

# ‘Beautiful’ Medicine

## Gender Segregation by Medical Specialty in Ukraine

Maryna Nading

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### Abstract

In Ukraine and in other former Soviet socialist republics, women make up a sizeable majority of those practicing medicine—a proportion estimated at around 70% over the course of the 20th century. Women predominate in most specialties, including prestigious disciplines such as cardiology or oncology, with the stark exception of surgical fields. While gender segregation by medical specialty has often been explained as women having been channelled out from more lucrative fields and into less prestigious medical specialties such as primary care, I suggest that broader sociopolitical and cultural forces are primarily responsible for this horizontal segregation. The central pillars of Ukraine’s dominant version of femininity—motherhood and beauty—gain special place in the nation’s decolonisation process and position women to take up medicine as a profession, while simultaneously preventing them from specialising in surgery in the same high numbers. In medical school and at work, gendered bodies are read to be in the right or wrong place as communities of practice informally instruct students and young practitioners about how easy or difficult it will be for them to belong to certain subfields. ‘Beautiful’ (non-surgical) specialties enhance women’s cultural authority even if they are not always as well-remunerated as the surgical ones. They permit flexible schedules and career paths, connote social grace, and solidify women’s central role in families, and ultimately in national reproduction.

### Keywords

Gender segregation, Medical specialty, Beauty, Motherhood, Time, Post-socialism, Ukraine.

## Introduction

Biomedicine (a form of medicine recognised by and institutionalised in most countries) has throughout the 20th century been largely dominated by men. This was not so in the Soviet Union, however, where 70% of practicing doctors with medical degrees were women (Korolev 1975, 78). In post-socialist Ukraine, women constitute 65% of practicing physicians across a wide range of specialties (Derzhstat 2016); nevertheless, in stark contrast to an overall feminised field, men predominate in surgery. This manifestation of horizontal segregation is at the heart of this article. I explore how cultural, historical, economic, and political factors intersect to create this pattern of gender segregation by medical specialty, relying on ethnographic evidence collected among Ukrainian medical providers over the last decade. I will demonstrate how non-surgical areas of medicine open doors for women to enjoy full 'community membership' (Lave and Wenger 2009, 37), both because they are coded as feminine spaces where women are trusted as competent providers, and because they centre women as pillars of their families and the nation.

Both horizontal and vertical segregation have been documented in countries which have a near gender balance in medicine (Boulis and Jacobs 2008; Riska 2001; Harden 2001). It has also been proposed that gender segregation by medical specialty generally indicates the disempowerment of women (Ku 2011; Lorber 1993; Riska, Aaltonen, and Kentala 2015). Although physicians in Ukraine are vulnerable to the instabilities of the country's domestic and foreign politics and the market, and their economic wellbeing is far from secure in a dynamic healthcare sector, it does not nevertheless follow that women are uniquely disempowered in this system when compared with their male colleagues. They are involved in virtually every medical specialty and they predominate in fields far beyond those associated with children's or women's health, fields that socialisation theories suggest particularly draw in women (Allen 2005; Hakim 2000). For example, women constitute 85% of gastroenterologists, 82% of haematologists, 74% of cardiologists, and 54% of oncologists (Derzhstat 2016). Furthermore, while official wages of Ukrainian physicians are not high, averaging around 400 USD per month (Derzhstat 2021), their incomes are also often supplemented by informal payments from patients (Danyliv et al. 2012), work with clinical research trials, and so on. Therefore, a gendered pattern of men clustering in surgical specialties (comprising 97% of those working in orthopaedic surgery and trauma; 92% of neurosurgery; 88% of general surgery) cannot be solely explained by an exclusion of women from the profitable medical field of surgery, since those in other fields also earn a reasonable or even good income.

There are several forces that channel women into medicine: among them, the persistent cultural significance of motherhood that spans the socialist and post-socialist experience; national revitalisation and decolonisation processes that offer up gender discourses essentialising women as the 'fair sex' (in opposition to the socialist vision of women as workers and comrades); and the economic imperative whereby families' financial wellbeing depends upon two incomes and a robust personal network. I argue that the cult of motherhood and family spans regimes and generations and favourably positions women to take up practicing medicine in a highly dynamic sociopolitical context—but that the very same notions also prevent women from specialising in surgery in the same high numbers. New gender discourses that emphasise femininity further position hands-on surgical work as incompatible with living and working as a woman.

While similar gender segregation by medical specialty was observed in the Soviet Union, where fewer than 40% of surgeons were female (Navarro 1977, 78), the sociopolitical forces that shaped distribution then differ from those of the present day, although more specific numbers broken down by surgical subspecialty are hard to find. In the Soviet Union, notions of social grace essentialised women as mothers in a similar fashion as happens in Ukraine today, but then women were also envisioned as workers: strong and centred, rather than dainty or feminine (Zhurzhenko 2001). Further, women and men both worked in a climate where loyalty to the state was prioritised over loyalty to the family; retreating into the domestic sphere was not an option for Soviet citizens. While continuity with the Soviet pattern of gender segregation is important to acknowledge, it is also essential that we look at the ethnographic evidence to see how the various historical, sociopolitical, and cultural forces work together to create this pattern of horizontal occupational segregation.

Physicians in Ukraine navigate a resource-poor system in a politically and economically volatile environment. Medical students learn that their financial stability is uncertain and will ultimately rely on a significant investment of time in building pathways to success. For women, these professional uncertainties are partially transcended by notions of 'respectable femininity' (Radhakrishnan 2011), which connect professional status with devotion to family in the context of Ukraine's nation-building project. By selecting non-surgical medical specialties, which are culturally coded as clean and graceful, women can productively fulfil their responsibilities for regulating the temporal and spatial dimensions of family life in the short-term, and also cultivate a professional identity that they hope will pay off in the future. Surgical fields, on the other hand, involve boundary crossing (Cassell 2000; Prentice 2012) that is cast as an applied kind of clinical labour, not easily merged with the notions of femininity that enjoy social currency today.

