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Hospital ethnography: introduction

Sjaak van der Geest[a,*], Kaja Finkler[b]

[a] *Medical Anthropology & Sociology Unit, University of Amsterdam, Oudezijds Achterburgwal 185, 1012 DK Amsterdam, The Netherlands*

[b] *Department of Anthropology, University of North Carolina at Chapel Hill, CB 3115, Chapel Hill, NC 27514, USA*

Abstract

The introduction sets out two central ideas around which this collection of articles on hospital ethnography has been organised. The first is that hospitals are not identical clones of a global biomedical model. Hospitals take on different forms in different cultures and societies. Medical views and technical facilities may vary considerably leading to different diagnostic and therapeutic traditions. The second idea, related to the first, is that biomedicine and the hospital as its foremost institution is a domain where the core values and beliefs of a culture come into view. Hospitals both reflect and reinforce dominant social and cultural processes of their societies. The authors further discuss some methodological and ethical complexities of doing feildwork in a hospital setting and present brief summaries of the contributions, which deal with hospitals in Ghana, South Africa, Bangladesh, Mexico, Italy, The Netherlands, Papua New Guinea, Egypt and Lebanon.

Keywords: Hospital; Ethnography; Globalization; Localization; Fieldwork

In recent years anthropology has moved away from studies of the conventional pastoral village in ''primitive'' societies and turned its gaze on Western institutions, including biomedicine. Whereas in the past medical anthropology has focussed on traditional ethnic medical beliefs and practices, more recently interest has shifted to technologically advanced medicine in clinical settings. Before, when biomedicine was discussed it was usually juxtaposed with traditional healing systems within the context of medical pluralism. Generally speaking, the focus was on hierarchies of resort and medical choice (e.g. Crandon-Malamud, 1991). With few notable exceptions (Lock, 1980; Feldman, 1992; Maretzki, 1989; Sachs, 1989), the studies of medical pluralism assume that biomedicine is a more or less monolithic enterprise, following what are regarded as the core universal characteristics of biomedical practice, irrespective of the cultural setting. But while there has been concern with biomedical beliefs and practices in Western societies, less attention has been given to the hospital as the premier institution of biomedicine cross-culturally.

Significantly, the first medical anthropology handbook, Foster and Anderson (1978, pp. 163–174) devoted a full chapter to the anthropology of the hospital, but these authors remarked that most of studies were the work of non-anthropologists. Anthropological collections focussing on biomedicine (e.g. Wright & Treacher, 1982; Lock & Gordon, 1986; Hahn & Gaines, 1985; Williams & Calnan, 1996; Johnson & Sargent, 1990) rarely include discussions of the nature and function of hospitals. Surprisingly, Delvecchio Good's (1995) research agenda for studies of biomedicine refers to only a handful of investigations based on the ethnography of hospitals.

One reason why studies of hospitals are lacking may be associated with the fact that on first glance they appear to be deceptively familiar. The world over, similar hospital organisation, especially the bureaucracy, the division of the wards, the medical nomenclature, staff dress codes, and technological accoutrements, all create the appearance of familiarity to any member of Western society. In fact, hospitals have been regarded as places where established universal principles of biomedicine were practised uniformly

*Corresponding author.
E-mail address: vandergeest@pscw.uva.nl (S. van der Geest).

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across cultures with little added "couleur locale". Another explanation for the lack of hospital ethnographies may be associated with the defensiveness of hospital authorities and their hesitation in allowing observers to enter their workplace. After all, some social scientists researching hospitals have not always had favourable experiences with hospital staffs. For example, in 1978, a study of a Dutch cancer hospital was destroyed by court order because the authorities disagreed with the contents and claimed they would be harmful to patients (Van Dantzig & De Swaan, 1978; Van der Geest, 1989).

