre-requisite for delivering a quality service. Rather, it follows treatment. A physician is expected to first demonstrate his or her professionalism, provide satisfactory treatment, upon completion of which the informal exchange would ideally take place. In the physicians’ subculture in Ukraine, besides the biomedical knowledge and skills, good physicians are those who accept monetary or material gratitude, while bad physicians are those that demand bribes. In order to attract more clientele wiling to pay privately, physicians therefore must either be extraordinarily talented in medicine, so their moral flaws are excused, or they must first demonstrate their skill, personability and kindness before winning over the patient and his or her
wallet. A good professional is someone who makes the effort to make money, who works for every cent earned informally. In this dimension, physicians play with morality – positioning themselves as legitimate healers who accept payments under the table, but they do so without demanding them and as a reward for their job well done. Olena, an internal medicine specialist in a clinic with over twenty years of experience, reasoned that she always had to work hard in order to earn the reputation before it would start working for her:

In order to earn this authority, physician must give (her or his) 100 percent to every patient regardless of his or her social status. It does not matter for me whose child is in my office, first of all he is my patient, and I treat him as my own child. I try to help and understand the problem, because what goes around comes around.

Inga, a female physician who works in the childrens’ emergency hospital, agrees:

I empathize with my patients. I understand it this way: harvest depends on the seeds that you plant. I empathize with my patients, I try to relate to them… and in return they give me something (before, it was chocolate or some gift, now money).

Bobrov (2009) also comments on the paramount importance of discretion and prior hard work to deserve the right “to take:”

It is important to know your place in the ranks. Taking outside of your league is highly reprimandable. The right for taking the “tribute” needs to be earned by long years of selfless and devoted work when you have been stuck in the endless night shifts like the cursed, when you have kept up with all the paperwork. Have lived at work from dusk to dawn without any days off, have not slept at night, starved, seen your wife and children rarely and only between surgeries, manipulations, meetings, Communist volunteering, party service and night shifts... Now you are on good terms with everyone, have earned the right position in the hierarchy, have not let anyone down. And only then, only then – you have deserved the unofficial, but very real right “to take.”

At the same time, a disbeliever would think of the judgement physicians must inadvertantly make before they provide their services by evaluating their patient’s
appearance, his or her clothing, people accompanying him or her to the check-up, etc. All of these visible characteristics could easily serve as cues to the patients’ creditability. In Ukrainian culture, especially, physical looks are an important expression of status, and wearing one’s wealth on one’s sleeve is common. We therefore should remain mindful about this possibility of prior judgement and subsequent payment, even if the transaction takes place after the service is provided. This reaffirms Haller and Shore’s (2005:17) suspicion of scholars who sometimes romanticize local standards of exchange, emphasizing that informal payments always occur in the context of power relations.

Problematizing Rivkin-Fish’s (2005b:63) view of “interpersonal relations (in healthcare) as the primary site for fair exchange and ethical compensation,” I suggest that for many physicians the transition into informal money-making is far from conflict-free. For many, it is a struggle to resolve their financial ambitions by drawing directly on their patients’ resources. Some of my respondents called patients’ financial gratitude demeaning and pitiful. Therefore, other venues for biomedical income are also extensively exploited. These include work in private clinics, labs and diagnostic centers; cooperation with international companies that conduct clinical research trials; work for the pharmaceutical companies; short and long-term migration to the countries with former socialist allegiances (African countries and the countries of the former Eastern European socialist block). In addition, physicians are involved in non-professional job mobility, such as conducting various business ventures in conjunction with their clinical work (sales, investments, car repair shops, etc.) or leaving their state positions to devote their full time to non-medical operations (commerce, manual labor migration to the Western Europe and beyond as care-givers for children, sick and elderly, etc.). Thus,
having a secondary source of income, in biomedical sphere or unrelated to it, effectively frees physicians from making choices about morality of their professional behavior.

Olena, whom you have met before, put it this way:

“Left” (informal) payments are quite shameful. When patients ask me how much they owe me, I never tell them the price. I say that we are a state facility and we service patients free of charge. I never look into the patients’ pocket or mouth, because I have a second income. Older physicians who are almost retirement age and cannot work two jobs often talk among each other about which patient has given them something and which has not. This is wrong and demeaning.

Vadym is a male neurosurgeon who works in one of the largest Kyiv hospitals. During our focus group, he and other male surgeons spent most of our time discussing the private kitchen of medical work. They were openly ridiculing their salary. Vadym pointed at the paycheck slip of his April salary – it was 1,114 hryvnia (about 140 USD).

Smiling at my disbelief (after all, these neurosurgeons worked in trauma unit in one of the largest Kyiv hospitals), Vadym shrugged his shoulders; they used to receive 1,500 hryvnia with Chernovetsky’s (Kyiv’s controversial Mayor) 50% base salary monthly bonus, but the bonus has been retracted and they were back to square one. Seemingly unabashed about this miniscule salary, Vadym explained:

I own a business in Georgia, a construction business. Frankly, I would prefer to focus only on medicine if the salary was reasonable. I like it much more when I enter the hospital staff room [ординаторська] and put on my white robe. I enjoy checking on my patients in my off hours, examining their bandages or how their incisions are healing. I enjoy seeing positive results… Overall, I am satisfied with my job. I know that if I bustled and maneuvered more, I would achieve a higher level doing just the medicine. However, since I do not live by medicine alone, financially – I mean, I have this positive mind set.

Perhaps, Vadym’s positive mindset was also influenced by his informal income in the hospital, besides the business venture in Georgia. According to my informants, Kyiv
neurosurgeons are notorious for buying new cars as often as if they were gloves, with their unofficial income exceeding the state salary at least tenfold.

Related to the idea of having a second income as a way to resolve conflict of informal payments is having a spouse who works outside of the biomedical field and makes more of the money for the family. Such an arrangement is generally true mostly for women physicians whose husbands worked in private business, finance, or banking. Countless times, physicians commented on the ideal image of a physician as someone who has a luxury not “to take.” Svitlana, an endocrinologist in a capital diabetes clinic sung praises of her husband, a well-off construction developer, whose salary allowed their children to study in London colleges, for giving her a chance not to worry about making money, but simply do her job: “I am eternally grateful to my husband for allowing me to work just for my heart and soul.” Thus, working and making money are sometimes conceptually separated notions, with clinical duties placed in the realm of having a calling or work that garners satisfaction and joy, and making money the unpleasant necessity. This gendered aspect of physicians’ work in post-socialist healthcare is very important in understanding gender composition of the profession, a topic to which we return in the chapters to follow.

Many scholars have discussed re-negotiation of balance between moral obligations and new consumer-oriented materialist values in post-socialist societies (Caldwell 2004; Patico 2005, 2008; Wanner 2007; Zigon 2008). This mixed, hybrid nature of the current biomedical profession was a salient theme running through the narratives of the Ukrainian medical doctors. I borrow Marciniak’s (Marciniak 2009:178) definition of hybridity as a potent metaphor describing the encounter of “material and
emotional architecture that mixes enduring socialist realities with the welcome arrival of western goods, images, and new models of desirable identities.” A desire to partake in the newly available international consumption and freedoms is layered with attempts to reaffirm a new meaningful identity, national culture, and fear of being considered a “second” or “third” world citizens (Marciniak 2009). In the context of post-socialist Ukrainian medicine, morality is not tied distinctly to the Soviet ideology. It draws on the ideology of healthcare as a right rather than a business, but it also draws on spiritual considerations not rooted in socialism. Ukrainian physicians’ participation in informal economy is a combination of their desire to live well, and also be recognized as professionals who are doing important work. Since post-socialist changes bring market-based relations to the forefront, it is tempting to ascribe analytical primacy to the materialist considerations of maximization of profit and newly accessible consumption. However, more careful examination reveals that this search for the economic capital on the part of the physicians reflects not only the desire for physical comfort, but just as importantly the desire for re-negotiated social status in the context when relationships between social classes are changing. Physicians are eager to reposition themselves in a way that would allow them to have the status of respectable experts, but that would also allow them to gain additional dimensions of prestige as economically freed professionals. An attestation to that is the layered nature of discourses that combine concerns for monetary remunerations with quandaries about dignity and morality.
V. Private and Public.

Materialist and humanitarian pursuits of Ukrainian physicians, as well as their contentious relationships with the state, come to light in analysis of their involvement in private healthcare facilities as compared to state-run facilities. In my original research design, I intended to investigate how female physicians are involved in private versus public healthcare to detect any patterns of empowerment or disadvantage. Very quickly, I was corrected by my respondents who unanimously pointed out that this separation into public and private does not exist in Ukraine. They insisted that the same physicians worked in both spheres combining several jobs, and that private healthcare was nested in the state-run facilities, which highlights the hybrid nature of the Ukrainian post-socialist biomedicine. Since official salaries are miniscule, physicians are in constant search for additional incomes. One of the respondents, Alina, told me this popular joke about the work of Ukrainian physicians today:

We work just like this joke describes: when a new policeman graduates from police academy, his superiors give him a traffic policeman’s baton and tell him to go ahead and earn his salary (which implies taking bribes from traffic violators). We have exactly the same situation (our baton is our medical diploma). Many doctors work several jobs here. I cannot do that … I have two young children.

Alina underscores the hectic and disorderly nature of physicians’ work. They no longer can count on their employer – the state, and provide for themselves. They often use their positions in the state-run clinics as the base upon which they build their private professional activities. Physicians consult patients who schedule appointments through the official state-run clinic services, and if patients are interested, new arrangements are made for private consultations in the state clinics or in private facilities with which physicians have affiliations. State-run clinics are often the initial and the main point of
contact, from which personalized doctor-patient relationships develop. Consultations in state-run facilities are an important recruitment strategy, and physicians are therefore often not interested in abandoning their underpaid official positions. In addition, if a physician manages to make a reputable name for herself, patients flock in and pay for their hospitalization and treatment in state-run clinics informally. Remaining under the umbrella of a state-run clinic or hospital is often advantageous because physicians do not need to worry about obtaining and maintaining a special license for private practice that is expensive and difficult to obtain; they do not need to pay for renting the office space, providing beds and meals for their patients, and paying for utilities; they have a convenient and easy access to different labs housed in state-run clinics; and other specialists are within easy reach for further consultation in case of any complications that patients may experience. The list of advantages does not stop here. Physicians often feel sheltered by the state-run facilities, but they have to arrange for this protection with the hospital or clinic administrators as well as their colleagues and staff. Extensive personalized agreements and negotiations are key, and physicians must be well connected in order to prosper in this hybrid private practice run from the state hospital premises.

Olena, who has a degree in obstetrics and gynecology and a specialization in birth pathologies and reproductive technologies, runs a private reproductive health clinic, heads a unit in birth pathologies in a state-run hospital, and is also a head of the Obstetrics and Gynecology Department in a large medical school. Here is a brief story of Olena’s engagement with public and private medicine:

Four years ago, a branch of reproductive care clinic “Remedy” was opened in our town. We work with problems of endocrine gynecology and infertility. We offer a very wide scope of services, we solve a variety of problems. The doctors who work here also work in the city birth clinic [Ukr. роддом] and women’s
consultation. So we have a closed circle here. That is, those people who come to us to treat infertility are first examined here and they receive stimulation treatments here. They then travel to Odesa (a large city where the main branch of “Remedy” clinic is located) where they undergo puncture and embryonic transfer. After that, they return back to our clinic, and register for pregnancy care in the state clinic where I have a special unit in pregnancy pathology. Our patients give birth in the state clinic where our doctors conduct the delivery. In fact, our clinic (private clinic “Remedy”) is like a birth clinic branch as well, because I invited about half of my state clinic doctors to also work here, and about half of them stayed back.

Olena describes a full circle of services that include procedures conducted in state clinics and private reproductive health center, making it impossible to disconnect private and public. When I asked about how patients make sense of the system and locate necessary facility, my respondents told me that people search for “a specialist,” and not private or public clinic. Rather then using the public and private distinction to analyze the quality and development of healthcare, it appears to be more productive to think in terms of specialists. Specialist is a medical doctor who is popular, has a good reputation, professional fame, and recommendations of other patients and physicians. The word of mouth is important even in large cities, and the fame of the specialist is central to her success in the informal exchange networks. Because of the issue of trust towards the formal healthcare structures, increasingly many people do their best to locate a good specialist, regardless of her practice location in private or public realm. Halyna, who is a pediatrician working also as a private practice homeopathy specialist, describes where one could find a good specialist in the following way:

Patients search for a specialist (personality) and could not care less where this person sees her patients: be it a basement or a chic private office. Even if the specialist is not a very pleasant person, but a good professional … still. We have such people and we can name their names. If one needs a urologist – we have one, a dentist – same story. It is not important where they are. Patients choose… Patients can clearly differentiate (a good specialist from a bad one). The fact that somebody has pretty walls and restroom does not mean that this office will
provide a highly qualified medical help. Good physicians do not need this type of advertising or gloss. Their fame will spread by the word of mouth, people will come looking for them on their own.

Participation in private biomedical ventures, therefore, does not preclude physicians from continuing their work in state-run clinics. In fact, this work for the state may often be a source and even pre-requisite for successful private undertakings for additional income. Yet, there is more to physicians’ work in state facilities than only pragmatic considerations. As I discussed in previous chapter on prestige, work in commercial structures (and private practice is deemed as such) is not always endowed with high status. My respondents have often shared with me that private medicine does not always translate into good quality, and the most trustworthy and tested by time clinics are those run and regulated by the state. Private clinics are risky, since patients could become subjects of what my respondents call “commercial diagnoses.” These are diagnoses motivated by extraction of the highest possible payment from a patient, and they exaggerate or even lie about the true condition of a patient’s health. Private clinics also rarely possess sufficient capital to purchase reliable top-notch equipment and usually work on second-hand technology, donated from the West and repaired dozens of times.

Yaroslav, a successful psychiatrist who continues working in the state system despite having sufficient clientele and capital to start a private practice, explains his decision to stay with his current position in this way:

I don’t want to “do (private) medical tours” [Ukr. гастролювати], I want to have just one job. I have my clients. On the one hand, I have worked for the state for so many years and I feel sorry to abandon my old clients. On the other hand, I like the legal protection that I have in the state clinic. I am not prepared to work in the private structures just for the sake of making money. I am prepared only to do my job.
Yaroslav highlights that leaving state-run clinic for private practice is not the best choice even if it allows him to make more money. His current clients would no longer be able to afford his services, and Yaroslav is reluctant to let them down. He also dislikes the disorderly and unpredictable nature of private practice, which he emphasizes by using the term “medical tours,” meaning the need to rush from one project to another in eternal pursuit of money. As a psychiatrist, he uses pharmaceuticals that only physicians in state clinics are allowed to dispense. Abandoning state practice also means making a do without “pink forms,” the color of prescription forms authorizing purchase of psychotropic medications that he needs to continue the treatment strategies that he developed in the course of his medical career.

This ethnographic evidence shows the ways in which private and public medical practices intertwine in post-socialist biomedicine, making it impossible to separate the two. These findings are supported by observations of other scholars working in post-socialist societies, most notably in the education system in Russia (Lisovskaia 1997; Lisovskaya et al. 2001; Patico 2008; Suspitsin et al. 2007). In the next section, I discuss the contested relationships between physicians and the state that come to light in analysis of informal exchanges in biomedicine.

VI. Rhetoric separation from state bureaucracy and capitalization on the clinical role.

Many physicians have reported during our interviews that their transition to monetary-based medical work is not free of internal conflict and negotiation, first of all with themselves, and then with patients and society. Patients were sensitive to the discourses of rights and entitlements, and physicians were employing their new ideas of
what it meant to be a good doctor to re-negotiate their authority, both biomedical and as financially freed citizens. While their relationships were far from smooth, physicians and patients both were actively trying to carve out new social positions for themselves. They were vocal in their critique of the political clans and lack of the rule of law. The neo-Marxist perspective of medical work (Navarro 1977, Reskin & Roos 1990, Riska 2001) imbues the economic processes with deterministic qualities. These studies argue that because in socialist and many post-socialist states the healthcare field is state sponsored, physicians essentially become bureaucratic employees instead of organized professionals (Schecter 1997). In contrast, in my fieldwork research, I found that physicians were capitalizing on their role of clinicians and were rhetorically separating themselves from the state and its political games. The attitudes of physicians towards the activities of their hospital managers were ambiguous, though usually critical. Hospital administrators are in position to make especially good money via unofficial sources, such as regular fees from subordinate administrators (i.e. pyramidal “tribute” schemes at their workplaces were reported by many informants), payments for hiring new employees, a portion of revenue from the hospital store, pharmacy, cafeteria, etc. Many physicians frowned upon the ways in which administrators managed their workplaces, calling some of the more unscrupulous head physicians “feudal warlords” who run their facilities at whim. In contrast to such evaluation of work of the healthcare officials, most doctors viewed the clinical work of their practicing physicians-colleagues as moral. This goes back to distinction between bribe and gratitude, where receiving reward for clinical help is viewed positively, but manipulating the finances of the medical facility in illegal ways
does not garner respect. The surgical nurse Lubov tells me about the pyramidal system at her workplace, a prestigious medical research facility in Kyiv:

Take, for example, the head physician’s birthday. We all had to chip in according to our salary range to get him, say, gold jewelry with diamonds. Of course, this is stupid and even laughable. I don’t even know him personally, why should I give him anything for his birthday? I don’t even respect him... All of them (administration) think only about themselves. It is like a free bird-feeder for those at power, so no one is going to do anything about this. Manus manum lavat - One hand washes the other. The favor for the favor.

Vasyl, a young male physician who is well-off financially, further comments:

State officials do not need reforms in healthcare. If physicians start to receive good salary, patients will stop paying under the table. If patients stop paying under the table, the chain will break. The head of the unit will stop getting his or her share, and so will the head physician and the Minister, after all. The Prime-Minister too, by the way. Kniazevych (current Minister of Health) will stop bringing money to Yulia Volodymyrivna (Tymoschenko). The pyramid system (that is operating today) is good for them. One, two, three - and people on the top are happy. This is not going to change any time soon... Among all those who work in healthcare, maybe people up to the head of the unit are more or less interested in change, but not above that. Because no matter how high their salary becomes, it won’t be enough to have a vacation home [дача] in Pushcha Vodytsia (a lucrative Kyiv suburb where the elite has their country houses). It is possible to reform the system that would give a sufficient salary to a physiotherapist, for instance, but not to those who are at the top...

One of the national medical publications “News of Medicine and Pharmacy,” publishes regularly on social aspects of healthcare, including problematic status of post-socialist physicians and the balance between their rights and obligations. In a series of articles, cardiologist and lawyer Akhmetshyn (2008:24) has offered legal discussions of an important distinction between bribe and gratitude, attesting once again to the salience that this distinction has for contemporary Ukrainian physicians. He focuses on Article 368 of Ukrainian Criminal Code “Accepting a Bribe.” Akhmetshyn suggests that according to this law, it is fully legal for physicians to accept financial gratitude for conducting their professional responsibilities. There is no criminal content in such
behavior on the part of regular physicians, although the situation is different if
physicians hold administrative offices, such as the head of the unit, head physician, main
nurse, etc. A regular physician is therefore emphasized as a professional worker who is
fully deserving of the monetary remuneration via official or informal channels for his or
her work, but not as a representative of the state.

While so many physicians tried to separate themselves rhetorically from the state
and emphasized their role as clinicians, they also rationalized informal activities of their
officials. In doing so, they focused on disorder in the society, complete disarray in the
healthcare system, unrealistic expectations from the healthcare facilities in face of
inefficient management by the Ministry of Health and extreme under-financing. Alla, a
public health specialist working in the WHO office in Kyiv who has previously worked
in the tuberculosis clinic as a clinical physician, suggested that administrators must have
a special sense of humor [почуття гумору] in order to handle the post-socialist disorder
and constant political shuffle:

Most administrators did not get to their level by chance alone. I mean, these are
people who have achieved something. It is not important how they got there or if
they are crystally honest. The main thing is that they have enough talent and
ability to get there. This means, these people have some brains! That’s why the
administrators deserve some respect at least for this fact. Personal enrichment is a
norm of life, everyone wants to live well… To be able to handle this mess.
Nobody taught them how to do it in medical school… Our administration must
have a special sense of humor to survive everything that they are bombarded with
and keep their facility afloat.

Significantly, physicians are convinced that the system of informal payments has
its utility not only because it provides them with a new sense of self-worth and
professionalism in post-socialist environment, but also because the entire healthcare
system stays afloat largely due to the efforts of physicians, patients and administrators
who are not afraid to bend the rigid boundaries that no longer make practical sense, and who are willing to compromise with their conscience and break formal rules. Informal economies are propelled to a great degree by disjuncture between the official discourse of the state that emphasizes benevolence and equal access to free healthcare and people’s lived experience of hypocrisy this creates. Informal economies, however dysfunctional they may seem, demonstrate their internal logic whereby the participants of the process are each using any means available to them to negotiate the acceptable outcome. The population, healthcare providers, and representatives of the state authority have all contributed to the creation and maintenance of the alternative payment system in healthcare. The neurosurgeons’ focus group whom you have met in the earlier pages agreed with countless other physicians that without the informal system and its various participants, the whole healthcare enterprise in post-socialist Ukraine would have already crashed. It is people making localized decisions and circumventing the official rules who keep the system running, albeit sometimes unjustly and in highly personalized ways. To the degree that their personal motivations, moral convictions, education and life ideologies dictate, all participants of the healthcare system maneuver amongst the various pitfalls the post-socialist society has in store for them:

Today, the entire medical system is afloat only because someone is paying somebody for something under the table. If this stops, not only will physicians stop working, medicine itself will cease to exist. For example, in my ward – if patients stop paying for their medications, three of them will die. They have money to buy their own medications, so the hospital funds remain for those who will definitely not be able to afford the drugs. In a way, they are saving other people by buying their own drugs. If my patients’ relatives stop paying me, I will have to stop going to work, because I cannot work for 1,000 hryvnia a month, my child eats more than that! This is simply laughable. I will have to quit and do something else. Thanks God, there are other ways to make money in Kyiv…
The healthcare remains a state-sponsored project in post-socialist Ukraine; despite this association, the participants of the system often regard the state as such having already retreated from this space. As one male respondent who heads the Narcology clinic in a peripheral town succinctly put it: “You understand, free healthcare as such does not exist. The state or the people must pay for it. In Ukraine, the state ceased to exist a long time ago, therefore people are paying” (respondent’s emphasis). The problems of healthcare are left untackled, while the providers scramble to continue making income and doing meaningful work. Dunn (2008) discusses similar processes in Georgia, where via her analysis of the canned food industry and its current retreat into the domestic sphere, she shows how some “social spaces remain uncolonized, unpenetrated and largely abandoned” in post-socialist contexts. Though initially these “stateless spaces” are created by withdrawal of the Soviet regime, they subsequently continue to grow and expand because of the disregard by the new state. The rules by which the Ukrainian healthcare system is supposed to operate have shown to be incompatible with the current socio-economic architecture. Continuing imposition of these rules in an effort to push a certain image of the state creates double standards and backfires. From the sphere most commonly associated with the state, Ukrainian healthcare is effectively becoming a “stateless space” (Dunn 2008).

VII. Conclusion

In Ukraine, informal norms and formal law are currently out of synch, making it next to impossible for the actors to follow the rules. Ukrainians learned to maneuver between law and social norms (Hrymych 2008). Good or bad, people participate in
informal exchanges since it enables results in a most convenient way. Because of the inconsistent and opportunistic nature of informal practices, it is difficult for people to navigate Ukrainian healthcare, which fuels conflicts between healthcare workers and patients. Reliance on informal practices is a testament to the failure of the formal institutions to satisfy the needs of most participants of the system. Medical workers specifically, and Ukrainians generally, are not “legally nihilistic” (Bondarenko 2008), but they distrust the law-makers and read the law with a grain of salt, informed by their everyday experiences of corruption.

Multiple moral codes are currently operating in the Ukrainian healthcare system, where the ideas of right and wrong and state-citizen obligations and responsibilities are now being re-negotiated. What was once considered immoral comes to be not only socially acceptable, but formative in the construction of new ideas of professional success. This reflects the paradoxical angle of informal practices: they are debilitating in many ways, but creative and innovative in other ways. In a sense, each unit or even each provider represented a microcosmic individualized version of the self-reformed healthcare system, with its personalized norms and expectations. Each physician has developed some frames that help her or him feel professional. Similarly, each patient decides for himself or herself how they are going to approach their health problem. Though internally logical, these miniature self-regulated systems together create chaos in the healthcare sphere, where multiple agents push and pull in different directions, eager to satisfy first and foremost their own needs.
Chapter V. "Beautiful" Medicine and Feminism: Women and the Practice of Post-Socialist Biomedicine in Millennial Ukraine.

I. Introduction.

The collapse of communism and post-socialist transformations associated with liberalization and marketization have certain costs, but these costs are experienced by women and men differently. Gender and ideas about gender shape political and economic change, and gender categories are constructed depending on the historical, political, and social context in different societies (Gal and Kligman 2000). Many scholars have argued that post-socialist social, economic and political transformations have had a marginalizing effect on women (Einhorn 1993; Funk and Mueller 1993; Gal and Kligman 2000, Marsh 1996, Moghadam 1994). Ukrainian women are underrepresented in politics, experience gender discrimination in the labor market, poor health, loss of state welfare benefits for childbearing and childcare, and the proliferation of paternalist/nationalist discourses that positions women as “reproducers” (Phillips 2008). Yet, new ethnographic evidence supports the idea that women’s experiences of post-socialist transformations have not been universally negative or disadvantaging, and that many of them were able to benefit from these changes (Fedyuk 2009, Ghodsee 2005, Phillips 2008). Ghodsee (2005) argues that statistics are not the most accurate tool for capturing real-life experiences, and more layered ethnographic analysis is the key.

Taking this key, I ask in this chapter: how do gender and ideas about appropriate gender roles shape the biomedical profession in Ukraine today? Is increased participation of women in this already feminized profession a testament to women’s empowerment or
in what ways could it be disadvantageous or problematic for gender equality in Ukraine? What does it mean to be a physician in post-socialist society today, and what makes women more likely candidates for the job? What types of skills does current medical work require and why are mainly women drawn to this new content?

Sociological studies that use the neo-Marxist perspective (Navarro 1977, McKinlay 1988) and feminist studies that draw on Marxism (Lorber 1993, Reskin & Roos 1990, Schecter 1997) suggest that women’s involvement in the medical profession grows if the underlying economic factors create an open niche that men refuse to fill. In the former Soviet Union, women started to enter the medical profession in increasing numbers in the 1930s (Field 1957), as a part of the proletarianization of the profession and the socialist ideology that celebrated female emancipation and required every citizen to participate in social production (Watson 1994). According to Riska (2001), women entered the field as labor resources to assist the industrialization and collectivization projects. Men were more drawn to heavy industry, which was prioritized by the Stalinist government. While these authors explain the economic factors in place, they leave out culturally embedded local processes that may have influenced women’s entrance into the biomedical profession. My research turns to narratives of Ukrainian women physicians to tease out not only the economic factors that are affecting their entering the profession in increasing numbers, but also builds on a critical interpretive perspective (Cassell 2000, Rivkin-Fish 2005) to provide a more culturally embedded understanding of the processes involved in a woman’s decision to practice medicine than neo-Marxist studies currently offer.
I analyze competing gender discourses circulating in Ukraine in order to assess their reflections in the Ukrainian biomedical profession. To capture these contradictions, the analytical tool of “braided narrative” (Phillips 2008) is especially productive. This technique recognizes that people’s narratives are constrained by the discursive contexts in which they are embedded, and with the help of “framing” (Lemon 2000) it dissects ideologies that inform the narratives.

I argue that the reason for increasing female participation in biomedicine is linked to women’s choice of and culturally embedded beliefs about particular medical specialties. The gendered practice of medicine in Ukraine is organized around ideas of “beautiful” and “clean” work, which serves as one of the ways in which women are inserted into post-socialist circulations of ideology and capital. “Beautiful” and “clean” medical work encompasses narrow non-surgical specialties that require analytical skills, patience and detail-oriented inquisitiveness; particular surgical fields, such as obstetrics and gynecology, ophthalmology, otolaryngology that require artistry or are associated with motherhood; and burgeoning private fields, such as assisted reproductive technologies, aesthetic dentistry, MRI and other advanced diagnostic technologies. “Beautiful” and “clean” work is also understood as a humanitarian pursuit of healing, harmony, and purity associated with female sphere in Ukrainian culture. This understanding highlights women as erudite intellectuals with artistic vision, which complicates simplistic explanations of women’s position in non-surgical fields as marginalized professionally.

Because of the structural peculiarities of the Ukrainian biomedical sector, female physicians are able to maintain a meaningful professional identity while also pursuing
their familial associations. I argue that they perform culturally appropriate healing work guided by familial associations, and in so doing reinforce their moral and cultural authority. In addition, women are expanding their professional repertoires by claiming new lucrative biomedical fields. They employ new completing gender discourses and become agents of change in the biomedical profession in Ukraine.

This chapter explores how female mobility in the biomedical field complicates conceptualization of women as losers in post-socialist transformations. The gendered biomedical work manifests itself in a particular non-Western version of feminism where women emphasize their social position and connections within the profession as some of the most salient factors shaping their careers. In my ethnographic scenario, social capital is very significant in determining physicians’ paths in post-socialist biomedicine, which speaks to the argument for intersectionality in understanding gender as a category of analysis.

This chapter argues that female prevalence in the biomedical field offers a door to understanding complex transformative social processes where moral codes are being actively re-negotiated.

II. Gender discourses and their reflections in the Ukrainian biomedical profession.

II.1. Women as losers in post-socialist transformations.

Biomedical systems are embedded in a broader social framework, which includes local understandings of gender roles (Lock 1988, Ong 1988, Scheper-Hughes 1992). Gal and Kligman (2000) are the first anthropologists to theorize gender as the main lens for understanding post-socialism. They contend that “democratization comes more clearly
into view if one asks how men and women are differently imagined as citizens, or how politics itself is being redefined as a distinctively masculine endeavor. Similarly, by examining how women and men are differently located in the emerging economies, one foregrounds the usually unremarked yet pervasive and often feminized phenomenon of small-scale, service sector marketization” (2000:3). An implicit assumption in Gal and Kligman’s theorization of gender is that women have so far not been able to benefit from post-socialist marketization. Many scholars focusing on gender categories in Eastern Europe and the former Soviet Union emphasize these negative effects that post-socialist transformations had on women’s socioeconomic status (Einhorn 1993, Funk and Mueller 1993, Marsh 2000, Wolchik 1993). According to them, in the absence of active women’s rights movements, women are disproportionately marginalized by ineffective economic transformations. They experience discrimination at work, lack of access to political power, withdrawal of the welfare services that would allow for childcare, as well as limited involvement in large-scale private entrepreneurship. Thus, Moghadam (1994) argues that the reasons for increasing gender inequality in the region are historical and stem from the pre-World War II patriarchal ideologies that were never changed by the socialist emancipation, but rather quietly persisted and are now re-emerging. Other scholars (Einhorn 1993, Wolchik 1993, Rubchak 1996, Pavlychko 1996) suggest that lack of public discussion about women’s marginalization is a product of the backlash against socialist propaganda and unpopular notions of emancipation. They argue that people feel deceived by socialism, and many post-socialist ideologies are constructed in opposition to the socialist world order. Thus, the Soviet experience of the double burden of participation in the labor force and being almost solely responsible for childcare is
linked to women’s current willingness to be homemakers and relative lack of interest in political activism (Wolchik 1993). The revival of religious tradition has also impacted gender relations in Eastern Europe and the former Soviet Union. Thus, Tabyshalieva (2000) argues that the re-Islamization of women in post-Soviet Central Asian republics (Uzbekistan, Kazakhstan, Tajikistan) increasingly closes the possibility of gender dialogue. Similarly, Nowicka (2000) discusses the prohibition of abortion for non-medical reasons in Poland as an example of the revival of patriarchy that goes in hand with the empowerment of the Polish Catholic Church. Einhorn (2000) addresses the problem of a shrinking social welfare system that had been largely directed at supporting women’s and children’s needs. She argues that although a developed welfare system may be a double-edge sword that could push women further into domestic sphere of childcare, she views it as essential at this point of uncertainty: “Government legislation and policy alone cannot bring gender equality. However, within the context of a neo-liberal market-dominated model of development, the state sector shrinks in favor of the market, leaving much social provision to NGOs and civil society initiatives. This is inadequate. An example is childcare, which women need if they are to have an equal access to the market as economic actors or the public sphere of national, mainstream politics” (Einhorn 2000:110).

In contrast to concentrating on the double-burden of labor and childcare, Rethman (1999) suggests that more attention should be paid to gender constructions, images and performances. Marketization and privatization speak the masculine language where such qualities as aggression and rationality, traditionally perceived as male, are valued. Women, on the other hand, are associated with domesticity and frailness in the popular
discourse, and thus are often viewed as not apt for “neoliberal excursions” (Rethman 1999). These symbolic dimensions of gender have economic and political consequences, and Rethman argues that the challenge is to explore not only national gender politics, but also the ways in which women refute and resist them. It is exactly this last point that my dissertation seeks to explore. I aim to identify and discuss spaces where gender roles and conceptions of hegemonic femininity and masculinity are re-negotiated. After discussing gender discourses and “retraditionalization,” I then explore spaces and strategies of empowerment in Ukraine, focusing specifically on the biomedical profession.

II.2. Gender, nation, and reproduction as politics.

