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POWER CHALLENGES FOR HEAD DOCTORS IN MATERNITY HOSPITALS: BEYOND HEGEMONIC MASCULINITIES¹

The article analyses the contexts and practices of head doctors regarding childbirth, whether reproducing or challenging the gender regimes. The research sheds light on men's practices and representations of masculinities in hospital maternity wards and links the personal practices and structural mechanisms reproducing men's positions of power in the Czech organization of childbirth. It is based on data from research interviews and the public speeches of senior Czech obstetricians and head doctors of maternity wards (15 in-depth interviews and 3 panel discussions). Two basic topics are taken into detailed consideration when discussing the patterns of men's practices and their discursive representations: (1) defence of the status quo (compliance with the *lege artis* approach) in contrast to alternative approaches to childbirth by some head doctors and (2) the living paradox of the hospital setting presented as being a formal institution par excellence, while at the same time being an environment for the very informal, individual authority of head doctors.

Keywords: power challenges, men in medical profession, medicalised hospital childbirth, complicit femininities, complicit practices, counter-hegemonic men's practices and settings, gender order, authoritative knowledge

This article addresses the complexity of the gendered practices of medical doctors in the setting of hospital maternity wards. Specific attention is paid to the practices of head doctors² (men) presented by them in in-depth research interviews, to representations of hegemonic masculinities required by the Czech hospital setting, and to resistance strategies

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² The translation of the terminology used for categorising the positions of doctors in the Czech hospital hierarchy is not easy. In its simplified form, the person in the position of the head doctor bears sole responsibility for any specialist (gynaecological-obstetrical) professional performance and procedures, for example in a maternity hospital. It is the top expert position in a hospital specialisation. In big hospitals and university clinics the structure is a bit more complex, as the maternity ward is under the umbrella of a senior consultant, the immediate superiors of head doctors, and smaller sets of units and specific wards are led by senior doctors (heads of divisions) who are subordinates to the head doctors.

to medicalisation from within the medical field. The analysis elaborates on the conflicting requirements, (formal) expectations, and (informal) practice of hospital childbirth that head doctors face in their everyday routine. Evidence emphasizing context-bound approaches to childbirth is provided in order to enable an understanding of both the complicit and counter-hegemonic practices there. This focus is supplemented by notes on the complicit practices of women in the profession, labelled as complicit femininities³. Nevertheless, the analysis is presented with an acknowledgement of the structural disadvantages of women in the profession, hierarchies in interactions in the hospital setting beyond its staff (especially in the patient-doctor relationship), as well as power games in the biomedical arena itself.

In certain respects, such a research focus follows the old traits of medical sociology (by focussing on representatives of the profession, the doctors, and the organization of hospitals) rather than the sociology of health and illness (targeting its individual embodied experience). However, there are two twists in this conservative interpretation. The first investigation by the author into the topic of gender relations concerning childbirth was directed to women giving birth and their accompanying partners at childbirth (Šmídová 2008), i.e. to the “patient’s” view. That study revealed the strong genderedness of the event and its intense medicalised (interventionist) context. Secondly, there is a need to fill in the gaps in the critical understanding of the medical profession, the hospital setting and their gender aspects, which has only relatively recently begun to receive any analytical attention in the Czech context⁴.

This article targets the aspects in negotiating men’s practices and masculinities among medical professionals, an angle which has not yet been studied in the national context⁵. The core analytical goal of this article revolves around the reproduction of the status quo of hospital childbirth in the Czech context and its changes as articulated by representatives of the relevant authorities, i.e. head doctors. Since these positions are filled by men, aspects of their practices and institutionalised requirements concerning their masculine performance are elaborated in this particular article. Furthermore, resistance strategies to the interventionist medicalised model are explored.

³ The practices of women doctors in a hospital setting are not only compliant with the dual gender scheme. They actively participate in reproducing the power structures and occupy a significant share of the hegemonic or patriarchal dividend arising from the professional hierarchy. Thus, I call them complicit, rather than compliant or emphasized femininity – with reference to Connell’s concept (Connell and Messerschmidt 2005) defining a counterpart to hegemonic masculinity. Complicit practices of women health professionals form a significant axis in the gendered organization (Acker 1990) of hospitals and in the formalized requirements of health professions.

⁴ Czech sociology has a serious gap in researching these issues. Medical sociology or the sociology of health and illness has only begun to form very recently. Among the few recent exceptions to the rule, there is the focus on practices in Czech reproductive medicine, and all these endeavours take gender as a core category or a perspective for analysis (Hasmanová Marhánková 2008; Slepíčková 2009; Hrešanová and Hasmanová Marhánková 2008; Dudová 2012; Hrešanová 2008; Slepíčková, Šlesingerová and Šmídová 2012). It is not surprising to concentrate on aspects of reproductive medicine in combination with the gender perspective. In the hospital setting itself, several levels of gendered practices are interwoven in the everyday routine and accounts of it.

⁵ The author of this article approaches the issue from several angles, one of which is presented in the chapter of her book “Condemned to Rule: Masculine Domination and Hegemonic Masculinities of Doctors in Maternity Wards” (Šmídová 2015b).

FIELDWORK AND CONTEXT

The data under scrutiny come from in-depth research interviews with fifteen (15) senior Czech obstetricians and gynaecologists (both men and women), collected in multiple locations in the Czech Republic by a snowball sample method, initiated by addressing three physicians at a medical conference. Some of the interviews involved repeated meetings and thus multiple interviews with the same interviewee, all of which have been transcribed verbatim, making up more than 550 transcribed pages excluding field notes. Other data used included additional interviews with other actors and stakeholders involved (i.e. midwives, doulas, lawyers, recipients of care, activists), field notes from thematic events and contexts taken during a four-year research project, and from transcribed recordings taken during several public or semi-public events⁶ providing the public speeches of medical doctors working in Czech maternity wards in the years 2012–2014 for further analysis. All the interviews were collected in person (between 2012 and 2013). Other data such as presentations and documents have been provided by the authors themselves with consent for use in the study. Some data were also made publicly available by the event organisers on their web pages, such as audio recordings of a thematic seminar in Czech Parliament and a university panel discussion on home birth.

