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Punitive Gynaecology in Modern Russia: Crafting the Docile Female

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Maria Andriukhina

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Abstract

Punitive gynaecology is a set of healthcare-related attitudes and practices that aim to take control of a woman's body, sexuality and reproductive system in order to produce a reformed body. This thesis scrutinizes the phenomenon of punitive gynaecology in modern Russia. Narrative inquiry was conducted to provide an understanding of the ways punitive gynaecology works on the female body, restructures it and inscribes meanings. Autobiographical narratives are analysed and located within a wider socio-political context to concretize the dimensions of punitive practices in gynaecology. The main foci of analysis are the medical gaze, the spatial organization of the gynaecological clinic, pastoral power and agency in the gynaecological examination, the sexuality of the examination, the contingencies of shame, pain and embarrassment. The research uses a Foucauldian framework to uncover power relations permeating the doctor-patient interaction in the gynaecological examination. This thesis thus offers a reflection on the preferred modes of embodiment and docility that punitive gynaecology attempts to instil in its' subject.

Keywords: punitive gynaecology, discipline, power, gaze, agency, body, hegemonic femininity, clinic, doctor-patient interaction, docility

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Introduction

This thesis will scrutinize "punitive gynaecology", a phenomenon characteristic to the healthcare system of post-Soviet Russia. Punitive gynaecology is widely understood as psychological and physical violence directed towards the patient in the setting of a gynaecological examination. Typical manifestations of violence in gynaecological examinations include boundary violations, unsought for personal remarks, reproductive pressure, shaming of bodily comportment and sexual behaviours of the patient (Takie Dela 2018).

Whilst punitive gynaecology has become a topic of frequent discussion on various online platforms, such as online media[1] and social networks[2], it has so far resisted concrete definition in Russian feminist and broader scholarship. Examples of patient testimonies on outright punitive medical practices can be rarely located in academic works (see, for example, Belousova 1996; Shepanskaya 1999) that mostly deal with legacies of Soviet healthcare for women and conceptualize punitive gynaecology as a practice translated through governmental and social institutions.

When it comes to international scholarship, the term appears to be often premeditated, anticipated, but only rarely uttered. The concept is explicitly brought up by Gail Kligman in her award-winning book "The Politics of Duplicity: Controlling Reproduction in Ceausescu's Romania" (1998). Kligman speaks about the punitive dimension of gynaecology in the context of criminalization of abortion, implemented and operationalized by the state to hit pronatalist targets. Věra Sokolová argues similarly in her work "Cultural Politics of Ethnicity: Discourses on Roma in Communist Czechoslovakia" (2008), viewing gynaecology as a punitive practice capable of deliberately imposing restrictions on the bodily materiality of Roma women and controlling their reproductive behaviour to serve the interests of pronatalist state policies.

The interrelations of gynaecology and punishment have been metaphorically outlined by the American radical feminist writer Mary Daly. Her most famous publication "Gyn/ecology: the metaethics of radical feminism" contains a cross-

[1] See, for example, the articles on punitive gynaecology in feminist magazines Knife and Wonderzine, online holdings BBC.ru, Gazeta.ru, Cosmopolitan, Kommersant and others

[2] See, for example, communities dedicated to violence in pregnancy and delivery, such as Nasilie v rodakh [Violence in delivery] of the social media network Vkontakte, Livejournal posts. See also posts included in hashtag campaigns #насилие_в_родах [Violence in delivery]

cultural comparison of Nazi medicine and American gynaecology. Albeit the analysis branches into an almost excessively metaphorical (and pejorative) dimension that does not render it applicable for this paper, Daly (2006) makes a curious statement that I would like to allude to further: "Nowhere does the mechanism of banalizing evil function more smoothly and insidiously than in gynaecology" (p. 306). Daly places her contemplations on the practices of American gynaecology in line with hunting down and burning witches in medieval Europe, suttees in India, foot-binding in China. While embedding gynaecology into this narrative of atrocities might raise eyebrows, this kind of articulation allows Daly's reader to understand in what ways the handling of the female body in gynaecology enacts the practices of patriarchal culture. Even though Daly writes specifically about American gynaecology, her metaphors are productive for meaning-making about the gynaecological practice in general.

Scholars across the world have observed violence in gynaecology extensively but most have so far avoided dubbing it as a "punishment", albeit acknowledging the possibility of clinic encounters having traumatizing effects on the patient (see Arney 1985; Cook 2013; Glover, Novakovic and Hunter 2002; Grundström, Wallin and Berterö 2011; Meerabeau 1999; Temkina 2011 and others). Related explorations have been indeed vague and inconsistent, appearing in search of more precise formulations. The relative invisibility of the term prompted me to conduct this research and produce a thesis focused explicitly and exclusively on punitive gynaecology.

My thesis attempts to answer the following main research question: In which ways does punitive gynaecology in Russia work on the female body? I will seek to find a language that would not only speak of sufferings that gynaecology patients are subject to in contemporary Russia but also about the reasons behind this suffering, about the partly unconscious articulations of power relations that put this punitive biomedical machine in motion. To answer the main research question, this paper will need to also elaborate on the following: In which ways does punitive gynaecology restructure the body? Does the body merely become a surface for the inscription of dominant ideologies? Does punitive gynaecology purport to create a monolithic assemblage of docile bodies?

To seek answers for these research questions I collected thirty-one autobiographical narratives from women willing to share their experiences with punitive gynaecology. My conceptualization of punitive gynaecology will be relevant primarily to their experiences and opinions. I will attempt to place these

autobiographical narratives within a wider framework of discourse on punitive gynaecology (both academic and popular) to produce an understanding of the ways it may work on a woman's body.

Bringing punitive gynaecology "up to date" in contemporary academic discourse is no easy task for two reasons. The first has to do with overall vagueness surrounding the articulation of discomfort in healthcare settings not only in related research but in patients' accounts. As Greenhalgh (2001) notes in her study on representations of chronically ill patients:

> Because patients have no way to articulate their inner wounds in the dominant discourse of truth, objectivity, and beneficence, however, these injuries often remain below the level of consciousness, expressing themselves in vague feelings of discomfort and distress surrounding the medical encounter. In describing these interior injuries as unintentional products of biomedical discourse and rhetoric, I am hoping to find a language in which we can speak about extrabodily patient pain—or suffering (p. 289).

The second reason has to do with the pejorative sounding of the term "punitive gynaecology". A researcher venturing to speak about the term risks coming across as someone daring to point an accusing finger in the direction of the entire medical establishment, seeking to incriminate medical professionals that are only carrying out their duties. Further chapters will explain why coming forward with a conceptualization of punitive gynaecology has little to do with imposing blame or liability.

This thesis is divided into two bigger parts: theoretical and analytical. Chapter 1 "Theorizing punitive gynaecology" begins with a provisional definition of punitive gynaecology based on Foucauldian understanding of punishment. Paragraph 1.2 proceeds to introduce concepts that are central to this thesis, such as power, discipline, medical clinic, gaze, complicity. In this brief conceptual introduction, I also outline how I expect to engage with these concepts when carrying out narrative analysis.

Chapter 2 "Contextualizing punitive gynaecology" elaborates on the contexts where punitive gynaecology comes into being. I begin with scrutinizing academic discourse on punitive gynaecology in Paragraph 2.1, first looking at wider international academia, then narrowing my field of vision to publications produced in Russian academia. Following the literature review, in Paragraph 2.2 proceed to disentangle the local sociopolitical context of punitive gynaecology. In the respective paragraph, I first look at the discourse of traditional values that gained momentum in

Russia during the last decade to locate the context where punitive gynaecology can now flourish. In Paragraph 2.3 I scrutinize the gynaecological clinic as a site where discourses on women's health become operationalized and punitive practices unfold. I also look at the hegemonic patient of the Russian gynaecological clinic, examining how discourses on hegemonic femininity seep into medical settings. I close Chapter 2 with a brief detour into the contemporary media discourse on punitive gynaecology in Paragraph 2.3. In this last paragraph, I look at the ways punitive gynaecology is reflected on in contemporary Russian media and the spectrum of meanings that become attached to this phenomenon.

Chapter 3 "Methodology" provides an overview of the methods of data collection and analysis I used when conducting this research. I start by explaining my positionality and motivation for writing this thesis in Paragraph 3.1. I then proceed to introduce the research design, explaining why narrative inquiry was singled out as the method of choice 3.2. The closing Paragraph 3.3 elaborates on the strength of narrative inquiry as a research method and on all the insecurities I needed to work through as a researcher.

Chapter 4 "Punitive gynaecology narrated" forms the analytical part of this thesis. Divided into five paragraphs, it is entirely devoted to the analysis of autobiographical narratives collected from the communication partners. Paragraph 4.1 examines the medical gaze in an attempt to outline a logic of visibility in the gynaecological clinic. Paragraph 4.2 elaborates on the spatial continuity of the gynaecological clinic, analyzing how space and gaze are interwoven in the narratives. Paragraph 4.3 speaks of the power relations in a gynaecological examination. Here I specifically apply the Foucauldian definition of pastoral power. In Paragraph 4.4 I observe how the gynaecological examination can be sexual and when this ever-present sexuality borders on violence. Finally, I close the chapter with Paragraph 4.5 where I examine the most decisive workings of power on a female body in the gynaecological clinic (those of shame, pain and surrender).

A - Theoretical part

Chapter 1: Theorizing punitive gynaecology

1.1 Possible definitions

My understanding of the term "punitive gynaecology" was first inspired by Michel Foucault's "Punitive society". As the methodology and vision of my work were partly informed by a Foucauldian vision (I write "partly" as there are many points in Foucault's corpus of work that I intend to polemize with), it now appears reasonable to delineate what the philosopher considers to be punitive techniques. In the famous series of lectures delivered at the Collège de France in 1972-1973, Foucault notes exclusion, redemption (the offender being forcibly held within a set of constraining commitments and a network of obligations), marking (leaving the marks of sovereignty on the punished body) and confinement as the main constituent elements of punishment (Foucault, Harcourt and Burchell 2015, pp. 6-10). The empirical chapters of this work will show how these elements actualize themselves in the space of the clinical encounter and how they operate on the bodily surfaces of the female patient, making it a subject of punitive practice.

This general introduction calls for at least a provisional definition of punitive gynaecology. The one that I will now outline stems from media representations of punitive gynaecology that will be elaborated on in the empirical part of this paper. This sort of rendering is a valid starting point for discussion of the term, but surely not an exhaustive explanation of it. Punitive gynaecology can be loosely defined as a set of healthcare-related attitudes and practices that tend to take control over the woman's body, sexuality and reproductive system. It can be characterized as an ensemble of unconscious behavioural strategies that female patients are subjected to in the course of a medical consultation. This dynamic creates an imbalance of power and results in the female patient being deprived of agency.

Such a definition, however, appears somewhat lacking in depth. It conjures a simplistic binary of a powerless patient subjected to an agenda of the omnipotent doctor. To avoid falling into this binary, I will rather attempt to view the actions of the doctors through the lens of "complicity/ duplicity" (Kligman 1998) to prove that the doctors are, most of the time, unknowing accomplices. Gynaecologists can remain unaware of the punitive dimension of their actions. However, their patients often reach

the emotional point where they feel that they are being deliberately coerced and punished.

It is common knowledge that a check-up with a gynaecologist is not ever a pleasant event. However, a different narrative emerges at the point when mere unpleasantness morphs into violence, symbolic or physical. This is where the term of punitive gynaecology comes into play. To begin with investigating the term, providing a more complex definition and tracking a phenomenology, it is necessary to first plunge into casual utterances that have contributed to the term becoming part and parcel of public discourse on Russian gynaecology.

Firstly, let us turn to a particular figure of speech that many a patient of a Russian gynaecological clinic recollects from personal experience. It goes as follows: "Stop yelling, you fool, everyone here is in pain!" (Gribatskaya 2018). This turn of phrase has been circulating in online media over and over with increasing frequency, becoming a legendary (for want of a better word) symbol depicting all the emotional baggage of shame and guilt that a clinic encounter with a gynaecologist comes with in Russia. This utterance has easily become word of mouth, repeated by patients that recall their experiences of pregnancy monitoring and delivery. Usually, the exclamation is uttered with the intent to silence a woman in the process of giving birth. One of the respondents for this research comes up with a remarkably on-point interpretation: "They [the doctors] are not just annoyed. They think that we are disrupting their process. Our screams make them think about us, not the baby. They want to work with a curt little body. It's like they want to punish us" (Kateryna, 27).

This way of re-thinking the experience prompted me to consider the punitive aspects of gynaecology in the first place. A vague concept began to outline itself against the backdrop of this shared narrative of shame, dehumanization (and depersonalization) and suffering. It seemed alarmingly familiar, relevant to a concept that was previously voiced and determined in multiple public and academic settings – that of punitive psychiatry (to be further elaborated on in the following section).

The "curt little body" instantly conjures up a reference to the Foucauldian docile body. If we are to look at the bodies of the female patients and perceive them as constructed and manipulable, Foucault's approach to docility becomes all the more pertinent: "A body is docile that may be subjected, used, transformed and improved" (Foucault 1977/1995, 136). This definition goes in line with the main premises of this

research that will seek to explore not only punitive gynaecology as a phenomenon but with all the different ways its' practices re-elaborate bodily materiality.

As stated previously, this thesis does not propose to lash down on the medical doctors, nor does it presume that medical staff operates with a pre-given agenda to punish. Rather, it will attempt to outline a certain power dynamic, to ground this peculiar phenomenon in context and retrieve the causes for constituting the female body as a subject to be punished.

1.2 Core concepts

This chapter will provide a brief detour into concepts that are foundational for following empirical research: power, discipline, punishment, medical clinic. I will seek to scrutinize how discipline is instilled by medical doctors, how punishment is carried out and why hegemonic femininity is so important for agendas in the space of ZKs. I will further outline how exactly I intend to operate with these concepts.

The interconnectedness of medicine, discipline and punishment has been closely reviewed by Michel Foucault. As concisely worded by Foucault in one of his lectures at the Collège de France (1972-1973): "Medicine as a science of normality of the bodies took place at the heart of a penal practice" (Foucault, Harcourt and Burchell 2015, 261).

It would be improper to view the misconduct of medical doctors as a mere realization of a pre-existing agenda, passed down by an abstract authority. Nor should a researcher delegate full responsibility to the so-called governmental authorities. Even though it is tempting to make claims about political subjects being invested in pursuing certain pre-articulated interests in "taming" and "pruning" bodies, it is important to understand that there is no specified incentive coming from "upwards". Rather, the concept of punitive gynaecology and all the disciplinary acts it entails is something produced discursively, and its' constant re-elaboration is dispersed between different powerholders. Again, we turn to a Foucauldian explanation of power and its application by institutions:

> Power relations are rooted deep in the social nexus, not reconstituted "above" society as a supplementary structure whose radical effacement one could perhaps dream of…One sees why the analysis of power relations within a

> society cannot be reduced to the study of a series of institutions, not even to the study of all those institutions that would merit the name "political". Power relations are rooted in the system of social networks" (p. 791).

Applying this framework of power will assist me to not succumb to the temptation of being carried away by this rhetorical seduction to explain "power to power" or split the "patient" and the "authority". It takes punitive mechanisms and power for punitive gynaecology to exist, and it does not cease to exist outside of the examination room or in the doctor's absence. When conceptualizing power, Foucault was drawing on Bentham's famous formulation: "Consequently, it does not matter who exercises power. Any individual, taken almost at random, can operate the machine: in the absence of a director, his family, his friends, his visitors, even his servants" (Bentham 1843/2015, p. 45).

I will use this definition when attempting to crystallize the biopolitical gist of doctor-patient encounters in gynaecological facilities. I will seek to prove that punitive gynaecology is never an established or pre-meditated routine, carried out knowingly. Nor is it in the strict sense a discrete set of random acts of punishment, happening of their own accord. Rather, it is built-in and results from the networks of power permeating the Russian medical establishment.

Instead of viewing medical doctors as agents punishing the patients' bodies, I will shift my focus to analysing their *complicity* in penal practices. I will rely on Kligman's (1998) understanding of complicity that is more cautious in regards to intentionality. According to Kligman, even active partnership in evil action may be unintentional, occurring out of fear or indifference. In this research, I will not proceed to argue that punitive techniques in Russian gynaecology are not merely a twisted manifestation of medical paternalism that seeks to interfere with the patient's bodily autonomy for their own clinical benefit (McCullough 2010). On the contrary, I will attempt to outline that punitive gynaecology benefits neither the doctor nor the patient.

Kligman (1998) speaks of state control of reproduction in socialist Romania as being managed through a "studied combination of vertically and horizontally interwoven sanctions, suspicions, fears and enticements" (p. 61). I consider this rendition of power suitable for modern Russian medical establishments as well. The sanctions and enticements are most certainly of different origin (provided the difference of contexts), and I will seek to unravel their exact source.

Applying a Foucauldian perspective to the analysis of power relations in the course of a gynaecological examination is by no means ground-breaking. It goes well in line with the existing research of modern gynaecology that uses the term of sovereign power, introduced by Foucault to describe the domination of sovereigns over subjects (Cook 2013). Foucault's conceptualizations of surveillance and gaze (Foucault 1973, 1977) are, in fact, so relevant and self-explanatory that it seems only natural to apply them to a research that focuses primarily on the marking and inscriptions of patients' bodily boundaries. One of the premises this research will try to prove is that modern gynaecology in Russia tends to produce not only docile and obedient but also reformed bodies.

Foucault argues that the body in medical encounters is not something naturally given and pre-existing. Rather, it becomes constructed through the medical examination, as well as imbued with meaning. It is not only the body that becomes a subject of re-thinking in a medical setting, but also the health issue that the patient comes forward with. Disease is not something that gets unproblematically treated in medicine (Jones 2006). Given, that gynaecology deals with issues that already come with a whole trail of societal expectations (such as reproduction, prevention of sexually transmitted diseases, intimate hygiene), it is only logical that these meanings get re-enacted in the course of treatment. The specificity of doctor-patient intercourse does not begin in the gynaecological doctor's office, nor does it end there. Contrary to the first provisional definition, punitive gynaecology begins its' mediations on the body long before the woman acquires the institutionalized status of the patient. The empirical part of this research will demonstrate when the first marks of power leave their traces on the material body, and how they go on to gnaw at the patient's materialities and subjectivities long after the clinical encounter has been concluded. In this paper, I examine how political objectives tend to be specified in the "vocabulary and grammar of medicine" (ibid).

I do not intend to turn this research into a further re-iteration of hypotheses on power relations permeating the doctor-patient relationship. I will proceed to establish a more radical perspective on intercourse in the clinician's office, attempting to uncover when a medical examination merges into actual punishment, pushing forward the tentative hypotheses on the controlling function of medicine.

"Embodiment", "disciplinary power", "lived objectivity", "bioethics", "surveillance", "clinical gaze", "doctor-patient relationship" are several further

concepts central to the terminological apparatus of this research. The main sources I used to expand my knowledge of these concepts are: "The birth of a clinic: the archaeology of medical perception" (1960), "To discipline and punish" (Foucault 1977), "The birth of biopolitics: Lectures at the College de France 1978-1979" (Foucault, Harcourt and Burchell 2015).

It was important to study "Discipline and punish: the birth of a prison" thoroughly to develop a well-centred perspective on punishment itself and on how penal systems are subject to change according to historical periods and dominant discourses. This fundamental Foucauldian work helped me study the "economy of publicity" in punitive techniques and how they get enacted in gynaecological medicine in particular. And, of course, this is so far the most extensive and comprehensive of all existing publications on power, control and docility.

"The birth of the clinic" (Foucault 1963) offers insight not only in the spatiality of clinical encounters but also into the concept of the "clinical gaze". Foucault starts with acknowledging the "reductive gaze of the doctor" and ruminations on the restrained nature of clinical discourses (…[their] abandonment of systems…lack of philosophy, all so proudly proclaimed by doctors) and proceeds to re-think the "collective structure of medical experience" (Foucault 1963/2003, p. 19). Studying the Foucauldian notions of the medical gaze is crucial for the reason that this research will be reliant on them. At the same time, it will re-think and reconstruct the reality of "gazing" and "viewing" in Russian gynaecology. This research will seek to establish that a doctor's gaze in the said context is everything but reductive and that the studied medical discourses are everything but philosophically lacking.

Taking into account the centrality of Foucauldian perspectives for this paper, it is nonetheless important to re-consider them to avoid researcher bias and rejection of other pertinent theories, especially when it comes to theories of bodily materiality. For example, Bordo re-examines the Foucauldian perspective in "Feminism, Foucault and the politics of the body" (1999). In her critical re-reading, Bordo formulates the reasons why Foucault's take on power is still attractive for the contemporary researcher: "…Modern power is non-authoritarian, non-conspiratorial, non-orchestrated, yet it nonetheless produces and normalizes bodies to serve prevailing relations of dominance and subordination" (Bordo 1999, p. 26). This statement re-asserts why the Foucauldian perspective of power is so important for this research that claims itself separate from any kind of conspiratorial theories when it comes to power

relations in medical settings. A further relevant point Bordo makes deals with the ways power always entails resistance. This conceptualization will assist me to argue why the construction of docile bodies by post-Soviet punitive gynaecology is neither monolithic nor simplistic, as it may seem at first glance. Bordo underlines that it is precisely this seemingly simple docility that can be culturally transforming (ibid).

This paper is obligated to be interdisciplinary to be able to introduce its' points. The research will assemble and re-think insights from fields like gynaecology studies, embodiment theories, medical geography studies (when considering the spatiality of doctor-patient intercourse), studies of reproduction.

The notions of the gynaecologist's gaze and visuality in the doctor's office will undeniably be central for this paper. Contemporary visuality has been associated with gynaecology previously on a significant number of occasions at the intersections of art and science. Uparella and Jáuregui (2018), for example, produced an extensive essay on sovereign vision and the vagina where they closely observe the gyneco-scopic regimes of modernity.

Chapter 2: Contextualizing punitive gynaecology

2.1 Punitive gynaecology in academic discourse

When selecting and studying theoretical literature for this research, I faced an imminent dilemma. Provided that the research focused on women's experiences in Russia, one would expect to rely at least partially on sources authored by academicians from the post-Soviet area. However, the result of a primary inquiry into "domestic sources" was thoroughly disappointing: it proved almost impossible to locate any substantial analyses dealing with the topic.

As maintained by (Visweswaran 1994) in her recommendations on feminist research methods, a researcher should attempt to "hear" the silences and make sense of them, instead of seeking to dramatize them. The absence of a constituted discourse on punitive gynaecology in post-Soviet academia is in itself a very important finding. The opening chapters of this paper mentioned that the term of punitive gynaecology has not yet been incorporated into academic discourse, thus, the absence of findings is, one the one hand, not surprising. On the other hand, it proved problematic to seek out literature that would deal with markers of punitive gynaecology even without the explicit mentioning of the "parent phenomenon" (such as abuse of power, verbal abuse, hiding information from the patient). For this reason, it was necessary to turn to international academia to single out relevant sources even sooner, than expected.