As a newly independent nation, Ukraine is now engaged in active nation-building (Wanner 1998, Popson 2003), and rediscovering its “historical memory and identity” (Rubchak 1996:315). Rubchak argues that the Ukrainian state has made this “restoration and revitalization of historical traditions a conscious program as a way of authenticating its collective being” (1996:315). Citing Gupta (1992:74), she also claims that in this nationalization project, “women are generally recognized only in their role as producer of citizens and (they) are thus precariously positioned as subjects of the nation.” As a part of this nation-building project (Phillips 2005, Rubchak 1996, Pavlychko 1996, Zhurzhenko 2001), an ancient Ukrainian myth of Berehynia is now becoming popular in Ukraine. Berehynia is an ancient pagan Goddess of domestic hearth that symbolizes a mother-protector of her children, home and the nation. According to this myth, Ukrainian women have always enjoyed equality in difference. They never competed with men for their public roles, but were nevertheless greatly respected and equal to men. In the post-
socialist context, this myth serves as a tool to design a new gendered space within nation-building project. Rubchak (1996:319) provides an example of Berehynia representation in the Ukrainian popular press:

The Ukrainian woman has a responsible mission (she is perhaps the only woman in the world, emancipated from her very inception, who never waged a battle for equal rights with her husband, but always fought instead for the equal rights and liberty of Ukraine). Like the Blessed Virgin, the Ukrainian woman must give birth to the Ukrainian Savior…

The image of Berehynia is also infused with Christian motifs, as Ukraine experiences a large-scale revitalization of Christianity. Religious revival and re-writing of Ukrainian history are a part of the search for Ukrainian roots that will help the newly territorialized state to create a shared sense of identity. In the Ukrainian context, this is deemed especially important due to the considerable loss of Ukrainian language and cultural practices over the centuries of Russian domination (Bilaniuk 2005). The revival of Orthodox Christianity influences gender relations. Known for its patriarchal ideology, Orthodox Christianity, coupled with state-sponsored revitalization of “patriarchal mythology” (Pavlychko 1996), further locates women within the domestic realm as mothers and care-givers. Rubchak (1996) offers a radical feminist view, accusing the Ukrainian women for their passivity. She praises the de-colonizing effort on the part of the new Ukrainian state and resurrecting its history. However, she urges the use of these symbols with caution. She states that “they cling to gender-specific roles, as exemplified in various configurations of symbols - … in the images of the Virgin May and the Berehynia” (1996:325). Paternalist discourses do not indicate only a return to traditions, but they also represent active negotiations of meaningful politics in which issues of reproduction are the key to nation-building (Gal and Kligman 2000: 21-22).
II.3. Competing discourses, international influences.

Since Ukraine gained its independence in 1991, women have been introduced to new and often competing gender discourses. New gendered spaces are being constructed and negotiated in the state that until recently has been petitioning for European Union membership.

To further develop my argument of multivocality within gendered spaces, I would like to discuss another popular discourse circulating in Ukraine today - the Western conception of empowerment and individualism. While savoring their femininity and ability to practice what was not allowed or accessible in the socialist Ukraine, women today are re-negotiating their public roles.

The open market ideology draws a vision of a successful woman entrepreneur. The image of a successful business woman is quite popular. Feminist scholars suggest that mass media lulls women into the belief that they are as active in the business environment as men, creating a businesswoman identity as a form of legitimizing identity that justifies the existing order without challenging it (Zhurzhenko 2001). While women find niches of empowerment (Ghodsee 2005, Phillips 2008), when it comes to large business enterprises women manage three times fewer companies than men (UN report 2004). Zhurzhenko’s main argument is that women’s choice of identity is essentially limited to the two mutually exclusive categories of housewife-Berehynia or businesswoman. The current gender situation in Ukraine is not a new creation of post-socialist order that in some intrinsic way disadvantages women. It is not a change per se, but rather the epitomizing of the already existing socialist categories, taking them to the extreme (Bazylevych 2005). Indeed, motherhood has always been articulated by the
socialist state as an inherently female responsibility (Posadskaya 1993). The image of a working mother was promulgated as a social norm to ensure ample labor force that the industrializing country desperately needed. According to Zhurzhenko, post-socialist reality brought these two images to their extreme forms, creating the dichotomous options of housewife versus businesswoman without an apparent option of combining family and work.

In contrast to Rubchak’s and Zhurzhenko’s critical views, Phillips (2005, 2008) suggests that women’s involvement in new domains of public life created by the open market does not necessarily indicate exclusive categorization. In her research on women civic activists in Ukraine, she found that Western ideas of civil society and women’s roles are being re-written by local actors. Many women who are leaders of nongovernmental organizations have become fluent in the international “NGO terminology” (Phillips 2008) and successfully obtain funding from international donors. However, when they are communicating with local women during workshops and meetings, international gender rhetoric is being muted or even disappears to render these new ideas in a more culturally acceptable manner.

In this regard, a popular Ukrainian political leader emerges as a particularly colorful example of how Western cosmopolitan ideas of gender roles intersect with locally relevant post-socialist gender discourses. Yulia Tymoshenko is a former Prime-Minister of Ukraine and a current opposition leader who became especially prominent during the 2005 Orange Revolution. In the beginning of her political career, Tymoshenko was a noticeable figure, however not a top-ranking politician. Caught in a conflict with the President at the time, Leonid Kuchma, she made a dramatic move that changed her
career and immensely increased her popularity. Tymoshenko changed her hairstyle and wardrobe to infuse her image, the internationally oriented democratic politician, with a traditional hairstyle – a braid that bears clear association with pre-revolutionary peasant Slavic women, stereotyped as mothers and care-givers. She also modified her designer wardrobe to incorporate more feminine elements: lace, stiletto heels, feminine skirts, puffy sleeves, floral fabrics, and coral beads. The transformation of Tymoshenko’s public image signals that she understands her position as a new Ukrainian cosmopolitan, European-oriented politician, whose priorities are, however, rooted in Ukrainian traditions. Her image is the amalgamation of what is now viewed as progressive and Western rather than colonial Soviet, and at the same time feminine and traditional. Tymoshenko’s image serves as an example of how women can construct and contest their identities, using the tools provided by the gender spaces that are configured by the state, international influences and local cultural conceptions. Pavlychko (1996:306) similarly exposes multiple gender discourses in Ukraine, dubbing them “utopias” – local and imported. The local utopia signifies the “national revival” of Ukrainian traditions in contrast to Soviet or Russian values, while imported utopia stands for the imported invasion of mass culture from the West. Women need not be buying any of the promoted discourses whole-sale; they also need not be operating in vacuum. Instead, gendered space emerges as a historically contextualizing hub of competing discourses that to some degree circumscribe gender roles in the society. Depending on the flexibility of the ruling regime, women and men may or may not be able to pick and choose various threads of gender identity (Bazylevych 2010). Negotiating these discourses has led to production of complex and contradictory subjectivities among women in post-socialist Ukraine.
III. Locating new niches for empowerment.

My dissertation investigates professional predicament of women and the extent of their participation in new potentially lucrative developments in the biomedical field. As I mentioned above, research that took place in the early post-socialist years tended to emphasize the disadvantaged position of women in “transition”xxiii (Einhorn 1993, Gal and Kligman 2000, Johnson 2007, Lokar 2000, Zhurzhenko 2001). However, some of the more recent studies (Fedyuk 2009, Ghodsee 2005, Phillips 2008, Solari in press) have suggested that women may be able to craft new identities and locate niches for their empowerment. My research explores how women’s mobility in the biomedical field illuminates these gendered processes and complicates conceptualization of women as losers in post-socialist transformations.

Thus, Phillips (2008) argues that women carved out a niche for their empowerment as leaders of humanitarian-oriented NGOs in Ukraine (68% of all welfare-oriented organizations are women). In this way, Phillips argues against Gal (1997) and Watson (1997) who claim that “civil society” has become a male domain. Phillips conceptualizes the social space of civic organizations as a locus of complex personal, local, state-level, and transnational transformations. She argues that women employ “empowering accounts of self-sufficiency and collective action to counter narratives that would position them as helpless, defenseless throwbacks from a backwards Soviet past… Such articulations allowed them to reconstitute themselves as persons and shore up their sense of self as socially worthy agents” (Phillips 2005).

Another locus of potential women’s empowerment has been discussed by scholars studying migration patterns (Solari 2010; Fedyuk 2009). Thus, Fedyuk discusses large-
scale female migration of Ukrainian women to Italy where they are hired as care-givers for the sick and the elderly. While the lives of these migrant women are not easy, they express feelings of freedom, independence and fulfillment from being able to provide for their families in Ukraine. In addition, Fedyuk’s female respondents narrate stories of rediscovered sexualities and romance in a land far from home. Ukraine-Italy migration has been dubbed “grandma” migration due to the age of women-migrants who tend to be older (in their 50s and older). Many of them have experienced difficult situations in their families, and their relocation to Italy creates new opportunities for them, which include not only hard work in order to send money home to Ukraine, but also renewed sense of self and freedom. Solari (2010) has a slightly different take on the same migration pattern of Ukrainian women travelling to Italy and argues that they play a crucial role in Ukrainian nation-building project. Ukrainian women who are migrating to Italy today are temporary migrants. The capital that they are able to send home is used in multiple and contradictory ways. Ukrainian families of migrant women often use this money to sponsor the younger women’s stay at home with children, thus providing “the structural basis for the realization of state’s domestic goals of reorganizing the institutions of family and work,” which envisions men as breadwinners and women as Berehynias (protectors of home). In so doing, migrant women enjoy the role of providers and co-producers of the new Ukraine, yet the end result of their activities for women in Ukraine is contradictory.

Finally, Ghodsee (2005) discusses how Bulgarian women were able to excel in post-socialist tourist industry using their interpersonal, educational, and material resources gained during socialism. Using Bourdieu’s ideas about social and cultural
capital, she argues that women developed valuable portfolios of stock in cultural capital in socialist Bulgaria (education, fluency in foreign languages, work experience with foreigners, etc.), which have positioned women to thrive in the tourist industry in the open market. The education and cultural capital that Bulgarian women gained during socialism became the key to their success in post-socialist times.

Ghodsee argues against lumping women together under one category of analysis—gender. Current scholarship discounts experiences women like her respondents, who feel offended that their successes are being neglected. Instead, she argues for more in-depth research while paying attention to the macro-level economic processes that enable or disable certain trends in women’s lives. In so doing, Ghodsee echoes Mohanty’s (1986) dissatisfaction with the term “oppression” that tends to over-generalize women’s struggles across classes and cultures. By looking at women only through the lens of their losses, or oppression, scholars homogenize their experiences or create binary analytical categories: oppressors (states, patriarchy) and oppressed. Similarly, power is understood in a binary way: source of power and reaction to power. As the third-wave feminists (Abu-Lughod 1993, Behar 1993, Butler 1993, Lamphere et al. 1997, Narayan 1993, Rosaldo 1980) have argued, defining power in terms of possessing it versus being powerless does not fully capture women’s experiences across the world. Different women possess different degrees of power, and their class, ethnicity, health status, and other factors create different degrees of privilege and oppression.

I now turn to analysis of my ethnographic evidence in order to introduce different narratives that women and men physicians employ to explain their gendered motivations and experiences of practicing biomedicine. Paying attention to the microcontexts that
contextualize different experiences and macrocontexts that shape them, I will discuss both the successes and failures of women physicians. I will demonstrate how women use their cultural capital in the biomedical arena.

IV. Essentializing gender difference.

Slava is a female neurologist in her early 30s who works in one of the largest city hospitals. She works night shifts in an urgent care unit, which makes her schedule flexible enough to squeeze in a second job in a private doctor’s office. Her boss at the second job hired her to work in a private office that he opened, specializing in vascular ultrasound diagnostics. After several years of working two jobs and with the help of her parents’ investment, Slava quit her second job and purchased her own diagnostic equipment. She rented out a small office space and took her clients with her. She is very protective of her knowledge and does not want to train any assistants for fear of competition. Slava has never been married, she is very sociable, she likes to go out and meet new people. She also dreams about having a family. She wants a husband and a child. She has not met the right person just yet, explaining that Ukrainian men have become “defective” or too weak, a concept that I will return to later in this chapter:

In a man I am looking for the qualities that have been important for centuries… A man must provide for the family: provide for them financially and emotionally. In general, a man must be a hunter (a provider). Today, well, men are not like that. They are a little defective. The good men who want to make money will be able to find ways. It depends on the character. There are plenty of young doctors making great incomes because they want to, they are not afraid to work two or even more jobs. The rest are just lazy, they do not try.

What Slava illustrates is one of the salient themes running through my respondents’ narratives – their seeming essentializing of gender differences. The
traditionalist view of a man as first and foremost a breadwinner (“a hunter,” in Slava’s words), superficially, tends to prevail among physicians, paralleling popular views in Ukrainian society as a whole. For women, it appears to be less problematic when their (women’s) desired income does not immediately translate into real earnings, since the primary role of a woman is often seen as being a mother and a protector of the home hearth. These essentialist views can be considered part of a nationalist revival (Rubchak 1996, Pavlychko 1996), and also a continuity with the pre-socialist division of labor at home where women carried out most household tasks, which socialist egalitarianism project was not able to fully deconstruct (Einhorn 1993). While both female and male physicians desire well-paid jobs, most of them share the view that it is much more important for men rather than for women to make good money. Both women and men seem to agree that it is harder for men to pick the medical profession today, since the mechanisms of making reliable incomes in healthcare are vague for today’s fresh graduates. Iryna, a female pediatrics specialist and a pediatrics board member at a municipal public health department, illustrates this view:

A man must earn income and support his family, because he is a man. It is difficult to earn a lot of money in medicine. Perhaps, it would be easier in a private clinic of some sort, but it is unclear in what capacity and on what terms he is going to be able to work there. That’s why men pick professional fields that will allow them to provide for their families. As far as male physicians – there are only a few. I had 120 people in my class in the medical school, and only 16 of them were men. Half of them have already quit medical field. Those few who remain are either surgeons or trauma specialists, but they have left pediatrics. The salary does not allow one to feed his family. For a woman – this is more or less OK. A woman is a woman.

However, unlike the usual interpretation of feminized professions as those left unwanted by men, women’s narratives complicate this view. In choosing their profession, women appear to have relative freedom, more freedom than men have. Although
women’s primary roles are located in their families, women are also expected to work outside of their homes due to not only difficult economic circumstances, but also the consideration of professional identity as an important part of their lives. Work outside of the home is a part of familiar trajectory for women, entrenched in the course of socialist history. The same local gender norms that attempt to locate a woman in the private domain, in a sense, frees her from the cultural pressure to take a job that pays well, but is not desirable. Instead, women are able to pursue the jobs they really want. My respondent Slava, who so much wants to have her own family, does not shy away from housework. She cooks amazing dinners for friends, she pickles her own vegetables, she keeps a vegetable garden, and she single-handedly remodels her apartment (not just decorating, but moving walls and tiling the floors). Yet, she is extremely negative about women who center their entire lives on their homes. Like many other informants, Slava despises housewives, linking them to under-educated class of the newly rich who idle at home instead of doing something useful. Yet, she is protective of the spheres that have traditionally been controlled by women: care-related work and management of the household:

I would oppose it if my husband decided to take parental leave and stay at home with our child. I would not be able to tolerate him. It is not just about staying at home and taking care of the house, but also controlling time and space. If he stayed at home, he would start asking me: “Why are you done with work late today? Why did you go out for beers?” No, a child will go to kindergarten! Being a housewife or a househusband is like a brain tumor, for women and men alike. I know one guy who is on parental leave. But he is just using the leave in order to work at his second job in a private medical center… For women, [бабів] – a stay at home dad is not just a step into their territory, but a direct attack against them. This is the space that women have always controlled. It would have been horrible!
Here, Slava claims that while women want high salaries and good jobs, they are also not about to give up the reigns of their mini-kingdoms (households) to men. In their eyes, running a household is a leadership role, not discrimination. While I cannot claim that this view is shared by all, it is certainly the case for quite a few of my respondents. My ethnographic evidence challenges this assumption, and proposes that being a primary leader in household management may not necessarily mean only oppression. Ghodsee (2005), for example, argues that in early and mid 90s, women in post-socialist states benefited greatly from being the ones primarily responsible for keeping their homes. They were able to achieve a degree of fulfillment, while men who did not have this outlet and who also were losing their jobs and public position felt lost and on edge. I will return to discussion of differing views on oppression later in this chapter.

Men in post-Soviet Ukraine report feeling more pressure to earn money and feeling more constrained to follow gender expectations. If they enter the medical profession, usually it is due to family tradition of practicing medicine (the so-called “clan” nature of the biomedical profession), expectation of a good job via family networks, or early determination to work in specialty fields deemed lucrative (surgery, cardiology, etc.).

As is true for many parts of the world, essentialist notions about “intrinsically” female qualities are used by men and women respondents to explain the attractiveness and suitability of the biomedical profession for women. Compassion, ability to relate to others, experience in care-giving, and empathy – are all perceived as qualities that help women be good physicians sought after by their patients. A number of female physicians have related this understanding of their special abilities in the medical sphere. Here are
just a few of their thoughts, with informants ranging from an elderly retired primary healthcare provider to a young single neurologist running a private practice:

Women are more trustworthy (than men); we are good and kind… On a subconscious level, we are more developed than men. We have intuition. It is almost like a sixth sense, but not quite.

A woman is genetically programmed to want to take care of others: to nurture, to raise and rear, to nurse, to tend to, to look after [Rus. взращивать, вскармливать, ухаживать, выхаживать].

Women have compassion, an ability to extend a helping hand. Perhaps, a womanly kindness is the root of this motivation to become a physician. So that we could help others.

Raisa, a fifty year old female radiologist who works in an oncology clinic, recounts how her parents decided on the medical profession for her, rationalizing their decision in essentialist terms:

My parents are teachers. I have personally always been interested in foreign languages and jurisprudence. I think it is not right that in our country sixteen year olds have to choose their profession.xxv I think that we should go through more experiences before we can make this choice, before we even fully understand our talents. I don’t know how other people do it, but in my case, my parents made the choice for me. They have decided that I have a humanitarian type of mind, and since I am a girl – I could be a physician. This is what they decided, and this is how I ended up in medicine.

The same qualities that qualify women for practicing the majority of the biomedical specialties, are also the ones perceived by many as disqualifying them from practicing surgery. The majority of surgeons, trauma specialists, pathologists and orthopedists in Ukraine today are male, while women dominate most other specialties. In the previous chapter, I discussed the potential sources of advantage and disadvantage in surgery and pediatrics, arguing that both of these specialties create productive spaces for physicians. It would be too simplistic to understand surgery as universally prestigious and pediatrics as a universally devalued medical specialty. Multiple areas for empowerment
exist within both of these fields for differently situated subjects. When my respondents insist that surgery is not for women, they usually understand this gender difference primarily in essentialist terms rather than in materialist terms, such as higher salary.

During a focus group that I conducted with neurosurgeons from a large emergency hospital, three men in their mid to late 30s Vadym, Denys, and Dmytro reflected on the differences that they perceived between men and women surgeons:

We have women surgeons in our hospital, and we respect them. However, with age it is increasingly difficult for them, on both the moral and physical level. It somehow becomes easier for men to carry this load with age. We do not keep our work as close to our hearts as women do. I once had a night shift with a woman surgeon. She kept asking me to check on a patient again and again and again. I know what and when I need to check. She ended up going to that patient’s bed five, maybe, ten times. Surgeons must not burn for their patients [Rus. гореть больным нельзя]. A patient is like a machine, I am sorry if it sounds too crude. The only difference is that a worker can make a mistake when he works with a machine, but we are not allowed to make a mistake in our work. This is the only difference. Surgeons must not think that this patient could have had a child, or he could have achieved something in life. These thoughts are very bad, because when you start thinking, feeling the patient’s pain, feeling sorry for his family and friends, it interferes with accuracy and logics. Sometimes we must make decisions in a flash, so no special relationships between us and our patients should interfere. This is why surgeons never operate on their own friends and family. Personal relationships interfere with our work. This is not because we are afraid of getting hurt emotionally, but because these thoughts really do stand in the way during surgery [Rus. реально мешают]. Women tend to take things closer to their hearts, and this is why I believe that women do not need surgical specialties. It is not their element. There are thousands of other specialties where men are just as out of place, while women excel, and this is wonderful. For example, ophthalmology, otolaryngology, cardiology, MRI diagnostics – women are superb at these. We should not try to reinvent the wheel… Anesthesiology is also full of women who are excellent. They are the bombs and can get the better of any men. However, this works when they are young. When they get older, like I mentioned, it becomes more difficult to carry this on their shoulders.

Thus, physicians explain gender division by specialty not in terms of control of resources, but also using essentialist understanding of gender. Men are, in their view, usually better at applied medical work where they can use their hands and raw physical
strength. The tendency to make snap decisions, rational straightforward thinking without emotions, make males better surgeons, in the view of many of my respondents. Alla, a female general practitioner in her early 30s who moved to the city from a rural area and has worked her way up to have two jobs and a good income, illustrates this view:

Surgeons (men) are more radical, tough, and direct. General practitioners and other non-surgical specialists are more conservative in their methods… I have a girl friend who works in an emergency hospital in Kyiv as a surgeon. She has always wanted to be a surgeon starting from her freshman year. Her character is perfect for that: she is aggressive and bellicose, and large. She has a male character.

Alla proceeded to tell me a joke that dozens of my respondents shared with me, “A woman-surgeon is like a guinea pig. Not a pig, and not in Guinea.” This joke implies that a woman who is a surgeon is not truly a surgeon and not truly a woman. This highlights once again essentialist understanding of gender division by specialty.

Similarly, Riska and Novelskaite (2008a) report that in post-socialist Lithuania skills that qualify men for being good surgeons are conceptualized as inherently male: physical strength and mental endurance, while skills that qualify women for pediatric specialty are seen as intrinsically female: empathy, ability to communicate and a holistic view.

In contrast to men, women sport more abstract thinking, great attention to detail and careful decisions. Consistent with the rhetoric of man the hunter, male physicians are deemed as more primordial, using their physicality, being able to be tough and make quick decisions. Female doctors, on the other hand, are viewed as more analytical, being able to empathize, think through potential treatment schedules and make accurate conclusions. Women are still construed not only as a weak gender, but also as intellectuals who are more analytical than men. That is why, as my respondents suggest, women dominate analytical specialties that focus on biomedical diagnostics (radiology,
microbiology, MRI labs, ultrasound labs, etc.) In my ethnographic context, women are able to exercise control over certain medical specialties, and they are perceived, perhaps, as more intellectual than their male colleagues who tend to work with their hands rather than their heads.

Although such gender-based conceptualization of “equality in difference” (Rubchak 1996) is a binary and does not reflect the complete picture, it nevertheless complicates the traditional framework that social scientists put forward, according to which male doctors control and gate-keep the majority of prestigious positions in biomedicine. In my ethnographic scenario, women do not only work in specialties associated with caring for children and other women that are deemed appropriate for them due to their ability to empathize, instead they are heavily involved in prestigious and analytically rigorous narrow specialties and lucrative diagnostic fields. This finding contradicts Reskin and Roos (1990) explanatory framework of “double queuing.” They distinguish between “job queues” and “labor queues,” where men are the first in line to pick a profession of their choosing, while women have to make do with the men’s leftovers and take whatever remains in the labor queue, as opposed to the job queue. I am more inclined to side with Witz (1992) who offers a concept of occupational closure to explain gender division by specialty (cited in Riska 2001:19). Exclusionary closure is used by the members of the group in order to prevent undesired members to enter or excel in a given profession, whereas inclusionary closure is often employed by minority groups in the profession, such as women in biomedicine in the USA or men in biomedicine in Ukraine, who tend to cluster in the same medical specialties and exclude members of the majority group. Riska (2001) offers a theory of gender casting and
gender inclusion to understand the ways in which different genders legitimize their dominance in medical specialties through narrative strategies. Her analysis is based on ethnographic work with women pathologists in the USA. Pathology is perceived by the outsiders as a type of dirty work, “there is a notion that it’s somehow macabre and sick and bewildering” (Riska 2001), and therefore it is associated with a male specialty, similar to surgery or orthopedics. In spite of that, increasing number of women in the USA chooses this specialty. In 1998, as many as 45% of pathologists were women. Riska argues that women pathologists construct “medical lore” whereby they portray themselves as more suitable then men for modern work in pathology. Unlike common perception that pathology is all about dissections, real work involves mostly microscopic analysis of tissue. Women in Riska’s research claim that they possess “a sense of thoroughness, order, and detail, they are handy and diligent,” in contrast to men. Instead of being victimized, these doctors use essentialist notions of gender to excel in this field. In addition to gender inclusion strategy, women in pathology contribute to increasing women’s status through gender casting, that is “assigning certain tasks… that are a priori considered to belong to women…such as dissection of tissue samples taken from children and embryos” (Riska 2001). These concepts are useful to ponder the empowerment strategies that both genders use in Ukrainian biomedicine.

V. “Beautiful” medicine.

Valentyna is a female plastic surgeon that has recently quit her state job to start private practice. Her story of her pursuit of a neurosurgery unit position unveils some of the structural barriers in the biomedical field:
At the time, Professor Pavlenko was the main neurosurgeon in our hospital. He was really a physician from God\textsuperscript{xvi}. He could operate on anything. He could make uterus extirpation or skull trepanation – anything and everything. The professor was hard of hearing, and he was very blatant and loud. It was his character. I worked with him sometimes, and he would yell at me in the process. Still, I continued working and I used to tell him that I was going to transfer from my unit to his. I really wanted to be a neurosurgeon. He told me that he could not stand women in medicine, and especially not in neurosurgery. Though he said that if I insisted, he would give me a five-year trial period when I would just be holding the hooks (and not operating myself). I told him that I did not mind that. Any good surgeon must go through these pains, especially in neurosurgery. Then he told me, “OK. I agree. But you will be responsible for all of our paperwork and administrative tasks.” I did not like that. There was something in his tone.

This turn of her career reveals a very significant aspect of gendered experiences in the biomedical profession, that of a “beautiful” surgery. Valentyna ended up refusing the coveted position in neurosurgery, and decided to join a burn unit instead. She explains how she had received a call from the head of the burn unit, asking her to join their team. It takes her a while to make up her mind. She wanted neurosurgery, but she hated the tone of Professor Pavlenko. She was offended by him. She decided to follow her intuition and asked the head physician for advice, who told her, “If you insist on being a surgeon, then at least pick a beautiful surgery! As a neurosurgeon, you will have no other life, you absolutely have to throw everything else out of your head. The entire region will be your responsibility, and when you are on call, you may have to rush to see patients at any time of the day. There is no comparison. Any blunt head trauma in our town is yours. You just have to pick up and leave, and maybe operate right there on the spot in horrible conditions. This is how it is.” Finally, Valentyna took the burn unit position where she has worked for many years. Here is what she has to say about what exactly “beautiful” surgery means:

Private doctor’s offices, plastic surgery. Everybody knows that plastic surgeons are extraordinarily rich. Private dentist’s offices, gynecology. These are both
prestigious and beautiful specialties… If a woman works in intensive care, which would also be true for me, she should not work there more than 4-5 years. This is according to general statistics. Because this is a difficult, nerve-wrecking and dangerous job… For a woman, if she wants to be a surgeon, there are plenty of beautiful specialties. Ophthalmology, for example, is also a beautiful specialty. You can help people, feel good, and know that you are useful. You can achieve a lot.

Though my respondents are clear that women are not afraid to get down and dirty with truly difficult medical tasks, like Valentyna, they also suggest that medicine is a particularly beautiful work for women. Their narratives portray an ideal woman physician as someone immaculately clean, wearing a white starched doctor’s uniform and hat, intelligent, inquisitive, patient, and serious. Two metaphors represent these narratives most accurately: beautiful and clean. I understand this metaphor in two main respects.

First, the pursuit of healing that brings balance, harmony, cleanliness and beauty appears to be associated with female sphere, going back centuries in Ukrainian history. The most appropriate jobs for women in biomedicine are exactly the ones that have been described to me as beautiful: highly specialized medical fields (cardiology, neurology, pediatrics, general practice, endocrinology, etc.), or beautiful types of surgery – plastic surgery, ophthalmology, otolaryngology, aesthetic dentistry, pediatric surgery, obstetrics and gynecology. In this conceptualization of purity and beauty in medicine as the most attractive for women, we witness a connection to traditional visions of women as beautiful and wholesome, and also as those that bring about beauty and harmony into the world.

Phillips (2004) contributes to anthropological understanding of this phenomenon with her discussion of the medical practices of Ukrainian babky sheptukhy [Ukr. бабки-шептухи] – elderly women who possess traditional knowledge and skills to perform
healing rituals imbued with religious symbolism. Contemporary women physicians may feel comfortable in their healing roles, since historically women have always been associated with healing qualities in Ukrainian culture. Prior to professionalization of biomedicine in the 19th c., women have been responsible for providing healthcare and have been viewed as possessing medical talents. This has also been true for healthcare outside of the biomedical institutions for all of the Ukrainian history, including Soviet times. The Soviet government strictly prohibited religion as well as alternative systems of medical knowledge, since they were viewed as hideous remnants of false consciousness that drew people away from the productive construction of socialism. Babky provided their services in secret. Women therefore were leaders in healing roles in the official biomedical realm, as well as the unofficial realm of alternative medicine. In contemporary Ukraine, babky are once again becoming a socially acceptable means of dealing with health problems. Phillips argues that this return to non-medicalized ways of healing in part reflects the country’s general trend towards a revitalization of spirituality. In this sense, the concept of healing acquires a double meaning: the direct notion of improving one’s health condition, and figurative meaning of healing the Ukrainian society. “In today’s trying times … Ukrainian babky carry out gendered performances that accord them a measure of prestige and power; complement and replace the system of state medicine; act as psychotherapists; and specialize in psychosocial ailments to simultaneously heal persons and communities” (Phillips 2004:25-26). Healing is therefore a part of traditional understanding of harmony and beauty associated with the female sphere.
Second, beautiful and clean specialties are also associated with private healthcare and burgeoning fields in biomedicine, such as assisted reproductive technologies, MRIs and other advanced diagnostic technologies, laser cosmetology, trichology, aesthetic dentistry, and many more. Riska (2008) and Zetka (2003) argue that new biomedical technologies now require new skills, more specifically "artistic eyes" rather than "good hands." These new skills are popularly conceptualized as skills where females have an edge. As I mentioned earlier, in Ukrainian cultural logic, male physicians are perceived as more physical and primordial, good at applied tasks, such as surgery or orthopedics, and women are viewed as more detail-oriented, thorough and analytical. Women are also understood as good at creative, artistic types of medical work, and those linked to children’s and women’s care. It is therefore not surprising to see women taking dominant hand in these new biomedical fields. While savoring their femininity and ability to practice what was not allowed or accessible in the socialist Ukraine, women today are also attracted to the Western conception of empowerment and individualism. In the new biomedical fields, women have an opportunity to combine their interests in new European-oriented practices, and also root them in Ukrainian traditions. Their image to some extent is comparable to what I described in regard to the ex-Prime Minister Yulia Tymoshenko. It is the amalgamation of what is now viewed as progressive and Western rather than colonial Soviet, and at the same time feminine and traditional.

In this aspect, we see the association of beauty with prestige and desirability that comes with new market and global circulation of ideas. The Western conception of empowerment and individualism, brought about by the open market ideology, is becoming increasingly popular in people’s imagination. The image of a successful
business woman is quite popular. Perhaps, not accidentally I found that many product managers in the pharmaceutical business in Ukraine are former female doctors. The pharmaceutical industry in general is full of women who are earning incomes higher than that of an average physician in a state facility. Beauty emerges as a complex concept that is imbued with traditionalist understanding of women as healers, as well as envisioning women as particularly apt in learning new technologies and sophisticated treatment methods. An important pre-requisite for beauty, in this cultural logic, is cleanliness. Thus, many women are attracted to non-life threatening, not excessively bloody specialties, which allow them to perform highly detail-oriented and intellectual tasks, at the same time maintaining clean hands, meticulously starched uniforms, and spotless dispositions. Women perform culturally appropriate healing roles and at the same time champion their cleanliness, beauty and femininity.

I trace ideas about beautiful specialties to gender discourses that emphasize a woman as both Berehynia or the carrier of national traditions, and at the same time as a cosmopolitan woman empowered financially and professionally.

VI. Debunking essentialist notions of gender. “Бабы, вперед на баррикады!” [Girls, to the barricades!]

Although this understanding of women as intellectuals and men as physical workers in biomedicine does complicate simplistic explanations of women’s position in non-surgical fields as marginalized professionally, it is nevertheless important to analyze their narratives for evidence of conflicts or structural barriers. Essentialist conceptualizations do not go unchallenged. Quite a few respondents, both male and
female, dismissed gender-based explanatory models, and acknowledged the social construction of gender division by specialty. They recounted many instances of women successfully working in traditionally male fields. Structural barriers came to the forefront in these narratives, such examples include the absence of female role models in surgery, trauma units and orthopedics, privileging male students for surgical tracks in medical schools and residency programs, as well as continuous need for women in these specialties to prove their worth in male teams. Slava, introduced a few paragraphs ago, recollects the gendered aspects of her training in the medical school:

So, right from the start (when I was going through the entrance exams) I knew that a surgical specialty is not for me because I am a woman. I knew that before I even got to school, I had this mindset…. In med school, surgery professors were all men and they did not take girls (female students) seriously. They required a lot from the boys, but not us. If girls did not know something, the professors usually let it slide. Since they would know that were not targeting surgical positions. We are programmed this way from the very start.