Qualitative textual thematic analysis was conducted, inspired by discourse analysis, selecting the analysed topics based on specific project research questions. For this article, power challenges faced by the hospital ward head doctors have been selected to further elaborate the issues of men's practices and masculinities related to everyday hospital routine in reproduction and resistance to gender (stereotypical) regimes. In particular, the inseparable mixture of everyday practice and its interpretation or recollections by the individuals is targeted by the analysis as a setting for the negotiations and practices of men (and women) demonstrating as well as (re)asserting their positions of power in this arena. The focus is also on the environments and structures that enable such reassertion (the actor-structure relationship, Bourdieu 1990). Yet another angle is formed by contextualising their performance and language used to grasp the everyday gendered experience in their (professional) lives. Their actions and the discursive representations of the actions are then framed and interpreted in

⁶ This data includes two university-based panel discussions: "Hospital as the sole safe place for childbirth/delivery" (involving two physicians and two other expert actors), and a thematic discussion symposium organised by our project team: "Medicine of Reproduction/Reproduction of Medicine" (with two medical doctors' presentations), then the fieldwork data also encompasses audio-recordings and presentations from a seminar organized in Czech Parliament: "Home births – a step forward or backward" (two presentations from a broader variety of doctors' speeches were analysed for the purpose of this research study), a roundtable panel discussion organized in a venture between NGOs and the university (for registered professional applicants). This event was organized as a part of the program "The week of respect for birth" with an invited keynote speech by Michel Odent, a well-known and respected international medical expert on natural birth (an audio-recording and a transcript of this event was made available to the author. Besides Dr Odent, there was one more medical specialist in the panel and several others in the audience). The author chaired the half-day discussion, which was recorded and agreed to be used for the research study by the participants. In addition, a transcript of the audio track of an independent documentary film "The Birth Plan" was used (several physicians present their attitudes there). The data was supplemented by field notes from personally attending two national conferences of the Czech Ob-Gyn Society (in 2012 and 2014).

the perspective of the gender universe (symbolic universe, Harding 1987) inspired by some perspectives employed in Critical Studies on Men and Masculinities, CSMM (Connell 1995; Hearn 2004; Hearn 2014; Connell and Messerschmidt 2005; Donaldson 1993; Howson 2006; Kimmel 1987; Haywood and Ghail 2007). These theoretical inspirations guide the analytical direction explored in this article and formulated as research questions: What are the performed, aspired and required masculinities in the field? What mechanisms are at play to (re)produce men's hegemonic, complicit, even counter-hegemonic or progressively-hegemonic practices?

Men (practices of men in medical management positions) and masculinities (representations of the required gendered practice)⁷ can be tackled from many different perspectives and yet remain bound to the setting of maternity wards and practices of hospital childbirth in the Czech Republic. The positions of power in the hospital hierarchy, combined with the prestige of the medical profession itself, evoke a position of omnipotence. Nevertheless, gender relations reproduced in the gender universe (Harding 1987) have a complex structure that does not allow for straightforward conclusions of a black-and-white nature on the dominance of men head doctors. Rather, the analysis in this article aims to point to the complex nature of the system perpetuating the dominance of men and the subordination of women on personal, institutional and symbolic levels based on accounts from the daily practice of the actors in the setting of maternity wards. First of all, we need to introduce the setting of Czech maternity hospitals and the organization of health care provision in order to better understand the context of gender relations in this specific environment and to explore the challenges of power faced by the involved actors, and men in particular.

CZECH MATERNITY HOSPITALS ON THE RESEARCH AGENDA

The hospital represents a formal organization and institution in the labour market and, in the context of the Czech Republic, a segment of the national health care system. The complex system of self-assuring procedures and status-reproducing mechanisms have long been targeted in critical social-sciences analyses of biopolitics and systems of governmentality (Foucault 1990; Foucault 2009) and in studies of medicalised childbirth (Cahill 2001; Davis-Floyd and Sargent 1997; Jordan 1997; Oakley 1994; O'Brien 1983; Van Teijlingen, Lowis, McCaffery and Porter 2004; Inhorn 2007; Kilminster, Downes, Gough, Murdoch-Eaton et al. 2007; Reiger 2008; Riska 2012; Acker 1990; Hearn 2014). A more complex research focus has only recently managed to enter the agenda in the Czech Republic as well as to become the focus of public debates.

The practices of late-modern medicine in the field of human reproduction offer a stimulating melting pot for negotiation: acquiring sets of authoritative knowledge (Jordan 1997; Davis-Floyd and Sargent 1997; Foucault 1990) and power plays exercised over the prevailing routines in any national context. The situation of the Czech Republic, as a representative of

⁷ By pointing both to men's practices and to (flexible) forms of lived masculinities, and to embodied masculinities, I refer to recent debates in CSMM on the material – the discursive understanding of researching men, men's practices and masculinities (Hearn 2004; Hearn 2014; Carrigan, Connell and Lee 1985).

a country with a totalitarian state socialist past, nevertheless demonstrates a complex system of top biomedical care in the subfield of human reproduction, with the country ranking very high in international biostatistical charts and indexes. The contemporary system of national health-care provision provides citizens with a very high standard of medical care. Despite recent democratic transformations in the system of health care provision concentrating on biostatistical measures documenting biomedical advancements, there is still an environment of neglect concerning the personalised care and wellbeing of people as objects of medical care. In fact, the systematic neglect of the human side of medicine has a strong impact even on the providers of the care themselves. Their own personal wellbeing and bodily needs are also often neglected or downplayed. Perhaps such lack of professionalism in the interpersonal aspect of care combined with the stress on technological indicators (equipment and investment in construction) of current biomedical care make the position of the Czech Republic a representative, or a symptomatic, case of the countries undergoing turbulent transformations after the breakdown of the Communist bloc.

The aura of contemporary (bio)medical advancements, the strongly formalised and certified attributes of the profession itself and its social prestige have put (bio)medicine into a position where some of its representatives do not allow their performance to be questioned, doubted or reviewed and thus have their expert authority challenged. This is definitely true in the context of Czech medicalised childbirth, despite growing fears arising from the atmosphere of mushrooming malpractice suits, during which such attitudes are debunked.

The public debate on Czech childbirth practice is split, ideologically polarised between the biomedical, interventionist practice framed by risk prevention and safety, and the human rights framework articulating the right of choice in the way and place of birth (often labelled the “natural” or assisting model of childbirth). The allocation of power in these opinion pools is crystal clear. The vast majority of babies are born in hospitals under the supervision and responsibility of medical doctors (hospital midwifery has only recently started to be emancipated as a competent profession). On the other hand, homebirths and the services of independent midwives are penalized. Such a situation surrounding the practices of (hospital) childbirth has repeatedly caused tension and the escalation of both public and expert debates⁸. Part of the problem is clearly defined in gender terms. In such an atmosphere, the analysis of practices and opinions articulated by head doctors in maternity wards offer a vital tool to help understand the conflicting debate concerning attitudes to childbirth as reduced to two clearly-distinct and seemingly antagonistic sets of key players. A debate to overcome such a simplified dual approach is not taking place in the Czech context. Thus research interviews among physicians offer an opportunity to dig beneath the homogenous surface and get a glimpse of a far more complex picture of opinions within their camp.