For the sake of convenience, I have divided the literature into "geographical" blocks. The first block includes academic literature in English, covering directly the theorizations of doctor-patient encounters in the course of a gynaecological examination. Overrepresentation of authors of European and American origin is a pronounced feature of the second block. In this instance, an ethical question arises: can the researcher stay true to the principles of standpoint epistemology, but still turn to evidence from different social, political and cultural locations to theorize experiences emerging within a spatially limited and very specific context? Applying enlarged optics to a phenomenon that originated in Russia will allow for "expressing democracy in the text" (Braidotti 2018) and fostering the collective production of knowledge.

The second block deals with the academic literature on the intersections of medicine/psychology/law written in Russian. The sources of this block provide an overview of patient positioning and clinical relationships in modern Russian medicine.

2.1.1 International academic literature on doctor-patient encounters

Even a superficial excursion into academic literature published abroad is sufficient to determine that the topic of gynaecological examination has been theorized in terms of embodiment, ethics and materiality on many occasions. The cartography of international literature is diverse and certainly not limited to specific institutions/research bodies/ publishing houses. Many academicians have been keen to thematize and decipher the invisible forces at play in the gynaecological clinic.

For the research to be centred and well-balanced, a clear conventional definition of a gynaecological examination is in order. It appears to be a shared representation that a gynaecological examination is simply a process where a doctor examines a woman's genitals in a medical setting (Emerson 2008). However, there is a variety of nuances to the term that needs to be theorized to come up with an interpretation of the event of examination. What exactly is a "medical setting", and to what extent is the idea of it socially constructed? Should it conform to the principles of neutrality and lack of intimacy? In this case, is it possible to view the examination as a routine medical procedure, even if it involves a doctor's somewhat "privileged access to the patient's private parts" (ibid)? Is it possible to take precautions to prevent the intersection of medicine and intimacy, and is it really necessary?

Most academicians dealing with the reality of gynaecological examination note the importance of perceiving the procedure as a "medical situation". This performance of a medical situation is needed to ensure a patient's cooperation without threatening her dignity (Emerson 2008). Thus, the woman as the subject of the examination appears to be depersonalized and her body somewhat "dismembered", as the gynaecologist tends to view the private parts as separate from the actual body. However, doesn't the forced neutrality limit the exploration of feelings or the display of any "overt criticism by patient or doctor" (Meerabeau 1999)? It has been suggested by Giuffre and Williams (2000) that the use of objectification in highly scripted performances is necessary to desexualize the process. Stewart (2005) also describes the doctor-patient interaction as "highly ritualized", regarding it as a "strategy for establishing power differentials" (p. 587). Desexualisation can also be a useful technique of putting the patient at ease when in a shared environment with a male doctor, decreasing the suggestiveness of him being alone with a female patient (Emerson 2008). On a different note, desexualisation can be driven by the very

organizational context of the medical sphere and the related habits (Giuffre and Williams 2000).

There is no doubt that personalization and depersonalization is generally a hot topic reflected in both academic research and lived experience. Many of the research participants associated the punitive aspect of their gynaecological examinations specifically with being reduced to an assemblage of body parts. Others noted that gynaecologists made depreciating assumptions about their entire personality based on the outcomes of the examination and wished that the doctors focused solely on the medical problem instead. This repetitive oscillation between absolute neutrality and unasked-for intimacy appears to be particularly relevant when trying to arrive at a definition of "punitive gynaecology". Is it possible that a gynaecological examination can potentially turn into a punishment when the intricate balance between neutrality and intimacy is swayed in either direction? Moreover, may it be possible that maintaining a balance between personalization and depersonalization is what makes a gynaecological examination just?

The interpretation of a vaginal examination offered by Henslin & Biggs is especially appealing in this particular regard. Even though the authors do not attempt to deny the depersonalizing effect a pre-set series of rituals can have during the examination, which constructs the vagina as a "cooperative object" (Meerabeau 1999), their classification still leaves room for the consideration of the patient's humanity. Henslin and Biggs list the examination phases as following: 1) waiting room stage (pre-patient) 2) the personalized stage 3) the depersonalizing stage 4) the depersonalized stage ("the person as the pelvic"), repersonalization (Henslin and Biggs 2007). This break-down of phases, albeit idealistic, is the one that I believe to be the most pertinent for a medical examination. In the course of narrative inquiry, I will devote special attention to potential deviations of the doctor or the patient from this sequence of events.

Both Meerabeau (1999) and Emerson (2008) note reduced eye contact during a gynaecological examination. While Meerabeau scrutinizes the gaze of the patient, linking eye contact reduction primarily to embarrassment, Emerson goes on to trace the direction of the doctor's glance. She specifically notes the "unavailability of an acceptable place to rest the eyes", simultaneously noting that the logical focus (the patient's internal parts) is not accessible (ibid). The concept of gazing is central to Foucauldian interpretations of the medical encounter. Meticulous, loquacious,

empirical are some of the few adjectives used by Foucault (1963) to describe the gaze in his famous “Birth of a clinic”.

Studying the gaze is essential for the reason that the empirical part of this paper will endeavour to track the encounter of gaze and body in the gynaecological examinations. It is important to map the gaze in Foucauldian terms, to see it as a source of clarity, as something that brings darkness into light, that directs itself to the “basis of the patient” (ibid, p. 9). The directions of the glance may be manifold and speak volumes on the construction of boundaries in clinical relationships (Frank 2002). The subject of gaze and genitals intersects many spheres of inquiry. Gyneco-scopic regimes in art covered by Uparella and Jáuregui (2018) became one of the most important inspirations for this paper, helping to theorize the focalization of the vagina across various regimes of visual sovereignty.

Provided that the essay by Uparella and Jáuregui mostly touches upon matters of art, therein emerges the definition of gyneco-scopic visuality that may be applied to this research. Drawing on Foucauldian terminology, the essay provides one of the few straightforward mentions of gynaecology and the eye by scrutinizing how the vagina gets represented by the artist.

The essay presents early anatomists as “great men of science” that are by default validated by their “gender, social class and academic positions” (Uparella and Jáuregui 2018). The power hierarchy becomes even more apparent as the authors go on to provide an overview of how the “early fathers of gynaecology” obtained the bodies for observation. Drawing on the controversial work practice of the famous nineteenth-century anatomist and physician Dr William Hunt, the authors go on to recap in which ways the gaze of the gynaecologist rested on the bodies of those observed. The widespread practice of gaining knowledge by examining bodies of executed criminals allows for defining the anatomical specimen as the “corpus delicti”, in other words, “the body of a crime” (ibid). Thus, the first bodies that allowed deep scrutiny were the so-called “criminal bodies”. These bodies were lifeless, obedient, docile, showing no resistance to the omnipresent gaze of the potent doctor. This metaphor, albeit taken to the extreme provides for the emergence of one of the pivotal thematic tenets of this paper and path the way for the question of the gaze and agency.

According to Uparella and Jáuregui, the gyneco-scopic regime is founded in “the synecdochal slice, the product of a gaze that cuts the body into pieces, making

visual, anatomical and aesthetic cuts to produce territories of genital organs. These chunks of the body are recodified as synecdoches (that is, the part represents the whole: woman is represented by a piece of herself, genitals represent gender, etc.)" (ibid, p. 81).

It is essential not to take this synecdoche literally, as it would deprive both the patients and the health professionals of humanity and agency, limiting them simply to body and gaze. It is best to take the metaphor as a starting point and see to what discoveries it can lead us in the observations of agency and power relations in the doctor-patient relationship. Is it possible to find parallels of this incriminating discourse in modern gynaecology? Is the body of the patient still perceived as the "corpus delicti" in certain instances of the doctor-patient interaction? How does gyneco-scopic sovereignty play into the fabric of the doctor-patient relationship?

Readings about the gaze in gynaecological settings helped me shape the anticipations of empirical analysis. It was clear from the beginning that scrutiny of the gaze would be no easy task, provided that the gaze can have a different structural expression in the specific architecture of clinical space. The circulation of the medical gaze always takes place in an enclosed space where it is "controlled only by itself, in sovereign fashion" (Foucault 1960). That said, the gaze does not strike decisively through clinical space to distribute knowledge and meaning, it does not rest only on the patient's body, but also rests on objects and obstacles, like screens in waiting rooms (or their absence), the positioning of the gynaecological chair, windows and the arrangement of objects in the clinician's cabinet. Explorations of patienthood modalities in waiting rooms (Skřepská 2013) and the positioning of the patient on the examination chair (Ehrnberger et al. 2017) provide valuable insight on the interconnectedness of space and gaze and the impossibility of studying one without the other in empirical analysis.

The controlling function of medical practices has been theorized extensively in international academia. Again, we cannot underestimate the importance of studying gaze and space when speaking of control. The subject of surveillance in gynaecology is mostly thematized within a framework of technology (performance of ultrasound and other screening procedures). Kukla (2011) voices it especially straightforwardly in her book devoted to the bodies of mothers: "…New pressures on maternal bodies to serve as seats of civic harmony and moral order converged with institutionalized medicalization and with the corresponding quest to open up the space of the womb for

public surveillance, examination and scientific regulation – opening the gendered interior to the non-gendered public gaze" (p. 107).

Kukla goes on to speak of manipulation at the level of policy, insisting that "the insides if a pregnant women's body comes to have a distinct institutionalized public status" (ibid, p. 108). Thus, a compulsory visibility of the uterus emerges in a Foucauldian sense, while the personhood of the woman remains muted, insignificant: "Disciplinary power…is exercised through its' invisibility, at the same time it imposes on those whom it subjects a compulsory visibility. In discipline, it is the subjects who have to be seen" (Foucault 1977/ 1995, p. 187).

Compulsory visibility in women's health is more often associated with the pregnant/maternal body. This paper will operate with the term extensively to uncover how the modes of visual sovereignty and compulsory visibility function to discipline a wider selection of bodies in the gynaecological examination, not necessarily limited to pregnant bodies.

The subject of the doctor-patient relationships has inspired many papers and even paved the way for the introduction of new methodologies. As noted by Carson (2002), narrative theorists of medical ethics purport that the doctor-patient relationship can be improved by animating dialogue about the patient experience. While existing research can be characterized as slightly more patient-centric, it does not exclude the voices of the doctors. They, too, come forward with empathetic perspectives on the distress clinicians may in turn experience throughout the examination (Cook 2013).

The anxieties of the patients echoed across different research papers are as follows: embarrassment about undressing, worries about cleanliness, qualms about vaginal disorder (Hilden et al. 2003). The feelings of shame and guilt incited by physicians are discussed in a wide range of papers (Darby, Henniger and Harris 2014; Glover, Novakovic and Hunter 2002; Grundström, Wallin and Berterö 2011; Hilden et al. 2003). The subject of reproductive shame is implicitly pre-supposed even before the patient enters the space of the clinical encounter (Johnston-Robledo et al. 2007). The overall importance of shame and embarrassment for my research topic prompted me to scrutinize shame globally in terms of how the affective economy of shame can shape individual existences (Ahmed 2004; Wüschner 2017).

The above works mostly reflect on the workings of power in individual doctor-patient encounters. However, clinical relationships can be woven into a larger

framework of oppression, where the state develops a heavy symbolic presence and proactively shapes clinical boundaries between doctor and patient.

Dorothy Roberts elaborates on the racial dimension of reproductive oppression in her book "Killing the black body: Race, reproduction and the meaning of liberty" (1997). Roberts scrutinizes the American state's punitive response to Black motherhood. She works with the example of prosecution of drug-dependent Black mothers. One of the most common punitive techniques was the incarceration of Black women for drug use in the course of pregnancy. Another method, at times replacing incarceration, was the insertion of the contraceptive Norplant into the woman's body.

This is where the institution of obstetrics and gynaecology comes into the story: Norplant was embraced by politicians and was mandated in criminal cases. The woman was often given a choice between serving substantial jail time or inserting Norplant as a birth control method. This would prevent the woman from getting pregnant while on her probation period, as judges and politicians declared her unable to mother a child during this time. The woman herself was not able to remove Norplant (as it basically worked as an implant), which left her fully at the discretion of the authorities (ibid).

Thus, the woman's body was both marked (by the implant), excluded (from motherhood), confined (within a network of constraining obligations). The above intrusions into the woman's bodily materiality are all indicative of an event of punishment in a Foucauldian sense.

Gail Kligman touches upon the medicalization of repression in her work "The Politics Of Duplicity: Controlling Reproduction In Ceausescu's Romania" (1998). Kligman explores how obstetrics and gynaecology were directly involved with the production of acceptable demographic methods in the context of declining fertility. Selective surveillance in maternity wards of hospitals, women being forced to take a pregnancy test during routine medical check-ups is only some of the many coercive methods of control that Kligman outlines. Decree 770 accepted in 1966 banning abortion in almost all circumstances served to straightforwardly legislate and penalize reproductive behaviour.

Kligman explicitly uses the terminology of discipline and punishment, devoting an entire chapter to "disciplining and punishing the medical body". She speaks of women's bodies being pervaded by the state, their boundaries policed by aggressive prenatal care. While postulating doctors as agents aiding the state, Kligman

contends that doctors themselves were "caught in a web of institutionalized surveillance". Together with that, her comparison of hospitals' chief obgyns to "watchmen" conjures a very strong Panoptic image in the best Foucauldian tradition.

A different angle a state can pursue is encouraging only specific categories of citizens to reproduce for the sake of hitting pronatalist targets while penalizing the fertility of certain social groups. Věra Sokolová investigates this phenomenon in the context of policing the bodies of Roma women in communist Czechoslovakia. Sokolová (2008) draws on Roberts (1997) to uncover the ways punitive medicine takes on a racial dimension, targeting specifically the bodies of Roma women and preventing them from exercising their reproductive rights. One of the main punitive practices Sokolová describes is forced sterilization of Roma women that often happened in the wake of delivery of the first child. Sterilization was carried out without obtaining the woman's consent, often when the woman was unconscious under anaesthesia. Sokolová draws on some of the main arguments of Kligman, viewing medical doctors as deliberate agents of punitive practices.

2.1.2 Russian academic literature on gynaecology

Which are the contexts that allow for the emergence of the concept of punishment in contemporary medical discourses in Russia? The concept of "punishment" in medical situations tends to emerge at the intersections of clinical and legal frameworks. If we look at the sphere of genital disease in particular (that is more relevant to gynaecology, although not exclusive to it), the "crime and punishment" dichotomy holds prominence in relation to the criminalization of sexually transmitted diseases.

The RSFSR law from the year 1960 first paved the way for theorizing punishment in medical contexts. According to paragraph 115.1 of the law, criminal prosecution was in order if the patient proved not cooperative enough in treating his STD-related health condition or avoided treatment altogether. Following the enactment of this law, medical institutions and legal bodies gained the right to directly interfere in and control an individual's intimate health.

Paragraph 121 of the currently valid Russian Criminal Code (1996) envisages liability for prosecution if the individual suffering from the disease intentionally

endangers other individuals by subjecting them to the disease (for example, being careless about contraception).

Thus, the idea of punishment in a Russian context intersects with the medical field mostly in contexts lying within a legal framework. Legal punishment is imposed to sanction individuals whose careless sexual behaviour may endanger the health of others.

Matters of doctor-patient interactions in gynaecology are being raised with increasing frequency in contemporary academic literature. The existing literature on the subject is by no means monolithic. To illustrate the divide in contemporary thought on Russian gynaecology, it is best to separately outline examples of research both in medical and social sciences literature.

I agree that any such cartographic account is "necessarily selective, partial and never exclusive" (Braidotti 2018, p. 33). I do not attempt to generalize the methods and findings of medical literature. Rather, the below examples demonstrate representations of medical authority and patienthood that somehow stand out in contemporary medical literature on obstetrics and gynaecology in Russia.

For example, a study of the violation of medical ethics in paediatric gynaecology by Balasanyan and Mikirtachian (2004) was published as a contribution to a professional medical journal of obstetrics and gynaecological diseases ("Zhurnal akusherstva i zhenskih boleznei"). The study was carried out utilizing highly structured questionnaires whose contents appeared generalized to an extreme. For this study, mothers were encouraged to express their attitude to interactions between their daughters and their treating doctors by selecting a type of emotional reaction from the scale of "absolutely impermissible – very positive". Semi-structured or unstructured testimonies or additional comments were not gathered from women. The voice of the actual patient is bypassed altogether, mothers are left to speak for their daughters from a position of authority. The underage patient is in turn, dismissively depicted as "an individual not mature enough, lacking sufficient autonomy to be able to formulate their preferences and protect their well-being" (Balasanyan and Mikirtachian 2004, p. 117). The authors go on to describe parents as "often possessing a poor culture of communication and a great degree of distrust for the doctor" (ibid, p. 119).

This highly structuralized method of knowledge production does not allow for the inclusion of patients' lived experiences in the research. While the choice of quantitative methodology appears reasonable for research in the medical field, an

exploration of doctor-patient interaction would call for a more personalized model of inquiry.

Medical discourse on gynaecology tends to echo the sociological concerns on "authoritarianism" in the doctor-patient relationship. In some instances, sociological perspectives get incorporated into research carried out in the medical field. Doctor-patient relations become a subject of scrutiny; however, the doctor's point of view is privileged to that of the patient. A study of gynaecologist's roles in the process of birth delivery exposed two types of dispositions doctors can have towards their patients: "soft paternalism" and "hard paternalism" (Tkachenko et al. 2017). Little is voiced in regards to possible standpoints in-between the two ends of the spectrum.

Another striking feature of professional discourses on gynaecology is frequent superficiality and general nature of research questions, carelessness in using loaded terminology and overall eagerness to indulge in defending certain vested interests. Some authors straightforwardly demonstrate engagement with state ideologies and religious beliefs. Academic papers tend to apply bioethics as a central concept, the term appearing to relate mostly to the dispositions of medical practitioners. For example, the woman seeking medical help can be described as merely an "anxious personality" (Aylamazyan and Tsvelev 2004, p. 94) without any deeper inquiry into the causes of such anxiety. Moreover, this anxious disposition is explained as a pre-existing condition that might be provoked by the environment of the gynaecological examination but is never deemed to be a result of it. The doctor, in turn, is pictured as the party "exhibiting patience without limits" (ibid).

In certain instances, the focus of bioethically oriented research tends to shift from the centrality of doctor-patient interactions and include the unborn. Pro-life dispositions are actively brought forward in a pejorative and rhetorical manner. Aylamazyan and Tsvelev (2004) delineate the rights of the embryo as one of the most important bioethical problems. The authors proceed with his line of argument by stating that it is difficult not to agree with the position of the Russian Orthodox Church (ibid), thus making evident their embeddedness in a specific sociocultural context. The volume of publications becomes increasingly high when it comes to the intersections of bioethics and assisted reproduction, with authors going into great detail while attempting to define the rights of the unborn.

I cannot help noting the degree of pathos authors tend to exhibit when describing what the doctor-patient interaction should ideally look like. The specifics

of a gynaecologist's profession demand "pronounced compliance with the principles of medical ethics" (Balasanyan and Mikirtachian 2004, p. 117).

Taking into account all of the above, it is evident that the patient remains strangely voiceless and depersonalized in academic accounts and theorizations, while the figure of the doctor gains especial prominence and significance. Even though academicians do not deny that doctors might develop unethical and antagonistic dispositions in the course of the gynaecological examination, questions of control, corporeality, power, hierarchy and punishment remain largely unexplored.

Evidence of a more holistic approach can be found in literature from the social sciences. This type of approach takes into account the social aspects of doctor-patient interaction throughout the encounter at the gynaecologist's office. Attempts to offer a refreshing perspective on the patient's lived experience date back to the aftermath of the Soviet Union demise. One of the earliest works capturing the challenges of patienthood in an obstetric clinic was published as part of an anthology dedicated to the history of repressions in the USSR. The collection of texts emerged as a result of a year-long project of young historians (mostly students in their last year of studies) covering the history of totalitarianism. It is noteworthy that the anthology was published by the Memorial society, one of the best-known human rights groups in Russia.

In her work "Nashi sovremennitsy o rodovspomozhenii v Rossii" ["Our contemporaries on obstetrics in Russia"] (1996) the author Belousova scrutinizes the post-Soviet obstetric clinic as an oppressive social institution that partly assumes the legacy of centralized communist medicine. The author relies on thirty-two qualitative interviews with women of different age categories and diverse social backgrounds. While contending that medical institutions were going through a liberation of sorts following the collapse of the Soviet Union, Belousova writes that the power dynamic of obstetrics remains the same: the dominant position of the doctor and the passive, subordinate position of the patient. The author speaks of home birth as a viable alternative to delivery at public hospitals. However, she notes that the practice of home birth is very new to Russia and thus only at the beginning of its development. Belousova contrasts the limited agency of the Russia patient with that of the patients in developed democracies:

In democratic [Western] countries, the authoritarianism of the doctor in the system of obstetrics has a more civilized character (the woman in childbirth has a

range of rights and guarantees and is insured from upfront abuse), whilst in countries with totalitarian regimes, this factor may have perverse, ugly dimensions, often bordering on unlawful action.

The circumstance that Belousova's work was published as a part of an anthology devoted to studies of totalitarianism further underscores the strong link between abuse in obstetrics and the character of the political regime. The author writes about patients' experiences in obstetrics in the wake of the Soviet Union demise, contrasting them rather unambiguously with patient treatment in "Western" or "European" democracies, even though her bibliography does not provide a substantial list of sources on the state of affairs in Western medicine. Regardless of this shortcoming, Belousova's work remains a landmark of early post-Soviet qualitative research on obstetrics. Provided the scarcity of literature on obstetrics for this historical period, Belousova's work is extensively quoted in later works on the topic.

Situating the gynaecological patients' experience in the framework of an authoritarian institution is an approach applied in the later 1999 publication by Shepanskaya "Mifologiya sotsialnych institutov: Rodovspomozheniye ["The mythology of social institutions: obstetrics"] (1999). This research paper focuses primarily on women's perceptions of their experience at public obstetric clinics and explores the metaphors women unintentionally use to describe the process of birth-giving (metaphors of "death", "animality", "motherhood"). Both Belousova (1996) and Shepanskaya (1999) speak of home birth as a way of demonopolizing institutional power in post-Soviet obstetrics. It is noteworthy that neither author operates with the concept of corporeal punishment in their respective work, mostly framing patients' experiences like abuse or violation of rights.