Several other women who work in surgical fields have commented on structural barriers that make their work difficult and discouraging. They suggest that they have to continuously prove themselves as surgeons while male surgeons do not need to, since their colleagues perceive men as a more natural fit in specialty. They have to work harder for fear of being labeled as incompetent, and they are allowed no room for mistakes. Yet, if they manage to convince their colleagues that they are the right persons for the job, they are taken seriously, and they do not need to masculinize in order to do that. Lilia, a surgical nurse in a major neurosurgery clinic, knows many surgeons, both men and women, through her professional work. She shared with me this story of continuous effort by female surgeons in her hospital:

People don’t like female surgeons, men don’t like them for sure. They (female surgeons) have to hear a lot of sneers and gibes. I think only the most persistent
women survive here… Nadiya Myroslavivna is a professor and a famous person in our circles. But as far as I can tell, she has to prove herself all the time, which men do not need to do. At the same time, she has an edge over them because she has not lost her empathy and touch… There are definitely women who are very talented surgeons. When I think about Nadia Myroslavivna, for example, I can only think of good things to say. Because she is always smiling, and sincere (she is a pediatric neurosurgeon). In spite of her high status and her professor position, she still has to fight men, I think. Literally. I think it is difficult for her.

Natalia is a female surgeon in her early 30s who has recently quit her job for a career in journalism (something not uncommon for prerevolutionary medical doctors in the Russian Empire of which Eastern Ukraine has been a part). She is interesting, since she is the only respondent out of over 150 people who identified herself as a feminist. Her story reflects multiple conflicts culminating in giving up her profession. Yet, I would not call Natalia’s story a story of defeat. She feels empowered by her experiences, does well financially, owns an apartment in prestigious part of Kyiv, and drives a car. Natalia was drawn into medicine by her grandmother’s striking career as a military surgeon followed by years of post-war surgical practice in Kyiv. Natalia spent her childhood with her grandmother, and had always known that she was going to be a surgeon one day. Natalia went through years of tutoring in preparation for medical school, and successfully completed it with a red diploma (the Ukrainian equivalent of 4.0 GPA). She married a fellow student. Residency decisions in Ukrainian medical schools are a highly personalized matter, and there is no clear system of application and evaluation of candidates based on merit. Instead, students must locate personal contacts through which to secure their residency. If they are not successful, the medical school will locate a position. However, these positions are usually highly undesirable (rural locations, policlinic consultations as opposed to active operating career, etc.) In Natalia’s case, the medical school told her and her husband to choose which one of them would
take a surgical residency position in a good clinic, and which one would go to the
policlinic consultation (where only minor surgical procedures are carried out). Natalia’s
husband took the better job. Their marriage ended in divorce soon after. According to
Natalia, her ex-husband’s professional career is currently in dire straits due to a fatal
mistake that he made during an operation. She takes this case as a testament to the
inefficiency of the system and as an example of bad decision making by the medical
school. Natalia worked in the policlinic for a while, and managed to transfer into one of
the city hospitals. As a younger surgeon, she did not mind getting the “worst” patients
(“undesirables,” like homeless and elderly – those who cannot pay anything extra for the
services rendered). She wanted experience. One time, changing in the common locker
room (since there were no separate locker rooms for men and women surgeons in her
hospital), her colleague made an unwanted advance. Natalia broke his nose. Eventually,
Natalia grew resentful of her situation. She took on a second job writing for one of the
pharmaceutical companies in Kyiv and began teaching leadership training. Soon, she
made enough money to buy her own car. She finally decided to quit her surgical career,
since she felt that without connections she was not able to go further professionally.
Natalia’s story emphasizes the ways in which male surgeons have taken advantage of her
vulnerable position as a new employee. The most significant disadvantage for her was not
the sexual harassment incident, but the inability to get “good” patients who would pay
informally. In Ukraine, not having additional income as a surgeon means living on less
than 200USD per month, a task that is very difficult in the capital. Natalia, however, does
not regret her choice. She feels that this experience of an unfulfilled biomedical career
has opened new doors for her. She feels accomplished in her teaching leadership career.
Her narrative illuminates the structural barriers that women face in surgery combined
with the difficulty of negotiating gender expectations and stereotypes.

Yet, my respondents rationalize this gender-casting in surgery not just as driven
by the desire of male physicians to hoard the financial resources available in this
specialty, but also as what Cassell (2000) called embodied, gut-level protection of their
territory. Similarly, many female physicians were protective of medical specialties where
they traditionally enjoyed dominance, such as pediatrics, and were suspicious of male
doctors venturing into their field. Harden (2001) reports similarly essentialist
understanding of the gendered division of labor in the Russian biomedical profession.
After years of fieldwork among American surgeons, Cassell came to understand that
simple gendered categories are not sufficient, and she offers to supplement the concept of
“doing gender” (West & Zimmerman 1987) with the notion of “embodiment” drawing
from the work of Bourdieu on habitus (Cassell 2002:259). She understands habitus as “a
set of structuring principles and common schemes of perception and conception that
generate practices and representations. These principles are embodied through repetition
and enactment” (Cassell 1996:43). Habitus is a permanent embodiment of the manner of
speaking, thinking, feeling that comes to be through the process of practice, habit, tied to
particular body of a person. In Bourdieu’s words, “the ultimate values, as they are called,
are never anything other than the primary primitive dispositions of the body, “visceral”
tastes and distastes, in which the group’s most vital interests are embedded…”
(1984:474-475). Cassell argues that women surgeons appear to their colleagues and
outsiders to have “a wrong body in the wrong place” (1996:45). Negative reaction to such
woman whose body appears to be in the wrong dress of a surgeon instead of expected
nurse is not a simple discriminatory action, it is rather an embodied reaction, the one that comes to be through habitus (1996:45). Cassell offers a concept of “dialectic of difference” as a theoretical tool based on Bourdieu’s concept of habitus that does not replace the notions of “doing and negotiating gender,” neo-Marxist perspectives that foreground struggle for scarce economic resources, or Foucauldian investigation of power relationships, but to contribute to these approaches through “more flexible, sensitive, and powerful dialectic of difference” (1996: 49). In her placing the body of a woman surgeon into the research focus, Cassell responds to Lock’s plea of more “anthropology of the body per se” (1993). She joins a group of scholars that “situate body as a product of specific social, cultural, and historical contexts; who have engaged in the nature/culture or mind/body debates…or who have grappled with the poetics and politics of the production and reproduction of bodies” (Lock 1993). Her contribution, in my view, is in pointing out the middle ground in some of the dichotomies described by Lock (1993) that anthropology has been dealing with for a long time, such as nature/culture, and mind/body. Cassell’s embodiment theory gives us analytical tools to weave a larger story from women’s and men’s accounts that often essentializes the roles of men and women. Her approach allows us to see that while men and women may be perfectly convinced on a conscious level that gender is a socially constructed category, they may still have certain deeply set expectations and reactions to various gendered situations.

Female physicians in particular sometimes challenged the view that surgery was not suitable for them due to exhausting and unpredictable work schedules and the need for masculine “firm hand.” Women constitute the majority of emergency service doctors and intensive care unit internists (called “reanimatologists” in Ukraine), as well as
surgical nurses and other assistant medical staff regularly working unpredictable hours in an intensely charged atmosphere – so my female respondents wondered if they were actually the ones doing really hard work in Ukrainian healthcare. This reminds me of an encounter that I observed during one of the night shifts in a city emergency hospital. I was interviewing a young female neurologist when she was called to one of the exam rooms to see a patient with spiking blood pressure whom the emergency brigade had just brought in. When we walked into the room, I saw three women sitting around the desk. One of them was obviously a general practitioner on duty – a vibrant woman in her 50s wearing a white uniform and a starched hat (standard form of dress for Ukrainian physicians). Another person was a young nurse, jotting down notes on the medical record that the physician was dictating to her. It appeared to me that the third woman was the patient who was being examined. She was wearing a blue jacket and pants, slumped on a chair and resting her head on her arm. She looked exhausted, quietly listing symptoms to the nurse. I heard her say “headache and dizziness.” To me, it seemed to describe the way she looked just about right. To my amazement, the neurosurgeon whom I was accompanying soon announced that this actually was the emergency brigade doctor, and the patient that she had brought in for hospitalization was in a different exam room. This tired woman doctor stands in my mind as a colorful example of the medical specialty that could have been considered too difficult for women, just like surgery, but for some reason is not. Most women in emergency service in Ukraine are women, working night shifts, lifting patients to put them on stretchers, entering dark buildings at night, and driving into the dark in the middle of the night. The conditions of their work are quite dire, and they do not have expensive technology that would ease this labor. Popular press
has recently publicized the car crash of Natalia Mohylevska – a popular Ukrainian singer.

When the emergency brigade came to her rescue, the singer was so shocked with the condition of the emergency car that she donated a spanking new auto to the city emergency service upon her hospital discharge. More details about the work of emergency doctors come through in Liudmyla’s account. This female emergency physician in her late 40s tells me about her work:

I love my job, but it literally has made me ill. Our emergency cars are the worst. Currently, I suffer from myeloele in two spinal disks. But despite this disability I continue working. I did try something different at one point, I worked in the dispatching unit – but it was not for me. A dispatcher is not truly a medical professional. All I did was phone consultations. But this live communication with people, this real help, what you see with your eyes – this is what is the most interesting in the medical field. But emergency work is very hard, especially for women. Emergency work is not for women… I don’t know, 70% or so, majority of us are women, this is for sure. In general, we have far fewer men in healthcare. Even among medical students. Mainly girls go to med schools… Emergency work is difficult exactly in this physical sense, that’s why I say it is not for women. Even if we were paid well, it would be hard regardless. Maybe, if we got better emergency cars, like Volkswagen or Mercedes, it would be different. Right now we have a Gazelle (a former Soviet model vehicle, now produced in Russia), and when you are driving you feel like a bag of potatoes tossed all over the place. Imagine when we have a patient with cardio infarct! This is the reverse side of the medal, so even if I got 5,000 hryvnia (a little over 600USD, as compared to current salary under 200USD) – it would be a difficult job.

Liudmyla’s narrative emphasizes the incongruence of considering surgery too difficult for women, but at the same time having the majority of women in emergency medicine. Interview data suggest that flexible work hours in emergency service may be one of the more attractive sides of this specialty as opposed to surgery. Since women’s priorities are supposed to be with their families, emergency work seems more accommodating: emergency physicians work a twenty-four hour shift followed by two full days off. This schedule is also helpful if a physician seeks second job, for instance, as a pharmaceutical representative, which is very popular in among Ukrainian doctors. An
emergency service job is therefore advantageous in terms of flexibility. However, it is definitely less financially rewarding than good positions in surgery. While women’s work in emergency medicine certainly debunks the stereotype of women as the gentle and fair sex, it nevertheless highlights structural barriers that women without significant connections face in the biomedical field. Lucrative positions in surgery are indeed occupied mainly by men. The ethnographic evidence suggests, however, that the main reason for this disadvantage is not physicians’ gender alone, but rather a combination of gender and social capital. The overwhelming majority of my respondents argue that good connections and money will open doors regardless of the person’s gender. I also had plenty of narratives from men who were not able to establish themselves in the surgical field despite their red diplomas and great talents, disadvantaged by their lack of connections. While gender roles played their part, for my respondents at least, their social position and connections were determining factors in the types of biomedical positions they were able to pursue. This ethnographic evidence brings us to an argument for intersectionality (Abu-Lughod 1993, Behar 1993, Butler 1993, Lamphere et al. 1997, Narayan 1993, Rosaldo 1980). Intersectionality appears to be the most viable approach, since it acknowledges that gender is not only an inextricable part of identity that influences social relations and plays a defining role in equality and civil rights histories, but that gender interacts with other significant factors, such as race, class, ethnicity, sexuality, disability, to produce differing degrees of privilege and experiences of oppression. In my ethnographic scenario, social capital was very significant in determining physicians’ careers in biomedicine.
Phillips (2005) argues that in post-socialist societies, women often take on activist roles in welfare fields, seeing that only by taking it upon themselves will any significant results be achieved. Similarly, my female respondents cited numerous instances of women as the ones getting the job done. As one of my respondents put it, “Бабы, вперед на баррикады!” [Girls, to the barricades!], underscoring women’s leadership roles in resolving some of the most difficult social issues. One of the most talked about women in a policlinic that I often visited during fieldwork is an example of one such woman-leader. This female surgeon, whom her colleagues refer to by her last name Temkina, is nearing 70 years old. She works double shifts, supports her retired husband, her daughter and her daughter’s spouse who reside with them in the same apartment in Kyiv, and three cats. Her colleagues admire her as someone who is able to find time in her busy schedule for everything, including being solely responsible for cooking all the meals for her household. In the same vein, when the Ukrainian first lady Kateryna Yuschenko raised money for a neonatal intensive care at my secondary field site, my female respondents were quick to point out that this woman was able to achieve more in a few months than “our beer-bellied officials” have in their life-time. This central position of women in tackling pressing issues has been questioned by Mohanty (2002), who is unsure whether this type of leadership points to empowerment or disadvantage. She argues that since women are central in the lives of their neighborhoods and communities, they often take on leadership roles in this sphere, which highlights gender as a “productive and necessary avenue of theorizing and enacting anticapitalist resistance” (Mohanty 2002:515). For her, this leadership may be productive in women’s lives, but it reflects women’s marginalized social position overall. Consistent with her understanding of historical materialism,
Mohanty argues that the capitalist economy is a form of colonization that is especially detrimental to women. Thus, in post-socialist spheres where the state retreats and the social welfare net breaks (Dunn 2008, Phillips in press), it is women who pick up the pieces. Even though they may feel empowered by doing this meaningful work, many scholars believe that this empowerment nevertheless stems from marginalization. A research focus on women is therefore very valuable to expose various forms of subjugation (not only by gender, but more importantly by social position and class) in women’s and men’s lives.

Above, I have outlined the ways in which women take on leadership roles in places where state support retreats is one of the ways in which people challenge gender division by specialty. Another way in which physicians confront gender stereotypes in biomedicine is through direct debunking of dichotomous understanding of gender roles. Here is what one of my informants, Yaroslav, has to say in this regard. Yaroslav is a well-established psychiatrist in a smaller town. He bears no illusions about the social construction of gender, though he connects it to Soviet experiences as opposed to the longer social history of gender categories:

I think that these fairytales about male and female psychology may play a small role in the way that physicians practice medicine, but more likely this is just an excuse and a way of getting out of responsibility. These explanations are just justifications for weaknesses. When it comes to it, all (both genders) can beautifully handle any situation. Both men and women are perfectly successful when they need to be. I believe that these are old systemic Soviet insecurities, and we carry them inside. It is time to get away from them!

Anastasiia is a pediatrician working two jobs, and a grandmother of two. She recollects her daughter’s recent birthing experiences in one of the capital’s hospitals, questioning essentialist explanations of gender:
Everything depends on an individual. Olia gave birth in one of Kyiv’s hospitals twice. It is a progressive clinic that allows a birth partner – her husband. Her doctor was a woman – the most unpleasant person. However, she is a real professional – she is the Mom of my daughter’s friend. She has this firm masculine character. We paid her ahead of time, and we were very pleased. For example, she kicked out medical students who wanted to observe Olia’s delivery. So, I think everything depends on the person. When Olia was deciding on her obstetrician, one physician that she saw was a man. He was soft and kind, gently helped her with everything, but when she asked if he would allow birthing with a partner, he said, gently, “why do you need a partner?!” It all depends. A man can easily be a pediatrician, and a woman can be a surgeon. Max, my grandson, for example, has a male pediatrician – an excellent elderly doctor of the highest caliber!

In Anastasia’s story, the male physician displays a character more commonly associated with women, while the female obstetrician acts like a man. For Anastasiia, this demonstrates little utility of gender categories as potentially shaping factors in biomedicine.

Despite the significance of these structural barriers or essentialist rationalizations, my respondents far more often explained gender division by specialty by the role of family in women’s lives as compared to men’s lives. I agree with feminist scholars in their argument that physicians are a self-interested group, like any other profession. However, my ethnographic evidence testifies that while both women and men are well aware of structural barriers surrounding their work, they still argue that other considerations, rooted in history and culture of Ukraine and new ideologies travelling through the globe, influence their biomedical careers in more profound and significant ways than material desire to control certain resources. Following Ghodsee (2010) and Mahmood (2001), I argue that when women speak, anthropologists ought to listen without imposing their political activist agenda. If a woman does not feel that her agency is blocked, should we argue that it is? I believe my task is to voice my respondents’ ideas,
while at the same time weaving them into a larger picture. The next section develops this discussion of the significance of family in biomedical professional considerations.

VII. Biomedicine and families.

Andriy is a pediatric intensive care specialist and an anesthesiologist in a prestigious children’s hospital in Kyiv. He is middle-aged, introverted, and systematic in the ways he carries out conversation with me and communicates with other hospital staff. I talked to him during his night shift in the hospital, since during the daytime Andriy works for three different units in the hospital and does not have even a minute to spare. Andriy regularly works with surgeons during operations. He has no qualms about most of them being men, but he tosses essentialist categories out the window, explaining this division of labor by the social roles that men and women play outside of their profession. He does not think that women are a fair sex or incapable of doing surgical work. Instead, he suggests, women are too busy outside of their professional life with familial obligations to be able to devote themselves to a time-consuming specialty like surgery. This job requires frequent night shifts and unpredictable hours, which does not mix well if children are involved. Here is what Andriy has to say:

The issue is not in innate qualities or abilities. Women are more familial than men, and usually want to spend more time with their family. Now, surgeons give a lot of their time and effort to their work. It is simply more difficult for women to do what is necessary in order to be a good surgeon… In general, the medical field today is unisex. There is not much difference between women and men. As a matter of fact, women can work much better than men due to their brains and strong character. Everything depends on a person and his circumstances.

Plastic surgeon Valentyna whom you have met previously, is a mother. She shares some of her memories about surgery work and its relationship to mothering:
In neurosurgery or thoracic surgery, the minute you pick up a needle – you can get anything: like shock or a blood pressure spike. You must figure out the way to fix it, and you are watching him (the patient) die in front of your eyes. And after this, you come home and you don’t want anything: neither your husband, nor your kids, nor money. You see, it is on a different level. Emptiness. And if you have children patients (I sometimes did), it is like you are in a stupor. I could not do anything when I would get home. All I was doing is thinking about him (the child patient) and hoping only that he lives till you get back to work tomorrow. It is very difficult. That is why I think: Why would one want to go into surgery if one could become an internist, a dermatologist, or cosmetologist? For example, in our town there is no good trichologist (specialist in hair health), there is so much there to explore. One just needs to get into it and there is a lot of money to make in this field (trichology). You can help people, be rich – all you have to do is work!

For Valentyna, the emotional burdens associated with intensive care and the surgical field are disproportional to the rewards that the physician is able to derive from it. Although she is extremely successful in the surgical field, Valentyna does not recommend this specialty for women due to the toll that the job takes on the physician’s own family. My interviews do not show significant age difference among respondents who share this view. Yul’ia, a young female physician in her early 30s, agrees with Valentyna and Andriy:

Surgical fields require complete devotion. And if you have a family, it is not possible to combine both of them to a full extent. It is one thing to jump off the bed in the middle of the night and run to the hospital if you are on call and you are single. It is a completely different thing if you have a family. All household affairs are on women’s shoulders. If a woman is up all night in the surgery room, and then has a house to keep… That’s why we all must choose where to put our energies – at work, or at home. Personally, I would certainly choose family. It depends on your priorities. That’s why there are fewer women in this specialty. And since this has been going on for years, surgical teams are mostly male, and a woman will have a hard time there. They have their own nuances, so a woman will not have a hard time, but she will also feel uncomfortable.

The concept “due to family circumstances” [Rus. по семейным обстоятельствам] (which can be loosely translated as “family comes first”) emerges as a guiding principle for most of my female respondents. This cultural concept is a metaphor
that captures local gender norms. Female physicians often shape their careers and daily schedules in order to attend to their families. This is true for older and younger physicians. Angela has worked as a district pediatrician for over seven years. She is in her late 30s, and she is contemplating moving from this position to a research institute where she would get back into clinical research rather than practice. She says it is now possible because her daughter is now in middle school. Angela says:

It is a little easier to be a district pediatrician, because we have a flexible schedule. Sometimes we can make it an early day, or we can carve out some free time during the day. So, this job is good, for example, for a mother who is raising her child. She can stop by the school, pick up the child and take her home, feed her, check her homework, and then go back to work. However this job is not helpful for professional growth or even for physician’s self-improvement. There are few if any interesting cases, like emergency specialists have, for example. It is routine: paperwork, medical histories, reports, statistics, and endless updates. These (district pediatricians) are the people who are constantly submerged in their paperwork and reports.

The focus on motherhood comes through clearly in Angela’s account. More specifically, my female respondents emphasize their primary focus on children, as opposed to a husband. Motherhood is taken to mean more than womanhood overall. Thus, a woman is seen as first and foremost as a mother, and secondarily as a wife or a professional. Vira, who is a very accomplished pediatric oncologist in a large research institution, has a son who is about 12 years old. Her office is full of his pictures. She does not talk about him, but when I ask about the boy, she gives me her take on motherhood and biomedical work:

I remember when I was free. I could just get on a plane and go wherever I wanted. But when you have a family and a child, you know very clearly that you are not going anywhere. Because first of all you think about your child. I tell my medical students who are getting close to their graduation and residency to act on all their dreams early before they have children. Because when you have children, everything else fades away. This is dominant for any woman…When women approach me with a request to advise their work towards doctoral candidacy, I
always ask them whether they have children. If they say yes, I ask about the age. If they tell me that the baby is younger than one year old, I tell them to wait a little. Wait till your child grows up a little, and then write your dissertation. For now, you belong to your child. And when you are writing, you must belong to the school, to our department. Your head must be absolutely free of other worries. And any mother will first of all think about her baby, and she will hurry home from work if her baby is too small. If a baby-sitter calls and says that the baby has sneezed, and this is enough for the mom to drop everything and run home, while she has to be thinking about patients, statistics, and literature review. As an adviser, I will not work with such students.

Without realizing how limiting her approach may be for young women who are mothers, Vira has decades of experience to argue that the majority of female students in such a situation will indeed always prioritize their child over studies. Because the choice of adviser and dissertation committee is a personalized process like everything else in Ukrainian biomedicine, there are no strict rules in place that would defend mothers’ rights in pursuing their education. Significantly, my informants did not only prioritize children over their husbands, but they also sometimes portrayed their husbands as yet another chore to take care of as opposed to partners. Lilia, who is a surgical nurse in neurosurgery institute, tells me that it is women who have families, not men. Men remain perpetually single regardless of their marital status due to their small input into daily routine in the house:

If you think about it, women have families on top of everything else, house, and husband. For men – they can just come home from work and rest on the sofa in front of TV or work on research. So, for women it is more difficult.

These accounts are testaments to motherhood as an informing agent for women physicians, as well as the ongoing double-burden for female professionals. Women’s choices are often shaped by family considerations, including the choice of the biomedical profession itself. While familial obligations associated with gender roles impede many women’s entrance into surgical and intensive care fields, the same familial obligations
may usher women into the medical field in general. In the most mundane and immediate respect, the professional knowledge of female physicians applies first and foremost to their own families. Because personalization has such a great significance in post-socialist medicine (Rivkin-Fish 2005), people often believe that it is beneficial to have at least one physician in the family. This was also the case in the Soviet Union where one could not rely on money alone in achieving one’s desired goals. A “designated physician” (author’s term) has become a liaison between the institutionalized and hard to navigate healthcare system and the kin network. For women, biomedical work allows maintaining a meaningful professional identity. In addition, it allows many of them to pursue their loyalties at home, which corresponds perfectly to local cultural logic. In this respect, work as a physician boosts not only women’s professional sense of belonging, but also familial associations. Morantz-Sanchez (1985, 2001) offers a theory of “professionalization of womanhood,” according to which female doctors openly embrace essentialist notions of womanhood in order to establish themselves in biomedicine as natural healers and in this way create pathways into the medical profession. This perspective has clear parallels with Riska’s (2001) gender casting model. Ukrainian women use this strategy in part to discursively position themselves as more capable in certain specialties, such as pediatrics. Yet, this process is somewhat reversed in Ukrainian scenario, whereby women enter the biomedical profession with an idea in mind that it will then be useful for their families. On some level, they professionalize in order to pursue womanhood and motherhood in a more efficient way.
VIII. Coefficient of propitious time [Rus. Коэффициент полезного времени].

In Ukraine as well as in other post-socialist societies, healthcare can offer lucrative income, however money-making as well as earning prestige in the biomedical profession requires significant investment of time and personal effort. Western medical school graduates can count on a lucrative position and high social status upon successfully completing their studies. There is a certain ascribed status to the biomedical profession, the link between cultural capital and economic capital is clear cut (Bourdieu 1984). In post-socialist Ukraine, however, there is no direct link between successful biomedical education and income. There is no universal prestige offered by the biomedical profession in the post-socialist context; instead each physician needs to actively negotiate it through her or his everyday practices. Since it takes a long time and great effort to launch a career and start making money in biomedicine, not everyone has the resources and networks sufficient to support this professional choice. Since income strategies are currently so personalized and are embedded to a large extent in informal networks, physicians must be prepared to spend a significant number of years to gain the necessary experience and contacts and to insert themselves plausibly into the professional scene. Women appear to be particularly well suited to be a physician in the post-socialist context. There is less social pressure on women to make money and support a family financially. Quite the opposite, women are expected to invest their loyalties in their children and families. Undertaking a medical career endows women with useful skills and knowledge for nurturing their families and making little income for the first eight to ten years does not seem as detrimental as it would be for men. Though they are not making much money at first, women can still feel accomplished by working for the future
and building their family. As Collier noted (Lamphere, Rapp, Rubin 2007), women, in this sense, can be understood as strategists, or “the worms inside the patrilineal apple,” because they do political work strategizing and trying to get power in places where they do not immediately have it.

Men are under immense cultural pressure to be the main providers in their families, and when a young man must choose his future profession, he will usually search for a path that would allow him to reach a short-term, clearly visible set of goals to satisfy the most immediate needs of the family. Women can afford to accept more uncertainty and less definable material benefits in their profession, because of local gender norms. Practicing biomedicine in a post-socialist context emerges as a luxury one must be able to afford. This job is not for everyone, and while men well plugged in to the biomedical networks can pursue this path, it is often easier for women to invest years for future success at the sacrifice of initial income. I borrow the term “coefficient of propitious time” from Halyna, a female physician who has moved from her work in the tuberculosis clinic to an insurance company, and then WHO office in Kyiv, to capture this gendered phenomenon of entry into the medical profession. Coefficient of propitious time is a term borrowed from physics that signifies a relationship between overall length of life of an engine and time that the engine is actually able to operate in the production process after the time for maintenance and repair has been deducted. In the simplest terms, the coefficient of propitious time indicates the length of time that a certain device is able to function in economically efficient way, i.e. producing profits. In the biomedical profession, physicians are able to achieve the coefficient of propitious time significantly later than in other professions, such as business, banking, or IT. They first have to invest
significant time into developing skills and networks, before they can get a return on them. In addition, there is no guarantee that their investments will reap significant returns. This job is not for those who are looking to make decent money quickly upon graduation. It is therefore harder for men to dedicate themselves to this expected stage of relative poverty and inability to meet the designated gender role of a breadwinner. For some women physicians it is just as essential that their husbands are able to make good incomes, even if they themselves are prospering at work and the family is not lacking for anything.

Quite a few of my female respondents who would otherwise appear to be emancipated, working in leadership positions in the biomedical field, and making good money – long for “strong men” (respondents’ term). They criticize their husbands or male colleagues who do not make sufficient effort to engage in money-making activities of all sorts. A lazy man is viewed as abominable. Kay (2006) has recently discussed the claims of emasculation of men during socialism and the intensification of these claims in post-socialist times. It has been argued that men have been emasculated by the Soviet state, unable to practice traditional gender roles of patriarchs in control of their households, since state repossessed this role (Gal and Kligman 2000). In post-socialist crisis, popular opinion concurs, men became increasingly weak, “it is as if the degeneration of a nation can best be typified by the image of the self-pitying drunk men, defeated by circumstance, spiraling into an early grave” (Kay 2006). For several of my married respondents, achievement of income higher than their husbands (in some instances, exceeding it six times and more if a woman was employed in pharmaceutical industry) has eventually led to divorce. While more than money alone is likely the cause, income-generating activities of men are certainly in the spotlight.
Olena is a very successful obstetrician-gynecologist and a medical researcher in the cutting-edge field of the assisted reproductive technologies. She runs a private clinic in one of the urban medical centers, teaches classes in the medical school and also heads a unit in a state hospital. She juggles an amazing career and a family, all the while pointing at motherhood as her primary responsibility. Since Ukraine has some of the lowest fertility rates in the world (1.2 in 2005, Parelli-Harris), it is difficult to see evidence for women retreating into domesticity. For Olena, women were unable to pursue their private sphere paths to the degree that they might like to, because they had to take it upon themselves to make money and create positive change:

There are now many women in surgical specialties. Perhaps, this is due to urbanization, and women wanting to be independent and more masculine. Perhaps, it is because our men have become weak. Any woman wants to be weak, however we are usually not able to do that due to various circumstances. I do not think that a woman is born and she thinks that now she is going to operate on twenty patients and then still have time to play with her baby at home, meanwhile feeling beside herself with joy. All women want to be at home and work just for their pleasure (rather than money), however this is usually not possible.

Going back to the vision of women in medicine as the actors who roll up their sleeves and get the job done, Olena in part essentializes women without realizing her own position as an incredible role model for future generations of women physicians. In post-socialist context, she says, women usually cannot afford to retreat into private sphere. Instead, they become increasingly active publicly, for the sake of their own families, themselves, and also the broader society, thus challenging essentialist notions of gender. This is what Bohachevsky-Chomiak (1988) called “feminists despite themselves” and what Phillips (2008) observed in NGO leadership in Ukraine. In Ukraine, as well as other post-socialist states, the popular opinion often portrays men as morally weak, unreliable and irresponsible. This popular image stands in stark contrast to scholarship that claims
men as the winners of post-socialist transformations, discussed earlier. I agree with Kay’s (2006) critique of dividing men and women into winners and losers, “where one side’s loss is automatically the other side’s gain and vice versa.” Similarly, Riska and Novelskaite (2008b) find in their study of Lithuanian physicians that women expressed higher commitment to the profession than men, Osinsky and Mueller (2004) report the same for Russia. However, these authors also suggest that female commitment is different than male, since women express “commitment to the traditional ideals of being a physician” while men’s commitment is more about “the instrumental aspects of work… related to their role as the main breadwinner” (Riska and Novelskaite 2008b). My ethnographic evidence does not support this. I find that women are interested in a good income just as men are, however familial considerations are more important to them, which in part makes them more likely candidates for the current biomedical profession. Women do not express a stronger sense of a higher calling or morality than men, but the pragmatics of their lives as mothers and household keepers makes the biomedical profession a good choice.

IX. “Male reproductive cells are more sensitive to stress and unfavorable environments and female cells are more capable of mutation.”

Given the rich ethnographic evidence of post-socialist re-negotiation of values and corresponding shifts in social hierarchies (Ghodsee 2005, Patico 2008, Phillips in press), I argue that prestige in the post-socialist biomedical profession should be understood as a process, and not an automatic endowment commensurable with the medical degree. Prestige quandaries illustrate such social phenomena as formation of new
social contract between physicians and patients, renegotiation of their rights and responsibilities in the context of reorganization of social classes. I have previously stated that women may be currently better positioned to accept more professional uncertainty and take more risks with their jobs due to local gender expectations. Are women better positioned, or are they more willing to accept the uncertainty?

I would like to conclude the ethnographic section of this chapter with this final complication of women’s role in post-socialist biomedicine and their importance in the society as a whole. Referring to male and female roles in the society, the reproductive technologies specialist Olena introduced a few pages back, once shared with me her brilliant observation: “Male reproductive cells are much more sensitive to stress and unfavorable environments and female cells are more capable of mutation.” Olena ingeniously applied her observations from research on assisted reproductive technologies to developments in the Ukrainian society as a whole. Keeping in mind that the origins of gendered responses to change are socially constructed and not biological, I understand Olena’s observation not as biologically reductionist, but as a great metaphor that captures the gist of gendered response to change in the eyes of many Ukrainians. Men are viewed as more rigid and unwilling to adjust and cope with unexpected stressors. Women, on the other hand, seem to be better equipped for change. Similar to female reproductive cells, they are more capable of “mutation,” adjustment to new circumstances and navigation of uncertainty. In the disorderly post-socialist healthcare system, men seem to be unwilling to take on additional burdens that carry only a vague promise of success later in time. Women, however, seem to be better placed or more willing to morph into various shapes and take on superficially less attractive roles and not only survive in them, but thrive.
Using Ghodsee’s (2005) framework of stocks of cultural capital, I argue that women physicians in Ukraine were able to locate routes to invest their education, training, and culturally based motivations and expectations into the biomedical profession. Women physicians appear to be better candidates for physicians’ roles that are focused on clinical expertise as opposed to participation in bureaucracy and politics in contemporary Ukraine, for better or worse. Gender interplays with changing ideologies of social worth or class, and nation building and is reflected in individualized, gendered efforts to deploy cultural and social capital. A concept of respectable femininity (Radhakrishnan 2009) may be useful in capturing women’s participation in Ukrainian biomedicine. Basing her analysis on professional female software specialists in urban India, Radhakrishnan argues that a new type of respectable femininity is constructed through gender and class. This profession allows these professional women to enhance their symbolic capital (culturally authorized middle-classness, in this case) not only as representatives of modern workplaces, but of a new India where the culture of the middle-class family lies at the center. These women signal professional success, but success not for selfish consumption, but family. Ukrainian physicians’ rationalizations of their participation in healthcare similarly position female doctors as icons of respectable femininity. They are performing culturally appropriate healing work in specialties that are considered to be the most suitable and guided by familial considerations. In so doing, they reinforce their moral and cultural authority. Women are also expanding their repertoires by participating in burgeoning new biomedical fields and taking on leadership roles in spheres requiring the most reform. While they are subject to traditionalist understanding of gender, women
physicians employ competing and new gender discourses in order to become the agents of change in the biomedical profession in Ukraine.