With this collection of papers our goal is to expand medical anthropological concerns by focusing on the ways in which broader social and cultural processes are played out in hospital settings. We propose two important premises regarding the social and cultural world of hospitals. First, contrary to a commonly held notion that hospitals are nearly identical clones of a global biomedical model, anthropologists are beginning to describe and interpret *the variety of hospital cultures in different countries*. Medical views and technical facilities may vary considerably leading to different diagnostic and therapeutic traditions. Second, and related to the first, *is that biomedicine, and the hospital as its foremost institution, is a domain where the core values and beliefs of a culture come into view*. As most of the papers demonstrate, hospitals both reflect and reinforce dominant social and cultural processes of a given society.

Indeed, scholars have observed that all medical beliefs and practices are embedded in broader social and cultural forms. In Helman's (2000, pp. 4–5) words, "beliefs and practices relating to ill-health are a central feature of the culture". We take this to mean that in situations and processes of illness and recovery, people's "true" values, convictions and moral rules become most clearly visible. Illness, Fainzang (2001, p. 88) writes, is a paradigmatic example of misfortune, which "reveals the nature of social relationships". In the same vein, Lock (1986, p. 8) notes that "the study of health, illness and medicine provides us with one of the most revealing mirrors of the relationship between individuals, society, and culture; it is an exciting task which has only just begun". To this mirror we must add life in the hospital.

A brief history of biomedicine and hospitals

Historically, biomedicine developed in Europe and moved to North America. It was a cultural invention of 19th century France and Germany, and it penetrated almost every corner of the globe. Initially, Western medical care was disseminated world-wide by missionaries who established clinics and offered medicine to the people they wished to convert (Janzen, 1978; Rubenstein & Lane, 1990; Vaughan, 1991; Ranger, 1992; Gallagher, 1993) and by colonizers who wished to save the indigenous labour force from infectious diseases, as well as to protect themselves from such diseases (Rubinstein & Lane, 1990; Vaughan, 1991; Curtin, 1992; Arnold, 1993; Iliffe, 1998).

However, hospitals clearly have a longer history than biomedicine in Western society (Starr, 1982; Stevens, 2001). Previous to the 18th century they were institutions of charity and welfare, and warehouses for the poor. The modern hospital had its origins in the 18th century at which time it became a place for training physicians, using the poor as "objects of instruction" (Foucault, 1973, p. 84), and arguably hospitals were spaces for surveillance of the people in them (Foucault, 1973).

With the introduction of antiseptics and anaesthesia, the modern hospital gradually changed from an institution of charity and welfare to a place of high technology, especially focussed on surgery (Starr, 1982). Hospitals in the last two centuries evolved into venues where the marvels of modern technology could be displayed. Moreover, as Starr observes, "the rise of hospitals offers a study in the penetration of the market into the ideology and social relations of a pre-capitalist institution" (Starr, 1982, p. 148). The hospital evolved from care taking to treatment; from being presumably an institution of kindness to an institution of professionalism that gave great power to physicians (Starr, 1982, p. 148; Rothman, 1991). Most important, the hospital became a bureaucratic structure that integrated the staff and medical data by means of the medical record, and it replaced the home as a centre of care (Reiser, 1984). As a result, the modern hospital is seen as separating the medical world from the non-medical world (Rothman, 1991), and patients institutionalized in it become removed from the world at large. Significantly, however, as we see in Tanassi's, Vermeulen's and Zaman's papers in this volume, or in Schneider's (2001) work in China, the hospital cannot divorce the patient from his or her family, or from other social institutions.

Biomedicine and hospitals within the context of globalization and localization

Theorists of globalization have sought to elucidate the globalization process of world societies and cultures and have sought new approaches to it by advancing notions such as "homogenization and heterogenization" (Appadurai, 1990, p. 5; 1991), hybridization (Canclini, 1995; Escobar, 1995) and creolisation (Hannerz, 1992) of the world. Undoubtedly, the explosion of new technologies in general, and medical technologies in particular, the creation of new forms of communication, the mass marketing of popular culture, the internationalization of labour, and massive population displacements have

created hitherto unprecedented conditions for socio-cultural fluidity, transcending geography and our sense of space.