The turn of the century brings about more extensive studies of doctor-patient encounters in the course of gynaecological examinations in general, not necessarily limited to the field of obstetrics. Authors tend to look into aspects of trust in the doctor-patient relationship during the gynaecological examination (see Zdravomyslova 2009; Zdravomyslova and Temkina 2011; Temkina 2017 etc.), the concept of care (Borozdina 2010; Larivaara 2011 etc.), and the medicalization of treatment (Temkina 2011, 2015). A very large body of work related to the sociology of the Russian gynaecological consultation was produced at the Department of Sociology and Political studies of the European University at Saint Petersburg (under the wing of the Gender studies program). The University hosted the publication of two anthologies

that are invaluable to the study of reproductive medicine, gynaecology and obstetrics in contemporary Russia: "Zdoroviye i doveriye: gendernyi podhod k reproduktivnoi meditsine" ["Health and trust: the gendered approach to reproductive medicine"] (2009) and "Zdoroviye i intimnaya zhizn: sociologicheskiye podhody" ["Health and intimate life: sociological approaches"] (2011).

This way, the cartography of the sites of knowledge production is somewhat skewed, with Saint Petersburg (and, specifically, the European University) becoming a centre of research on power relations in gynaecology. This can be explained by the overall European orientation of the University and its' vast network of connections with other European Universities. The positionality of the academicians at the University was formulated by professor Vladimir Y. Gelman, one of the leading political scientists in Russia: "The European University's problem is that it is European…The set of principles followed by our school — academic freedom, self-organization, and international openness — is the opposite of the one followed by today's Russia: centralized control, power vertical and isolationism".

Saint-Petersburg becomes a site for knowledge production also for the reason of its' geographical proximity to Europe. Rotkirch and Kesseli (2010) note that Saint Petersburg is somewhat of a European city from a cultural perspective, which makes it an interesting site to research fertility patterns compared to Europe. The publication by Rotkirch and Kesseli on the Russian tradition of family births was a part of the project on fertility patterns and family norms sponsored by the Academy of Finland. Research published in the same year on health services utilization across three women's clinics at Saint Petersburg provides a note on the site of research, describing Saint Petersburg as a "rather privileged and wealthy part of Russia…[that] does not provide a typical example of the whole country" (Dubikaytis et al. 2010). Saint Petersburg also became a site of research for Meri Larivaara of Helsinki University in her exploration of reproductive health services and gynaecologists' power-knowledge for her PhD (Larivaara 2012).

This way, scrutiny of power relations in Russian obstetrics, gynaecology and fertility tends to be carried out against a backdrop of European-oriented academic research, with European scientists directly contributing to knowledge production.

My approach to the power-knowledge entanglement in gynaecological examinations was largely informed by perspectives of Saint Petersburg-based research. When I first formulated my intention to operate within a Foucauldian

framework in the study of gynaecological power, I relied on these works in particular to set me en route.

One of the first topics that come to mind when thinking about discipline in women's health services is that of abortion. The research on trust-based cooperation in the doctor-patient relationship by Zdravomyslova and Temkina (2011) theorizes the contemporary Russian female body in terms of continuity of Soviet abortion culture, straightforwardly mentioning the aspects of power and discipline: "Modern young women do not perceive the procedure of abortion as a punishment that disciplines the body" (Zdravomyslova and Temkina 2011, p. 233). While opinions may differ, the topic of discipline enforcement in the practice of abortion remains a contestable territory. Even though this paper does not engage with narratives on abortion (due to lack of access), it will attempt to crystallize the disciplinary techniques that permeate the very structure of any gynaecological encounter and argue that a routine visit to a gynaecologist may in itself be a disciplining process.

Another disciplining technique in the context of the women's health sphere that immediately comes to mind is that of contraception and medicalization of reproduction. The topic was extensively covered by Temkina in several papers (Temkina 2011, 2013, 2014, 2015). Temkina explicitly frames the medicalization of reproduction as a resource of power for gynaecologists as a professional group (Temkina 2013). In a later paper, Temkina draws extensively on perspectives offered by Davis-Floyd and Rivkin-Fish in the late 1990s to situate the patient in "technocratic" discourses, where the body is understood as lacking perfection and always requiring external assistance (Temkina 2014). The attitudinal variable of the "technocratic" explanation was also utilized by Krasilnikova (2011) in her research of doctor role enactment, where she observed two different gynaecologists at work. Whilst one treated her patients in a "technical" manner, perceiving them as "objects of examination", the other treated her patients in a "personalized" manner, by maintaining a friendly attitude, inquiring about their families, etc. The "technical" doctor perceives the patient as an "incubator", whose main aim is to carry a child term and give birth (ibid).

Further analysis is carried out in Temkina's work "The gynaecologist's gaze: Inconsistent medicalization of contraception" (2015)

. In the introduction to her work, Temkina uses the no uncertain terms of "discipline", "tactics" and "agents" to outline the purposes of her research: "I explore

the disciplining discourse and tactics of gynaecologists as experts who aim to orient women towards properly planned and prepared pregnancy…Gynaecologists are important agents of reproductive control because they instruct women in detail about reproductive health and contraception" (Temkina 2015, p. 1527). Pronatalist incentives and the way they are articulated in the medical field are important tenets of Temkina's vision. She seeks to underscore that gynaecologists have an agency of their own when retranslating governmental imperatives to the patients and "are aligned to state pronatalist goals by prioritizing services for pregnant women" (ibid, p. 1544). She purports that "women are presented unambiguously as mothers who should regulate their life and take responsibility for their fertility with the help of contraception" (ibid).

Temkina thus crafts an image of a gynaecological doctor who is a dominant authority figure, fully in control of the situation and, to some degree, always politically conscious, aligned to the pronatalist values. The figure of the patient is somewhat submissive, subject to moralization and criticism for their choices and behaviour. When analyzing how doctors see their patients, she notices that their judgements follow a binary logic. Women can be either disciplined (always following the doctor's advice, proactively planning a pregnancy or ruling it out by using contraception) or undisciplined ("…doctors do not consider women to be responsible, others are identified as ignorant, irresponsible or undisciplined" – ibid, p. 1539).

As indicated by the above review of existing literature on Russian obstetrics and gynaecology, the figure of a doctor represents more than a mere provider of medical services. The doctors seek not only to educate the patients in terms of women's health but also use constant surveillance as a tool to discipline the gendered and sexed bodies of the patients (Krause and De Zordo 2012).

Overall, scrutiny of academic literature on a worldwide scale was beneficial for expanding the cartography of local ("Russian") knowledge and for discovering new foci of analysis. Discourses on gynaecology, technologies of clinical encounter have been studied extensively from perspectives of power, knowledge production, corporeality.

In light of the overview presented above, a clear dichotomy between post-Soviet and Western academic literature on societal aspects of gynaecology presents itself. Challenging this dichotomy appears to be an increasingly difficult task for the reason that the nature of this spectrum is not merely ideological. The overall isolated

character of Soviet medicine has seeped into contemporary Russian medicine and continues to reproduce itself. Most of the analysed publications present extensive use of self-referencing and do not engage in publishing about socio-medical problems. Science studies reports articulate the relatively recent tendency of Russian medical researchers to publish in international journals with an established reputation before they even consider contributing to Russian medical literature (Vlassov and Danishevskiy 2008). This creates a somewhat grey area where Russian medical science is concerned. It remains encapsulated in the compartment of Russian-language science that is not well-reflected by world citation and international databases (ibid).

When scrutinizing contemporary medical discourses, I cannot exclude the significance of the so-called "Soviet heritage". Looking back at the research methods and ways of knowledge production in the Soviet period, the application of a positivist epistemology throughout the entire body of research is apparent. While the "progressive" Saint-Petersburg centred body of sociological and anthropological research presents a welcome enclave, it remains somewhat detached from the entirety of the sociological scene and does not seem to be cited in medical literature.

This literature review shows that path departure is of extreme importance for this research. As mentioned previously, post-Soviet academics have for the larger part been inclined to using quantitative methodologies to study patients' experiences and dispositions. Even though narrative medicine is claimed to become "increasingly central to medical contexts" (Richards and Macnaughton 2016), this observation remains largely inapplicable to conventional ways of knowledge production in the post-Soviet areas. Using patients' narratives to theorize clinical encounters will hopefully open up new possibilities for the scrutiny of medical situations.

The reasons discussed above make it impossible for me to estrange myself from the problematic binary of Wester-Eastern knowledge production. Thus, it remains a crucial task to negotiate context-awareness to make up for this missing pillar. Even though it is impossible to disengage oneself completely from this academic dependency on Western literature, it remains within my reach to locate common themes in Euro-American-centric visions and local post-Soviet counter-narratives. Theorizing lived experiences without neglecting their embeddedness in local contexts will allow me to discover a unique pronunciation of the world – not generalized, yet not exclusive to a certain location

2.2 The socio-political context of punitive gynaecology

2.2.1 The discourse of traditional values

This chapter will elaborate on the context that made it possible for this research to emerge. I would not like to presume that punitive gynaecology as a phenomenon is limited to the geographical and biopolitical boundaries of Russia (or the post-Soviet area) only. There is no doubt that it is spread wider, if not worldwide. However, methodological convenience calls for limiting the geography of this research to Russia, given the specificity of local biopolitics and the discourse of "traditional values" promoted by the Russian Orthodox Church.

The normative, moralizing discourses of "traditional values" as opposed to the "moral decay" of the West (Makarychev and Medvedev 2015) are especially fascinating when contextualizing punitive gynaecology. To analyze boundary violation in medicine, it will prove fruitful to first look at a wider context, where the permissibility of state interventionism into the private is explicitly articulated. The following paragraphs will scrutinize several documents crucial to understanding the regulation of citizens' subjectivity from above.

The discourse of traditional values officially emerged in Russia between 2009-2012, when the UN was reviewing resolution 12/21 'Promoting human rights and fundamental freedoms through a better understanding of traditional values of humankind" offered by Russia (and worked on with the participation of the Russian Orthodox Church). The final accepted version of the resolution did not contain the normative traditionalist agenda, nor constructive input from Russian traditionalist actors (Stoeckl 2016). However, the notion of "traditional values" lingered, with the Russian Orthodox Church becoming the primary agent enforcing the related moral norms (ibid). The "Concept of family policy" document published in 2013 proposes to give the Russian Orthodox Church the right to interfere in the state's family policies (Makarychev and Medvedev 2015).

The discourse of "traditional values" serves to ensure hypervisibilation of heteropatriarchal patriotic masculinities (Stoeckl 2016), to enforce remascunalization and refeminization of the population (Dukhanova 2018), to manipulate citizens into aligning themselves with hegemonic ideals of masculinity and femininity. The importance of adhering to traditional values is heavily underscored at the level of

political discourse. Paragraph 78 of the Russian National Security Strategy (2015) offers the following rendering of traditional values:

> Traditional Russian spiritual and moral values include the priority of the spiritual over the material, protection of human life and of human rights and freedoms, the family, creative labour, service to the homeland, the norms of morals and morality, humanism, charity, fairness, mutual assistance, collectivism, the historical unity of the peoples of Russia, and the continuity of our motherland's history.
>
> (Russian National Security Strategy, 2015, par. 78)

Albeit the definition offered in Paragraph 78 is vague, it is obvious that the censoring of gender relations is declared a necessity. According to Ukhova (2018), "traditional values" happen to be referenced in several legislations: The 2013 anti-homopropaganda law, the 2014 Concept of the Russian Federation's State Family Policy up to 2025, the 2016 proposal to exclude abortions from the Compulsory Medical Insurance coverage, the 2017 law decriminalizing domestic battery. All the above proposals and laws reflect both the institutionalized status of the female body in contemporary Russia and the demands on femininity.

The involvement of the Russian Orthodox Church in matters of women's health became all the more obvious with the onslaught of the COVID-19 pandemic. A proposal issued by the secretary of patriarchal committee Fedor Lukiyanov offered to impose a moratorium on abortion in times of the pandemic. The main argument stated that both patients and doctors would be highly exposed to the risk of infection in the course of the procedure. The exact formulation goes as following: "Abortion is a planned surgical operation and most certainly not a treatment procedure, and also seriously threatens the health of the woman and [her] future children" (Yushkov 2020). The incentive to put abortions on hold despite the time-sensitive nature of the procedure thus straightforwardly penalizes the woman, leaving her without the opportunity to make choices on her reproductive trajectories. The argument about abortion involving certain health risks forces the woman into normative motherhood without giving any regard to her psychosocial well-being. Women choosing to have an abortion in the times of the pandemic are also presented as carriers of infectious illness, endangering themselves, their unborn children and medical professionals.

While no official regulation in regards to abortion in the times of pandemic was imposed, access to abortions was not readily provided. Journalists from the non-profit organization Nasiliyu.net contacted all of Moscow's forty-four public health clinics, only three clinics confirmed that they would provide abortion. The other clinics confirmed that abortion would be performed only in case the patient is brought in by ambulance (Nasiliyu.net 2020).

A mere month later, Children Rights Commissioner for the President of the Russian Federation Anna Kuznetsova voiced a suggestion on decreasing financing for hospitals performing abortion: "The clinic must be interested in preserving the child, not in providing services for artificial abortion" (Interfax.ru 2020). This short quote carries special significance, as it explicitly reintroduces the institutional dimension of gynaecology, presenting clinics as possible agents of reproduction control. At the same time, hospitals do not become actors in their own right when it comes to clinical decision-making, as they risk facing financial setbacks in case they don't give up their role as abortion providers.

This example prompts me to examine the gynaecological hospital in more detail. All the events narrated by the communication partners for this research transpire specifically on the site of the gynaecological hospital. The next paragraph will focus on the description of the space of the gynaecological clinic where discourses on women's health become operationalized.

2.2.2 The gynaecological clinic

Why is it so important to look back at the historical circumstances of women's public health? When in the process of gathering data for this research and striking acquaintances with the research participants, one of the narrators noted in the course of a private conversation: "If you disregard the Soviet legacy, you will not get anywhere with this research. It is not the same in different countries. This Soviet system, it says it all about gynaecology" (Valeria, 41).

The very term of "punitive gynaecology" connotes with formulations about "punitive" Soviet medicine that has been extensively articulated in research papers. Medical experience in Soviet times is often described as "punitive" and "traumatic" (Angelova and Temkina 2009). Women's medical biographies tend to think of medicine as a controlling and repressive establishment, a punitive institution

(Baraulina 2002). The institution of obstetrics had unlimited control over the woman's body also for the simple reason that no alternative was possible during the communist rule (Belousova 1996).

The narratives submitted for this research describe events that take place at the so-called "Zhenskaya konsultatsiya", which stands for public health gynaecological clinics, where women patients are usually registered according to the address of residence (Larivaara 2011). "Zhenskaya konsultatsiya" can be rendered as "women's consultation". It is possible to chance upon the term "women's consultation" in academic literature (for example, see Donnay, Frolova and Stephenson 1998), however, this paper will use the abbreviation "ZK" (instead of a more conventional-sounding "gynaecological clinic") to be able to operate with the connotation-laden sounding of the original term.

ZKs are certainly not a new development, dating back to the first years after the Great October Socialist revolution. While appearing to be a convenient institution for providing health care for women in a centralized manner, these women's health clinics were set up as a central institution meant to exert control over the female body (Baraulina 2002). As is obvious from the very formulation, ZK is almost exclusively a female space where women doctors interact with women patients. Thus, ZK were separated from other medical institutions not only in the spatial but also in the functional sense (ibid).

Albeit it was not my intent to focus exclusively on the public sector of medicine, the opportunity to somewhat narrow the analyzed spaces to governmentally funded clinics presented itself naturally. The authors of the narratives were not prompted to speak only of their experiences with public sector gynaecology, nevertheless, mentions of private clinics were only sporadic. Private clinics were mentioned only twice across all the body of narratives. Following her traumatic experience, Olga (37) writes: "After all this, I will never set foot in a public gynaecological clinic, I go to private clinics, I had a medical abortion at a private clinic, I paid for pregnancy monitoring, I gave birth outside of Russia". Veronika (25) speaks of having a stress-free experience at a private clinic after the ordeal at a ZK: "…I left without getting a proper examination (at the ZK). Went to a private clinic where I got examined without an issue".

Both women describe private clinics as a space where they "escape" from the realities of a ZK not only for more qualified treatment but also in pursuit of a stress-

free medical encounter. It would, however, be a crude generalization to speak of private clinics as providers of treatment of better quality. For example, Kateryna (27) narrates her experience of being the victim of deliberate disinformation at a private clinic: she was treated with electrocoagulation despite being reassured that she would be receiving laser treatment.

The legacy of the Soviet system appears to be retaining its' influence in current times as well. The Soviet system refused to engage with the concept of a patient as a psychosocial being, giving preference to narrow expertise. Women tend to complain of neglect, as visits are rushed and centred on physiological monitoring, leaving little room for engaging with the patient emotionally. Some women report doctors making follow-up calls to patients after missed appointments to reprimand them for refusing to follow medical advice. This kind of conduct is described as paternalistic, authoritative and disturbing.

ZKs continue to be more than just women's health clinics. Contemporary medical literature presents ZKs not only as clinical spaces where gynaecological diseases are treated and pregnancies monitored but also as spaces of enlightenment, discipline and training. As formulated by Radzinskyi, Ordiyants and Orazmudarov (2010), one of the most important functions of ZK's work with women is that of "health education" which includes promoting a responsible attitude towards following prescribed treatment plans. These health trainings should aim to create a "stereotype of behaviour" (*sic!*) that prevents the complication of illness and the possibility of it recurring altogether (p. 32).

Ideally, teenage patients are expected to undergo more extensive training: "It is important to tactfully talk about conception and pregnancy, elaborate on the undesirability of patting, early physical intimacy, on the harmful effects of the first abortion as the consequence of premature sexual activity" (ibid, p. 34). Interestingly, this recommendation does not address the vital role of contraception in the prevention of unwanted pregnancies. Moreover, it implicitly establishes a causal relationship between early sexual intercourse (whilst avoiding a demarcation of acceptable age to enter sexual relationships) and pregnancy. This causal twist denies the younger woman of reproductive age the capability to have agentive awareness of her own body and sexuality. The female body is thus delineated as a mere receptive surface that the event of pregnancy "happens to" as a direct consequence of "marginal" behaviours and intervention from the outside. Thus, the suggested "pep talk" with a new patient

of the ZK would seek to create discord between the woman and her bodily materiality, dismissing the patient as an agent in her intimate relationships.

ZKs are fully authorized to exercise control over the woman's body from the moment the patient reports the beginning of a pregnancy. In case of an uncomplicated course of pregnancy, the patient is obligated to visit the ZK on time, which is 7-10 times per pregnancy. In case the patient does not show in two days from the planned day of check-up, the ZK may enforce antenatal care: following up with the patient to clarify what prevented her from arriving for the check-up (ibid). To these days, medicine continues to be a tool of state control over the female body, using repressive and propagandist methods of forcing the woman to live up to her "woman's destiny".

It is not altogether accurate that men remain barred from the space of the modern ZK. The gynaecological clinic hosts both "Schools of mothers" and "schools of fathers" for expecting parents (Radzinskyi, Ordiyants and Orazmudarov 2010). Mothers and fathers do not necessarily have to be separated for schooling, some ZKs set up sessions for all parents regardless of gender (this information was sought out and verified via websites of random ZKs). Albeit expecting fathers are thus deemed to play an equal part in the upcoming family unit, further chapters will show that their presence has little consequences in the setting of the ZK. While there is no formal rule that would regulate male presence in the ZK, restrictions can be introduced sporadically. In her autobiographical novel "Posmotri na nego" ("Look at him") dedicated to the termination of a desired pregnancy for medical reasons, the Russian author Anna Starobinets recounts her visit to the ZK with her husband:

> - You are not allowed to enter with men – a gloomy sturdy man blocks the way.
>
> This is the security guard. He guards the ZK of Khamovniki [district]. From men.
>
> - This is my husband, – I say.
> - You can't enter with men, - he repeats, looking bored. – These are the rules.
> - Let me pass, please, - says my husband. He seems to believe that it is possible to explain something to this gloomy man in the mouse-coloured sweater. – Our situation is serious. Really serious. We need to speak to the doctor together.
> - Men can't enter here, man, - the guard stands astride as if to demonstrate that no power in the world can prevent him from fulfilling his duty. – This is a female institution. Let the woman go alone. In the meantime, you can sit down here, on the bench (p. 27)

The empirical chapters of this thesis will engage with the elaborated context to illustrate how power relations unfold in the physical and ideological spaces of the ZK.

2.2.3 The hegemonic patient of a gynaecological clinic

While "hegemonic masculinity" remains a highly frequented term in academic discourse since its' original formulation by Connell more than three decades ago (1987), not many academics extensively operate with the supposedly logical counterpart of "hegemonic femininity". Even though "hegemonic femininity" was first conceived of in tandem with "hegemonic masculinity", it was soon replaced with "emphasized femininity" (Connell and Messerschmidt 2005). The term has often been dismissed from theorizations for the reason that femininity is perceived by many a researcher as the Other of masculinity (Paechter 2018), whereas the entire range of different femininities is believed to be simplistically subordinate to a hegemonic masculinity.

As I will be operating with the term of hegemonic femininity extensively, a working definition is in place. Schippers (2007) draws on Connell's definition of hegemonic masculinity (by replacing a few words) to provide a concise definition of hegemonic femininity (p. 94): "Hegemonic femininity consists of the characteristics defined as womanly that establish and legitimate a hierarchical and complementary relationship to hegemonic masculinity and that, by doing so, guarantee the dominant position of men and subordination of women". Shippers elaborates on the hierarchized co-existence of multiple femininities by outlining "pariah femininities": undesirable femininities contaminating the relationship between masculinity and femininity (ibid, p. 95).

In this chapter, I will use this definition to discuss hegemonic femininity in contemporary Russia. As further research will show, the gynaecological consultation becomes a field where femininities get contested, constituted and re-enacted. While medicine is widely (and erroneously) believed to have little to do with anything but the physical body, I will proceed to argue that medical establishments in Russia contribute to negotiating and shaping femininities. For this reason, a brief illustration of the concept is vital.

It would not be an overstatement to acknowledge that femininity in Russia has become a political category, acquiring political meaning through state policies and

propaganda. According to Dukhanova (2018), state pronatalist policies operate with the concept of "ideal" modern Russian woman who is presented as a mother and a worker. This "ideal woman" acknowledges the economic losses associated with motherhood, even if this state of affairs does not foster equality at the workplace (ibid).

Another reason why femininity is so important is the need to break with the Soviet past where the woman was so often presented as being in control of her body. Abortion was a particularly routinized practice that a woman could use for pregnancy prevention, a common experience shared by almost every Soviet woman (Zdravomyslova 2009)[3]. Modern Russian women are incentivized to re-enact "authentic femininity" to discredit the Soviet legacy by painting a picture of the "ideal woman" (Baraulina 2002): a wife, mother and homemaker. Worries about Russia's shrinking population, the increasing momentum of traditionalist movements urges the state to create financial and ideological incentives for child-bearing and enforcing femininity (Ferris-Rotman 2017).

