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No Room for Balancing: Mothers and Professors  
in Czech Maternity Hospitals

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### Abstract

The paper analyses the complex issue of work-life balance in the medical setting of Czech maternity hospitals. The issue of work-life balance has not been dealt with adequately; the organisation of professional careers in medicine is understood in terms of making sacrifices for the profession. However, analysis of the everyday lives of members of the profession provides insight into the practices and strategies that are adopted for coping with demanding work and gender prejudices, and the striving to create a satisfactory personal life. The article targets the structural mechanisms that reproduce Czech hospital gender regimes and their effects on work-life balance according to the individual coping strategies of the actors involved. These are conceptually framed using the symbolic system of the gender universe (Harding, 1987) and the theory of gendered organisations (Acker, 1990). The empirical data used in the analysis comes from qualitative research (2011-2014) into Czech reproductive medicine, specifically obstetrics. It is primarily based on in-depth interviews with senior physicians, although other data sources were also utilised. Physicians' own reflections of the current status quo in Czech hospitals are critically assessed and framed in a structural context with reference to the broader social mechanisms that re/produce gender in/equality in the labour market.

*Keywords:* medical profession; gendered organization; gender universe; work-life balance; qualitative research; sociology.

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## *Introduction*

In this paper we peek into the microcosm of the everyday lives and attitudes of actors on a hospital ward. The driving idea is to explain and make sense of the existing gender regimes that are reproduced in Czech hospitals and to identify the structural mechanisms that underlie them. By doing so, we may better understand what factors affect work-life balance in the medical profession, or rather, what lies behind the lack of policies for promoting harmony between work and life in this long-standing and prestigious profession. The sociological analysis presented herein conceptually draws on feminist theories of gendered organisations (Acker, 1990) and conceptualisations of the gender system of gender differences, or the ‘gender universe’, as introduced by Sandra Harding (Harding, 1987) and developed in the Czech context by Gerlinda Šmausová (Šmausová, 2002). According to this conceptual framework, work-life (im)balance is understood as a gendered and culturally (structurally as well as symbolically) conditioned category with diverging normative expectations towards professional women and men with respect to their commitments in private life and implications for their professional careers.

The empirical data described herein are based predominantly on a series of in-depth interviews with senior physicians (in terms of the hospital hierarchy this status is obtained after experience is gained after a second or European board certification), obstetricians and gynaecologists who have worked long years in maternity hospitals. In the Czech Republic these organisations are state-owned and belong to the very widespread national health care system that undertakes cutting-edge care in biomedical terms; i.e. those that practice Western, technologically-advanced medicine.

The article is divided into five thematic sections, each targeting a specific feature of work-life balance relevant to the hospital setting of Czech maternity wards. Each of these sections comprise an introduction and description of methodology and are followed by conclusions. The five sections include an examination of: 1) hierarchies within the medical profession that influence power imbalances and the gender-stereotypical modes of decision making processes, 2) dual perspectives about the practice of balancing work-life, 3) compromise strategies of physicians who attempt to harmonise work with private life, and their interpretations of the status quo, 4) the relationship between the private and organizational approach to work-life balance, and 5) conditions for promoting work-life balance, or rather their absence, in the cutting-edge scientific environment of university clinics. Throughout these sections, understanding the role of gender is the key target as well as the analytical lens.

## *Methodology*

Some information about the Czech context, sampling methods and research participants is provided here before the text moves on to describe the analytical thematic areas. The interview subjects were senior physicians; this generally meant physicians with at least 10 years’ experience in the profession (many had more), who were at least 40 years old at the time of interview. The Czech Republic has the highest number of gynaecologists and obstetricians per capita among all OECD countries, and

this trend has persisted over time. There were approximately 50 specialists per 100 000 women in 2011 (OECD, 2013; the same figure is 23,2 in Hungary and 14,5 in New Zealand). In 2013, there were a total of 2499 gynaecologists and obstetricians in the Czech Republic (1358 men and 1141 women – the percentage of women is thus 46 per cent; ÚZIS, 2014), making this specialisation the fourth most common (7,7 per cent of all male medical doctors work as gynaecologists and obstetricians and 5,5 per cent of all professional women; ÚZIS, 2014). The generational trend among men and women in the profession involves an increase in the numbers of junior women doctors, and thus a higher concentration of men in the older, thus professionally senior, generation (the percentage of women drops from 77 per cent in the youngest age category (-29) to less than 35 per cent in the 50+ group, and only increases a little to 37 per cent in the 70+ group, according to ÚZIS, 2014 data).