Whereas economists and political scientists foresee a homogenized world following the United States pattern, other social scientists, including Canclini (1995), Hannerz (1992), Escobar (1995) and Giddens (1990) have problematized the degree to which globalization has led to cultural homogenization and variation. Giddens defines globalization as "the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa" (1990, p. 64). He argues that "Local transformation is as much a part of globalisation as the lateral extension of social connections across time and space" (Giddens, 1990, p. 64). For Giddens, globalization is a dialectical process that "results in the spread of modernity in terms of an ongoing relation between distanciation and the chronic mutability of local circumstances and local engagements" (1991, p. 22). His definition of globalization comes into bold relief in contemporary hospital settings the world over, as can be seen in the papers in the volume.

It is, therefore, surprising that theories of globalization have neglected biomedicine and its institutions, especially the hospital, since biomedical practice formed an intrinsic part of this process and may have even been at its vanguard, carrying with it Western cultural baggage (cf. Macleod & Lewis, 1988). Through the hegemonic rule of Western society, biomedicine was diffused throughout the world and as it spread came to be regarded as the mark of the "modern" in developing nations. Scholars who have studied medical institutions in socialist venues, for example, Navarro (1986), Waitzkin (1980), like most, seem to assume that biomedicine is unproblematically practiced in a universal manner and that only the structural arrangements for its delivery vary.

In fact, on the surface one is led to believe that the "homogenization" theories are correct as they pertain to biomedicine and its institutions, especially the hospital. The medical world today is a technologized world, and the modern hospital becomes more than ever subject to globalization. Indeed, globalization has accelerated the process of social and cultural transformations the world over, and it has impacted the nature of hospitals and biomedical practice. However, notwithstanding the homogenizing forces, we propose that diversity and heterogeneity of cultures and medical institutions such as the hospital are being re-emphasized. Since, as we noted earlier, medicine reflects the larger society, we must ask in what ways its beliefs, practices and institutions stay the same or become reinterpreted and restructured by the receiving society as its institutions diffuse from industrialized to developing nations.

Certainly, the cross-cultural spread of biomedicine has been variously interpreted as a badge of modernization, as an inevitable outcome of Third World dependency, or as an arm of imperialism (Macleod & Lewis, 1988). As these authors point out, "a common culture of medicine—sustained by the image of science as the universal agent of progress, and scientific medicine as its servant—became the hallmark of European empires throughout the world" (Macleod & Lewis, 1988, p. 3). By introducing the germ theory of disease, biomedicine furnished a "set of doctrines—a model, based upon the discovery of specific aetiologies and disease—causing mechanisms" (Macleod & Lewis, 1988, p. 7). But even though biomedicine disperses globally it does not suggest that it is practiced homogeneously, or that hospitals function in a uniform manner. In fact, variations in biomedical practice are evident among technologically developed nations.

The few available cross-cultural studies of biomedicine suggest differentiated cultural production, both within Western societies and across the world. For instance, Henderson and Cohen (1984), describing a Chinese hospital, found that Chinese and USA physicians make different uses of laboratory procedures. Chinese physicians depend on clinical symptomatologies to make a diagnosis and they make their diagnosis on the basis of inclusion: "a diagnosis is confirmed or rejected on the basis of the patient's response" (Henderson & Cohen, 1984, p. 130). Others, including Low found that sickness is dealt with in a cultural way (Low, 1985, p. 28), as has Lock (1980). Finkler in this issue describes the Mexican interpretation of biomedical diagnostics and therapeutics. Most studies that explicitly discuss biomedical practice and its clinics emphasize chiefly the dispensing of its treatment. For example, Janzen tells us that in Zaire, western medicine is associated with the prescribing of pills, injections, surgical procedures and X-rays (Janzen, 1978). Maretzki's (1989) work on the Kur discloses that in Germany, unlike in the USA, thermal baths are incorporated in biomedical treatments. Feldman (1992) observed the different understandings that French and American physicians brought to AIDS. In the United States, AIDS is regarded as a form of cancer, whereas in France it is conceived as an infectious disease, following a tuberculosis model. Feldman concludes, "French biomedical models and treatment practices regarding AIDS arise out of culturally distinct conceptualisations of how the body works in response to disease" (Feldman, 1992, p. 348). "The two systems are dissimilar in structure, social relations and physiological concepts" Feldman, 1992, p. 347). Hadler (1994) demonstrated how backaches were differently assessed in three European countries, and Jordan's (1993) work on comparative birthing practices in Europe and the United States revealed biomedicine's divergent approaches to birthing within Western societies. Townsend (1978), summarising various studies, noted how British and