“We are only convincing the convinced” is a summary of the experience presented by one head doctor from a regional hospital, Dr Milky⁹, at an educational meeting (a round table

⁸ The author elaborates more on the relevant conflicts in the Czech public debate in the chapter entitled “Medical Childbirth Made in the Czech Republic: Required and Desired Practices” in the book *Games of Life: Czech Reproductive Biomedicine. Sociological Perspectives* (Šmidová, Šlesingerová and Slepíčková 2015).

⁹ All names used in the text referring to research participants are aliases.

discussion with an internationally-renowned guest lecturer, professor Michel Odent, advocating natural birth). Dr Milky referred to his encounters with an audience of similar composition in such meetings. Proponents and opponents of particular trends in hospital childbirth form specific forums and there is no room for any exchange. Arguments raised by physicians against interventionist hospital childbirth are thus not heard by their opponents, with board members of influential specialised professional committees often setting the agenda and guidelines for *lege artis* and *non lege artis* practice¹⁰.

HOSPITAL HIERARCHY, EMBODIED POWER STRUCTURES AND MEN HEAD DOCTORS

Seemingly, the power of head doctors at Czech maternity hospitals is omnipotent and their standpoint regarding the practices of childbirth is homogenous¹¹. Medical doctors are simply presented as being on the biomedical side of the fence, as homogenous defenders of biomedical, interventionist childbirth (delivery) in the media reports and in their own consciously built self-image of the professional boards. Mechanisms or practices reproducing the daily routine in the profession may help us form a more structural, symbolic element of the dual image for interpretation. These structural mechanisms and milestones also involve a gender dimension and organisational masculinity within the structure of hospitals.

There is no doubt that the power lies professionally, organisationally and personally with men. Although a paradox of perceived powerlessness of head doctors can also be addressed (Šmídová 2016), the analysis presented here elaborates the attitudes of doctors and their institutionalised settings from a different perspective. Positions of neglect in combination with the fact that they have full responsibility for their hospital ward (measured) outputs has stimulated some of the regional head doctors to diverge from the mainstream guidelines. In many ways, some of them have thus moved forward to bridge the polarised childbirth ideological camps by systematic acts of disobedience legitimized, in their eyes, by their professional dissatisfaction arising from their professional underrepresentation in the decision-making

¹⁰ The formula is used in reference to the latin “*de lege artis medicinae*” – according to the law of the art (of medicine). Any “*non lege artis*” practice is highly sanctioned and the threat of legal action is often made in this context. The second part of his argument followed the line that in their region, in fact, there is no demand from women to change the hospital routine. So for him, the other target audience for raising the public awareness should be directed at women (less educated and mostly from rural areas). In other contexts, these are the women described as ideal patients by many obstetricians and hospital personnel.

¹¹ It is not easy to estimate the ratio of women among head doctors in maternity wards. Recent statistics indicate, that there were 45 percent women gynaecologists and obstetricians in the Czech health care system in 2013 (<http://www.uzis.cz/>), and overall, the general share of all female doctors was 56 percent in the same year (ibid). The sex category ratio is not publicly unavailable for hierarchical positions in the medical profession. However, the Czech Medical Chamber (professional organisation) published some information on this issue in 2009: at that time, there were 29% women among all senior doctors (source: http://zpravy.idnes.cz/chirurgie-neni-pro-zeny-nejsou-rozhodne-jako-muzi-tvrdi-lekari-pvs-/domaci.aspx?c=A090302_085633_domaci_lpo). As indicated in footnote No. 2 of this text, “senior doctor” is a wider and hierarchically lower category than “head doctor”, and since gynaecology and obstetrics is a more traditionally gendered specialisation, too, it is most likely that the men to women ratio in the head positions will be structurally even more reinforced.

bodies. They were forced to resolve the conflicting demands of some patients and their professional guidelines, which could potentially result in court cases (without being backed by professional bodies), in a pragmatic way.

In these processes, professional hierarchies (within and between hospitals) and gender regimes, including the specific practices of men and associated masculinities, mix with the aforementioned aura of the latest modern medicine with its power to guarantee the superiority of biomedical knowledge over other ideologies of childbirth. However, the setting is definitely rather complex. Despite the vanity of many doctors, their daily professional routine, at least in the Czech context, is far from an idyll. The hospital routine gets embodied, under their skin and skull, both in the physical performance of their specialist profession and in the organisation of hospital routine. In the physical practice, skilful hands and physical strength is required, and the hospital obligations involve serving long shifts over nights and weekends, as well as overtime. The organisation of hospital work has been compared to army drill in several of the research interviews, including bullying, and career rivalries (especially in university hospitals), resulting in long-term exhaustion, burnout, and perceived helplessness in critical life-threatening situations, not to mention structural injustice. Inequalities embedded in the system relate to junior and senior positions, gender imbalance and the already-mentioned inter-professional tensions and the central-peripheral position of the hospital itself nationwide. The regimes of huge university clinics are much more hostile in many respects in comparison to the otherwise-ostracized regional hospitals (Slepičková and Šmídová 2014).

PHYSICIANS' COMPLIANCE, COMPLICITY, COUNTER-HEGEMONY AND INFORMAL AUTHORITY

There are two noteworthy practices that head doctors employ when being challenged on the status quo of the power relations in the profession and the gender regime concerning Czech childbirth. Firstly, the fieldwork data reveal that advocating a particular medical attitude depends on the specific context in which the expert knowledge is being presented. This text analyses these forming contexts that restructure gender relations and how these mechanisms are reflected by the head doctors. The second elaborated aspect touches on the surprising disassociation between the formal organization of a (state-run, public) hospital, bound by many rules and state policies, and the relatively independent, autonomous practices of its individual head doctors. These two areas have turned out to be the most striking elements in analysing doctors' speech (performed in public or in relative privacy between the research participants and the researcher), and both of them bear strong gender-loaded connotations. Both of them enable us to deconstruct the uniform, homogenous image of the practices of head doctors and shed some light on gender relations in the field, especially in the compliances, hegemony or potential subversion related to men's practices in those positions.