The analysis of discursive handling of the female bodies in medical clinics will also contribute to defining what "hegemonic femininity" means in a Russian context. Larivaara (2011) explored the notion of perfect patienthood in contemporary Russia, offering the following picture of an ideal female patient:

> She should be young enough, although albeit maybe not too young, and preferably married, prepared to plan her pregnancy with a physician, educated but not postponing her pregnancy too much for career reasons, interested in finding financial stability for her child, health-conscious and willing to follow medical advice.

This rendering of "hegemonic patienthood" will be applied to the exploration of hegemonic femininities enacted in the course of gynaecological consultations.

It might be best to illustrate the interventions of medical clinics into Russian femininity with an anecdote that became a subject of public discussion in 2015. Yurii Lvov, the then editor of the prominent Russian business magazine Kommersant-Dengi, reported an unusual incident on the online radio Kommersant FM (Lvov 2015). Lvov's female acquaintance received a brochure containing "handy tips" for strengthening family relations in the course of a visit to a ZK in the Sokol district of

[3] The Soviet Union was the first ever country in the world to legalize abortion in 2020. Abortion was then outlawed in 1936 and then made legal again in 1955 (Zdravomyslova 2009).

Moscow. The brochure, handed out as a part of a medical report, provided all sorts of advice for women on how to handle relationships with their husbands[4]. According to the brochure, the woman is advised not to "devilize" her man ("not to wake up the monster in the man" in literal translation). The woman is advised to "be the second", as this is the best value for her and the man. A further quote from the brochure maps the power relations in an ideal Russian family: "The man does not tolerate control from his wife – you can't control the head of the family". References to Christian values were apparent, the role of the husband as head of the family is claimed to be God-given.

This remarkable occurrence in the ZK was covered by several other prominent media. The magazine "Afisha" sought out Yulia Markina, the author of the brochure, with the request to comment on the reasoning behind handing the brochure out as part of pregnancy health record ("dispansernaya karta"), which is official medical documentation. Her response was as follows: "This advice is based on normal Christian values. My life experience also shows that these recommendations work" (Afisha Daily 2015). According to Markina, other doctors in the ZK expressed support for her enterprise with the creation of such a brochure. It proved impossible to obtain a concise explanation as to why this unsolicited advice would be issued along with medical documentation. The Moscow City Health Department did not come forward with a comment.

Despite the marked silence of authorities, the appearance of the brochure triggered heated reactions from the public. Feminist Leda Garina characterized the contents of the brochure as "unconstitutional" and "anti-science" (ibid). Professor of the Higher School of Economics Elena Rozhdestvenskaya questioned why the brochure would be printed out as part of an official medical record, despite not being surprised by the appearance of the text itself: "…It was to be expected given the pronatalist policies of the government".

Lvov, who originally covered the story, also expressed great unease at the fact of participation of medicine in shaping women's subjectivities: "…The topic of feminism [in Russia] seems farfetched to me…However, if it is the public health department that now intends to return the woman to the kitchen – then consider me a

[4] The brochures mention explicitly interactions of women with their husbands inside marriage, bypassing civil partnerships or any other forms of relations.

feminist". Lvov also notes the curious partnership of Christian values and public health: "Seems like the OMI [Obligatory medical insurance] policy now comes with divine coverage and Domostroi[5] rhetorics".

Womanhood and especially motherhood, however, come at a serious price. It is frequently mentioned in popular discourse that a woman is obligated to suffer. Russian feminist columnist Arina Holina (2013) refers to birth-giving at public hospitals as a "personal female Pearl Harbor", a validation of womanhood: "Only after ten hours of labour pain, when you are laying alone in a cold chamber on dirty sheets, after internal organ damage and being in the emergency unit you receive the right to be called a woman and a mother".

Interestingly, Aygerim Maleeva (2018) describes Kazakh femininity in similar terms through the lens of punitive gynaecology: "Starting from childhood, we are being prepared for a confrontation with punitive gynaecology. Pain, pain, pain. And humiliation. Moral sadism. This is the main theme. You need to go through hellish, horrible pain, be humiliated by the obstetrician-gynaecologist to be called a woman". This reiteration of normative motherhood in the context of a different Post-Soviet country illuminates the continuity of Soviet heritage of punitive gynaecology. This statement also straightforwardly points out the reality that gynaecologists can resort to punitive techniques to enact normative motherhood.

It is worth mentioning that Russian women are active agents when it comes to enacting and supporting hegemonic femininity. For example, Holina in her article on punitive gynaecology Reproduktsiya unizheniya in nenavisti [The reproduction of shame and hate] (2013) critically explores the "Russian female community", dubbing it a "harem with its' own intrigues and petty fights, where women ally against each other". The lack of solidarity is also noted by Anna Starobinets in her book "Look at him" (2017) dedicated to termination of a wanted pregnancy for medical reasons in Russia. Starobinets contrasts the content of discussion forums for Russian and English speakers that face the necessity of late-term abortion for medical reasons. She compares forums for Russian speakers to "pathological reports from hell" where women are subjected to insults and humiliating remarks for considering to terminate

[5] Domostroi is a 16th century Russian guide of unknown authorship, containing rules on household management. Domostroi is well-known for its' misogynistic statements. The legacy of Domostroi is still widely referenced in contemporary Russia in discussions on misogynistic politics, legislations and gendered citizenship.

a pregnancy for medical reasons (p. 21). Regarding forums for English-speakers, she notes very low tolerance for insulting remarks towards pregnant women faced with a hard choice:

> Generally, forums for English speakers remind caves to a much lesser degree…I didn't meet a single aggressive idiot with an opinion on "mothers-murderers" on any of the thematic forums [for English speakers]. Not because there are no aggressive idiots in the US, Canada or Australia – there's not less than here [in Russia] - but because there are rules. Their [English speakers] discussion of congenital [fetal] anomalies and pregnancy termination is a form of psychotherapy. While "ours" [Russian speakers discussion] is a form of self-castigation (p. 23).

Thus, Starobinets notes the absence of protective mechanisms for women even in the context of online discussion boards. She registers an absolute lack of supportive communities even outside institutional obstetrics and gynaecology. In fact, she brings up the non-existence of solidarity in the circle of women, painting an increasingly hopeless atmosphere.

In the following chapters of this paper, I will operate with the concept of hegemonic Russian femininity as both imposed from above and in part performed by women themselves. Furthermore, I will seek to determine how gynaecological clinics become communities of normalizing practices where hegemonic femininity is produced, reinforced and discursively inscribed on the female body.

2.3 The discourses on punitive gynaecology in contemporary Russian media

Academic literature in Russia has so far avoided using the term "punitive gynaecology" conceptually, however, its' use in media and informal exchanges remains quite frequent. This becomes apparent after reviewing articles in popular Russian online media. One of the most extensive and prominent articles was published on the news website Takie Dela, which is an official platform of the charity organization "Nuzhna Pomosh" ("Help needed")[6]. The news content is mostly related to spreading awareness about topical social issues. The article in question offers an all-encompassing definition of "punitive gynaecology" and heavily relies on the lived experiences of the author herself and of the people who shared their stories with her.

The journalist Serenko (2018) used the snowball method to locate potential respondents and used social networks to communicate with women of all ages and walks of life. Having collected and read through over 400 stories, the author outlined the following ways punitive gynaecology can manifest itself during a doctor-patient exchange:

- Sexual harassment of the patient by the medical doctor
- Inflicting physical injury during the examination due to carelessness
- The doctor shaming the patient (for being overweight, for not depilating her pubic hair etc)
- The doctor offering the patient non-medical advice (insisting that the patient will be cured by having sexual intercourse ("the healing male penis")
- Subjecting the patient to reproductive pressure (the patient should give birth to be cured)
- The doctor deliberately disbelieving the patient and mocking her ("do not presume to tell me that you are a virgin")
- The doctor making demeaning remarks about the patient's sex life/sexuality

I find this classification to be especially accurate, as it encapsulates almost all the occasions a woman can be discriminated in a gynaecologist's office. Of course, punitive gynaecology most probably operates with a larger number of methods, some of which have not yet come to public attention or otherwise emerged in discourse. The article by Snezhana Gribatskaya for the Cosmopolitan magazine (2018) offers an interpretation that takes the ideas of patients' embodiment and femininity even further: "They prepare us for the confrontation with punitive gynaecology in advance… Starting from childhood we are taught to accept that, first of all, birth-giving is excruciatingly painful, and, secondly, you should endure it: If you are born a girl, be patient".

The concept received actual visibility during a feminist protest that took place on March 08.03.2019 in Ufa, Bashkiria. The banner's text is originally as follows: "Women are not soulless machines for the reproduction of the population. Punitive gynaecology is the disgrace of Russian medicine" (UTV.ru 2019). In this instance, punitive gynaecology becomes discursively linked to reproduction and birth-giving in general, overlooking other issues that might trigger medical doctors to harass their

patients. The protesters who crafted the banner project a certain perception of bodily making in punitive gynaecology to the mob: it is devoid of humanity and agency, its' functions are purely technological. The aim of all bodies is similar and linked to the function of producing new bodies only. Gribatskaya (2018) also underlines the dehumanization of the patient, linking it with the Soviet heritage.

It is noteworthy that the message of the banner equates the woman with her embodiment. The authors compare women who experienced punitive gynaecology to reproductive machines. Did the protesters use this particular phrasing because they did not know any better, or with the intent to show that the modern Russian woman does not exist outside of her embodiment? The same undertones are apparent in the above-mentioned article by Serenko (2018). According to the testimonies of Serenko's respondents, women experience visits to gynaecologists as an "occupational health check": "It feels like we are being evaluated for professional competence, they are sizing us up to see how well we are carrying out our "female" roles". Serenko goes on to say that "this is actually about politics that begin at the level of the body. This is about fertility that serves the state". Serenko also makes a pertinent note on the nature of a woman's embodiment that goes in line with the ideology of fertility serving the state: "We do not belong to ourselves in the gynaecological examination chair". Thus, the belonging of the female patient is delegated to an external authority that is not otherwise specified, whose power may well be dispersed among state and medical authority.

This way, the vision of the protesters goes well in line with Serenko's vision. The female body is declared as more of a professional tool that aims to serve the state. The entire assemblage of female bodies is accentuated as a monolithic mass, each of the bodies is ascribed the same set of tasks. It seems a significant coincidence that this narrative is shared by women from different regions, of different ages, colours, social standings, professional occupations, lifestyles. The "machine metaphor" was also reflected on by my respondent Olga (37) in her narrative. She took it even further, comparing the gynaecological examination to a beltline. Olga's testimony focused on her traumatic memory about a routine gynaecological examination for adolescent girls[7]. Her "machine metaphor" runs as following: "The gynaecologist makes the girls

[7] It is mandatory for students in the last year of school to get a medical certificate confirming that their general health condition allows them to study at University.

enter the examination room in pairs so that the "beltline" runs faster". This, again, connotes with discipline and rigour, evokes a metaphor of "putting things in order".

A further common perception that survivors share in their testimonies is the highly ritualized nature of the examination. Gribatskaya refers to a gynaecological examination as a rite of passage (to use her words, "a ritual of agonizing female initiation"). Western academic literature tends to theorize the ritualization of the gynaecological examination (Emerson 2008; Henslin and Biggs 2007) as a necessary procedure. However, while the academics writing about the phenomenon tend to perceive this ritualization as a necessary means of diffusing the anxiety of both parties involved (the doctor and the patient equally), the survivors of punitive gynaecology throughout the post-Soviet area see the rituals as the means to humiliate. In the empirical parts of this thesis, I attempt to prove that it is certainly a little bit of both.

B – Analytical part

Chapter 3: Methodology

3.1 Positionality

This paragraph will elaborate on my positionality as a researcher, explaining my engagement with the social and political context of the research, with the different theories used and with the research participants.

In short, I am a twenty-five-year-old woman who spent her later childhood and adolescence in Moscow. I have encountered many of the manifestations of punitive gynaecology that the empirical chapters will proceed to describe, in my own life. I have been a patient of ZKs and met very different doctors along the way.

I am writing this paper from Prague, where I am a student of the Gender Studies department at the Faculty of Humanities at Charles University. Despite not having to face the horrors of Russian gynaecology for several years now, it is not possible to forget them. I felt the need to research the topic, to engage with experiences of other women and to produce a work that would speak about the topic openly, honestly and in detail.

When reflecting on my positionality, I gave a great deal of thought to how my identity as a researcher interacts with meaning-making using the method of narrative inquiry. I was mainly afraid of over-analyzing narratives, trying to seek out meanings that it did not originally contain and, thus, distort the truth of my communication partner.

The mentioned danger of over-analysing was looked into by Poirier and Ayres in their joint publication "Endings, secrets and silences: Overreading in narrative inquiry" (1997). This work was especially instrumental in diffusing certain anxieties of mine regarding some narratives being of a less detailed nature. Poirier and Ayres provide an invaluable reminder that no story can be narrated in its' entirety and that neither interpreter nor narrator can be fully omniscient. The perspectives offered also prompted me to be methodologically conscious and, most importantly, humble when it comes to analyzing personal stories.

Poirier and Ayres point out the danger that stories can be created to fit an author's purpose (ibid). It is this statement in particular that urged me to design the call for narratives in a way that would enable the narrators to tell their stories in their own words and convey the facts, meanings and interpretations that seemed important

to them instead of trying to tailor their texts to my needs. A further fundamental perspective this source introduced deals with the narrative not being a means to an end, but rather a way to identify an interviewee's confusion or avoidance of certain subjects (ibid). This identification, however, should never be a call to re-narrate, re-enact the lived experience or somehow change the attitude of the narrator. I adopted this as a universal rule for my research. This was also one of the reasons why I finally decided to not use memory work as a research method, as it would include a re-enactment of the narrator's experience.

In the end, the refusal to engage in over-reading and the commitment to "letting the story flow in its' own way" can be wrought with complications as well. The application of such a perspective might carry within it a danger to over-empathize with lived experiences brought forward by the narrators for my scrutiny. This is where I needed to educate herself in feminist research methodology offered by Donna Haraway in "Situated knowledges: the science question of feminism and the privilege of partial perspective" (1988). The only way for me to abstain from meddling with the narratives, however unconsciously, is by committing myself to "mobile positioning" and "passionate detachment" (ibid). Haraway's work falls into the centre of the methodological spectrum of this research for the reason that it scrutinizes the embodied nature of all vision, and, at the same time, provides leverage to research the material in a focused, present and empathic way.

Engagement with different embodiment theories was pivotal in establishing the theoretical framework for this paper. On several occasions, I felt seduced to view the embodiment of the research participants as entirely manipulated and orchestrated by discourse, thus stripping my narrators of agency. This way of thinking was attuned to widespread perceptions of embodiment that conjure up the dichotomy between "external discourse" and "internal materiality". For ethics and preserving agency, I tried to venture beyond the limits of cultural inscriptions. It felt necessary to take into account not only the normalizing mechanisms that discipline the body and, at the same time, not be lured away into studying actual identities beyond the doctor-patient setting. The last thing I would like to assume in terms of embodiment is conceiving the body as merely a "surface upon which culture is layered" (Moss and Dyck 2003, p. 24) and applying the wretched dichotomy between "active construction" and "inert complicity". This is precisely what one should be cautioned against when exploring pregnancy narratives, warning that women are neither "simply the agents of their

pregnancies, nor…passive and paternalistic pawns of paternalistic authority" (Kukla 2011, p. 134).

Taking all of the above into careful consideration, I will exercise rigour and self-command to not be manipulated into perceiving bodily materiality of the narrators as either "lived" or "inscribed", as it has been frequently concluded in academic research. To provide a typical example, Greenhalgh (2001) in her exploration of patients' bodily materiality under the scrutiny of the medical gaze notes that biomedical discourses separate the emotions from the physical body, removing the patient's authority to control the body (ibid).

3.2 Research design: deciding on methodology

The main purpose of this research is to provide an understanding of how punitive gynaecology works on the female body in modern Russia, what techniques it operates with and what meanings it maps onto the bodies of individuals. The research aim is best addressed by a qualitative methodology engaging with an interpretivist approach, as one of the most effective ways of producing meaning on the realities of women's lives (Ramazanoglu and Holland 2002).

Several methods were carefully considered before embarking on the research. Each of the methods mentioned in the original draft of this work (including semi-structured interviewing, memory work, discourse analysis) was inclined towards qualitative retrieval of knowledge. However, none of them seemed to give as much freedom of expression to the research participants as was required by the research aims. It was important to be able to offer the research participants to co-produce knowledge for the sake of the research, to work within the topic of punitive gynaecology and to not pressure the research participants into answering a rigid set of questions.

In the end, I decided against using even semi-structured interviewing, as it would still imply steering the conversation in certain directions, however unconsciously. Even if the researcher and respondent negotiate full freedom of expression, the respondent might well follow the cues the researcher might be unconsciously sending out. Another downside of using semi-structured interviewing for this research is that the sensitivity of the topic might lead to pro-longing the exchange and straying away from one specific experience to making general

observations about the state of affairs in modern gynaecology. Another danger would lie in the field of temptation to conduct the interview in a way that would be overloaded with an "excessive attention for…converging and diverging thematical threads in the data" (Galletta 2013, p. 77).

It was of extreme importance to design the research in a way that would help the respondents to contribute with their lived experiences without feeling manipulated and coerced. Almost every respondent reported feeling deprived of personhood and agency in the course of the gynaecological examination. It was this shared narrative that first made me consider using the method of memory work for the revision of earlier memories to re-actualize a desire for expanded agency (Lorenz-Meyer 2015). This, in turn, would make room for enabling a different past and a different future to emerge (ibid).

The re-enactment of personal experience, however desirable, was not one of the goals, so the possibility of using memory work was ruled out as well after careful consideration. It certainly might have been empowering for the research participants to take part in memory work, however, a certain number of circumstances should coincide to organize the set-up.

Given that the respondents are scattered geographically and do not share any locations nor activities in common with the researcher, it would be problematic to follow through with all the steps of memory work without having a designated meeting space. After all, memory work prioritizes the participants coming together in a designated physical meeting space, by introducing "practical and imaginative training zones" (ibid). Moreover, I would not like the respondents to become coerced into committing to extensive research that would ideally include so many steps and teamwork. Given that many women report feeling exposed to public scrutiny during the gynaecological examination, which later on crystallizes into an intensely traumatic experience, I considered it inappropriate to ask the women to collaborate with each other for the sake of this research. As suggested by Lorenz-Meyer (2015), one cannot re-enact one's memory single-handedly.

Discourse analysis would not allow for the sought-after reciprocity. As a researcher, I need to interact with actual women behind texts that would be contributed willingly. A vital point was also to secure the consent of the respondents with using their stories for research purposes.

Finally, narrative analysis was singled out as the most effective and empathetic research method, even though not devoid of shortcomings. I ruled in favour of narrative inquiry not only because individual and communal storytelling is likely to rule in favour of social and political change (Greenhalgh 2001). As Frank (1997) puts it in the exploration of narrativizing experiences in clinic settings, storytelling allows the narrator to hear her own voice, sometimes for the very first time. It is through the vulnerable and precarious act of storytelling that heretofore silenced perceptions and subjectivities will emerge. Narrative inquiry would allow me to channel the flow of data that leads up to events and theorize it with respect to detail.

Another important resource was "Stories matter: the role of narrative in medical ethics (reflective bioethics)" edited by Rita Charon and Martha Montello (2002). This lengthy work provides examples of high-quality analysis and re-thinking of both patients' and doctors' narratives. It helps to frame the reality of the medical encounter as a non-singular event, that can be subjected to re-thinking, re-telling and re-construction. Most importantly, Charon proposes a research methodology with a particular focus on the patients as the moral agents who enact choices (ibid). This statement is re-iterated by Carson who author's chapter 5 "Hypephanated space: liminality in doctor-patient relationships". To make this point, Carson quotes Montgomery: "Without the patient's story the doctor would not have anything to work with" (ibid). Carson brings up the metaphor of silence in a medical examination and explains how the doctor's silent attitude can border on the devastating feeling of psychological abandonment, oftentimes experienced by the patient. This paper will inquire actively into the meanings of these silences and abandonments, as well as statements, utterances, ejaculations.

The centrality of the patient's story is iterated in "Investigating subjectivity: Research on lived experience (SAGE focus edition)" by Sue Ellis and Flaherty (1992). They claim that only animating a dialogue about the experience can place the patient back to the centre of the clinical encounter. This work acknowledges patients' voices in a very dignified manner, accepting that they are usually "shrouded in secrecy" (ibid) and need to be voiced.

3.3 Working with narrative inquiry

As soon as the research method was finally decided on, I commenced my search for communication partners. It so happened I was already familiar with and, simultaneously, a participant in the terrain of meaning-making on punitive gynaecology in modern Russia. Being part of online discussion platforms dedicated to violence in gynaecology (specifically in matters of pregnancy, delivery, abortion), such as Nasilie v rodakh [Violence in birthgiving], Pravda o beremennosti, rodakh i materinstve [The truth about pregnancy, delivery and motherhood], Moi abort [My abortion] and others[8], I had access to a wide variety of texts, narratives and comments. I myself submitted personal stories anonymously for these communities on several occasions.

While there was a wide variety of ready narratives to choose from, I did not want to do so without women being aware that their texts would be used for research. I decided to start from a blank slate, seeking women out, asking them to tell their stories, working with them as active agents of meaning-making. I got in touch with the administrators of the group Pravda o beremennosti, rodakh i materinstve [The truth about pregnancy, delivery and motherhood], asking if they would allow me to publish a post looking for narrators. The administrators agreed, saying that the research has extreme social importance for women and wishing me good luck.

After the post was published, I received a response from women that was even bigger than I initially hoped for. The women that volunteered to share their personal stories for the sake of this research were then asked to write down their narrative of their experience with punitive gynaecology in whichever form they deemed the more convenient.

It was important for me to not set boundaries and not to restrict research participants by specific criteria, such as type of experience (delivery or a routine visit to the gynaecologist, medical emergency etc) or time, or type of clinic, or age. Several ways of submitting stories were offered: via email, via social networks directly to my inbox and anonymously via a file-sharing service.

[8] All the mentioned and other online discussion communities can be found in the prominent Russian social network Vkontakte (Vk.com). Some of them have sister communities on Facebook, but do not have a strong presence on the latter.

At this point, it is important to mention that it was not only online discussion boards I used to seek out narrators. Being a universal female experience, punitive gynaecology had affected the lives of many of my friends and acquaintances, as well as their friends and acquaintances. Also, I wanted to decisively shift away from the comfort of consensus of opinion that online discussion groups offered. The snowball method was instrumental in helping me get in touch with further to-be research participants. Nineteen women agreed to submit their narratives. Some of the women submitted several narratives, describing different gynaecological appointments. In the end, thirty-one narratives were assembled in total.