American psychiatrists differed in their diagnostic practices. Townsend emphasised that the differences between Britain and the USA were not an issue of differential labelling but rather "psychiatrists (in Britain and USA) were actually perceiving different symptoms in the patients' behaviour" (1978, pp. 69–70). Townsend showed that contrary to the existence of any universal understanding of mental illness, German psychiatrists and laymen shared a closer understanding of mental illness than did American and German psychiatrists. In both countries, one could say, psychiatrists are Americans or Germans first and professionals second.

By and large, however, anthropologists have hardly investigated biomedical practice or its hospitals outside the industrialized world. Because this volume examines the ways in which globalization influences the structure and practices of hospitals in various venues of the world, we trust that these articles will deepen our understanding of biomedical practices in contemporary hospitals.

The hospital: Island or mainland?

The extant studies of hospital life suggest that it is a world apart, a culture which is altogether different from the "real" world or even a reversal of normal life. Coser (1962) called the hospital ward "a tight little island". Salisbury, quoted in Foster and Anderson (1978, p. 167) found the (mental) hospital a relatively self-contained community, and Goffman (1961) in his classical work on mental hospitals revealed how the hospital as a closed cultural institution affects the core identity of its inmates. Parsons' (1951) definition of the sick role as a time-out during which the patient prepared himself to return to normal life and resume his tasks, implied a view of the hospital as a "different" place, where the rules and obligations of ordinary life have been temporarily lifted. In short, the hospital was seen as a place of exception and exemption. Even Marxist scholars who, in a reaction to Parson's functionalist approach, described health care—and the hospital in particular—as an institution which masked social reality (e.g. Taussig, 1980) confirmed what Parsons had argued: that hospitals contributed to the reproduction of society even though they are different from that society. Brown who speaks of a "stripping process" that the patient undergoes when entering the hospital, refers to the same process: "The patient's roles in normal life recede into the background: he becomes a "case" in a numbered room" (cited in Foster & Anderson, 1978, p. 170). The normal distinctions between people of different class, profession and status are almost wiped out and do not seem to count in the treatment, which is said to be mainly concerned with an—anonymous—body.

The contributors to this volume take another view of hospital culture, which logically derives from the thesis advanced earlier that biomedical institutions are reinterpreted by the local culture in which they occur and as Finkler argues in this volume, this is significant both theoretically and practically. The authors contend that life in the hospital should not be regarded in contrast with life outside the hospital, the "real" world, but that it is shaped by everyday society. The hospital is not an island but an important part, if not the "capital", of the "mainland". The continuation of societal hierarchies, inequality and conflict into the hospital are vividly described by several contributors to this issue, in particular by Van Amstel and van der Geest for Papua New Guinea, Andersen for Ghana, Gibson for South Africa and Zaman for Bangladesh (see also Zaman, 2003). These hospital ethnographies open, as it were, a window to the society and culture in which the hospital is situated. The articles not only portray cultural variations in the organisation, execution and experience of biomedical care but also relate these variations to wider social and cultural issues.

Doing fieldwork in a hospital

The canons of anthropological research pose special problems for carrying out fieldwork in a hospital. How can, or should, the participatory aspect be realized? If the researcher in the hospital wants to be a "natural" person whose presence in the ward can be continuous, he has, basically, three possibilities to choose from: joining the staff, the patients or the visitors.

It is our impression that most researchers do the first and play—more or less explicitly—the role of doctor or nurse. They may put on a white coat and be regarded by patients as "one of them" (e.g. Weiss, 1993; McDonnel, 1994; Jones, 1994; The, 1999; Frisby, 1998; Kuckert, 2001; Pool, 2000; Van Amstel & Van der Geest and Gibson, this issue). Such research will tend to represent the professional's point of view more than the patient's.