The analysed transcripts (research sample and data) are derived from in-depth research interviews with fifteen (15) senior Czech obstetricians and gynaecologists (six men and nine women), collected from multiple locations across the Czech Republic using a snowball sampling method initiated by addressing three physicians at a medical conference. Some of the interviews involved repeated meetings and thus multiple interviews with the same interviewees, all of which were transcribed verbatim creating more than 550 transcribed pages, excluding field notes. Other methods of data collection used in the analysis include additional interviews with other actors and stakeholders (i.e. midwives, doulas, lawyers, recipients of care and activists), field notes from thematic events and relevant situations during a four-year research project and from transcribed recordings made at several public or semi-public events, and the public speeches of medical doctors (mostly men). All the interviews were collected in person (between 2012 and 2013). Other data were collected from presentations and documents which were provided with consent for use in the study. Some data were also made publicly available by event organisers on their web pages, such as audio recordings of a thematic seminar in the Czech Parliament and a thematic university panel discussion. Qualitative textual thematic analysis, inspired by discourse analysis and David Silverman's approach to using interpretive research methods for analysing textual data (Silverman, 2001) was conducted, selecting the topics to be analysed based on the specific project research questions. The explorative research goal was to describe, explain and shed light on practices in Czech reproductive medicine, particularly childbirth routines, in relation to the reproduction of inequalities and gender relations in Czech health care organisations.

### ***1. Gendered Hierarchies: Seniority, Generations, or 'Society is Set up so that a Guy is a Guy'***

The conditions for gender relations at hospitals as workplaces, including work-life balance, depend significantly on the existence of a sense of justice or equality, and the sensitivity to gender issues of individual personalities such as the heads of hospital departments. Explicit, overt instances of discrimination can occur, as elaborated elsewhere (Šmídová, 2015a; Šmídová, 2015b), as well as more covert instances in a form of 'non-events' (Husu, 2005) which occur when women in the profession lack the support (in the form of inclusion and career advancement) that is awarded their

male colleagues. Overall, cultural expectations that reproduce established gender roles often originate in superiors in the hospital hierarchy.

Generational seniority may also give rise to resentment concerning the conditions for work-life balance. Some older female doctors criticize the younger generation of mothers (parents), as occurred in one public debate on Czech practices in maternity wards. In this case, a doctor highlighted the fact that when she had small children the need to harmonise work-life balance was not even an issue for public debate: it was generally understood at the time that it was up to individuals to sort out their private lives and not to bother anybody with motherhood-related concerns. Accordingly, this approach is what she expects from the following generation(s) of women in the profession.

Despite many critical voices from within the profession and attempts to reflect upon such experiences, the attitude towards this issue generally still emphasises the need for individuals to strive to deal with this structural problem by themselves. Such rigidity leaves many of the actors who are affected in doubt and resigned to accepting the status quo; they describe themselves as helpless cogs in the machinery. One of the unintended consequences of such attitudes is that many women in the profession find themselves childless and/or single. However, this experience is framed by some of them as a legitimate sacrifice for their professional career, since entering the medical profession is still understood to involve a choice between being a professional or having a family. Yet this affects the organizational context for performance in the profession, not only for women but also for men – for whom there exists an additional challenge relating to seniority or generation. This is grounded in the fact that male doctors receive relatively little financial reward for engaging in this demanding professional work in the state sector, despite having gone through a long period of education and training. The pay they receive does not reach the level which would be expected according to pre-existing gendered expectations related to the symbolic system of gender differences, as described by Sandra Harding (Harding, 1987: 16-17); i.e. the duality of women as primary caregivers and men as breadwinners that we tend to interpret and channel our experiences into.

Harding outlines a multi-layered feminist theory that ‘touches especially raw nerves’ as a feminist critique of the social order (Harding 1987: 17), believing that such a feminist approach benefits from incorporating insights from multiple movements, being especially critical of the concept of the division of labour according to gender which is commonly understood as ‘natural’ and ‘social’. This approach challenges our core sense of personal identity in terms of the expression of gender in individual ‘social practices, which for most men and women [provide] deeply satisfying parts of self-identity’ (Harding, 1987: 17). At a third level, in terms of the institutionalised division of labour and individual identities, Harding formulates criticism of the symbolic system based on gender differences. She describes it as ‘the most ancient, most universal, and most powerful origin of many morally valued conceptualisations of everything else in the world around us. Cultures assign a gender to nonhuman entities’, continues Harding, who wraps up in a concluding thesis that: ‘we have organized our social and natural worlds in terms of gender meanings within which other historically specific institutions and meanings have been constructed’ (Harding, 1987: 17). Šmausová has further elaborated these three levels of gendered

social structure, pointing out how rather plural and flexible individual social identities are channelled through the institutionalized division of labour into the dual, hierarchically fixed symbolic system of gender difference – the ‘gender universe’. This system is characterized by a dominating, public masculinity represented by a professional career, and a subordinated, private femininity represented by care and motherhood (Šmausová, 2002).

