

## Anthropology of hospitals: a General Overview

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### Abstract

This anthology of hospital ethnography essays is structured around two main principles, which are introduced in the introduction. To start, it needs to be said that there is no universally accepted standard for biomedical design in hospitals. The transmission of this information is paramount. The ideal layout of a hospital has varied conceptions in every culture and civilization. When coupled with the availability of ever-more-advanced diagnostic and treatment technologies, the many medical schools of thought can provide a vast spectrum of diagnostic and therapeutic techniques. The second premise states that hospitals and biomedicine can only thrive if they reflect the fundamental ideas and values of the society in which they are rooted. A society's hospitals both mirror and reinforce its prevailing social and cultural standards. In a sense, hospitals are both exemplars of and keeper of these values. Along with providing concise overviews of the contributions pertaining to hospitals, the writers delve into the methodological and ethical difficulties that develop while doing fieldwork in an institutional setting, such as a hospital. Among the nations included are the following: South Africa, Ghana, Egypt, Lebanon, Mexico, Papua New Guinea, the Netherlands, and Egypt. Bangladesh is also on the list. Upon its first publication in 2004, Elsevier Ltd. acquired the rights to the work. Since 2011, copyright laws have served to prevent the content's infringement.

**Keywords:** Hospital; Fieldwork; Ethnography; Globalization; Localization

### Introduction

Anthropology used to study traditional pastoral villages in "primitive" societies, but these days it studies Western organizations, especially biomedicine. In the past, medical anthropology has mostly looked at the beliefs and practices of different ethnic groups when it comes to medicine. There has been a recent uptick in research in contemporary healthcare settings. Talks regarding medical diversity have, for the most part, centered on the biomedical sector. Healthcare policy and resort design occupied most of the conversation (Crandon-Malamud, 1991). Research on medical diversity (Lock, 1980; Feldman, 1992; Maretzki, 1989; Sachs, 1989) generally presumes, with a few notable exceptions, that biomedicine is a relatively homogeneous enterprise that adheres to the basic principles of biomedical practice, irrespective of cultural background. In the West, medical theories and practices are less revered than the hospital, even though the latter is the preeminent biomedical institution in the world.

A full chapter in the first medical anthropological guide was devoted to the study of hospital anthropology by Foster and Anderson (1978, pp. 163-174). But these authors did admit that people who weren't anthropologists did most of the study. The primary function and objectives of hospitals are frequently disregarded in anthropological collections that center on biomedicine. Williams & Calnan (1996),

Hahn & Gaines (1985), Wright & Treacher (1982), Lock & Gordon (1986), and Johnson & Sargent (1990) all found this to be true. According to Delvecchio Good's 1995 research design for biological investigations, hospital ethnographies were not frequently used in the examined studies. Because hospitals don't usually stand out, they could not get the attention they need. When it comes to permitted technologies and clothing requirements, hospitals around the world are very similar. People used to Western culture may feel more at ease in this environment because it is familiar to them. In the past, hospitals were seen as places where universally accepted biological principles were applied, often at the expense of local knowledge and understanding.

The unwillingness of hospital administrators to let outsiders tour their facilities may explain why there are so few hospital ethnographies. Some social scientists who have done fieldwork in hospitals have had negative interactions with patients and staff. A court in the Netherlands blocked the publication of a study from 1978 that had been conducted in a cancer hospital. Officials at the hospital were worried that the results would be harmful to the patients, which led them to disagree with the study (VanDantzig&DeSwaaan, 1978; VanderGeest, 1989). The collection's overarching goal is to advance medical anthropology by delving deeper into the broader social and cultural phenomena that occur in healthcare facilities. Institutions function according to two fundamental ideas that mold the cultural and social milieu. In an effort to disprove the widely held belief that hospitals worldwide adhere to a uniform biological framework, anthropologists are gathering information about the cultural differences across hospitals around the world.

There may be different ways of diagnosing and treating patients due to the presence of different technical resources and medical perspectives. Because of their central role in biomedicine, hospitals can also serve as venues for investigating fundamental cultural values and ideas. A large body of research shows that healthcare facilities not only mirror but also shape the cultural and social norms of the communities in which they are located. According to studies, all medical theories and practices are based on larger social and cultural conventions. Social norms and ideas around unhealthy living are crucial, argues Heilman (2000, pp. 4-5). Healing and fulfillment are pathways by which people show their true views, values, and convictions. On page 88 of Fainzang's (2001) thesis, the importance of social relationships is emphasized by highlighting disease as a major disaster that reveals this. If you want to see how people, communities, and cultures are all interconnected, Lock says you need look into health, sickness, and medicine (1986, p. 8). "This is a fascinating endeavor in its early stages." No text was provided by the user. Thinking about the hospital as it is right now is essential for this reflection.