It is important to document both attitudes and ideological postures, presented to particular audiences, in such an analysis, while also considering daily practice as embodied routines. Local authorities and informal practices may form the basis for potential challenge and subversion as well as serving as a bastion of the status quo – often as both – which makes

this environment a vital target of enquiry and endeavours for a better understanding of the mechanisms beyond them. The processes of compliance and resistance to the medicalisation of childbirth from within the medical field are approached from the perspective of senior doctors, mostly men, who experience and administer power over the everyday routine and pass it on to their professional successors and subordinates.

SETTINGS TO COMPLY WITH OR TO PROMPT COUNTER-HEGEMONIC CHANGE

The remarks in the text above have already pointed to the fact that varying practices require different justifications. Nonconventional practice presented in front of a certain audience (“of those convinced”) or a very complying presentation in front of an audience full of professional cadres provide a comparative setting for what follows.

Professional meetings in medical specialisations provide an excellent opportunity for discussing the strength of the status quo. General assemblies or annual specialised conferences in particular provide demonstrations of maximum loyalty and conformity to the formal and official standards. At the same time, more specific professional events that attract interested segments of physicians offer an alternative scene where assurances for fringe approaches modifying mainstream trends are advocated. I will now provide an example of each of these two types of event.

Dr White (head doctor in a local maternity hospital with over 25 years of experience in the medical specialisation) presenting his alternative practice at the same occasion as Dr Milky, with no need to justify it, is talking to “the convinced”. He goes on and describes in detail the conventional practice in delivery rooms and moves on to provide evidence of the contrasting arrangements he himself implemented in their hospital maternity ward. Dr White explicitly distances himself from the strongly medicalised approach to childbirth, represented by the high proportions of Caesarean Sections and induced labour (even in cases of overdue births). He describes the necessary modifications to the routine management of hospital birth, where foremost tasks include time management and time provision for each individual woman in labour. He has a very strong rhetoric of trust in natural processes and relies on his staff to be disciplined, patient and able to wait as befits those providing professional care and complies with the requests coming from such care recipients. The stress in his speech on (the subjectivity of) mothers-to-be and the importance of their experience, as those who have themselves managed, who experienced giving birth to their babies instead of having them delivered, was distinct and made self-evident as opposing the mainstream hospital routine. Moreover, Dr White also reflects and describes the power of medical doctors over patients (he even questions the appropriateness of the term patients for women in the maternity ward). He acknowledges the ease with which doctors can manipulate the statistics to provide figures in support of their own beliefs.

Our power is so great, that if we touch up the data, we can put the objects of our endeavour into either the left or right corner and will still be able to support our course of action with plenty of arguments. I have inner problems with that, so I have decided to follow a different path. And in the 25 years since I started learning the obstetrician practice, I believe women have practically not changed. I have the feeling that they are as capable of giving birth as they were before in former

times, and thus I have serious problems with the officially published statistics, documenting, for example the growing number of Caesarean Sections (Dr White, man, head doctor in a local maternity hospital).

Both physicians, the international guest professor lecturer at the roundtable discussion Odent and the above cited Czech head doctor White, have simultaneously pointed out the long-term consequences of biomedical interventions into the spontaneous process of childbirth. Dr White then admits to a professional lack of understanding of the physiological processes themselves in the medical practice as such. (This argument is in a sharp contrast to the practised understanding of childbirth as a medicalised and intervention-requiring process).

I can see that an array of the processes of giving birth go very smoothly in situations that would have been considered in the old-fashioned way as precarious and in need of medical intervention. This is yet another issue to be learnt that is not easy or simple as the traditional management of birth was set in a way that these are the situations when doctors intervene, when they go on to do something about it. However, when we limit our interventions only to monitoring the heartbeat and the mother is fine and feels safe and insists on the set course and wants to continue with it, so then we are very positively surprised by how things turn out, how wide and flexible the processes are, whilst being physiological (Dr White, man, head doctor in a local maternity hospital)¹².

And he gives an example that is even more striking and fundamental for him, as the woman giving birth was a medical doctor herself. She voluntarily and purposefully disobeyed the formal guidelines (prompting to induce and speed up her birth).

And then I say, “This has gone too far”. This is completely against their routine, we have to monitor you, do the tests more often, so if you do not give birth by Friday, we have to end it. And she does, I do not know how, under what influence, but she gave birth the night before with zero complications. Then she came to thank me, she wrote a story on how grateful she was that I let her have a spontaneous birth lasting 68 hours. And I wished the ground had swallowed me up. But her point was important in making me realize that the closer we get to the beginning of trouble, the longer these processes take, the more precise and professional work is required. And when it reaches a certain point, these people show respect for our efforts and do not protest against our interventions because they have experienced the process of us not making rash-headed decisions following the standard routine to make things easy for us (Dr White, man, head doctor in a local maternity hospital).

Dr Milky bears full responsibility for the outcome of the process of giving birth in the conventional Czech understanding of the role of a hospital’s head doctor. Here – backed by the professional opinion of a colleague – he took a risk and explored a medically off-limits experience. At the same time, he was confident enough of his own specific abilities, his well-coordinated ward team and his relationship with the patients to undertake such a professionally-unprecedented challenge. Nevertheless the back-up coming from a professional colleague, not just any woman in labour, legitimises in his view the desired direction of his work arrangements and the established trend in childbirth practice. In contrast to some (albeit

¹² It is worth noticing here that Dr White refers to an old-fashioned and traditional management of birth when he describes the routine medicalised, interventionist practices in childbirth.

also few) women obstetricians, and especially independent midwives, raising their critical voices and getting involved in civic initiatives for change in hospital birth practices, Dr Milky is in an organisational position of power. Thus his standpoint presented at the roundtable discussion – a semi-public forum of “those already convinced”, targeted at professional health care workers concerned or already sympathetic with such trend – makes a more significant difference. Moreover, it is enforced by the fact that he is a man (with all its symbolic gender connotations), besides being a professional standing high in the specialisation hierarchy. Such public courage in subverting the *lege artis* practice and professional guidelines is particularly exceptional in the Czech system of hospital care and its respective level of compliance with the *lege artis* standards of the profession. Thus this individual practice of the head doctor, who has exercised his power to subvert the practice of childbirth and has stepped out of the herd, represents an example of the complexity of the hegemonic and counterhegemonic practices of the representatives of the powerful posts in the medical profession.