In this article, I pull together theoretical threads that elaborate on Ukraine's gender politics, the gender-socialised values involved in medical training and work, and the temporal dimensions of specialty choice. First, I consider how non-surgical fields reinforce women's cultural and moral authority because this type of clinical labour amplifies their social role as mothers and symbolically extends it to the body of the nation. In Ukraine, many ideologies are intended to challenge Soviet policies (Funk and Mueller 1993). Some of these trends include increasing emphasis on femininity and motherhood and the national revival of 'masculine culture' (Pavlychko 1996; Rubchak 1996) where men are linked to the reconstruction of the nation as protectors; women as reproducers (Onuch and Martsenyuk 2014). In the conversations I had with my respondents, women and men alike often focused on such essentialist notions of gender to imagine themselves as bringing a particular set of skills to the table (care-taking and empathy for women; risk-taking and control of emotions for men).

Second, I consider how gender-socialised values help explain why women predominate in specialties that match their expectations of performing caring roles (Hakim 2000; Ku 2011) and in specialties that are associated with clean and safe daily labour (Bradley 1989; Cuzzocrea 2015). The essentialist notions of womanhood as nurturing, empathetic, and patient are mobilised as 'gender casting' (Riska 2001). When women put on the physician's white coat that is the uniform of non-surgical specialties, they perform culturally appropriate or 'beautiful' work (Hull 2017; Walker 2003). This internalisation and enactment of culture-specific gender expectations is shaped by the hidden curriculum in medical schools (Hafferty and Franks 1994) and in the workplace (Cassell 2000; Hull 2017) and conspires to separate women from surgical fields.

Third, I discuss the temporal dimensions of medical specialties. Gender structures the 'ontology of time' (Andaya and Fleming 2016) in a way that makes it more possible for women to enter medical school and commit to the predictable financial uncertainty of Ukraine's medical field. Although the Ukrainian healthcare system is ailing, it can offer lucrative incomes to those who can wait until their initial investments pay off, through their participation in dense informal or semi-formal networks. Recent medical school graduates invest time in developing skills and networks without the guarantee of receiving significant returns, due to the changing and unstable healthcare system. For female doctors, years of low income may be mitigated by commitment to children and family and by developing skills that are also valuable for household management. In addition, the expectation of daily routines being structured primarily around family commitments and secondarily around a work schedule is commensurable with the pursuit of certain types of medical work and is seen as enhancing women's moral authority. For men, the social mandate of financial success directs them towards jobs that guarantee

income to support the family, even if those jobs are not associated with 'social elegance' (Hull 2017, 23), such as construction work, or seasonal labour migration.

After discussion of research methods and relevant background, I ethnographically contextualise my argument within these theoretical discussions to provide a situated interrogation of gender politics in post-socialist Ukraine that place women in the centre of kin groups and teach them to take on non-surgical work. This is followed by a discussion of the 'dialectic of difference' (Cassell 2000) involved in the gendered understanding of clinical labour. The article concludes with a look at temporal agency and its role in this process.

## **Talking and documenting: Setting and methods**

This article is based primarily on dissertation fieldwork research that I conducted in 2007–2008 in central and western Ukraine, with a focus on its capital Kyiv and several peripheral towns. My primary research objective was to understand the reasons behind the continued feminisation of healthcare in a post-socialist context (Ukraine) and the implications of this beyond the region. My question was whether the high number of women in post-socialist medicine was a result of Ukrainian women's empowerment; of women being pushed away from more lucrative jobs in the finance and banking sectors; of interrelations between local gender constructions and economic transformations; or perhaps of a complex interplay of all of these factors. My research took place in state-run policlinics (hospital departments where outpatients are treated), inpatient hospital facilities, research hospitals, private clinics, and private doctors' offices. I collected over 150 semi-structured interviews, lasting anywhere between 45 minutes and several hours.

In conducting my research, I was able to see some of the daily routines of the physicians, and their communication with other doctors, medical staff, patients, and visitors, although I did not specifically focus on observing people whom the providers served. Some physicians allowed me to join them during their overnight shifts and introduced me to other healthcare professionals at their workplaces and in their social networks. This snowballing technique means that the selection of respondents was not truly random. Nonetheless, this method has been recommended for 'studying up', i.e. studying people whose power and social standing are higher than those of a researcher (Souleles 2018). This technique also allowed me to discern the patterns of informal exchanges (Morris and Polese 2014), since I was inadvertently also gaining insight into the dynamics of specific networks of physicians. For example, I learned that the medical profession offers diverse opportunities for income while retaining relative prestige. I also saw that these opportunities are not evenly distributed and are in fact determined by

providers' assessment of their patients' vulnerabilities versus vulnerabilities of their own (Bazylevych 2015).

Although my fieldwork research strategies sought more broadly to examine both cognitive and behavioural categories—local concepts, beliefs, attitudes, and values as well as what people do and how they interact (Ehn, Löfgren, and Wilk 2015)—here I rely primarily on my analysis of the interviews for two important reasons. First, the interviews gave me a particularly rich data source in the context of my research question. I understand the interactions with my participants as 'metacommunicative events' (Briggs 1984), co-constructed by physicians in this study and me, and expressive of our positions and priorities. In other words, our ethnographic encounters were co-constructed: physicians as 'one kind of knowledge specialist(s)' or 'experts' (Boyer 2008, 39), and me re-framing their points of view in the anthropological analytical categories (Ibid., 41). Our conversations yielded sincere and robust sharing opportunities and I thus view these conversations as being essential to the 'inter-expert collaboration' as a particularly suited research methodology. I echo João Biehl (2007), who sees ethnographic challenge in finding 'the means to make visible the mutual presence of trajectories and becomings' (114). This was achieved via conversations with my interlocutors about the processes of them becoming experts in their various medical specialties. Indeed, my research question had to do with their career trajectories that spanned years, even decades, which of course I could not witness. I was not alongside my participants when their families were getting them tutors in biology and chemistry to pass rigorous medical school entrance exams. Neither was I there when some of them enlisted in the army, went to a community college to study nursing, or spent years obtaining work experience to increase their chances of getting into medical school. Neither was I there during their nerve-racking residency searches. However, I could hear about all of this. The stories of my participants' 'becomings' are of paramount importance to my study.