Research carried out from the patient's perspective is more challenging practically and ethically. Caudill (1958) studied life in a psychiatric hospital, "disguised" as a mental patient. While he carried out the research, over a period of 2 months, only two staff members knew his identity. Rosenhan (1973) described a similar research involving eight researchers in psychiatric hospitals who had been admitted on the diagnosis of insanity. Significant in their case was that they had great problems in convincing the staff later on that they were not "insane". This experience proved a crucial clue for their critical analysis of the concept of "insanity" (see also Goldman et al., 1970).

We are hardly aware of researchers who were admitted as patients in an "ordinary" hospital. The experiment by Van der Geest and Sarkodie (1998) in which the latter became a fake patient in a Ghanaian

hospital stands virtually alone using this research technique (see also French et al., 1972). Ethical objections and personal unease on the part of the researcher are probably the main reasons for not embarking on such "candid camera" research. Anthropological reflection on a stay as a "real" patient in a hospital exist, however (e.g. Murphy, 1990). One intriguing example is Gerhard Nijhof's (2001) autobiographic account of his stay in a Dutch hospital as a cancer patient. Nijhof, a medical sociologist, describes how his experiences in the ward opened his eyes to aspects of hospital care and being sick that he had not noticed before, while strong and healthy. One example was his trust in medical machinery, where most social scientists had decried technology as depersonalising the patient. The length of the night, the work of nurses and cleaners, and the contribution of relatives were other "discoveries" in his book. Nijhof's participatory "study" is a promising example of hospital ethnography from within. The absence of this technique in the present collection probably points at the difficulty of combining the fieldworker's role with being a true patient (or staff member). Indeed, full participation discourages researchers. Many anthropologists have come to realize that in a hospital, participant observation in the true sense of the term is an oxymoron. Van Amstel experienced this acutely when he attempted to employ his job as a physiotherapist in a rural hospital in Papua New Guinea for anthropological research.

Some researchers presented themselves as visitors. Mpabulungi (1995) who studied the role of relatives in patient care in a Ugandan hospital is a case in point. The position of visitor facilitates a natural presence on the ward and often allows the researcher to carry out minor tasks of patient care. Bluebond-Langner (1978) chose the role of a special kind of visitor during her research among terminally ill children in the United Sates. She did not want to be associated with the staff, but also emphasized that she was different from the parents. Others, for example Vega (2000), Inhorn, Vermeulen and Zaman (the last three in this volume) chose a more liminal role and manoeuvred between acting as visitors and doctors/nurses.

The contributors to this special issue have been asked to describe their fieldwork methods. From these depictions it can be seen that possibilities for anthropological research in hospitals vary. While it is difficult to get permission for such research in "Western" hospitals due to the presence of Institutional Review Boards, which strictly guard the privacy and well-being of patients (and protect staff members from priers), concerns for the privacy of patients in African and Asian hospitals is much less an issue, allowing researchers easier access to the wards. Inhorn (in this issue) devotes considerable attention to problems of access and privacy in her research among IVF clients in hospitals in Egypt and Lebanon. The difference in access is one other significant indication of cultural and social variations among hospital organizations world wide, and thus calls attention to the meaning of privacy and confidentiality.

Contributions

Helle Max Andersen demonstrates how hospital organization and structure replicates the class structures and relations, as well as the bureaucratic organization of the larger society and shows how social inequality in Northern Ghana reproduces the differential treatment of patients. The author explains the production, maintenance and legitimization of the unequal treatment from the perspective of health workers and suggests that the tendency to assume a fundamental conflict between broader socio-cultural processes and the bureaucratic structure must be replaced with a more complex approach to such conflicts.