After reading through all the narratives, I began to notice a pattern. All the women wrote down lengthy concise texts and the vast majority shared their files personally, with only one narrator deciding to stay anonymous. It was important for the narrators to not only be heard and somehow contribute to the research, but also to be seen by me and to engage with me. This way, communication took on a more direct and intimate character with both researcher and narrator being able to talk in real-time and sometimes put in shorter comments. To most communication partners this set-up seemed less structured and formal than having to formulate an extensive, yet concise email.

To make sure that my respondents gain visibility by sharing their personal stories, I wanted at first to keep all the names unchanged. The likelihood of my respondents being recognized would remain very low; however, they would have the opportunity to "locate" their narrative in the text and, thus, re-assert their feeling of visibility. However, some of the women requested me to use pseudonyms. This way, the initial narrative would acquire an intersubjective and public status but remain, first and foremost, intensely personal. This was also communicated to the research participants and all of them opted for having their names changed for the research.

As a researcher, I was constantly faced with overwhelming fears of somehow betraying the women I talked to, as well as leaving them with the feeling of abandonment. For communication with the narrators to proceed smoothly, I reminded myself of the need to exercise caution, rigour and humility (Poirier and Ayres 1997).

The desire to avoid attempts at conventional objectivity was purposefully and actively communicated to the research participants. The request for retrieving traumatic memories was not presented as a plea for a detailed reconstruction of the event in its' absolute entirety. It was rather a request to share whatever seemed

especially significant about the event, be it a particular detail of the doctor-patient interaction (chose of wording, style of communication), characteristics of space or impressions about the temporality of the traumatic event.

At the outset of most communications, the respondents tended to self-censor and structuralize the conversation, asking if there was a specific way I wanted them to design their narratives. After I reiterated that I would value receiving whatever they deemed important to convey, there was a certain feeling of "letting go" on the part of the respondents, and of readiness to share. This attitude proved especially beneficial to avoid the danger of "narrative vulnerability of both researcher and respondent" (Poirier and Ayres 1997). I did my very best to make it clear to my communication partners that they need not craft their stories to fit any specific purpose, nor should the described events be "pieced together as a means to narrative ends" (ibid). It was essential for the narrators to feel free to tell things "their own way" without any pressure to dichotomize their experiences into a strictly "negative/positive" dimension. The main aim of applying the above-mentioned methods was to simply "let the data speak" for itself with very limited support from sensitizing concepts of theory (ibid).

There are several observations I arrived at in the process of interacting with my communication partners. Firstly, a large number of the narrators seemed to consider their experiences not "interesting enough", not "traumatic enough" or not "significant enough" to be shared for academic research. This finding made apparent the preponderance of an unconsciously shared binary, presuming that there were either "deeply traumatic experiences" or those less significant that could pass off as fairly normal. In this particular instance, it is crucial for me as a researcher to assume the delicate responsibility of validation, steering the women as discreetly as only possible into believing that their stories deserve to be heard.

Natalia (28), for example, submitted two stories for this research. The first narrative centred around her experience at a public abortion facility where she decided to terminate a pregnancy that was a result of sexual violence. The second narrative touches upon her experience at a public gynaecological facility where she tried to register with a gynaecologist that would supervise her second pregnancy. Both stories she writes down are graphic in detail and contain descriptions of circumstances that were traumatizing for the narrator. However, she starts her second narrative by saying:

“This story is not as long as the first one, nor is it so horrible, it is just unpleasant, so I don’t know if it is suitable [for this research] or not”.

Inessa (24) describes her nervous breakdown that followed improper and depreciating remarks from her treating doctor when she explained her issues with vaginal pain that kept recurring year after year. She devotes special attention to the examination room, noting how certain aspects of space organization triggered an intense emotional reaction. The very last sentence of the narrative is as follows: “I am not sure if all that I wrote was up to the point. I can give more details if it is needed. Thank you”.

At the very beginning of her narrative, Anna (23) considers it the proper thing to do to “apologize in advance if some thoughts are worded incorrectly”. Alexandra (21) apologizes for “making this text so lengthy”. Olga (37) notes that she doesn’t visit gynaecologists frequently, so her stories “are shorter and cannot compare to the horrors that I [the researcher] will get to hear from women that went through pregnancy and birth-giving”. Kateryna (27) words her concerns even more explicitly: “Generally, rudeness, withholding information and disregard to the [patient’s] pain during a gynaecological examination are all very common. Somehow, I even think that “minor” cases will not be suitable for you, you see what it comes to, it’s like you get used to all that”.

Many respondents considered it necessary to apologize for their traumatic memories being “not brutal enough”, for their stories being “not lengthy enough” or “too lengthy”, thus “revealing the sense of inappropriateness of speaking out and revealing their mistreatment”, when the latter is considered to be a “natural” part of women’s existence[9].

Some of the respondents seemed to perceive me as superior when it came to intellectualizing the topic. For example, Maria (32) asked if verbal abuse from her doctor could be deemed a manifestation of punitive gynaecology, or if the term can be ascribed to physical abuse only. Thus, some of the women seemed to ascribe more power to the figure of the researcher, delegating me the responsibility to define, validate and structuralize their unique experience. It required certain reassurance on my part to collectively move away from this pronounced hierarchy to a mode of equality. At a certain point, the process of memory retrieval entered a stage that can

[9] For this apt observation I am indebted to Věra Sokolová.

be dubbed “the elimination of hierarchies”. This stage of the process was of crucial importance to me as a feminist researcher, as I did not want the respondents to think that they are simply the means to an end, the building block for a project. Given the prominence of the “machinery metaphors” in discourses on gynaecology, it became my obligation to show the communication partners that they are, first and foremost, my research participants with personhood, individuality, subjectivities and agencies of their own.

Despite possible initial insecurities, the research participants steadily moved on to working in an alliance with me. Each displayed a desire to be helpful in the research process. Maria (32) hoped that “her story would be useful for my project”, Tatiana (30) expressed hope that I “will be able to use something of what she wrote”. Fifteen women requested feedback on the results after the research is completed and conveyed their ready interest to read through the paper itself once it is accessible online. The process of research seemed to go along with the notion of “being in this together”. Thirteen respondents expressed their gratitude for going ahead with this research.

It is fair to say that I made a conscientious effort to engage the participants in generating and co-producing meaning. This kind of approach generally tends to increase the trustworthiness of the retrieved data (Galletta 2013), as it prompts the respondents to self-reflection as well. Of course, the use of the term “trustworthiness” does not refer to rigid verification in this paper. When acting by feminist methodologies, it is “important to honour the teller’s sincerity and fragility” (Poirier and Ayres 1997, p. 557). This is another reason why narrative analysis was selected as a research method, as it provides no opportunity to cross-question the respondent in real-time.

Notably, working in this sort of alliance proved therapeutic to several women. Sabina was particularly clear in expressing it: “…I even feel better all of a sudden. All these years I had no one to share it with”. Tatiana (30) remarked: “Feels like I am not so burdened by this memory anymore. I didn’t have anyone I could tell all that”. Sharing these thoughts most certainly helped alleviate my anxieties about not possessing enough expertise in responding to traumatic stories. Also, it revealed that the respondents indeed felt validated as an outcome of the exchange and that they did not experience the feeling of their stories being used as a commodity of privilege to improve the academic status of the researcher (Huisman 2008, p. 379).

Finally, most of the respondents appeared assured that the findings of the research would contribute primarily to the exposure of doctors' and nurses' misconduct at gynaecological clinics. Even though this paper will indeed point out a grave social problem, the standards of academic writing would not allow for judgmental attitudes or for offering recommendations on system reforms. Rather, it would attempt to add to the existing re-interpretations of Foucauldian theories and their applications to doctor-patient relations. As outlined earlier, an important ethical consideration is to abstain from incriminating medical doctors or holding them responsible for acting on an agenda that might be shared only partly, unconsciously or even not at all. It was explained to the participants that this paper is not exactly a call for justice, but rather an attempt to raise the topic of punitive gynaecology, thus giving a name to experiences that women have in common but rarely discuss in academic terms. Providing narrators with this specific explanation helped alleviate the feeling of being torn "between loyalty [of the researcher] to academia and the (researched) community" (ibid).

I have no intention to focus on individual accountability of the doctors or the patients for outcomes. The researched sphere of medical practice is over-saturated with judgement, offered by all involved parties and onlookers as well. As this research heavily relies on Foucauldian perspectives, it would not do to overlook Foucault's conceptualization of power when mentioning ethics and responsibility. Foucault does not tend to portray power as the exclusive property of a certain group or institution. Rather it is a heterogeneous ensemble of techniques and strategies (Jones 2006). In this regard, the question of collective accountability or conspiracy theories have low relevance to the research subject. All of the above was explained to the respondents, each of whom was informed that the purpose of the research was not to incur further judgement, but rather scrutinize the multi-layerdness of their clinical encounters.

I am well aware that this paper might face severe criticism for intentionally leaving out the voices of doctors. It is not only for the reason of limited access to doctors' experiences that they would be purposefully omitted. It is also because considering the implications behind the violations of ethical standards might cause the entire research to wade into different waters altogether (such as examining the precarious nature of the gynaecology doctors' profession). Not giving voice to the doctors is not decided upon with the intention to harm, nor label doctors as

wrongdoers, nor to incriminate them. This set-up was chosen rather for the reason that this paper is primarily for and about the women patients.

Keeping all the above in mind, there is a certain danger that the readers of this paper might perceive the medical doctor as a figure that proactively exercises violence over the female body in pursuing a dominant ideology. To indulge in this perspective would mean to exercise discursive violence over both the individual doctor and the patient, reducing them to actors in a medical establishment. This paper will, by all means, avoid implementing widespread binary approaches towards understanding power and responsibility in clinical interactions (Litvina, Novkunskaya and Temkina 2019).

To avoid falling into this trap, we look back to an eloquent and extremely brief conceptualization of power that Foucault (1980) provides in one of his extensive interviews: "It [power] becomes a machinery that no one owns" (Foucault, 1980). This research will adhere strictly to this understanding of power and reiterate that neither the doctor nor the patient can take full ownership of power relations in the course of clinical interaction. Certain instances of violence and abuse of power by the medical doctor will, of course, form an exception and will be touched upon briefly in the paper.

As observed by Foucault, the mediator of power may well be ignorant of the power make-up they are part of, nor do they need to acknowledge the existence of power. Power relations do not need to "take hold" of the body or be "interiorized in people's consciousness" for the sake of being reproduced (ibid).

While doctors can in certain aspects be understood as "agents of reproduction" (Temkina 2015), it would not do to disregard aspects of their sentiments and emotional reactions. For example, Temkina reports "increasing recognition (among physicians) that judging women for their behaviour is unacceptable" (p. 1541) in a research paper on the medicalization of contraception. Moreover, medical professionals in public health clinics find themselves in extraordinarily precarious circumstances. On the one hand, they are pressured by biomedical authority and "contradictory managerial-pronatalist state rules"; on the other hand, they are forced to cater to the growth of patients' demands (Litvina, Novkunskaya and Temkina 2019, p. 6).

3.4 Research participant information

Pseudonym	Age	City	Fieldsite	Narratives submitted
Daria	27	Doesn't say	Social networks	2
Anna	23	Ishima	Social networks	1
Regina	23	Bryansk	Social networks	1
Olga	37	Saint-Petersburg	Social networks	3
Kateryna	27	Doesn't say	Social networks	1
Natalia	28	Volokolamsk	Social networks	2
Veronika	25	Moscow oblast	Social networks	1
Ksenia	30	Doesn't say	Social networks	1
Evgenia	31	Doesn't say	Social networks	1
Nadezhda	22	Doesn't say	Social networks	4
Inessa	24	Moscow	Personal acquaintance	1
Alexandra	21	Doesn't say	Social networks	1
Svetlana	26	Murom	Social networks	3
Valeria	41	Moscow	Personal acquaintance	2
Elmira	25	Moscow	Personal acquaintance	2
Anastasia	24	Moscow oblast	Snowball method	1
Yana	22	Moscow oblast	Snowball method	2
Tatiana	30	Doesn't say	Social networks	1
Maria	32	Doesn't say	Snowball method	1

Chapter 4: Punitive gynaecology narrated

4.1 The medical gaze

This chapter will analyse the narratives submitted by the research participants to establish how the "economy of visibility" transforms itself into the "exercise of power" (Foucault 1975, p. 187) in the course of a gynaecological examination. The notion of the "medical gaze" in the Foucauldian sense will be heavily relied on to explain how the medical examination "combines the techniques on an observing hierarchy and those of a normalizing judgement" (ibid, p. 184).

It would be impossible to proceed without careful scrutiny of the gaze itself. When writing about the clinical experience and Western rationality, Foucault notes that the "opening up of a concrete individual…was soon taken as a simple, unconceptualized confrontation of a gaze and a face, or a glance and a silent body; a sort of contact prior to all discourse, free of the burdens of language, by which two living individuals are "trapped" in a common, but non-reciprocal situation" (Foucault 1963/2003, pp. 14-15). The above appears to be a description of an ideal doctor-patient encounter that is supposed to take place outside of any individuality or judgement, one that protects the anonymity of the bodily contours. One that grants the medical professional only the inevitable degree of authority over the body of the patient. The analysis presented below shows how inapplicable this description is to the clinical encounters the research participants described.

Recollections of "viewing" and "gazing" emerged as one of the main threads in most narratives. Throughout all the analysed stories, the gazes of the medical doctors never seem to be devoid of judgement, even in the instances when they border on neutrality. The patients do not share much about the directions of the gaze, but almost each of them mentions how the treating doctor scrutinized their bodily dispositions. Some of the contributors share the feeling that the fixity of the gaze exceeded medical necessity, that the gaze seemed to take in the patient as a whole, to view her in places where she never granted her consent to be viewed.

The concept of the gaze is not limited to viewing, shaping and producing meaning throughout the act of looking. The gaze also serves to convey knowledge "borrowed from afar" to the sphere of mundane experience, thus exercising control of individual subjectivities (Foucault 1963/2003, p. 31). This control may be exercised on several distinct levels. For example, it can size up the patient and appraise a

patient's body against conventional standards of "normality" in a casual way during individual consultations (for example, one of my respondents Anna (23) mentions the doctor describing her cervix as "ugly and stretched" while palpating it). Imposing certain medical habits for the "greater good" of the patient is another way to control the body through the sovereign knowledgeable gaze. For example, medicalization can be a means for doctors to expand their power: by overseeing and controlling contraception and intervening into reproductive choices" (Temkina 2015).

When analysing the narratives, I attempted to seek out all the occasions when the narrator used the verbs of "seeing", "glancing", "gazing", "viewing" and "looking" and their synonyms. One of the most straightforward statements is made by Ksenia (30): "They looked at me as if I was a prostitute, just because my health record mentioned that I suffered from a herpetic infection (it kept appearing on my lip once a year)".

Most of the doctors from the stories followed up with some sort of commentary after the initial gaze. Evgenia (31) describes how she was giving birth at a public healthcare facility: "The doctor arrived and said the following straightaway after entering the room: "Just *look* at them, they mess around until they are 30 and then they come here to give birth". This kind of remark subjects the body of the patient to almost public exposure of sorts. Anastasia (24) writes: "In the process of examining me, the doctor was interested to know if I am sexually active. I honestly answered that I am not, to which she reacted: 'Oh come on as if I don't *see* that you are (sexually active)'. To avoid further discomfort, Anna (23) warned the treating doctor that she had never had sexual intercourse with penetration. The doctor then "started to "joke" in the following manner: 'So who are you preserving yourself for?" Let's *see* what you have down there, go get undressed". Anna (23) decided to not even mention that she is a lesbian to the treating doctor. Natalia (28) describes her attempt to register with a gynaecologist to supervise her pregnancy: "…I enter the office, an old lady of very unpleasant appearance is sitting there, she *casts a glance* at me, which is full of disdain…".

The concepts of "looking", "glancing" and "viewing" is thus equated with superior scrutiny and presumed authority of the viewer. In all these instances, the "gaze" serves to inflict shame and is imminently followed by judgement.

The aspects of "exposure" and "compulsory visibility" were observed by Olga (37). She describes a routine gynaecological examination that female patients are

obligated to undergo before entering University in Russia. Olga underlines that "the girls were forced to enter the examination room in pairs so that the beltline works faster. You get onto the chair naked while your classmate stands by with her eyes closed, to not make you feel uncomfortable with her gaze". This way, the privacy of the doctor-patient encounter is intruded on and the gaze becomes shared. Elmira (21) recollects a different, yet very similar instance of "shared viewing":

> I enter the room and see three people sitting around a table. I sit down in front of the lady that appears to be a doctor. Behind me, the nurse is submersed in writing something down on a piece of paper, paying no attention to the surroundings. Another woman is sitting right behind me and it is only a couple of minutes later that I realize she is waiting for the nurse to write down her medical information. There are no computers, of course. The doctor asks me the usual questions: How old I am, what symptoms are bothering me. Of course, all of that right in front of another patient. I can't know for sure, but I really think she listens in. I came in suffering from severe acne and was already feeling ugly and uncomfortable without having to be questioned in front of a stranger. The doctor goes on to ask if I am having sex. It seems that she relishes asking it in front of all these people. I say yes. She demonstrates her genuine surprise by saying: "Really??!". As if having sex is the most surprising thing in the world to do. I get the impression she thinks I am too ugly or too young for anyone to have sex with me. (even though she has my card in front of her, she knows that I am nineteen). She asks about contraception – all in front of that other woman!!! I say I use condoms. She sighs in an exasperated sort of way and says: "That's why you are all covered in that acne. You need birth control". She points to the chair and I ask if I may have a towel. She rolls her eyes and shrieks: "Why didn't you bring your own? You are not at a theatre". She hands me a towel and examines me roughly. The only thing I am grateful for is that a screen detaches me from the woman sitting there.

Having submitted the narrative in written form, Elmira (25) went on to follow up in a private conversation that she never stopped feeling bewildered by the doctor's choice of metaphor. Why did the clinician decide to compare the perception of a gynaecological examination to a theatre? "It does feel like being on centre-stage. And I did feel like a performer with all these absolutely unnecessary people constantly watching me. It was like being a part of a horror movie, the whole indignity of it" – shares Elmira.

The equation of a gynaecological examination to a theatrical performance makes one consider the role of the gynaecologist as a performer as well. The gynaecologist in Elmira's narrative seems to feel burdened by the collective gaze of onlookers. The doctor's exasperation, seemingly directed at Elmira, can be situated

within a wider framework of the "monitoring paradigm", where doctors themselves become subjects of the gaze of non-medical professionals, as are parents, lawyers, prosecutors (Akrich and Pasveer 2000). Thus, the uncomfortable nagging feeling of "theatre" that both the doctor and patient are forced to enact may well be reinforced by the presence of other people in the examination room, as well as by the presence of an externalized sovereign "overseer".

Both Olga (37) and Elmira (25) note how the gaze of the clinician merges into shared public scrutiny that no one warned them about. Both women recollect feeling bewildered and ashamed. Both comment on the presence/absence of a screen in front of the examination chair. While Elmira is relieved that there is a screen separating her from another patient, Olga does not recollect feeling any such relief: "There is no screen. They probably think that classmates should not be ashamed to demonstrate their private parts to each other".

Thus, the screen that should be present in the examination room according to the protocol becomes a mark of power, boundaries, biomedical authority and punishment. Even if we disregard the violation of the basial tenet of doctor-patient privacy and the presence of other patients in the room during the examination, there is little doubt that both patients perceive the screen as a power-laden symbol. Elmira (25) sees the screen as offering minimal visual protection and no privacy. For Olga (37), the absence of a screen is not simply a violation of privacy, but a cue to an active demonstration. Both women find themselves in a Foucauldian mode of spatiality – "an enclosed, segmented space, observed at every point, in which the individuals are inserted in a fixed place, in which the slightest movements are supervised, in which all events are recorded, …in which each individual is constantly located, examined and distributed" (Foucault 1975, p. 197). "Insertion" and "fixation" become all the more pertinent when re-thinking the gynaecological examination chair that literally "fixes" the woman in space in a position of extreme vulnerability.

This "fixed vulnerability" is noted by Valeria (41). She writes about a gynaecological examination where she was observed not only by the doctor but by a "dozen trainees" as well: "They stood there, lined up, gazing between my legs intently. Not one of them averted the gaze. I told the doctor that I never agreed to have other people there. 'This is none of your concern', – she said. The students went on standing there. None of them tried to avert the gaze at least in respect for my words. None showed any decorum. Not one". Valeria goes to great lengths to describe this

collective gaze as “impenetrable and excruciating”. In this instance, the gaze does not belong to any particular individual, it spreads.

Valeria’s story conjures up a connotation with yet another Foucauldian concept of “general surveillance” that serves to buttress the punitive society. The continuity of a punitive society, writes Foucault, is “possible only on condition of general supervision (surveillance)” (Foucault, Harcourt and Burchell 2015, p. 195).

After writing her testimony, Valeria (41) followed up to share the thoughts that kept occurring to her. She reported feeling as if in the “middle of a scary ritual” during this examination, saying that “they” [the students] kept looking at her private parts “as if transfixed”. Valeria acknowledged that her reflection seemed to be straying away in the direction of medical ethics in general (particularly, the ethics of medical students being present at pelvic examinations).

We decided to focus more on her feeling of anger in this particular moment of being gazed at by the students. After giving it a thought, she went on to say: “This bitch [the doctor] seemed to look at me as if I’d committed a crime just by coming there and the others [the students] were a silent observing mass”. All in all, Valeria’ testimony appears to be saturated with instances of observing, gazing and testing, that is again reminiscent of the Foucauldian perspective:

> [It is] …a system of permanent checking of individuals…, rather, like a permanent test, with no final point. It is an inquiry, but before any offence, apart from any crime. …. We call the examination this uninterrupted, graduated and accumulated test…that makes it possible to follow the individual in each of his steps, to see if he is…normal or abnormal” (Foucault, Harcourt and Burchell 2015, p. 196).

Thus, Valeria seemed to be trapped in a confrontation that offered minimal reciprocity and no chance for retaliation. The gaze she described was, however, not the one that Foucault describes as “prior to all discourse” (Foucault 1963/2003). On the opposite, it is one that is burdened by discourse and pre-suppositions, it is highly suggestive and personal.

Valeria describes feeling “burdened”, “stuck”, “transfixed” while the medical students stand around looking at her. There is a further development to her story as well:

> This woman [the doctor] wants to send me away, saying that I'm just being a nuisance. I try to tell her that I was referred here for a curettage, that I need to have the uterus cleaned. She does not listen. Finally, I demand to call the doctor that was looking at me previously. He comes in and tells this honourable professor that I need to undergo curettage indeed. I had embarrassed her in front of the students. She did it (the curettage) without anaesthesia. I was dying of the pain and they all stood gaping. This is how she carried out the revenge.