Additionally, in instances of 'studying up' (Souleles 2018), ethnographers have noted a need for multi-sited ethnography, somewhat shorter interviews, and observations that are situational (Boyer 2008, 43) as opposed to traditional long-term observations at a single research site. My interlocutors were busy, juggling multiple jobs and obligations. They were involved in various informal or semi-formal exchanges and saw many patients. Long-term participant observation at a single site was not a feasible strategy for my project given that it was designed to navigate a variety of medical specialties. Instead, I focused on reaching out to a wide range of providers: making repeat visits to the same facilities; creating opportunities to visit the physicians outside work to 'engage the non-professional' aspects of their lives (Ibid., 44); scheduling interviews during their less busy hours,

such as night shifts; and speaking to providers in focus groups, among other things.

In the years that followed my initial research, I continued to track secondary data, namely relevant media reports, research published in major biomedical periodicals, and Ministry of Health reports and regulations, particularly in light of unfolding health reforms. I conducted additional fieldwork in the summers of 2012 and 2015 and the autumn of 2017 on the related topics of bioethics, health-seeking behaviours, and mobilisation of the health workers' trade union.

## **Women's inroads into medicine in Ukraine**

In Ukraine, the number of female physicians started growing prior to the socialist revolution of 1917 (Renner 2008), but a substantial increase took place during the time of the former Soviet Union in the 1930s (Field 1957) as a part of the proletarianisation of the profession and the socialist ideology that celebrated female emancipation and required every citizen to participate in public life through work and political agitation (Watson 1994; Wood 1997). Physicians were recruited from working class families to transform biomedical care from a pre-revolutionary elitist 'bourgeois' circle, with the aim of them becoming 'specialists instead of encyclopaedicians' (Popov 2001). In response to the dire health of the population following the First World War and the 1917 revolution, with raging epidemics of typhus and cholera, a hierarchical, centralised system was created, with its focus being workers' health (Field 1967, 54).

According to the neo-Marxist rationales behind the feminisation of professional fields such as healthcare, women enter the medical profession when male competition decreases, as it becomes less lucrative to be a physician (Lorber 1993; Navarro 1977; Reskin and Roos 1990). Riska (2001), for example, posited that women entered the field as labour resources to assist in the industrialisation and collectivisation projects, while men were moving into heavy industry, as prioritised by the Stalinist government. Harden (2001) suggested that engineering schools outcompeted medical schools, thus creating an entry path for female applicants in the Soviet Union. Yet the Soviet politics of value relied on notions of culturedness (Volkov 2000) more than on either money or professional autonomy—factors associated with prestige in Western European or North American contexts. Culturedness means behaving above material exigencies and it is demonstrated by being well-read, educated, well-kempt, proficient in etiquette and able to carry a conversation, among other things. There is also evidence that this notion persists in post-Soviet societies (Patino 2008; Rivkin-Fish 2009). Soviet physicians were also fundamentally important in building the groundwork for the

popularisation of socialism (Michaels 2000) and the Soviet modernisation project (Starks 2008) and enjoyed a fairly high social status.

Women therefore do not just queue for labour when men refuse to fill an open employment niche, as neo-Marxist scholars have suggested (see Reskin and Roos 1990). There are additional layers of cultural understandings that may accompany the feminisation of a particular professional field. For example, although a state-sponsored women's emancipation project did create opportunities for women in scientific and technical training that facilitated their entry into medicine (Lapidus 1978), the Soviet Union never had policies that especially privileged female applicants. Instead, entry depended on grades, work experience, military service, and family background. For instance, sometimes applicants from working class families did not need to compete in the general pool, and well-connected families could circumvent some of the official rules. In addition, early educational posters and enlightenment literature portrayed male, and not female physicians, as icons of science and of progress, fighting superstitious religious practices (Bernstein 2007, 107; 124). Healthcare was thus not visualised as a female profession per se, yet the numbers of women physicians in the Soviet Union continued to grow: from 51% in 1937 to 61% in 1940, peaking at 77% during the post-Second World War years, and then averaging 70% in the 1980s (Ryan 1990). However, in the early 1970s women constituted only around 30% of surgeons in the Soviet Union, while otherwise dominating the fields of paediatrics, obstetrics and gynaecology, cardiology, rheumatology, and endocrinology, comprising around 90% of physicians within these fields (Riska 2001, 81).

In paediatric specialties in Ukraine, women constitute upwards of 90% of all physicians, with the exception of paediatric surgery, where women comprise just 22%. The numbers are similarly high in laboratory diagnostics (95%), as well as other specialised fields like gastroenterology (85%), haematology (82%), obstetrics and gynaecology (77%), oncology (54%), and emergency medicine (53%). In primary care and family medicine, women constitute a majority of physicians at around 78%. The pattern is quite different in orthopaedic surgery and trauma (3% female); general surgery (12%) and other surgical subspecialties like neurosurgery (8%), oncological surgery (12%), as well as proctology (13%), endoscopy (25%), and anaesthesiology (35%) (Derzhstat 2016).

The Ukrainian healthcare system remained largely untouched by post-socialist reforms until a recent and still unfolding reform roll-out (Health Strategic Advisory Group 2014), as part of which free and universally accessible healthcare continues to be upheld (Constitution of Ukraine 1996) through provision of a single, centralised healthcare system. At the same time, both morbidity and mortality rates in Ukraine are some of the highest in Europe, the overall household expenditure

on health is often financially catastrophic for patients, and the infrastructure and public finance management procedures are cumbersome and rigid (Health Strategic Advisory Group 2014).

While Ukrainian physicians find themselves navigating a resource-poor environment for little remuneration, they earn additional income from informal patient payments (Danyliv et al. 2012), cooperation with pharmaceutical companies, consultations in private facilities and labs, and from other entrepreneurial ventures. Furthermore, despite this involvement in the informal economy, the medical profession remains relatively prestigious. The Ukrainian case therefore challenges the notion that women have only residual power in professional fields and have prominent roles only in the fields where pay is too low and therefore deters men (Schechter 2000). This invites us to consider a broader range of possibilities that bring them into biomedicine.

