

Disorder and Civilisation: The Future(s) of Ukrainian Medicine

MARYNA BAZYLEVYCH*

Luther College, Decorah

Abstract: Post-socialist societies are full of uncertainty, fragmentation, and competing discourses on social justice [Steinberg and Wanner 2008; Zigon 2011]. This article focuses on how Ukrainian physicians envision the future, present, and past of the health-care system and make sense of social change in their professional lives and society more broadly. The Ukrainian health-care system has remained largely untouched by post-socialist reforms, but it is nevertheless undergoing profound changes. These changes are occurring on the level of everyday practice and are shifting responsibility away from the state and onto the individual. The author traces how physicians navigate the persisting structures of the old system, and what hopes they carry for the present and the future. Post-socialist health care is bursting with competing interests, commitments, and notions of how health-care providers should relate to each other, their patients, administrations, and the state in general. This article therefore draws on physicians' narratives of the disorder in health care through the interpretive prism of 'ruination ... as a process that weighs on the future and shapes the present' and that represents a 'vital reconfiguration' [Stoler 2008: 194] or crafting of 'hope' [Lindquist 2006].

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Introduction

In reality, work conditions are horrific. In my opinion, the surgery room must be an ideal place ... it must be comfortable for everyone, and first of all for patients. Sometimes I wonder what patients think as they are being rolled into the surgery room. As we are rolling them through the hospital corridors, what do they see?! They see ruins, they see disarray ... (Lilia)

An overarching sense of disorder pervades the narratives of my respondents, as in Lilia's words above. A surgical nurse at the Neurosurgery Research Institute in Kyiv, she captures her daily experiences of disorder in the metaphor

* Direct all correspondence to: Maryna Bazylevych, Department of Sociology, Anthropology and Social Work, Luther College, 700 College Dr., Decorah, IA, 52101, USA, e-mail: bazyma01@luther.edu.

of illness. She identifies the material manifestations of disorder, the deterioration of the physical space at work, as symbolic of the overarching chaos in the country. This article focuses on how Ukrainian physicians make sense of social change in their professional lives and society more broadly. The medical¹ field has remained formally unreformed, creating a fertile ground for the exploration of the structures and practices that endure and those that transform. Taking a cue from Stoler [2008], I am interested in analysing health care as a remnant, as the ruins of socialist sensibilities. Yet, ruins that are not just inert refuse, but are undergoing a vital transformation.

Post-socialist health care is bursting with competing interests, commitments, and notions of how health-care providers should relate to each other, their patients, administrations, and the state in general. Similar to what Phillips [2010] has found among Ukrainian disability rights activists, physicians 'negotiate and rework these debates both under the auspices and outside of state discourses and policies'. With unfolding social differentiation, physicians seek to renegotiate their relationships with the state and also beyond it. They infuse new market sensibilities into the health-care system, where they work to craft hope and reap new forms of empowerment. At the same time, they continue to discursively rely on the state and hold it accountable for the current state of affairs in Ukrainian health care as well as its future reform. After all, 'ruin-making endeavours are typically state projects, ones that are often strategic, nation-building, and politically charged' [Stoler 2008: 202].

I begin here with a discussion of visions of the present: imperial debris in the remnants of the power structures that breed the double-bind in which physicians increasingly find themselves. I then go on to consider visions from the past or rather 'what could have been': ruins as a critique of the newly emerging mechanisms of structural violence and a familiar form with a familiar cultural logic [Oushakine 2007]. I then elaborate on how physicians live 'with and in ruins' [Stoler 2008: 196] and how they craft hope; and conclude with deliberations on visions of the future, what physicians hope to build from the imperial ruins of health care in Ukraine.

Research methods

This research is based on ethnographic fieldwork data collected in the central and Western parts of Ukraine in 2007–2008, with a focus on Kyiv, its capital city. The major administrative and educational centre for Ukraine's centralised health-care system, Kyiv (population 2.6 million) is at the forefront of the country's medical system. It is also one of the main sites for emerging private health-care facilities and a testing ground for new health-related policies, for example, private medical

¹ Hereinafter I will use 'medical' to refer to the biomedical field.

insurance. This central location has allowed me to keep a finger on the pulse of new developments in an actively changing field.

To explore potential differences between central and peripheral areas of the country, I also conducted fieldtrips to the smaller city of Vinnytsia in a remoter part of central Ukraine. Vinnytsia hosts one of the major medical universities in Ukraine, National Pirogov Memorial Medical University. Such access to the medical-education institutions in Vinnytsia (and in Kyiv) increased the potential pool of both the older generation of physicians educated in the Soviet Union and their students, younger respondents trained in post-socialist Ukraine.

