MORAL FOUNDATIONS AND SYMBOLIC POLLUTION: WHAT DO MIDWIVES SAY ABOUT HOSPITALIZED WOMEN?

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The aim of this study is to describe how the work organization of midwives is related to their moral judgements concerning pregnant women. This analysis is based on material gathered during ethnographic research undertaken at a gynaecology and maternity ward at a hospital in Slovakia. The interpretations of the research findings are informed by the work of Mary Douglas and Moral Foundations Theory. Using the analytical tools of the grid-group, this article then shows that the working environment of midwives is a type of hierarchical group. Douglas predicted that such a type of social structure would be built on values such as subordination, respect for authority, and purity. An analysis of the material confirms this assertion: midwives' narratives of pregnant women are in fact representations of moral values of authority and purity. Explicit statements of emotions of anger, contempt, disgust, and elevation serve as indicators of either the violation or observance of moral rules.

Key words: danger, narratives, emotions, healthcare

INTRODUCTION

Pregnant women in Slovakia can access healthcare in both public and private gynaecological clinics and hospitals.[1] The organizational structure of the health care system distinguishes three types of professions: higher (physicians), middle (nurses and midwives) and low (health care assistant) health care professionals. The work organization in these health facilities, similarly to other institutions, is governed by current legislation as well as informal rules and moral norms. This study is about the workflow of midwives at a district hospital in central Slovakia and provides a small analytical inquiry to the area of moral discourse in the work environment of this hospital.

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1 Last year more than 55,000 children were born in Slovakia in 54 maternity wards. For a long time research and statistical institutions have been warning that the Slovak population is getting older, which is a demographic trend in most European countries.

In Slovakia midwives and the other middle health care professionals are taught in a university, and the content of their training is controlled by the members of the profession. They are organized in the Slovak association of midwives and gynaecological nurses. The middle health care professions in Slovakia are mainly performed by women and moreover are underpaid. Besides that the health care system being in profound personal and financial crisis: it is lacking all types of medical professionals and is inadequately funded by the state and regional government (Ministerstvo zdravotníctva, 2015; Zachar, 2013). On this point I would like to emphasize that in this situation women are in a vulnerable position because their social security is threatened. Particularly single mothers and older women are in higher risk of poverty. This refers to the gender power imbalance in redistribution of resources (Bútorová, 2007; Kobová, 2015). In the last years middle medical professions were organizing strikes for better working conditions and pay. These issues in the health care system have an impact not only on the quality of the service but also on the quality of life of the medical professionals. Nowadays, these issues, especially the feminization of certain professions and poverty, are under-researched in Slovakia. Likewise, ethnological and anthropological research in biological reproduction is considered too marginal an issue in post-socialistic middle European countries. Although in the Czech Republic, Poland and Hungary we can find some studies concerning topics such as cultures of maternity wards (Hrešanová, 2008), fertility treatment and assisted reproductive technology (Radkovská-Walkowics, 2014; Slepičková, 2011; Slepičková, Šlesingerová, Šmídová, 2012), gender aspects of birth and health care professions (Šmídová, 2008; 2015), religion, politics and biological reproduction (Mishtal, 2015; Zielińska, 2004). In Slovakia the ethnological and anthropological research in biological reproduction is concerned with the issue of medicalization of birth-giving (Botíková, 2015), breastfeeding (Jágerová, 2011), or midwifery (Beňušková, 1990; Pekařová, 2013).

The aim of this study is to inform the empirical material by the work of Mary Douglas and Moral Fondations Theory (MFT). The basic ground of the analysis is that Mary Douglas's theory and MFT are complementary models of morality and social relations: "MFT examines the moral principle around the world people share; and Mary Douglas's theory offers a structure for framing MFT's model of morality in a theory of social interactions, while this model contributes moral lexicon currently missing in her theory" (Bruce, 2013: 34). Besides that, my purpose is also to emphasize some aspects of midwives' work that have had an impact on the quality of their life and social security. I will analyse the work environment of the midwives and narratives by them which describe situations when pregnant and delivering women were deemed to have broken these rules. These narratives reflect moral norms bound to the social role of hospitalized women, and their analysis can contribute to an understanding of the moral discourse of healthcare facilities in a certain socio-cultural context. I recorded these narratives during my research at a gynaecology and maternity ward at a district hospital in central Slovakia.

Douglas was mainly interested in cross-cultural comparison of the symbolic classifications and their social contexts. She reinstates some arguments of the French sociologists of L'Année sociologique group. In the introduction to her book *Natural symbols* (originally published 1970) she stated: "For if it is true, as they asserted, that the social relation of people provide the prototype for the logical relations between things, then, whenever this prototype falls into a common pattern, there should be

something common to be discerned in the system of symbols it uses. (…) A cross-cultural, pan-human pattern of symbols must be impossible. For one thing, each symbolic system develops autonomously according to its own rules. For another, cultural environments add their difference. For another, the social structures add a further range of variation (Douglas, 1996: xxxi). She identifies four distinctive systems of (natural) symbols. These are social systems in which the image of the body is used in different ways to reflect and enhance each person's experience of society (Douglas, 1996: xxxvi). She asserts that the attitudes and values of members of a given society depend on its forms of social structure (Douglas, 1996: xxxvii).

In its interpretation of the collected material, this study focuses on the working environment of midwives. It shall try to show that the norms and rules which feature in the midwives' accounts refer to a type of hierarchical social system where there are typical values of subordination (the importance of the collective over the individual); obedience (every position in a structure has defined roles which must be followed); and respect for authority, moral purity, and the group (the maintenance of the social boundaries of an organization) (Douglas, 1996: 62–63).

Moral emotions play a fundamental role in the identification of the breaking or maintenance of moral rules and norms. Douglas explicitly refers to emotions in her description of system of symbols, but she does not provide any theory of emotions as such (Douglas 1966; 1996). This is why this study uses MFT, which provides one way to interpret how emotions are linked to moral values on the level of cognitive processes (Graham et al., 2012).

In its first part, this study offers an explanation of theories which are used to frame the interpretation of the collected material and a description of the research environment. Then it analyses the working environment of midwives within the framework of Douglas's theory. Following this there is an analysis of the collected narratives, which are interpreted using MFT in combination with Douglas's concept of pollution. This study will show that the working environment of midwives is a type of hierarchical group. An analysis of the collected material confirms this assertion: midwives' accounts of pregnant women are in fact representations of moral values of authority and purity. The final part of the study summarizes the results of this interpretation.

SOCIAL STRUCTURE AND MORAL EMOTIONS

The basic foundation of Douglas's theory is that cultural variability is caused by a different social structure which creates various forms of symbolic classification. Douglas's aim was to empirically show that symbolic classifications depended on social structure. In order to go about this, Douglas constructed a methodological tool (the "grid-group diagram") designed to compare and explain cultural variability.

As a part of this diagram, Douglas defined four relatively stable configurations (or social systems) which refer to different social environments and symbolic classifications. These configurations were identified as representing individual, hierarchical (or positional), fatalistic (or isolate) or egalitarian (or enclave) group (terms cultures, societies or communities are also used by Douglas to describe configurations). High group and high grid configuration, hierarchical, is characterized by complex rules concerning personal interaction. Individual social experience is defined by the social boundary maintained between in-group members and external society and by the

clear ruled behaviour between group members. Roles are ascribed according to birth, gender, family or other structures, and ranked according to function and tradition. Low group and high grid emphasize as previously mentioned configuration of the social boundary and authority of the group, but is characterised by minimal role differentiation within the group. It repudiates the inequalities. Ranking and ordering are the main forms to control the members. The social experience of the individual (low group and low grid) lacks social prescriptions and group membership. The main form of control in this social environment is by competition. The last one, the fatalistic way of life is regulated by social rules and individual autonomy is minimized (Douglas, 1996, 1982; Douglas, Wildavsky, 1982).