## **The persistent trope of motherhood in the new Ukraine**

Women physicians are guided into the medical field in part by Ukraine's sociopolitical and cultural milieu, which relies on essentialist notions of gender and equates femininity with motherhood. In our conversations, female physicians in virtually every specialty often relied on essentialist notions of female qualities to speak about the good professional fit that the healthcare field presents for women who seek professional fulfilment. These qualities included 'compassion', 'a womanly kindness' and even 'being genetically programmed to care for others, to nurture, to raise and rear, to nurse, to tend to, to look after [*взращивать, вскармливать, ухаживать, выхаживать*]'.

Because women are primarily responsible in their families for things like 'health provision, nursing sickness, teaching health, mediating with health professionals, and dealing with health crises' (McKie, Bowlby, and Gregory 2004, 595), these care work activities easily extend to the professional sphere, especially in combination with sociopolitical and historical realities that make work outside of the home an expectation.

Indeed, the dominance of women in paediatrics, general practice, and obstetrics demonstrates the persistence of 'cultural gender beliefs for shaping narratives about gender and work' (Donley and Baird 2017, 97) where gender stands as a 'proxy for skill', with the 'dominant cultural narrative' describing women as 'communal, nurturing, caring' and men as 'agentic, rational, instrumental' (Ibid., 98). These essentialist views can be considered part of a national revival (Rubchak 1996; Pavlychko 1996), and also as contiguous with the pre-socialist division of labour at home, whereby women carried out most household tasks, which the socialist egalitarianism project did not fully deconstruct (Einhorn 1993). It also reflects the general Soviet Union pattern of gender segregation by medical

specialty where women constituted a majority (over 90%) of practitioners in the fields of paediatrics, general practice, and obstetrics (Navarro 1977), although the Second World War normalised invasive types of clinical labour among women to some degree, and some estimate that close to 40% of surgeons in the Soviet Union were women (Ibid.).

While many gender ideologies and practices that enjoy currency in Ukrainian society today are meant to counter the Soviet ethos, motherhood remains a persistent trope of femininity. For example, the head of a regional oncology clinic recollected how her parents settled on a medical school education for her because she was a girl:

My parents are teachers. I have personally always been interested in foreign languages and jurisprudence ... I don't know how other people do it, but in my case, my parents made the choice for me. They 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.

Although healthcare was not her first choice, she raised a family and worked her way up to earn a good income and have a successful career. Morantz-Sanchez (1985) dubs this pattern a 'professionalization of womanhood', or building upon socially significant norms to achieve professional fulfilment. Families often support women's choice to become a physician because they see such jobs as good for everyone, and invest the necessary resources for medical school, residency, and even subsequent job searching, all of which in Ukraine usually requires the assistance of informal networks. As an extension of the family, and especially as mothers, female physicians 'are symbolically at the helm of the family, and implicitly, the nation' (Radhakrishnan 2011, 147). Another female provider, who had reluctantly settled into the urgent care paediatrics field, explained that she had to choose where to put her energies—at work or at home:

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.

Motherhood was also an important element of Soviet femininity, and it shaped the public and private roles of women. Women had easy access to paid parental leave while men did not; workloads for women were restricted during certain stages of motherhood (pregnancy, birth, breastfeeding, caring for small children); and some jobs were deemed off limits to them due to the perceived 'psycho-physiological peculiarities of the female organism and women's social role as mothers' (Tolkunova 1980, 14). It was expected that women worked outside the home and

stayed engaged in social life beyond their kin group, with state-sponsored childcare supporting this socialist mandate (Wood 1997). While women achieved widespread presence in the public sphere, which was unprecedented cross-culturally in the industrialised world (Ghodsee 2010), their public lives supported by the state were clearly accompanied by the expectation of their parallel, primary role at home as mothers and grandmothers (Solari 2017), leading scholars to qualify it as a triple burden of housework, full-time employment, and party activism (Wolchik 1993).

Today, carrying out work outside the home is not as non-negotiable as it once was, though it often remains necessary for the family's survival (Solari 2017), and the trope of motherhood has grown in popularity. For example, when during one of my fieldwork visits I ran into an acquaintance whom I have not seen in a long time, she proudly shared as we sat in the courtyard watching her youngest child play in the sandbox that she did not have to work because her husband did that. An 'equality in difference' myth is dominant and widely promoted by politicians, women's organisations, writers, and a number of public figures. According to its tenets, women's status has always been high in Ukraine because of their central decision making place in the family. Therefore, women's less prominent role in the public domain ought not to be interpreted as disempowerment, but rather as a mark of there being separate zones of influence. Women are imagined as *berehynias*—protectresses of the home hearths, referencing an amalgam of pagan goddess and Christian motifs of maternal sacrifice (Kis 2005)—and men as Cossacks: masculine and strong, referencing Ukraine's mid-17th century military (Solari 2017, 201). For example, at a recent press conference devoted to healthcare personnel and the containment of COVID-19 in Ukraine, prominent leaders of the medical community referred to female physicians as *berehynias*, working tirelessly to protect their patients, families, and the nation (Active Group, Ukrainian Medical Association, and Association of Ukrainian Cities 2020).

Women also relied on this imagery in our interviews to couch their professional success as being secondary to motherhood, seen as their primary responsibility. This was especially visible in the stories of two female professors of medicine at a large medical school. One was a paediatric oncologist and the visit took place in her impressive office, decorated with diplomas and elegant furniture, standing in contrast with the otherwise drab, though clean, hospital building. The photos on display of her son added a personal touch to the space, and I asked about him. The professor immediately professed commitment to her son and a similar expectation of commitment to their own children from her female students:

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 well that you

are not going anywhere. Because first of all you think about your child. I tell my students who are nearing graduation to not delay going after their dreams before they have children. Because when you have children, everything else fades away.

She added that she did not take on research students who were mothers of young children and advised them, 'Wait until 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.'