I initiated my fieldwork research by conducting a series of open-ended interviews with a free-listing component, where my respondents were asked to select their own starting points according to what seemed most salient to them. This allowed me to elucidate the categories they prioritised without the researcher's bias. I collected over 100 semi-structured interviews, lasting anywhere from 45 minutes to four hours and longer. In my data analysis, I understood the interactions with my interlocutors as communicative events [Briggs 1986]. My informants and I brought our own sets of goals and investments, informed by the embedded social and political fields of our organisational contexts. When possible, I compared the interviews to my observations and to secondary data in order to bring to light these possible discrepancies. Most interviews were recorded digitally with the permission of the respondents. I usually took extensive notes upon completion of the interview session or participant observation event. All interactions were in Ukrainian or Russian, and the translations are my own.

In addition to interviews, I observed work in state-run polyclinics, inpatient hospital facilities, research hospitals, private clinics, and private doctors' offices at the primary and secondary location sites. These observations preceded and followed the interviews of many of the respondents, though not all. With some respondents, I followed their work for the entire year of my fieldwork. I also made regular visits to two health-care facilities at the secondary site (one an *oblast*-level, i.e. regional, clinic, and one a private polyclinic); and two facilities at the primary site (one a city-level large hospital; and one a city-level polyclinic). I was able to observe some of the physicians' daily routines, observe their communication with other doctors, medical staff, patients, patients' relatives, and with visitors to the health-care facilities. Some physicians allowed me to join them during their overnight shifts. They also introduced me to other health-care professionals at their workplaces and in their social networks. The use of this snowball technique is a limitation of this study, since the selection of respondents was not truly random. At the same time, this method allowed me to become privy to information that would otherwise be difficult to elicit, since I was inadvertently able to get an insight into the dynamics of specific circles of physicians. The project also incorporates an analysis of relevant press, major periodicals, and online readers' discussions, as well as Ministry of Health reports and regulations.

Additionally, my ethnographic data include six life histories of key informants (physicians trained in the Soviet Union and those who decided on the medi-

cal career in post-socialist Ukraine, female and male). I was also able to conduct seven focus groups: two mixed groups with male and female physicians, two only with male physicians, and three only with female physicians.

Since my project focused on medical professionals, I mostly interviewed health-care providers. Attention to patients' rationalisations was not a part of the research design and is a limitation of this work. However, my circulation through the clinical settings, different circles of friends and acquaintances, and mass media all added to the interactive aspect of my study. I routinely encountered people who had made health-care-related decisions in the past several years and who commented on their experiences. Health care became a prism through which it was possible to study transformations in the Ukrainian medical field, local value systems and ideologies, society at large and international exchanges.²

Theoretical considerations

In his analysis of Maxim Gorky's³ 'Order of Things', Oushakine [2004] points out that the importance of daily order in structuring one's life becomes especially visible when it falls apart. In this article, I inquire into what happens when the health-care structures created for the socialist present and future find themselves falling apart in the new market reality. I will utilise Stoler's [2008] framework of imperial debris⁴ to point to the processes of 'vital refiguration' that are unfolding in contemporary Ukrainian health care. Vital refigurations are not inert relics; examining them allows us to understand how some structures endure and others fall apart. Understanding the current Ukrainian health-care system as an imperial ruin allows us to see 'what people are left with, the aftershocks of the empire, the material and social afterlife of structures, sensibilities, and things. Such effects reside in the corroded hollows of landscapes, in the gutted infrastructures of segregated cityscapes and in the microecologies of matter and mind' [Stoler 2008: 194]. As an imperial ruin, the highly centralised Semashko system that Ukraine has inherited continues to inform 'modes of health care organization, but ceases to

² The research methods portion of this article is based on my article 'Moral Economy and Informal Exchanges in the Ukrainian Healthcare System' submitted for publication to the *Journal of Ukrainian Politics and Society*.

³ Maxim Gorky was one of the most prominent Soviet writers and the founder of the Soviet Council of Writers.