This also informs us about the critical standpoint towards routine interventions carried out in major clinics which set up the rules and *lege artis* guidelines for the whole medical specialization. The next example provides evidence for the opposite attitude, for compliance with the system. Dr Snowdrop is a member of the staff of a cutting edge university hospital and represents an example of such practice in her presentation at the national annual Czech Ob-Gyn Conference. Her conference presentations are very professional, and as far as I know from a broader research context, she is a respected expert among her colleagues and popular among the patients for her communicative and kind approach, as well¹³. Nevertheless, the contents of the conference paper has demonstrated total loyalty and conformity to the most interventionist approach to childbirth. It is important to note that the auditorium was full of powerful representatives of the professional society.

She advocated a pro-active (rather than expectant) management of childbirth there. Prevention of high risk situations (such as massive bleeding after birth) was used to legitimize interventions in the process of giving birth. Such pro-active management of birth was declared as the gold standard by Dr Snowdrop, who was representing a team of authors. The university hospital representatives have advocated for preventive interventions (use of drugs and invasive procedures) and have legitimized the prophylactic (preventive) application of them and thus have reasserted a (bio)medicalised approach to childbirth. Due to the complexity of the image of such a conference event and the composition of its participants, it is important to note that this is a setting for a show of loyalty to the mainstream practice. Reassurance and reconfirmation of the professional structure takes place there; only once in the full program of two such annual national conferences has there been a presentation openly criticising the status quo in Czech medical practice. Dr Snowdrop, despite not making this point explicitly, needed to demonstrate such compliance. In her ordinary hospital life, she has experienced a series of non-events (Husu 2005) that professional women encounter in the competitive research

¹³ Such an approach is not commonplace in the Czech context, especially in larger clinics, and thus it can also be associated with a kind of “alternative” practice in the routine of Czech hospital childbirth. The blatant incongruence between the top biomedical ranking of Czech Republic in various international comparisons and the long-term dissatisfaction and criticism concerning the wellbeing of birthing women especially in research university clinics is an evergreen topic of public debates and civic political demands.

environment. Despite informal recognition and her professional performance, Dr Snowdrop (with about 25 years in the profession) does not hold a head doctor's position in the university hospital, while younger men colleagues have been appointed to the position. In her case, the notorious harmonisation of family and professional life argument does not apply, as she has – in her words – sacrificed her private life for a professional one. Nevertheless, it seems her prospective potential career advancement requires yet more formal demonstration of her loyalty to the Czech professional organizations and the pro-active medicalised standards and practice in general. Thus her complicit femininity (aspiring to the professional career position defined in hegemonic masculine terms of the organisational practice and structure) is an enforced way of conduct, which generally further complicates the public involvement of women professionals in resistance strategies in comparison to their men colleagues.

Dr Milky is a man and he is in a top position in the (regional) hospital hierarchy, which allows him to behave differently. Dr Snowdrop, a senior woman physician in a big research clinic, needs to repeatedly show her loyalty with a doubtful career perspective in the cards. Yet, it is not only between the small and big hospitals where the power and gender games and demonstrations of authority take place. Nor do seniority and gender of doctors play the only roles in the hospital hierarchy. The uneven distribution of structural power and its execution applies to senior representatives of university hospitals as well.

In another example, a university hospital senior representative encounters downplaying by an even more central authority. As Dr Albino (deputy chair, or vice-senior consultant, of a university maternity hospital situated outside the capital) noted, major controversies are not exceptional even in top management positions in the Czech system of medical care. He describes his various feelings of impotent rage related to negotiations about authoritative decisions, political lobbying (proximity to the centre of decision-making bodies situated in Prague) as well as personal vanity:

Just yesterday afternoon, I was completely outraged over a dispute at the Ministry (of Health). We have worked hard to unify the concept of specialisation and its post-graduate education with European standards [...] and some totally old paranoid professors interfered to keep their personal monuments until their death, they went to extreme lengths to reverse the system back to non-functional and meaningless practice. But since they are so vigorous and the Prague lobby so powerful, and despite the fact that major representatives oppose it, including those from other specialisations, the Ministry representatives have decided to follow these old Gents. So such events make me angry (Dr Albino, man, vice-senior consultant at a university maternity clinic).

Compliance with the rules of this men's club is a rule. The closer to the centre of the power structures you are, the less diversion from the norm is tolerated. The gender hierarchy embedded in late-modern medicine is thus strengthened by seniority (measured by representative functions in the national professional bodies) and the centralisation of power in a geographical sense.

The last note, which refers to the environment in which the medical practices of Czech childbirth are being produced and respective power relations reinforced rather than challenged, relates to the internal structure of the hospital itself. Practices which comply with the status quo are being reinforced in both directions, not only from the top down but also from the

bottom up. Multiple accounts from the physicians of their early socialization into the profession stress the gender inequality in experience. Competencies at childbirth mostly include physical skills (learnt in repeated bodily contact and experience). Especially middle-level medical personnel take their share in the power over childbirth in the medical setting and they apply a gender specific approach to the negotiation of authority. Experienced hospital midwives (women) often bully junior physicians and thus offer their own professional expertise to be shared at a relatively high cost. Newcomers among women doctors describe their initiation into the hospital routine as going through hell. Although men doctors are sometimes exposed to more or less explicit sexual advances, on the other hand they are pampered, spoiled, on first-name terms and can enjoy jocular relationships with nurses and hospital midwives. As one almost-retired woman doctor, Dr Swan, now working in a private practice has pointed out:

In health care professions especially, it follows this line: 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 (Dr Swan, woman, owner of a private gynaecological practice, with long years of experience in a university maternity clinic).

Rivalries and power games have been described here to add colour to the often generalized image of medical doctors in obstetrics as homogenous powerful professionals burdened with following the (problematic) guidelines. The setting is strongly gendered, while at the same time hierarchies among representatives of the profession allow for different strategies for responding to the patients and the varying demands of the profession, and more generally to the transformation of the relevant professions and organization of everyday hospital care. The latter example brings us to the second major focus of the analysis presented in this text: the daily ward routine, to everyday life arrangements and relations in the formal organisation of a hospital. It refers to the relationship between the conduct expected in a formalised professional setting, and informal daily practices, specifically gendered, exercised by the health care personnel. This disassociation again opens space for complicit as well as counter-hegemonic conduct of the actors in various ranks of the organisational hierarchy.