The professor honed in on the kind of 'femininity that is driven by individual motivations and convictions, but also unwavering in its support and orientation towards the family' (Radhakrishnan 2011, 146). Her friend, a prominent obstetrician-gynaecologist specialising in assisted reproductive technologies, went even further in her emphasis on 'a sacred, feminized domestic sphere' (Ibid., 147) and suggested that her professional pursuits were driven by desire to support her family, rather than by academic ambition. Well-respected and even famous in regional medical circles, she nevertheless firmly identified motherhood as her primary responsibility:

I do not think that a woman is born and naturally expects 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 not work so hard, but this is usually not possible.

My interlocutor insisted that she simply did what she had to do to ensure the financial stability of her family. Feminist scholars note that the new ideal of 'male provider and domestic wife' rarely materialises because of economic necessity (Solari 2017), even though women's issues are too often subordinated 'to the goals of nation-state building' (Kis 2005, 110) and 'the quest for democracy' (Onuch and Martsenyuk 2014). Women's educational attainment in Ukraine is almost identical to men's, with 94% of women and 95% of men having at least a secondary education (UNDP 2020), and many women 'successfully study, work, act, compete, achieve, discuss ... make their lives their own' (Kis 2005, 129). Nevertheless, the persistent equation of femininity with motherhood informs women's and men's public lives in an important way. Women hold only 20.5% of parliamentary seats and their participation in the labour market is 46.7% compared with 63.1% for men (UNDP 2020), despite being entitled to the same rights (Verkhovna Rada of Ukraine 2005). In healthcare, I argue, gender segregation by medical specialty is due to the channelling of women into specialties that are seen as commensurate with motherhood, which simultaneously prevents women from pursuing surgical careers. Further, some of my interlocutors expressed that they

found women who are too committed to their professional pursuits in medicine suspicious, wondering why they were not pursuing other, family-related goals.

## **Good heads versus good hands**

On one hand, I find that the social significance of motherhood is centrally involved in the gender segregation by medical specialty that is seen in Ukraine. Women latch onto the gender discourses that cast them in essentialist terms and that predominate in family medicine, obstetrics, and paediatrics. On the other hand, they lead in nearly all other highly specialised and lucrative fields, where they achieve social respectability and financial security. Thus, 'gender casting' (Riska 2001) extends beyond the medical specialties that are less valued and less compensated to a very broad range of virtually every field, including cardiology, oncology, and so on, with the exception of surgery. The dichotomy cannot therefore simply be explained by the perceived level of competence or by ghettoisation (England 2010; Reskin and Roos 1990); in other words, women being relegated to the occupations that are interpreted as care work or emotional labour and therefore understood as requiring women's 'natural' characteristics, not requiring significant skill or training. I suggest that medical specialties where women are predominant enhance their moral and cultural authority not only through their association with motherhood, but also through the notions of social grace and beauty.

Beauty is another central pillar in the conception of Ukrainian femininity, even though it does not have the same long-standing history in this respect as does motherhood (Kis 2005). While the Soviet gender roles did rely on compulsory motherhood, women were also seen as workers and comrades. The national revival mythology now adds beauty as another important trope of femininity in contrast to Soviet masculinising discourses and practices of gender that forcefully pushed women towards pursuing loyalty to the state outside of the home as opposed to pursuing male admiration.

Today, women are subject to the cosmopolitan patriarchal discourses and practices that objectify and sexualise them. Feminist scholars have critiqued the many ways in which women are encouraged to work on their minds and bodies for male consumption (Zhurzhenko 2001). Beauty inspires Ukrainian 'heroes' fighting for Ukraine's democracy and territorial integrity (Onuch and Martsenyuk 2014; Phillips 2014) and motherly care provides stability and security. Both beauty and motherly care place women in the domain that supports the nation-building project. For example, Onuch and Martsenyuk (2014) document the gendered division of labour during Ukraine's 2014 Revolution of Dignity that involved months-long protests that eventually ousted the corrupt Russian-backed Yanukovich regime,

at great cost to human life. While many women were active in the protests, they were often in supporting roles of care-taking and organising logistics for the 'real fighters'; in fact, they were often referred to as 'mothers and daughters of the Maidan' (Onuch and Martsenyuk 2014, 92), referring to the central square in the heart of the city of Kyiv, where deadly force was used against the protesters, and which is also the location of a towering statue of Berehynia.

In its association with both motherhood and beauty, non-surgical clinical labour is connected to the sophistication and moral authority of femininity, whether remunerated or not. At the same time, there is something about the embodied nature of surgical work that does not easily fit into the dominant tropes of contemporary Ukrainian femininity. In its broadest sense, general medical practice is linked to a humanistic pursuit of healing, harmony, and purification—all qualities associated with the female domain. My respondents wielded metaphors like 'clean hands' and 'white coats' to speak about the 'cultural refinement' (Hull 2017, 23) of non-surgical clinical labour, where women could enjoy high social status associated with their expert knowledge while simultaneously retaining their femininity. Even less prestigious medical specialties, like primary care, were still a site for such 'social elegance' (Ibid.) of wearing a white doctor's coat and performing socially valuable and clean work. As an embodied practice, where physicians use their bodies to tend to the patients' bodies, biomedicine requires a degree of 'boundary crossing', of 'putting one's hands into someone's body and thereby getting them dirty' (Smith-Oka and Marshalla 2019, 117). Biomedical fields such as general practice demand a lesser degree of such manual handling. Surgical fields, on the other hand, are more action-oriented and have been compared to a 'body-contact sport' (Prentice 2012, 6) and even a 'controlled violence' (Ibid., 137).

At the same time, 'beautiful' work also encompasses prestigious narrow specialties that require years of training, patience, intellectual curiosity, critical thinking, and attention to detail. Cardiology, neurology, radiology, immunology and others all fall into this category. A female plastic surgeon, who has spent most of her career working at a burns unit of a regional hospital, shared how her initial desire to train in neurosurgery had been discouraged by an older colleague, who declared: 'if you insist on being a surgeon, at least pick a beautiful surgery!' Explaining what a beautiful surgery meant, this interlocutor spoke of highly specialised clinical labour in 'good conditions', i.e. a clean workplace, with the ability to control one's schedule, with less risk and good pay:

For a woman, if she wants to be a surgeon, there are plenty of beautiful specialties ... plastic surgery ... dentistry, gynaecology ... ophthalmology, are

[all] prestigious and beautiful specialties ... You can help people, feel good, and know that you are useful. You can achieve a lot.