#### **A short history of hospitals and biomedicine**

The history of biomedicine may be traced back to Europe, and then later moved to North America once it had already been established there. The cultural innovations that began in France and Germany in the 19th century and spread throughout diverse regions of the world had a significant and far-reaching impact on those areas. The first spread of Western medical care around the globe can be linked to the efforts of missionaries who created medical clinics and offered medications to those targeted for

conversion (Janzen, 1978; Rubinstein & Lane, 1990; Vaughan, 1991; Rangers, 1992; Gallagher, 1993). This can be found in the works of Janzen, Rubinstein, and Lane (1990); Vaughan (1991); Rangers (1992); and Gallagher (1993). It has been suggested by a number of academics, including Rubinstein and Lane (1990), Vaughan (1991), Curtin (1992), Arnold (1993), and Iliffe (1998), that the development of Western medical treatment was made easier by early settlers who were concerned about protecting themselves from infectious diseases and maintaining the health of the native labor force.

When compared to the field of biomedicine, hospitals have a far longer historical history in Western civilization (Starr, 1982; Stevens, 2001), which is something that should be taken into consideration. During the time period prior to the 18th century, these establishments served both as places for the storage of goods and as charity organizations that assisted persons who were living in poverty. People who came from disadvantaged socioeconomic situations were used as "objects of instruction" in the modern hospital, which was founded in the 18th century (Foucault, 1973, page 84). This practice began when the modern hospital was established as a designated location for medical students to get training. According to Foucault (1973), there is a possibility that hospitals were used as places for the observation of patients. As a result of the development of antiseptics and anesthesia, the contemporary hospital went through a transition from being a charitable and hospitable institution to becoming a technologically advanced facility that primarily focuses on surgical procedures (Starr, 1982).

Hospitals have seen a tremendous transformation over the course of the past two centuries, developing into facilities that are distinguished by the incorporation and exploitation of cutting-edge technological breakthroughs. The person in issue is characterized by a significant propensity toward excessive indulgence as well as a sense of entitlement. According to Starr (1982, page 148), the development of hospitals provides a fruitful way to investigate the extent to which market forces influence the ideology and social dynamics of an institution that existed prior to the arrival of capitalism. This is because hospitals were already in existence before capitalism came into existence. The hospital had a transition in its position, shifting from one focused on giving care to one focused on providing treatment. As a result, the hospital is now known for its treatment provision. As a consequence of this, the institution went from being seen as one that displayed compassion to being one in which doctors had a substantial amount of authority (Starr, 1982, page 148; Rothman, 1991). The home environment was supplanted by the hospital as the primary location for patients to receive treatment as a result of significant changes made to the latter.

This transformation took place as a result of the hospital's development into a bureaucratic entity (Reiser, 1984), which combined people and medical information by making use of medical records. According to Rothman (1991), the modern hospital is often considered as a physical and metaphorical wall that separates the medical domain from the non-medical realm, which ultimately results in the isolation of patients from the greater society. It is important to note that the contributions provided by Tanassi, Vermeulen, and Zaman in this volume, as well as the research

undertaken in China by Schneider (2001), bring to light the incapacity of hospitals to isolate patients from their families or other social institutions.

#### **Biomedicine and hospitals in the framework of localization and globalization**

Scholars in the field of globalization have introduced conceptual frameworks like "homogenization and heterogenization" (Appadurai, 1990, p. 5; 1991), "hybridization" (Canclini, 1995; Escobar, 1995), and "creolization" (Hannerz, 1992) in an effort to shed light on the phenomenon of global integration of civilizations and cultures. Without a doubt, the unprecedented circumstances of sociocultural dynamism that transcend geographical boundaries and challenge our perception of space have emerged as a result of the proliferation of novel technologies, including those in the medical field, the emergence of innovative communication methods, the widespread dissemination of popular culture, the globalization of labor, and the significant movement of populations.

Canclini (1995), Hannerz (1992), Escobar (1995), and Giddens (1990), among others, have expressed concerns about the effects of globalization on cultural diversity and homogenization. The term "globalization" was coined by Giddens, who defined it as the process through which social ties across the globe become more intertwined, resulting in a two-way influence on events occurring in different parts of the world. This is what page 90 of the given source says. According to Giddens (1990, p. 64), globalization is more than just the growth of global networks; it also includes the concomitant development of localized phenomena. Giddens (1991) argues that globalization is best understood as a dialectical phenomenon that results in the spread of modernity. This arises as a result of the interaction between physical distance and the fluidity of local conditions and social interactions (p. 22). The pieces in this book show that his vision of globalization meets strong resistance in modern healthcare systems around the world.