Thus, the experience of young men doctors may not correspond with what would be expected from the gender universe; the symbolic system is unreflective of gender as a system of organizing our world. When young men doctors finish their training and start their careers they are at the age when many desire to start families, but providing financially for their families is challenging.<sup>1</sup> They can either leave for the private sphere or commence a dual job career, thus minimizing their already limited potential for involvement in participatory child care. However, such doctors may be pampered by hospital bosses and made aware that they are most welcome to come back to the state system in the position of substitutes or senior colleagues. The appeal of such encouragement is strengthened by doctors’ potential membership in the imaginary men’s club and their expectations of being able to leave off caregiving duties in the private sphere. One woman doctor working at a major Czech clinic described this situation in a research interview as follows:

‘When I came in as a graduate,... men really made it into the operating room, while we stood in the corner.... The head of the clinic and several men doctors always decide what to do....And it was...hard, and I think that men really, really were privileged, that they really started to put us women to work more in the out-patient department...Well, it’s a little bit..., that “these girls” – most of the women doctors – are whooshed out to the out-patient rooms because they are more meticulous, hardworking, they can withstand the routine of seeing one patient after another and typing it up...The guys don’t have much patience, and they just try harder to get into surgery. Well,...I think they have an easier time of it.’ (Doctor Daisy)

Another woman doctor who left a state clinic for the private sector describes a similar situation:

‘He [the head doctor] selects a man, he does not go for a woman because if he does, it may be that they will have something together, or he is not interested in her and so he opts for a buddy, a bloke, right, who will not go off on maternity leave and they – I do not know – understand each other, and think that they are overall better off with them.’ (Doctor Pearl)

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<sup>1</sup> This situation has been documented in a representative survey into attitudes to current problems in Czech medicine as significant career obstacles, as perceived by young men in the profession, and of the potential factors behind early career burnout (Slepičková and Šmídová, 2014; Šmídová and Slepičková, 2013).

Joining the top club is very prestigious in terms of building a professional career. In the private sphere, professional women are judged for and have internalized these gendered criteria themselves. Another physician who left a clinic and started her own specialised private practice recalls:

‘Guys won’t let you in; really exceptional women make it to surgery, and they, in my opinion, do so at the expense of their private lives.’ (Doctor Ice)

Besides documenting the gender universe in such accounts, the recollected experiences are significant in terms of gendered organizations, as Joan Acker (Acker, 1990) describes them. Hospitals are seemingly neutral, formal (bureaucratic) organizations, where occupational performance and skill promote career advancement on the basis of democratic principles. Issues such as sexuality, embodied femininity or masculinity, emotions and private life are understood as ‘extra-functional’, or rather, should be regarded as such. An ideal employer should be approached and carry out their function in a gender-neutral way. In practice, informal curricula or rules follow a gendered pattern, as Harding (Harding, 1987) claims.

Seen from the perspective of the senior doctor in a leading position in the maternity ward of a county hospital, ‘this is how society is set up’:

‘In terms of out-patient service, I think these women have a number of advantages and privileges; on the other hand, in the wider field of hospitals and surgery, I think it’s more complicated for them to get ahead.... There is also the limitation placed on them by their family, that’s clear, because a guy can just say: “I’m on duty, I’m going”. And the woman takes care of the kids and it’s just that way. I think in the Czech Republic it couldn’t happen that a guy would be as involved in family life as a woman. The woman is always saddled with that. I know what I’m talking about – my mother was a doctor, my wife is a doctor, my sister is a doctor, my daughter is a doctor – so I know how it is for every generation. We have gone through a lot, and it’s always the guy who says first: “I’m going”. When there are two doctors, it’s the woman who has to spend more time with the family. If you ask me, maybe it will change now, but I don’t believe many guys would say: “Hey, sorry, I can’t take the shift because my wife already has something on”....Yep, it’s harder for them to get ahead. With regard to knowledge, skill, attention to detail, women may have a lot of advantages. But society is set up so that a guy is a guy. It’s the way it still is.’ (Doctor Chalk)

Hospitals as working organisations are imbued with a complex network of positions and relations. Men in positions of power are ‘assisted’ in the re/reproduction of gender regimes by the other professions which are involved. Cooperation and rivalry among these actors also help shape the atmosphere of professional performance and work-life balance in the working setting. A woman doctor who has now left the state hospital and started her own private practice pointed this out:

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‘In health care professions especially, it goes this way: a woman doctor is judged by how she is looked at by her boss, her male colleagues, even by her female colleagues, and three times more intensively by the mid-level health personnel. They actually hate young women doctors. Especially the nurses/midwives. Whereas the same nurses go crazy about men doctors.’ (Doctor Swan)

Thus ‘the way society is set up’ is significantly reinforced by the institutionalised division of labour in these organizations, and as a result of the intense socialisation that occurs in respective professions, gender becomes internalized. It becomes naturalized, as Pierre Bourdieu would label the process, when cultural processes become understood to be natural ones (Bourdieu, 2001).