⁴ In using Stoler's conceptual framework on imperial formations, I join a group of anthropologists of Eastern Europe [e.g. Barsegian 2000; Bunzl 2000; Carey and Raciborski 2004; Verdery 1996] who have noted that post-colonial scholarship has much to contribute to our understanding of post-socialist processes. At the same time, the scholarship of post- or neo-socialism(s) have much to contribute to post-colonial studies, lest the former become 'overconfident in its analytics and its conceptual vocabulary, too assured of what we presume to know about the principles and practices of empire ...' [Stoler 2008: 192].

function in ways it once did' [Stoler 2008: 203]. Stoler's theoretical framework of imperial debris will serve as a lens to analyse disorder in health care on two levels: as the persistence of old power structures that give rise to double standards; and as a poignant critique of free-market rationalities in medicine. At the same time, the imperial debris serves as a platform upon which the future is imagined, a platform for hope. They point us 'to the ways in which people negotiate and enact their disposition toward the present and future in relation to the imagined or remembered past' (anonymous reviewer 2014). Here, I understand hope as 'the existential and affective counterpart of agency that replaces it where channels for agency are blocked and presence in the world becomes precarious' [Lindquist 2006: 8]. While physicians in this study often found it impossible to affect desired change in their work, or in their personal life for that matter, they never relinquished their stake in the social game. Investment, or stake, in the game is what Bourdieu calls 'illusio', which is 'always oriented to the future, to something that is to be brought into being, in projects and desires, and it is therefore connected with the foundational existential condition of being, that of hope' [Lindquist 2006: 6]. This essay will therefore engage physicians' narratives of disorder in health care through the interpretative prism of 'ruination (as) a corrosive process that weighs on the future and shapes the present' [Stoler 2008: 194].

Visions of the present: the politics of disorder

This section will analyse the Ukrainian health-care system as a form of imperial debris that continues to preserve political and legislative structures that physicians see as obstacles to positive change. Two sites will be examined: the enduring socialist health-care legislation that continues to inform the realities of physicians' daily work; and the political mechanisms that serve to preserve the status quo. My approach seeks to 'redirect the engagement ... to the politics animated, to the common sense they disturb, to the critiques condensed or disallowed, and to the social relations avidly coalesced or shattered around them' [Stoler 2008: 196].

Given its centralised and state-sponsored nature, the health-care system is a strategic, politically charged project. The Constitution of Ukraine guarantees free and universal health care to all people living in Ukraine [Constitution of Ukraine 1996, Article 49]. However, the system is severely underfinanced and uncoordinated. The government's expenditure on health care as a proportion of GDP has not increased since the mid-1990s and according to some estimates [Lekhan et al. 2010] constitutes just about half of actual health-care expenditures. Health-care facilities therefore rely heavily on out-of-pocket payments to make up for this gap in funding [ibid.]. These payments vary in the degree of their formality and breed conflict between providers, patients and their kin, and administrators [Bazylevych 2013]. While health-care facilities are territorially and functionally subordinate to the Ministry of Health, managerially and financially they have to answer to the regional governments [Lekhan et al. 2010], creating a contradic-

tory chain of command. No significant health-care reforms have been proposed, which has only exacerbated the already increasing rates of avoidable mortality⁵ that are largely due to the worst political turmoil that Ukraine has seen since its independence in 1991. This double standard of not providing sufficient funds while still demanding that facilities offer free services, combined with the Ministry of Health's authority to punish local health-care practitioners for violating health-care laws, which (under the circumstances) are impossible to follow, rendered the health-care system and the state that runs it hypocritical in the eyes of most of my respondents. As one expert put it: 'We should stop pretending to be another North Korea. Ukraine has a market economy, and healthcare is not free of charge. Quite the opposite, it is expensive and inefficient. No matter how much money we pour in, there will be no result, not in seven years, nor in seventy-seven years.' [Paskhover 2008] Paskhover suggests removing the infamous Article 49 from the Constitution and putting it in the Museum of Medicine, underlining how inconsistent the Constitutional promise of free medicine is with people's everyday experiences. Consider, for example, Dmytro, who had been working in a regional hospital for over ten years at the time of our interview. He works two jobs: the night shift in a neurology unit and a day job in one of the pharmaceutical companies specialising in cardiology medications. He points out the extreme disillusionment with the law that is supposed to guide the health-care system, but has instead become a nuisance for physicians' daily work:

We no longer have communism in our country, but we do have it in health care ... People are used to it [free health care]. Sometimes they show up in the hospital in life-threatening conditions: shock, brain injury, a fractured skull, and coma. For the first 24 hours, we continuously run IVs, pour in litres and litres of medications, dozens of injections. So many treatments, but what kinds of resources do we have?! Our entire unit receives 3 pairs of disposable gloves per shift from our state. Our maximum capacity is 12 patients ... Now let's calculate. Our nurses use 3 pairs of gloves to take care of 12 patients per shift, and we are working with blood and wounds ... So what kind of free health care do we have? What are we talking about?!