I suggest that one of the ways to understand these contradictory discourses circulated by women is through an examination of the differences between Eastern and Western understandings of women’s rights. The next section offers a critical history of Eastern and Western feminisms and suggests links to help understand women’s issues in a post-socialist space.

X. Gender as a category of analysis in Eastern Europe. Theoretical considerations.

For the majority of my respondents, men and women alike, gender was not a salient category for understanding engagement in the medical profession. They would indulge me – a Western-trained anthropologist – and elaborate on some of the gendered aspects of their work. However, they rarely if ever explained any aspects of their work in terms of gender. This, however, does not mean that gender is not a useful category of analysis for post-socialist biomedicine. Quite the opposite, the absence of interest or concern about gender among Ukrainian physicians deserves closer inquiry. Paying attention to micro- and macropolitics of women’s involvement in biomedical field provides crucial knowledge about power and disadvantage within a newly forming capitalist system. In the focus on my analysis, I follow Mohanty (2002), who argues that gender is a locus of multiple local and global processes rooted in ideologies and practices of power. Mohanty’s attention to historical materialism is embedded in the understanding that “all marginalized locations yield crucial knowledge… and the particular standpoint of poor indigenous and Third World/South women provides the most inclusive viewing
of systemic power.” While I focus on women of the “Second World,” Mohanty’s framework remains useful, pointing at “the other” inside of Europe. Yet, my approach differs from Mohanty’s in my understanding of the global and travelling nature of ideas, industries and products. Mohanty (2002) views globalization as universally disadvantageous and disempowering for most places that are not in the economic core, and especially harmful for women, since “capital as it functions now depends on and exacerbates racist, patriarchal, and heterosexist relations of rule.” I am not convinced by this universally negative interpretation of the global open market. My ethnographic evidence suggests that changes in the biomedical sphere that are associated with the introduction of new market ideas, have been at least in part empowering for women professionals who have found new venues for investing their cultural capital.

A lot has been said about the relationship between Eastern and Western feminisms in relation to post-socialist states (Cerwonka 2008, Drakulic 1991, Funk 1993, 2007, Ghodsee 2010, Watson 1997). I employ the terms Eastern and Western feminisms, since these are established terms in scholarship addressing gender relations in post-socialist space. However, I use these terms cautiously. I realize deficiency of grouping feminist scholarship into the two broad categories of East and West. These terms are not meant to signify the entire Western scholarship or entire Eastern European scholarship. What I mean here is the mainstream feminist scholarship produced in North America and Western Europe and deployed in Eastern Europe through various NGO-led gender empowerment programs on one hand, and Eastern European and other post-socialist governments on the other hand. Scholarship produced by women of color and other underrepresented authors in American academia and third-world feminists is not
systematically described as a part of mainstream Western feminism in Eastern European context, and is therefore not included into my discussion here. Gender empowerment discourses that are imported to the Eastern Europe today largely promote views consistent with the second wave feminism that insists that women see themselves as a social grouping with which they should identify in order to achieve equal social status with men (Visweswaran 1997).

In so doing, I agree with Cerwonka (2008) in her argument that although we have seen popularization of international and global women’s voices, the Western agendas of hegemonic knowledge remain pervasive in research and in curriculum. In addition, I follow Mohanty (1986, 2002) in defining Western feminism not as a monolithic discipline, but as such that tends to “appropriate and codify “scholarship” and “knowledge” about women in the third world by particular analytic categories employed in specific writings in the subject which take as their referent feminist interests as they have been articulated in the US and Western Europe.” Thus, women in the East who use these analytic strategies to write and publish work about women, for me, also fall into this category of Western feminists.

Misunderstandings between women in Eastern Europe and the West often center on the degree of influence that gender exerts in forming women’s experiences of privilege or disadvantage. For many non-Western women, women of color and other marginalized groups in the West, poverty, class differences, violence or presence of other factors that block expression of agency on different levels (e.g. disability, ethnicity, religious affiliation) often seem more salient categories than gender (Whitsitt 2002, Ghodsee 2010). In everyday conversations, my respondents have sometimes suggested
that Western feminists had no real problems in their satisfied lives, so they created artificial problems, such as gender discrimination. They do not see gender as the root and explanation of all their experiences. On the other hand, some of the Western and Eastern European scholars working on gender issues in post-socialist states point out Eastern European women’s weak civic organization, political involvement and desire to forge a corporate identity to defend their rights (Attwood 1996, Einhorn 1993, Marsh 1996, Pavlychko 1996, Rivkin-Fish 2005, Rubchak 1996, Spencer 1996, Wejnert 1996).

Eastern European women’s frustration is often directed against the hegemonic influence and alleged imperialism of Western Feminism. Eastern European women are reluctant to import Western feminist prescriptions and formulas, for better or for worse. Individuals and organizations that advocate for women’s rights arrive at the region with their agenda, which promotes a limited number of programs. The broad goals of these programs have hardly changed since the times of the Cold War, and include projects targeting political rights (in various spheres) and legal remedies for discrimination, as opposed to the underlying causes of differential access to resources that are based in economic and political structures rather than gender stereotypes. Anthropologists have acknowledged interest in the representation of the original voices of women from post-socialist societies by some of these women’s rights advocates; yet, the critiques are bountiful (Hemment 2004, Rivkin-Fish 2004, 2005, Weiner 2009). These are especially pronounced in the newly annexed EU states that are now required to follow specific standards in assuring gender equality. Scholars working in these states (Miroiu 2006, Weiner 2009) have argued that this “new paternalism” from the EU arrived without internal “demand” or perceived “need”. States opt for policies that would ensure their legitimacy in the EU,
while the local logic of these interventions is often underemphasized (Weiner 2009). East European women overwhelmingly suggest that unemployment and poverty are their main problems, and this is the types of programs they would like to see, as opposed to projects on sexual harassment or sexist advertising (Weiner 2009). Visweswaran (1997) has argued that the critique of gender essentialism and dichotomizing the categories of a woman and a man, have been slow to incorporate them into feminist writings. Yet, other scholars (Hemment 2007, Phillips 2008, Weiner 2006) have shown how local NGOs well-plugged into international networks were able to partake in this Western feminist phraseology to gain increased access to resources and leverage their position vis-à-vis the state. Local agents tweak the international agendas to their own understandings and needs. Nevertheless, only a small number of NGOs are in position to take advantage of these programs, while the majority of groups in need of help do not receive it (Phillips 2005). In Ukraine, these NGOs working on Western agendas are dubbed grant-eaters [Укр. грантоїди], highlighting their questionable utility for the local population. By promoting programs that people view as superficial and even silly, do Western advocates for women’s right achieve their goals? Do local populations gain useful insights into the areas of disadvantage shaped by gender that they have previously been blind to, or are they turned away from engaging with the topic of gender even more than they have been prior to feminist interventions? This remains to be seen, though a number of social scholars argue for careful consideration of a gender equality policy, which may “achieve transnational currency, (but at the same time) hinder its functionality and imperil the wider political and economic aims that it seeks to promote” (Weiner 2009:303).
In explaining Eastern European aversion to Western discourses on gender and women’s rights, social scholars often link it to distinction between Eastern and Western experience of the public and private realms (Drakulic 1991, Edmondson 1996, Einhorn 1993, Stishova 1996, Watson 1993). In their accounts of the “woman question,” many social scientists, Eastern European and Western alike, tend to provide what I call an “evolutionary” approach to understanding feminism. They explain the difference between the meaning of private and public for Western and Eastern European women, implying that once post-socialist states become truly democratized, they will come to appreciate the goals of what I called mainstream Western feminism (Einhorn 1993, Pavlychko 1996). This approach also implies that Eastern European women simply misunderstand the messages of their Western counterparts and more education along with general democratization will solve the problem. I challenge this perspective and suggest that women in post-socialist societies have legitimate reasons for disagreeing with certain postulates of the feminist programs that are imported to the Eastern Europe. This disagreement does not stem from misunderstanding, but from different worldviews and different priorities. For instance, some of the local rationalizations stem from specifically post-colonial experiences in places like Ukraine. Post-colonial experiences may privilege preoccupation with nationalism, access to the resources previously blocked, ethnicity and class. Thus, Rubchak (1996:315) describes Ukraine as a post-colonial society that “strips away layer upon layer of accumulated colonial baggage… and striving to reclaim its lost heritage – its cultural, linguistic and spiritual traditions.” Pavlychko similarly explains what she calls “conscious anti-feminism and unconscious sexism” by “the lack of democratic traditions, the underdevelopment of civil society and low political
culture of contemporary Ukrainian society that is post-colonial, post-communist, and post-totalitarian” (1996:306). Others have pointed out that post-colonial disorder in politics makes fighting for equal opportunity and anti-discrimination in conditions when resources are becoming increasingly concentrated in the hands of the few impossible without paying very careful attention to the social category of class (Watson 2000). Similarly, women’s seeming apathy to political participation could be considered a pragmatic solution or “a politically savvy rejection of what many women perceive as illegitimate political systems in Eastern Europe” (Cerwonka 2008:812), as opposed to non-existent or conservative approach to women’s activism, as it is often labeled by mainstream feminists who work in Eastern Europe and other post-socialist locales. As anthropologists, we can appreciate that there is no universal truth, and people view their best options of achieving happiness and fulfillment in millions of creative ways (Mahmood 2001). Next I will discuss the evolutionary approach to East-West feminism debates, and then suggest my critiques and alternative explanations.

XI. Public and Private.

One of the most important goals of the first-wave feminist movement was opening the public sphere for women. In particular, early feminists fought for women’s civil and political rights, such as the right to vote. The public domain has been conceived by the early feminists as an essential way to express women’s ambitions, participate in social and political life, and be visible and active agents (Lewin 2006, Visweswaran 1997). These liberties, however, were mainly reserved for the white middle-class. Second-wave feminism further fought against gender-specific forms of oppression,
including unfair division of labor in the household and other critiques of the private domain. In contrast to this struggle for women’s rights, socialist states endowed their women with these privileges from the very start. According to socialist ideology, gender equality was the key, and women’s participation in production was viewed by socialist regimes as the key to achieving it. Women received not only a green light, but a forceful push to pursue education, gainful employment, participation in government on all levels, and active involvement in all things public (Engel 2004, Wood 1997). Despite the nominal value of some of these advantages and the fact that policies that supported family (maternal leaves) firmly placed women into care work, women achieved widespread presence in the public sphere, which was unprecedented cross-culturally in the industrialized world (Ghodsee 2010). It is widely acknowledged that true gender equality was never achieved in the Soviet Union, and women carried the triple burden of housework, full-time employment, and party activism (Patrushev 1986, Wolchik 1993). Because of this heavy burden that occupied women’s everyday lives, it is argued, they did not desire to also get involved in additional public work – gender activism. In addition, public activism was associated with the state, and Soviet citizens were hardly inclined to look up to the state for liberation. At this point in the evolutionary timeline, the reader is usually given a message about how patriarchy while widely present, was still not the major oppressor of socialist women, since the communist state took on this role of the main enemy (Kay 2006, Rubchak 1996). Social scholars depict this struggle against the state somewhat romantically, and their exact understanding of the concept of “the state” is rarely spelled out. Weiner (2009) explains, “In their resistance to their Communist regime’s repressive predilections, women and men became a united front –
allies against a Communist foe.” With the regime change, the economic situation went from bad to worse, and the issue of gender in people’s minds once again took a backseat, while the issues of poverty, access to the resources, gainful employment became the most salient. Men and women now are concerned with their economic survival and are tired of ideological games. It is therefore suggested, that the meaning of private sphere is very different from the Western understanding. Private is often taken to mean safe, free, friendly and loving, as opposed to a hostile, self-serving, and rigid public realm, “under the political and economic conditions of state socialism, participation in paid employment is not tantamount to independence in the same way as in a fully modern liberal market society. It is the family which is the source of autonomy, which is defined not in terms of individual claims, but in opposition to the state” (Watson 1994).

While this history of gender relations in public and private realms certainly reflects some of the socialist realities, I argue that this is a simplified and unilineal understanding of women’s experiences of socialism. Women’s accounts often point to significantly more complicated picture of life under socialism. I suggest that the most important divergence from a unilineal understanding of women’s lives under communism lies in the everyday experience of public and private sectors. Gal and Kligman (2000) challenge the conservative vision of public and private as distinct and clearly separated spaces, especially in post-socialist context. They argue that the notions of public and private are not constant, but they change, and they are contested, which produces different conceptions of private and public that define the framework of normativity. Relationships are always nested within each other, and thus they are not binary opposites or dichotomies. Gal and Kligman (2000:40) propose a “broadly cultural and semiotic
perspective” on the public and private concept. By semiotic, they mean “the signs and their relationships to the meaning-making properties of this dichotomy: how ordinary social actors, as well as social theorists, use and change the idea of public and private as they order and understand their social lives” (2000:40). From a historical perspective, the public and private distinction is an aspect of ideology, closely related to the historical circumstances. From a feminist approach, public and private define and constitute each other. They are nested, “within any public one can always create a private; within any private one can create a public” (2000:41).

First, the understanding of public sphere depends on the very definition of the “state.” Since the “we” of the private and the “they” of the public (Gal and Kligman 2000) are often the very same individuals, it is necessary to acknowledge that private is nested in the public. In both the socialist context and post-socialist context, people have often utilized connections and networks to work through bureaucracy and gain access to scarce goods and resources (Grodeland et al 1998, Ledeneva 1998, 2006, Lowell 2005), and this process mixes the private and public spheres. Barter relationships have also been a very salient category of analysis, especially prior to post-socialist monetization of informal economy. Thus, “public” time, money, state materials, property and land – continue to be used for private interest, demonstrating how the private is nested in the public. In my chapter on informal economy, I further discuss this nested character of the public and private. At this point, it will suffice to notice that we cannot easily discuss resurgence of patriarchy and increased desirability of the private realm, since this realm is not insulated from the public onw.
Secondly, I suggest reconsidering the assumption that during state socialism the private domain was considered to be the only productive sphere where people were unified against the hostile communist state. In fact, people built meaningful relationships, friendships, and networks at their workplaces, in their apartment buildings, in their neighborhoods, in their children’s kindergartens and schools, and even in the party structures and governmental organizations. While Weiner (2009) is correct to point out that association life outside of the mainstream party-affiliated organizations was not allowed and was deemed bourgeois, it would not be fair to assume that party-affiliated organizations did not provide space for public life or meaningful relationships. In my chapter on professionalism, I discuss the meanings of work collectives in socialist and post-socialist times in detail. This challenges the “evolutionary” perspective on feminism, where independent activism is considered to be the key. Even within state-sponsored organizations, people are able to forge meaningful and beneficial relationships.

XII. State Feminism or Emancipation?

While many scholars discuss the power imbalance between women in the West and in the Eastern Europe, the absolute majority of the published material dismisses most of the socialist activity in the realm of women’s rights as potentially empowering (Kapusta-Profahl, mobility workshop, UIUC, summer 2009). When socialist contributions to women’s rights are acknowledged (high percentage of employment, achievements of women in science and professional lives, developed childcare network and accessible education), they are usually prefaced with “although,” “while,” or immediately prefixed with “however,” pointing to the only partial success of these
policies (Einhorn 1993). Few if any scholars attempt to focus on the glass half full, as opposed to glass half empty, informed by the celebratory post Cold War discourses that demonize socialism. Ghodsee (2010) has recently discussed the fundamental need to seriously address the possibility that socialism may have produced a particular type of emancipation and even feminism. In particular, she delves into relationships between Western advocates for women’s rights and the socialist understanding of what women’s issues were, as it was divulged in the course of the United Nations decade for women. Both the Western and Eastern agendas were highly politicized, yet the underlying messages that they advocated for were drastically different. For Eastern European women representing the Soviet position, women’s problems were a part of political economy. They promoted the view that was in sync with the third wave Western feminism that has not gained dominant position in Western feminist agendas that have been exported abroad, arguing that oppression was nested not just in patriarchy, but more importantly in exploitation, colonialism, violence, war, and imperialism, which impoverished both genders. Western feminists’ agenda sanctioned by the American government, advocated for the political and legal rights of women, but ignored the systematic causes of women’s marginalization rooted in political economy. The socialist agenda targeting poverty and injustice was also shared by women from other parts of the world that struggled with post-colonialism. It is important to resurrect these debates, because they demonstrate that Western liberal feminism has not always been dominant in the world arena. In fact, the 70s and 80s witnessed a great influence of a distinct type of feminism that was developed in Central and Eastern Europe. Ghodsee shows how in the beginning of the United Nations decade for women, a socialist feminist agenda was successful in demonstrating
deficiencies of the American mainstream feminist agenda that pushed for equalizing opportunities without trying to change the fundamental system. Other scholars (Chabram 1990, Mahmood 2001, Sandoval 1991) have also pointed out that feminist ideas developed in other parts of the world have pushed the mainstream feminism to “authorize and inscribe diverse movements for political equality (Visweswaran 1997:616).

Although claims of Eastern Bloc women that they were already emancipated were premature, these women could demonstrate unprecedented achievements: the highest labor participation rates for women, the highest number of women professionals, scientists, and political leaders. In 1975, the USSR’s delegation was led by the first woman in space Valentina Nikolayeva-Tereshkova, while the American delegation was planning to send the wife of President Ford. It is not difficult to see how Eastern Bloc women could genuinely have qualms about listening about women’s equality from a woman who was representing the country not as an individual professional, but as a first lady. Ghodsee argues that both the Eastern Bloc “peace” agenda and the Western bloc “equality” agenda were the products of their governments, and yet it is conceivable to give credit to women representing these programs. They were, in all likelihood, not just brain-washed clones of their states, but in all likelihood shared some of their convictions. Ideological polemics are not an accurate account of the real situation (Cerwonka 2008).

In fact, Ghodsee (2010:6) reports that the American delegation was instructed to focus on women’s issues alone in order to avoid politicization, viewing the women’s rights struggle as not truly a political issue, which emphasizes once again the discursive value of the mainstream Western feminist agenda supported by the state as opposed to real life
changes. Eastern Bloc women, in their turn, were intent on focusing on political issues around the world, perhaps, as a strategy of not directing attention to their own states.

The influential work of Mohanty (1986, 2002) points out the problematic nature of any women’s rights movement that does not pay attention to the global political economy, but instead merely pays attention to the micropolitics of everyday life. The Eastern Bloc feminist “peace” agenda was right on target in its criticism of capitalism, naturalization of class differences, race and gender discrimination. By 1995, the collapse of the Soviet Union reoriented the international women’s movement toward the mainstream Western activist perspective, obliterating the decades of conversation between Eastern and Western feminists and “relegating the link between women’s issues and political economy to the proverbial dustbin of history as far as the international women’s movement was concerned” (Ghodsee 2010:9). According to Mohanty’s framework (2002), this shift towards the right poses great challenges to true advocacy for women’s rights, as current mainstream civil rights movements and scholarship do not challenge the capitalist system that underlines the inequalities of all sorts. The so-called victory of the United States in Cold War exacerbated many Eastern European women’s disappointments at the unfulfilled promises of their socialist governments, and pushed socialist ideas about a safety net (guaranteed employment, providing social benefits) out of the picture, leaving women to tackle rampant deregulation, privatization, and dismantling of institutions that have once helped women in maintaining their independence.

In many ways, narratives of my physician respondents, both those who were educated in Soviet Union, and the younger generations who went to medical schools in
independent Ukraine, criticized a totalizing rejection of socialist social organization as “anachronistic and failed program of social engineering” (Ghodsee 2010:9). Instead, they pointed out the many ways in which it was functional, as opposed to the current mess of post-socialism where people are left to sink or swim, and no one is accountable for anything. Understanding the history of women’s activism in post-socialist states, brings us one step closer to understanding why Eastern Europeans reject the idea of gender as a category in and of itself, separate from broader socio-economic relations. Fighting for equal opportunity and against discrimination in conditions where resources are becoming increasingly concentrated in the hands of the few, for many rightfully appears to be too narrow and even impossible to truly enforce without paying very careful attention to the social category of class (Watson P. 2000). Similarly, women’s seeming apathy to political participation could be considered a pragmatic solution or “a politically savvy rejection of what many women perceive as illegitimate political systems in Eastern Europe” (Cerwonka 2008:812) as opposed to non-existent or conservative approach to women’s activism, as it is often labeled by the mainstream feminism (Einhorn 1993).

XIII. Conclusions. Deconstructing the Binaries.

The binaries between East and West are problematic. Are there more useful ways to speak about feminisms? As Pratt notes (Cerwonka 2008:825), instead of trying to explain Eastern European feminism in terms of its differences from the Western hegemonic feminism, we should think of these ideas in terms of “copresence, interaction, interlocking understandings and practices, often with radically asymmetrical relations of power.” Acknowledging the voices of different women in feminism, there has been some
attention to providing space for expressing these differing views. Yet, Eastern European scholars (Cerwonka 2010) remain critical. They are often asked to articulate their ideas in relation to Western feminism, emphasizing the ways in which they are different. This approach reaffirms power imbalances, and further entrenches Eastern European women’s position as guests of the Western academy and not as equal contributors to scholarship. Being a mainstream Western feminist remains an unmarked category, while women advocates from other places in the world remain the perpetual “Other,” “new groups are accepted into the discipline as a gesture of inclusion or as a corrective to ethnocentrism, their inclusion in fact does not disrupt the centrality of American/Western women” (Cerwonka 2008:820). One of my ethnographic encounters in the field especially clearly illustrates this dynamic. One day, I sent my ”invitation to participate in research” email to a number of alumni of one of the major medical schools in Ukraine. Some responded, and others did not, however, one woman stood out. She sent me a response fuming with rage. This young woman in her early 30s wanted me to know that she did not want to express her opinions to someone associated with the West. She said that she did not need a channel for making her voice heard, and that everything that she needed or wanted was there for her. I should point out that my invitation letter was worded neutrally, being careful not to emphasize any expectations from my potential respondents. In my letter, I also made it clear that I was a Ukrainian, although I did point out my American academic affiliation, according to Internal Review Board regulations. For this young woman, the mere direction of interest in her knowledge (from West to East) was sufficient reason to resent it. This vignette points to saliency of awareness of power imbalances between
women in the West and in the East, and deficiency of looking at gender as the main point of identification or shared meaning.

Instead of thinking in terms of Eastern and Western feminisms, Cerwonka wants to focus on the circulation of feminist ideas and the ways in which they have been creatively transformed. I agree with both Cerwonka and Ghodsee in their arguments that Anglo-American feminism is usually assumed to be main origin of feminist theory and feminist activism, with people in other parts of the world passively adopting or rejecting its ideas. Marxist ideas shaped the intellectual landscape of the Eastern Bloc countries, and feminism drew and continues to draw heavily on Marxism. It is therefore feasible to suggest that women who have been living socialism and post-socialism, may indeed have valuable contributions to feminism, without being labeled as either apolitical or as another extreme – brainwashed by socialism. The more accurate approach is to look at feminism as a “set of ideas and practices that has developed through contact and negotiation” (Cerwonka 2008:829). This view acknowledges the agency of multiple players, while at the same time allowing for consideration of uneven power relations.

The precursor of Cerwonka’s approach is Mohanty’s (2002) comparative feminist studies or feminist solidarity model. Its main premise is that local and global constitute each other. These relationships (conceptual, material, temporal, contextual) suggest that all communities have interweaving histories, and allows researchers to look at individual and collective experiences of oppression at the same time. Mohanty (2002) argues that with increasing globalization, corporatization and privatization around the globe, women’s movements have become conservative and largely not able to offer a venue for productive resistance for women. While her critiques of Western feminism address the
dynamic of its relationships with the Third World (admittedly, a limited term that Mohanty substitutes with Two-Thirds World/South), her analysis of the mainstream Western feminism lands itself perfectly in the Eastern Europe and post-socialist space in general, as a new site for discursive colonization, understood as “a relation of structural domination, and a suppression… of the heterogeneity of the subjects in question” (Mohanty 1986:333). The collapse of the Soviet Union is often taken as a reason to discredit all rationalities and knowledge produced by it, which makes it easy for Eurocentric universalizing ideologies to occupy the post-socialist territory. Instead of promoting narrow agendas advocating for women’s rights, Mohanty (2002) argues for an approach that would focus on both – the “micropolitics of context, subjectivity, and struggle” and the “macropolitics of global economic and political systems and processes.”

Throughout this chapter, I have argued that women physicians are not a disempowered population. I have insisted on looking at power from a different angle, and challenged the Cold War categories that continue to inform scholarship about post-socialist societies. Yet, by focusing on the functional aspects of the biomedical profession, I may have overlooked instances and perhaps trends of structural injustice and discrimination against women in their workplace. Have post-socialist women really found their own voice? I saw a gap in social scholarship that views the feminization of the biomedical profession in East Europe narrowly as disempowerment. In contrast, I included analysis of different channels in which power, subjectivity, and agency operate in female physicians’ lives. It is difficult to find a balance between acknowledging that some populations (women, sexual minorities, the disabled) are being marginalized on the
one hand, and considering how they exercise agency on the other hand. As a way to avoid this pitfall, I support the third wave feminist idea of intersectionality (Abu-Lughod 1993, Behar 1993, Butler 1993, Lamphere et al. 1997, Narayan 1993, Rosaldo 1980), which understands gender not as the main principle of structuring social relations, but a form of subjectivity. Arguing for the universality of gender asymmetry and using gender category as “the endpoint of analysis” (Visweswaran 1997) runs the risk of essentializing, overgeneralizing, and lacking relevance for the research subjects. Intersectionality acknowledges that gender is not only an inextricable part of identity that influences social relations and plays defining role in equality and civil rights histories, but that gender interacts with other significant factors, such as race, class, ethnicity, sexuality, disability, to produce differing degrees of privilege and experiences of oppression. In Visweswaran’s words (1997:616), gender is best understood as “an entry point into complex systems of meaning and power.”
Chapter VI. Professionalism, Ethics and Social Change.

I. Introduction.

In this chapter, I will consider the multiple meanings of professionalism that emerge from cross-cultural studies of biomedicine and anthropological critiques of bioethics. My goal is to demonstrate how the case of Ukrainian healthcare transformations expands the understanding of profession and professionalism conceptualized by current sociology of professions. I discuss what happens to a professional group and the society that it serves when the state attempts to withdraw from the space previously controlled and administered by it, such as healthcare. As a starting point, I will use anthropological critiques of bioethics, which problematize universalizing ideas about biomedical professionalism and about morality. This critical medical anthropology focus will allow me to demonstrate how day-to-day practices of Ukrainian physicians are guided by personal and cultural interpretations of medical ethics and personal morality. The narratives of what it means to be a professional in the field of biomedicine in Ukraine today offer us a window into the chaotic post-socialist life where fascination with money and material prosperity are intertwined with quandaries about common good, just access to resources, and figuring out which will prevail, humanitarian or monetary pursuits.

This dissertation explores physicians’ understanding of what it means to be a part of the professional community. Similar to the hybrid conceptualization of biomedical prestige, Ukrainian physicians’ understanding of professionalism carries both socialist-era and new-found ideas brought about by the market. Scholars working in post-socialist
contexts (Buyandelgeriyn 2008; Dunn 2004; Humphrey 2002; Marciniak 2009; Verder 1999) are currently engaged in lively discussions about hybrid ways in which social life is currently unfolding. Socialist ideals and their reflection in institutional and personal lives are often alive and well, and they actively transform and adapt neo-liberal policies according to local norms and expectations. At the same time involvement in the global processes dictated by the market economy and open borders engender new dynamics. Similar to processes described by Ninetto (2005) in the Russian sciences, Ukrainian physicians are transforming structures that were available under socialism into hybrid state-private ventures, as has been discussed in the “Moral Economy and Informal Exchanges” chapter. This chapter explores the various ways in which physicians understand and reconfigure the relationships between healthcare, the state, and the new market economy. Ultimately I hope to use the physicians’ constructions of social change and professionalism to advocate for broadening the anthropological understanding of professionalism and medical morality and adopting a context-based approach (Finkler 2009).

II. Theoretical considerations of professionalism and bioethics.

Professional occupation has been defined in the social sciences as a “self-regulating occupation which requires training, specialization, and an orientation towards a core of ethics which entails corporate responsibility” (Abbott 1993; Schecter 2000, 1997b; Starr 1982). Perhaps, because the study of professions has traditionally been dominated by the sociological studies with their top-down research orientation, the ethnographically-based accounts in this field of theory have yet to be developed.
Professionalism has been conceptualized through the lens of Western occupations, which I will show can significantly benefit from understanding of the dynamics of professional groups in other societies, such as post-socialist Ukraine.

American sociologists (Cassell 2002; Macdonald 1995) have approached studying professional groups as corporate actors who have a relatively strong power separate from the state or outside capital (Mansurov, Yurchenko 2004). Professionalism in Western scholarship is understood first and foremost as autonomy (autonomy of professional activity, ability of the group to control the results of its labor, control of new members and training, and existence of strong professional association) and as success of a professional group in achieving high position in the social hierarchy (Mansurov, Yurchenko 2004). In Russian and Austrian-Hungarian Empires, physicians had strong interconnections with the state, but medical associations were quite common in the 19th century. Professionalization changed after the October Revolution of 1917. The state took increasing control over healthcare institutions (Field 1957). However, what does this affiliation of the biomedical profession with the state indicate? First of all it points to the fact that physicians must work within the bounds established by the state. Yet, Western physicians also must work within the bounds – those of the market economy as well as public health regulations. Both create structural barriers and limit the scope of professional activities. In fact, Mansurov and Yurchenko (2004) show that relative withdrawal of the state and introduction of market mechanisms in healthcare via national health insurance in Russia have not increased professional autonomy or material status of doctors.
Western scholars working with physicians in post-socialist states (Barr et al. 1996; Burton 2005; Field 1991, 1988; Ryan 1990; Schecter 1997a, b) offer a sharp critique of the medical profession, suggesting that ever since the socialist revolution physicians have lacked professional status. By professionalism, they scholars understand first and foremost autonomy of a professional group from the state, as well as its self-regulation of training, ethics, and specialization, and a strong sense of corporate identity and responsibility. In medical field, being a professional means following the rules and regulations of bioethics. Schecter (1997b) argues that the biomedical profession was stripped of its political power in the Soviet Union, because medical doctors were not independent from the state and instead were directly subordinate to state regulations in their practice. Schecter (1997b) and Field (1988, 1995) argue that state dependency was cultivated during the Soviet period, which created an “employee mentality” in healthcare workers, who did not perceive themselves as empowered enough to influence their circumstances at work. The crises that followed the dissolution of the Soviet empire have tremendously impoverished the middle class known in the Soviet Union as the intelligentsia. These factors, along with the isolationism of Soviet sciences and poor biotechnological development, have allegedly deprofessionalized physicians. Scholars such as Schecter have attempted to use health indicators in the late years of socialism as well as the current public health crisis in post-socialist societies as the evidence of poor professionalism of physicians. Yet, these authors do not take into consideration historical records (Frieden 1981, Hutchinson 1990) that highlight long-standing interrelations between the state and the medical profession that go far beyond the Soviet decades to the 19th c. They also do not explore ethnographic evidence (Farmer 2003, Kislitsyna 2009) or
even major epidemiological studies (McElroy and Townsend 2004) that have demonstrated the defining role of structural factors and behavioral patterns in the poor health indicators, as opposed to the influence of biomedical institutions and its professionals alone.

I argue that professionalism is conceptualized dramatically differently by Ukrainian physicians who do not view autonomy and independence from state interference as a number one indicator of their professionalism. Instead, professionalism is understood as a set of qualities that medical doctors can develop individually, rather than as a corporate group. Extensive knowledge, skills, and training, combined with ethical and moral qualities best characterize what post-socialist physicians view as professionalism. Being called a professional is not a small affair, and indicates particularly outstanding preparedness to perform one’s professional activities. It is almost an honorary term that reflects personal achievements and bears parallels with the idea of culturedness (Volkov 2000, Fitzpatrick 2000, Patico 2008) in its emphasis on moral education rather than independence, which will be discussed later in this chapter. Having acknowledged the validity of multiple understandings of professionalism, it appears that bioethics is an especially useful way to delve into the issues that post-socialist physicians view as essential for their professional identity.