Riska and Novelskaite (2008) and Zetka (2003) similarly note that more technologically sophisticated medicine demands skills that are often imagined as feminine, for instance requiring 'artistic eyes' rather than masculine 'good hands'. Good hands are a familiar metonym for describing the hands-on surgical labour that requires 'craft, skill and situational awareness' (Prentice 2012, 111). In Ukraine, women constitute 45.6% of pathologists, a significantly higher percentage than in other surgical specialties (Derzhstat 2016). In her study of female pathologists in the United States, Riska (2001) shows how their 'medical lore' focuses on a shared 'sense of thoroughness, order, and detail' that uniquely qualifies 'handy and diligent' women for this type of clinical labour. In this instance, pathology revolves around a microscopic analysis of tissue, despite popular imagination of this job as involving 'macabre' dissection (Ibid.). It is for this reason, my respondents suggested, that women dominate analytical specialties that focus on biomedical diagnostics, such as radiology, microbiology, MRI, and ultrasound labs.

In contrast to women's abstract thinking and attention to detail, male surgeons were described as operating on a more physical and even primitive level. Riska and Novelskaite (2008) find that this type of clinical labour is perceived as requiring physical strength and mental endurance, qualities that stand apart from empathy, ability to communicate, and a holistic view—the latter of which are coded as feminine and suited to non-surgical specialties. More primordial, male surgeons are imagined to use their applied technical skills (as opposed to analytical ones) to make difficult, quick decisions, thus embodying the dialectic of good hands versus good heads. During a focus group with neurosurgeons working in a large emergency hospital, three men in their late 30s reflected on the gendered differences in surgical practice. One observed:

We have women surgeons in our hospital, and we respect them ... I once had a night shift with a woman surgeon. She kept asking me to check on a patient again and again and again ... She ended up going to that patient's bed five, maybe ten times. Surgeons must not burn for their patients [*гореть больным нельзя*] ... Women tend to take things closer to their hearts, and this is why I believe that they 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, otorhinolaryngology, cardiology, MRI ... Anaesthesiology is also full of women who are 'the bomb'.

These neurosurgeons posit that their surgical ability depends not only on their skill but also, and importantly, on their ability to 'act coldly' (Prentice 2012, 128), which they perceive to be gendered. This 'dialectic of difference' (Cassell 2000) highlights how embodied processes are at play in gender segregation by medical specialty. Drawing on Bourdieu (1984), Cassell notes how 'visceral' reaction to a female body of a surgeon as 'a wrong body in the wrong place' is a result of 'common schemes of perception that generate practices and representations ... embodied through repetition and enactment' (1996, 43). Consider, for example, this joke (which was shared with me by multiple interlocutors): 'A woman surgeon is like a guinea pig. Not a pig, and not in Guinea [*Женщина-хирург, как морская свинка. Не свинка, и не морская*].' This is to say, a woman who is a surgeon is not truly a surgeon and not truly a woman; in other words, 'a wrong body in the wrong place'. A nurse zeroed in on this in her story about a female paediatric neurosurgeon at her hospital:

People don't like female surgeons, men don't like them for sure ... Nadiya Myroslavivna [a pseudonym] 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 ... In spite of her high status as a professor, she still has to fight men ... I think it is difficult for her.

This neurosurgeon, the nurse suggested, had to continuously prove that her female body in the operating room was indeed in the right place. Similarly, displaying qualities that are culturally cast as masculine helps one to be seen in the right place. For example, female surgeons were described to me with respect, but also with emphasis on certain qualities coded as masculine. They were described variously as 'aggressive and bellicose, and large', and 'does not say much, very tall, and dark'.

These ideas about beautiful medical fields are 'developed unconsciously by doctors, never explicitly taught or learned in practice, reproducing social difference' (Smith-Oka and Marshalla 2019, 113), highlighting that medical training involves both technical and social lessons (Prentice 2012). In fact, the lessons about how medical providers are seen by their colleagues, families, and patients, based on their medical specialty and gender, begin before they are even exposed to the 'hidden curriculum' at school or at work (Hafferty and Franks 1994). One female neurologist I interviewed somehow always knew surgery was off limits, saying: '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 medical school, I had this mindset'. The 'hidden curriculum' solidifies this mindset and female doctors easily recollected instances of not being taken seriously by their male surgery professors. Physicians' ideas about the right types

of clinical labour based on their gendered bodies evolve as they continue 'cultivating' their 'skillful practice' (Smith-Oka and Marshalla 2019, 115). A female oncology surgeon, for example, shared how she literally felt out of place on her hospital floor. With surgeons sharing a large office, she did not feel integrated into the 'collective', both because of her gender, and her age (34):

I ended up sitting there on my own. It would be the same for a man working in [a] predominantly female collective ... Medicine is a very nerve-racking profession, so it is important to have an emotional outlet. Whenever I feel down or get anxious, I go to the second floor [a female-dominated chemotherapy office, where this interview took place] and pour out my worries [выплюю душу]. I would never go to men on the fifth floor [the surgery floor] for that ... No matter how prestigious the job is, you will never feel comfortable if you do not have a good collective.

Gender segregation by medical specialty, in this instance, is metonymically extended to the physical spaces of the male fifth floor surgery unit, and the female second floor chemotherapy unit. This surgeon is learning 'the informal lessons ... through clinical apprenticeship' (Prentice 2012, 29). This apprenticeship includes not only the time spent in the operating room or by the patient's bedside, but also in her 'community of practice' (Lave and Wenger 2009). Her 'medical learning becomes embodied' (Prentice 2012, 29) as she reluctantly climbs the stairs to the fifth floor and inhales a cloud of cigarette smoke in the office that is shared with the male surgeons, whose workplace smoking is tolerated. Physicians' gendered bodies 'move to the center of medical learning' (Ibid., 135) where training is not only clinical, but also involves lessons in respectable femininity and masculinity.