## ***2. Work-Life Balance in Practice: ‘The Sacrifice and the Problem of Women’***

So far, this analysis has presented examples of stereotypes and gendered practice, indicating that the working organization of a hospital is a setting for reproducing gender inequality. With work-life balance as our particular focus, the contours of the gender universe become sharper. A woman obstetrician reflects upon her experience looking for a job at the same time as looking after a baby:

‘I was unable to find a job as a mother of a small child with little experience,...and finally, I was mercifully accepted to a clinic to do a part-time job. I worked full-time but got paid part-time...And the various senior consultants there, and those who negotiate with you, they let you know in so many ways, sneering at you and asking, how can you – a mother, educated though – be of any use to such a renowned clinic? I have literally heard this said by a senior consultant who checked whether I was capable of communicating in a foreign language or if my husband was rich enough and similar stuff, this really made me sick....And in later years they add, so where is your Ph.D. and where are your publications?’ (Doctor Pearl)

For women, work-life balance in maternity wards is still framed in the symbolic language of sacrifice and compromises. Personal and family life has to surrender to professional life, to the formal curricula of the hospital, which is informally engaged in reproducing a gendered organisational regime and the gender universe, and in creating symbolic harm (Acker, 1990; Bourdieu, 2001; Harding, 1987). Striving to have both a perfect career and a family was described by female respondents from the research study as being hazardous to one’s health, and the resulting arrangement was usually described as being ‘good enough’. Doctor Pearl continues describing the compromises she made trying to balance work and family:

‘You should be moderate in your ambitions, and be satisfied that you have a job that is valued socially because it is good, you enjoy it and you do it well and properly, you fulfil your own desires. This means being reliable, working autonomously, you help other people and do no harm. Well, I must say that’s

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it, if you want to have both [have a family and work in medical profession].’  
(Doctor Pearl)

The following citation represents the opinion of many of the women who were interviewed in terms of how it reflects on the hardships of their own experience, and provides a generalised perception of the roles of professional women in medicine:

‘As a woman, as a mother, I always say that a female physician cannot perform all of her three functions [mother, wife and doctor] equally well. You always cheat one to manage the other two. And, as a woman, you have loads of other headaches in comparison to the men there, which is logical....So the female physician is worse off precisely because she cannot devote so much time to her specialisation because she is spreading herself too thinly for the family and the profession...women have to go through these two ordeals by fire....So the guys have an advantage in this. It is easier for them professionally because they have fewer burdens. When they want to, when they arrange it well, they can have their professions. A woman will never be in such a position, or she has to give up her family, which involves terrible harm. That’s how things are.’ (Doctor Ice)

These women usually live in dual career marriages/partnerships, so besides being required to deal with negotiations and time management in the profession itself, organisation must also be coordinated between children and spouse so as to harmonize time schedules. This includes husbands’ business trips and other obligations, or the fact that spouses may not even be living in the same household (as is sometimes the case with dual medical career families when one of the adults works abroad). The women in the profession frame their experiences as sacrifices. Doctor Down, a mother of two children now employed in a private practice, says about this issue:

‘To stay in the OB-GYN clinic full time means sacrificing your own life. In my opinion.’ (Doctor Down)

Men colleagues may also interpret the working environment, conditions and context using a very dichotomous gendered perspective, representing the gender differences embodied in the symbolic system described by Harding. The compromises that women describe as sacrifices, men colleagues may see differently in a way that approves of and partly legitimises the status quo. One male doctor frames this as ‘the problem of women’:

‘The evergreen problem with the women here is that they leave the profession to go on maternity leave at such a delicate time - you can see how many young female doctors have to make a choice between the profession and having a family - and often when they return after these six or seven years of parental leave, the prime years for making the greatest professional efforts and striving for a career are gone, you know....So, after some two to three years of practice

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there comes a time when you start operating and doing the really hard stuff, and actually learning the skills, and this is precisely the time when the girls have a tendency to go on maternity leave. So, this is always the price of making a compromise.' (Doctor Sheep)