Thus, Valeria is very direct in defining the ordeal she underwent as "revenge". She proceeds to dub the procedure as a "ritual of sorts": "No one from the onlookers said a word, no one thought to ask her why she didn't anaesthetize me. It was a whole crowd". Valeria was, however, not aware that anaesthesia was not applied: "This would never have occurred to me, I just always thought that it [curettage] was supposed to be this painful. After all, they scrape your uterus out. It's supposed to hurt".

The full circumstances were revealed to Valeria later that day when she brought up the excruciating pain with a hospital nurse that was always friendly with her. "Didn't you know? – the nurse said. This bitch didn't give you any anaesthesia". The ignorance of the reality of curettage was the main factor that contributed to the behaviour Valeria decided to maintain in the course of the procedure:

> I did not want to embarrass myself in front of these students. I didn't want them to see that this bitch had got the better of me. I could hardly cope with the pain, but I was just telling myself to be quiet the whole time. It was a necessary procedure, I was feeling that I'd rather have her get it over with. Now I'm horrified that I never questioned this pain, that I didn't yell, nor wriggle. It's because they always tell us that delivery is the really painful thing, all that other stuff can't compare blab bla bla.

Looking back at the situation, Valeria thus acknowledges that she was forced to exercise a significant degree of control over her body and her pain. To survive the ordeal without making her pain apparent, continuous self-censorship had to be applied. The stance Valeria was coerced into adopting is immediately reminiscent of the way Foucault (1980) conceptualized self-surveillance in an interview: "…An inspecting gaze, a gaze which each individual under its' weight will end by interiorizing to the point he is his own overseer, each individual, thus, exercising surveillance over, and against, himself…".

Valeria did not possess the entirety of information about the procedure carried out on her uterus. She professes to have been guided by the general idea that curettage is necessary to treat her gynaecological problem. She had full trust for the reason that she was referred to the procedure by a doctor she trusted, and she had to restrain herself from reacting to the pain for the reason that she had a vague perception of the procedure always being painful. Having never had a curettage before and, thus, having no previous point of reference to fall back on, Valeria was understandably not equipped to quantify her pain or assess its' intensity. The setting of the examination, Valeria's immediate surroundings and the pointed "collective" gaze of the students seemed to have the "disciplinary" effect on Valeria to the extent that she felt the need, in Foucauldian terms, to exercise "surveillance over, and against, herself" (ibid).

The "gaze" is oftentimes accompanied by excessive, scrupulous writing that rarely remains unnoticed by the patients. Elmira describes the nurse "writing all the time, almost hysterically". Yet again, if we are to observe this act of "intense writing" through a Foucauldian perspective, it can well be constituted as yet another disciplinary/punitive technique. The writing during an examination constitutes the individual as "a describable, analysable object, not to reduce him to "specific" features…but to maintain him in his individual features…under the gaze of a permanent corpus of knowledge" (Foucault 1975, p. 190). Yet again, this makes us think that the depersonalization of the patient in the course of a medical examination does not imply reducing her to a mere assemblage of body parts, but serves a more complex purpose.

Olga (37) also mentions a collective gaze that spreads outside the clinician's office:

> I'm waiting in the line. The doctor asks a young woman to come in. In a few minutes, the doctor comes out of the office and goes to the reception area of the administrator in the same corridor: to take some papers to fill out. And informs the administrator (loudly, so that everyone sitting in that corridor can hear) that the young woman wants to have an abortion, that she is far along…and other details. All with a negative subtext ("abortion is a sin"). Disclosure of sensitive medical information. Everyone saw that young woman, everyone knew who the doctor was talking about, the whole queue.

The young woman described by Olga is, in fact, a victim of panoptic experience in no uncertain terms. She appears to be watched, collectively and

anonymously, by a generalized external "Other", subjected to scrutiny that has no specific source. In Foucauldian terms, there is no "God's eye" point of view to reveal a trustworthy picture, and everyone, even the scrutineers are under a scrutiny of sorts (Krips 2010). The patients waiting for their appointment in a hallway, the administrator at her desk all seem to constitute an audience enabled to interpret the doctor's gesture and information provided in retrospect. We can hence come forward with a framing of non-differentiated univocality of the audience, buttressed by silent collective observation that allowed no space for action. As Olga notes: "I should have made a big scandal, I am ashamed by my failure to take action [in reporting the doctor]. I couldn't leave because I already had my lab tests paid for and was about to go in for them".

In certain instances, it proves problematic to analyse the gaze without touching upon the spatial circumstances of the encounter. This is all the more apparent when looking at Olga's narrative. She describes not only the totality of the gaze itself but also pays attention to the space where the event took place. The organization of space allowed to extend the doctor-patient encounter outside the doctor's office, transforming it into a collective spectacle of sorts.

4.2 Spatiality: the gynaecological clinic as heterotopia

Analyzing the organization of space in the gynaecologist's office from a Foucauldian standpoint is no easy task. The qualities of space in the works of Foucault are metaphorical and rarely grounded in the physical. Foucault actively speaks of "other spaces" (heterotopias) and is attentive to the architecture of hospitals and prisons that ensures the smooth operation of the Panopticon. He elaborates on his inclination to architecture in one of his many interviews:

> …For me, architecture, in the very vague analyses of it which I have been able to undertake, consists merely an underlying element ensuring a certain distribution of people in space, a guidance of their circulation, as well as codification of relationships between them. Architecture thus constitutes not only an element of space: I think of it as being inserted in a field of social relationships, into which it introduces a number of specific effects (West-Pavlov 2009, p. 154).

Commonalities shared by the spatial organization of public health institutions and panoptic spaces have been observed on many occasions. Soviet gynaecological

hospitals in medical biographies are often equated to prisons, academic findings suggest that these patterns persist throughout the post-Soviet period as well (Angelova and Temkina 2009). This chapter will not seek to compare a modern ZK with a penitentiary institution, even though it might seem appealing. It will rather outline the specifics of power dispersal throughout the ZK, and its' commonalities with the workings of power inside correctional facilities. The space of a modern ZK is still that of a homosocial institution that does not allow access for men unless they are medical professionals (Baraulina 2002).

The following analysis will draw on the Foucauldian framework only to a certain extent. It is necessary to keep in mind that Foucault himself acknowledged the metaphorical nature of the spatial language he employed and that this language was largely inspired by his analytical goals (Punday, 2000). Thus, I will not seek to apply a "means-to-an-end" approach when dealing with space and gynaecology, but rather proceed intuitively. Opposed to the mostly metaphoric nature of Foucauldian conceptualizations, this analysis will also seek to focus on tangible aspects of space in gynaecological clinics.

In my scrutiny of a Russian gynaecological clinic, I look more at the space of the actual encounter to distinguish the tangible aspects of spatial organization that contribute to the power relations in the doctor-patient relationship. How are people and objects distributed in these spaces, what are the similarities of encounters with different doctors in different clinics? How does this space ensure surveillance and what can be said about the presence of devices that serve to exercise surveillance (cameras and such)?

It should be reiterated at the outset that the spaces of ZK are exclusive and segregatory by their very nature: being conceptually crafted as a female-only space. Even though modern ZKs encourage the participation of men at schoolings for future parents (Radzinskyi, Ordiyants and Orazmudarov 2010), they are still not frequent visitors. The exclusion of men is apparent not only in the physical spaces of a ZK. Conversations between the pregnant patient and the obstetrician rarely touch upon the father as an active participant of the upcoming delivery. The father appears as a spouse, conceiver and sexual partner and is rarely framed as a father-to-be. This is especially disproportionate with the normative pictures of a "good mother-to-be" that are incessantly produced in the course of doctor-patient conversations. The exchange centres around "balancing obstetric ideals with everyday realities" (Larivaara 2011).

Olga (37) sent in three narratives in total. One of them is only five sentences long. This particular narrative, curiously, omits any description of the doctor-patient encounter and focuses fully on the spatiality and surveillance modes surrounding the examination. The fact that Olga chose to group these observations into a separate narrative points out that these circumstances were already highly traumatizing for her. The narrative goes as follows:

> The clinic for cultural workers, Saint Petersburg, 2010 (?). In the gynaecologist's office, there is a couch where women can undress in one end of the room, the chair is at the other [end of the room]. To pass in-between (naked, of course), you need to go past a huge window. There are no curtains, it's summer, the window is open. Windows of a residential building are right across, it is fully visible what's going on there, the residents [of the building across the street] can also see everything.

Olga's narrative provides an interesting conceptual possibility of the intimate connection between the space and the gaze. This opens the next chapter where I will be looking at spatial aspects of discipline and biopower in the gynaecologist's office. I will seek to unravel how the clinician's gaze is located in geography and examine the spatial rationalities in place to ensure discipline.

The space described by Olga is to a certain extent panoptic, provided that she is scrutinized from every angle in her nakedness. Olga does not know if anyone is looking out of the window while she climbs on the chair, nor is she aware whether the inhabitants of the residential building can see what is happening inside. There is no "overseer" watching from a tower, and the hospital is not a prison (where the Foucauldian Panopticon originates). However, Olga most certainly feels that she is being watched, or might be watched, that a collective gaze of sorts is resting on her body.

It would be for the best to exercise methodological caution when trying to examine the spatiality of doctor-patient encounters through the lens of a panoptic logic of visibility. As Hannah (1997) mentions, Foucault never delineated how the panoptic logic would function in environments where "its' objects do not suffer continuous confinement" (Crampton and Elden 2007). Even though the Panopticon was originally not geared to conceptually map spaces outside the prison system, I will proceed to argue that the spatial rationalities of gynaecological clinics indeed allow for the application of Panoptic logic.

Interestingly, Elmira mentions an experience of being in front of a window in her narrative that is very similar to what Olga describes:

> …So it's evening, the lights are on and I go to this [examination] chair and I realize that it's right in front of this huge window. With the lights on here, everything must be perfectly visible to anyone that might be watching outside, because it's dark outside, and there are residential buildings with windows on the same level. While she [the doctor] is getting ready, you sit with your vagina turned towards the world. It's like it's saying look at me!.

Both women speak of the spatial organization of the office and both describe a compulsory sort of visibility. This "totalitarianism of the gaze" did not allow either woman to escape the surveillance altogether or somehow set boundaries of their exposure. Both reported a feeling of being constantly watched and being unable to determine whether their experiences were at least partly private.

Inessa (24) speaks of the spatial organization of the office in detail:

> I will now describe how the seats in the cabinet are located. The cabinet is rectangular, no secret here. There is a couch on the right hand from the entrance, where you want to sit down at once. But you are told that no, you should sit down closer, next to me [to the doctor]. Closer means the chair right next to the table. The doctor is seated on the right-hand side of the table. The table is not small, there are many items on it. The nurse is on the left side, across the table from the doctor. You talk, then you need to get undressed and take your place on the [examination] chair with your legs spread. There is nowhere you can leave your underwear, pants, etc., apart from the couch. Now the surprise comes! To reach the chair, that is to the left of the door behind the screen, you don't have any other way except running past the door with no pants on. And it's better to take everything off as fast as you can, as the door is not closed. It's not gonna be closed even when you sit down (on the gynaecological chair) and spread your legs. The doctor can even get distracted while examining you. No surprise here. You are laying down, it's comfy, right? Doesn't matter that you are naked in every sense of the word.

Olga (37) briefly mentions a hauntingly similar spatial setting: "She [the doctor] asks: "Why are you fiddling about, taking the pants off next to the chair? You should have taken that off earlier!'. But I didn't want to go across the room naked".

Both narrators pay special attention to the process of undressing. It is not only the undressing itself that makes the two patients feel uncomfortable and vulnerable but also the organization of the space where they are getting undressed. This has to do with the space being occupied with the transition between the identities of the women

and the patient (Galasiński and Ziółkowska 2007), between a sense of relative safety and extreme vulnerability. Neither of the women mentioned noticing whether they were being observed in the process of undressing but did bring up feeling visible. However, no "marked shifts in engagements" that would allow for the temporary distancing (Meerabeau 1999) on the side of the doctor were observed by any of the patients. The openness of the space to scrutiny, or the notion of its' openness, are, as it is, a valid prerequisite for generating embarrassment.

As noted by Emerson (2008), identifying the patient as a technical object would undoubtedly minimize the threat to her dignity and to manage the situation in a cooperative mode. The reality of several respondents not being able to undress discreetly (screened from any outsider gaze: be it the doctor/nurse/other patients), can by itself mark the precariousness of the patient's dignity in the whole encounter. Furthermore, certain research participants noted violations of their privacy while undressing, which is greatly contributed to their feeling of indignity. For example, Daria (27) recounts being on the receiving point of further remarks from the doctor and nurse: "Why are you taking the shirt off this way, you'll be undressing this way in front of men, now undress normally"[10]. A further explicitly transgressive remark Daria (27) was forced to hear out runs as following: "Why aren't you wearing a bra? Your boobs would look bigger".

The spatial organization of the doctor's office and of the clinic itself, their "openness" and "exposedness" allow for scrutiny not only by the medical staff but by casual onlookers as well (the patients in the corridors/waiting rooms, residents of the buildings across). This set-up constitutes a live example of Foucauldian space, pertaining not only to the distribution of objects but also to the distribution of people in it, as well as a specific codification of a relationship between them (West-Pavlov 2009).

Elmira's (25) note on the organization of space is especially pertinent here: "When she [the doctor] was talking to me [about the abortion], the whole corridor could hear every single word. It's as if she was making a whole point to speak loudly - as if they had built these doors on purpose without any proper noise isolation".

[10] Daria was 13 at the time this examination took place. She mentions that 14 years have passed from then and she still does not really have a clear understanding on how to undress "rormally".

This way, it is hardly necessary to thematize space as an origin of analysis. Rather, it evolves constantly within all the narratives, demonstrating unprecedented plasticity. Space becomes an "actor in its' own rights" (West-Pavlov 2009, p. 163), weaving into the fabric of power relations and interactions. All the above aspects of space: huge windows, doors wide open (or the absence of doors) seems to serve the logic of buttressing full visibility. The space of the gynaecological clinic appearing in the narratives is not so much physical space, but more of a "discursive space", one which interacts with "physical space in architectural, urban, institutional forms" (ibid, p. 112). The power relations described in all the analysed narratives become very intimately entangled with more, physical, tangible aspects of the patients' surroundings (ibid).

One of the most frequent observations in the series of narratives pertains to the gynaecological examination chair (GEC). The GEC, as a symbol of power relations, is worth mentioning separately. The chair seems to be a centre stage of sorts, where the climax of the doctor-patient encounter, the actual examination takes place. A woman "lying in dorsal position on an examination chair and the gynaecologist standing between her separated legs" (Galasiński and Ziółkowska 2007) is a depiction of the doctor-patient power dynamic, where the dominance of the doctor is taken as a necessary prerequisite that makes the examination possible. The position of the patient is not only extremely uncomfortable but is also accompanied by feelings of vulnerability and submission to the power of the doctor. The question of the design of the GEC has been a subject of continuous research, with women reporting "being exposed", having a "cold and sterile feeling", experiencing the environment as "cold and harsh", some even connoting the examination experience with "rape", "torture" and feeling "disempowered" (Ehrnberger et al. 2017). The Russian sociologists Zdravomyslova and Temkina, when outlining the extremely sensitive nature of a gynaecological examination, describe the GEC as placing the woman in a position that she would occupy in a missionary pose in the course of a sexual act (Zdravomyslova and Temkina 2011). Notably, Borozdina (2010) prefers to speak of the chair placing the woman in a submissive position, not the woman positioning herself on the chair. The above observation allows for the interpretation of a chair as an object in its' own right and the limited spectrum of choices a woman is eligible to make during the gynaecological examination.

It is, thus, crucial, to examine the GEC in the sequence of spaces that constitute the metaspace of the gynaecological clinic: waiting room/corridor – doctor's office/table (where the conversation about the symptoms takes place) – space for undressing/screen – chair. In logical terms, the shift of identities should become obvious when progressing through all these separate spaces. For example, the woman becomes a patient upon entering the doctor's office, consequently, the patient is reduced to a body part when on the GEC. Do the encounters examined in this chapter follow this sort of logic, or do certain spaces overlap or transgress each other/get transgressed?

These spaces are certainly not separated in Olga's (37) narratives, in fact, they even merge. She describes the chair being positioned on the other side of the room from the couch where the patients are supposed to undress. In another narrative, she mentions the absence of a screen that would separate the GEC not only from the space of the gynaecologist's office but from other patients as well[11].

Veronika (25) speaks about "being banished" from the chair because she was clenching her muscles because of feeling nervous and "not letting (the doctor) in". Anna (23), on the other hand, recounts not being able to get back off the chair for a while for the reason that her legs felt "rubbery" after the examination and was not able to stand up immediately.

Others mention the chair only casually in the narratives, mainly to provide context. Even though the chair occupies a place of significance in all the narratives, it does not stand for a space of superior symbolic significance. The chair becomes significant when interacting with further spaces (for example, the absence of the screen, or the position on the other end of the room from the couch). The way the chair appears interwoven into space demonstrates further supports the tenet of the omnipresent logic of visibility. The chair does not appear to be separated from the rest of the office (where the verbal doctor-patient interaction takes place), nor is the office actually separated from the waiting room/corridor or even from spaces outside the clinic (in several narratives, the chair faces the window). Taking into consideration all the above, it is, however, undeniable that the chair is a site where power and submission are pushed to their very extremes and rendered explicit while being

[11] In this particular narrative, Olga (37) describes a mandatory gynecological examination that all girls from her grade needed to undergo in order to get a health certificate. Olga talks about the "girls entering in pairs", as this would presumably speed up the process for the doctor.

implicitly interwoven into other parts of the examination. The chair thus becomes more than just technology and can be dubbed as a material-discursive entanglement of sorts (Johnson, 2020).

Kateryna (27) elaborates on the ways the chair influenced her decision-making in the course of the gynaecological examination. She was seeking treatment for cervical erosion and asked whether electrocoagulation would be used for the issue. The doctor reassured her that she would be treated with a laser, as all the equipment in the clinic adheres to modern standards. Kateryna goes on to recount: "I might have believed that I was being treated with a laser if it were not for my technical education. When I finally realized that this is not a laser but an ordinary electro coagulator they are treating me with, I was already sitting there with my legs stuck up in the air and didn't have the nerve to protest, unfortunately".

Hence, Kateryna might not have been physically coerced into going along with the procedure, but her fixation in space and physical immobility played an important part. Kateryna surrendered to the procedure because of being constricted both in space and agency by the technology and the situation itself.

This above spatial logic is observed very aptly by Elmira (25): "I am on this chair, she [the doctor] puts on the gloves and starts examining me. She tells me to relax. All the while, I am uncomfortably aware of the presence of this other woman patient in the room. I can also hear the door opening into the corridor, people going in and out".

Thus, the chair puts the woman in a position that is both precarious and exposed, that allows for the doctor to be "ergonomically comfortable" when reaching to the woman's genitals (Johnson, 2020). The existing technology in use does not allow for any alternative positioning of the patient, it locks her in space and makes her mimic the "missionary position of a sexual act" with her limited body language (Zdravomyslova and Temkina, 2011, p. 31)

The spaces described by the research participants do not bear the marks of space that would observe the "pronounced questions of modesty and privacy" (Meerabeau 1999) that are widely believed to be an integral part of the gynaecological examination. None of the participants recalls a vocabulary of signs of gestures being in place to separate the multitude of spaces or to establish the flow of the phases of examination (the personalized stage, the depersonalizing stage, the depersonalized stage). Space appears to be consolidated and unified across all the narratives, very

visible to the onlookers and outer spaces. These characteristics of space allow a similar question to emerge about the bodies of the patients in these spaces. Do the contours of the lived body coincide with the contours of the examined body? Is depersonalization an integral part of gynaecological practice in the assembled narratives? The following subchapter will seek to uncover the subjectivities of the patients in the course of gynaecological examinations and their perceptions of the doctor carrying out the examination.

4.3 Pastoral power and agency in gynaecological examinations

One of the most important conceptual standpoints for the following analysis would be that of pastoral-confessional power. Pastoral power is a term coined by Foucault to describe the aspect of productive power that is exercised in the care for others (Cook and Brunton 2015). While analyzing gynaecological examinations, it is best to utilize the concept of pastoral power for analysis, as it conveniently combines the natures of disciplinary and subjectifying modes of power that Foucault distinguished in his early career (Martin and Waring 2018).

Pastoral power attends to the well-being and moral propriety both of an individual and the community (ibid). Applying this concept to the gynaecological examination will help uncover the techniques that are in place to produce docile bodies for the greater good of both the individual and the society as a whole. Governmental pronatalist incentives get reproduced in the gynaecological office with high frequency, albeit this reproduction may not be necessarily intentional. This connotes with the "politicized nature" nature of gynaecology noted by Temkina: "The state expects gynaecologists to realize its' political will oriented towards population growth" (Zdravomyslova and Temkina 2011, p. 28). This point is echoed by Temkina in her research on contraception where she presents gynaecologists as "strong supporters of pregnancy planning and avoiding abortions" (Temkina 2015, p. 1534). Such strategies of fostering "moral behaviours" in the course of consultations go well in line with the principle of "alternate correspondence" which constitutes one of the main tenets of "pastoral power" (Waring and Latif 2017).

The analysis of the narratives submitted for this research uncovered that not only is the notion of procreation central to the examinations, but also the conditions allowing the woman to procreate (her sexual behaviour, sexuality). The phenomenon

of women refusing to discuss the issue of contraception with the doctor for fear of being stigmatized is outlined by Temkina in her research (Temkina 2011). Thus, it is not only optic and a tangible perception that are necessary for the effective exercise of pastoral power over a body, but all sorts of and varieties of perception and sensuality (Siisiainen 2013).

The most obvious markers of pastoral power arise in the stories of pregnant patients. The second narrative submitted by Elmira (25) touches upon her encounter with the gynaecologist when she was seeking a consultation for her possible pregnancy:

> I was very young indeed. Just returned from a semester abroad. The test said I'm pregnant. I was separating with my then-boyfriend, it was a toxic, horrendous relationship. I must say the gynaecologist was kind to me at first because she took me in without an appointment after I said it was urgent. But then the hell started. I sat down in front of her and told her my suspicions (about the pregnancy). She looked me in the eye and said: "If that's what the test showed, then it is true". I told her that I wanted to figure out what to do, and she looked surprised as if she did not understand me. There was no such moment, as in American movies, where the woman is informed about her "options". She just looked at me and said: "You shouldn't terminate your first pregnancy, it is not recommended. There is nothing to even talk about. This is a live being.