Dmytro's narrative emphasises the disjuncture between the official discourse on the one hand, which stresses the beneficence of the state, and on the other people's real experiences of making do with a severe shortage of resources. Physicians universally resent the double standard that technically preserves the image of a universally free and accessible system, while asking its medical staff to work hard, to work transparently and without informal payments, and paying them only a meagre salary in return.⁶ While many physicians manage to earn a

⁵ For details, visit the WHO Ukraine country profile at <http://www.who.int/gho/countries/ukr.pdf?ua=1>.

⁶ As of March 2014, the official salary of health-care workers (a generic category that does not distinguish the numbers by specialty, rank, or gender) was 2283 UAH (Ukrainian hry-

decent income by working several jobs, including emerging private-sector jobs, the majority continue working for the public hospitals as a risk mitigation strategy against the uncertainties of the free market. They therefore feel directly affected by health-care policies or the lack thereof. Iryna, a neurologist, humorously refers to the double standard in this excerpt:

A person who earns 500 hryvnia per month⁷ will not work as if she were paid 2000. This is a fact. If my salary were 2500 to 3000 hryvnia, I wouldn't want any 'livak' [Ukrainian for extra earnings on the side, informal income], not at all, because it's criminal. After all, why should I pick up the crumbs from my patients' tables?! However, my salary of 700 hryvnia at the hospital redeems everything. As the saying goes, when a physician is paid only this much she should do nothing and even cause a little harm.

The Constitutional double-bind is only a part of the issue, with political turmoil setting fire to the flammable imperial debris of health care. In the words of Alisa, an X-ray specialist who works in one of the most prestigious private hospitals in Kyiv:

When something is falling apart, it becomes easy to steal. Whenever there are radical changes in any system, not just health care, it is a great opportunity for some people to grab whatever is left lying around.

Because the health-care system is funded by the state, it is especially influenced by political changes. In thirteen years of independence, eighteen Ministers of Health have tried their hand at running the medical field, but faced 'significant challenges in overcoming popular distrust and fatigue in the face of necessary but as yet unimplemented reforms' [Lekhan et al. 2010: xx]. In their interviews, my respondents insisted that 'a fish starts rotting from the head', underscoring that the source of the disorder resides in the self-serving government. A brief recap of Stepan's life history below illustrates how 'to think with the ruins of empire is to emphasise less the artefacts of empire as dead matter or remnants of a defunct regime than to attend to their reappropriations and strategic and active positioning within the politics of the present' [Stoler 2008: 196].

Stepan is a successful dentist with one of the most prosperous private dental offices in a town in western Ukraine. His story is the Ukrainian equivalent of the American dream. Growing up in a remote rural area in the Carpathian Moun-

nia) per month, which is less than 200 USD. The data are provided by the State Statistics Service of Ukraine and can be accessed in Ukrainian at http://ukrstat.org/uk/operativ/operativ2014/gdn/Zarp_ek_p/zpp2014_u.htm (retrieved 1 March 2014).

⁷ 500 Ukrainian UAH was equal to approximately 60 USD at the time of this fieldwork in 2007–2008.

tains, he had to go to boarding school given the isolated location of his parents' home. University education was beyond his family's means, and so Stepan was drafted into the Soviet army and sent to Siberia. There, thousands of miles away from home, he started working as a medical aid, and gradually realised his calling. Upon completing his two-year army service, Stepan moved to a large university town in western Ukraine and was admitted to the dentistry department at a medical school. He has now become very successful. He has a beautiful clinic with well-to-do domestic and foreign clients, top-notch technology, and multiple certificates of achievement lining the clinic walls. Stepan is known as one of the richest men in town and regularly invests in construction projects in the area. He is also known in the town's medical circles as an especially bright and knowledgeable doctor who demands perfection from his employees. This quality is deemed unusual among private dentists who are often spoken of as greedy people with little professional development ambitions. Stepan documents his observations from his medical practice, and has collected an impressive amount of data that could be used in scientific work. Yet, he refuses to pursue his research interests formally by becoming affiliated with a medical research institution. He calls the current graduate and post-graduate Ukrainian education system fake and corrupt, where degrees are handed out on the basis of bribes and connections and not the quality of work. Stepan refuses to participate in the charade, even though he has the financial means to pursue this path. In so doing, he likens himself to Ukrainian writer Lina Kostenko, who refused to accept the 'Hero of Ukraine' Medal, the highest award handed out by the Ukrainian state, because she did not recognise the Ukrainian government (in 2008 at the time of the interview) as having the moral authority to bestow such an award. She believes that the politicians in power do not represent Ukrainian interests but their own business appetites. This sentiment is echoed in the refrain of a song by Tartak, a popular Ukrainian band: 'I don't want to be a hero of Ukraine, because my country does not value its heroes' (in Ukrainian Я не хочу бути героєм України, не ціную героїв моя країна). One wonders if Stepan's views may have changed in the light of the recent dramatic events in Ukraine, which began with peaceful demonstrations against Yanukovych's regime, followed by violent attacks against the protesters, the successful ousting of the Party of Regions elite, Putin's aggression in Crimea and southeast Ukraine, and the recent election of President Poroshenko.