Group	*fatalistic*	*hierarchical*
	individual	*egalitarian*
4 configurations	**Grid**	

Table 1: The grid and group diagram

She argued that symbols mark systems of classifications, and that classification systems are reflections of social systems (Douglas, 1996: 14). The second assertion in her theory is that every social unit tries to maintain and legitimize its internal structure through symbols and then match them to the meaning of human existence itself so that life has meaning for its members. A society only produces those symbols that are necessary for maintaining its social order, and it exercises control over them (Douglas, 1996: xxxi-xxxvii).

As a part of symbolic classification, there are universal symbolic patterns of purity and pollution which are based on messages directed at the human body and which Douglas called "dirt". This is a universal symbol which indicates the violation of the given order and which also legitimizes that order by determining its boundaries. Therefore, it has an important function in terms of symbolic classification: it defines its purpose by violating it. Dirt is the expression of an experience which does not correspond with the system created by a means of symbolic classification; this is why people then feel an internal need to correct it. Emotions of fear and disgust become important signals that something is not right, and that it is therefore necessary to eradicate, correct, or avoid such dangers. This is why dirt is an important and universal symbol of social structure and why emotions indicate a breach of moral rules (Douglas, 1966: 2–3).

MFT is a part of cultural psychology and focuses on emotions connected with moral rules. It is based on principles of evolutionary and cognitive psychology. A fundamental assumption is that the human mind is composed of a number of innate mental systems, all of which were formed as a part of the evolutionary process as adaptive solutions to specific problems in the environment. Moral domains are psychological systems which allow people and their actions to be perceived as proper or improper (Graham et al., 2012). However, as the cultural psychologists Haidt and Joseph have pointed out, they do not refer to the character traits of specific people; rather, they allow for a differentiation between people and their actions through presented indications within a social structure. These two researchers discuss moral domain as "moral taste receptors" (Haidt, Joseph, 2009: 111–112). According to MFT, moral emotions are a reaction to the violation or observation of moral rules and are

connected to a particular social environment and set of social information (Graham et al., 2012: 71-72). This is why MFT propositions are useful for studying disturbances to a given order; Douglas places them within her symbolic concept of "pollution".

Jonathan Haidt and other cultural psychologists defined five foundations of moral reasoning which have been best documented in research to date: harm/care, fairness/reciprocity, in-group/loyalty, authority/respect, and purity/sanctity (Graham et al., 2012: 54). They organize these five moral clusters into two distinct areas of morality: individual-based (harm/care and reciprocity/fairness) and group-based (in-group/loyalty, authority/respect and purity/sanctity) moral concerns (Graham, Haidt, Nosek, 2009). Each of these areas corresponds with specific reactions to the violation or maintenance of rules, and therefore to specific moral emotions as well. These emotions are defined as being connected with the interests or well-being of a society as a whole, or at least with other people. Haidt defined four categories of moral emotions: condemning others (contempt, anger, and disgust); self-consciousness (shame, embarrassment, and guilt); feelings towards the suffering of others (compassion); and praising others (gratitude and elevation). Each of these listed moral emotions has a specific evolutionary account, or function, which played a role in the adaptation of the human species. This account determines specific elicitors (events/objects which cause an emotion to be felt) and a tendency to behave in a way which is the result of having experienced the given emotion (Haidt, 2003: 853–856).

For the purposes of the present study, it is important to more closely specify moral emotions which are related to the condemnation of others (referring to symbolic pollution) and those which are related to the positive evaluation of others (referring to symbolic purity). Anger, disgust, and contempt are marked as emotions which protect the moral order and which motivate people to avoid or punish those who tried to cheat or exploit them. In terms of evolutionary theory, this is related to the creation of coalitions, altruism, and cooperation, and they were reactions to deception (an obstacle to creating coalitions or cooperation within a group) or abuse of relationships (violating the principles of altruism) (Haidt, 2003: 856).

Elicitors of anger include various failures, such as when trying to fulfil a goal and when experiencing moral agitation related to betrayal, an attack, or unjust treatment (Haidt, 2003: 857). Disgust is a reaction to physical objects as well as to the violation of social rules. According to Paul Rozin, Haidt, and Clark McCauley, in evolutional terms the oldest form of disgust is "core disgust", which accompanied the rejection of unsuitable food. Its function is the protection of the physical body against illnesses and infections. From this, disgust itself developed as something which is supposed to protect the body as a symbolic whole and which is a reaction to the violation of moral rules. This type of disgust is also known as the "guardian of the temple of the body"; one of its elicitors is the violation of the rules of a community in connection with how a person is supposed to look after their own body. For this type of disgust, there is a characteristic tendency to maintain hygienic rules, and avoid or break off contact with an unclean person or unclean behaviour (Rozin, Haidt, McCauley, 2000: 644–645). Contempt refers to situations when people feel morally superior and look at those around them "from a higher position". This arises in situations which are connected with disdain, the violation of rights, or a disturbance to the hierarchy (Haidt, 2003: 860).

Elevation is a type of moral emotion which is connected to the positive evaluation of other people. It confirms moral rules because the admired person is judged to be

moral and worthy of esteem and respect. Whereas disgust signals a violation of rules or boundaries, elevation is an indicator of the observance of these rules. Frequent elicitors of elevation include charity, kindness, loyalty, and self-sacrifice. A typical tendency of behaviour which emerges alongside elevation is the attempt to follow the example of people who are admired (Haidt, 2003: 868).

THE RESEARCH ENVIRONMENT

The analysed data were gathered during ethnographic research[2] (July 2014–June 2015) in the high-risk pregnancy unit of the gynaecology and maternity ward at a hospital in central Slovakia. The hospital's ethics committee approved the proposed research, which allowed access to this part of the ward. The gynaecology and maternity ward at the hospital has five parts: a gynaecology unit, a high-risk pregnancy unit, a delivery room, a postnatal unit, and a newborn unit (known colloquially as the "maternity unit"). In terms of work organization, every unit had designated midwives who worked in shifts. Midwives were assigned to a particular part of the ward (there were four in the high-risk pregnancy unit, four in the gynaecology unit, four in the postnatal unit, and eight in the delivery room). However, if a situation arose where one midwife could not come to work (e.g., due to holiday leave, an inability to work, or other reasons), a midwife from another part of the ward would come in as a replacement. If such situations occurred, midwives called it "helping each other out."

In addition to having a set area where I could move around, there were certain time limits on my research visits, which were determined following a mutual agreement with the head midwife.

The analysed data are of three types:

(1) the recording of semi-structured interviews held with four midwives who were assigned to the high-risk pregnancy unit and one unrecorded semi-structured interview with a midwife from the gynaecology unit who was "helping out" at the high-risk pregnancy unit;

(2) unrecorded conversations undertaken during my time at the ward. In total, twelve midwives from the high-risk pregnancy unit, the gynaecology unit, and the delivery room were spoken to;

(3) participant observation.