The somewhat confusing structure and the wording of Elmira's narrative are indicative of the confusing nature of the encounter itself. Elmira enters the scene of the encounter as a person, not a patient (by acknowledging that the doctor accepted to see her without an appointment following a personal conversation). When seated in front of the doctor and voicing her concerns and doubts about whether to go through with the pregnancy, Elmira is supposed to be halfway through the "depersonalizing" stage of the encounter. She is prepared to be informed of her "options", a standard procedure widely portrayed in mass culture. The doctor, however, follows a strikingly different scenario by refusing to go through with the depersonalization of the woman to patient. She makes direct eye contact with Elmira and does not provide answers to the questions of medical nature, choosing to advise Elmira to not consider pregnancy termination upfront. The interaction between Elmira and the doctor is an example of how discourse can be inscribed in "life-altering ways" (Greenhalgh 2001).

Elmira (25) does not specify which information she wanted to receive exactly in the course of the consultation, speaking more of her general confusion about the

procedure. However, she does mention that she wants to be aware of the options available to her, which implies that she is seeking out information to choose between different courses of action. The doctor, however, provides a very definite and final answer at the very beginning of the consultation, without examining Elmira and determining whether she is indeed pregnant. This way, the beginning of the narrative appears to indicate that the doctor may be regarding Elmira as a recipient of her passive guidance, a "docile sheep" (Waring and Latif 2017) of sorts. The doctor constructs Elmira as a woman in need of personal advice, as opposed to a patient in need of medical advice.

Elmira tried to offer justifications as to why the doctor acted this way: "She was not really on duty that day (in the sense of carrying out medical examinations). She was supposed to be overseeing physiotherapy sessions, she agreed to see me only out of courtesy. She was not even wearing the white doctor's robe". Thus, Elmira professes to offer justification for the gynaecologist's remarks by noting that the doctor was not supposed to conduct examinations that day and was on duty as a physiotherapist. This train of thought serves to underscore the initial expectations of Elmira concerning the nature of the examination and to her patienthood. Elmira anticipated a medical consultation with the inclusion of all its' standard attributes (a doctor officially "on duty" to conduct examinations, wearing the formal attire, providing strictly medical advice). The consultation Elmira received was more an "intensifier of ethicality", mobilizing feelings of shame and guilt (Rose 2001) as a result:

> She was making me feel really ashamed. I told her that I am a student and need to think about this pregnancy because I literally have no money and my boyfriend has already made it clear he is not going to help me in any way. She asked where I am studying and when I told her, she looked very surprised[12], rolled her eyes and said to the nurse: "See? She probably has issues at school as well.

I felt that I needed to defend myself and pointed out that I am a model student. I guess it seemed to her that if I make mistakes with contraception, it means I make mistakes with my education as well".

[12] Elmira is a student of one of the most prestigious Universities of Moscow

In light of the above, it is clear that the doctor does not proceed to depersonalize Elmira. Moreover, her questions are deeply personal and have little relevance to physical health. The answers that follow enable the doctor to make derogatory remarks about Elmira's studies and personal qualities, deeming her "at fault" in the field of education, making assumptions about her performance at school based on her current life situation.

Evgenia (31) writes about her experience of delivery following a problematic pregnancy. She also mentions a particular personal, and also somewhat derogatory remark from the doctor: "She came in and said this straight from the doorstep: "Just look at her, they fool around until they are 30, then they go and have babies". The doctor's statement is emotionally charged and conveys her displeasure at the fact that the patient presumably chose not to give birth at an earlier age[13]. Evgenia goes on to say: "I was screaming, asking for anaesthesia (when the doctor was applying stitches post-delivery), the doctor said: "Are you a drug addict? Only junkies yell like that".

Thus, the doctor was attempting to discipline Evgenia into being less vocal during birth and contain her emotions by comparing her reactions to labour pain with withdrawal.

Alexandra (21) also mentions verbal abuse when talking about her visit to the gynaecologist to treat a health emergency:

> I came to see the gynaecologist on duty after bleeding for 20 days. After my very first sentence "I am menstruating for 20 days and having pains in the right ovary" the doctor starts off very loudly "are you a fool? Why do you think it's the ovary (that's hurting") How can you be so stupid at 21?" and started explaining to me that I do not know medical terminology, that I don't have a medical education, she communicated with me aggressively and in a very sharp voice. She did not react when I requested her to stop insulting me and to examine me.

Alexandra then goes on to describe a consultation that is structured similarly to the one Elmira (25) underwent: "While she was yelling at me hysterically, I showed her the medical report from the previous ZK where I was examined (I wasn't able to get an appointment there this time). The doctor ignored it [the report] and told me she is not going to look at it. In the end, the conversation took as long as 30 minutes, it

[13] Women who choose to give birth at an age older than 35 in Russia are dubbed as "older mothers" or "geriatric" ["starorodyashaya"], and are often treated with contempt

mostly consisted of the doctor accusing me of "being dumb and not being able to formulate my thoughts correctly" (quote) and also accusing me of not having given birth by 21, which means that I will not be able to get healthy".

In this instance, Alexandra (21) and Elmira (25) share a common experience of not being depersonalized by the doctor. In Alexandra's case, depersonalization is not applied even during the examination itself:

> I asked her to stop palpating this [body] part, but she [the doctor] replied with further accusations regarding my "crooked hip" and "ugly, stretched cervix" – I underwent cone biopsy in 2015.

Straying away from the use of formal, standardized medical language and venturing into the sphere of the personal appears to be a common disciplining technique applied by many gynaecological doctors. On the one hand, the instances of discourtesy and incivility outlined above might be considered products of stressful conditions the doctors find themselves in, a coping mechanism of sorts. Russian gynaecologist Dmitrii Lubnin comes forward with a theory of his own concerning the rudeness of gynaecologists. According to Lubnin (2016), verbal abuse coming from gynaecologists is often a signal of frustration about the patient's negligence: many women do not arrange appointments with gynaecologists for years in a row and, as a result, develop significant health issues that could have easily been treated at the early stages.

On the other hand, all these derogatory remarks have a common feature setting them apart from ordinary displays of rudeness. These utterances, sometimes of a casual and euphemistic nature, sometimes very straightforward, signal the presence of a body politic the doctors attempt to adhere to. This is not an implication about doctors pursuing vested interests, but rather a confirmation that "good intentions can be carried out in abusive ways" (Greenhalgh 2001).

In the context of a gynaecological examination, it is the doctor that embodies the "panoptical male connoisseur" residing within the consciousness of most women (ibid). The role of the disciplinarian is in this instance taken on by the doctor, who is not necessarily male. The way the doctor demonstrates "care" is far from being morally neutral, but rather carries implications about how a conventional and disciplined body is supposed to operate (Baraulina 2002). Medicine operates through

determining normalcy and pathology, where normalcy is enacted via standardizing displays of pathology (ibid). As shown in the narratives, the rendering of pathologies in patients does not pertain exclusively to the physical body. Morality, behaviour, demeanour is strictly scrutinized as an ensemble of traits that characterize the female. Thus, the relationship between the doctor and patient in the ZK is always a relationship between two women (Larivaara 2011).

Interestingly, all the narrators describe experiences exclusively with female doctors and nurses, which raises a series of thought-provoking questions. Is it possible that the doctors are reproducing the notions of femininity that they appropriate as females? Is it female doctors playing the part of disciplinarians as they are more attuned to the discourses of femininity given the nature of their profession? As the gynaecologist's profession deals directly with women's bodily processes related to procreation, it is plausible that they might be to a certain degree inspired to derive their self-identification from these processes[14] and mark the patient accordingly. However, to assume that female gynaecologists are dominated by ideologies of reproduction and pass the ideologies onto women by disciplinary acts would be an incoherent oversimplification. Rather, doctors find themselves entangled in a web of power relations that influence decision-making in a clinical setting.

Some women expressed understanding for the doctors' hostility and lack of patience, linking these emotional responses to the challenges of working for an obstetric clinic in Russia (insufficient financial support, poverty and tiredness of the doctors – Belousova 1996). The obstetric clinic is often regarded as a victim of the state that prevents the clinic from properly functioning (Belousova 1996). Medicine thus becomes a counterpart, an accessory of the state (ibid). Every deficiency of Russian obstetrics copies the deficiencies of the state. Totalitarianism, authoritarianism, coercion, "conveyor", "stamping", police system, prison regime, disregard for the individual opinion – all of these prevail in the obstetric clinic. Everything is carried out in the best interest of the organization, bypassing the interests of an individual (ibid).

It would, however, be a gross exaggeration to presume that these modes of instilling discipline are unique and specific to Russia only. It was observed by Rose in

[14] I am indebted to Robert Hahn and his article "Women, body and reproduction" for this formulation

a wider context that micro-technologies of power become crystallized during clinical encounters, thus blurring the boundaries of coercion and consent (Rose 2001).

4.4 The sexuality of the vaginal examination

As mentioned in many instances in the previous chapters, there is an extensive body of work on the ritualized nature of gynaecological examinations. One of the functions of these rituals is the necessity to desexualize the woman's body as much as it is only possible, reduce the patient to merely a body part in the course of the actual examination with the speculum. This "ritualized form of social interaction" serves mostly to ease the anxiety of the woman that may feel threatened by the very nature of the examination (Henslin, 2007, p. 230).

Logically, transgressing the standard norms of communication during the vaginal examination may have considerable influence on the perception of the patient in terms of her trust for the doctor, confidence, etc. This chapter will seek to examine how patients perceive their exposure during vaginal examinations and the spectrum of meanings that emerge.

In some ways, it seems as if the expectations of a "perfect", "classic" body of a heterosexual female may warrant the doctors' derogatory remarks that are unconventional to the field of gynaecology[15]. These are not only remarks about the physical body of the patient, but also general observations about her bodily comportment, appearance, clothes. Above, we have already scrutinized some general assumptions about the patients' lived experiences that the doctor professed to make. This chapter, will, however, focus on doctor-patient communications specific to the bodily materiality of the patients.

Daria (27) recalls several derogatory remarks made by her children gynaecologist that correspond directly to her appearance:

> How come you don't have your period at (the age of 13)? Others already have babies by that age!" and "Why are you so skinny, are you an anorexic? Men

[15] This, of course, does not include medical jargon. Even though the jargon may crystallize certain workings of power, its' analysis would merit a separate paper.

> are not dogs, they don't pounce on bones"[16] and "Why are you not wearing a bra? Your boobs would look bigger" and "Why didn't you bring anything a napkin, don't you know what you are supposed to bring?[17] Spread your panties then (on the chair, instead of a napkin). And what kind of panties are these? You should be wearing thongs at this age.

Kateryna (27), when speaking of her examination in the ZK of her neighbourhood mentions the doctor explicitly criticizing her appearance: "The obstetrician had a go at me because I was wearing a leather coat. They asked me to undress fully as a sort of revenge. I was laying on the chair wearing my wristwatch only. They said they wanted to check my breasts too, but usually, they take turns to do it…".

The remarks both women recollect pertain to their appearances, not even to their actual bodies. In Daria's case, the gynaecologist assesses her appearance against a backdrop of strong, standardized femininity. The rapidly developing body of a teenage girl falls under the scrutiny of the heteronormative connoisseur that measures her against the standards of what a young woman of the procreative age is supposed to look like. The remarks of the gynaecologist also place this young developing body in the wider context of procreative femininity and heteronormative relationships. Even though the body of the patient is supposed to be fully desexualized at this stage of the examination, it, on the contrary, becomes heavily sexualized. The gynaecologist makes remarks about the patient's breasts and bodily weight with the implication that it is not sexy enough, thus, not fit to procreate, and should be worked on. Daria's body is framed as the receiving object of sexual attention and procreation incentives. Daria's appearance and developing sexuality are contextualized in the wider tendency of young women that are robust, sexy (according to the standards) and minder their attractivity to be able to get the needed attention and procreate. The wording of "men do not pounce of bones" uttered by the gynaecologist is especially conspicuous in the context of "institutionalized" heterosexuality where a woman becomes not only object but also prey to the man's desire (Bartky, 1988). The woman thus becomes the object (bones) that is to be hunted down. The disciplining remarks construct the patient as a

[16] Daria (27) notes: "I actually was very thin, weighed 38 kilos and was 168 cms tall, but didn't do anything to be like that".

[17] There seems to be no official regulation positing that the gynaecological office in a public medical facility should be equipped with reusable napkins. Many of the patients carry their own napkins or towels "just in case".

constant relational self, instrumentalizing existing discourse on femininity as a conceptual basis of treatment (Greenhalgh 2001).

At times, women's perceptions of their bodies during the gynaecological examination tend to have strong sexual connotations. Valeria (41) brings up sexual connotations explicitly when referring to her curettage experience: "I was like a rubber doll in that chair, in front of all these students. It felt like I'd been raped". In Valeria's eyes, the painful invasive procedure carried out in front of spectators becomes equivalent to full deprivation of her bodily autonomy. The comparison to a rubber doll is a demarcation of Valeria's helplessness. The exact choice of words exposes her understanding of agency in the medical situation she finds herself in. Valeria makes a straightforward parallel between a gynaecological procedure and abuse that happened in front of a receptive audience. At the very beginning of her narrative, Valeria comes forward with her opinion about gynaecology in general: "There is no way that gynaecology has nothing sexual about it. The gynaecologist touches the most sacred, the most private the woman has. We should be strict about this, there is only a thin line between gynaecology and rape and yes, at times they transgress it. If they do it, they should be judged at the highest court".

In this context, it is particularly conspicuous that Kateryna (27) happened to be on the receiving end of criticism for her leather coat. Leather coats are commonly worn and are considered to be a classic and fashionable item of outerwear all over the country. Nowadays, leather outerwear for women is no longer considered to be a strong symbol of protest and opposition, neither is it perceived as a marker of masculinity. However, it is not uncommon to chance upon opinions that leather outerwear makes a woman look masculine.

It appears that Kateryna was criticized for wearing leather because she did not appear like "the standard" gynaecological patient seeking a consultation about her health. The derogatory tone the gynaecologists used with both women and the nature of the remarks related to outer appearance can be framed as disciplinary acts, directed to regulate the contours of bodies that are deemed as deviant, not adhering to the standard design. In the above instances, the gynaecologist attempts to scrutinize the body aesthetically, it is by far not only the medically pertinent facts that get taken in by the gaze of the medical professional (Emerson, 2008, p. 78).

A further point for scrutiny is the spectrum of implications about the patient's sexuality and sexual life. When examining the topic of sexuality in medical

examinations, Emerson examines the demeanour of the medical staff towards the sexual connotations that may arise in the course of the examination: “In the medical world the pelvic is like any other part of the body; its’ private and sexual connotations are left behind when you enter the hospital” (ibid). Further scrutiny of the narratives showed that it is not medical definitions prevailing and that remarks of a medical professional can be overtly sexual.

Anna (23) never practised vaginal sex and was a lesbian. She warned the doctor that she never had sexual intercourse with penetration. When examined roughly, she cried out in pain. This is what she narrates in regards to this experience: “She [the doctor] decided to do a vaginal examination – with her finger - without letting me know in advance. I remember her saying:

> “There you go, you lied to me after all – you all love this”. I did not understand who are “we”, what we “love”, and why she is saying these things to me at all, as I was in pain…I was so lost, I remember asking whether I should get dressed, they [the doctor or the nurse] joked again in response: “Do you want to repeat it?

The gynaecologist, thus, does not sustain the proper medical definition of doctor-patient interaction when examining the patient on the GEC. By claiming that the patient lied to her, the doctor does not express explicit disbelief about the information the patient provided previously. The statement the gynaecologist makes pertains directly to the patient’s sexuality and preferences. Assuming that the patient receives pleasure from vaginal penetration automatically places the patients’ subjectivity and bodily materiality against a backdrop of the “generalizable” female body, that is the object of sexual activity and that passively receives it. In this case, the patient did not get reduced to a pelvic while on the chair, the gynaecologist’s comments applied directly to her personhood and private life. The generalizing remark the doctor makes about all women deriving pleasure from vaginal penetration automatically excludes non-heterosexual and queer women, women that do not have vaginal sex because of personal preference or their medical condition.

This way, the examination Anna (23) had to undergo was not only humiliating but also disciplinary. The unsolicited pelvic examination and the verbal non-medical remarks accompanying it exposed Anna’s assumed displacement in the context of “normalcy”. The gynaecologist frames Anna’s body as deviant, but still possible to

work on ("You lied to me after all, you all like this"). It is not particularly clear whether this is a joke that the doctor is trying to make, or whether she is perfectly serious. All in all, this is irrelevant, as the gynaecologist's words highlight the notion of the "perfect body", regardless of whether they were uttered jokingly or not.

The patient in Russia is widely assumed to be cisgender and heterosexual, leaving no room for alternative sexualities or self-representations. This is especially relevant for the gynaecological encounter, where lesbians are forced to respond negatively to the question of whether they are sexually active and whether they use contraception (Sabunayeva 2009). Not only does this approach bar from the patient effectively validating herself, but it also complicates the process of finding a remedy for the actual medical problem the patient presents. The patient is forced to answer questions prompted by the heterosexual viewpoint of the doctor, relating to the possibility of pregnancy, number of sexual partners, etc. This may be problematic, provided that some lesbians might not always conceptualize their sexual activity as valid, equal to heterosexual (Sabuyeva, 2009).

For example, Anna (23) made the conscious decision to not mention her sexuality to the doctor during her very first gynaecological examination at the age of 19. Instead, she decided to convey the medically necessary meaning by saying that she never actually had vaginal sex. The gynaecologist, "a woman of around 40…immediately started "joking" along the lines of "Who are you preserving yourself for? Get undressed then, let's take a look". The wording that Anna recollects the gynaecologist to have used blurs the boundaries of formal and informal encounters. The joking manner the doctor used also gives way to the emergence of sexual connotations.

In her narrative, Anna (23) writes about the complications attached to the necessity of hiding her sexuality: "Examination with a speculum does not fit me, and it triggers me too much to have to explain every time (while hiding my sexual orientation), why I'm not having vaginal sex and why I don't "stretch" [the hymen] myself".

Such a framing of virginity by the medical professional seems to be discursively situated outside the dominant perceptions of virginity as a precious circumstance. In Anna's experience, the doctor does not provide any medical commentary on virginity either. On the contrary, she asks Anna a question that is from the medical point of view non-sensical ("Who are you preserving yourself for?"). This

ironic statement actualizes the wider field of cultural references and makes them a part of the encounter. This way, Anna is no longer a pelvic, or a body, or a patient, or even an individual. She is merely an enactment of a generic femininity that postulates the sexuality of a woman as something depending on external circumstances (for example, preserving one's virginity for the someone "special"). Thus, physical virginity is considered a personal choice, nor the marker of a specific sexual lifestyle. Rejection of or abstinence from (institutionally enforced) vaginal intercourse becomes an impossibility (Wittig, 1999) that should be immediately dismissed as lacking plausibility.

The encounter described by Anna (23) stands out among the other narratives in the sense that a hybrid stigma gets attached to the patient. One part of it is Anna's lack of experience with vaginal sex, which seems unusual and amusing to the doctor. The other part is Anna's sexuality that she does not mention to the doctor. Thus, the particularities of certain implications for Anna's treatment (contraception, frequency of intercourse) become unknown and thus irrelevant for the doctor, while maintaining primary relevance for Anna. She does not receive relevant medical advice for the very reason that heterosexuality functions as an inbuilt assumption for women undergoing a smear test (Mckie 1995), or any different type of examination.

Nadezhda (22) talks about the fact of her virginity being problematized in the course of multiple encounters with gynaecologists: "On one of these occasions, I was being treated as an inpatient at the gynaecological department. I was 24. Even the nurse was asking me about it [the virginity] when I came in for the injections. I only ever told the doctor about this. I concluded that the doctor spread this information all over the gynaecological department".

Regina (23) recalls the doctor openly questioning her virginity:

> The woman [the gynaecologist], without asking anything and expressing any interest in my circumstances, brought the speculum, syringe for the puncture and other instruments. When I told her I am a virgin, she laughed and told me she does not believe me…and that she needs to do the puncture. I yelled that I am only just 14! Only after that she changed in the face and sprinted out of the examination room to pick up the nurse, muttering something about not being allowed to be in a room with a minor without a chaperone.

In all the cases described above, virginity appears to have an exaggerated relevance to the purely interactive part of the encounter, but not actually to the

treatment itself. A certain performance of virginity is expected. In the matter when accurate performance is not carried out (in the example of a patient past teenage years, or with a patient that looks older than her years), virginity becomes a matter to be contested without elaborating its' medical relevance. This brings the entire notion of the patient's sexual life in the terrain of the encounter, without pertinent questions frequently left unasked (contraception, etc.). The question of virginity opens a gateway into the private life of a patient, thus irreparably blending the contexts of the medical and the personal.

4.5 Shame, pain and surrender in the gynaecological examination

Natalia (28) was forced to seek treatment for early intrauterine fetal death. She was referred to undergo curettage to remove the fetus. Following the referral from her gynaecologist, Natalia arrived at the gynaecological department of the city's main public hospital. The gynaecologist at the hospital examined Natalia and spotted a discharged that might be indicative of an infection:

> I told her that it is not likely I have an infection and she replied: "Doesn't look like, they send God knows who from other cities here"[18]. I go tense because of the painful examination, she [says] to the nurse: "see how tender she is, what do you think she's gonna do when we clean her [do the curettage]? I thought I'd not heard it properly, I'd never have imagined that she would just clean me here in the examination room, without an anesthesiologist and deep anaesthesia. But it turned out to be true. The nurse brought instruments and a syringe with lidocaine, made multiple injections to the cervix, and started cleaning me [doing the curettage] without waiting for it [lidocaine] to kick in…I have never experienced such pain. The nurse seemed to sympathize with me, saying that they'll get it done soon, but the doctor only yelled at me. When she had finished, she pressed my belly several times, said: "what a bloody girl you are", then she ordered me to get up and go to the hospital room with the bloody napkin between my legs.

Natalia speaks of her body being marked as deviant after the gynaecologist spotted that she might have an infection. The accompanying remark of the doctor makes little sense medically ("they send God knows who from other cities here"). It is not clear what was implicated by this statement, and there are several possibilities.

[18] There is no literal translation for the expression the gynecologist used, the closest is "God knows who". What she means by that is that the

Natalia was sent over to the hospital from a different town, thus she was framed as an "outside" from the beginning of the encounter, as a patient "belonging" elsewhere (to a different hospital). Given the stressful nature of hospital work, it is most likely that the doctor was voicing her displeasure with having to treat patients from a different area. This makes the relevance of the possible infection all the more interesting: an outsider with a vaginal infection becomes the "Other", someone unknown and unwelcome in this specific setting.