Visions of the past: what might have been

'Ruins draw on residual pasts to make claim on futures. But they can also create a sense of irretrievability of futures lost' [Stoler 2008: 202]. Health-care ruins, sometimes in the quite literal sense of an abandoned dilapidated clinic building, or an unused deteriorating hospital wing, remind people 'of what could have been rather than what was. This sense of arrested rather than possible futures and the ruins they produce is one way to convey the problematic processes of develop-

ment policies' [ibid.]. The lived experience of socialism provides Ukrainians with conceptual tools to critique the post-socialist 'transition' [Ghodsee 2011]. Not only are physicians fully versant in Marxist critiques of the capitalist system and know how to recognise the mechanisms of oppression, but they also possess the everyday knowledge of things that worked in the past and the systems that allowed for broader social justice. Svitlana, who used to work at the tuberculosis clinic in Kyiv for over ten years, is convinced that even questionably efficient rules are better than the current anarchy. She says that, in the past, physicians may have been dissatisfied and wished for change, but at the very least they were working and they had clear views on what could and should be done at their facilities. 'Now', Svitlana says, 'many physicians do not even have an opinion. They are at a complete loss and do not know where to run ... There is an infinite amount of work that needs to be done [reforms], starting with financing and ending with legislature'.

This conceptualisation of imperial debris as a critique of post-socialist liberalisation agrees with Caldwell's [2008] view of post-socialist transformations as a form of colonisation by political and economic missionaries and Mohanty's [2002] view of globalisation as capitalist injustice. My ethnographic data show that most physicians are critical of the post-socialist changes in medicine, mainly because they feel trapped between a rock and a hard place. They are legally responsible to provide free care, but are left with only minimal tools to accomplish this task. This critique is twofold: On one hand, physicians are disillusioned with the political leadership of the country, which makes it easy to link the health-care disorder to the perceived moral handicaps of the government and extreme politicisation of social life in contemporary Ukraine. On the other hand, physicians are clear about the new issues of structural violence that emerged with the open market and were not nearly as big a problem in Soviet health care. Never before has one's financial status been such a determining factor in what treatment a patient can get as it is today. Never before was the informal economy so prevalent. Never before have physicians worked with such marginalised, impoverished patients with such advanced stages of disease because they delayed seeking treatment. Many of the providers are outraged to see the re-emergence of such diseases of poverty as tuberculosis, which is now rampant in Ukraine and affects close to 1.4% of the population [Lekhan et al. 2010: xv]. While it is true that the structural reasons for this disorder are not completely understood, and physicians usually struggle to identify what exact changes they would like, they correctly identify the lack of political commitment to health-care improvement as a problem. Elsewhere, I have suggested that physicians are already involved in renegotiating their corporate agendas and conceptualisations of professionalism [Bazylevych 2013], which might be a first step to more forceful collective action. Meanwhile, physicians rely on familiar approaches to coping with professional risks and critiquing new injustices, and one such approach is the 'work collective'.

While physicians are organised into trade unions, they still believe they are unprotected from the newly emerging litigious culture, corrupt administrators, or trials staged as a pretence of justice, problems that intensified with the Yanukovych presidency. To create a safety net for the everyday difficulties and extreme situations they face, physicians often develop unofficial support networks. Thus, physicians in an oncology clinic collected money out of their own pockets to repair the office where they worked nightshifts. Many workplaces regularly take the same approach to conduct repairs, renovations, and other technical improvements. Physicians often back each other up if any conflict with the administration occurs. Iryna, who has been working in a paediatric emergency clinic serving one Kyiv neighbourhood for almost ten years, is proud of her collective:

We have four physicians in our unit. We keep in touch over the phone, if necessary, and make decisions about suspicious conditions together. In April, I had a difficult situation. I was called to see one child in our neighbourhood twice in a brief period of time, and after that the child was hospitalised and died within six hours. My colleagues helped me so much at that time. They supported me morally, they helped me fill out all the paperwork, since I was in shock, completely stressed out, and unable to see or hear. Doctors in our collective trust each other. We all do our work and we do not compete with each other. I know it happens in other places. We divided up responsibilities. Oleksiy, for example, is very good at digestive problems. Everyone has his or her strong areas. Because we are an emergency clinic. Once we had a situation where one of our doctors saw a child in the evening and did not catch any problem, but in the morning during my shift I found meningitis. These are children, their conditions progress so fast. Nobody is safe here. Ten hours later anything can happen. I trust that during her shift the meningitis was not yet detectable, and by the time I got there it was. Of course, I protected my colleague, I calmed down the parents, explained everything. Otherwise, we would have had huge problems and an investigation. But it can happen to anyone, at any time. That's why we are very collegial in our collective.