Despite the fact that biomedical practice played a crucial role in this process and may have even been at the vanguard, carrying along Western cultural influences, its importance in globalization has been largely overlooked in theories of globalization. Since biomedicine became widely available due to the influence of Western civilization, many developing countries have come to view it as a hallmark of progress. Navarro (1986) and Waitzkin (1980) provide evidence of the widespread agreement among academics who have studied medical institutions in communist contexts, suggesting that there is a widespread belief in the seamless implementation of biomedicine and that the main differences lie in the organizational frameworks that govern its provision. At first look, "homogenization" views about biomedicine and its institutions (especially hospitals) appear to be true. Technological improvements in the modern healthcare sector have made hospitals more vulnerable to the impact of globalization.

As a matter of fact, the phenomena of globalization has had a profound effect on the makeup of hospitals and biomedical practice, while also hastening the pace of social and cultural shifts on a global scale. It is argued that, despite widespread homogenizing trends, there has been a recent uptick in interest in the unique characteristics of various hospitals and other medical facilities. Medicine, as was previously said, is indicative of larger societal trends. Therefore, it is necessary to

consider whether medical institutions and practices remain constant over time or undergo reinterpretation and rearrangement when new civilizations form. Many different perspectives have been taken on the transcultural spread of biomedicine, with some seeing it as a tool of imperialism, others as a sign of modernity, and yet others as an unavoidable result of the reliance faced by Third World nations (Macleod & Lewis, 1988).

The authors argue that European diplomats around the world shared a common medical culture based on the belief that science is a driving force for progress everywhere in the world and that scientific medicine is subservient to this belief. In their research, Douglas and Macleod (1988, p. The germ hypothesis of illness provided biomedicine with a complete framework, consisting of a set of principles and concepts based on the isolation of specific etiologies and mechanisms responsible for the emergence of disease (Macleod & Lewis, 1988, p.7). Although biomedicine has been widely adopted, this has not necessarily translated into standardized hospital procedures or biomedical practice. In reality, countries with high levels of technical development use a wide variety of approaches to biomedical practice.

#### **Fieldwork in a hospital**

When used to the conduct of research within a medical environment, anthropological research principles bring their own unique set of challenges. How exactly, if at all, should the interactive component be included into the overall design? There are primarily three options available to a hospital researcher who is interested in establishing a genuine and ongoing presence within the ward. The researcher can either join the hospital staff, play the role of a patient, or participate in the ward as a visitor. According to our knowledge, a sizeable percentage of researchers voluntarily take on the responsibilities that are often associated with medical professionals like physicians and nurses.

Previous research (for example, Weiss, 1993; McDonnel, 1994; Jones, 1994; The, 1999; Frisby, 1998; Kochert, 2001; Pool, 2000; Van Amstel & Vander Geestand Gibson, current issue) has shown that healthcare professionals may choose to wear white clothing, which may cause patients to perceive them as being a member of their own group. This is because patients are more likely to associate white clothing with members of their own community. This particular method of study has a tendency to give more weight to the perspectives of medical experts than those of patients. When conducting research from the point of view of the patient, there are problems to be faced from both a practical and a moral stance. In a fundamental study that was carried out in 1958 by Caudill, the researcher pretended to be a mental patient in order to carry out an inquiry on the lived experiences that occur within a psychiatric institution. Caudill's study was considered to be the first of its kind. After an intensive investigation that lasted for two months, it was determined that just two people working there are aware of his genuine identity. A group of eight researchers were deceived into entering psychiatric hospitals under the guise that they had been diagnosed with mental illness as part of a major study that was carried out by Rosenhan (1973). The fact that they encountered such a tremendous uphill battle in



trying to convince the staff that they did not have a mental illness is an important facet of the conditions in which they found themselves.

The interaction that was described above resulted in the acquisition of substantial new knowledge that aided in the researchers' complete investigation of the concept of "insanity" (see also Goldman et al., 1970). Researchers being treated as patients at traditional medical facilities is a rare occurrence, as evidenced by the fact that it is rarely documented. The research methodology that VanderGee and Sarkodie (1998) used in their experiment, in which Sarkodie pretended to be a patient at a hospital in Ghana, is very novel in its approach. Sarkodie played the role of a patient at the hospital. Frenschel et al. (1972) utilized a methodology that was conceptually analogous to the one described here. Anxiety on the part of the researcher and concerns about ethical implications are often the two key factors that stand in the way of the successful completion of a "candid camera" study. In spite of this, academic research has been conducted in the field of anthropology to investigate the phenomena of people who identify themselves as genuine hospital patients (Murphy, 1990).