The conversations and interactions with midwives took place in the high-risk pregnancy unit, the delivery room, the maternity unit, and in the corridors of the gynaecology and maternity ward. In addition, I met a number of times with midwives in the broader area of the hospital. The average age of the midwives who were spoken to as part of this research was 55 years: the youngest midwife was 23 years old, and the oldest midwife was 61 years old. Nine midwives were married, two were single (one of these was divorced), and the youngest midwife in the ward was in an informal relationship. With exception of two all midwives have got children (but no more than

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2   This study forms part of my doctoral research, which examines representations of the female body and threats faced by pregnant, delivering and breastfeeding women. This issue is examined in two groups: (1) pregnant women and women up to three years after having given birth, and (2) healthcare personnel.

three) and two of them have got already grandchildren. As I mentioned in the introduction the conditions of the contemporary health care system are threatening the social security of its employees, especially vulnerable are single women and mothers.

Respondents (except the youngest) studied midwifery during the previous political regime when these health care professionals were prepared on the secondary vocational school. The most profound changes in midwifery education happened after Slovakia joined the European Union in 2004 when the university education for midwifery became mandatory for newly trained midwives. The youngest respondent studied under these changed conditions. Just two from the older generation of the respondents acquired a university degree because of the career advancement opportunities. In addition, there are legal obligations for continuous education for midwives.

The names of the informants in the text are anonymous, and the emic expressions are given in inverted commas. The collected data were examined in the form of domain, taxonomic, componential and thematic analyses (Spradley, 1979; 1980).

THE WORK ORGANIZATION OF MIDWIVES

This section discusses the working environment that midwives experience using an analytical tool which Douglas created with the purpose of precisely characterizing social bonds in a given society. This type of analysis was done upon the basis of two variables: the grid and the group (Douglas, 1996).

The grid expresses the level of freedom of the actions of an individual in the process of interacting with other members of a social unit: a low grid suggests freedom of action or interaction with others as equals, whereas a high grid suggests isolation or a more limited acceptance of individual decision-making. This coordinate refers to the control of time and space in relation to social roles. The group is defined by demands which the social structure places on its members; it refers to boundaries which encircle them as well as their rights as granted by the system (such as various forms of protection, taxes, and restrictions). The group indicates the exclusivity of membership in the given social unit (who can get in and under what conditions) and its stances towards those outside this group (how outsiders are described and what rules dictate contact with them). According to Douglas, the aim of such an analysis is not the determination of precise coordinates but rather the description of the presence or absence of a strong grid and strong group (Douglas 1996, 59–62).

The midwives' working environment and the organization of their work indicates the existence of a strong grid and strong group. An analysis of the collected material suggests that midwives work according to clearly defined rules and norms and they have little chance of influencing them. Their position is clearly determined according to expertise and performance in the table below.

Laws and internal regulations at the hospital
One of the signs of a strong grid and strong group are sets of regulations and obligations in relation to social roles which are not dependent on particular people and are determined by the system itself (Douglas, 1996: 63–64). As a part of this work organization, midwives abide by state legislation, the internal regulations of the hospital, and the formal rules of the gynaecology and maternity ward. Their work is

Strong grid The level of freedom of action by a midwife within the organization is low.	Strong group The degree of group cohesion among midwives in their work organization is high.
long-term job description: a work schedule which is created by the head midwife	current state legislation and internal regulations at the hospital
job description during the day: examinations which physicians determine for each hospitalized female patient	competences allocated upon the basis of specialized training
the place of work and clothing according to a midwife's work competences: a high-risk unit which they cannot leave – the requirement to wear white medical clothing and a name badge	meetings and seminars
limited breaks for lunch	the checking of people coming into the ward
clearly defined working hours	a common midwives' budget to help run the ward, which included contributions from the midwives themselves
	celebrating colleagues' birthdays and name days in the workplace
	all-hospital excursions and other forms of teambuilding

Table 2: The grid and group level of the work organization of midwives

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strictly defined in terms of time and space by people who are in a higher position in the set hierarchy.

The work organization of midwives is specifically determined by the Labour Code, the Healthcare Act, and the internal norms of the ward. Midwives worked twelve-hour day and night shifts, which were planned one month in advance. The work schedules were made by the head midwife, and the other midwives only had a limited opportunity to influence when they would be working. The midwives knew what shifts they would have for the next month but not for a period further ahead. An exception to this was the summer holiday period, when holiday leave was planned a number of months in advance. In addition, there were changes that could arise according to the head midwife's instructions. Changes to the work schedule could also happen as a result of certain personal circumstances; for example, if midwives fell ill, or were not able to make it to work for some other reason, this was a matter of great consideration as the opportunity to take holiday leave was limited by the Labour Code.

Other limitations which midwives could not influence concerned their pay. Midwives had fixed salaries set by the law. Generally, they were not paid for working overtime, even though working overtime was a common occurrence due to the low staffing levels at the ward; some midwives did receive overtime rates, but the amount paid out was pitiful. The chance to have overtime paid was influenced by the budget for running the ward, which was set by the hospital management for each ward in the hospital. If the need arose for more financial resources during the budgetary period (such as for new instruments and machines), there was either no possibility of meet-

ing this need or negotiations had to be held with the hospital management, where the justification for the need would have to be properly made. I was told that the success of such negotiations depended on the importance of the ward within the hospital structure.

Within the budgetary constraints, the number of overtime hours worked that should have been remunerated was not taken into account. There were situations when, as a part of budgetary planning, financial resources could be saved (e.g., if a midwife went on long-term sick leave) and the head midwife could then add a small financial bonus to the monthly salaries of those staff who had worked the most amount of overtime. However, this depended on the adeptness and benevolence of the head midwife, and other midwives had no influence concerning this matter.

Other regulations which midwives had to abide by included systematic training in the field. Midwives mentioned compulsory seminars which they had to attend. Additionally, every five years they would have a meeting where they had to show how they had worked on their education and training. The requirement to attend seminars, even when they were instructive and inspirational, was viewed by midwives negatively. For one thing, they had to meet the costs of these seminars themselves from a low salary. Furthermore, the seminars were often organized away from the midwives' homes or workplaces, and sometimes even during holiday leave, which meant that the midwives had to make arrangements for running their households or looking after family members (particularly schoolchildren and older relatives) and that they lost the chance to rest.

In addition to legal norms and internal regulations, the tasks of midwives during shifts were influenced by the physicians on duty. This was something which midwives could not influence, as it was affected by the state of health of the patients and the type of treatment prescribed by the physician as a medical authority.

The bureaucratization of the work of midwives

The importance of administrative tasks within work duties is another example of the clearly set rules regarding social roles which midwives could not freely determine. This aspect is another manifestation of a strong group and strong grid. The performance of administrative obligations was supervised vertically; if midwives did not complete these tasks, they would be reprimanded or would receive another form of unpleasant feedback from their superiors. There is also a horizontal form of checking; if a midwife did not complete the necessary paperwork before the end of a shift, this task had to be done by the midwife on the following shift, which could cause conflict in the workplace. In other words, not completing administrative obligations threatened the cohesion of the group.