This doctor, who works in a county hospital, reflects on the professional careers of women from the perspective of his practice and an experience of uninterrupted career advancement. He assumes that professional mothers go on long parental leave with each of their children (the assumption is that there will be two), which is statistically not the case, especially for women in the medical profession (Kuchařová et al., 2006). Thus, this man doctor is interpreting the world using a dualistic symbolic gender perspective by assigning the drive for a career to the early stages of professional experience, and by interpreting the parental involvement of women as an exclusive, extended period of separation from work. He uses this perspective as an argument for legitimizing the status quo: the dissociation between having a professional career and being a mother in a hospital environment. He follows this by describing the context using the rhetoric that women 'lose their personal ambition' to advance with their careers, their reluctance to take 'senior positions in hospital shifts', their unwillingness to work overtime or take on weekend shifts, and their reluctance to engage in surgery and preference for working with out-patient services in order to align their working hours with the opening times of childcare facilities. He acknowledges the hardships mothers have with combining family and professional life, and understands their retreat from the profession. He also mentions that the only possible way to remain working in surgery is to have relatives (esp. grandmothers) who can help out to a significant extent, and having a husband/partner who can cope with the demands placed on a medical professional as well. However, he interprets the situation overall as being the responsibility of the individual, not a structural or even gendered phenomenon.

Doctor Plaster, a head doctor in a county maternity hospital, reflects on the changing patterns of family and care arrangements. However, as a boss, his analysis of the situation is simple and similar to the formerly described:

'There is no difference in the quality of the work of a lady or a gentleman, you know. Absolutely none. But with the ladies, there is the terrible thing called pregnancy....When they come back, and they do this when their child is a year or a year-and-a-half old..., they return and get straight to it, they even take shifts or share shifts with someone else. After all it is more difficult to leave a small kid to go to work on a night shift, isn't it?' (Doctor Plaster)

The message is clear: the caring world of women should be isolated from the working regime of the profession. Motherhood (pregnancy) is presented as being something isolated and disconnected from the integral world of hospital life, the mother is framed as being the sole caregiver and/or a professional who is very likely to undertake only a limited spectrum of tasks that fit into the routine of the hospital. There is no room for balance within the institution, or more generally within the Czech health care system.

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### *3. Compromises: 'Women Buying their Rights to their Jobs'*

The opportunities and challenges of maintaining a work-life balance are not solely related to the working environment but depend on arrangements in the private sphere. The analysis has so far already touched upon how dual careers are accommodated into the regimes of the medical profession in the context of the gender universe which symbolically differentiates between motherly care and a manly career. The balancing act can become more complicated in the case of single mothers or distant families but the assumption of the existence of a normative pattern of heterosexual marriages still prevails. And here, despite plural and multiple individual arrangements and shared practices, the symbolic framing and language used to describe the lives of medical professionals strongly reproduces the pattern of gender differences.

Topical research into the least conventional family arrangement – fathers playing a nurturing role on parental leave with young children – revealed the strong inclination to interpret such choices in gender terms, complying with dualistic stereotypical expectations (Šmídová, 2008b). The symbolic gender order betrays this arrangement, despite individual everyday practices and the unconventional division of labour institutionalized by the father on parental leave (Harding, 1987). The symbolically powerful association of women with caring motherhood and men as breadwinners results in silence about women's careers in these families, and acts to preserve certain areas of motherhood as symbolically dominant over everyday men's care. Thus women with spouses on parental leave did not talk publicly about their family arrangements in relation to their own role as the primary breadwinners. However, they often had the final say about childcare-related decisions (for example, the choice of appropriate clothing, or healthcare emergencies (Šmídová, 2008b).

Bonnie Fox (Fox, 2009), Caroline Gatrell (Gatrell, 2005), Arlie Hochschild (Hochschild, 1989), Kathy Backett-Milburn (Backett-Milburn, 1982) and others have highlighted various other difficulties that are encountered when attempting to harmonize professional work with family and personal lives at the level of private sphere arrangements from a feminist social science position. The general outcome of such empirical inquiries indicates that men are valued for both their conventional and nonconventional approaches to family arrangements, whereas women in dual career families are looked at with caution (and are expected to fail in terms of their mothering involvements), or their enormous workloads over those two shifts is observed with silence and taken for granted. These conclusions are valid in the hospital context and in terms of work-life balance in the medical profession. A doctor in a senior hospital position characterises these attitudes in an interview in these terms:

‘A woman hurtling back home after a night shift, getting there tired to death, makes sure that she does the shopping, cooks, and cleans up the flat to make everything ready for her husband to get home. So domestic harmony is being created, and this is a means for the woman to buy her right to do her own job and live in her chosen environment. When her performance is excellent in this respect, nobody can blame her, right? Isn't this terrible?’ (Doctor Pearl)

Male physicians with small children refer to different arrangements for maintaining work-life balance. They may take regular absences from family life. Some of them described the arrangements they made to collect overtime to allow them to take long holidays with their families within a fixed time period. One doctor stated that he sees role as being like that of a sailor spending periods of time at sea, and then sailing home to his haven. Others added that they savour the status of being 'precious items' for their kids when they go home, and receiving the full service provided by their wives. In this respect, their attitudes do not differ much from those identified with other early-stage families documented in similar research efforts in the Czech context (Šmídová, 2008a; Šmídová, 2011b).