Bioethics is “an inquiry into the ethical implications of scientific and technological developments in medicine” (Muller 1994). In the Western context, bioethical principles are supposed to govern medical practice, and the professionalism of healthcare providers is often judged based on their exercise of the main bioethical principles of respect for privacy, beneficence, nonmaleficence, and justice. I would argue
that Schecter’s view of Soviet and post-Soviet biomedicine as deprofessionalized stems from Western understanding of the role of bioethics and professionalism. Many foundational works in medical anthropology (Finkler 2008, Fox and Swazey 1984, Gordon 1988, Muller 1994, Rivkin-Fish 2005) have exposed Western biases lurking in bioethical principles that claim to be universal for the biomedical profession worldwide. The conceptual foundations of bioethics originate in a Western philosophy that prioritizes individual rights, self-determination and privacy and that focuses on logic, codified rules and techniques, and objective thinking (Gordon 1988). Western morality defends the sovereignty of the individual, freedom from interference, equal treatment and opportunity for development. With its utmost emphasis on the individual, bioethics pays less attention to the shaping influences of culture, community, and socio-economic factors. Medical anthropologists argue that moral decision making of biomedical professionals is contextual. It cannot be separated from institutional, political, economic, social, and cultural contexts. Because bioethical concepts are grounded in Western philosophy, they are often idealistic and ethnocentric because they ignore duties that people have in the family and community, and the interconnectedness of individuals (Fox and Swazey 1984). Western scholars who apply bioethical considerations in determining professionalism of medical doctors in other parts of the world often disregard the significance of communitarian ethics, culture, and life stories. The bioethical approach with its emphasis on patient autonomy, beneficence, nonmaleficence, and justice, is very abstract, removed from moral and psychological realities (Muller 1994). Current anthropological vision suggests that in studying medical morality, scholars should highlight relationships between individuals, their responsibilities, commitments, and
emotional bonds to each other, the significance of the groups and society to which they belong, and the inward and outward influence that they have on the individual and his or her sense of the moral. Farmer (1999, 2003) and Singer (1995) have also added to the understanding of bioethics by drawing attention to political economy. They emphasize that questions of poverty, inequality, and access to treatment should be central for social studies of healthcare. Farmer (1999) insists that structural violence disenfranchises both patients and medical providers, and is the modern plague.

I join Finkler (2008) in arguing that professionalism of the medical providers should be understood as context-based. Using the Mexican biomedical profession as her analytical site, Finkler (2008) shows that preoccupation with confidentiality, privacy or autonomy, which are all deemed as cornerstones of professionalism in Western logic, are not a part of the Mexican cultural baggage that physicians bring into biomedicine. The bioethical principle of justice is also regrettably impossible to enforce due to challenging socio-economic situation in the country. Similarly, Rivkin-Fish (2005) convincingly shows how in the Russian context, Western public health experts mistakenly blamed healthcare professionals for their nondemocratic style of biomedical practice, ignoring the structural obstacles. They failed to engage in strategies that would mobilize communal forms of action, and instead placed individual responsibility on the healthcare providers alone. Finkler (2008) argues that instead of Western-based and universalizing bioethical principles, global bioethics should be developed. Global bioethics would be context-based and able to transplant to developing nations or communities undergoing rapid social change. At the same time, global bioethics would retain the concern with justice, inequality and structural violence that Farmer argues for in his work.
Ethnographic method is very suitable for examination of the ways in which moral problems are perceived and handled by people, as well as how they are defined and framed. In the next section, I trace the everyday ethics of Ukrainian physicians that illustrate their understanding of professionalism in post-socialist context. With a discussion of my ethnographic evidence, I will demonstrate how day-to-day practices of Ukrainian physicians are guided by personal and cultural interpretations of medical ethics. In the “Moral Economy and Informal Exchanges” chapter, I focused on everyday informal practices, in which physicians are routinely engaged. I had established that professionalism should be understood as a delicate balance between receiving adequate income and maintaining a sense of humanity, which for physicians has meant justification for their informal practices. Here I focus on broader discourses that underline physicians’ engagement with their profession and its social role. I trace the ways in which medical doctors understand how social changes influence the biomedical profession and in what ways they should respond to these transformations.

III. Professionalism and ethical considerations in Ukrainian healthcare.

In this section, I will outline competing moral discourses presented by my informants. I begin with a discussion of the critiques by physicians of the market and its intrusion into the biomedical profession, followed by their attempts to draw discursive lines between medical help and business, as well as their conceptualization of post-socialist medicine as an ultimate test of professionalism. This discussion reflects the critical stance that many physicians take as they grapple with fundamental social change.
III.1. Critiques of the market intrusion into the biomedical profession.

The most poignant moral quandary that Ukrainian physicians must deal with is monetization of relationships in society and consequently in the biomedical sphere. For some respondents, this monetization was expected, normal, and desirable, while for others it was regrettable and frustrating. In this section, I discuss these contrasting views, focusing first on the critiques of marketization, followed by discussion of what I call “market moralities,” or various ways in which physicians understand and reconfigure the relationship between biomedicine, state, and market in Ukraine (Ninetto 2005).

Liudmyla is in pediatrics. She is in her mid 50s, working as a physician in a specialized kindergarten for children diagnosed with weak health status and managing her private homeopathic practice. She has not yet made peace with introducing market principles into mainstream healthcare, even though she stands to benefit from it as a healthcare provider. Instead, she applies her professional ambitions and curiosity in the field outside of her main expertise – homeopathy. Here is what she has to say:

I was chatting with my neighbor last week, and she was telling me how she had to see a cardiologist. She was asking for my help in finding a good doctor for her. I started calling my contacts, and the neighbor refused to go to the doctor I had found. I asked her why? She said that she had heard that they asked for too much money in that hospital (under the table). She also did not want to go to the municipal hospital because her husband went there during his heart attack, and they were asked to pay 1,500 hryvnia (187.5USD) right off the bat, while they were only asked to pay 500 hryvnia in the military hospital. I don’t know, I have worked my entire life in the hospital, but I have never said to anyone, “This is my fee that you have to pay.” It is true that we all (doctors) take money, this is for sure, for consulting a new patient. But I don’t ask for it myself. Especially in my first years at work – I did not even take chocolates or bottles (meaning, expensive liquor and wines). But today, you see, all questions are resolved with money. They are resolved in an ugly way. Both physicians and patients humiliate themselves by asking for help and offering money.
Plastic surgeon Valentyna, whom you’ve met in previous chapters, agrees with Liudmyla. She says that while she used to be able to ask her colleagues for free consultations for her relatives and friends, this is no longer the case. Now she always prepares some cash and worries about how to give it and whether or not her colleagues will accept it. Another respondent, Myroslav, who is an established psychiatrist with over 20 years of experience, compares healthcare with show-business. He critiques the commercialization of medical help:

Healthcare has become another show-business. Just like pop singers do not even need to have a good voice to make big bucks, physicians do not need to work hard, they are losing their healing art. This cancer has already spread through our profession. We did not use to have this before. We used to help first, and then see if we get some extra payment. So, we would first provide care, and then if patients wanted, they would thank their doctor, buy something for her.

Andaya reflects on similar preoccupations for Cuban physicians, and Mansurov and Yurchenko (2004) for Russian physicians. They explain that those providers who leave state healthcare sector for private practice are viewed by their colleagues as those who have abandoned their professional values for the sake of money, which undermines their professional respect. Physicians working in private facilities contribute to these views themselves. Rarely if ever do they identify private practice as their main professional status, and instead refer to it as “additional income” [Rus. подработка]. This underscores the contested value that money plays in physicians’ conceptualization of professionalism. The potential for more lucrative income in and of itself does not translate into increased professional status, which points to the insufficiency of professionalization theories that underscore professional autonomy and power.

In her recent work Wanner (2005) argues that one of the socialist legacies is a moralizing lens through which people evaluate wealth. She suggests that people’s
uneasiness with wealth stems in part from extremely successful Soviet campaign against acquiring wealth independent of one’s own labor or speculation. Yet, using whatever means available to provide for the well-being of one’s family and close associates in face of disillusionment with the state are also some of the most significant priorities for many Ukrainians. Competing notions of morality are concerned with balancing individual and collective interests in the pursuit of wealth. In healthcare, understandings of moral obligation shape everyday exchanges and social relationships that accompany them. It is acceptable for physicians to try their hand at multiple jobs and use public space of state hospitals to engage in private entrepreneurial activities if they still manage to be respected as moral and good people.

III. 1. A. Healthcare and business.

These quandaries about the role of money in healthcare are especially well illustrated by the distinction that physicians make between medicine and business. My respondents are universally adamant that a clear distinction should exist between medical help and medical services. Medical help should be free, and medical services should be fee-based. Physicians cannot imagine scenario in which a person without money should be refused life-saving treatment, and a guaranteed minimum of healthcare provision is a must for them. Yet, people should be asked to pay for extras as well as routine preventative care. Anastasiia is a pediatrician in her late 30s who works in a large pediatric clinic in Kyiv. She is very critical of the business model for healthcare and believes it is not a field where the market should be a governing principle, since people’s lives and health are at stake:
Here healthcare has not become business yet. Here, medicine is still humane. Despite our small salaries, our doctors are still trying to help people whether or not their patients pay them… Business in not humane, because wherever money takes the front seat, human niceties lose their relevance. Business has cruel laws: I pay you, you pay me. If one of us is not happy, we will take it to court. You cannot even smell humanity here. I am not talking about businessmen – a businessman is a human, and humans can be humane even if they are businessmen. However, the sphere of business itself is not humane. I am against making healthcare into another business. I prefer that it remains even in the form that it is now to openly turning it into cruel business.

A successful oncology surgeon in his early 40s, Yuriy, agrees with Anastasiia:

Everyone should receive equal medical help, and those who want special attention and special help – should pay. Healthcare is not commerce; it cannot be fully fee-based. Look at our pharmacies. They have become fully commercial, and what do we have now? Huge kickbacks to doctors, managers, and soaring prices. Ultimately, patients pay for all of this. Why would one want that in healthcare? I prefer that our government finally takes this matter into its hands and controls all the pricing and standardization.

Ukrainian doctors posit that the Ministry of Health should focus on providing medical help, while the market will take care of the rest. Similar to what Ninetto (2005) has shown for Russian science, Ukrainian physicians do not set state and market in opposition. Instead, they seek the ways to reconnect the state and the biomedical profession in a more functional way than today. These attempts “both draw upon and break from the Soviet-era configurations” (Ninetto 2005). When people employ some of the ideas and considerations that may at the first glance appear as socialist debris, Ninetto suggests taking a careful second look. Citing Burawoy and Verdery (1999), she suggests that rather than remnants of the old mentality, these may be responses directly produced by the market. In their critique of monetization of biomedicine, physicians attempt to reestablish their moral value as experts in a socially needed field and as members of the intelligentsia. They also attempt to parcel out the new roles that state and market should play in post-socialist medicine.
III. 1. B. Trial by fire.

My physician respondents often spoke about working in post-socialist medicine as an ultimate test of professionalism and morality, with only the most professional of them surviving in these conditions of disorder and uncertainty. A young product manager in a foreign pharmaceutical company, Anastasiia, has made an enormously successful career for herself after quitting her state job as an anesthesiologist and urgent care specialist. She bought her own apartment in the capital, a new Toyota, and is able to travel the world. Yet, she talks of herself as someone who has failed her trial by fire [Rus. проверка на вшивость]. Valeria, who has worked as a pediatrician and is now contemplating moving to a research position in one of the Kyiv institutes, agrees that altruism is a must for good physicians today:

I believe that only true altruists work in this profession today. People who love their profession, because if you anything less than love it, you won’t be able to work here. You should not take somebody else’s position if your heart and soul are not in this… You must love people. When we are choosing this profession we must be crystal clear about this. The fact that we are much underpaid is a whole other story.

This trial by adversity that identifies doctors with a true calling out of the rest is also reflected in physicians’ narratives of their personal choice to work according to the principles of inherent goodness, as opposed to monetary considerations. This discourse goes further in time than socialist morality, and reflects centuries-old traditions that are rooted in Christian ideals in the Ukrainian context. Until socialist revolution, Ukraine has been a deeply religious country practicing mainly Orthodox Christianity, as well as Greek and Roman Catholicism. Many Soviet citizens continued practicing their religious beliefs in secret during the Soviet years. They baptized their children in isolated villages, attended traditional babky healers, and sometimes followed religious calendars.
testament to non-abating Christian spirituality was Stalin’s brief reopening of the churches during World War II, when the Soviet state sensed that its citizens needed greater motivations than defending the state. In the medical sphere, healthcare has been a prerogative of monks and churches for centuries, which also links medicine to humanitarian ethics. Anna, who is a senior nurse in one of the pediatric clinics in Kyiv, is a good example of this continuing connection to spirituality. Here is what she says about her work:

I cannot say that I go to work just waiting for the day to be over. I work conscientiously. Well, sometimes there are moments when I am not fully following all the rules, I won’t lie. Sometimes it happens that I don’t follow all the deadlines. But as far as my patients go, I help them. I always do injections, regardless of what they pay. If they pay me, I say “thank you.” If they don’t, I say “you are welcome.” For example, Tanya (my co-worker) will not take patients who don’t pay extra. She goes, “I won’t work with this one, I won’t work with that one.”

Another respondent, Stanislava, who has worked in the tuberculosis clinic most of her career and has since moved to work in the WHO office in Kyiv, communicates with many powerful people in the Ministry of Health due to the nature of her current job. She argues that conscientiousness and morality do not depend on one’s salary. People are either ethical or not, regardless of whether they are well paid or underpaid, because the measure of good income is relative:

Conscientiousness and quality of one’s work do not depend on the salary. People may earn sky-high incomes and still do a bad job. By the same token, underpaid people can be highly qualified and respectable. These are the matters of personal morals. At the same time, we cannot place responsibility, especially criminal responsibility, on doctors who make less than 200USD per month. It is not reasonable to demand great accountability and at the same time give next to nothing in return. Informal payments – well, they are necessary, but they corrupt us, because there is no accountability.
Similarly to Zigon’s (2008) argument about parallels between the Soviet and Christian discipline, doctors that I have been communicating with draw parallels between Soviet morality and the neoliberal rhetoric of individual success in their emphasis on self-discipline. In a way, the American dream is not so different from an ideal Soviet success story, except that collective good precedes personal benefit in Soviet mythology. Plastic surgeon Valentyna recollects the years when she was the head of the burn unit as an example of what she calls “the debt of socialist competition.” She recollects her constant desire to improve her workplace, to beautify it, to find sponsors, to locate funds for maintenance and repairs, or to obtain new medications. She wondered what was driving her to work hard without substantial remuneration or even acknowledgement. Her explanation for this is her socialist training that has taught her that the only right way to work is to work altruistically, without thinking whether or not she will benefit from her work personally. Another respondent, Nadiia, who heads the pediatrics unit in one of the largest Kyiv children’s clinics, similarly points out that the most reliable and valuable doctors are those who think in socialist terms of “debt to the society.” Andaya (2009:371) has discussed these debates between socialist notions of morality as “self-sacrifice and reciprocity” and new ideologies that emphasize economic standing. My respondent Nadiia thinks that if not for these people who “have been raised in the spirit of respect for their Motherland” there would not be anyone to pick up the pieces of the Ukrainian dilapidated healthcare system.

Valentyna and Nadiia promote the idea that inherent goodness and maintaining humanity are the ultimate test of professionalism. I argue that it has roots not just in socialist morality that emphasizes self sacrifice for the good of the country and fellow
citizens, who are supposed to be each other’s “friends, comrades, and brothers” in words of one of my respondents. It goes further into pre-revolutionary, spiritual rhetoric of brotherly love and kind heart. It also stands as a critique of the open market in the way that it functions in Ukraine today. This has also been discussed in the chapter on informal economy, which highlights the practice angle of morality narratives. Ethnographic evidence indicates that physicians employ multiple morality discourses that contest market rationalities. This is not to say that the latter do not have their validity for the biomedical professionals. I now turn to discussion of what I call market morality, as envisioned by Ukrainian physicians.


I now present the opposite side of the coin, or what I call “market moralities.” These discourses, emerging from interviews with the Ukrainian medical doctors, demonstrate various ways in which they are able to engage monetization and marketization in their profession to boost their understanding and practice of professionalism. I employ Humphrey and Mandel’s (2002) understanding of the market not as a purely economic phenomenon, but as experienced in diverse contexts, starting from advertisements, and ending with social differentiation and increasing stratification. Within this section on market moralities, I discuss current contestations of the Hippocratic Oath that demonstrate physicians’ revision of their moral obligations and professional identities in post-socialist context. I explore here the relationship between physicians’ understanding of professionalism and current processes of social differentiation and re-negotiation of class divisions in the larger society. I show how
these changes are influenced by both local and global hierarchies. I then attempt to show how conflicts between different generations of physicians (those trained in the Soviet Union as opposed to those trained in contemporary Ukraine) reflect changes in the biomedical field and professional ethics shaped by the new market economy. I suggest that competing discourses that guide younger and older biomedical generations’ ideas about professionalism should be understood as “overlapping domains held in productive tension” (Ninetto 2005).

III.2. A. Contesting the Hippocratic Oath. When Hippocratic Oath becomes Hypocritical.

One professional practice of Ukrainian physicians offers an especially useful illustration of the ways in which physicians understand the relationship between biomedicine, state, and market in Ukraine – the Hippocratic Oath. In medical universities, graduates are sworn into their profession with the Hippocratic Oath. This is the case for many medical educational facilities throughout the world. Yet, this practice gains special meaning in Ukrainian context. This practice has graduated into the site of conflicting discourses in biomedicine. In the Soviet context, the Hippocratic Oath was understood as a pledge to practice medicine in a professional manner. In popular understanding, the Hippocratic Oath meant a physician’s promise of doing everything possible to help patients regardless of circumstances or financial remuneration. There was no space for discussion of money in the Soviet version of the Oath, since physicians were remunerated by the state and private entrepreneurship did not exist. Currently, the Hippocratic Oath figures prominently in conflicts between physicians and patients. Patients have been
engaged in re-negotiation of their rights and responsibilities, and often contest the biomedical practices that they find unsatisfactory. Both physicians and general population often bring up the Hippocratic Oath in their quandaries, but to very different ends. Patients point to the Oath to hold physicians accountable for helping them regardless of their compensation. Physicians, on the other hand, have re-analyzed the Oath in search for meanings deeper than state-sponsored version have been offering. They search for meaning that makes sense for them under new circumstances. In my interviews, many physicians interpreted the oath as a myth that was created for the socialist project that now should be dethroned.

The classical translation of the Hippocratic Oath from the Greek reads (Edelstein 1943):

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant: To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else. I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice. I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art. I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work. Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves. What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.
If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

The version that is currently used in Ukraine is slightly abridged; however it contains all the major arguments of the translated original that has been in circulation since 1848 when Geneva physicians adopted a “combed” version of the Oath (Bobrov 2004). Ukrainian physicians who have brought up the Oath in our interviews energetically point to the absence of any requirement to treat patients without decent payment in return. Some display reprints of the Oath on their office walls. Many circulate copies of writings of a popular critic Oleg Bobrov, in particular his piece on “Myths and Illusions of the Hippocratic Oath.” A practicing surgeon himself, Bobrov combines prolific careers as a cardiac surgeon and a social critic. He publishes short essays in medical press, and has recently attempted to reach a more general audience with a book (Bobrov 2004a). However, rather than purchasing a book that is not widely sold in the bookstores, physicians circulate home-made crude copies of his works almost as an underground subversive act, hiding the reprints from patients’ and administrators’ eyes. Although the times have passed when people did not have the freedom of reading what they wanted, Bobrov’s works are still too edgy in their questioning the idea of a benevolent physician and arguing for an empowered physician who is a part of the intellectual elite recognized as such in material and discursive terms. These worn-out pages tucked under the medical histories on the physicians’ desks represent their hopes and aspirations with rebellious flair. Many of them mention that although they feel entitled to all the benefits that Bobrov argues for, they feel that these ideas will undoubtedly be met with outrage by the public.
In “Myths and Illusions of the Hippocratic Oath,” Bobrov insists on decrowning the oath as an artificial social construction that currently holds the Ukrainian physicians as “intellectual slaves” (Bobrov 2004b). He says, “After doctors are sworn into the profession with the Hippocratic Oath, a stethoscope is tied around their necks like a rope, and their lives are cursed with a big red cross.” In his view, the socialist state has promoted an image of a physician as a healer who is poor, but brilliant – the so called yurodivy or God’s fool:

Gradually, society developed a deep belief in this myth and internalized the image of disfranchised doctor-beggar, who is either yurodivy (God’s fool) or a hermit monk, completely deprived of material or spiritual needs. At any physician’s attempt to change their situation, the apologists of this mythology almost religiously refer to this Oath – “Have you sworn to it? Then – bear the Oath!”

Purportedly, the Greek original of the Oath also contained paragraphs that emphasized the business nature of the biomedical profession, stating that physicians should customarily charge patients a fee and perform free services only occasionally in order to promote the humanitarian image of the medical professional and market his labor (the original refers only to male physicians). Many Ukrainian physicians today are excited to hear this message: it is normal to accept money from the patients if the state fails to reimburse for their labor. These doctors find legitimization for their informal money-making activities and reaffirm their professional status in this re-negotiation of their rights and responsibilities. Bobrov utilizes the term medical apportionment [Rus. медразверстка] to draw parallels between current status of Ukrainian physicians and the Stalinist policy of division and redistribution of land that took place in the late 20s and early 30s of this century. Using Marxist language, in which most Ukrainians trained in
the Soviet Union are conversant after years of required classes in Marxism-Leninism, he claims:

Populist demands of free healthcare, so popular among politicians and the general population, essentially led to the “med apportionment” whereby physicians’ labor, qualifications, knowledge and talents are forcefully alienated from them for meager wage or sometimes no wage at all.

Veronika, who is a senior pediatrician in one of Kyiv pediatric clinics, similarly criticizes socialist rhetoric to emphasize that the current contract between physicians and society needs to be revisited, since it does not correspond to the market-based world order. She displays a copy of the Oath on the wall of her office. During one of our meetings, we discuss why she has placed this document for everyone to see. Here is what Veronika says:

Go ahead, read what it (the Oath) says. It does not say that the medical treatment should be free of charge – we need to think about how we will feed our families… We often hear “You gave the Hippocratic Oath – so you must treat me, and you also must do many other “musts.” Now we have this call-center, do you know what it is? It is a place where people call to complain. An old lady who has nothing else to do calls and asks to “issue” her a doctor. Currently, we already feel the shortage of physicians in our clinic. How can we suddenly produce a doctor for her? People are encouraged to call the center and demand a physician, as if we were the objects to be distributed and not live humans.

Veronika’s narrative exposes a conflict between healthcare providers and consumers of their services. In Ukrainian society, new forms of inequality and social distinction are developing (Phillips 2010, Wanner 2005). Rivkin-Fish (2009) has shown that understanding the ways in which class gets expressed and contested is the key for understanding post-socialism. Given the contested status of the medical doctors, I offer a brief look into the ways in which class is implicated in this professional dynamic. In the next section, I explore relationship between physicians’ understanding of professionalism and current process of social differentiation.
III. 2. B. Resurrecting class struggle.

Discussion of class is in many ways illuminates physicians’ understanding of professionalism. It sheds light on the hierarchies in which physicians are involved and how they understand their rights and responsibilities. In her recent work on Russian physicians, Rivkin-Fish (2009) discusses the saliency of class as a signifier of distinction that apportions recognition and prestige to others. She understands class more than just “people’s place in the stratified social setting that shapes their opportunities” (2009:81). In her view, class is also “a subjective category of identification through which Russian people give expression to their horizons of opportunity and with which they perform distinction from others” (2009:81). Rivkin-Fish deploys the concept of social memory to understand how class is expressed and contested today. She goes back to the formative years of Soviet history to discuss the emergence of class categories, and their continuing importance in post-Soviet context.

Soviet Union deployed the notion of class based not on characteristics of wealth and education, but rather on social origins and, important for this essay, occupational differentiation. Working class was discursively associated with the revolution and the state. Although not all industrial workers must have shared revolutionary goals and values, in the minds of the general populace they were seen as representatives and supporters of the government. At the same time, Soviet State sought to modernize and civilize the country. While this work involved material improvements, such as building new roads, houses, offices, extending electricity to the countryside, motorizing collective farms, etc., it also included what Rivkin-Fish calls “moral education,” which means training Soviet citizens to be clean, honest, decent, have good manners, and life goals
consistent with the socialist project. This “moral education” is known under the term culturedness [Rus. культу́рно́сть]. Culturedness is “an admonitory and educative … combination of polite manners, hygiene, and basic knowledge of high culture, as well as sanctioning a particular kind of consumerism that took root in the 1930s and remained a central aspect of social and moral life from that time forward (Fitzpatrick 1999). In the absence of discussion of poverty or inequality, performing culturedness was associated with being a part of the Soviet middle class or intelligentsia. Intelligentsia is a category of distinction that symbolizes “high education, and the attendant respect and authority that one can derive from honesty and moral righteousness” (Rivkin-Fish 2009:81). Although the Soviet state never officially changed its stance toward glorifying the working class, in reality the values of intelligentsia became highly desirable. Kelly and Volkov (1998:312) ingeniously summarize the culturedness campaign in the following paragraph:

Kul’turnost’ campaign… reached across classes to construct an ideal collective in which those spurning the new values could be seen as reef-raff (‘hooligans,’ ‘bohemians’), but those who were too overt in their material attachments might be lambasted as ‘vulgar.’ By providing not only a pattern of conduct, but also a model for day-to-day living, and by harnessing, rather than challenging, the self-betterment aspiration that had been obvious among working people well before the Revolution, as well as satisfying the desires of the new and old bourgeoisies, it was to prove far and away the most successful ‘programme for identity’ evolved in the Soviet period.”

Supporting Kelly’s and Volkov’s argument, other scholars working in post-Soviet communities (Patico 2008, Rivkin-Fish 2005, 2009) have pointed out the persistent valence of the intelligentsia’s value of culturedness, which continues at least in part to inform class identity not as material actions, but rather as aspirations. Here, Rivkin-Fish (2009) agrees with Lindquist (2006), who has argued that agency is just as much about the intention and desire to act as it is about the capacity to implement this desire. For
many people, materializing their plans is often blocked by structural violence of post-
socialist life, yet they develop alternative ways of gaining more reassurance in their
present and future. Relying on the intelligentsia’s values that emphasize morality as
opposed to being able to consume and perform material prosperity is one such
mechanism. People are seeking to understand according to which criteria material
privileges are supposed to be distributed today.

In her ethnographic context, Rivkin-Fish noticed that physicians mixed the
categories of culturedness and patients’ willingness to pay for their healthcare. Patients
who opted for fee-based services were viewed by physicians and staff of reproductive
care facilities in St. Petersburg as educated and cultured, as the aspiring middle class. In
so doing, she argues, they legitimized burgeoning social stratification. They viewed it as
moral restitution for the middle class or intelligentsia that was prosecuted and
dispossessed during the early Soviet decades. Patients who participated in fee-for-service
healthcare are seen as responsible, respectable, and civilized. It is not only their cash that
matters, for critiques of the Russian new rich are abundant (Humphrey 1995). Yet, it is
the combination of material capital and “symbolic markers that resonate with locally
authoritative ideologies … that make wealth a signifier of distinction” (Rivkin-Fish
2009:89).

Similarly, my respondents suggest that patients seeking treatment in private
clinics are more cultured: they respect physicians and staff, and listen carefully to the
medical advice. In general, they claim, patients come prepared to participate in a new
type of doctor-patient relationships, which are more civil and orderly than in the early
post-socialist years. For those who have left state-sponsored healthcare facilities for jobs
in private offices, a more respectful and relaxing environment is often among the main reasons for leaving. Iryna, who is a female physician in her early 30s working in both state city hospital and private doctor’s office, compares the two in the following way:

Attitude is quite different. When people come to the private office, they are already counting on getting good help, and they want to get maximum return. Therefore, they behave properly… But at my work in the city hospital… Patients often offend me, yell at me. One time, a woman of my age shoved me with her elbow for no reason, just because she did not like something about me. Patients also constantly throw the Hippocratic Oath in my face …

In the same vein, my respondents often conceive of patients who arrive at their offices in advanced stages of illnesses as uncultured, uncivilized, and in need of discipline. These patients are dubbed (in Rus.) “запущенные,” which can be loosely translated as neglectful and neglected at the same time. On the one hand, healthcare providers are very critical of such patients and their families, viewing them as almost criminally negligent to their health and uneducated brutes. On the other hand, this term “запущенные” also implies that the patients are forgotten by the system, by their families, and society as a whole. Physicians’ interviews reflect both of these meanings. For example, Halyna’s account represents a more critical angle. She is a pediatrician who also runs a gym. In her late 40s, Halyna has slimmed down to almost half of her body mass, and then started a gym business with another trainer. Getting a new lease on life, she feels that as a rule Ukrainian population is passive and inert, not taking care of themselves:

They (people) don’t want to do anything, but at the same time they want free healthcare. They do not want to think about their health themselves, instead counting on a “free” doctor who will run to their rescue with an injection, and they will turn healthy immediately… They are not prepared to take care of their health, and even less so to pay money for it. They don’t even want to care about themselves in general… This is our culture.
Less critical respondent Yana, who is the head of the unit in one of the specialized clinics in a smaller town, recognizes the inefficiencies of the system that cause certain patients to slip through the cracks. Especially for village population where healthcare services are dilapidated and often nonexistent, access to timely checkups is a problem of more than just personal negligence. Yana recollects one of her night shifts when she had to do one of the most difficult things in her working career:

The paramedics brought in an old woman screaming of pain, lying on the stretcher. Our clinic is not a hospice, and it is not a general admission hospital. It is a specialized center, where we treat only those who still have a chance. We do not provide end of life care. They (paramedics) sometimes bring us patients who we are not allowed to admit. Their illness is too advanced, but it is their first time seeking medical help. This old woman, she had cancer everywhere, metastases to major organs, spinal cord snapped from cancerous cells. I had to send her to a regional hospital, because it is their jurisdiction. I had no right to issue morphine to her, because she had not been exhaustively diagnosed. If I did, it would have been a criminal violation.

Yana understands that the elderly patient was deserving of treatment, but structural barriers have prevented her from seeking timely help, leading to a disastrous situation when pain became unbearable. Yana is worried about the woman’s chances in the regional hospital as well. This narrative, supported by many other interviews, suggests that Ukrainian physicians do not see new social hierarchies as solely restoring the lost moral order damaged by the Soviet Union. They understand the unfairness and ugliness, since they have become the enforcers of some of the mechanisms of new structural violence. While in the past regular medical check-ups were conducted in all rural areas (even if they were not exhaustive), today, marginalized patients have no access. Some of them would have to physically walk for kilometers at end to get to the nearest clinic. Physicians see such examples every day, and for the most part have no illusions about the future. While they have been resentful of low salaries that were
apportioned for them by the Soviet state, today they still regard Soviet healthcare as an example of order and function, as compared to post-socialist dysfunction and mess. My ethnographic data, therefore, at least in part disagree with what Rivkin-Fish (2009) has found in Russia where she argues physicians understand “social inequalities … as societal progress, a moral form of development.”

Rivkin-Fish does complicate this rather simplified vision of class relationships by acknowledging the ways in which intelligentsia has always been entangled in power structures during the Soviet regime and afterwards, as well as the ways in which working class people were contesting the socialist state, especially given their struggles for material well-being and access to the resources. Similarly, in post-socialist societies, the earning potential of many has nothing to do with their culturedness, and has everything to do with structural barriers. In fact, many of my respondents questioned the culturedness of physicians themselves. Ihor, who is a young anesthesiologist fresh out of medical school, compares some of his co-workers to uneducated bazaar traders, who yell and shout, debase each other and their staff, have no interest in professional news, and smoke incessantly. Other respondents criticize their co-workers for diminished respect for their collective work, lack of collegiality and interest in new developments in the field, as well as spreading themselves too thin among several jobs, which make them unable to commit fully to either one. These internal criticisms on the part of physicians themselves point to their critical engagement with changes that come with market reforms. Physicians do not always contrast themselves as cultured intelligentsia to uncivilized patients in need of discipline. Sometimes, they wish some of this discipline upon themselves. Rivkin-Fish does not discuss these internal conflicts within the biomedical profession, nevertheless
she convincingly shows how social memory is at least in part instrumental in the processes of legitimization of social differentiation, which renders some people blind toward larger social barriers.

Phillips (2008) concurs with Rivkin-Fish and Lindquist in her consideration of class as a discursive channel rather than social differentiation based on consumption in the burgeoning new market economies (Patico 2005, 2008; Humphrey 1995). Employing Stark’s (1994) sociology of worth, Phillips argues that in Ukraine women social activists, whom she worked with, discursively created distinctive social orders – a privileged modernized “Western” and marginalized devalued “Soviet” social order. In my ethnographic scenario, physicians similarly used discursive means as a way to repair their sense of personhood and position themselves above the newly rich portions of population.

A thread that runs through most interviews is a sense of bewilderment at the imbalance between low official salary of the medical doctors, and intense training and critical responsibility of their daily work. Andaya (2009:359) notes these tensions between “socialist ideologies of moral standing and new social hierarchies based on wealth” in her work on Cuban healthcare as well. Physicians attempt to position themselves above most other professions as a highly intellectual field of knowledge. Many resent popular association of healthcare with the service sector. My respondents do not view their job as one that does not produce anything – in fact, its product, they argue, is invaluable – health and lives of the Ukrainian population, which should be especially treasured today when the state faces negative population growth and peaking migration
rates. Physician-social critic Bobrov (2004b) captures these feeling in the following picturesque and provocative way:

And then physicians start to think – “Why is it that a prostitute can set a price for her services; a talentless, but pretty singer can demand a thousand dollar honorarium for her lip syncing and grimacing on stage; a cab driver won’t drive without pay; an official won’t sign a document without “respect;” a policeman won’t wish you a safe trip for mere “thank you;” a lawyer won’t take on a case for free; a waiter won’t serve without a tip; a hair-dresser won’t style hair; a deputy won’t vote, but they – physicians who rescue lives, are not permitted to name a price for their work?!