Administrative tasks comprised a significant part of duties in the workplace; midwives saw these tasks as a waste of time which took them away from caring for patients. Nonetheless, the importance of administrative tasks had a visual representation in the midwives' common room (the "nurses' room"), where the walls and the noticeboard displayed instructions, warnings, and other information regarding their work duties: these included what they must not forget to write down when admitting a patient; a reminder that they were not allowed to file the laboratory reports of samples taken from patients until a physicians had seen them; telephone numbers to other wards in the hospital; and the periods within which sample analyses were completed. Over the course of the research, I noticed that some written instructions on

the wall would change, particularly concerning requirements from the head midwife or senior physician regarding health insurance companies and the current stock of medications and other healthcare supplies. In this way, midwives were explicitly reminded during their shift of a number of formal obligations.

Work impacts on family life, leisure, and health

The inability to influence working conditions had an impact on the organization of time spent outside of work: time spent with one's spouse, children, or grandchildren, or time for relaxation after exhausting shifts. One midwife, called Margita, described this situation as like having "life pass you by". The set working conditions also affected the midwives' state of health. They said that frequent shifts, a stressful environment, and an inadequate amount of rest after work led to midwives suffering from high blood pressure, headaches, and overall exhaustion. Furthermore, they stated that during their shifts they sometimes had no time to eat, rest (even for a moment), or complete the necessary administrative tasks. This aspect illustrates the fact that the functioning of the whole collective was given preference over the interests of the individual, which Douglas saw as a core principle of a hierarchical group.

Hierarchy and the division of competences in midwives' work

Social units with a strong group and strong grid have a characteristic tendency to have a developed hierarchy and clearly defined social sectors with separate obligations and privileges (Douglas, 1996: 61). The relationships between midwives and other staff in the ward were fixed upon the basis of hierarchical competences, which were determined upon the basis of levels of training and education. The running of the ward in terms of material, administration, and organizational matters was the responsibility of the midwives themselves, who were helped by orderlies and other aides. In addition to this, midwives would undertake certain medical procedures in the ward as determined by the physicians.

The set of obligations and competencies was defined by the physical space in the ward, which, according to Douglas, is one of the indicators of a strong grid (rules concerning space in relation to social roles) (Douglas, 1996: 62). Responsibility for the running of the ward (competences in relation to space) also appeared when midwives observed who was in the ward and at what time. This particularly concerned whether a person was entitled to be there in the first place, visits, and pregnant women who were not hospitalized in "their" part of the ward (possessive pronouns and adjectives were used very often by midwives when they were talking about which part of the hospital they worked in).[3] A number of times during the initial stages of the research, a midwife would approach me when I was changing in the delivery room and ask what I was doing there. The midwife would add, "The physician told me that someone [from outside] was here." At other times, I was already wearing the compulsory white clothing but no name badge, a midwife passing by would ask me who I was visiting. The physicians would never ask such questions (except the senior physician, who was responsible for the running of the whole ward). Even though they registered

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3   Over time, I was accepted by midwives as "one of ours", which can be interpreted as a sign of my relationship to others in the ward being verbally classified; I was no longer an outsider but rather a part of the organization being studied. I was described to the medical staff as someone who was "on an internship" and who was "interested in how pregnant women feel [here]". Given that the ward welcomed medical students and young women studying midwifery, I was placed into this existing relationship structure.

me and often gave me looks of suspicion, the physicians would usually send a midwife to investigate so as to "put things in order in the ward"; this statement was heard often from midwives when they discussed what the physicians tended to say to them. Given the fact that the place of research was a relatively small hospital, and the gynaecology and maternity ward was rather small in terms of the number of healthcare professionals and other staff, it was easy to identify outsiders, even when they were wearing the required medical clothing.

Another of the indicators of a strong group is the maintenance of social boundaries between the group and outsiders; hierarchical groups have a "well-developed sense of bounded social unit" (Douglas, 1996: 63). This feature can be explained by describing visits to the ward. During certain hours, there were people "from outside" present in the ward who were not recipients of medical care and who were not part of the organization. Therefore, their presence in the ward was temporally and spatially regulated and checked by midwives. These people would announce themselves using a doorbell, and a midwife would then open the door to the ward and direct them to the patient they had come to visit. Sometimes the door to the ward was left open, and visitors could enter the wards without the midwives' knowledge. In spite of this, the midwives always had a clear idea of who was in the ward, as they were constantly entering patients' rooms to administer treatments or whenever they heard any kind of noise which was out of the ordinary. Visits were limited by time; if people wanted to pay a visit outside of visiting hours, they had to have the permission of the senior physician or physician on duty. This meant that even though the midwives had the running of the ward on their hands, physicians still determined who could cross the ward's spatial boundaries (normally defined by fixed visiting hours and patient admissions) even outside of these set rules. If the senior physician was not on duty, midwives would allow visits outside of visiting hours. However, if the senior physician was present, they would be careful to make sure that the rules were followed in order to avoid being reprimanded.

The separation of competences was also expressed in the way in which my questions regarding the running of the ward and the provision of healthcare were answered. When answering questions regarding contracts with insurance companies, diseases during pregnancy, or complications during delivery, the midwives would say that they did not have the competence to talk about such matters and that the physicians or head midwife would be in a better position to answer inquiries concerning the provision of services and the administrative running of the ward. Even though in conversations over time they would answer a lot of these questions, their statements were not direct answers and only emerged in conversations on other topics.

The division of competences and social control in the collective

The clearly defined obligations and competences within the group as an expression of a strong grid are regulated within the group through the quality of working relationships. The quality of relationships is formed through maintaining cooperation as well as sharing leisure-time activities. Each position within the organization was dependent on others. If staff did not fulfil their duties within a certain timeframe, conflicts or tension between staff would result. Hospital aides would be unpleasant to midwives if they were unable to distribute lunch or dinner on time; there was also disapproval if one midwife was late for work when coming to take over a shift from another, or if a midwife did not manage to complete the necessary administrative tasks

during her shift, thus leaving them for the incoming midwife. This can be interpreted as an expression of internal supervision, where each level of the organization monitors the observance of the rules. However, whether or not tension erupted depended on the quality of workplace cooperation and not on the official relationship as such. Midwives told me that if they had good relationships with the aides and orderlies, they would help each other out. This is an expression of cooperation within hierarchical relationships (this level of relationship was recorded between two midwives and one hospital aide).

A strong grid assumes the existence of a network of rules in the process of social interaction (Douglas, 1996: 61). Physicians, midwives, orderlies, and aides mostly met with each other during shifts while performing their respective duties, and they had competences which related to their position in the workplace. Outside of the performance of work duties, all levels of the organization would meet at the annual ward meeting (although not all would attend). A strong group has a lot of activities which function as a means of maintaining a feeling of belonging to that group (Douglas, 1996: 63). Birthday and name day celebrations, as well as other important events in life, were activities which brought members of the group together. Other forms of interaction between different levels of the organization included hospital-wide team-building events and organized excursions.

Midwives from different parts of the gynaecology ward would meet at regular meetings and at seminars, but not all of them would meet at the same time. Working relationships between midwives in the ward were strengthened by means of a common money box. Every month midwives would individually contribute two euros to a common fund which was used to purchase necessary administrative and hygienic material (such as pens, notepads, toilet paper, and paper towels). Alongside the limited budget for salaries, the work of midwives was also limited by the hospital management in its provision of material aid which was essential to the ward's administrative operation. The example of the common money box shows the level of cooperation of people working on the same level as well as the fact that the interests of the group were placed above the needs of individuals.

