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Prestige Concept Reconsidered. Hybridity of Prestige in Post-Socialist Biomedical Profession

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ABSTRACT

This article 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. I argue against the assumption that the biomedical profession in post-socialist societies is not prestigious. My ethnographic data suggest that the search for the economic capital reflects not only desire of physical comfort, but just as importantly, desire for re-negotiated social status in the context where relationships between social classes change. The concept of prestige emerges as a nuanced process rather than static notion, underlying the multiple factors influencing post-socialist physicians' status.

Keywords: Prestige, social capital, hybridity, biomedical profession, post-socialism

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INTRODUCTION

This article 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 article, 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.

In my broader study, I focus 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 health care 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). The ethnographic data that I collected during my year-long ethnographic fieldwork in Ukraine demonstrated this strictly materialist explanation as 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 health care 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)?

In this article, I focus 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. I will also not focus on the gendered aspects of professional prestige, as this constitutes a larger project that I could not give sufficient credit within the limits of this paper. I proceed with a brief discussion of my research methods and previous theorization of prestige in social sciences, followed by contextualization of the issue in post-socialist biomedical sphere, and the analysis of various angles of prestige that systematically emerged from my respondents' narratives. I conclude with discussion of personalization of health care delivery in post-socialist context and argue for conceptualization of prestige as a dynamic process.

RESEARCH METHODS

This research is based on the ethnographic fieldwork data collected in the central and western parts of Ukraine in 2007-2008. I use data from interviews, life histories of key participants, and focus groups. Through the eyes of insiders of the health care system, I track local understandings of the unfolding socioeconomic, political, and institutional transformations to unpack the concept of *prestige*. The participants for this study were recruited

from different positions in the health care system, including health care administrators (head physicians, municipal authorities), established physicians in state-sponsored clinics and some private facilities, and primary providers. I focus on diverse health care professionals to capture a variety of voices, including older generations of providers trained in Soviet Union and younger physicians who made their professional choices after Ukrainian independence. The data were collected in the capital city of Kyiv, as well as Vinnytsia, a more remote town, to compare center-periphery dynamics in the medical profession.

I initiated my fieldwork research by conducting a series of open-ended interviews with 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. All interactions were in Ukrainian or Russian[1], 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. I also made regular visits to two health care 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, some of the patients' relatives, and with the visitors to the health care facilities. Some physicians invited me to accompany them at several overnight shifts. They also introduced me to other health care professionals at their work places and their social networks. This snow-balling technique is a limitation of this study, since 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. Since my larger project focused on medical professionals and changing ideas of professionalism and gender, I interviewed mostly health care providers. Attention to patients' rationalizations was not a part of the research design, and is a limitation of this work.

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[1] 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).

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 health care. 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.

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. Here, I discuss the ways in which the post-socialist biomedical profession is hybrid: it combines socialist and new market ideologies that inform everyday practice.

Today, Ukraine continues to use the hierarchical and centralized Soviet health care model mandated by the Ministry of Health. Constitutionally, the Ukrainian state guarantees free and universally accessible health care, continuing Soviet rhetoric on health as a human right rather than individual responsibility. 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. Ukraine is currently experiencing a mortality crisis with average life expectancy 73 years for female and 67 years for male population, which is, on average, 11.8 years lower than in Western European countries. The country's socioeconomic crisis has created an environment where health problems flourish. In the context of skyrocketing prices on pharmaceuticals, medical supplies, equipment, energy and utility costs, "free" and "accessible" health care is essentially replaced by an informal fee-for-service system. The Ukrainian National Academy of Medical Sciences (Polischuk 2006) estimate that over 50% of all health care financing originates from unofficial and quasi-formal payments. Patients may incur any of the following informal costs: the purchase of medications and supplies; payments to the physicians or the surgery teams; payments to nurses or sanitary workers; and miscellaneous fees to speed up access to scarce resources and services (Thompson and Witter 2000). It is hard to over-emphasize the discontent of the local population. Health care administrators, physicians, and patients alike scream from the pages of newspapers, interview tapes, and television screens that health care is not accessible to all, does not offer consistently high quality services, and lacks advanced technology, medications and supplies. Physicians' official salaries are some of the lowest in the non-industrial sector of the Ukrainian economy and constitute only 1,145 hryvnia as compared to 1,665 hryvnia national

average across industries[2] (DerzhKomStat 2009). Health care remains a state-sponsored project in post-socialist Ukraine; despite this association, the participants of the system often relegate the state as such that has already retreated from this space. As one male respondent who heads the Narcology clinic in a peripheral town succinctly put it, "You understand, free health care as such does not exist. The state or the people must pay for it. In Ukraine, *the state has ceased to exist* long time ago, therefore people are paying" (respondent's emphasis). The problems of health care are left untackled, while the providers and patients scramble to continue making sense of the system. In Ukraine, informal norms and formal law are currently out of sync, making it next to impossible for the actors to follow the rules. Ukrainians learned to maneuver in between law and social norms. Reliance on informal practices is a testament to the failure of the formal institutions to satisfy the needs of most participants of the system.

At first glance, it is tempting to instantaneously 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 health care system as a whole and at physicians only secondarily, in their role as representatives of the system rather than knowledgeable experts[3]:

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[2] The official currency exchange rate is currently 1 USD to 7.9 UAH (Ukrainian hryvnia), according to the National Bank of Ukraine. 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 now back to 8 UAH.

[3] All interview excerpts were translated by the author from Ukrainian and Russian languages (the original languages of the interviews) to accommodate English-speaking readers.

> Politicians are provoking negative attitude towards physicians among the patients. It is a socio-political problem. Something is not fully thought-through in our health care system. It is not undergoing the necessary reforms. Primary health care 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 health care 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.

PRESTIGE AND THE ASSOCIATION OF THE HEALTH CARE 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 health care 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][4]. 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

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[4] 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).

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.

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 health care system.

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 health care 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. Tetyana, 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.

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.

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 3 to 5 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 Lyudmyla 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 health care, 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."

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.

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) health care 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 health care, 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.

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 health care 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 health care 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 health care. 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 health care 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 18, 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.

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 health care 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 health care. 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 health care 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.

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.

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.

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