PROFESSIONAL RULES VERSUS THE AUTONOMOUS, INFORMAL PRACTICES OF HEAD DOCTORS

The conclusions of the section that elaborates on complying and counterhegemonic performance settings in the profession leads us to examples of the hospital routine that impedes or cultivates practices recognising gender inequality. Hospitals as such represent one of the most regulated formal organizations, bound by huge sets of regulations, state provisions and ordinances as well as the professional (including ethical) self-regulation of representatives of the health profession. Thus, the relative autonomy of individual head doctors employed in their everyday practice emerged from the collected research data as a surprise¹⁴. A particular authority, professional and personal, sets up the daily routine in a maternity hospital to a degree

¹⁴ Some aspects of this practice are also explored in another text by the author: “Medical Childbirth Made in the Czech Republic: Required and Desired Practices“ (Šmídová 2015b).

that one would not expect in such a formal organization as that of a hospital. Personal traits, attitudes, management competencies, expert skills and also gender preconceptions intervene in the ward's daily routine, interaction and reproduction of hierarchies in decision-making processes. Every head physician, every new boss, brings a set of rules with him, his "school" (these are predominantly men, so far, in the Czech context). While with his exit the particular school may come to an end, the head doctors frequently make great efforts to train up their successors. Both professional competencies and personal attitudes are passed on in this process. Several women doctors are sensitive to the practice of this "cultivation" or "breeding" of male successors, whom they referred to as "stud horses" in the interviews.

This text has already pointed out the autonomy of Dr White in his local maternity hospital, where a non-intervention school is being put into practice. In contrast to the "old-fashioned" and "traditional" biomedical routine, he calls his own approach "conservative", and presents his strong conviction that it is the trend that represents the desired new approach to childbirth in the Czech context, more than the required "cutting-edge" guidelines set by the large Czech clinics and professional societies. On the other hand, it has also been pointed out that a certain nonconformity is accepted more easily in local hospitals and when practiced by men. Therefore, Dr Snowdrop had to demonstrate full formal loyalty to the interventionist approach to "delivery" in front of the representative conference audience.

The example of Dr Milky, in particular, provides evidence for a significant shift in favour of subjectifying women patients. Thus, in the broad perspective, his attitude challenges the status quo in gender relations in the birthing setting. Yet, at the same time the everyday hospital routine often goes beyond the prescribed formal protocol of conduct and in a manner that reinforces gender inequality rather than subverts it.

The immediate power of the head doctors, supported by their formal status, may result in situations of direct discrimination. Here is an example of such a practice in a university hospital, provided by a senior physician, Dr Pearl (a woman), in the maternity ward in a research interview with reference to her woman colleague:

She is extremely talented and [...] really an excellent surgeon – if she'd had space, which she did not, because she had it at the beginning and then went on maternity leave. Now she's come back but it's already like the end. She would have shown all those men that she's simply much better. She is really very good, precise, super-talented [...]. Well, she, she's just a much better surgeon than he (the head doctor) is, and he sees that, you know. So, he found that out a couple of times. Then he completely stopped writing her down for the operating room, and she basically told me that he hasn't let her in on anything since then. What's more, she's attractive; it's just like, it's, it's simply a disaster, you know? (Dr Pearl, woman, senior physician without a managerial position in a university maternity clinic)

This example is a part of an on-going socialization process, the initiation into the profession and its informal rules that often favour men regardless of their skills and talent¹⁵. Such gendered bossing is not seen as such, not even as being individual discrimination. Regional head doctors perform versatile personnel management and serve as top liminal

¹⁵ More examples of such practices are elaborated on in detail in the chapter "Condemned to Rule" (Šmídová 2015b).

experts in their hospitals. In the research interviews, they, the bosses, present how they face up to obstacles that mirror the gendered social division of labour resulting in a shortage of qualified women doctors (mothers) in the profession available for senior positions. They recognize care for children as a woman's job and a professional career with all its long working hours as a man's job. The head doctors see such "natural" arrangements as only complicating their job in assigning more responsible working posts to women physicians. They often say it is on the women's own request not to be promoted, in order to better manage the harmonisation of their professional, already demanding working positions with their personal and family lives. Yet, the head doctors do not often see themselves as agents of any change in this area. In this respect it seems that the proximity of the geographical location of the hospital to the (urban) centres may play an opposite role, situating regional, local hospital head doctors into a more conventional position regarding gender-relation arrangements. As Dr Chalk, a head doctor of a maternity hospital in one Czech region, puts it, "this is how society is set up":

In out-patient service, I think these women have a number of advantages and privileges; on the other hand in the whole field in hospitals and surgery, I think it's more complicated for them to get ahead there [...]. There is also the limitation of the family, that's clear [...] Yep, it's harder for them to get ahead. When it comes to knowledge, skill, attention to detail, women may have a lot of advantages. But society is set up so that a man is a man. It's the way it still is (Dr Chalk, man, head doctor in a local maternity hospital).

Such a conventional attitude of head doctors, combined with the complicit practices of other personnel, including both men and women, contribute to the reproduction of unchallenged gender hierarchy in the hospital setting regarding both the personnel and the patients.

There are few notable exceptions, such as Dr White. There are two areas of his own practice that are worth mentioning besides the already-described non-interventionist approach to the process of giving birth. His resistance to the medicalisation of childbirth translates into the division of labour in his maternity hospital and to the relationship towards women giving birth.

Thus, he has altered the hierarchically-set collaboration between health professionals in his maternity hospital. The organization of care in his hospital benefits from much broader competencies delegated to midwives, a historically downgraded profession in the Czech context. Moreover, these reassigned borders of competence for professions involved in childbirth have a strong gender impact. Midwifery is a feminised profession, as is women-centred assistance throughout childbirth. Thus, broadening the range for it in the (bio)medicalised hospital setting de facto empowers women and allows an alternative set of authoritative knowledge (Davis-Floyd and Sargent 1997), represented by the assistant ideology of childbirth, to make a more solid entry into the practice. The rhetoric of Dr White is rather pragmatic in this respect: such an arrangement saves the precious time of the physicians, who otherwise tend to quit the demanding and exhausting hospital work for private practices which are less time-consuming. Nevertheless, the consequences of letting independent midwives in and enabling the hospital midwives to gain more responsible job competencies is a breakthrough in the position of the biomedical authoritative knowledge (Foucault 1990; Jordan 1997; Davis-Floyd and Sargent 1997; Reiger 2008) and the self-assuring dominant status-quo of late-modern medicine in controlling Czech hospital childbirth described in earlier sections

of this text. It violates the unquestioned aura of contemporary (bio)medical advancements and its hegemony in its dispensability.