One of the most colorful parallels that physicians like to draw is between themselves and janitors. A proverbial janitor working in one of the newly sprung banks, allegedly, won’t work for anything lower than 500 USD per month. Physicians bring this as an example of new class injustice, comparing their own 200USD official salaries and hypocritical attitudes of society, instigated by the state. This hypocrisy of the state has also been discussed in the chapter addressing the concept of prestige. Physicians also comment on other service professions, such as hairdressers, plumbers, repairmen, as well as construction workers, as examples of mismatch between education, responsibility, and remuneration. Ukrainian physicians deploy the categories of intelligentsia and blue-collar worker, as a way to expose hypocritical state policies that they wish to see changed. The next chapter will discuss the ways in which physicians’ imagine the role of the state in healthcare transformations.

III.2. C. Looking abroad for ammunition.

At this point, it is important to mention that physicians look abroad for comparisons and ammunition to challenge this developing class injustice: official salary incommensurate with their status as intelligentsia and performance of culturedness.
Ukrainian physicians certainly see and compare their position to that of doctors in other places in the world. Ihor has a positive mindset and he is convinced that he will do well for himself professionally. Yet, he feels humiliated by the difference between his official salary below 100USD and the salaries of commercial professionals in nonintellectual jobs with little responsibility, such as real estate brokers or bank tellers. He is an avid internet user and an English speaker, which enables him to chat in the international online forums. During these conversations, he gains insights into the professional life in the West and engages in sharp critique of domestic healthcare politics:

I am very resentful. I read American forums, and I see that American anesthesiologist receives 300 thousand dollars per year, and he can receive anywhere from 1,000 to 8,000 dollars just for one shift. Even nurses make good money – but here (in Ukraine), I don’t even know how our nurses survive. Here, mediocre managers in supermarkets earn twice as much as physicians… Our level of professional responsibility and training does not even compare to those of the supermarket managers…

Physicians like the young anesthesiologist Ihor chastise their colleagues for what they call excessive patience and inertia. They sometimes personalize the failures of the healthcare system and dole out responsibility for the lack of change to the people themselves. Three neurosurgeons in their late 30s who work in one of the largest Kyiv hospitals had this to say:

Our physicians are apolitical and inert. Look, everybody is out protesting, but not physicians. And we (doctors) have a good excuse: the law forbids physicians to go on strike and discontinue our services. However, there are loopholes. For example, those who are not on their shift can gather for demonstrations. There is no law prohibiting expression of negative emotions in your free time. But no one is doing this. Everyone is quietly complaining and spewing steam. In our hospital, physicians are complaining that Kyiv city administration took away additional payments that we used to have as an adjustment for the cost of living in the capital. They say, “We should write a complaint.” Go ahead and write it! But all they do is talk… Nobody wants to work to change anything. I call this immune inertia. It is genetically programmed in us. The entire country of Ukraine is too quiet and calm. I have no clue how we managed to have this Orange Revolution –
so many people finally stood up for themselves! But usually, everyone is quiet here. If everything is good – wonderful! If it is bad – we will take it, we will wait it out. Ukraine has always been under different imperial rules or exploitation: Tatars, Poles, what have you. Our country is too young, and we do not have that feeling, self-realization that we are individuals who are capable of voicing our will. Perhaps, the young generation is more active, but older ones are totally pushed into the ground by all of this baggage.

Disappointments like this lead some physicians to search for the opportunities to migrate abroad. In general, thousands of Ukrainians have been migrating after the break down of the Soviet Union, either permanently or for temporary jobs. For those migrating west, the United States and Italy are the two largest receiving countries (Solari in press). Usually, migrants perform manual labor, employed in construction, agriculture, janitorial, and other jobs that are not connected to their professional histories. For women, caretaking jobs have been popular, such as baby-sitting and caring for terminally ill or elderlyxxxvi. It is not uncommon for professionals to quit their severely underpaid jobs for a five-year bout in Italy or Portugal for a promise of being able to earn enough to purchase an apartment and a car upon return to Ukraine. In my fieldwork, I have established a friendship with a senior nurse who quit her administrative position in intensive care unit of a specialized clinic for an illegal job in the US taking care of an elderly couple for 2,000USD per month. She has since gone back to Ukraine and continues working in the same clinic, though in a different position.

It is problematic for Ukrainian doctors who want to continue working in their field of expertise to migrate abroad. The medical profession in the West is notoriously protective of its zone of influence, and Ukrainian medical degrees do not allow physicians to start working immediately. Extensive re-testing and exams are necessary, which are expensive and unfamiliar. During my fieldwork research with highly qualified
people with broad access to information, only one respondent tried migrating to the West – more specifically, Canada. Grygoriy graduated from the most prestigious medical school in Ukraine with a red diploma (the highest honors) in surgery. He successfully completed all the tests and was granted Canadian permanent residency. However, when he travelled to Canada in hopes of starting a new job or locating a residency program, he was unable to locate a single opportunity for himself in the course of three years. He was disappointed in the hypocrisy of the Western medical programs that claim being democratic and accessible to those who follow the rules. In reality, Grygoriy found residency programs to be reclusive, based on networks of academic connections and powerful references, none of which he had. He returned to Ukraine, since his goal was not migration for the sake of leaving Ukraine, but rather migration for the sake of better professional future. When he realized that he will not be able to achieve it in Canada, Grygoriy started clinical research trial business in Kyiv with one of his friends. He is now a highly successful and prosperous individual, albeit embittered by failed dreams of being a surgeon.

Yet another type of migration in which Ukrainian physicians are involved is journeying to countries with previous socialist affiliations where doctors are able to practice medicine instead of performing non-medical labor. I interviewed several alumni of a major medical school in Ukraine who worked in Angola in the early 1980s and returned to Mozambique in mid 1990s. As a part of the socialist internationalism project, Soviet physicians served multiple-year contracts in pro-socialist African countries. These contracts were ideally awarded on a competitive basis to the most accomplished medical graduates after painstaking background checks and vigorous pre-
departure training. They were coveted by the Soviet physicians because they carried significant financial benefits and access to scarce goods. These appointments carried high prestige: they were a sign of professional success and they opened a window to the forbidden fruit of the world abroad. At the same time, Soviet physicians felt secure and wanted at their host workplaces as representatives of a powerful regime. In the post-socialist context, the labor migration of ex-Soviet physicians to Africa continues, albeit on different terms. The status of the East European doctors at their host workplaces has changed with the shift in global distribution of power. In addition to cultural differences, racial prejudice on both sides, as well as quarrels about remuneration (since domestic doctors receive higher salaries), these physicians center their frustrati on differences between Western medical training and Soviet medical training. While Western medicine pays attention to rules and treatment algorithms based on medical protocols, Soviet training has allowed physicians more individual freedom in making clinical decisions and more authority over the patients. Ex-Soviet physicians are convinced that the protocols are deficient and even dangerous in underdeveloped context, such as Africa or Ukraine. Medical protocols, in their view, provide little space for individualized approach, especially in face of severe lack of material resources. Many Soviet-trained physicians used this critique of the Western biomedical approach as a way to legitimize their medical abilities as broad and even encyclopedic, which allow them to undertake a wide range of clinical responsibilities without dependency on biotechnologies. In contrast, they view Western-trained physicians who rely on the protocols as incapable of developing creative treatment schedules that the situation and resources call for. For them, it is a testament to mistakes or even failures of Western biomedical training. One of these
migrant doctors, Valeriy, for instance, is convinced that at least on several occasions he could have saved his patient if local doctors allowed his unconventional interference. Similar to Ukrainian physicians returning to their prior African destinations, doctors who stay at home also use daily hardships of their work environments as an analytical tool to position themselves above their Western colleagues. During my interviews, doctors with or without knowledge of Western healthcare, have routinely emphasized their high qualifications and their better preparedness compared to their rich colleagues abroad whose clinical thinking, they argue, have suffered atrophy due to excessive reliance on technology. Instead, they stress their own ingenuity and skills that they have developed in face of extreme hardship.

Thus, physicians are aware of and make their attempts at employing their skills abroad, so far without much success. Especially with increased internet access, physicians are acutely aware of the higher socio-economic status that their Western colleagues enjoy. They use this information toward different ends: sometimes deploying it discursively to emphasize their own moral and professional position as above those of medical doctors from abroad; and also using this information in staking claims with the state. According to the Ministry of Health, healthcare has already started experiencing shortage of the medical staff, including doctors (20% shortage). Although none of the healthcare facilities that I visited in the course of my fieldwork lacked physicians, many commented on the dire need of nurses. Anecdotal evidence suggests that nearly six thousand physicians left the country in 2007, yet it is unknown where and how they are employed (Yasynchuk 2008). In the next chapter, I will discuss the ways in which physicians address the state in their renegotiation of the social contract.
In assessing the role of the international position of the biomedical professionals for Ukrainian doctors, it is also important to discuss discourses about culturedness as it pertains to physicians’ visions of order and future, which they have dubbed simply “civilization.” This value-ridden term requires detailed discussion, which will be offered in the next chapter.

IV. New generation of physicians?

The contrast between discourses that chastise monetization of healthcare sphere and those that celebrate the market is best reflected in generational differences, or at least, perceived differences. To highlight them, I will compare narratives of physicians who were trained and who worked in Soviet Union, and those who came of age in independent Ukraine. Many older physicians express deep concern with post-Soviet medical students, their alleged low professional level, little worry about their patients’ well-being, lack of desire to gain new skills and knowledge, and zero loyalty to their workplace. Younger generations of Ukrainian doctors are often narratively associated with low expertise, but sky-high ambitions. Older physicians reminisced about how hard it was to be accepted into the medical school during Soviet times and how proud they were to get in. Now, they feel, medical schools accept whoever is ready to pay, regardless of their motivations and preparedness. In Soviet Union, they explain, even students with powerful connections were prepared and had to study hard. Today, they compare medical students to paying customers of the medical universities rather than future physicians. Often, they worryingly told me, “Who is going to treat us when we are old?!?” hinting that they would
not entrust their health to today’s youngsters. In the mind of many physicians, medical schools should not be fee-based, but should instead have very high admission standards that would attract only the most outstanding and smartest students, regardless of how much money they have in their pockets. This is how emergency physician Mykola describes his younger colleagues:

Young doctors have lost their morals. All they have is cynicism and the sparkle of dollars in their eyes. They do not have empathy or kind souls. When I run into some of them at work, I am baffled by their sheer lack of competence.

Another respondent Victoriia, who is herself from a younger generation, trained in early 90s, is utterly disappointed in physicians of her age whom she dealt with during a serious illness of her newborn son Serezha:

I am very negative about my own experiences. We had health issues when Serezha was born. I had not encountered our healthcare from the patient’s side before. But during that time, I finally saw up close how cynical they (physicians) were. They were absolutely indifferent to the patients. All they wanted from us was money. And even when we gave them money, they did not want to work for it … Negligence, cynicism… Horrible. When we finally left the hospital, I was deeply offended by my colleagues’ attitudes. Other than their own ambitions, nothing else interests them. There is nothing humane in them. They have probably never even heard about ethics and deontology.

What do these young physicians have to say in their defense? They vehemently disagree with these depictions of their over-monetization of work obligations. Indeed, during the data analysis, I was not able to find any systematic differences in narrative responses based on age. Different attitudes about what it means to be a professional tend to stem from people’s life trajectories influenced by family background, social origins, personal, educational and professional exposures, networks of friends and colleagues, rather than age and education in Soviet or Ukrainian medical schools. This is not to say, however, that physicians are completely against market relationships in healthcare. Many
point out that the current switch to monetary relations is normal and expected, and therefore not morally wrong. Indeed, some physicians praised younger doctors for their ambitiousness, mobility and energy. Dina, for instance, who works in the lab of a prestigious diabetes clinic, praises her son and his friends for their individualism, energy and creativity. Her son attends two universities at once: a prestigious engineering school to please his parents, and another technical college where he learns web design, which is his true passion. Working only part-time, he is already making more money than his biochemist mom, and his parents are proud. Older physicians hope that young people may be able to finally open the doors that have remained closed for them and usher in meaningful reforms. Though frustrated with younger doctors’ unwillingness to help them bear the burdens of unpopular biomedical work, they also recognize that younger doctors’ attitudes may speed up desirable changes in the healthcare. Here is how these two female physicians who work together as primary healthcare providers in Kyiv explain this:

Young doctors will no longer go out of their way to save somebody. Our society is now free, everyone is free. Younger physicians have decided that if they are not paid they will not work. Perhaps, this is the right attitude. Finally our officials and politicians will have to think about healthcare when there will be no one to pick up the pieces. The times of philanthropy are over, and people refuse to work for free.

Young people at least attempt to bark, they want and they try to make themselves heard. There is some sort of protest coming from them. Those who are older are keeping silent, or they say something quietly, but they do not try to fight.

Younger physicians in part agree with this view. They feel like they are more progressive than their older colleagues who have what they call “Soviet mentality.” What they mean by this is inflexibility, living by the book even if the rules no longer make sense, and feeling entitled to benefits instead of trying to fend for themselves. Denis who
is a male medical resident in one of the psychiatric clinics, describes this “Soviet mentality” in the following way:

These are retired doctors, communists. These are people from Soviet times who are used to living by the book. They continue awaiting the bright and glorious future. You understand whom I have in mind. We have already moved on, we understand that one must pay to get high quality of services. This ship has sailed.

Young doctors can also have Soviet mentality, according to my respondents. This is a matter of attitude rather than age. A discussion during one of my focus groups comes to mind. I spent an evening talking to two female physicians in their early 30s, Kateryna and Eugenia and a 40-year old Kateryna’s male cousin Constantine who is a successful IT specialist in Kyiv. He worked on a number of IT projects in various healthcare facilities, including new reproductive technologies clinics and several research labs. He is also a co-founder of a private clinic in his home town and he has created the first computer response system in emergency hospitals throughout Ukraine. Our discussion centers on the roles and responsibilities of physicians in contemporary healthcare.

Kateryna is not satisfied with her main job. She works as an admitting physician in a regional hospital, responsible for the intake of patients hospitalized by the emergency service. She has to take double shifts, because of poor organization of work responsibilities by her boss and in general inefficient healthcare delivery system in the town where she lives, not far from Kyiv. As many other physicians, she has a second job that she really enjoys. When her daughter started having digestive problems and biomedicine did not help, Kateryna got into homeopathy and eventually received additional training in this field, and regularly takes new courses in homeopathy. However, she is reluctant to even consider quitting her unsatisfactory and poorly reimbursed job in the regional hospital in order to open private homeopathy practice.
Constantine has been trying to convince his cousin that he and his wife will help her if she starts her private enterprise. He thinks Kateryna’s is the problem of the mindset, not circumstances. In his view, she is scared to move to an unknown territory and she feels responsible for things she should not worry about (such as who will be able to pick up her shifts if she quits), since it should be her head physician’s headache, and not hers. Constantine believes that Kateryna’s good intentions are misguided, and because of people like her, the inefficient institutions keep afloat. Instead of worrying about the no good system, Constantine argues, she should think about her own good. Kateryna parries that there are a number of structural problems that make private practice impossible: approval of the regional senior specialist, favorable decision of Kyiv-based licensing committee, qualification exams every five years of practice, extensive written reports, and committee meetings with regional specialists. For Kateryna the degree of bureaucracy involved in this process is insurmountable. Yet, Constantine views these reasons just as excuses. For him, Kateryna simply has Soviet mentality, she is unable to see the forest for the trees and keep her eyes on the prize. Kateryna and Constantine reflect diametrically different opinions. For him, keeping in step with time is a must even if it involves unpopular decisions and some isolation from previous circle of colleagues. For her, navigation of the new system that has combined market rationality with excessive bureaucracy seems impossible, and she is also unwilling to let down her colleagues at work who would have to pick up her shifts if she were to leave. A younger physician in her 30s shares more socialist ideals than her cousin who is a generation older than her.
Younger doctors also challenge the assumption that they are guilty of back-stabbing and cut-throat attitudes at work. Instead, they argue, it is more established physicians who hoard the resources and are unwilling to share their expertise. Kateryna, for instance, reminisces that she has learned next to nothing during her residency at the hospital. Physicians who were supposed to mentor her viewed her as a burden in their busy schedule. Other young doctors have confirmed that competition in the hospitals is fierce. Newcomers are viewed as potential threat rather than colleagues. Young doctors feel that the only older doctors willing to share their expertise are either family members or friends. In Ukraine, medical students who receive full scholarships from the state are assigned to their residency locations, and local doctors have little to say in choosing new incumbents. Those who pay for their tuition also have to pay for their residency placements, and even with money they are not guaranteed attention of their mentors. One of the rumors circulating in the medical circles at the time of my fieldwork was that surgeons would try to block the view of the newcomer residents during operations so that they do not learn the techniques. Medicine tends to be a so-called clan profession where entire families are often involved in this field. Many of my older respondents share that they have supported their children who decided to attend medical school, because “it is better to teach my own child than somebody else’s” (in regards to residency training). In response to the older physicians’ question of “who is going to treat us when we are old?!”, younger physician respond through the words of Alina, a young general practitioner:

In order to have good specialists when they (older physicians) get old – they should teach us at least a little. Every student has had a teacher who shared her experience. Not everyone was born a big boss or a luminary.
Competition for resources and access to information, clearly are becoming an important component of physicians’ symbolic capital. Successful physicians are in constant movement, combining different jobs and trying new things. Yet a number of informants believe that the entire generation problem is non-existent, and is instead an eternal philosophical quandary where parents criticize their children. Natalia who is in her early 30s, for example, says:

I think all of this (generational differences in attitude to work) is just gossip. It has always been like that: the young do not know anything, cannot do anything, are bad students, etc… There are plenty of ambitions and aggression everywhere—among old and among young. It is sometimes next to impossible to get through to our older colleagues.

As the interview data show, physicians employ both socialist-rooted and new market rationalizations in their practice, as well as more philosophical centuries-old morality narratives. Neither set of discourses is a winner. They are criticized and applauded intermittently, highlighting social change on one hand and continuing relevance of Soviet experiences on the other hand. Competing discourses that guide younger and older biomedical generations’ ideas about professionalism should be understood as “overlapping domains held in productive tension with one another, and not as autonomous and self-governing domains whose interactions consist predominantly of constraints on each other” (Ninetto 2005). This becomes especially clear as we are unable to draw a clear line between Soviet-trained and contemporary Ukrainian physicians’ expectations, practices and ambitions.
V. Conclusions.

In this chapter, I have discussed the conceptualizations of professionalism and the ways in which they are deployed by the medical doctors in Ukraine. Western sociologists approach studying professional groups as corporate actors, theorizing professionalism as first and foremost a sense of autonomy. Because Soviet and post-Soviet physicians are employed by the state that shapes their professional activities to some degree, Western scholars have argued that post-socialist physicians are deprofessionalized with an “employee mentality” (Barr et al. 1996; Burton 2005; Field 1991, 1988; Ryan 1990; Schecter 1997b). However, my ethnographic evidence suggests that professionalism is conceptualized quite differently by Ukrainian physicians. They do not view independence from state interference as a number one indicator of their professionalism. Instead, it is understood as a set of qualities that medical doctors can develop individually or within a collective, rather than in an autonomous corporate group. Extensive knowledge, skills, and training, combined with ethical and moral qualities best describe what post-socialist physicians view as professionalism.

I argue that the decision-making of medical professionals is contextual and it cannot be separated from institutional, political, economic, social and cultural contexts. Because bioethical principles that are supposed to govern the work of biomedical professions are grounded in Western philosophy, they are often idealistic and ethnocentric, because they ignore duties that people have in their families and communities, and the interconnectedness of the individuals. I have used critiques of medical anthropology to argue that professionalism of the medical providers should be understood as context based, and should take into consideration relationships between
individuals, their responsibilities, emotional bonds to each other, and the significance of the groups and society to which they belong. I therefore trace the ways in which medical doctors understand how social changes influence their profession and in what ways they should respond to these transformations. I focus the everyday ethics of Ukrainian physicians to illustrate their understanding of professionalism in post-socialist context.

Building on interviews with female and male physicians, I identified the following domains as crucial for understanding professionalism: critiques of the market intrusion into the biomedical profession and corresponding monetization of relationships; and market moralities, or the ways in which doctors reconfigure the existing resources and attempt to carve out a niche for themselves.

I have shown how competing notions of morality are concerned with balancing individual and collective interests in the pursuit of material and emotional well-being. When physicians argue against monetization of biomedical relationships, they do not display nostalgia for Soviet world order, but instead their responses are produced by post-socialist marketization. By invoking discourses on trial by adversity and market test of professionalism, they attempt to reestablish their moral value as experts in a socially needed field and as members of intelligentsia.

At the same time, ethnographic evidence emerges that market rationalities also have great currency among the biomedical professionals. This is illustrated by physicians’ re-reading and re-analyzing of the Hippocratic Oath in search for legitimization of the informal incomes and re-negotiation of their rights and responsibilities vis-à-vis the state and the patients. Following Rivkin-Fish (2009), I have also suggested that discussion of class illuminates the ways in which physicians deploy
categories of intelligentsia and blue-collar workers as a way to expose hypocritical state policies that they wish to see changed. Physicians also look abroad for comparisons and ammunition to challenge the developing inequalities and class injustices. On one hand, they position themselves above their Western colleagues based on their resourcefulness and ingenuity that were trained in them by post-socialist adversities and intense old-school Soviet encyclopedic education. On the other hand, they seek out the opportunities to work abroad and compare their situation to that of their colleagues abroad. In so doing, medical doctors engage in discussions of civilization, a topic to which I return in the next chapter.

I demonstrate how contestations between older and younger generations of medical doctors represent competing discourses that guide their ideas about professionalism. This becomes especially clear as we are unable to draw a clear line between Soviet-trained and contemporary Ukrainian physicians’ expectations, practices and ambitions. The competing professionalism discourses that criticize and at the same time engage with market rationalities, should be understood as “overlapping domains held in productive tension with one another, and not as autonomous and self-governing domains whose interactions consist predominantly of constraints on each other” (Ninetto 2005). Professionalism, therefore, emerges as a contested field where contemporary preoccupations with material and moral well-being intertwine and employ socialist and neoliberal rationalization in pursuit of meaningful professional identities.

Next chapter will turn to discussion of physicians’ relationship with the state and their visions of the future of the biomedical profession and beyond.
I. Introduction.

Post-socialist societies have been described as plagued with moral disorder, corruption, uncertainty, fragmentation, and competing discourses on proper behavior and social justice (Henig 2010, Lindquist 2006; Steinberg, Wanner 2008). In this chapter, I focus on the ways in which Ukrainian physicians make sense of social change in their professional lives and society more broadly. I will address different ways in which they engage with change and act on it. Given my analysis of post-socialist biomedical profession as a field that is undergoing profound transformations and is simultaneously transformative for its agents, I am particularly interested in the ways in which people may be able to convert their struggles and pains into forms of agency. In this chapter, I move to a discussion of overarching understandings of morality, social order, and the relationship between citizens and the state. In “Moral Economy and Informal Exchanges” chapter (IV), I focused on mundane, everyday informal practices in biomedicine. Chapter VI, “Professionalism, Ethics and Social Change,” delved into a broader understanding of the changes in the biomedical field and professional ethics as they have been shaped by new market economy. This chapter will offer a somewhat summative discussion of even broader conceptualizations of morality. I ask, what are physicians’ dreams and aspirations? What is right and wrong? How do physicians engage with the concept of morality?

Post-socialist healthcare is bursting with competing interests, commitments, and notions of how healthcare providers should relate to each other, their patients,
administrations, and the state in general. Similar to what Phillips (2010) has found among Ukrainian disability rights activists, physicians negotiate and rework these debates both under the auspices and outside of state discourses and policies.” As the previous chapter has demonstrated, social differentiation and new class formations are prevalent, and physicians seek to renegotiate their relationships with the state and also beyond it. They reach for new market discourses to carve out a more lucrative niche for themselves and reap new forms of empowerment. At the same time, they continue to discursively rely on the state and hold it accountable for the current state of affairs in the Ukrainian healthcare as well as future reforms.

My ethnographic evidence highlights competing notions of morality, shaped by market developments, on one hand, and enduring socialist discourses on the other hand. Questions of the state and the structures of power that govern people’s lives are central to discussion of morality. The centrality of questions of governmentality and subjectivity for post-socialist societies has been pointed out by Phillips and others in recent special issue of Ethnos (2005). My respondents concur, and the state features prominently in their critiques of current visions of the open market and state’s role in the new economy.

I begin with anthropological theorizations of multiple moralities and disorder. I contextualize these notions in my ethnographic material, proceeding to discuss physicians’ engagements with the state. I first address disorder and dysfunction conceptualized in respondents’ critiques of the Ukrainian Constitution and neoliberal policies. I continue with a discussion of the types of relationships and interactions that disorder gives rise to. I consider the notions of everyday uncertainty, work collective, biomedical leadership, and new communities of support, linking these ideas to Roitman’s
II. Theoretical considerations.

II.1. What does the morality framework mean for the anthropological discipline?

In their recent influential edited volume, Steinberg and Wanner (2008:3) define morality as a force “shaping how people explain suffering, form values, craft identities, and imagine change.” In particular, I am interested in the ways in which Wanner and Steinberg tackle understanding of loss and disorder, rebuilding community and healing, integration, and shared values, on both local and globalized levels.

Drawing on Heidegger (1953) and Logstrup (1997), Zigon (2007:148) argues that a distinction must be made between “the unreflective, moral dispositions of everyday life and the conscious ethical tactics performed in the ethical moment.” The concept of morality reflects the normally unquestioned, unreflective mode of everyday life. However, occasionally disagreement arises and something breaks down. The moment Foucault calls “problematization” (Zigon 2007:137) turns the everyday unreflective state of mind upside down and is a moment when decision-making takes place and ethics must be performed. Zigon calls this moment a moral breakdown, and argues that this should be the main locus of investigation since it is the most indicative of a person’s self-work and changes in the everyday. A person must perform an ethics act in order to restore the unreflective moral disposition, even though it will never be the same as prior to the moral breakdown. A moment of moral breakdown allows us to learn a lot about an individual,
but it also has a strong interpersonal component. Because individuals draw upon their socio-historic-cultural repertoires, during a moral breakdown, a demand is being placed on them. The demand is social, and thus the main motivation for responding to it is to get out of the breakdown. This focus on morality not in its routine unreflective state, but rather at the time of stepping away from everydayness and responding to ethical dilemmas, appears to shed the most light on social understandings of right and wrong as reflections of society, culture, and power.

In societies that undergo rapid and profound social change, such as post-socialist states, this approach promises to be especially productive. For the past twenty years, Ukrainians have experienced great social, political, and economic changes and what Zigon (2007:142) has called “unprecedented… cultural and epistemological questioning.” I suggest that the biomedical profession is a particularly fruitful area for the investigation of morality due to its precarious position as the socialist model of healthcare de facto facing open market economy and double standards outlined in chapter X, “Informal Exchange and Moral Economy.” What happens to Zigon’s morality framework if every day is a moral breakdown? I will use my ethnographic evidence to try to answer this question.

According to Zigon (1008a:112), morality is “an interpretive derivation,” and not a simple aggregation or accumulation of experience. It is “not an imposition of institutions and transcendent structures onto passive agents, but is best conceived as the interpreted locus of the personal and the shared, a locus that might best be called experience.” Zigon offers a multifaceted and heteroglossic understanding of morality on three levels: emotions and feelings; temporality; and self. Thus, emotions must be
controlled by morality (self-discipline). A person first has a feeling, and then decides or sometimes automatically knows how to act (as a part of an embodied sense of morality acquired through cultural routines). The temporal dimension is reflected in the fact that morality is performed in the present context of a moral dilemma by utilizing certain aspects of the past by means of memory (mentalistic, bodily, or emotional), and by evoking the future by means of hope, desire, or anticipation (Zigon 2008a:110). Finally, the emotive and temporal aspects of morality are tied to the understanding of self. Moral knowledge is a particular “embodied kind of morality” (Zigon 2008a:111). It is not an abstract or distanced notion that informs moral convictions, but rather, it is a person’s “sense of self, her emotions and feelings, her own memories and hopes” (Zigon 2008a:112). Thus, the morality paradigm offers a more intimate entry into everyday lives of subjects, and allows us to better see the ways in which “the moral dispositions themselves are shaped and reshaped” (Zigon 2007a:148).

Morality is also about hope. Lindquist (2006:4) defines hope as “the existential and affective counterpart of agency that replaces it where channels for agency are blocked and presence in the world becomes precarious.” Focusing on Russia, she challenges the western concept of agency as inadequate for understanding the realities of life in the post-Soviet space. When people’s will is rarely sufficient for persevering and the rules of the game constantly change, an anthropologist must look at “the cultural tools to change people’s subjectivity in ways that makes their lives livable” (2006:4). Lindquist argues that the western idea of agency conflates two notions: intention, desire, or will to act; and the capacity to implement this desire. For some people, the constraining qualities of larger structures are predominant, and for others the enabling qualities are more
salient. The author argues that when the sheer physical being is not a given and the channels for materializing rational plans are often beyond individual control, people develop alternative ways to gain more reassurance in their present and future. Lindquist uses Bourdieu’s concept of illusio to analyze the intrinsic quality of humans to hope – or to have a stake in the social game. Her main argument is that contemporary Russians use magic to change their subjective feeling of control and infuse their lives with hope, which the author refers to as present pregnant with future.

Ethnographic data from this study also suggest that the notions of the will to act and the capacity to act should be separated in analysis of agency. In my analysis, I focus on respondents’ narratives, which are especially reflective of their desires and intentions. This angle is productive for our understanding of physicians’ agency. Yet, in assessing their empowerment, I also pay attention to physicians’ capacity to act, which illustrate the structural barriers and broader processes of political economy that contextualize the desires and plans of my respondents. I maintain that both of these constitutive parts of agency are equally important for our understanding of the medical profession in Ukraine.

II. 2. Multiple Moralities.

Caldwell (2008) has suggested that post-Soviet liberalization is a form of colonization by political and economic missionaries. Her argument agrees with Mohanty’s (2002) view of globalization as capitalist oppression. This framework challenges those that posit the Soviet experience as a type of colonialism. Socialist discourses still have prominence in Ukraine and post-Soviet space in general. Though discredited in many ways, so is the post-socialist “transition.” The past is being
reinterpreted and not forgotten. This analytical approach reflects continuities in people’s thinking about healthcare and the role of the state, but at the same time it illuminates changes that have occurred in this realm.

Oushakin (2004) skillfully explores the discursive production of Soviet modernity, which helps to explain the reasons for persistent relevance of some of these discourses in Ukraine today. He steps away from over-politization of the everyday life under Soviet power, and instead highlights the discursive means of production. The emphasis on industrial production and technology has gradually become equated with “self-fashioning” or “self-production” of modernity. In particular, Oushakin (2004) traces the main themes in the works of three tremendously influential Soviet thinkers: writer Maxim Gorky’s calls to tame nature; agronomist and biologist Lysenko’s emphasis on training flexible and pliant organisms; and pedagogy specialist Makarenko’s use of militarized organization of labor, in order to produce a new order of things and living organisms. This corresponds to some of the most esteemed values in socialism: activism and energy to build socialism, loyalty to the state, sharing the ideals of socialism, determination and self-discipline, and hard work and achievements for the collective, as opposed to individual success. The Soviet preoccupation with technology, materiality and objectivity is therefore a typically modern preoccupation, not unique to Soviet Union. Modernizing discourses, in Oushakin’s view (2004:416), should be understood as “attempts to frame new social and personal experience, to give it a stabilizing structure and a graspable meaning.” Using this framework, it is easier to understand the current use of socialist discourses in morality quandaries not just as nostalgia, but as the fully rational consideration of identity frames that are deeply anchored in the Soviet world order, which
was stable, systematic, predictable, and otherwise modern. This is in stark contrast with today’s “crisis of collective and personal identities, fragmentation of social networks, and the abandonment of social conventions” (Oushakin 2004: 396).

It is also important to understand that during socialism, people did not need to buy into the entire state discourse wholesale. People shared some of the sentiments, and rejected others, although it did not usually occur in the official sphere. Yurchak (1997) discusses how state power and ideology operated in late socialism (a period from the late 1960s to mid-1980s). The omnipresence and immutability of Soviet ideology led to a hegemony of representation, by which Yurchak (1997:166) understands “a symbolic order of tightly interconnected signifiers that were exclusively state-controlled and permeated most aspects of everyday life in the official sphere. These were verbal formulas, visual images, mass rituals, the topics in the media, literature, popular culture, and tightly structured events of daily public life.” By hegemony of representation he does not mean a totalitarian system where people do not contest it due to fear or because they are brainwashed. Instead, Yurchak (1997:164,174) argues, citing Zizek, that people turn into “cynical subjects” who are quite aware of the falsity of the official mask and domesticate power by transforming it into humorous triviality. People simulate their support for official ideological messages by ridiculing their own inability to change anything while at the same time suppressing their recognition of falsity of the official ideology. Yurchak distinguishes between the official and unofficial spheres, as opposed to public and private spheres. Thus, practices in the official sphere can be controlled and observed by the state, while practices in the nonofficial sphere usually are not. Both practices may occur simultaneously, such as reading a book during official party meeting
or not paying any attention to the slogans that oneself carries during the parade, instead enjoying the company of friends and a day off work. Yurchak offers the notion of parallel events to signify this complex pretense behavior and underline that it should be understood neither as resistance nor as fear, but instead as a guarantee of having a normal and enjoyable life under socialism. Cynical subjects strive for safe, self-manageable, enjoyable lives away from the official sphere, perceiving both communist activists and dissidents as suspicious and self-interested careerists betting on domestic bureaucratic structures or recognition from abroad. Oushakin’s modern Soviet citizen is thus transformed with time into cynical, but “normal” (Yurchak 1997) individual fully conversant in socialist phraseology, able to distinguish reality from the mask, and regularly making choices about which discourses to ignore, block out with parallel events, and which to participate in. This discussion of Oushakin’s and Yurchak’s research is important to grasp the meanings that some socialist discourses have for post-socialist understandings of morality.