According to Douglas, social groups with a strong group and strong grid have a characteristic tendency towards hierarchy and a classification with clearly defined social sectors. She added that it is possible to determine the values and moral rules in every social unit which legitimize the system and keep it in order. A hierarchical group gives priority to the collective over the well-being of the individual: it requires individuals to sacrifice themselves for the good of the group, it positively evaluates the fulfilment of obligations with respect to social position and moral purity, and the core governing value is authority (Douglas, 1966: 62–63). A grid-group analysis takes place on a level where people consider it necessary to explain and justify their actions, doing so in the form of narratives. This is why an analysis of the accounts of midwives concerning hospitalized patients, which will be discussed below, is a useful tool for describing the moral values governing the working environment.

WHAT MIDWIVES SAID ABOUT PREGNANT AND DELIVERING WOMEN

According to the selected theories, the body as a symbol refers to moral rules, and the concept of symbolic pollution indicates a violation of these rules. While analysing the midwives' accounts of interacting with patients, I identified symbolic pollution in explicit emotional expressions of anger, disgust, and contempt, which are all emotions which exist in order to protect the moral order. Here an account also had to contain comments with negative connotations relating to patient behaviour (e.g., "That's not the done thing," or "She shouldn't have done that") and character (e.g., "She's messy," or "She's an unfit mother"). Symbolic purity was identified upon the basis of expressions of admiration and recognition in verbal statements and positive evaluations of patients and their behaviour.[4] In the conversations with midwives, various themes came up in the accounts regarding women hospitalized in the high-risk part of the ward and those who gave birth in the delivery room. The related experiences were either experienced by the midwife telling the account or had happened to another member of the working collective. Twenty accounts were recorded in total.

The analysis of these statements includes midwives' short descriptions of pregnant women. At the beginning of the fieldwork, I asked the midwives which patients I could approach. The aim was to ascertain which women were in a suitable state of health to be interviewed. Over time, the midwives themselves began to reveal what sorts of women were hospitalized, and they added their own opinions on their character or social background, in addition to describing their state of health. Their descriptions were sometimes accompanied by expressiveness (gestures such as waving the hands; facial expressions including frowning, raising the corners of the mouth and grimacing; and raising one's voice). These characteristics sometimes led to the retelling of accounts with the line, "We've had someone like that here before." The manner in which the hospitalized women were described related to the categories which have been identified above as elicitors of the concept of symbolic pollution, which will be later defined in the text.

Upon the basis of whether accounts form representations of symbolic pollution or purity, I created two categories: midwives' accounts concerning pollution and those concerning purity. The following analysis of accounts was created by placing pregnant and delivering women on a purity–pollution scale. In the collected material, two types of accounts concerning pollution were identified: the first of these was when women who had already been placed in the impure category acted incorrectly, and the second type was the recollection of events where a woman who had been classified as pure did not behave in the way that was expected of her. There were also two types of accounts about purity: when a pure woman behaved as was expected of her, and when an impure woman did not act in the way that was expected of her, therefore acting in accordance with the rules on purity.

In the midwives' narrations, accounts about pollution dominated (16); accounts concerning purity were present to a much lesser degree (4), and their function was to create a contrast to the described events connected with impure behaviour. Initially, the midwives would usually relate an experience about pollution, and in some cases

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4   It is important to emphasize here that the terms purity, pollution, and dirt are not used in a pejorative sense but rather as analytical expressions which refer to a symbolic classification.

they would add one about purity where they described a woman's correct behaviour. It is possible that the higher number of accounts about pollution is related to the way in which healthcare personnel interact with pregnant women. Upon the basis of participant observation, it can be said that the hospital staff would give patients verbal warnings if they violated hospital rules or acted in a way which was considered inappropriate for pregnant women (i.e., walking quickly). However, if a patient acted in accordance with the set norms, they would not say anything. This can be interpreted as an expression of the confirmation of existing rules by emphasizing their violation, which corresponds with Douglas's assertion on pollution as having a paradoxical function by legitimizing a set of rules through their very violation (Douglas, 1966: 2).

The concept of pollution and moral foundations

When identifying moral foundations determining the rule which impure or pure women broke or observed was important. In one account, there could be references to the violation of multiple moral foundations. After an analysis of the midwives' accounts, I was able to determine moral domains which were significant for work organization in the ward in terms of the staff's relationship to patients. Within the intentions of MFT, the analysed accounts mostly represent the moral values of hierarchy and purity.

The most violations of moral rules were regarding authority (most often towards physicians, and in one account towards a midwife). The breaking of rules in this foundation is a reaction to the organization of hierarchical relationships within the social order, such as rules of relationships of dominance, obedience, and respect (Graham et al., 2012: 70). The second most numerous group was the breaking of rules regarding how a proper woman and mother should act so that a healthy descendant could be born, referring to the symbolic purity of motherhood. Within this foundation of morality, this is a reaction to physical and spiritual pollution (Graham et al., 2012: 71). Pollution ideas are the products of representation of ideal society and ideal individual (Douglas, Wildavsky, 1982: 36). Motherhood, one of the ideologies of femininity, prescribes the norms and social roles for women who are marked by society as mothers. It is an ideology which is variable in terms of culture and time, and it comprises social, moral and biological properties. Motherhood's biological aspects include experience with pregnancy, giving birth, and breastfeeding; the social aspects include everyday activities connected to being responsible for the nutrition, education, and health of one's children; and finally there is their spiritual development, language learning, and the provision of care and protection (Walks, 2011). Analysis shows that midwives highly regarded following moral properties in mothers: when women don't manifest weakness or complain; and when women suppressed their own interest in favour of the well-being of their children or other people.

In some accounts, there was a connection between domains of authority and purity if a woman broke the rule of respect for a physician as a medical authority and failed as a proper mother. This indicates that moral rules concerning a physician's authority and feminine purity support each other. In the midwives' accounts, there was admiration expressed for those pregnant women who lived up to the values of self-sacrifice, obedience, and honesty. MFT claims that group-based clusters of moral reasoning emphasize group-binding loyalty, duty, and self-control (Graham, Haidt, Nosek, 2009).

The classification of hospitalized women

In the midwives' accounts, categories of pregnant women were identified on a purity–pollution scale in accordance with the chosen theories and within two bodies: the individual body (see Table 2), which refers to the behaviour of pregnant women, and the social body[5] (see Table 3), which refers to the women's social characteristics. This section will characterize the types of body according to the elicitors which triggered in the midwives either a perception of symbolic pollution or symbolic purity. Every elicitor has an allocated moral emotion. This refers to a model of classification of presented indications of morally superior and inferior pregnant women during hospitalization who behaved in a way that was expected of them; women in the morally superior category were expected to present pure behaviour, whereas those in the inferior category were expected to behave in a worse manner. However, people do not behave according to models of classification, and the midwives' accounts featured instances where the women in question did not act in the way that was expected of them.