## **The coefficient of propitious time**

In the previous sections, I demonstrated how two dominant tropes of femininity—motherhood and beauty (Kis 2005), produced by the tension between the 'utopia' of national revival (Pavlychko 1996, 306) and the Soviet emancipation project—are centrally involved in the feminisation of healthcare and in gender segregation by medical specialty. Next, I show how remuneration intersects with these dominant gender tropes. I suggest that physicians attempt to strike a balance between their professional and gender identities. Remuneration is an important aspect of their professional identity (Bazylevych 2015), while family life and social grace are an important aspect of their gender identities. I suggest that navigation of work and family time (both daily and over the course of one's life) is deeply gendered and is constitutive of gendered division of labour in medicine.

With the Ukrainian healthcare system ailing as it struggles to deliver the constitutional promise of being universally accessible in the midst of political

changes and economic hardships, physicians receive poor remuneration. Yet, clinical labour can still offer lucrative income if significant time is invested in building professional connections, pursuing several jobs at the same time, and otherwise building a reputation that will eventually lead to being sought out by patients for clinical advice and treatment and by colleagues for consultations, referrals, and professional collaborations. With no direct guarantee of immediate financial return upon graduation from medical school, however, newly minted doctors tend to spend a significant number of years accumulating the necessary cultural capital before they reach 'the coefficient of propitious time'. In mechanics, this term defines the productive life of a device. In one interview, my interlocutor used it to define the productive life of a physician—as a period during one's lifetime when one's work yields financial profit.

I first heard this particular wording from one of the public health workers at a large international organisation in Kyiv. She specialised in infectious diseases and had previously worked in phlebology (tuberculosis treatment). We were sipping tea behind her work desk in a shared office and talking about the overall predominance of women in Ukraine's healthcare system. I mentioned how a Ministry of Health official who met with me to discuss gender composition statistics referred to the female predominance as 'a problem' of 'boys not wanting to go into medicine'. My interlocutor did not share the official's feeling that it was a problem, but she thought that consideration of 'propitious time' played its role in the overall feminisation of medicine.

Recent medical school graduates have to invest significant time in developing skills and networks before they can expect to earn decent incomes. In addition, there is no guarantee that their investments will pay off. Indeed, some abandon the practice of medicine to work for pharmaceutical companies, clinical research trial companies, and cosmetic medicine facilities. The public health officer who shared her insights with me thought that gender strongly shaped physicians' decisions about whether they could afford the risk of spending many years before seeing returns on their investments in education and training. For female doctors, she concluded, years of low income were mitigated by their investment of time in children and family.

Female respondents considered that pursuing a medical career had endowed them with other valuable capital, such as skills and knowledge of broad health issues. For male participants, taking a leap of faith into anticipated years of relative poverty was not felt to be matched by other benefits. The responsibility for the health of the family fell on their female partners, so while female providers could productively 'navigate through healthscapes' in the short-, medium-, and long term (McKie, Bowlby, and Gregory 2004, 605), it was more difficult for male physicians,

whose primary responsibility was that of generating income. This point is underscored by this female paediatrician:

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 ... There were 120 students in my class in medical school, and only 16 of them were men. Half of them have already quit. Those few who remain are either surgeons or trauma specialists ... The salary does not allow them to feed their families. For women this [pay] is more or less OK.

Although a minority, men still comprise around 35% of practicing physicians in Ukraine. Among those who took part in my study, male physicians worked in a variety of specialties, including paediatrics, general practice, dentistry, psychiatry, and public health, but many were in surgical fields. One of my respondents, who had changed his surgical gown for the business casual of a clinical research trials recruitment officer, specifically explained this shift by his inability to find a surgical job. Even though he graduated with high honours, he lacked the connections to find a good job in this medical specialty, and he did not want to practice any other line of medical work. Might it be possible that the teachings about male and female labour along with the perceived ability to exercise temporal agency—referring to the 'temporal dimensions of their lives, and whether they are able to influence them' (Moroşanu and Ringel 2016, 17)—ushers male physicians towards surgery, due to its higher official pay and greater informal pay potential, available earlier in their careers? Coupled with surgical labour being seen as a good fit for their male bodies, this is a persuasive narrative. Conversely, might female physicians take up a broader range of medical specialties because in doing so they can feel feminine and graceful (in accordance with current tropes), benefit their families relatively soon, and still hold onto the promise of financial return at some point down the line?

In addition to the boundary-crossing and applied nature of surgical work, it further contradicts the dominant femininity trope of motherhood because it is seen as incompatible with women carrying the primary responsibility for their family's routine needs. Medical labour has been described as 'all hours work' (Smithson and Stokoe 2005) or a 'more than full-time work ethos' (Lyon and Woodward 2004), referring to the workers' complete temporal commitment to their profession, which is made explicit by their availability to work all hours of the day and to go above and beyond the full-time contractual agreement. This 'heroic' ethos requires 'extensive temporal commitment that sweeps away personal time, leisure, domestic life and family responsibilities' (Ozbiglin, Tsouroufli, and Smith 2011, 1591). The regulation of time in many professions, including medicine, is connected to a 'traditional model of the ideal worker who is available to work all

hours' (Ibid., 1590). Indeed, the 'all hours work' applies to the surgical specialties in both the official institutional setting and in the unofficial setting, where private patients pay informally and expect around-the-clock contact. A burns unit surgeon recollected how, early in her career, the head physician dissuaded her from neurosurgery, citing precisely this 'more than full-time work' ethos:

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.

Conversely, medical specialties where it is possible to combine responsibilities for care work at home and outside the home attract large numbers of women, even when the clinical labour entails the hands-on elements that are not deemed appropriately feminine. Emergency services work is one example. While the job involves irregular hours, physical labour including lifting patients to place them on stretchers, as well as the requirement to enter residences at any hour of the day or night, 53% of emergency physicians are women. In Ukraine, ambulances are staffed with emergency physicians and mid-level providers called *feldshers*, as well as by various specialty teams (including cardiology, trauma, and psychiatry). The goal is to provide on-the-spot care, and transfer rates to hospitals are low: between 20% and 50% of patients are taken to hospital (Wright et al. 2000). During a focus group, several emergency care providers concurred with the statement made by one of them:

I love my job ... this communication with people, this real help, what you see with your own eyes—this is what is the most interesting in medicine. But emergency work is difficult in this physical sense, that's why I say it is not for women ... Maybe if we had better ambulance cars, like a Volkswagen or a Mercedes ... right now in our Gazelle [a Soviet-era ambulance] we feel like a sack of potatoes tossed around. Imagine how the patients feel!