Many of my respondents have pointed out (also supported by Zigon’s ethnographic findings) that Soviet and re-emerging Christian morality have many similarities. “Distinction between the two is not always obvious, and within the context of everyday life they can be often translated, exchanged and intermingled” (Zigon 2008a,b). Zigon’s key informant, Aleksandra Vladimirovna, has directly compared the Ten Commandments to the “Moral Code of the Builders of Communism,” because both emphasize self-discipline for the common good. For many, both Soviet and Christian morality are representative of moral or ethical behavior, ordered by certain codes of what
is right and what is wrong, predictable, and easy to navigate. This is in stark contrast to current disorder, instability, not knowing what and when to expect, and lawlessness.

In his analysis of Maxim Gorky’s “Order of Things,” Oushakin (2004) points out that the importance of daily order in structuring one’s life becomes especially visible when it falls apart. In the same vein, my respondents gave significant consideration to the theme of disorder. I now turn to the meanings of post-socialist disorder, paying attention to its dysfunctional aspects as well as potentially productive domains.

III. Disorder in “post-colony.”

In the previous chapter, I discussed how Ukrainian physicians are transforming structures that were available under socialism into hybrid post-socialist ventures. Here, I would like to extend the discussion of the ways in which Soviet imperial “debris” (Stoler 2008) could be understood not as the remnants of a discredited world order, but as the productive foundation of responses to the global market. I use Stoler’s (2008) concept of “imperial formations” as opposed to colony or empire, given their contested applicability to Soviet experience. This term emphasizes the “connective tissue that continues to bind human potentials” to their recent environments. It also allows us to register the ongoing processes by which some relations of power endure and the continuing process of decimation. Stoler’s (2008:194) focus is not on the inert debris, but on their “vital refiguration.”

What people are left with, the aftershocks of the empire, the material and social afterlife of structures, sensibilities, and things. Such effects reside in the corroded hollows of landscapes, in the gutted infrastructures of segregated cityscapes and in the microecologies of matter and mind. The question is pointed: How do imperial formations persist in their material debris, in ruined landscapes and through the social ruination of people’s lives?
I suggest that Ukrainian healthcare may in part be conceptualized as an example of such an imperial ruin that continues to inform modes of social organization but that ceases to function in ways it once did (Stoler 2008). Given its centralized and state-sponsored nature, the healthcare system is a strategic, politically charged project. According to the constitution, healthcare must be free and accessible to all; however, medical facilities are unable to provide such care and increasingly rely on the informal economy. Multiple moral codes are currently operating in the Ukrainian healthcare system, where the ideas of right and wrong and state-citizen obligations and responsibilities are now being re-negotiated. This feeds conflicts between physicians, patients, and the state. What was once considered immoral comes to be not only socially acceptable, but formative in the construction of new ideas of professional success. This conflict is especially prominent upon examining the differing views on morality held by different generations of those participating in the healthcare field. Healthcare could be a fruitful field for winning the voters’ loyalty, yet none of the political forces in Ukraine today offers a clear-cut health policy plan. No matter what reforms will eventually take place in Ukraine, they are bound to meet some degree of resistance, because the direction of the reforms is towards shifting the responsibility for health onto individuals and away from the state. The political parties are wary of such unpopular statements. Significantly, healthcare reforms are stalled by the political deadlocks between different lobbying groups that are trying to gain control over the million-dollar medical industry.

I have previously argued (Bazylevych 2009) that healthcare polemics in Ukraine can at least in part be explained by conflicts between the ways in which the state wishes to project its role and the ways in which the individuals imagine it. Using Ferguson and
Gupta’s (2002) theory of state spatialization, I have argued that in Ukrainian society where free healthcare is formulated as a fundamental right, radical reforms could be a major blow to the legitimacy and authority of the state, for we are dealing not only with the reformulation of the healthcare structure and financing, but also ideology – the metaphors in which the state is imagined. Spatialization of the state is a dynamic process, and competing public discourses that emphasize varying degrees of individual and state responsibility inform healthcare transformations. These processes point to the ways in which states continue to use some of the imperial formations for new nation-building projects.

The state features prominently in my respondents’ narratives of critique of the dilapidated healthcare system, current visions of open market, and the state’s role in the new economy. Ukrainians are suspicious of state officials who have lost the trust of the population after failed revolutions and unfulfilled promises. A sense of overarching disorder permeates the narratives of my respondents. A surgical nurse, Lilia, from Neurosurgery Research Institute in Kyiv, captures this experience of disorder in the metaphor of illness. She conceives of the material manifestation of disorder (deterioration of the physical space at work) as symbolic of overarching mess in the country. Here is how she envisions it:

In reality, work conditions are horrific. In my opinion, the surgery room must be an ideal place… it must be comfortable for everyone, and first of all for patients. Sometimes I wonder what patients think as they are being rolled into the surgery room. As we are rolling them through the hospital corridors, what do they see? They see ruins, they see disarray…
I now turn to discussion of socialist formations, such as the ideal of constitutionally guaranteed free healthcare, to demonstrate how the imperial ruins expose the problems of both socialism and capitalism.


The most important disillusionment that my respondents expressed centered on unfulfilled Constitutional promises. The Constitution of Ukraine proclaims the guarantee of free and universally accessible healthcare to all people living in Ukraine (Constitution of Ukraine 1996. Article 49). In reality, however, the system is severely underfinanced and uncoordinated. This double standard of not providing sufficient funds, but at the same time demanding local facilities offer free services, together with the Ministry of Health’s ability to punish local healthcare administrations for violating laws that are impossible to follow – deem the healthcare system and the state that runs it hypocritical in the eyes of most of my respondents. As one of the experts put it, “We should stop pretending to be another North Korea. Ukraine has market economy, and healthcare is not free of charge. Quite the opposite, it is expensive and inefficient. No matter how much money we pour in, there will be no result, neither in seven years, nor in seventy seven years” (Paskhover 2008). The author proceeds with the suggestion to move the infamous Article 49 out of Constitution and into the Museum of Medicine, underlining how inconsistency the idea of free medicine is with people’s everyday experiences.

One of my respondents expressed similar sentiments. Dmytro had been working in a regional hospital for over ten years at the time of our interview. He works two jobs: the night shift in a neurology unit and a day job for one of the pharmaceutical companies
specializing in cardiology medications. He points out the extreme disillusionment with the law that is supposed to guide the healthcare system, but has instead become a nuisance for physicians’ daily work:

We no longer have communism in our country, but we do have it in healthcare… People are used to it [free healthcare]. Sometimes they show up in the hospital in borderline condition: shock, brain injury, fractured skulls, and coma. For the first 24 hours, we continuously run IVs, pour liters and liters of medications, dozens of injections. So many manipulations, but what kinds of resources do we have?! Our entire unit receives 3 pairs of disposable gloves per shift from our state. Our maximum capacity is 12 patients… Now we can calculate. Our nurses use 3 pairs of gloves to take care of 12 patients per shift, and we are working with blood and wounds… So what kind of free healthcare do we have? What are we talking about?!... I am a physician, but when my mother had surgery, I paid for everything out of my pocket. In reality, we have nothing, and medications are not cheap. We calculated that pancreatitis costs about 75 USD per day; pneumonia – additional 20 USD per day.

Dmytro’s narrative emphasizes the disjunction between the official discourse, which emphasizes the beneficence of the state as a legitimization strategy, and people’s lived experience with a severe dearth of resources and lawmakers’ and authorities’ lack of respect for order. Proven and alleged violations by powerful politicians and businessmen with political protection are so ubiquitous that popular respect towards the country’s elite and leaders is miniscule. In their stories, physicians almost universally describe their low official salaries as an injustice stemming from the incompetent and corrupt government. Many physicians highlight the double standard in Ukrainian medicine. It technically preserves the image of a universally free and accessible system, while asking its medical staff to assume an angel-like disposition: to work hard, work transparently without informal exchanges, and receive meager 200 USD per month in return when the cost of living is catching up with the Western Europe and the USA. A
neurologist, Iryna, whom you have met in previous chapters, has this to say about the double-standard:

A person who earns 500 hryvnia per month will not work as if she were paid 2,000. This is the fact. If my salary were 2,500 – 3,000 hryvnia, I would not want any “livak” (Ukrainian for leftover money, informal income), none at all, because it is criminal. After all, why should I pick up crumbs from my patients’ tables? However, my salary of 700 hryvnia at the hospital redeems everything. As the saying goes, when a physician is paid 500 hryvnia per month (63USD), she should do nothing and even cause a little harm.

III.2. The Politics of (Dis)order.

Political unrest permeates Ukrainian society. Because healthcare is sponsored by the state, it is especially influenced by sways in political power. In the past five years, at least four Ministers of Health have tried their hand at running the biomedical field. None of them made much of headway (Bobrov 2004). In their interviews, my respondents insisted that “the fish starts rotting from its head,” emphasizing that the source of disorder is nestled in the self-serving government that no longer cares about its people. Alisa is an X-ray specialist who works in one of the most prestigious private hospitals in Kyiv. She says:

When something is falling apart, it becomes easy to steal. Whenever there are radical changes in any system, not just the healthcare, it is a great opportunity for some people to snatch anything left lying around loose.

Stepan is a successful dentist with one of the most prosperous private dental offices in a town in Western Ukraine. His story is that of the American dream. Growing up in a remote rural area in Carpathian mountains, he was forced to go to boarding school due to isolated location of his parents’ home. Going to university was beyond his family’s means, and so Stepan was drafted to army and sent to Siberia. There, thousands of kilometers away from home, he started working as a medical aid, gradually realizing
his calling. Upon finishing his two-year army service, Stepan moved to a large university town in Western Ukraine and managed to enter the dental department at a medical school. In Soviet time, he says, it was much more difficult to get into the internal medicine or surgery, but it was easier to enter dentistry and pediatrics for young people without powerful connections. Today, his success is notable. His is a beautiful clinic with well-to-do domestic and foreign clients, top-notch technology, and multiple certificates of achievements lining its walls. Stepan is known as one of the richest men in town, who invests regularly in construction businesses in the area. He is also known in the town medical circles as an especially bright and knowledgeable doctor who demands perfection from his employees. This quality is deemed unusual among private dentists who are usually perceived as greedy people with little research ambitions. Stepan documents his medical practice observations, and has collected an impressive amount of data that could be used in scientific work. Yet, he refuses to pursue his research interests officially by becoming affiliated with one of the medical research institutions. He calls the current graduate and post-graduate Ukrainian education system fake and corrupt, where degrees are handed out based on bribes and connections, and not the quality of work. Stepan refuses to participate in the charade, even though he has the financial ability to pursue this path. In so doing, he compares himself to a Ukrainian writer Lina Kostenko, who has rejected the highest medal awarded by the Ukrainian state, “Hero of Ukraine,” because she does not recognize the current Ukrainian government as worthy of the country or to give out such awards. This sentiment is echoed in the refrain of one song by the popular Ukrainian band, Tartak: “I don’t want to be a hero of Ukraine,
because my country does not value its heroes” [Ukr. Я не хочу бути героєм України, не цінує героїв моя країна].

These narratives criticize healthcare bureaucrats and officials and place the responsibility for the failures of post-socialism on the individuals in power. In so doing, physicians are involved in a type of misrecognition. Rivkin-Fish (2005) argues that physicians in Russia consider their actions qualitatively different from the actions of the state bureaucrats whom they resent, and thus misrecognize the similarities, namely, their own techniques for controlling patients. This misrecognition leads to incomplete understanding of the structural reasons underlining disorder and the need to forge full-fledged solidarity in order to push for meaningful reforms. Rivkin-Fish explains that this misrecognition leads physicians and their patients to use personalizing strategies in their clinical activities. Instead of forging a corporate identity and uniting to make positive structural changes in the system, she claims, physicians and patients cast accusations and assign responsibility for the unsatisfactory situation upon each other and state bureaucrats (Rivkin-Fish 2005).

Mykola is in his 60s, and has had a colorful life. He made his way from post-war rural poverty to the ranks of practicing surgeon and senior healthcare administrator [Ukr. голова райздороввідділу] in one of the provinces in central Ukraine. Post-socialist transformations have literally turned his life upside down. In search of better opportunities for his children, who wanted to go to universities in the capital, he moved his family to Kyiv only to find himself marginalized and unable to squeeze into the capital power structures. After a bitter divorce and the loss of his home, Mykola is now happily re-married and working double shifts in the emergency clinic. He is not
embittered, but he is very critical of the direction of change in Ukrainian healthcare and Ukrainian politics in general. He says:

The spiritual and moral standards of our people have plummeted, our moral principles have changed. People used to relate to each other as friends, brothers and comrades – openly and kind-heartedly. What we have today is the wrong type of capitalism. It is not the type of capitalism we are supposed to have. It has an ugly mask. It is not truly capitalism… Capitalism should have a human face… It is neither capitalism, nor communism. All we have is total corruption and collapse. Everything depends on our leaders, but our government just sits back and watches how people are dying. Our president is doing nothing. He is fighting for power.

Like so many others, Mykola is convinced that politicians are busy dividing the state’s resources and accumulating personal wealth. They simply do not have time, knowledge, or ability to implement structural changes, with each of them pulling the blanket of the national budget to their sides, unable to reach agreement on any issue. He continues:

We are now witnessing the division of zones of influence between powerful people in the country. Until they are done dividing Ukraine, there will be no order. Europe understands this, and no one wants us in the EU or NATO in the shape and form that we are in now.

Lev is a municipal healthcare administrator in one of towns in central Ukraine. From other people in his circle, I found that he quit his previous, higher ranking position in administration due to a conflict with a new boss, who was known as one of the most unscrupulous administrators in town. Lev emphasizes how disorder originates in the political rather than professional choice of healthcare administrators and other public officials. He also blames the Soviet legacy of sticking to a plan at all cost, and the lack of basic epidemiological knowledge and statistics skills on the part of politically influential bureaucrats:
These watchdogs of the Plan (respondent’s emphasis) are a very serious problem. It is completely absurd! … Do not trust any statistical information that is “cooked” here. Mortality rates and some other intensive care indicators are more or less reliable, but not the analytical data. Because they are gathered and analyzed in an absolutely absurd, incorrect way. If I pulled these kinds of tricks in med school, I would have never graduated! All this speaks to the “cadres’ politics,” when people without basic skills and knowledge occupy positions of power… This is a simple case of dilettantism [Rus. ободу́йство,] of the ignorance of people in important positions. It is unprofessionalism of the highest caliber.

Lev also points to continuities with Soviet-style management, where emphasis on achievements was more important than the actual state of affairs. Just like during Soviet times, Ukrainian officials in managerial positions are pressured to produce excellent indicators by any and all means possible instead of reporting their difficulties and looking for the ways to address them. While the Soviet regime is no more, its logics and rationalizations have often remained in place. Das and Poole (2004) suggest the “illegibility” of state practices as a term that captures the ways in which state practices are becoming unintelligible to the people on whom they are forced. Many healthcare policies are experienced by Ukrainians as illegible or self-serving. While state regulations are embodied in the law (Asad 2004), people find it quite distant from their everyday lives. Their problems are rarely resolved, and state bureaucracy seems irrelevant. At the same time, state policies are sometimes overwhelming when they come crashing into people’s lives, for example, when working within the state-regulated centralized healthcare system. Coming from a discredited state, the purposes of its ministries and administrations seem unreadable, so the population ascribes their own varying meanings to them. It is therefore not surprising that physicians are suspicious of state decisions and loyalties.
Most physicians who worked in Soviet medicine are dissatisfied with post-socialist changes. However, they do not see it as the problem of globalized capitalism, but instead view it as the moral handicaps and extreme politicization of social life in contemporary Ukraine. I argue that this blame game feeds into continuing the uncertainty and disorder in the Ukrainian healthcare system.

IV. Productive disorder?

My interview data show that, although disorder is ever present, it is not necessarily disabling or immobilizing. Over and over again, my respondents, regardless of their age and gender, characterized post-socialist medicine and the country in general as a mess, yet their professional endeavors often indicate considerable success. In this section, I would like to discuss the types of interactions and relationships that disorder creates.

IV.1. Living on a prayer.

Although I tried to keep my mind open before embarking on my fieldwork research, I still harbored a preconceived notion that biomedical work in the post-socialist environment is likely to be a mess and physicians must desire reforms. Although I realized that there are niches of empowerment that are not immediately obvious, I still thought that the majority of my respondents would not lack for words to answer my question as to what they would like to change at their workplace and in the Ukrainian healthcare in general. To my surprise, most doctors disliked this question and did not have answers. An excerpt of my conversation with Vitalina, an exuberant female general
practitioner in her early 40s, will help explain this. Vitalina has several jobs, but she considers her main position to be at the Medical Center of Civil Aviation where she works in the department of pilot certification. Vitalina works as a general practitioner who conducts extensive diagnostic testing in order to determine pilots’ condition for operating aircrafts. Here is her take on uncertainty and disorder:

I will tell you this. We conduct pilot certifications here, and our diagnostic procedures are of high caliber. However, we can control the situation. I myself am not without sin. Obviously, pilots make a lot of money in our Airsvit, and they can afford to converse with the doctors in such a way as to be able to continue their pilot activity. We work with them, and we get paid for this. I am not talking about some serious pathology here, no. But, if it is a matter of small things here and there – I don’t mind supporting our pilots with the necessary legal paperwork so that they are ready to fly. In addition, I also make sure that I have documentary evidence as well, and that is that. Some may say it is corruption. But we do things this way everywhere. But back to your question, “what do I not like in our healthcare?” I don’t really know. I guess this is exactly what I do like about Ukrainian healthcare. More freedom of action, so to say. Frankly, I feel like tsar and God at the same time here. The patients depend on us completely. In my case, I work with men, our pilots are mainly men. All of them try to please me, and I am used to this. It feels good. I have crowds of visitors on March 8th, who bring flowers and gifts from airline companies. This is what I like about my job. In general, however, I am confident that our physicians who study well in medical school are great clinicians. They are very well trained. This is what I can say based on my observations.

For Vitalina and a number of other physicians, the uncertainty and disorder of the everyday life paradoxically means more freedom of action. Currently, rules and guidelines are being hotly debated, even if not yet officially renegotiated. What is right and wrong is not certain, and creative energetic individuals are able to find multiple ways to make situations work for them and derive significant benefits. When I asked Vitalina whether she would be interested in working just one well-paid job in a private clinic as opposed to her current busy schedule that keeps her at work nearly 24 hours a day, she answered “No” without hesitation. She insisted that she is able “to carol” [Ukr.
наколядувати] much more this way. By caroling, Vitalina means an old Ukrainian tradition of knocking on people's doors, singing carols and collecting gifts and money on Christmas, which is usually performed by children. Vitalina uses this term to capture the variety of professional activities she regularly undertakes to add to her income, and the uncertainty of the expected capital, since remuneration depends on her performance and the disposition of her clients who pay informally. For many Ukrainian physicians today it makes sense to fish in troubled waters as their hands are freed to undertake what they wish. New areas of biomedical practice are developing, and physicians’ horizons are not constricted if they are well connected to the power structures. When accountability is low, physicians feel like masters of their own destinies. They feel in control. These feelings are not shared by all, but rather by those doctors who are “successful” in adjusting to post-socialist uncertainty thanks to their talents, connections, and capital. I place “successful” in parenthesis here, because viewing these strategies as empowering or advantageous still seems at least in part contentious. For others, these channels for expressing agency may have been blocked. This is an apt example of Lindquist’s argument that agency should be understood in two meanings: as the will to act and as the capacity to act. As Vitalina has both of these channels open, she is able to be fully empowered in the western sense of having desires and acting upon them. For other physicians, only the channel of hopes and plans may be open, while the venues for acting upon these wishes may be blocked either temporarily or for prolonged periods of time. This discussion of “disorderly advantages” (author’s term) does not point to socialist ruins as much as it points to the unexpected ways in which ideologies of the open market are performed in Ukraine. One of the respondents went as far as citing the Bible to
explain how physicians cope with perpetual uncertainty and disorder, “The Bible says that we should live one day at a time. I believe this is how we live now. We are not certain of anything: neither health, nor material well-being, nothing. We are living on a prayer.”

IV.2. Collective.

In the absence of state protection or any other guarantee of their security and rights, physicians often develop unofficial mutual support networks. Thus, physicians in an oncology clinic collected money out of their own pockets to repair the office where they spent their night shifts. Many workplaces regularly use the same techniques to conduct repairs, remodelings, and other technical improvements. Physicians often back each other up if conflict with administration occurs in a practice they call securing each other [Rus. подстраховать]. Iryna, who has been working in a pediatric emergency clinic serving one Kyivan neighborhood for almost ten years, is proud of her collective:

We have four physicians in our unit. We keep in touch over the phone, if necessary, and make decisions about suspicious conditions together. In April, I had a difficult situation. I was called to see one child in our neighborhood twice in a brief period of time, and after that the child was hospitalized and died in six hours. My colleagues helped me so much at that time. They supported me morally, they helped me fill out all the paperwork, since I was in shock, completely stressed out and unable to see or hear. Doctors in our collective trust each other. We all do our work and we do not compete with each other (I know it happens in other places). We split responsibilities, Oleksiy, for example, is very good at digestive issues. Everyone has his or her strong sides. Because we are an emergency clinic. Once we had a situation when one of our doctors saw a child in the evening and did not catch any problem, but in the morning during my shift I found meningitis. These are children, their conditions progress so fast. Nobody is safe here. Ten hours later anything may emerge. I trust that during her shift, meningitis was not detectable yet, and by the time I got there – it was. Of course, I protected my colleague, I calmed down the parents, explained everything. Otherwise, we would have huge problems and investigation. But it can happen to anyone, at any time. That’s why we are very collegial in our collective.
By protecting each other, doctors protect themselves. Ukrainian biomedical practitioners do not use malpractice lawsuits to this end. Instead, like many other relationships in healthcare, their strategies are individual and personalized, for better or worse. Personalized networks are formative in establishing trust among the biomedical professionals, and they substitute for their lack of trust towards the state and its officials.

Work collectives, as the interviews demonstrate, have not lost their relevance. The same has been reported by Patico (2008) and Bloch (2005) in Russia. In facilities where the atmosphere is more competitive and intense, collectives are still present discursively in people’s lamentations about their absence. Collectives are not always gendered, but sometimes this aspect gains especial currency. This is especially true of surgical units that tend to be male-dominated, as has been discussed in previous chapters. Ivanna is an oncology surgeon specializing in breast cancer. She is 34, and she is mentored by her mother and father who are both surgeons in the same clinic where she works. Ivanna finds her work enjoyable and profitable, yet she tries not to spend too much time in the office that she shares with the rest of the surgeons in her unit who are all men. She has found a different collective where she feels comfortable, that of chemotherapists who are all women. Here is what Ivanna says about the significance of her collective:

Men are more forward and tactless, for example our surgeons on the 4th and 5th floors of the clinic. Women are more tactful and considerate. Our work is difficult. After I climb the stairs to the 5th floor, all I see in my office is a cloud of cigarette smoke. It is not pleasant to spend all day like this. In any female collective you can relax, talk about something that bothers you, and you can share your problems. You cannot do this to the same degree with men. I end up sitting there on my own. It is the same for men who work in predominantly female collectives. It would be great to have 50/50! But if the majority is one gender, then it is uncomfortable. Medicine is in general a very nerve-wrecking profession. So it is important to have an emotional outlet. Whenever I feel down or get hysterical, I go to the chemotherapists on the 2nd floor and let my worries out [Rus. вылью душу]. I immediately feel better. I would never think to go to men
on the 5th floor to talk about my problems. But an emotional outlet must be there, and a collective is very important for this. No matter how prestigious your job is, if your collective is not good, you will not be satisfied at work.

Bloch (2005) argues that the revitalization of socialist ideals should be understood as a form of critique of the neoliberal logics emerging in post-socialist societies. The emerging social stratification and new inequalities make people reexamine their conceptions of social order. Bloch argues that rather than dismissing these sensibilities as nostalgia and false consciousness, it is more accurate and productive to explore the ambiguities of lives under state socialism and the open markets. Oushakin (2007) offers a slightly different take. He criticizes scholars who got excessively excited about the notions of nostalgia for socialism as an act of resistance to neoliberalism. He argues against the politicization of nostalgia, and suggests that exploring the old and familiar form in which messages and sensibilities are delivered is key. Oushakin (2007:453) demonstrates that “the cultural logic of these reincarnations has more in common with the act of mechanical retrofitting … rather than with the process of political restoration.” He disagrees with the major criticism of nostalgia that emphasizes a profound gap between the sanitized nostalgic reproductions and the actual traumatic socialist history. Socialist experiences differed, and both Bloch and Oushakin agree that a more fine-grained exploration of socialist sensibilities is necessary for understanding contemporary issues in the post-socialist space and beyond.


Valeria, who is a WHO employed physician specializing in tuberculosis and now working mainly in public health projects, refuses to participate in the blame game and
identify the source of disorder in biomedicine as the moral flaws of the officials. Instead, she argues, these are extremely bright and outstanding people who happen to do this important work in the worst time possible, becoming targets of public discontent.

Similarly to Lev, who is one of the local healthcare administrators, Valeria traces the current disorder in healthcare to inefficiencies in a system that has not undergone the changes necessary to align it with the realities of contemporary life. She feels that the system continues to work according to Soviet logic of punishing for mistakes instead of creating workable solutions to problems. She believes that local healthcare administrators are motivated to micro-manage their facilities and never address structural problems out of the fear of inviting ministerial auditors whose sole purpose is to expose and establish guilt in the Soviet spirit. Valeria and Lev both think that audits, the purpose of which is exposure rather than constructive feedback, are useless, and they agree that healthcare administrators must be especially talented and bright in order to keep their facilities afloat, please the Ministry of Health, and satisfy their patients. Valeria has called this quality a “special sense of humor.” When I asked why auditors themselves were not interested in knowing the real picture on the ground and were instead satisfied with the façade, Valeria explained:

The task of local administrators is not to make things work well at their workplaces, but to show that this is so in their reports. Head physicians and regional administrators know the situation in their districts very well and they are prepared to work hard. However, they also know that if they show unfavorable data to their superiors they will have too many problems. Nobody wants this. Those who have strong hearts and good sense of humor sometimes release truthful data. But what’s the point? The structure is vertical. If their superiors know them in person and have good relationship, they call and tell them to rewrite the report. But if they do not get along, the truthful administrators achieve only reprimands and are often kicked out of their positions. On rare occasions when an entire region decides to produce truthful data on certain health related issues, the Ministry of Health begins to assign blame: this oblast is good, and that oblast is
bad. Maybe they won’t be slammed with penalty fees, but they will get a lot of headaches and serious reprimands. Some heads will roll.

In her narrative, Valeria conceives of administrators as smart pilots of the dilapidated and inefficient healthcare system. Yet, in so doing, she does not see how the actions of these administrators feed into the continuing inefficiency of the system and push the possibility of positive change even further away. Nevertheless, her words are illustrative of some of the more productive ways in which people handle disorder and uncertainty in healthcare.

Roitman (2004, 2005) offers the term “productivity of the margins” to argue that, while informal exchanges and unofficial management are often conceptualized as outside of the state or opposing the state, in fact, these activities are fundamentally linked to the state and are essential to the re-composition of state power in conditions of extreme austerity. In performing “fiscal disobedience,” people etch out new economic spaces with the goal to “fill the postcolonial state’s coffers and finance its constituents” (Roitman 2004:192). In Ukraine, the state lacks authority and legitimacy in the domestic realm; however, according to Roitman’s logic, this does not signify a weak state. Roitman’s critique is that the states deemed as weak can still derive power from other sources, or what Foucault calls the “capillary effects of state power” – those forms of power that exceed the state bureaucracy and its central institutions. For Roitman, capillary power is just as strong as the rational-legal state’s power. Thus, state infrastructures can still be efficacious even if unregulated activities flourish. Thus, the Ukrainian healthcare sector continues to stay afloat and even display relatively good health indicators, which converge with Roitman’s overarching argument that state power may be both unstable yet effective.
IV.4. New communities of support.

Another respondent, Inna, a young female surgical nurse, agrees that one must be able to trust at least some public figures, for life without hope is unbearable. During my focus group with two nurses who also hold administrative positions in the clinics where they work, a fascinating discussion developed. We were discussing the recent donation of expensive equipment for the neonatal care unit of a local children’s hospital by the ex-President Yuschenko’s wife Kateryna Yuschenko. Both nurses were pleased, but Yulia said that real reforms are necessary, and not just donations that would never solve the problems. She called Kateryna Yuschenko’s donation a crumb from her table. In response, Inna launched into a debate:

Yulia, these are not crumbs! That is our money, why don’t you understand? This is the money that they (the government) owe us. First of all, we pay taxes that go into the national budget. Second, what about charity events? I can’t exactly remember the name of the event on my mind, I think it was “3,000.” You could call and donate money. I did, and my husband did, and Dima (a mutual friend) did. I sent a text message, and it took money out of my account for this cause.

Yulia proceeded to cynically doubt that the money that Inna’s family had sent would really go according to the address. Yet Inna was not convinced. She retorted, “We must trust people, it is not right not to trust anyone.” This scenario highlights the types of relationships that are produced by disorder. On one hand, it may trigger disillusionment and refusal to be a part of broader community, but on the other hand, it may push people to create meaningful new associations and networks that take it upon themselves to create positive change instead of waiting for the beneficent state that is unlikely to ensure welfare of its citizens in a foreseeable future.

Some of these dynamics emerge in Phillips’ (2008) work on Ukrainian care-oriented mutual-aid associations. The author discusses how women activists are involved
in civic organization and take upon themselves the roles for which the state bears official responsibility (such as care for the elderly, disable, children). These women leaders believe that they are doing the state’s job of caring for the disadvantaged groups of citizens. Yet, Phillips argues, this care work should not be considered merely a burden on the resources and time of women. Instead, women reinvigorate their sense of self, carve out niches for potential empowerment, and also boost social healing. In so doing, they are involved in recreating functional social order and claim civil society as a female domain.

In the same vein, Szmagalska-Follis (2008) traces “restoration and redemption” at the collective farm in Ukraine’s western borderland where former prisoners engage in collective work to attempt to return to meaningful personhood and restore suspended citizenship. Via the creation of new socialities using old methods and infrastructures, the author argues, Soviet life is not “unmade” (Humphrey 2002), but it is instead remade to reproduce what has been in part lost – the order and domain of collective work and life.

I now turn to a discussion of the ways in which physicians envision a new social order that they would like to see in Ukraine.

V. Visions of civilization.

Physicians envision their future in terms of hope for positive change, order, and civilization. They variously engage this concept, incorporating critical views of the state and domestic politics, as well as shaping ideas from abroad.

On one hand, they look up to the West for ideas that work, such as health insurance. Civilization is often associated with Europe and the West more broadly. What civilization denotes is a combination of material well-being, advanced technologies and
the general comforts of everyday life, as well as an orderly system of respectable relationships between people, institutions, and states. Yana, who is the head of chemotherapy unit in an oncology clinic, compares conditions in her facility to a Finnish hospital that she visited during an exchange trip:

It is 21st century, but we still have seven people per hospital room… For IVs, we still do not have dosimeters. The whole world now uses transfusators where one can calculate the number of drops per minute depending on patient’s need. We have to do it all manually. When I was in Finland, I noticed that patients get their treatment in ambulatory, i.e. during the day. They just walk in, get their IVs and procedures done, and leave. It is cheaper for everyone, and easier for the facility. Fewer staff members, no need for hotel services (food services, bed sheets, etc.) However, see, our country is not small. We get patients from villages, so they can’t just go home for the night… We do not have any transfusators. Our state does not provide them, even though they are relatively affordable, less than USD 2,000, and all we need is 15-20 of them.

Here, Yana acknowledges the primitive treatment methods still used at her clinic while affordable and significantly more functional instruments are now available. She expects the state to keep its hand on the pulse of new developments, however, she realizes that they have yet to wait for that. Ruslana expresses a similar lack of trust in the state and the chances for significant changes to take place in the foreseeable future. Ruslana is an oncologist who is currently on a parental leave taking care of her son and working for a German pharmaceutical company. Like many other respondents, she believes that even if the Ministry of Health manages to implement reforms, such as national health insurance, it won’t fix the systematic problems, since the same power-hungry officials will meddle in it:

If we had a well-designed health insurance system like civilized countries have, it would be a goldmine! If it worked as orderly and predictably as grammar does… Would not it be nice?! I would vote for health insurance twice! Alas, not in the shape and form that it is here. It is not a trustworthy situation. Only if the reforms are conducted in well-researched manner and only if they cover the entire country will we see some result. Today, nobody trusts health insurance. When companies
sell the policies, they sign contracts with banks. If the bank collapses (as they often do), or disappears, the money is gone! What if a person gets into a car accident, God forbid, or has fallen seriously ill, then what? The collapsed bank does not return any money... So, you see, people do not trust. And if there is no trust, then the system will not function. Right now, it is just a mechanism for making money.