Diana Gibson draws on Foucault's work on social surveillance and "normalization" to analyse procedures in a South African hospital. The gaze has become a metaphor for the disciplinary "technologies" in medical institutions. The transformation from an oppressive State to a more democratic one has played itself out in particular ways in the hospital setting. Rather than being under the constant surveillance by the State or by medicine, there are numerous instances when patients become "invisible" (the "gaps in the gaze"). The lack of economic resources leads to unequal treatment in the hospital despite the recent ideological transformations that call for equal access to health care. There is thus a continuous shifting of patients, services and staff in an attempt to provide redress and equal health services for all. Decisions must be made regarding who should get access to beds and to maximum care owing to a lack of funds.

Shahaduz Zaman did the research in an orthopaedic ward of a government teaching hospital in a large Bangladeshi city and shows how hospital organizations reinforce the hierarchical structure and social relationships within the larger society. Life and work in the ward result in a culture that is simultaneously created by its inhabitants and by the conditions in which they must exist. The hospital attends to poor patients who are at the bottom of the social ladder and the doctors and other staff are frequently professionally frustrated by the lack of resources. The hospital depends on family members to nurse and provide various kinds of support to their hospitalized relatives. Patients give small bribes to ward boys and cleaners to obtain their day-to-day necessities. Interestingly, patients create a little universe of their own by joking with each other and mock the senior doctors and thereby neutralize their powerlessness and drive away the monotony of their stay.

Kaja Finkler carried out extensive fieldwork in a Mexican hospital. She demonstrates the ways in which hospital physicians in an outpatient clinic of a large hospital in Mexico City reinterpret biomedicine in cultural ways, and localize medical practice despite the globalization of biomedicine. She stresses that use of the same medical nomenclature in diagnosing patients does not signify that these diagnoses transcend cultural understanding of patients' specific conditions. She explores the theoretical consequences of physicians' redefinitions of diagnostic categories by showing the local nature of a globalized practice, and also the practical consequences of establishing epidemiological profiles that rely on diagnoses physicians provide. She asserts that clinical judgements are not made in an acultural way and do not follow a universal standard.

Lucia Tanassi's article highlights the importance of personalized relations in institutionalized obstetric care in St. Mary's Hospital in Rome, Italy. Her ethnography illustrates the ways in which obstetrics wards reproduce and reinforce cultural perceptions of women as passive. But Tanassi also observes that while women are objectified by hospital practices, they nevertheless exercise agency, even though they may appear "compliant". Expectant mothers were pleased to comply with their doctors' instructions, even when such indications may have required significant sacrifices, or suffering because they were geared towards the fulfilment of their desires to become mothers.

Eric Vermeulen's article, based on research conducted in Amsterdam University Hospital's neonatal ward addresses ethical decisions that must be made regarding which newborns should or should not receive life prolonging treatment. He suggests that these decisions are arrived at by negotiation between parents and health providers and that the negotiating process mirrors Dutch cultural values of mediation and bargaining.

Hans van Amstel and Sjaak van der Geest describe how a hospital in the Papua New Guinea Highlands assumes a role in political and judicial affairs. Interestingly, this modern institution is not just concerned with treating the sick but paradoxically also acts to reinforce traditional cultural sensibilities of justice by adjudicating compensation claims requiring retribution for physical damages resulting from violence or accident.

Marcia Inhorn's concern is with the ethics of doing research in a hospital when the focus of the investigation is on a stigmatized condition, such as infertility. She discusses privacy, privatization, and the politics of patronage as key issues affecting anthropological research in hospital-based IVF clinics in Egypt and Lebanon. IVF-seeking patients generally desire privacy, even total secrecy, when pursuing these treatments, due to cultural issues of stigmatization, particularly regarding male infertility. Thus, ethical issues surrounding the informed consent process are of prime importance. Furthermore, privatization of medical services in the Middle East has left patients—and anthropologists—with few choices other than private IVF clinic settings in which to pursue treatment and research. Both the ethos of patient privacy and medical privatization affect the ability of anthropologists to "penetrate" the secret world of IVF.

We hope that this collection of articles published as a special issue in Social Science & Medicine will further stimulate cross-cultural studies of biomedicine and hospitals.

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