The physical clinical labour of emergency care providers does not mark it as beautiful (safe, clean, or prestigious); however, its flexible hours can be accommodating of both family needs and provide additional income-generating opportunities. A typical shift is 24 hours with two days off between shifts. This point was underscored by a participant who led one of the emergency brigade units in a large peripheral town. She explained that although she did not initially dream about being an ambulance doctor, she came to appreciate the flexible hours and even the adrenaline rush of emergency work. A mother of three children, and at one point a pharmaceutical representative, she is now involved in the administrative

line of emergency care work, but she still picks up a few ambulance shifts every month.

In other words, family and pay considerations impact both men and women, though in somewhat different ways. My research findings show that women are interested in good income just as men are, but the moral authority derived from building a family while also pursuing a 'beautiful' line of work is also very rewarding. Men take less time to receive financial returns on their training, because few have an expectation of becoming primary caregivers at home. In their UK-based study, Drinkwater, Tully, and Dornan (2008) find clear differences in the ways medical students plan to achieve family–work balance, with women prepared to prioritise motherhood and men having 'high aspirations by tacitly assuming their partner, as mother, would care for their children' (424). One female neurologist and mother of two children even compared a stay-at-home dad scenario to 'an attack ... on women's territory ... it is not just about staying home, but also about controlling time and space'. While 'women's lives are often marked by less linearity and greater complexity' (Cuzzocrea 2015, 86) than are men's, this 'dominant social perspective ... of men as breadwinners and women as mothers' (Drinkwater et al. 2008, 424) may paradoxically position them well to practice a greater number of medical specialties in the post-socialist context, while at the same time preventing their commitment to surgical fields.

## **Conclusion**

In this article, I focused on explaining how the type of clinical labour involved in different medical specialties intersects with a broader sociopolitical context, including dominant gender discourses and practices and the ways that these inform subtle ways of learning about medical work, ultimately producing the overall feminised field with its stark horizontal segregation. I suggested that gender composition in medicine can be particularly well illuminated by extending the analysis from issues of remuneration alone to consider a broader scope of meaning making.

I linked the gendered division of medical work to these overarching factors: gender discourses and practices that amplify women's cultural authority when they select many (but not all) fields of medical practice; consideration of gendered bodies in daily clinical labour associated with different specialties and informal ways of learning in families, medical school, and at work; and temporal considerations of multiple scales that allow female providers in non-surgical specialties to productively negotiate their gender and professional identities.

Men and women in Ukraine navigate economic instabilities in the context of political crises and the national revival mythology that glorifies women's central

place in families as mothers and as beautiful inspirational figures. A trope of a mother who is also a worker (of a specific type) is also familiar to women from the socialist experience. When women put on a physician's white coat, they perform culturally significant or 'beautiful' work and reinforce their moral authority. Experts in care and social grace, women are seen as and report feeling like they are a good fit in the medical community of practice and can earn a decent living while their skills and time are also serving to build up their families. Surgery is conspicuously excluded from an otherwise long list of medical specialties where women predominate, even though there are plenty of women in other hands-on specialties, such as emergency work. While emergency work violates one of the dominant tropes of Ukrainian femininity—beauty—it fits well with the more poignant one of motherhood, which has remained central for women since their en masse entry into the medical profession in the Soviet era. For male physicians, taking a leap of faith into predictable years of relative poverty while they are building their professional reputations is not matched by other immediate benefits as it is for women, who are simultaneously occupying their primary role as beautiful mothers. Indeed, male physicians in my study have often opted for medical careers either because they were born into medical dynasties, had generational wealth, or were exceptionally committed and entrepreneurial, all of which gave them a firmer promise of professional success in the healthcare field.

Women are predominant in almost every non-surgical field, including the less prestigious general practice and specialties perceived as an extension of motherhood such as obstetrics or paediatrics, but also in a wide range of narrowly specialised fields, like gastroenterology or oncology. The common denominator is not so much the level of financial return, but rather the ways in which physicians' gendered bodies and outlooks are at play. Ukraine's nation-building project solidifies a vision of women as primarily mothers and secondarily as inspirational characters supporting their kin and their country. The archetype of a mother who is a worker is also informed by Soviet labour practices and the fact that the new ideal of a stay-at-home mother is difficult to achieve in the reality of ongoing economic turmoil and the need for two incomes. In this picture, the balance between professional and gender identities hinges upon performing work in reputable fields that are commensurate with family responsibilities and socially recognised as female spaces. The non-linear trajectory of women's lives which involves performing the lion's share of caretaking enables them to devote longer stretches of time in the course of a lifetime to invest in beautiful medicine without immediate financial return, while at the same time enhancing their moral authority as mothers. These processes entrench non-surgical medical specialties as feminine and simultaneously create barriers for women's uptake of surgical fields in equally high numbers.

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## About the author

*Maryna (Bazylevych) Nading* is an Associate Professor of Anthropology at Luther College, Iowa. Her research focuses on issues of professionalisation, remuneration, class, and feminisation in the healthcare sector, including gender segregation by medical specialty. Some of her published works include research on clinical labour in a healthcare system facing neoliberalisation; the Hippocratic Oath and significance of remuneration and class; and on vaccination anxieties in post-socialist Ukraine, published in *Medical Anthropology Quarterly* and awarded the Society for Medical Anthropology's Steven Polgar paper prize. As a Nena Amundson professor at Luther College, Maryna Nading has conducted research on risk categories and health seeking behaviours among college youth in millennial Ukraine. Her teaching interests include medical anthropology, gender, health, and medicine, global health, qualitative research methods, and related fields.

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