The individual body

	Elicitors of symbolic purity	Moral emotion	Elicitors of symbolic pollution/symbols of dirt	Moral emotion
Individual body	physical and mental strength	admiration	unhygienic behaviour	disgust
	selflessness	admiration	physical and mental weakness	disgust, contempt
	honesty	recognition	making up health problems and pain	contempt
			screaming and yelling when giving birth	contempt, indignation
			wearing make-up during hospitalization	indignation
			complaining about the rooms' furnishings	indignation
			refusing a vaginal examination	indignation
			smoking	indignation
			using vulgar language, raising the tone of one's voice, or arguing when talking to a medical authority (physician)	disgust, indignation
			doubting the medical procedures	indignation
			lack of gratitude	contempt

Table 3: The classification of women on the level of the individual body

In the descriptions of unhygienic behaviour, three themes in the accounts were recorded. The first theme was when a woman acted in an unhygienic manner: e.g., not having soap, shower gel, or shampoo during hospitalization; eating away from the table; or not washing her hands after using the toilet. The second theme com-

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5   Here the concept of "social body" does not refer to Douglas's use of the term but is used instead to indicate a classification of pregnant and delivering women according to their social characteristics.

prised accounts of men and children lying in bed together with the patients. The midwives explained that this was inappropriate behaviour because people who were not sterile (due to the fact that they were wearing ordinary clothing instead of pyjamas or suitable medical clothing) should not be lying in bed with the patients, who are often not wearing any underwear. This sort of behaviour can apparently result in the patients getting a vaginal infection. If the midwives discovered that visitors were lying or sitting on the bed, they would tell them to move away. In these two themes in the accounts, there is a presence of disgust which is tied to protecting the body from diseases and infections (core disgust).

However, it is worth mentioning that if patients sat with their visitors on the corridor benches, or went to walk around the hospital with them, the midwives would not consider this to be a threat. This was seen as standard behaviour during visiting hours. This is why it is likely that the accounts concerning visitors in bed could have something to do with a third theme: the organization of work. This type of account was included in the analysis because they described people who exist outside the boundaries of the ward and who, in the opinion of the midwives, were loud, dirtied the floors, and used the toilets reserved for people from the ward. One midwife even said that she would abolish visits for this reason. These accounts indicate a form of disgust in interpersonal relationships where disgust indicates the presence of a threat to the rules of social boundaries. According to Douglas, social groups with a strong grid and strong group have clearly defined rules of social boundaries between the group and outsiders (Douglas, 1996: 61).

The physical and mental weakness of pregnant women was another elicitor of symbolic pollution. This category includes accounts of "flaccid women", strong women who suffered everything for the well-being of the infant, and women crying. Midwives considered weak women to be those who cried easily and who were oversensitive and indecisive, as well as those who did not know about the course of pregnancy, or were not even interested in finding out. These women were characterized as being incapable of giving birth or of being good mothers. Accounts were recorded about "flaccid women", who, according to the midwives, had a low pain threshold and "can't take anything", or who were inactive while giving birth. In such cases, the women giving birth apparently expected the other people present to breathe for them, or they would ask others to press down on their belly, as they no longer felt capable of pushing the baby out themselves. This characteristic indicated that these women had not taken on the role of being a mother; this is aptly illustrated in a statement by a 60-year-old midwife called Hana: "They think that their mother will do everything for them; but they will be mothers themselves, so they had better pull themselves together."

The fact that physical and mental weakness is connected to a value judgement concerning motherhood was also indicated in the positive evaluation of women. If pregnant women had pain or a serious health problem and, despite this fact, did not complain or cry, they were seen by the midwives as being strong and good mothers. In addition, the midwives would evaluate to what extent patients' crying was justified. They considered crying to be unjustified when pregnant women exaggerated pain in order to gain sympathy from their surroundings or so that they could manipulate others to their own advantage. Crying was also seen as a form of negative behaviour if it was provoked by selfish motives.

If women made up health problems, they were considered to be exaggerating. Mid-

wives would weigh up how much a patient was feigning pain, and they would resort to undertaking a biomedical examination and using measurement apparatus. If the medical equipment or examination did not register anything unusual or confirm a source of pain, the midwives would then believe that the patient was making it up. Therefore, such patients had no cause to cry or to feel sorry for themselves. The simulation of pain was a central theme of two accounts about women who were hospitalized often, were reluctant to leave the hospital, and who demanded numerous medical procedures.

Excessive screaming while in labour was viewed negatively and the women who did so were also seen to be "exaggerating" their experience. In one case, a woman was screaming so loudly that the physician present ordered that the windows be closed so as not to alarm the people outside the room. One midwife explained that screaming during the delivery was an inappropriate form of behaviour because it posed a threat to the baby; if a mother screams while giving birth, she is depriving the infant of oxygen and needlessly exhausting herself, thus losing the necessary strength to push the baby out. This aspect can be explained within the intentions of Douglas's theory as an expression of denial of body processes at a time of an increased perception of danger. During a crisis there is an applicable rule of distance from physiological origin which states that when there is a stronger emphasis placed on social control and observing the set rules, body processes are ignored to a greater extent and are clearly positioned outside of any interaction (Douglas, 1966: 97). The medical staff talked about the process of delivery as being unpredictable; it could even result in the death of the mother or the baby. "This maternity ward is really unpredictable. You can say that everything is going fine and then in an instant the delivery starts to change. And neither the mother nor anyone else can influence it. Nature itself is unpredictable and does with us what it wants," said a 58-year-old midwife called Júlia. According to the midwives, women giving birth are liberated of physiological matter such as urine and faeces, they are not allowed to eat or drink, their pubic hair is shaved, even their very breathing is regulated during delivery ("controlled breathing"), and they are not supposed to yell or scream.

Women who complained about the provision of healthcare or the ward's equipment and furnishings, or who wore make-up during their stay in hospital, were judged in a negative light by the midwives. In these cases, the midwives would say that these women had come for medical treatment, not for some recreational stay. Another example of symbolic pollution can be seen in midwives' accounts about women who "acted up" during vaginal examinations; they would refuse to be examined because they had not shaved their legs or pubic hair. When describing such cases, the midwives would add that such examinations are part of a day's work and that the examining physician was certainly not at all interested in "how it looks [down there]". This sort of behaviour from patients triggered a feeling of indignation among midwives, similarly to the cases where patients wore make-up or complained about the ward.

Two accounts were presented which dealt with the rule forbidding smoking by pregnant women. One account concerned a young woman who actually smoked in her room during the youngest midwife's shift. When an older midwife described this event, she said that the patient had dared to do so because a "young" midwife was on duty; if an older midwife had been present, she would not have been so brazen. The other account relating to this rule concerned the positive evaluation of a patient of Roma origin who admitted to staff that she was going out of the ward to smoke. The

midwife who related this account stated that she appreciated the patient's honesty, which she contrasted with those patients who asserted that they had not smoked even though it was obvious that they had from the odour which remained in the room. The accounts of smoking primarily focus on expressions of indignation regarding the breaking of rules of respect and honesty rather than the behaviour of these pregnant women who, according to the norms of biomedicine, were acting in a risky manner.

The breaking of rules concerning moral authority included accounts where patients used vulgar language or a raised tone of voice when interacting with physicians, argued with them, or showed arrogance during ward rounds by not turning off the television or by continuing to use their mobile phone when being spoken to by physicians. There were a number of accounts of patients who disputed or argued with physicians while being examined or during ward rounds; this most often happened to the senior and other physicians in charge of high-risk parts of the ward. In these cases, the midwives expressed a certain degree of anger. In cases where there was a conflict between patients and the senior physician, the midwives would describe the patients in question as either coming from a low social background or being assertive and brazen women. However, the senior physician was hardly the most popular person among staff, and midwives would also express some admiration for people who stood up to a man who everyone else in the ward was afraid of.