The organization of hospital life, a formal working organisation, is considerably less flexible than the arrangements in place in the private sphere. Long shifts followed by night shifts, emergencies that need to be dealt with at the end of scheduled working hours and a lack of flexibility as concerns individual cases, the entrenched hierarchy in decision-making processes, protocols and competencies, etc. all influence the demands on performance in the profession. The situation is complicated by the gender regime which exists at the hospitals. Despite the feminisation of this area of work, it seems, based on the research interviews that were conducted, that it is not well understood that women in healthcare frequently work in 'assistant' positions (and professions) for 'the professionals' (professors), and their role as caregivers is interpreted as natural and primary.

On the one hand, the gender-stereotypical understanding of women in the medical profession primarily as caregivers is imprinted in the framework that bosses (senior consultants, head doctors) use in anticipating their future successors. It is even reflected in the level of willingness these professional women are expected to have to make sacrifices in terms of the work-life divide. Thus women encounter a lack of understanding from bosses, all men, who follow the conventional approach to careers in the medical profession: the sacrifice of a personal life. The insurmountable problems include requests to be allowed to finish on time in order to get to kindergartens before closing time, or arrangements for temporary absences from weekend shift lists, or even requests for part-time jobs. On the other hand, some women in the profession go along with this pattern due to their long years of work in such an atmosphere and the existence of gendered expectations, in combination with typically conventional and less flexible private arrangements.

#### ***4. Private Arrangements and Organizational Momentum Combined in 'Doing Both Tasks Well Enough'***

Disregarding particular family arrangements or phases of the family life cycle, some women expect special treatment or some relief from work due to their status as mothers. Others actively struggle to meet demands and refer to compromises they make to maintain a standard of 'good-enough' in the spheres of work and life, as mentioned earlier. The gender universe in the heads of the decision makers channels them all into one group.

Then, at a certain stage in their life, women turn out to be a desirable group of employees, as Doctor Pearl agrees. Their careers as mothers and their striving for a

better work-life balance places them in a very specific situation in the job market; this applies at least to those who have remained in a hospital working environment.

‘Your plans with reproduction are finished, and first of all you are more willing to work for less pay. It goes without saying that a woman always asks for less, behaves more politely, and is more considerate and less confident in her relationships with her employer. She is always loyal, and does not threaten her boss, either professionally or financially. She has ‘other troubles’ after all, such as taking care of the family, and is usually not in the position of being the main breadwinner. I have first-hand experience of this, and have heard it many times from my female colleagues.’ (Doctor Pearl)

Some physicians, however, in harmonizing work and life chose a different path. Their solution to a stressful work-life (im)balance is exit. They leave hospitals to work in private practices, as their regime enables them to better manage their time as primary caregivers, benefitting from a less demanding workload. Doctor Down reflects upon the reasons for her exit in combination with resentment and regret, although she claims to miss the adrenaline and the way she was appreciated in the hospital setting as a ‘life-saver’. She also refers to her own naivety when originally planning to return to a full-time hospital job after maternity leave:

‘I regretted losing touch with the delivery room, the surgery, so when I called them back, I only asked for an adjustment to be made, until my children grow up a bit, meaning that I would be able to work part time, which turned out to be a major problem. A critical problem. Unsurmountable by hospital management. It was ‘either or’: work full-time, meaning 6 or 7 overnight shifts a month, which I felt was too much, or nothing. And the financial reward was (low), when I look back at it, for all the stress at the surgery. I cannot imagine taking the same steps now, arriving there, saying, so here I am.... As I see it, the girls – physicians – after getting pregnant, they never return.’ (Doctor Down)

Doctor Ice, owner of a private practice and a mother of a disabled daughter, recalls her experience as follows:

‘No one has ever shown any consideration of this, although I had not expected it; what I did mind, though, was the situation of never knowing till the very last moment whether I would be able to leave to arrive in time for her medical check-ups, which were planned long ahead of time. Now I am my own boss, which is the biggest bonus. I can organize work for myself and need not beg anybody. There was such an atmosphere there... I was not sure at the clinic till the very last hour, if they would let... if I would manage to leave or not, because the organisation of time was kind of... at that time in the clinic, not as it should have been. So I took it as an injustice because you could always..., there was no will to help, I would say. So there came the moment when I decided to be my own boss, organize my work in a better way and have less stress, you know.’ (Doctor Ice)

Doctor Down then developed the notion – as clarified in the interview – of an informal hospital curricula that helps team members to combine work and family. However, even this arrangement may be gendered in a very particular way. Childless young women are more willing, in her opinion, to step in to do extra work in case of need, whereas their male peers tend to disappear in the same situations. This gender pattern becomes somewhat fixed, despite the fact that work-life issues that emerge at later stages of life affect women more than men. The expectations that professionals should ‘be available’ in unexpected situations are unequally placed on mothers.