Not one physician whom I met during the fieldwork had or had heard of anyone who had malpractice insurance. Instead, as with many other aspects in health care, their strategies are individual and personalised. Personalised networks are conducive to establishing trust among medical professionals and they substitute for the lack of trust they feel towards the state and its officials [Rivkin-Fish 2005]. The relevance of work collectives has also been reported by Patico [2008] and Bloch [2005] in Russia, testifying to the saliency of this imperial ruin. In facilities where the atmosphere is more competitive and intense, collectives are still present discursively in people's regrets about their absence. The endurance of the imperial debris of a collective as a support structure in health care is more than nostalgia. After all, few physicians would advocate for a return of the Soviet Union. Instead, 'the cultural logic of these reincarnations has more in common with the act of mechanical retrofitting ... rather than with the process

of political restoration' [Oushakine 2007: 453]. Reliance on the collective has a 'positive structuring effect that old shapes could produce, even when they are not supported by their primary contexts' [Oushakine 2007: 454]. The imperial debris of the collective persists not only because it is familiar, but also as a critique of market logic [Bloch 2005]. The emerging social stratification and new inequalities invited people to re-examine their conceptions of social order. Bloch argues that rather than dismissing these sensibilities as nostalgia and false consciousness, it is more productive to explore the ambiguities of life under state socialism and life in the free market. I suggest that the salience of the value of a reliable collective in Ukraine today could be understood as a mode of sociability that may be especially productive not only in coping with a current disorder, but perhaps also in mobilising health-care professionals in collective action to promote professional interests of this group. In the same vein, Szmagalska-Follis [2008] has traced 'restoration and redemption' at a collective farm in Ukraine's western borderland, where former prisoners engage in collective work in an attempt to return to meaningful personhood and regain suspended citizenship. By creating new socialities using old methods and infrastructures, the author argues, Soviet life is not 'unmade' [Humphrey 2002], but is instead remade to reproduce what has been in part lost—the order and domain of collective work and life.

Life 'with and in ruins'

'The Bible says that we should live one day at a time. I believe this is how we live now. We are not certain of anything: neither health, nor material well-being, nothing. We are living on a prayer.' I would like to begin this section with this quote from one of my respondents to underscore the role of 'hope [as] a vision of the present in the state of pregnancy' [Lindquist 2006: 8]. How do Ukrainian physicians live with and in the 'ruins' [Stoler 2008: 196] of health-care structures? How do they go about 'crafting hope' [Lindquist 2006: 8]? They claim the debris and develop new understandings of morality in order to inhabit these 'zones of vulnerability' [Stoler 2008: 200].

Engaging in the informal economy is one way of making the health-care ruin inhabitable. When I embarked on my fieldwork research, I did not intend to study the informal economy; rather I was looking at the gendered aspects of changes in health care [Bazylevych 2010]. Yet, participation in the informal economy was so ubiquitous and figured so prominently in the everyday sensibilities of my respondents that it was necessary to investigate it. A study by Danyliv et al. [2012] provides sociological confirmation of these findings, with 57% to 73% of patients reporting the use of out-of-pocket payments in obtaining treatment in a 'free-of-charge' system. Consider the view of Vitalina, who sometimes consults on pilot-certification boards, and describes here the uncertainty and disorder in her field:

I will tell you this. We provide pilot certification here, and we have high-calibre diagnostic procedures. However, we can control the situation. I myself am not without sin. Obviously, pilots make a lot of money in Airsvit,⁸ and they can afford to converse with doctors in such a way that lets them continue working as a pilot. We work with them, and we get paid for this. I am not talking about some serious pathology here, no. But, if it's a matter of small things here and there—I don't mind supporting our pilots with the necessary legal paperwork so that they are ready to fly. In addition, I also make sure that I have documentation as well, and that's that. Some may say it is corruption. But we do things this way everywhere. But back to your question, 'what don't I like about our health care?' I don't really know. I guess this is exactly what I do like about Ukrainian health care. More freedom of action, so to speak. Frankly, I feel like the Tsar and God at the same time here ... This is what I like about my job. In general, however, I am confident that our physicians, who study well at medical school, are great clinicians. They are very well trained. This is what I can say based on my observations.