The second rearrangement by Dr White involves a relationship between hospital staff and (women) patients. He declares a change in the hierarchical relationship between the patients and the medical personnel by “becoming friends” as he puts it. Based on his experience, a more equal relationship also has very practical consequences. It prevents and limits the potential legal consequences of gynaecological or obstetrical performance. The spirit of team activity builds an atmosphere, proving the interest of the hospital staff in individual women’s cases or situations. With negative reference to lawsuits or the Czech Medical Chamber trials, he establishes partnership relationships between patient and doctor, based on the provision of information and the negotiation of the steps to undertake. Dr White challenges the established causality between “fear of a court trial” and “routine preventive interventions” in a favourable direction. And he acknowledges such pitfalls of the routine biomedical practice at birth:

All of these (misunderstandings and mistakes being taken to court) can be blamed on us to a certain extent, since we had practically no communication with the woman patient. She did not trust us, one did not know what the other did, one doctor came after another providing contradictory information, and the patient got lost in it. It is easier in general practices than in hospitals to follow this strategy but I still consider this approach to be the most pragmatic for our defence. It means that we communicate with the patient, inform her even of our wrongdoings and apologize, clarify and explain the complications encountered and keep them involved and motivated to solve the situation and to right the wrongs again. This is the key thing in my opinion (Dr White, man, head doctor in a local maternity hospital).

Here again the institutionalised gender imbalance is being challenged. Firstly, the power bias in professional versus lay actors is being compensated. Secondly, the formal masculine traits of the medical profession (Acker 1990; Cahill 2001; Riska 2012; Reiger 2008; Oakley 1994) and the formal hierarchical arrangement of the hospital setting are being challenged by involving women patients as people, not merely the objects of care. Certain caution is appropriate as the declared team spirit and disruption of the established power relations can be abused (mainly by the medical side in power), as manipulation instead of the provision of factual information and patient involvement can take place there. The environment of intervention may nevertheless be altered by the head doctors’ dedication to a more interactive attitude towards patients, at least to a certain degree.

The management practices of Dr White as head doctor of the local maternity hospital change the gender bias in hospital childbirth practice in the Czech Republic and also indicate the means that head doctors can apply for if they proceed. Both Dr White and even Dr Chalk, represent a certain departure from the mainstream formal, and informal, routine. Dr White does so by his change of practice in inter-profession and doctor-patient relationships, and Dr Chalk by a reflection of gender injustice in the obstetrical profession (yet lacking action to stop or prevent it). Both of them challenge the unquestioned professional aura of late-modern biomedical practices in maternity hospitals and empower or at least acknowledge potential alternative arrangements to reduce gender imbalance in the profession and in the provision of care. They do so informally, at their own responsibility, and in a safe distance from the “cutting-edge” trend-setting centres of university clinics.

In alliance with the experience of these two head doctors, Doctor Milky as head of another regional hospital follows and expands the notion of individual responsibility and its potential high cost. He implies that the power of the *lege artis* interventionist biomedical routine is reproduced in an atmosphere of fear of lawsuits that are strongly perceived as threats to doctors, and by fear of losing the backing of professional organisations represented by the old guard. This strong incentive forces most head doctors to comply with preventive interventionist approaches. Dr Milky suggests a detour from this omnipresent atmosphere of anxiety, saying:

I have never heard of a hospital or an obstetrician being sued for excessive or redundant interventions, or complications resulting from a Caesarean Section. Whereas all the lawsuits I know of are directed on such cases when biomedical interventions have not taken place. The doctors are questioned why they did not intervene by this or that. Or in cases where midwives are being sued, any independent step taken by them is criticized for their lack of formal competencies and unprecedented crossing of their professional borders. All these, most often publicized, cases are those connected with spontaneous, noninterventionist approaches to childbirth (Dr Milky, man, head doctor in a local maternity hospital).

Dr Milky is convinced that the logic of such arguments needs to be reversed. He concludes: “until then, we will be crying on the wrong tomb, I’m afraid to say”. There is yet one more threat, according to Dr Milky, that hinders obstetricians from providing good service to their patients (women giving birth). There is the structural pressure, according to Dr Milky, that illuminates the motto of recent practice in maternity wards:

We will not do what is good for our patients, we have to follow the European legislation, which is our delegated assignment. None of the obstetricians agree to that internally but all of us are faced by a *fait accompli* (Dr Milky, man, head doctor in a local maternity hospital).

Here, yet another formal authority is brought up to point out the processes limiting the autonomous authority of regional head doctors, often practised as informal. For the Czech context, associating the EU’s agenda with restrictions is rather typical, even in cases such as this, where in fact the international system of standards for hospital birth would break up at least some aspects of the criticized interventionist routine.

The last example enables us to sum up the atmosphere of anxiety into a broader atmosphere of mistrust in public bodies and state-run – or international-level – organizations. In many respects, Dr Milky voices the attitude of many Czechs, even many Czech professionals’ experiences with the faults in transforming huge public systems, such as health care. This perspective, among others, would deserve detailed analytical attention in yet other topical texts. Nevertheless it seems that such complicity is not unanimous.

CONCLUSIONS TO HEAD DOCTORS’ POWER CHALLENGES IN A BROADER PICTURE

Dr White’s case shows that it is possible to resist the medicalisation of childbirth, to challenge the existing gendered organisation of hospital routine and to change attitudes

towards the recipients of care. It is even more likely that men, who are much too often in the top hierarchical positions as a result of their belonging to the “group of men”, have greater bargaining power if they decide to use it. Their individual hegemonic position of power in a prestigious profession provides support in making their individual hospital ward become more relaxed towards the professional *lege artis* rule and gender order. The analysis has indicated that challenges to the gendered routine may come even as a result of pragmatic managerial decisions to ease the pain doctors have in their demanding and insufficiently-remunerated hospital work and to prevent law suits from ignored patients. The interview accounts of hospital head doctors also imply that conventionally-understood “heroic masculine traits” such as having the courage to step out of the crowd, taking personal responsibility or following the “school” of the boss are much more likely to be interpreted as the desired and honourable traits of senior men doctors than for women in senior professional positions, as the examples of Dr Snowdrop and Dr Swan have outlined. The symbolic universe (Harding 1987) favours the action, decisiveness and rationality of men, while those in hegemonic positions are in many ways freer to relax on their imperatives (Šmídová 2014).

The aim of this article was to point out the complexity of the powerful positions of men head doctors – their exercise of power over their respective maternity hospitals, reproducing or challenging the practice of medicalised childbirth, and often unreflectively, nevertheless actively, maintaining the gender hierarchy in the gendered organization of the hospital itself.