The fact that being employed in a hospital involves long working hours and overnight shifts was mentioned by men and women physicians alike as an obstacle to the creation of a harmonious family life. Some of the burden, then, also falls on the shoulders of (male) physicians in senior positions. The head doctor of a county maternity hospital outlines the situation as follows:

‘Especially when you take into consideration certain time slots, when in fact you work from 7 a.m. till 2 p.m. or 3 p.m., sometimes 8 p.m., and then from 8 p.m. in order to earn some money at the hospital you do overnight shifts, this is the everlasting hospital rule. Well, and the overnight shift, no matter whether it is a hard or an easy one... you can get careworn simply by sitting here, you know.... And the fact you are still here is usually not enjoyed by spouses.’ (Doctor Plaster)

This doctor then goes on to explain how emergencies and the absences of colleagues influence the 24/7 rhythm of a hospital ward and the negative effect they have on private life, in his case meaning that his own partner is unable to rely on him participating in any shared activities. From the perspective of the working organization, this indicates that the lenses of gender universe are well embedded. The following excerpt from a citation precedes and also follows the earlier one which referred to ‘women getting pregnant’:

‘Men are in a terribly short supply in medicine. ... Men usually take the shift work. So seen from the operational perspective, a guy is more valuable, you know. Than a woman. The single reason for this is that they do not get pregnant.’ (Doctor Plaster)

Despite the symbolic dual gender framing, which legitimizes men as those who ‘take the shifts’, Doctor Plaster is now training his third male successor in a row. Both preceding doctors have left for jobs in the private sector. Thus, Doctor Plaster must deal with professional staff leaving his ward in two opposing directions along the gender axis: his young male colleagues that he selects for training for entry into executive positions (ideally those with the most gifted and skilled hands) tend to leave create their own private businesses. Working at private gynaecological practices or clinics means that they can financially provide for their families and often benefit from more flexible working time arrangements. These physicians often maintain a part-time job at a hospital to keep them up-to-date with their specialisation. They may even

bring private clients to the hospital if surgery is required, but they are not willing to take on executive positions, no matter how readily they would be awarded them by a boss. From their experience they know how much professional responsibility and even legal responsibility would be placed on their shoulders in a county hospital setting. Accordingly, it is often a boss (a head doctor), who steps in to serve in the case of the unexpected absence of colleagues.

Women, on the other hand, 'tend to get pregnant', and when they return are too bound-up with their private lives to sacrifice them for 24/7 hospital life. And while they may individually struggle to maintain a reasonable work-life balance in the inflexible setting of hospital work, they sometimes leave for the private sphere and start their own private practices, obtain employment in existing ones, or at private clinics (often) for assisted reproduction. Those who stay typically avoid taking on senior, advanced positions which involve full responsibility for a hospital ward, or must sacrifice their family lives for this purpose. They do so in a situation when they are not taken into account for executive positions in any way. I have previously described the factors involved in the systematic exclusion of professional women from the most prestigious types of work on a gender basis in a different context (a subchapter entitled *Bosses and mothers: reproducing the status quo* (Šmídová, 2014: 134-135).

Individual experiences of powerlessness in the organizational setting are thus not exclusive to team members. Bosses may also struggle with adapting to the personal life strategies of their colleagues too. The resulting feeling of being left on their own to sort things out only adds to the general perception of their situation as cogs in the machine, as stated earlier. The traits of organizational gender order and the effects of a gendered organization are more powerful than individual strategies, and the least flexible issue of all is again the stereotypically little-reflected-on category of gender which structures power relations and sets up opportunities or barriers to the creation of different work-life balance arrangements.