For Vitalina and a number of other physicians the imperial debris allow for freedom of action. What is right and wrong is not certain, and energetic individuals are able to find multiple ways of making situations work for them. Physicians perform 'fiscal disobedience', but this 'rejection of regulatory or fiscal authority is not the outright violation, but rather disagreement over the intelligibility of the exercise of that authority' [Roitman 2005, 2004: 198]. Physicians find that working transparently and abiding by the contradictory rules is impossible, and they question the persisting power structures and lack of meaningful change. However, in so doing, they do follow a moral compass, even if it is not embedded in the 'rational-legal state's power' [Roitman 2004: 194]. It is critical to make a distinction between informal transactions viewed as moral and placed in the affective realm (gratitude) and transactions considered unprofessional and located in the realm of obligation (bribes) [Bazylevych 2013]. Most avoid taking payments from the deserving poor, such as the elderly or families with many children. It is also considered highly reprehensible to take money from patients who are at risk of dying. The timing and the way in which money is given also matter. Like Rivkin-Fish's findings [2005: 60], my respondents wanted to receive informal payments as an acknowledgement of their skills from the patients rather than be cynically paid off. Ukrainian physicians consider retaining their humanity while they conduct money-making activities to be an important aspect of professional ethics [Bazylevych forthcoming].

When I asked Vitalina whether she would be interested in working just one well-paid job in a private clinic as opposed to her current busy schedule that keeps her at work for impossibly long hours, she answered 'no' without hesitation. She insisted that she was able to 'carol' (in Ukrainian *Наколядувати*) much more this way. By 'carolling', Vitalina means the old Ukrainian tradition of, usually chil-

⁸ Airsvit, based in Kyiv, is one of Ukraine's largest airline companies.

dren, knocking on people's doors, singing carols, and collecting gifts and money at Christmas. Vitalina uses this term to capture the variety of professional activities she regularly undertakes to add to her income, and the uncertainty about what her income will be, since remuneration depends on her performance and on the disposition of the clients who pay her informally. These feelings are not shared by everyone, but are by those doctors whose convictions, connections, and capital have helped them to be 'successful' in adapting to post-socialist uncertainties. I put 'successful' in quotation marks here, because to view these strategies as empowering or advantageous would obfuscate the risks that come with the lack of any formal accountability between patients and doctors [Danyliv et al. 2012]. Until reforms in health care are introduced to mitigate the structural violence of the free market, physicians will likely continue to be involved in the 'economy of the bush ... covert and insurgent ... where claims to the right to wealth are being articulated and enacted ... and the status of licit versus illicit practice ... is the basis for the reconfiguration of governmental relationships' [Roitman 2004: 194, 197, 222]. This underscores Stoler's point that 'ruins are not just found, they are made. They become repositories of public knowledge and new concentrations of public declaration' [Stoler 2008: 201].

Visions of the future

Even if their working life is 'in ruins', physicians craft ways to survive and even prosper, and retain their stakes in the social game through 'illutio' or hope [Lindquist 2006]. Remember that 'ruins draw on residual pasts to make claim on futures' [Stoler 2008: 202]. They envision their future in terms of hope for justice, order, and civilisation. They variously engage the concept of civilisation, incorporating critical views of the state and domestic politics, as well as drawing on ideas from abroad.

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

It is the 21st century, but we still have seven people per hospital room ... For IVs, we still do not have dosimeters. The whole world now uses infusion pumps, where it's possible to calculate the number of drops per minute depending on the patient's needs. We have to do it all manually. When I was in Finland, I noticed that patients get their treatment as outpatients, i.e. during the day. They just walk in, get their IVs and procedures done, and leave. It's cheaper for everyone, and easier for the facility. Fewer staff members, no need for hotel services [food services, bed sheets, etc.]

However, see, our country is not small. We get patients from villages, so they can't just go home for the night ... We do not have any infusion pumps. Our state does not provide them, even though they are relatively affordable, less than USD 2000, and all we need is 15 to 20 of them.