In this passage, Ruslana questions the legitimacy of healthcare administrations. Her ideas are shaped by a disjuncture between the official discourse of the state, which emphasizes democratization and transparency, and her lived experience of corruption and lack of respect for order on the part of lawmakers and the authorities themselves (Butt 2005: 418).

The association of Europe and the West in general with civilization is not new: European urban lifestyles were the standard to which Soviet citizens aspired. This lifestyle fully captures the value of culturedness as a code of public conduct and a template for responsible consumption in an industrialized and urbanized setting (Patico 2008). This shows that domestic social order and Western discourses are not neatly separated, but have intertwined over the course of history. It is more accurate to suggest that physicians hope for more order and function in their society, regardless of the shaping ideologies. The recent presidential elections, when the main nemesis of the Orange Revolution was elected, are a testament to this longing for order as opposed to politics. I suggest that it is more accurate to consider how the attribute of “cultured” is now transforming into “civil.” Both represent desirable sociability, though “cultured” engages socialist values of collective good, moral over material values, the sacrifice of individualism and privacy for the state; while “civil” denotes more democratic values of respect for community, but also personal well-being, the power of associations, and respectable living. One illustration of this discursive move is in doctors’ perception of
civilization as a society where vulnerable groups are taken care of instead of thrown overboard. Valeria who works for the WHO in Ukraine, envisions civilization in this way:

I think the average quality of life of a Ukrainian and a Swede is about the same. However, their (Swedish) salary is ten times higher than ours, and they pay half of that in taxes that cover social needs. This is the key difference. This is the level of socio-economic development of the state. Their attitudes towards the elderly, children, and other vulnerable groups.

Valeria espouses values that may seem socialist to a Ukrainian: she advocates for sharing as much as half of people’s incomes for the state. Yet, what she champions is a slightly different form of sociality. Valeria wants social safety net, but on different terms where relationships of trust between citizens and the state would signal order and civilization. Patico (2008:11) has analyzed similar processes in Russia, arguing that the abrupt political and economic transformations “have provoked an especially intensive process of interrogating the correspondences between collective and private interests and between material and moral values.” The socialist legacy is not a relic or an obstacle, but is better understood as evolution of different approaches and rationalizations that people use to tackle challenges of transformations and the arrival of post-socialist capitalism (Patico 2008, Burawoy and Verdery 1999). Thus, some of the middle-class ideas to which physicians currently aspire partially converge with some of the values of socialist intelligentsia. Moral and material values interplay in physicians’ desire to be cultured, middle-class, and civilized.
VI. Conclusions.

This chapter has focused on the ways Ukrainian physicians make sense of social change in their professional lives and society more broadly. I have argued that people understand disorder not only as an immobilizing and fragmenting experience, but also as a transformative one. Through the words of my informants, I have shown their frustrations are mainly directed at the state, as well as the ways in which people convert their struggles and pains into forms of agency. The main question that this chapter has attempted to answer was: How do physicians engage with the concept of morality?

The ethnographic evidence presented here demonstrates how medical doctors reach for new market discourses to carve out a more lucrative niche for themselves and reap new forms of empowerment. At the same time, they continue to discursively rely on the state and hold it accountable for the current state of affairs in Ukrainian healthcare as well as for future reforms. Interviews with medical doctors illuminate competing notions of morality, shaped by market developments on one hand, enduring socialist discourses on the other hand, and broader notions of good and spirituality more generally. They also show how questions of the state and the structures of power that govern people’s lives are central to discussion of morality.

I have used Zigon’s (2008) theorization of moral breakdown as the most reflective of a person’s self-work and changes in the everyday. My ethnographic evidence has shown what happens to ideas of morality and order when every day is perceived as a moral breakdown and ultimate uncertainty. Oushakin’s (2004) skillful exploration of discursive production of Soviet modernity and Yurchak’s (1997) concept of a cynical
subject have provided a background for understanding people’s engagement with multiple moralities.

Using Stoler’s conceptualization of imperial formations, Bloch’s dismissal of scholarship that views socialist-inspired sensibilities as false consciousness, and Oushakin’s explorations of old and familiar forms in which messages are delivered, I have shown that it is accurate and productive to explore multiple moralities as a commentary on the ambiguities of lives under state socialism and the open markets. Soviet imperial debris should be understood not as remnants of a discredited world order, but as a productive foundation of responses to the global market.

I have suggested that Ukrainian healthcare may in part be conceptualized as an example of such imperial ruin that continues to inform modes of social organization but that ceases to function in ways it once did. Given its centralized and state-sponsored nature, the healthcare system is a strategic, politically charged project. According to the constitution, healthcare must be free and accessible to all, however medical facilities are unable to provide such care and increasingly rely on informal economy. Officials in managerial positions are pressured to produce excellent indicators by all means possible, instead of reporting on the difficulties and looking for the ways to address them. Using Das and Poole (2004), I have shown how healthcare policies are experienced by Ukrainians in many ways as illegible or self-serving. Their problems are rarely resolved, and state bureaucracy seems irrelevant. At the same time, state policies are sometimes overwhelming when they come crashing into people’s lives, for example, when working within the state-regulated centralized healthcare system. Coming from a discredited state, the purposes of its ministries and administrations seem unreadable. My ethnographic
evidence has demonstrated the multiple moral codes currently operating in the Ukrainian healthcare system, where the ideas of right and wrong and state-citizen obligations and responsibilities are now being re-negotiated.

In discussing the domains of uncertainty, the collective, and healthcare administrators’ “sense of humor,” I have shown the ways in which disorder and uncertainty may display the “productivity of the margins” (Roitman 2004, 2005). My ethnographic evidence has shown the ways in which some people are able to find the channels to act upon the disorderly matter of the state to reap significant benefits. I also discussed how new communities of support emerge from the chaos and how functional social order is recreated in the process. In the discussion of civilization as a category employed by my respondents to ponder about the future of the biomedical profession and beyond it, I have shown that the socialist legacy is not a relic or an obstacle, but is better understood as “evolving sensibilities and strategies that may be reappropriated, adapted, and transformed as citizens confront the many new challenges that have arisen from reorganization in a capitalist mode” (Patico 2008)

This chapter has therefore tackled the overarching understandings of morality, social order, and relationship between citizens and the state.
VIII. Conclusions.

My dissertation research has explored the healthcare system changes generated by Ukraine’s post-socialist transformations, and it has tracked how they influence prestige of the medical profession and women’s involvement in it. I investigated professional predicament of women and the extent of their participation in new potentially lucrative developments in the biomedical field. Research that took place in the early post-socialist years tended to emphasize the disadvantaged position of women in “transition” (Einhorn 1993, Johnson 2007, Lokar 2000, Zhurzhenko 2001). However, some of the more recent studies (Fedyuk 2009, Ghodsee 2005, Phillips 2008, Solari 2010) have suggested that women may be able to craft new identities and locate niches for their empowerment. My study have explored how women’s mobility in the biomedical field illuminates these gendered processes and complicates conceptualization of women as losers in post-socialist transformations.

While most literature that discusses status of medical doctors in post-socialist space conceives of them as lacking prestige and deprofessionalized (Field 1988, Schecter 1997b, Riska 2001), my ethnographic data suggest quite the opposite. Prestige of the biomedical professionals is not uniform, instead it is highly individualized and hybrid, which is consistent with personalization in post-socialist biomedicine (Rivkin-Fish 2005, Temkina 2008). I understand prestige as a distinction that people derive from a combination of materialist and non-materialist pursuits. Because post-socialist changes are associated with move to market relationships and class differentiation, analysis of economic factors have often come to the forefront in other studies. Thus, low official salary and dilapidating facilities in many corners of post-Soviet world, is taken as a sign
of low status of the medical profession. While official wages of Ukrainian physicians are
low, they often represent a fraction of their unofficial income, such as patients’ informal
payments. New venues for biomedical income have emerged, triggering intense
professional mobility, both short and long-term. These include work in private clinics,
labs and diagnostic centers; cooperation with international companies that conduct
clinical research trials; work for the pharmaceutical companies; short and long-term
migration to the countries with former socialist allegiances (African countries and the
countries of the former Eastern European socialist block). In addition, physicians are
involved in non-professional job mobility, such as conducting various business ventures
in conjunction with their clinical work (sales, investments, car repair shops, etc.) or
leaving their state positions to devote their full time to non-medical operations
(commerce, manual labor migration to the Western Europe and beyond as care-givers for
children, sick and elderly, etc.). In addition to existence of new venues for maximizing
materialist benefits, physicians are also repositioning themselves in ways to allow them
to retain the status of respectable experts that they enjoyed during Soviet regime and that
could allow them to gain additional dimensions of prestige in post-socialist context. Thus,
physicians draw on the state to demand and strategically use some of the resources that
are available to them to stake their position as vitally important professionals. They also
express anxieties about changing geopolitics and foreign influences in the Ukrainian
biomedical field, which especially comes to light in conflicts between pharmaceutical
representatives and clinical doctors. Higher economic capital of pharmaceutical
representatives, who are trained as physicians according to Ukrainian regulations, does
not translate into higher status or increased professional respect. Thus, legitimacy of
clinical medical knowledge is re-affirmed in post-socialist context. It draws on the socialist discourses that glorify the supremacy of science and pure knowledge and contrast them to monetary pursuits, as well as newly accessible information about high international status of the medical professionals and the heroic ethos of clinical medicine. Personalization of relationships with patients, infused with new monetary exchanges, also serves as a way to renegotiate social position of physicians and achieve a more desirable level of prestige in all of its aspects, materialist and non-materialist ones.

This preoccupation with both aspects of prestige is illustrated by physicians’ understandings of their participation in informal exchanges, where they combine concerns for monetary remunerations with quandaries about dignity and morality. Multiple moral codes are currently operating in the Ukrainian healthcare system where the ideas of right and wrong and state-citizen obligations and responsibilities are now being renegotiated. This highlights the double-edged nature of informal exchanges. On one hand, they allow people to achieve desired health results under the circumstances of inefficient organization and delivery of healthcare services that do not satisfy the needs of the population. Informal economy testifies to political awareness and creativity of the biomedical professionals and patients who are dismissing state rules and regulations and are instead guided by localized and personalized understandings of right and wrong. On the other hand, informal practices are debilitating in their inadvertent covering the gaps of the dilapidated system, thus delaying structural reforms even further. They also profoundly disadvantage underprivileged patients who are unable to enter into the informal exchange with their providers. Although guided by informal norms, unofficial exchanges in biomedicine are inconsistent and opportunistic, making it difficult and
frustrating for all to navigate the system. Ample conflicts between patients, physicians, and healthcare administrations illustrate this unpredictability that informal economy creates. Some of my friends in Ukraine who are well positioned to have access to healthcare, often called me during my time in the field specifically to express their frustrations of not being able to reach desired help even with money and connection at hand.

I have argued that in Ukraine, healthcare can offer lucrative income via some of the venues discussed here, however money-making as well as earning prestige in the biomedical profession requires significant investment of time and personalized efforts. Since income strategies are currently so personalized and are embedded to a large extent in informal networks, physicians must be prepared to spend significant number of years to gain necessary experience, contacts and insert themselves plausibly into the professional scene. Women appear to be particularly well suited to afford being a physician in post-socialist context. There is less social pressure on women to make money and support family financially. Quite opposite, women are expected to invest their loyalties in their children and families. Undertaking medical career endows women with useful skills and knowledge for nurturing their families, and making little income for the first eight to ten years does not seem as detrimental as it would have been for men. These jobs are not for those who are looking to make decent money quickly upon graduation. It is therefore harder for men to dedicate to this expected stage of relative poverty and inability to meet designated gender role of a main breadwinner. In disorderly post-socialist healthcare system, men seem to be unwilling to take on additional burdens that carry a vague promise of success later in time. Women, however, seem to be better
placed or more willing to morph into various shapes and take on superficially less attractive roles not only to survive, but thrive. Using Ghodsee’s framework of portfolio of stocks of cultural capital (2005), I argue that women physicians in Ukraine were able to locate routes to invest their education, training, and culturally based motivations and expectations into the biomedical profession. Women physicians appear to be better candidates for physicians’ roles that are focused on clinical expertise as opposed to participation in bureaucracy and politics. This also influences their choice of medical specialties. Many women tend to choose specialization that bolsters culturally embedded ideas about qualities and strengths of female gender. Thus, female special strength in analytical skills and erudition is conceived as women’s advantage in narrow specialties. An image of cleanliness, beauty and respectable femininity that many specialties offer in Ukrainian context, makes it an attractive choice for many women, consistent with cultural value placed on motherhood and womanhood. I argue that Ukrainian women physicians are not disempowered. Instead, they are able to align their ambitions and desires with some of the locally embedded gender roles to take a center stage in medicine. In so doing, they are practicing a particular non-Western version of feminism.

In “Moral Economy and Informal Exchanges” chapter, I focused on everyday informal practices, in which physicians are routinely engaged. I have established that professionalism should be understood as a delicate balance between receiving adequate income and maintaining a sense of humanity, which for physicians meant justification of their informal practices. In final chapters, I delved into broader discourses that underline physicians’ engagement with their profession, state, and visions of social order and change. I traced the ways in which medical doctors understand how social changes
influence biomedical profession and in what ways they should respond to these transformations. My final chapter discussed the overarching understandings of morality, social order, and relationship between citizens and the state.

I argued for context-based understanding of professionalism and ethics in biomedicine. Ukrainian physicians do not associate autonomy from the state as a prerequisite for professionalism. Instead, they believe that professional qualities, such as biomedical skills and knowledge, combined with ethical and moral qualities, can be developed individually or within a workplace collective. I have shown that it is not possible to draw a clear line between Soviet-trained and contemporary Ukrainian physicians’ expectations, practices and ambitions. Professionalism is not clearly associated with social or post-socialist training and values. It is a contested field where contemporary preoccupation with material and moral well-being intertwine and employ socialist and neoliberal rationalizations in pursuit of meaningful professional identities.

Throughout this dissertation, I have argued that people understand disorder not only as immobilizing and fragmenting experience, but also as a transformative one. Through the words of my informants I have shown their frustrations, mainly directed at the state; as well as the ways in which people convert their struggles and pains into forms of agency. I have shown how some physicians, and especially women, are able to find the channels to transform disorder into significant benefits. I have used Zigon’s (2008) theorization of moral breakdown as the most reflective of a person’s self-work and changes in the everyday. My ethnographic data have shown what happens to ideas of morality and order when every day is perceived as a moral breakdown and ultimate uncertainty.
Multiple moralities, or “braided narratives” (Phillips 2008), that combine socialist rationalizations and neoliberal readings of new social order demonstrate that the ruins left by the Soviet regime should be understood not as remnants of the discredited world order, but as productive foundation for responses to the global market. Ukrainian healthcare may in part be conceptualized as an example of such imperial ruin that continues to inform modes of social organization but that ceases to function in ways it once did. It is not an anachronistic remnant of old regime, but an evolving segment of economy that speaks volumes about relationships between the main stakeholders in the biomedical field and society as a whole. Thus, physicians often emphasize their clinical knowledge, intent on separating themselves from healthcare administrators whom they view as state bureaucrats rather than productive contributors to the healthcare system. They are willing to bend the policies according to their understanding of professionalism and personalized priorities. Patients, physicians, and healthcare administrators have different views about what exactly constitutes their rights and responsibilities and what relationships and power each of them should enjoy. All of them, however, agree in their critique of post-socialist capitalism and the Ukrainian politics of the open market. In the words of Ashforth (2004), healthcare debates in Ukraine have transformed “matters of public health from questions of appropriate policies into questions concerning the fundamental character and legitimacy of state power in general.”

My research makes new anthropological contributions to the fields of political economy, gender and the culture of medicine. It addresses the interactions between economic factors and systems of cultural knowledge in the realm of gender relations. The Ukrainian medical profession challenges the notion that women tend to have only
residual power in professional fields. Through an investigation of the ways in which women make their professional decisions and use their cultural capital, I explore how people use cultural logic and local gender constructions in their interactions with broad socio-economic processes (Burawoy & Verdery 1999). My research also contributes to anthropological theory that examines gender interactions in biomedicine and professional organizations (Morantz-Sanchez 2001, Walker 2003); gender politics as a factor in reshaping social relationships in emerging market societies (Gal & Kligman 2000, Marsh 1996, Verdery 1996) and “everyday economies” in post-socialist transformations (Humphrey 2002, Rivkin-Fish 2005). It adds to anthropological knowledge about professional culture and organizations (van der Geest 2004, Gellner & Hirsch 2001, Rosen 2000, Wright 1994), which is currently under-explored. The study of medical profession and the study of professions in general, has been dominated by the sociological discipline that has traditionally focused on the Western societies (Becker 1961, Witz 1992). This dissertation is a step forward in anthropological micro-level investigation stemming from the view of the insiders of the professional groups, rather than macro-level top-down approach of the sociological perspective. This study contributes to research in medical anthropology and sociology: it explores biomedicine as a cultural system (Baer 2003, Lindenbaum 1993, Lock 1988), it reflects on an internalization of gender roles in medicine (Cassell 1998), it dissects the narratives women employ in explaining their involvement in biomedicine (Atkinson 1995, Harden 2001). This research is also a timely contribution to small but growing body of anthropological literature focusing on Ukraine (Petryna 2002, Phillips 2002-2005, Wanner 1998).
Endnotes.

i Ukraine is essentially a bilingual country, although Ukrainian is the only official language. For more information on Ukrainian language politics see Laada Bilaniuk’s work (2005).

ii Oblast is an administrative division in Ukraine, comparable to American state and Canadian province; and Region is comparable to American county.

iii In this context, I use the term “modernization” in narrow sense, as a range of policies aimed at aligning Russia with the level of economic, educational, humanitarian, and artistic development characteristics of Europe of the time. I am aware of contested nature of this term and the multiple readings of it. These discourses, however, will not be discussed within the frames of this dissertation.

iv For more information about the national vaccination schedule in Soviet Union and its comparison to the US vaccination schedule see Brinton and Ladyzhesky 1992.

v This pattern, however, changed. Starting from the late 1960s till present day, life expectance has been stagnant (for females) or rapidly falling (for males), making the countries of the former Soviet Union the only industrialized nations in the world with such patterns in longevity (Feshbach 1988:120). Ukraine currently experiences mortality crisis with average life expectancy 75 years for female and 63 years for male population, which is on average 11.76 years less than in Western European countries.

vi Soviet Union fought in the World War II from 1940 to 1945.

vii Pliushch (1970:15) lists the different varieties of folk healers as the following, in Ukrainian: знахарі і знахарки, відуни, лечці, знавці, народні медики.

viii The HDI measures average achievements in a country, but it does not incorporate the degree of gender imbalance in these achievements. The gender-related development index (GDI), introduced in Human Development Report 1995, measures achievements in the same dimensions using the same indicators as the HDI but captures inequalities in achievement between women and men. It is simply the HDI adjusted downward for gender inequality. The greater the gender disparity in basic human development, the lower is a country's GDI relative to its HDI. Ukraine's GDI value, 0.793 should be compared to its HDI value of 0.796. Its GDI value is 99.6% of its HDI value. For more information, please see http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_UKR.html

ix For more information, visit http://www.ipu.org/wmn-e/arc/classif251297.htm

x For more information, visit http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_UKR.html

xi For more information, visit http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_UKR.html

xii Закон України «Про забезпечення рівних прав та можливостей жінок і чоловіків» від 8 вересня 2005 р. № 2866-IV, який набув чинності з 1 січня 2006 року.

xiii Personal communication with one of the municipal health care administrators.

xiv Throughout this dissertation, I will transliterate proper names of Ukrainian origin according to Ukrainian spelling rules. In so doing, I join Ukrainian public and scholars who argue for abandoning transliteration of Ukrainian proper names according to Russian spelling rules, which is widely present in English publications. Thus, I use Ukrainian spelling Chornobyl, as opposed to currently more widely used Russified Chernobyl.

xv All interview excerpts were translated by the author from Ukrainian and Russian languages (the original languages of the interviews) to accommodate English-speaking readers.
Some Ukrainian words are included with their corresponding translations to indicate the terms and concepts that do not have clear parallels in the English language, but are important for understanding the context (such as, cultural idioms or slang words).

In the course of this research, I have regularly referred to major national press, including weekly journals Korrespondent, Focus, Ukrains'kyi Tyzhden, Profil; popular newspapers Den, Dzerkalo Tyzhnya, Vysokyi Zamok, Vseukrayins'ka Gazeta V V, Express, Kyiv Weekly, Business Ukraine; specialized medical periodicals Novyny Medytsyny i Farmatsiyi, Zdorov'ya Ukrainy, Vashe Zdorov'ya; and popular press for parents of young children Khoroshie Roditeli, Moi Rebenok, and many others.

According to Kyiv International Sociology Institute (KISI), 65% of Ukrainians believe that the best way to fight the corruption is to educate citizens about their rights and encourage them to fight for them, as well as exert more control over the work of corrupt professionals and administrative officials.

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The official currency exchange rate is currently 1 USD to 8 UAH (Ukrainian hryvnia), according to the National Bank of Ukraine (http://www.bank.gov.ua/kurs/engl/last_kurs1.htm). However, the exchange rate is not stable and fluctuates. In the last few years it went from 1 USD to 4.5 UAH to 5.5 UAH, 7 UAH, 10 UAH and not back to 8 UAH.

Regional clinics serve the population of an entire oblast, a Ukrainian administrative unit comparable to American state or Canadian province.

These numbers are the average estimates that about 150 respondents working in the capital and peripheral healthcare facilities have shared with me. The numbers were generally consistent, and also reflected the amounts suggested in popular press.

Transition theory is the economic concept suggesting that the best way to understand the changes in post-socialist societies is by envisioning them at the transitional state from socialist order to capitalism and the open market (Lipton and Sachs 1990, Cohen 1985, Szelenyi 1988). Transition theory suggests that social and political issues that post-socialist societies face are determined by the economic processes associated with progressive change from failed socialist experiment to triumphant capitalism. The anthropologists who work in postsocialist societies, however, almost unanimously criticize this social evolutionist view and argue that accepting capitalism as a uniform and a single possible model is inaccurate. It dichotomizes socialism and capitalism in the Cold War fashion and ignores the cultural variation on the ground. Thus, Barsegian (2000: 119) argues that the dichotomy that is being created by transition theory is that of the “advanced West versus the undeveloped East.” Gal and Kligman (2000: 10) add that transition theory is “consonant with Marxism-Leninism and American modernization theory since it assumes evolutionary progress from one well-known “stage” of history to another. It thereby inadvertently continues the Cold War morality tale … that pitted two “sides” against each other in an implicit contest for who was “ahead.” Transition theory also tends to homogenize different ways in which capitalism and socialism have been practiced and offers us a sort of unilineal evolutionary perspective. Dichotomization “ignores nuances in the complex social relationships which shaped Soviet politics, as well as the elaborate gray or shadow economy, whose operation, in fact, often kept the state-planned economy functioning” (Barsegian 2000: 121). Similarly, Burawoy and Verdery (1999:302) argue that market economy will always have a local face, and its character cannot be completely controlled, “markets can
generate a retreat to barter relations or criminalized trade...can lead to involution rather than revolution or
evolution; markets can be the agents of primitive disaccumulation rather than advanced accumulation.
According to them, transition is an active state of creation of new economic and cultural constructions that
build on the old framework, rather than move from one abstract construction to the next. Similarly,
Kligman and Verdery (1999:308) argue that without close empirical investigation we cannot understand the
ways in which local population in Eastern Europe and former Soviet Union perceive and act upon new
market concepts (such as privatization, property, economic exchange, market, voting, democracy,
representation, etc.).

xxiv Baba is a term signifying an illiterate, superstitious, small-minded, irrational and overly emotional
female figure, usually a peasant. For more information on history of this term, see Wood 1997. The baba
and the comrade: gender and politics in revolutionary Russia. Bloomington: Indiana University Press;
Attwood 1997. The Bolsheviks and the Genealogy of the Woman Question. In The Baba and the Comrade:

xxv This respondent refers to the education system structure in Ukraine. High school graduates must decide
what major to pursue even before they graduate from high school, in order to prepare for rigorous entrance
exams into universities. Students are required to pursue mandatory programs toward their degrees, which
are developed by the university faculty and staff and approved by the Ministry of Education. Students do
not usually have any elective courses toward their college degrees. This system is currently undergoing first
experimental attempts to reform into European-based and more democratic Bologna system.

xxvi A physician from God [лікар від Бога] is a stable phrase in Ukrainian and Russian languages,
signifying an especially outstanding and talented physician.

xxvii I use the term “Eastern” to signify women from former Soviet republics as well as the countries of the
former socialist block in Eastern and Central Europe. I do so in order to speak to the body of literature that
addresses tensions between different ways in which feminism is understood and practiced in this part of the
world, as compared to the West (Cerwonka2008; Drakulic 1991; Einhorn 1993; Funk 1993, 2007;
Holmgren, Sopronenko, Ruder 2009).

xxviii Some of these “gendered” questions included the following: What do you think about women medical
doctors compared to men? Does gender play any role? Could you help me to understand why or why not it
is important for a physician to be a woman or a man? Does the specialty matter? What do you think women
bring to the medical practice in Ukraine? What do you think men bring to the medical practice in Ukraine?
In your experience, does it matter if you are a woman or a man when it comes to your salary? Do you know
if you get paid the same as your male colleagues (please, do not mention any names)?

xxix I agree with Mohanty (2002) in her use of the terms First and Third World. She refers to them not in
terms of geography, but rather as “political and analytic sites and methodologies.” These categories do
retain a political and explanatory value in today’s world that “appropriates and assimilates multiculturalism
and ‘difference’ through commodification and consumption” (Mohanty 2002).

XXX Among some of the popular programs are those focusing on human trafficking, domestic violence,
women in politics, gender education, and others, underscoring autonomy of the individual. This approach
underscores Western value of individualism as opposed to attention to networks, social relations and
interconnectedness of people.

xxxi Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia (May 2004); Bulgaria,
Romania (January 2007).

xxsii Recent Roadmap for Equality Between Women and Men (2006-2010) by European Commission
delineates gender equality agenda with specific obligations by all member states and without alternative
ways for achieving the goals set by the map. Belonging is assured by consent, not dissent in this scenario
(Weiner 2009).
Many anthropologists of the Eastern Europe (Hann 1993, Humphrey 1993, 2002, Verdery 1996, Carey and Raciborski 2004, Bunzl 2000) argue that colonial paradigm is accurate for understanding the post-socialist area. In this context, Russian-based communist party elite is viewed as the colonizers, and people of the fifteen Soviet Socialist Republics and socialist countries of the Eastern and Central Europe are considered to be the colonized. Moscow-based government controlled political, economic, and social life in its zone of influence, imposed its socialist ideology and appropriated the natural resources of the subjugated territories over the course of over seventy years (1917 – 1991). The demise of Soviet Union led to decolonization of most of the republics, and currently they are undergoing deep political-economic transformations. Although Soviet Union was a type of an empire, how exactly does it compare to the “classic” Western colonial states? Verdery (1993) outlines the comparative paradigm in order to explore how applicable the concept of colonialism and decolonization is for post-socialist societies. She points out that like other colonial states, Soviet Union was an empire, however its goal was not the accumulation of the capital, but rather control over the means of production that allowed it to dominate the distribution of the resources, “Moscow center aimed to integrate its dependencies into a process of accumulating not capital, but … allocative power through accumulating means of production” (1993:16). Also, Soviet Union, unlike Western colonial states, had two “tiers” of “colonies” (1993:16) – “inner tier” of Soviet Republics, and “outer tier” of Eastern European countries of the socialist bloc. Verdery also finds that similar to Western empires Soviet state was a product of interaction between the “metropole” and the “colony” (1993:16), and yet she argues that Moscow center was exceptionally transformed and reconstituted through these interactions. Most importantly, Verdery argues (1993:17), colonial history of Soviet Union brought about new conceptualizations of “knowledge and representation.” The Cold War created particular kind of knowledge that informed the lives of the entire world. It dichotomized the world into East and West, communism and capitalism, “the global order that gave rise not only to neocolonialism, but to postcolonial studies itself, was an order structured by the Cold War, whose very existence compelled Western states to struggle for pieces of countries and regions that were not directly part of the Soviet bloc” (Verdery 1993: 18). Thus, the application of postcolonial theory to understanding of the post-socialist region will involve repositioning the Third World in the colonial paradigm.

The categories of decolonization and post-socialism also bear some parallels (Verdery 1996b: 78), such as adoption of capitalism and reconfiguration of the state that included creating new constitutions, establishing new relationship to foreign capital, negotiating criteria for citizenship and homogenizing local populations around the concept of the nation-state, as well as transforming the institutions. However, decolonization paradigm also bears resemblance to the transition theory, which is not an adequate conceptualization of post-socialist transformations. Both concepts, transition and decolonization, suggest that the unfortunate and often tragic past is over and the country, or the area, is undergoing transformations that will sooner or later end in one inevitable point – capitalism. Such view, which is upheld by most of the international political-economic community, ignores the continuities between past and present in decolonized territories as well as their ex-colonizers (Hann 1993, Verdery 1993, Bazylevych 2005: 45). It also does not describe the existing arrangements of socioeconomic life accurately. For instance, Verdery (1996: 210) argues that transition in post-socialist states has many elements of feudalism rather than capitalism, with their reversion to natural economy, barter, fragmentation of the states into small “suzerainties” controlled by corrupted clans who manipulate privatization process. In the same vein, Barsegian (2000:121) suggests that post-socialist societies are a particular social type where many elements of socialism remain alongside with newly introduced capitalistic features. He illustrates this view by pointing out continuing dependency of people on the state that was very prevalent in socialist era and remains prevalent today. Terms “decolonization” and “transition,” therefore, demonstrate evolutionist and Eurocentric categories. Implied in them is the idea of progress which is measured in a uniform way for all the range of different societies throughout the world. It is measured in terms of industrialization, GDP, average wages, etc. Eurocentrism of the terms “decolonization” and “transition” can be seen in positioning the capitalistic mode of production at the top of the social evolution. Decolonized states are thus expected to move towards capitalism as supposedly the only logical end to their development.

For more information on applicability of the colonial paradigm for understanding the complex processes in Ukraine see Wanner (1998). Being a nation without the state or a unified territory for many centuries in
different periods in history, Ukrainian cultural production has been influenced by its statelessness. Wanner (1998) focuses on the institutionalization of the Ukrainian culture. She investigates popular and state-sponsored representations of four historical events: the Bolshevik Revolution of 1917, the Famine of 1932-1933, the Soviet victory in World War II, and the Chernobyl nuclear power plant accident in order to explore how “distinctly post-Soviet Ukrainian histories and myths are being institutionalized in an effort to create a culturally based allegiance to the new Ukrainian state” (xvii). Wanner argues that institutionalization of these historical events in such sites as schools, festivals, state calendar, and monuments legitimizes Ukrainian state through emphasis on the unifying elements in the Ukrainian past and by introducing new interpretations of history.

Eastern Bloc agenda was known as “peace” perspective, which argued that women had unique ability to promote peace and fight against violence and war (Ghodsee 2010).

A few of these kindergartens still remain throughout Ukraine today from Soviet times. These kindergartens are sponsored by the state and provide specialized care, nutrition and attention to children with diminished health status, especially those from families with tuberculosis. Once being sent to such facility used to be shameful, the families were viewed as contagious and somehow contaminating. Today, however, many families with good connections try to place their children in such kindergartens in search for more solid and reliable care.

For more on Ukrainian labor migration, see Solari 2006, 2010; and Fedyuk 2009.


Studying hard for entrance exams, working nursing aid jobs to get credit for work experience, serving in the army, going through nursing program before applying for the med school, applying multiple times, searching for powerful connections, etc.

Work with patients from lower socioeconomic strata, “undeserving” patients (prisoners, HIV/AIDS patients, drug addicts and alcoholics), emergency care that gives little opportunity to get to know patients and earn additional informal income, etc.

Maksim Gorky is one of the most prominent Soviet writers and the founder of the Soviet Council of Writers.

One of the theoretical paradigms highly utilized by the anthropologists of East Europe, and especially by the scholars who focus on the post-Soviet societies, is colonialism and decolonization. Many anthropologists of the Eastern Europe (Hann 1993, Humphrey 1993, Verdery 1996a, Carey & Raciborski 2004, Bunzl 2000) argue that colonial paradigm is accurate for understanding the post-socialist area, and it can also be a link that allows this subdiscipline to contribute to the anthropological science at large. In this context, Russian-based communist party elite is viewed as the colonizers, and people of the fifteen Soviet Socialist Republics and socialist countries of the Eastern and Central Europe are considered to be the colonized. Moscow-based government controlled political, economic, and social life in its zone of influence, imposed its socialist ideology and appropriated the natural resources of the subjugated territories over the course of over seventy years (1917 – 1991). The demise of Soviet Union led to decolonization of most of the republics, and currently they are undergoing deep political-economic transformations.

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Airsvit is one of the largest Ukrainian airline companies, based in Kyiv.

March 8th is celebrated in Ukraine as an international women’s day. It continues to be one of the most celebrated holidays, first established by socialist government. It most closely corresponds to the American mother’s day, except all women are supposed to be celebrated on the 8th of March.
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