Women who requested medicine and medical examinations outside of what had been prescribed by physicians were viewed negatively. In the eyes of the midwives, such women had "gone too far" and not had trusted the advice of medical staff. Some midwives said that patients who questioned medical examinations and procedures would be identified as being "oversensitive". In addition,women in labour would be evaluated negatively if they "did not cooperate" with staff by not doing what was asked of them or by arguing about the delivery procedure. The midwives considered such women to be irresponsible. The midwives added that the medical staff did not wish the patients any harm and that they did not understand why patients would not follow instructions or would dispute the course of treatment.

 The abuse of the goodwill of medical staff was viewed negatively by the midwives. There were two accounts which were given on this matter: one concerned a homeless woman and the other concerned a female drug addict. In both cases, the midwives helped these women by bringing them sanitary products, and in the case of the drug addict, one (female) physician also brought her some pyjamas. According to the midwives, the homeless woman did not show an adequate amount of gratitude, and she even brought her partner, who was also homeless, to the ward; he then used the ward's sanitary facilities. The drug addict triggered indignation among midwives due to her lack of gratitude for the charity displayed towards her when she accused the medical staff of having stolen her bra.

The social body

Social body	Elicitors of symbolic purity	Moral emotion	Elicitors of symbolic pollution/symbols of dirt	Moral emotion
	academic degree	admiration	socioeconomic characteristics: women who are poor, homeless, or addicted to drugs	disgust, contempt, indignation
			ethnicity: Roma women	disgust, contempt, indignation
			mental health: mentally disabled pregnant women	disgust, contempt, indignation
			pregnant women of an older age (over 40)	disgust, contempt, indignation
			pregnant women who were overweight	disgust, contempt, indignation

Table 4: A classification of pregnant women as social bodies

Socioeconomic background plays an important role in symbolic classification. Upon the basis of the present analysis, the category of those women who were considered "impure" included the poor, the homeless, and drug addicts. These women primarily featured in midwives' accounts referring to patients' unhygienic behaviour, complaints about conditions at the hospital, expressions of disrespect when interacting with medical staff, and accounts concerning (a lack of) gratitude.

"Skin colour" was another indicator of symbolic pollution. Roma women were seen as unclean, and midwives expected unhygienic behaviour from them. An exception to this assumption were Wallachian Roma women, who were always clean and had everything they required with them; the midwives even added that gold "hung off them". Midwives' accounts about Roma patients were dominated by stories of Roma women fleeing the hospital or not observing the formal and informal rules of the ward (e.g., smoking, leaving the ward without permission, and arguing with physicians). According to the midwives, Roma women complained the most and had poor discipline. In addition, they would apparently "thump their bellies" to make their children disabled, thus making them bad mothers. In one case, a midwife added that she knew about these practices from a Roma woman, which can be viewed as an attempt by the storyteller to justify the factual legitimacy of the midwives' testimonies. While the senior physician was happy enough to "yell at women" in general, he was afraid to do so to Roma women because "he is afraid of being beaten up."

Women who were mentally disabled, in the eyes of the staff, formed another category of symbolic pollution. This could have a lot to do with the norms of biomedicine, where the aim of every birth is to produce a physically and mentally healthy baby. According to the midwives, mentally disabled mothers faced a higher risk of giving birth to an unhealthy baby, and they considered such women to be incapable of looking after a child. Mentally disabled women featured in midwives' accounts concerning unhygienic behaviour as well as mental and physical weakness.

Women over 40 years of age and those who were overweight (i.e., gaining more than 12 kg) during pregnancy were also seen as risky categories. Pregnant women who were older or overweight were not seen as "bad mothers" by the midwives, but

they were judged to have violated the biomedical norms of the course of pregnancy.

An academic degree was seen as a pre-requisite for a pregnant woman to receive a positive evaluation on the purity–pollution scale. It is likely that this aspect is related to the hierarchization in the workplace upon the basis of completed education.

The social body, physical body, and the contrast in expectations

The classification of women according to types of symbolic pollution and symbolic purity presents a model of moral expectations where the individual body conforms to the social body. However, if a woman who on the level of the social body was labelled as pure but on the level of the individual body behaved in an impure manner, or vice versa, the midwives would perceive this to be a disruption to the expected behaviour. There were two such types of accounts which were identified in the midwives' statements:

1. In some accounts, the unhygienic behaviour of "white women" was compared to the hygienic behaviour of Roma women. Here the midwives would say how the "white [women] were often worse than the Gypsies". In these types of account, the Roma women were described in terms of smell and the cleanliness of clothing. If they were clean and did not give off an unpleasant odour, the midwives would be surprised and would express admiration for the women in question.
2. If women with tertiary-level education showed signs of physical and especially mental weakness, this prompted feelings of agitation among the midwives. This happened in cases where such women seemed to lack adequate knowledge about pregnancy or would ask nonsensical questions.

The classification of pregnant women in language

The above classification of women as being pure or polluted also appeared in the form of the language used. When midwives discussed women they considered to be "polluted", they would have a raised tone of voice, often rolling their eyes, frowning, rotating their hands, waving their whole arms around, and saying, "You know, she's like that." They also used vulgar language and ridicule when they spoke about them. There were also cases of them thumping the fist or palm on the table.

When ridiculing Roma women, midwives would mimic their accent. If midwives were talking about women who they considered to be exaggerating pain, they would mimic the way in which these patients moved around the ward corridors. This form of imitation was often accompanied by laughter. They would also smile when talking about women who were in the pure category, but they usually did not change their tone of voice or mimic them, which can be put down to the fact that if women behaved in accordance with the norms, they were not really noticed.

The form of expression and words used by midwives depended on their own personalities. The midwives also differed from each other in terms of what themes they would often dwell upon. For instance, one midwife focused on Roma women, another on women who displayed physical or mental weakness, and another would give accounts from the delivery room. However, each midwife's repertoire contained all types of account. There was no difference in the accounts in terms of the presented indications (i.e. an elicitor and a description of the woman being discussed).

CONCLUSION

The purpose of the study was to emphasize how moral biases of midwives could be linked to the structure of their work environment. When a woman is admitted into the gynaecology and maternity ward, she is regulated for a certain time by the hierarchical institution which is present and which has clearly defined competences and roles. The analysed accounts highlight the existence of rules which pregnant and delivering women are expected to follow. These are mostly unwritten cultural rules which are seldom explicitly expressed by the midwives. In the analysed accounts, these rules appeared most often in descriptions of situations when pregnant women had broken a rule of the organization. Often the rules of a particular group are only found out when they are broken and when people experience moral agitation as a result. The violation of the moral rules in the analysed accounts was predominantly accompanied by other-condemning moral emotions (contempt, anger, and disgust) which are due to MFT reactions to deception or abuse of relationship. In these cases it was the deception and abuse of relationships within the work organization of midwives.

Upon the basis of this analysis, it can be asserted that the work organization of midwives is a type of hierarchical (positional) structure to which Douglas attributed a tendency to create hierarchical systems of classification and positively evaluate authority and moral purity (Douglas, 1996: 62–63). Midwives' work-flow is set by the health care system which assigned place, time and tasks of their work on a daily basis. Douglas defined hierarchical as a type of group in which all roles are ascribed, all behaviour governed by positional rules and interest of the whole (hierarchical) group is more valued than the individual (or sectional) interest. This type of group avoids changes (or everything that could threaten the structure) and gives the priority to the threats of the whole: the same social system that has worked so well in the past will be able to do so in the future (Douglas, Wildavsky, 1982). Within the intentions of MFT, the analysed accounts by midwives are primarily representations of moral values of obedience to authority, self-sacrifice, honesty and purity. These values are linked to group-based moral concerns and emphasize duty and self-control of pregnant women during their stay in hospital. Analysis has shown that midwives had negative attitudes mainly toward pregnant women who broke the rules of the hospital unit, disobeyed the physicians and violated their ideal of motherhood.