The performed, aspired and required masculinity in the medical field of maternity hospitals is strongly bound to skilled hands, gender stereotypes and personal, individualised authority in addition to the professional performance and formalised hierarchy set by organisational and national rules. It is not easy to disentangle the mechanisms reproducing men’s hegemonic and complicit practices or their incentives for counter-hegemonic actions. The examples analysed in this text, i.e. settings that prompt change or complicity and the lived experience of disassociation between formal rules and individual performance, indicate how gender order is embodied in the everyday routine of head doctors and that it can be challenged by very pragmatic incentives. The lived experience of men in power does not necessarily translate into an individually satisfying life experience (Connell and Messerschmidt 2005) and the text has analysed the structural settings contributing to such individual assessments. At the same time the experience of being cogs in the organisational and professional machinery has spurred some head doctors to subvert the mainstream and required (*lege artis*) obligations in favour of other overshadowed professions involved (including midwifery) and requests coming from various segments of the recipients of care.

Head doctors from regional and small-scale hospitals experience powerlessness when facing recent trends in the biomedical approach to childbirth, when reaching their bodily limits bound to the physical strain of the profession, and when facing the effects of a gender-stereotypical organization of harmonizing work with family (personal) lives in Czech society. As Dr Chalk reflected, care is delegated to (even professional) women accompanied with a lack of institutional provision of public care facilities, and breadwinning (financially lucrative job) expectations are bound to men in the profession. This structural setting leaves head doctors often with no senior staff to rely on or to whom they can pass on their position to. Men leave public hospitals for the private sector, and women are partly unwilling and partly misunderstood for fully competent consideration.

The momentum of the system is kept in place by a series of mechanisms, two of which have been described in this paper. The space for transforming the dominant practice of Czech childbirth towards a more gender-balanced arrangement lies probably more in the peripheries of the system of health care provision than on the prominent cutting-edge institutions. Moreover, this depends on the very individual authority and attitude of relevant heads of the maternity hospitals and their informal understanding of gender relations. They act in various environments, most of them reconfirming the dual and hierarchical understanding of gender relations in the everyday routine of the field. Complying subordinated colleagues, junior-senior hierarchy, mid-level health professionals and a serious segment of patients insist on the existing strongly-hierarchical arrangements which bring them either a share of the power or an exemption from accepting full responsibility for one's professional competencies or individual health. Examples of these have been provided: gender prejudices, complicit women doctors, hospital midwives and nurses delegating the formal responsibility to doctors and taking their part in spoiling young men doctors whilst contesting young women doctors. Challenges to the well-established practice have not yet come from the deputies of professional bodies, where personal vanity also plays a significant role. A key quality of medical professionals is understood at these forums in terms of compliance, conformity and loyalty, the degree of which prevents any systematic change. Nevertheless, it seems that the masculinity combating the hegemonic practices of the most powerful representatives of the profession has found its subversive ways of enabling the settlement of the everyday-life examples of systemic faults.

Practices in late-modern medicine in the field of human reproduction analysed in this text represent the biopolitics and governmentality of the Czech state, and at the same time shed some light on opening up spaces for change from within the medical field represented by men head doctors. Medicalised childbirth and the authoritative knowledge associated with it reproduces the aura of contemporary medical advancements cemented in the formalised and certified attributes of the profession and its social prestige. It also has its other side of the coin. Practices of some head doctors in their maternity hospitals indicate the plurality of medical professionals in approaches to practices at childbirth, including gender regimes in their working organisations and thus enable us to overcome the simplified duality presented in topical public debates. An analysis of particular men's practices in positions of power also helps the understanding of the post-socialist processes at work transforming the national health care system. This text is a contribution to reflections on critical studies on men and masculinities concentrated on powerful masculinities – on the practices of men in prestigious professions and positions of power in their working organisations. Some of them act as agents of change. As a supplementary aspect, the texts open the issue of complicit femininities or professional women's practices in gaining their recognition in the medical specialisation. In the case of the senior physician Dr Snowdrop, such complicity may be interpreted as structurally-enforced and involuntary, while not actually bringing comparative advantages.

I conclude that the practices of (men) head doctors in the current Czech system of the structure of maternity hospitals (university clinics versus regional smaller hospitals) represent a challenge and offer a counter-hegemonic model to the undisputed association of head doctors with power and/or their unanimous acceptance of the dominant biomedical approach to childbirth. Some of the structural asymmetries of gender relations are being challenged

there, while at the same time such an option has apparently not been open to women doctors. Considering the scarcity of protesting voices being articulated publicly from the camp of medical doctors, and the conventional understanding of desired masculinity as being active, public, competitive and not departing from the men's club, all these make the position of the head doctors, such as Dr White, Dr Milky or Dr Chalk, strong and worthy of encouragement. These men in (peripheral) power positions offer a feasible model, a counter-hegemony, to be followed in the Czech system of Czech practices of hospital birth. Yet, the same men very often do not leave the men's club in respect to intra- and inter-profession gender hierarchy. Backed by the complicit performance of their professional colleagues and the personnel involved, there is still a long road ahead to gender equality.

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ORDYNATORZY SZPITALI POŁOŻNICZYCH I RELACJE WŁADZY:
WYZWANIA DLA MĘSKOŚCI HEGEMINICZNYCH

Artykuł stanowi analizę kontekstów i praktyk, jakie stosują ordynatorzy szpitali położniczych odnośnie do porodów, skupiając się na praktykach reprodukcji, które kwestionują zastane porządki genderowe. Badania rzucają światło na męskie praktyki i reprezentacje męskości w szpitalach położniczych i wiążą jednostkowe praktyki ze strukturalnymi mechanizmami reprodukcji, specyficzne pozycjonowanie mężczyzn w strukturach władzy w kontekście organizacji porodu w Czechach. Analizy oparte są na danych pochodzących z socjologicznych wywiadów jakościowych oraz publicznych wypowiedziach starszych lekarzy położników oraz ordynatorów oddziałów położniczych (15 pogłębionych wywiadów jakościowych oraz trzy panele dyskusyjne). W artykule skupiono się na dwóch podstawowych problemach dotyczących wzorów męskich praktyk oraz ich dyskursywnej reprezentacji: (1) obrona status quo (uległość wobec *lege artis*) jako przeciwwaga dla alternatywnych podejść do porodu reprezentowanych przez niektórych ordynatorów oraz (2) paradoks szpitala jako formalnej instytucji *par excellence* będącej jednocześnie środowiskiem nieformalnej, indywidualnej władzy ordynatorów.

Słowa kluczowe: wyzwania władzy, mężczyźni w zawodach medycznych, medykacja porodu, kobiecość współdziałająca, praktyki współdziałania, kontrhegemoniczne męskie praktyki, porządek genderowy, autorytatywna wiedza