Here, Yana acknowledges the primitive treatment methods still used at her clinic while affordable and significantly more functional instruments are now available, underscoring the ruinous condition of health care. The association of Europe and the West in general with civilisation is not new: European urban lifestyles were the standard to which Soviet citizens aspired. This lifestyle represents the value of culturedness as a code of public conduct and a template for responsible consumption in an industrialised and urbanised setting [Patiko 2008]. This shows that the domestic Ukrainian social order and Western discourses are not neatly separated, but have intertwined over the course of history. It is more accurate to suggest that physicians hope for greater order and functionality in their society, regardless of the shaping ideologies. The recent protests in Ukraine are a testament to that. People died on the streets in wintery cold not to support a specific political candidate but to protest disorder and injustice. I suggest that it is more accurate to consider how the attribute of 'cultured' is now transforming into 'civil'. Both represent a desirable sociability, though 'cultured' engages socialist values of collective good, moral over material values, the sacrifice of individualism and privacy for the state; while 'civil' denotes more democratic values of respect for community, but also personal well-being, the power of associations, and respectable living. One illustration of this discursive move is the doctors' perception of civilisation as a society where vulnerable groups are taken care of instead of thrown overboard. Valeria who works for the WHO in Ukraine, envisions civilisation as follows:

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

Valeria wants a social safety net, but on different terms, where relationships of trust between citizens and the state signal order and civilisation and signal the re-building of imperial debris into a working structure guided by social justice, so that the Ukrainian safety net is not just a copy of a system of some Western nation. Patiko [2008: 11] has analysed similar processes in Russia, arguing that the abrupt political and economic transformations 'have provoked an especially intensive process of interrogating the correspondences between collective and private interests and between material and moral values'. The socialist legacy is not an inert relic, but is better understood as evolution of different approaches

and rationalisations that people use to tackle challenges of transformations and the arrival of post-socialist capitalism [Patino 2008; Burawoy and Verdery 1999]. Thus, some of the middle-class ideas to which physicians currently aspire partially converge with some of the values of the socialist intelligentsia. There is an interplay of moral and material values behind the physicians' desire to be 'cultured', middle-class, and 'civilised'. In this discussion of hope, I would like to take my turn to express hope that this article will not be interpreted as an attempt to 'mount a charge that every injustice of the contemporary world has imperial roots but, rather, to delineate the specific ways in which waste accumulates, where debris falls, and what constitutes "the rot that remains"' [Stoler 2008: 211].

Conclusion

This article utilised Stoler's framework of imperial formations to analyse the health-care system in Ukraine through the eyes of its physicians. I argued that the Ukrainian medical system, which remains only marginally touched by formal reforms but is simultaneously undergoing profound changes connected with the free market, can be understood as an imperial ruin. Its persistent features are political structures that have preserved the status quo and magnified chaos by creating a double-bind of Constitutional promises and effective inability to carry them out. At the same time, physicians and other health-care professionals have found themselves in a double-bind: often required to offer free and accessible medical care largely without any semblance of resources to do so. This imperial ruin is at the same time a testament to people's reluctance to embrace the free market in medicine owing to concerns about the hypocrisy and structural violence that they have already begun to see. I also showed how this imperial debris serves as a platform for hope. The disorder in health care is productive albeit balancing on the edge of being a 'bush economy' [Roitman 2004] with the significant associated risks thereof. In the discussion of civilisation as a category employed by my respondents to ponder the future of medicine and beyond, I have shown that the socialist legacy is not a relic or an obstacle, but is better understood as 'evolving sensibilities and strategies that may be reappropriated, adapted, and transformed as citizens confront the many new challenges that have arisen from reorganization in a capitalist mode' [Patino 2008].

We now must ask: 'what work does it do to identify these as ruins of empire? What insights does it offer to recast these generic processes as patterned imperial effects that produce subjects with more limited possibilities and who are hampered differently by what is left?' [Stoler 2008: 200] The answer is simple: people living in Ukraine, physicians, and those who use their services, have no choice, but to live 'with and in these ruins', because, 'these are zones of vulnerability that the living inhabit and to which we should attend' [Stoler 2008: 200].

MARYNA BAZYLEVYCH is an assistant professor of Anthropology and Women and Gender Studies at Luther College in the United States. She focuses on social change and multiple value systems, gender and health-care professionals, medical systems, public health, and post-socialism. She obtained a PhD in anthropology from SUNY at Albany in 2010 with a dissertation titled 'The Female Face of Post-socialist Biomedicine: Ukrainian Women Physicians at Post-socialist Crossroads. Changing Ideas of Professionalism and Morality'. Her dissertation chapter titled "'Beautiful" Medicine and Feminism: Women and the Practice of Post-socialist Biomedicine in Millennial Ukraine' received the Graduate Student Essay Award from the Association for Women in Slavic Studies. She serves as a book editor for the Anthropology of East Europe Review.

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