### *5. The Gender Universe of the Clinic*

Clinics are a spectacular arena for examining the combination of strong organizational momentum regarding the symbolic system of the gender universe. I dwell on them in the final analytical section of this article. At clinics, there the same framing of women professionals occurs as in other environments, drawing on the research interview analysis. The customary limitation of (potential) motherhood is further complicated by the need for competition in scientific performance, and perceived injustices may be even more intense (this was touched upon earlier when citing doctor Pearl, who was asked: 'So, where is your Ph.D. and where are your publications?') Doctor Zinc herself left a university hospital for a smaller county hospital after working at the former for more than ten years; at the time of the research interview she was on a maternity leave. Her recollection of the competitive professional and scientific environment characteristic of larger clinics is rather harsh:

'So, you know, interpersonal relationships were related to this, there were people who pretty blatantly and bluntly ...it was evident what they were up to,

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only striving to further their own careers at any cost. Stopping at nothing - bulldozing others, or going to bed, and the like. I can put it like that.' (Doctor Zinc)

Disclosure of the fact that clinical practice is far from ideal for those in need was a factor repeated in the descriptions of disillusionment with the profession. This context is again important when analysing the choices that men and women can make in this profession. Motherhood is still understood as a socially legitimate exit, and a desirable one, despite its professional effects on individual women or the organization of hospital wards for professors and head doctors. Doctor Snowdrop, a childless single professional, adds a gender perspective to her description of career-related competition based on her own experience, which explicitly excluded women (disregarding their status as mothers). Part of the explanation for such practices is precisely the stereotypical gendered expectations that generalize about female professional 'qualities' that extend beyond motherhood, but which become institutionalised in the gatekeeping process and the competition for hospital positions. These have already been alluded to when documenting the general, overall experience of women, but in the clinical setting, the impact may be augmented.

'It was only at the job interview (at a university hospital) when I understood that it was all fake. They had already made their choice of a colleague (a man) but they needed to go through an official process, so I arrived there as a meek lamb, as a scapegoat, it was all so ridiculous. ... The boss of the clinic is still there nowadays (I admired him for his professionalism then) but what he did at the interview (humiliating me)!...so I learned they saw me as a freak, and all of the members of the scientific board came to the show. ... This was totally discouraging and disconcerting and I concluded that in fact I was happy in my former job (at a county hospital), and my reasons for leaving that job were ridiculous ..., so I was glad, suddenly, that I had a job to return to, and I did.' (Doctor Snowdrop)

Doctor Snowdrop frames her experience as a gendered one. At the time of our research interview she was working at a university clinic in a different city, holding a semi-executive position in an area of specialisation. When asked about her private or family life, she responded that she had none. I also interviewed some of her colleagues, two of whom (women) indicated that she had been overlooked in the career advancement process at the clinic, although she had undoubtedly deserved promotion based on her professional performance. The head doctor positions for two of the relevant and specialised posts were awarded to younger, male colleagues.

### *Conclusion*

The experiences described in the previous sections indicate the existence of a deep structure embedded in the organizational decision-making processes that reaches beyond need to harmonize work and life. In this example, the objective obstacle to caregiving in the private sphere did not apply, and Doctor Snowdrop's ambitions of

being a senior doctor corresponded to her professional performance. The symbolic universe, the gender universe, and the institutionalised division of labour between bosses (professors) and mothers, even in a highly prestigious profession, follows a gendered pattern, as Sandra Harding reveals (Harding, 1987; Šmausová, 2002), with significant impact, especially at the symbolic level.

It is important to note that embedded into the system of hospital care is the legacy of the strong paternalistic system present in the Czech context before 1989, and of the distorted approach to professional performance from the time of the Soviet bloc and the rapid transformation of the post-socialist period (Heitlinger, 1987; Speier et al., 2014; ŠmíDOVÁ et al., 2015). It is also clear, however, that the existence of such gender regimes requires urgent organizational rather than individual corrective measures. Despite the statistical feminisation of the medical profession, the institutionalised structures in hospital regimes remain resistant to change (Oakley, 1993; OECD, 2013 and 2015; Riska and Novelskaite, 2008; Riska and Wegar, 1993; Riska, 2012; Zetka, 2008; O'Brien, 1983; Kilminster et al., 2007; Laqueur, 2002; Becker et al., 1977) and the visibility of women in medicine both as patients and as professionals is highly distorted (Treichler et al., 1998; ŠmíDOVÁ, 2015a; ŠmíDOVÁ, 2011a).

The scientific and professional prestige of career advancement is reserved for men, while women are seen through the lens of motherhood. Hospitals and clinics are gendered organizations (Acker, 1990) with very strong formal as well as informal regimes that act to reproduce the duality of mothers and professors. This symbolic duality of professors and mothers is reproduced in the gender universe, the symbol system of gender difference (Harding, 1987) that is not taken into account by the key actors in the hospital hierarchy. So far, evidence that refutes or has effectively been used to subvert the status quo remains exceptional. Individual cases remain framed as exceptions, confirming the rule of the status quo of the gender universe. In such a discursive setting, any policies directed towards improving work-life balance have only a very limited reach, affecting the top ranking positions in the medical hierarchy.

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