This study constitutes a limited inquiry into the world of moral norms and rules which midwives abide by in their work, and it is a contribution towards forming a better understanding of the provision of healthcare to pregnant women. This sort of research into moral emotions is a particularly important part of a more precise description of the moral rules of groups (Graham et al., 2012; Lock, Scheper-Hughes, 1987; Shweder, Haidt, 2000). My aim was to inform the interpretation of the empirical material by Douglas's theory and MFT which are considered as complementary models of morality and social interaction. The message of these theories could be the following: to understand who we are and how and what we think, we must first know a social structure where people live and what are their mental functions. These uniting theories could be a useful analytical tool for comparative analysis of the institutions of the health care systems. But as Bruce highlights "considerable work must be done to illustrate that the model of morality truly does augment Douglas's model of social relations and symbolic classification" (Bruce, 2013: 48). As I mentioned in the introduction the Slovak health care system is in serious crisis which affects not only pa-

tients but also medical professionals. In this case women are especially vulnerable. There is a grave need for ethnological or social research in general in health care systems which could provide profound understanding of social and cultural settings in a broader context.

REFERENCES

Beňušková, Z. (1990). Profesia pôrodných báb z kultúrno-historického aspektu. *Slovenský národopis*, 38(1-2), 205–2l4.

Botiková, M. (2015). Medzi tradíciou a medikalizáciou. Tehotenstvo a pôrod v biografických rozprávaniach. In: Z. Plašienková (Ed.), *Biotické výzvy a súčasnosť*. Bratislava: Stimul, p. 201–215.

Bútorová, Z. (Ed.) (2007). *Ženy, muži a vek v štatistikách na trhu práce*. Bratislava: Inštitút pre verejné otázky.

Bruce, J. (2013). Uniting theories of morality, religion, and social interaction: Grid-Group cultural theory, the "big three" ethics, and moral foundation theory. *Psychology and society*, 5(1), 37–50.

Bužeková, T. (2009). *Nepriateľ zvnútra*. Bratislava: Veda.

Douglas, M. (1966). *Purity and Danger*. New York: Routledge.

Douglas, M. (1996). *Natural Symbols*. New York: Taylor & Francis.

Douglas, M. (Ed.) (1982). *Essays in the Sociology of Perception.* New York: Routledge.

Douglas, M., Wildavsky, A. (1982). *Risk and Culture. An essay on the selection of the technological and environmental dangers*. Berkeley: University of California Press.

Graham, J., Haidt, J., Nosek, B. (2009). Liberals and Conservatives Rely on Different Sets of Moral Foundations. *Journal of Personality and Social Psychology*, 96(5), 1029–1046.

Graham, J., Haidt, J., Koleva, S., Motyl, M., Iyer, R., Wojcik, S. P., Ditto, P. H. (2012). Moral Foundations Theory: The Pragmatic Validity of Moral Pluralism. *Advances in Experimental Social Psychology*, 42, 50–130.

Haidt, J. (2003). The Moral Emotions. In: R. Davidson, K. Scherer, H. Goldsmith (Eds.),

Handbook of Affective Sciences. Oxford: Oxford University Press, p. 854–872.

Haidt, J., Joseph, C. (2009). Above and Below Left–Right: Ideological Narratives and Moral Foundations. *Psychological Inquiry 20*, 110–119.

Hrešanová, E. (2008). *Kultury dvou porodnic: etnografická studie*. Plzeň: Západočeská univerzita v Plzni.

Jágerová, M. (2011). Dojčenie a starostlivosť o novorodenca – štúdium zmien na príklade dvoch generácií matiek. *Slovenský národopis*, 59(2), 155–177.

Kobová, Ľ. (Ed.) (2015). *Feministky hovoria o práci. Ako sa ženy stávajú subjektmi kapitalizmu*. Bratislava: Aspekt.

Lock, M., Scheper-Hughes, N. (1987). The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly*, 1(1), 6–41.

Ministerstvo zdravotníctva. (2015). *Správa o stave zdravotníctva pre Výbor NRSR pre zdravotníctvo*. Bratislava: Ministerstvo zdravotníctva SR.

Mishtal, J. (2015). *Politics of Morality: The Church, the State, and Reproductive Rights in Postsocialist Poland*. Ohio University Press Polish and Polish-American Studies Series.

Pekařová, K. (2013). Niekoľko poznámok k dejinám vzdelávania babíc do roku 1918. In: A. Rollerová (Ed.), *Dimenzie jazykového vzdelávania v nefilologických odboroch*. Bratislava: LF UK, p. 151–161.

Radkowska-Walkowicz, M. (2014). Between Advanced Medical Technology and Prayer: Infertility Treatment in Post-socialist Poland. *Sociologický časopis*, 50(6), 939–960.

Rozin, P., Haidt, J., McCauley, C. (2000). Dis-

gust. In: M. Lewis, M. Haviland-Jones (Eds.), *Handbook of Emotions (2ⁿᵈ edition)*. New York: Guilford Press, p. 637–653.

Shweder, R. A., Haidt, J. (2000). The Cultural Psychology of the Emotions: Ancient and New. In: M. Lewis, J. Haviland (Eds.), *Handbook of Emotions (2nd edition)*. New York: Guilford, p. 397–414.

Slepičková, L. (2011). Cizí geny, naše dítě? Rozhodování o rodičovství v procesu léčby neplodnosti. *Sociální studia*, *8*(4), 125–144.

Slepičková, L., Šlesingerová, E, Šmídová, I. (2012). Biomoc a reprodukční medicína: konceptuální inspirace pro český kontext. *Sociologický časopis*, *48*(1), 85–106.

Spradley, J. (1979). *The Ethnographic Interview*. Belmont: Wadsworth Group/Thomson Learning.

Spradley, J. (1980). *Participant Observation*. Belmont: Wadsworth Group/Thomson Learning.

Šmídová, Iva (2008). Otcovství u porodu. Rekonstrukce genderových vztahů v rodině. *Sociální studia*, *5*(1), 11–34.

Šmídová, I. (2015). Invisible lady doctors and bald femininity: professional conference in czech reproductive medicine. *Sociální studia*, *12*(1), 31–52.

Walks, M. (2011). Introduction: Identifying an Anthropology of Mothering. In: M., Walks, N. McPherson (Eds.), *An Anthropology of Mothering*. Bradford: Demeter Press, p. 1–47.

Zachar, D. (2013). *Zdravotnícky systém v SR (2012-2013)*. Bratislava: Ineko. Dostupné z: http://www.i-health.sk/analyzy/1435_zdravotnicky-system-v-sr-2012-2013

Zielińska, E. (2004). Between Ideology, Politics and Common Sense: The Discourse about Reproductive Rights in Poland. In: S. Gal, G. Kligman (Eds.), *Reproducing Gender. Politics, Publics, and Everyday Life after Socialism*. Princeton, NJ: Princeton University Press, p. 23–58.

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