The gynaecologist does not provide any prior explanation of the procedure to Natalia and simply goes on to do the necessary manipulations. Natalia does not actively voice her protest or come forward with questions, she appears to surrender to the procedure entirely.

This pattern echoes the sequence of events Kateryna (27) described in her narrative when she realized she was being treated with an electro coagulator instead of a laser. Similar to Natalia, Kateryna did not voice disagreement or refuse to go along with the procedure. Both women seem to go along with the procedure despite experiencing excruciating pain. Both explain this decision by the factor of their conditions being serious and requiring urgent treatment. Natalia talks about lacking the courage to protest because she was already seated with "her legs locked up in the air".

In both these narratives, pain becomes more than just a sensation, or a part of the lived experience. According to Ahmed (2004), it is through the intensification of pain that bodies and surroundings materialize, it is due to the effects of pain that productions of boundaries and fixity occur.

Valeria's (41) experience of unanesthetized curettage is technically very similar. However, Valeria outlines the punitive aspect of the procedure explicitly, linking it to her exchange with the doctor that preceded the medical manipulation. She analyzes the intensity of the pain she experienced and the traumatizing effects of the procedure:

> I did not want to embarrass myself in front of these students. I didn't want them to see that this bitch had got the better of me. I could hardly cope with the pain, but I was just telling myself to be quiet the whole time. It was a necessary procedure, I was feeling that I'd rather have her get it over with. Now I'm horrified that I never questioned this pain, that I didn't yell, nor wriggle.

At the moment, Valeria was experiencing the procedure as a power struggle between herself, the doctor and the students. She disciplined herself and her body to perform against the disciplining actions of the gynaecologist. Her entire comportment was, at that time, performative. Valeria was well aware of the gazes of the medical students, she needed to counteract that gaze to regain a sense of dignity, a sense of self.

Moreover, Valeria brought herself to endure the pain for the reason that she had a certain expectation, related to curettage procedures generally being painful. This is where her narrative echoes that of Natalia (28). The women were not provided with any information about the manipulations they were to undergo, none was informed about the estimated intensity and degree of pain.

Pain takes on the characteristics of a ubiquitous phenomenon that shapes both women's perceptions of their immediate surroundings, of spaces and interactions in the framework of the encounter. Both women elaborate on the fact that they had certain preconceptions about the procedures being painful, so none of them interrupts the procedure or complains of the pain. They settle with the "socially acceptable" scenario of vocalizing their pain through cries. The pain both women experienced can be described as so "incontestably real", that they both do not think, at that moment, to question the legitimacy of the powers that brought this pain into being and extrapolated it onto their bodies (Scarry, 1985). The described medical procedures sometimes take on the nature of punishment for the failure to enact normative motherhood (Baraulina 2002).

This "contingency of pain" in both medical encounters brings us back to the utterance of "Don't yell you fool, everyone is in pain here" that was mentioned at the beginning of this research. The respective sentence has become something of an iconic catchphrase, often cited in media articles and reports about the state of affairs in Russian gynaecology. This catchphrase initially emerged in the context of labour pain but has now spread to the wider terrain of generally painful gynaecological procedures. How is the experience of living through pain relevant to the framework of punitive gynaecology? Pain is supposedly part and parcel of most medical practices, so how is it different in gynaecology, and how does it relate to punishment?

Physicians' approaches to the patients' pain have been extensively researched. As noted by Scarry, medical professionals tend to perceive the voice of the patient as an "unreliable narrator of bodily events" when it comes to vocalizing painful

sensations (Scarry, 1985). After all, it is only the person experiencing pain that has absolute certainty, the doctor-onlooker is the one to have doubt (ibid). To reach an understanding of the special meaning of pain in practices of punitive gynaecology, it is worth to look at several reflections on pain present across almost all the narratives.

Regina (23): “I just cried out in pain, but all the doctors around me looked genuinely surprised. “why are you yelling like that, it doesn’t hurt at all”.

Kateryna (27): “One of the doctors I visited wasn’t rude, but she was gaslighting all the time along the lines “it can’t hurt that much, what are you making such a fuss about”

Nadezhda (22): “A very old-school gynaecologist (around 80 or so) was aware that I was not sexually active and used the largest possible speculum on me. To me saying that it hurts she reacted by claiming that it is not hurting me, that I am making this up and that I am too fussy”.

Inessa (24): “Everyone is suffering here, so you need to suffer too”.

Elmira (25): “After my very first visit to the gynaecologist, my Mom told me that pain is part of being a woman”.

The above narrators all recount their experiences of pain being readily dismissed. Moreover, the gynaecologists claim that narrators are not telling the truth about being in pain, thus denying the credibility of the patients' accounts of their bodily sensations. An event that may occur in any sphere of medicine gets imbued with further meanings when perceived in the context of gynaecological manipulations specifically. The gynaecological patient appears to be utterly exposed in the examination. The position the patient finds herself in when on the gynaecological chair limits her potential scope of reaction both physically and emotionally. The patient is not able to move when the speculum is already inserted, nor is she able to get off the chair when having cytology or an invasive procedure, such as curettage, abortion or similar. The woman seated in the chair is at her most vulnerable and does not have the option to budge and get off the chair when an invasive procedure is already underway. The woman can change her position only if the gynaecologist contends to stop the examination. It is problematic for her to exercise the right of stopping the procedure when her pain is being readily dismissed. As outlined above, most of the narrators already had certain expectations about the intensity of pain that usually accompanies invasive procedures. Valeria (41), for example, was not informed that she would

undergo curettage without being anaesthetized. Hence, she was not aware that the pain she experienced had an abnormal degree of intensity to it.

Taking all the above into account, it is legitimate to assume that pain has somewhat of an exceptional meaning in gynaecological examinations. Many of the women and doctors described in the narratives seem to deem pain an inherent part of a woman's existence. According to the accounts analyzed and those often spread by word of mouth, a woman is biologically determined to experience pain as a part of everyday existence (menstruation, childbearing, labour). The exchanges narrated above make it obvious that the pain women patients go through is dismissed as not bearing comparison to labour pain. These incidents of patients' pain may be diminished also for the reason of both the women and the doctors framing them as an inherent part of the woman's bodily existence. As eloquently formulated by Jamison (2014), suffering is at risk of being transformed from an aspect of female experience into an element of female constitution each time the topic of a woman in pain is discussed.

An interesting account that centred specifically on pain was provided by Maria (32) who describes how she went into labour. Maria (32) was living abroad at the moment (she chose not to specify the country) and contrasts her experience of labour and gynaecology in general with the one she had in Russia:

> "Had it been in Russia, I would have died in labour. Here I was just laying alone in the hospital room. They were giving me oxytocin via a dropper. The obstetrician came in.
> Asked: "Why do you look so bad".
> Me: It hurts.
> She: Why?
> Me: I am giving birth
> She: So why are you in pain?
> This dialogue went on for a long time. In the end, she gave up and summoned the anesthesiologist. I had an epidural. While the anesthesiologist was administering the drug, the obstetrician held my hand and gave me directions on what to do, so that it would be easier for the doctor. Afterwards, I asked her why she did not understand what I was saying about pain. Upon hearing her answer, you could have knocked me down with a feather. LABOR DOES NOT HAVE TO BE PAINFUL. She did not say a single rude word. I am scared for Russia.

When reading into the text, it appears Maria is not attempting to contrast so much the gynaecological practices in Russia and the country of her residence, but

rather to contrast the meanings attached to pain in the two different countries. Maria describes her shock on hearing that labour need not be a painful process and frames her confusion as cultural. In her narrative, pain takes on the quality of a national/cultural trait. Maria does not understand pain as an inherent part of women' existence in the general sense. Rather, she attributes it to the context of her home country. Pain emerges as a culturally specific attribute in Maria's narrative, one that is not considered a default of womanhood in different cultural contexts, one that does not necessarily need to be reproduced. This narrative provides space for reflection on the very politics of pain in Russian gynaecological settings and prompts to consider why pain in Russian gynaecology may take on a unique and different meaning.

In this instance, coercion is directed at the very processes of bodily activity (gynaecologists making verbal statements to normalize intense pain as a normal part of an encounter). This uninterrupted functioning of pain is one of the main requirements for the production of docile bodies (Bartky, 1988). Pain, thus, becomes instrumental in maintaining the necessary discipline by becoming a part of the very semiotics of the female body.

Of course, the meanings and interpretations of women's pain and the clinicians' approaches to it are entangled with further discourses on pain.

Both Natalia (28) and Valeria (41) share a very similar experience of curettage without anaesthesia. Both describe how not only their bodies suffered from the painful procedure but also the deep humiliation.

Ksenia (30) briefly mentions the doctor "looking at her as if she is a prostitute" because a herpetic infection was mentioned in her medical records.

The incitement of shame and guilt may also constitute an important aspect of disciplinary technique. Almost all the analyzed narratives speak of shame as the strongest, primary feeling following the examination.

Daria (27), in her recollection of the aftermath of the examination, brings up specifically the feelings of "fear" and "humiliation":

> It felt like they'd been flinging dirt at me…I was a modest and shy girl, I was polite and tactful, I was a typical nerd and student from a family of intelligentsia where no one ever used this tone to speak to each other. I could never have imagined that doctors were capable of talking like that, humiliating, tormenting, making a laughingstock out of appearance and behaviour. I am writing to you now – and I'm feeling immense anger, indignation, hurt – what

> kind of fleabag can possibly do this to a child that can't even defend herself? It was a terrible experience.

Anna (23) also mentions the feeling of being raped: "I felt humiliated, I had this recurring thought that I'd been raped".

Marina: "I was a 14-year old girl playing dolls. When I came for the first-ever examination, the doctor started shaming me for not coming earlier, she started yelling that "dumb idiots" like me become barren and then blame the doctors for not having helped them on time…She also yelled at my Mom for not bringing me to her immediately".

Valeria (41): "She wanted to humiliate me in front of all these students".

The authors of the above narratives seem to have been marked as wrongdoers, their bodies deviating from norms, their actions not adhering to procedures (not having the proper "robust" body, not being sexually active upon entering the reproductive age, not addressing a medical problem at the early stages to preserve their reproductive health). Marina was shamed for consulting the doctor earlier for a problem that might damage her reproductive health (irregular menstruations), Valeria was shamed for talking back to the doctor. It seems that neither woman was able to avoid the shame because of not entering the "contract of the social bond", not adhering to the standards of discipline and normalcy (Ahmed, 2004).

The continuity of shame in the gynaecological experience brings us back to the subject of discipline. Instilling shame in the patient appears to be a way of enacting dispositions of obedience on the female body.

The concept of consent readily comes to mind when trying to make sense of regulation of shame and embarrassment: "They [the doctors] prefer not to warn you in advance that this (the examination is going to hurt. Probably because they don't want you to refuse the examination. No one's ever heard of informed consent here)" (Natalia, 28). Not explaining the technicalities and logistics of procedures to the patient functions appears to be a way of bypassing the obtainment of explicit consent. Painful and invasive medical procedures are thus framed as necessary and normal, something taken as a matter of course and not requiring further explanation. Several extreme examples in the narratives expose a parallel of gynaecology and sexual abuse, an event when a woman is at her most helpless and vulnerable. The above-examined narratives provide that the very notions of boundaries, patient hood and autonomy

become blurred and dislocated in the process of the doctor-patient encounter. The centrality of the examination becomes absorbed by the notions of femininity, reproductive identity. The personality of the woman and her self-discipline blot out the identity of the patient. The identity of the doctor becomes somehow replaced with a generic identity of the connoisseur and onlooker.

While the gynaecologist's office may in certain terms represent a "confessional", the subjectivity of the doctor is increasingly more complex than that of a priest or a shepherd (Rose, 2001) that serves state interests and governs individual bodies. The patient also represents more than merely a "well-tamed" (Mol, 2011) obedient body with a clay-like quality, one that can be shaped by the hands of the powerful doctor. The gynaecologist is under no obligation to "serve" the state, they merely become a part of the larger entanglement of pastoral governance. It is the pastor-like government of life and well-being (Curtis, 2002) that unfolds in the course of a gynaecological encounter. It would be an exaggeration to claim that pronatalist governance endeavours to exert its' influence on each body, or that there is a body politic working on the multitude of bodies "en masse" (Rose, 2001).

The "docile body" does not emerge as a uniform concept in the above narratives. According to the accounts of the patients, the requirements of the doctors towards patients' bodies differ and clash. In the end, the shared notion would denote a body that is fit and robust, one that has sex appeal but does not look too "slutty". A patient should be disciplined in matters of her reproductive choice-making. The patient should be sexually active at her reproductive age and be strictly monogamous.

The body in the consultation room cannot be by default completely silent and fully obedient. It is an entity that reacts to the touch of the doctor, that speaks (Moll, 2011) even when the patient does not vocalize her sensations. The very acts of touching the body while carrying out the gynaecological examination, the acts of "articulating or refraining" from certain actions all become the means of articulating particular positions within institutionalized obstetrics (Akrich and Pasveer 2000). The actions of both doctor and patients are thus political, even though neither party may intentionally politicize them.

The modern gynaecological patient is no longer one that simply gets the medication prescribed and follows the recommendations of the clinician. The contexts of sexuality, privacy get blended in the context of the gynaecological examination. The interaction with the gynaecologist articulates the variety of life choices a woman

can make to render her body more disciplined. While the Foucauldian framework of pastoralism is consistently applied to the analyzed gynaecological encounters, it would be an exaggeration to claim that this version pastoralism looks after every individual in particular (Foucault, 1982).

Conclusion

This thesis has examined the entanglements of biomedical authority, hegemonic and alternative femininities that become actualized in the course of a doctor-patient encounter. It has scrutinized the projections of state and medical power on the female body while outlining the important role of the gaze, the spatiality of the encounter, the implosion of medical and other discourses.

While the workings of power in punitive gynaecology were understood to be the main focus of this research, making it more analytical rather than theoretical, the paper managed to delve into the very phenomenology of the punitive gynaecological practice. As stated in the opening chapter, punitive gynaecology is something that the post-Soviet woman might read about in the media or hear mentioned briefly in the conversation. Albeit punitive functions of gynaecology have been theorized in academic works (Temkina, Belousova – to continue), there has (to my knowledge) been no attempt to provide an exhaustive theorization of the term. Scholars have rather chosen to focus on the livelihood of the female body in medicine, underscoring how discourses become emblazoned on the bodily contours that become, metamorphosized in the process. I, in turn, have tentatively attempted to offer an academic rendering of punitive gynaecology while focusing on the centrality of the patient experience.

In the end, it is not only me working on this project as an author. At the outset of this research, "the world kicked back"[19] and the participants became my active collaborators in looking for and shaping meaning. The memories they presented described not only experiences themselves and related afterthoughts but were also especially attentive to spaces of the encounter. Participants were well aware that the findings of this research would be used in an academic setting and made the conscious effort to present a careful and detailed rendering of events.

Several research participants expressed concern about how this paper would potentially be received at the time of defence. When asked to elaborate on these concerns, the participants voiced their fears about the paper not been very welcome in the context of Russian academia, assuming that the paper would be written and defended at a Russian University. Upon explaining that the paper would be written and defended in English outside of Russia, several participants expressed

[19] I am grateful for this eloquent formulation to Karen Bard and her work Getting Real: Technoscientific Practices and the Materialization of Reality (1999)

disappointment. Understandably, this disappointment was brought about by the unfortunate fact that some of the participants would not have immediate access to the findings of this research (as only a few participants are English speakers). The participants felt somehow betrayed, as they saw this research as a means of opening up their experience to a wider public, they wished for the research to be exclusively about them and for them.

Another point casually mentioned by participants pertained to my motivation for knowledge production outside the geography of described incidents (abroad). "Why would they (the foreign readers) be interested in our experiences?" – was a concern Elmira (25) raised. The prospect of the paper being defended in a "safe" zone (several participants unequivocally consider any European University to be a safe zone) seemed daunting for the participants, as this state of affairs seemed to only intensify the silence that surrounds their experience in Russia. Thus, some participants seemed to unknowingly frame as an experience "exclusive" to Russia (or to the post-Soviet area in general).

As the literature review showed at the beginning of this paper, it is impossible to limit the functioning of punitive gynaecology to one medical clinic, one neighbourhood, one city or one country. Many authors worldwide paid attention to disciplining practices of gynaecology in their research, a great many spoke about abuse. Women's bodies become the subjects of gynaecological discipline disregarding whether the patient is being treated in the "East" or "West", a public clinic or a private. However, it is particularly interesting that "punitive gynaecology" emerged as a term in Russia and went on to circulate in the media. This I willingly link with the politics, discourses and incentives of the term's "host country".

Overall, the communication with the participants proved fruitful not only for the production of knowledge in this research but also for the very methods of knowledge production. Certain tensions between me and the participants first exposed the "world's active agency" (Haraway 1988) in practice to me as a researcher. These exchanges made all the more obvious the danger of perceiving the participants' bodies as resources rather than agents (ibid). I resisted the temptation to singlehandedly plough through the data that I obtained with relative ease, to gruffly handle the gathered material by subjecting it to the analysis I had planned. At this point of the conclusion, it is safe to say that the participants and I were "all in this together".

The collaborative nature of this project served to magnify the extent of my responsibility towards the research participants. While being immensely thankful for the stories shared and the time that my participants took to engage with the project, I understand that it will never be finished until I at least present a Russian translation to the community of participants that supported me. Thus, the moment of finality is yet to come for this project, this conclusion is rather indicative of a preliminary pause.

Narrative inquiry proved itself as a salient research method also for the reason that it highlighted the topics that were marked by silence.

Interestingly, some of the subjects I was anticipating and taking for granted failed to emerge in any of the narratives. For instance, I was confident that an Orthodox narrative would come into this story. Provided the incessant interplay of "Russian traditional values" and Orthodox Christian thought, and the occasional Christian propaganda in ZKs (elaborated upon in Chapter -), it would have been on point for the subject to be brought up in either implicit or explicit form. However, none of the narrators recounted any instances of symbolism that could point at the actualization of Orthodox values (for example, pro-life banners in the hallways of clinics, etc.). While banners of this kind can be glimpsed at ZKs frequently, they were not mentioned by the participants. This also proves that punitive gynaecology is a much more complex phenomenon than mere enforcement of pronatalist ideologies, accompanied by physical roughness. Pronatalism does not necessarily crystallize itself in the process of the doctor-patient encounter.

From what the communication partners reported, giving birth to a baby was framed as part and parcel of a woman's existence. This was neither questioned, nor discussed in any of the encounters. A woman registering with a gynaecological clinic is already considered to be anticipating motherhood and seeking to actively prepare for it. Thus, there appears to be no real need to preach about the importance of procreation during the gynaecological examination or verbally articulate it in any concrete way: the incentive of procreation is articulated prior to the actual encounter of the patient and her assigned doctor, the deal is sealed the moment a woman signs her registration list.

Another topic marked by silence is that of the doctors' personality. While the gynaecologist is a crucial participant of the encounter, we rarely get some sort of personality description. Research participants mostly highlight the comportment of the doctor: the words and actions, the personality is not a topic of rumination. Some

respondents try to situate the doctor's attitudes within a broader context, for example, explaining the clinician's demeanour by the extreme levels of exhaustion and lack of financial security. The gynaecologists in the narratives appear to be members of a homogeneous and extremely monolithic group with the shared need of mapping discipline over the patients' bodies. Other than that, rarely do the respondents venture so far as to "personalize" the gynaecologist. This may well be the result of method: knowing that they were to play an important part in conceptualizing the phenomenon of punitive gynaecology, the research participants were eager to perceive it as a machinery, excluding the personalities of those that exercise its' effects.

Narrative analysis has demonstrated that punishment in gynaecology follows a Foucauldian model of exclusion, redemption, marking and confinement (Foucault, Harcourt and Burchell 2015, pp. 6-10). Marking is the most prominent method of punitive gynaecology. There is no specific set of criteria for determining a deviant body, but a crystal-clear logic is always observed. A body is considered deviant when it is for whatever reason deemed unsuitable for reproduction when it brings itself in a manner that is hard to regulate and contain. Hence, the metaphorical lashing of bodies that appear too promiscuous or too virginal, too old or too young, too oversexed or too sexy when observed by the ever-present "male connoisseur" embodied by the gynaecologist.

A deviant body can be marked verbally through the use of derogatory statements. It can also be marked by silence: if we think of abortions being unofficially put on hold throughout the Covid-19 crisis. It can be marked painfully and physically, as described by women that underwent curettage without anaesthesia.

Marking in punitive gynaecology is soon followed by redemption where the cultural code of suffering becomes actualized. Initiation into womanhood takes place only after a load of severe physical pain and suffering is shouldered by the woman. As I note in Paragraph 5.5, labour pain is the one type of pain that seems to have credibility in the gynaecological examination, with all other types of pain being dismissed and deemed "not strong enough". Going through pain appears to be a logical punishment for not being "enough of a woman". It is in the form of constant pain that redemption plays out on the female body. In the empirical part of this work, I was drawing on Bartky (1988, 1998) to prove that infliction of pain is a method of enacting a disciplinary femininity.

Exclusion and confinement are also part and parcel of punitive techniques in gynaecology. Following verbal and visual marking, "deviant" bodies become symbolically dismissed (excluded) from attention and care. Such is the ordeal awaiting the bodies of non-heterosexual women, women seeking abortion, women who do not have heterosexual sex (thus deemed not ready to procreate). Based on the analysed narratives, a female body should be healthy and fit, ready for conception. It should also be attractive and receptive for men. Gynaecologists instil the needed discipline by remarks on the women's appearance, reproductive behaviour and, sometimes, private life. At the same time, gynaecologists are rarely aware of their role as disciplinarians. However, this does not change the reality that gynaecologists and obstetricians have the "discursive freedom" (Sokolová and Umland 2012) to interpret and apply widespread stereotypes about gender and sexuality when treating a patient.

As I mentioned at the very beginning of this thesis, a woman's encounter with punitive gynaecology does not begin when she enters the doctor's office, nor does it end there. The actual examination merely highlights the long-standing involvement of the woman with punitive gynaecology. The deal is sealed as soon as the woman registers at the district clinic. By doing this, she becomes a subject of surveillance. In the event of pregnancy, the woman becomes obligated to attend regular check-ups at the ZK (Radzinskyi, Ordiyants and Orazmudarov 2010). Several of my narrative partners mentioned obligatory gynaecological check-ups at schools. This is where the aspect of redemption comes into play.

In this thesis, I have analysed various aspects of punitive gynaecology through a Foucauldian lens. While this work has managed to uncover many controversial dimensions of punitive gynaecology, I believe that there remains a great deal to discover about the topic. I hope that this thesis will be a solid starting point to catalyse further research. Ultimately, it has fulfilled its' aim: to shine a light on women's dismissed experiences with punitive gynaecology.

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