The autobiographical narrative written by Gerhard Nijhof (2001), which describes his experiences as a cancer patient while he was being treated at a Dutch hospital, is an example that is particularly noteworthy. In his report, medical sociologist Nijhof elucidates the fresh insights he received during his time on the ward. He sheds light on several aspects of hospital care and sickness that had previously slipped his notice, despite the fact that he was in good health and had a lot of physical vigor. Nijhof's story was published in the journal *Medical Sociology*. A sizeable portion of social scientists have voiced their dissatisfaction with the effect that technology has had on the rebuilding of human existence. His book included further facts about the length of nighttime periods, the work done by custodians and medical professionals, as well as the engagement of others within a person's familial network. The "study" that Nijhof conducted through interaction is an example of a possible instance of hospital ethnography.

The fact that this methodology was not utilized within the current compilation suggests the inherent difficulties associated with successfully handling the combined obligations of a field worker and an actual patient (or member of staff). In point of fact, exhaustive participation acts as a barrier to the progress of study. An increasing number of anthropologists have arrived at the conclusion that it is impossible to conduct conventional participant observation in a clinical setting without producing contradicting results. In the course of Van Amstel's work as a physiotherapist in a rural hospital in Papua New Guinea, he participated in anthropological research, and he had a profound realization of this fact as a result. Several of the researchers referred to themselves as visitors. For instance, the research that was carried out by Mpabulungi (1995) looked into the participation of patients' family members in the process of providing medical care to hospitalized patients in Uganda.

The researcher is frequently able to do some of the more menial tasks that are associated with patient care because the presence of visitors on the ward imparts an air of normalcy to the environment. In 1978, Blue bond-Langner made the choice to send a specific kind of visitor to hospitals in the United States that cared for children

who were in the final stages of a life-threatening illness. The individual made it quite evident that she no longer associated herself with her parents and that she had no interest in being cared for by the staff. Between patients and healthcare professionals, Vega (2000) and other scholars, such as Inhorn, Vermeulen, and Zaman (the latter three writers in this collection), accepted the role of an intermediate in order to facilitate dialogue and act in this capacity. An invitation to elaborate on the methodology utilized by the writers of this special edition was offered to them so that they might discuss their fieldwork.

These examples highlight the numerous opportunities for anthropological research that are present within medical settings. It is difficult to get permission to do research in "Western" universities because of the severe regulations established by institutional review boards. The patients' privacy and their overall well-being, as well as the staff members' safety from any potential injury, are both extremely important concerns that are addressed by these boards. However, the level of patient privacy concerns is significantly reduced in hospitals located in Africa and Asia, which makes it easier for researchers to gain access to hospital wards in these regions. In the most recent issue of Inhorn, the topic of privacy and access issues raised by persons receiving in vitro fertilization (IVF) treatment in institutions located in Egypt and Lebanon is investigated in depth. The observed disparity in accessibility, which highlights the relevance of privacy and secrecy, provides as more proof of the cultural and sociological disparities among hospital institutions worldwide. These differences may be seen as a result of the fact that different countries place different values and more importance on privacy and secrecy.

### **Contribution**

In his work, Max Andersen elucidates the correlation between the organizational framework and management of hospitals with the broader societal interactions and class hierarchies. Additionally, Andersen highlights the repercussions of the bureaucratic structure prevalent in Northern Ghana, which engenders disparities in the treatment received by patients. The author elucidates the processes by which health professionals perceive, generate, sustain, and validate uneven treatment. The individual proposes that the hypothesis put forth by the author, which posits an inherent clash between wider socio-cultural dynamics and the bureaucratic framework, might benefit from being complemented by a more nuanced methodology for addressing these conflicts. In her analysis, Diana Gibson investigates the hospital procedures implemented in South Africa, drawing upon the theoretical framework proposed by Michel Foucault, particularly his concepts of "normalization" and social surveillance.

The concept of the gaze has been metaphorically employed to represent the various "technologies" employed within healthcare institutions. Within the realm of healthcare institutions, the shift from an authoritarian to a more participatory governance structure has materialized in distinct manners. Patients often encounter a phenomenon characterized by a sense of being overlooked or disregarded by both governmental entities and healthcare practitioners, commonly known as "gaps in the gaze." "Despite the presence of ideological changes advocating for equal healthcare

access, the absence of financial means leads to unequal treatment in hospitals. In order to ensure equal treatment and healthcare for all individuals, there is a continuous process of reorganizing patients, services, and workers. Decisions pertaining to the allocation of accommodations and the extent of therapy required are compelled by financial limitations. Shahaduz Zaman did a research study within the orthopedic ward of a government teaching hospital of significant size. The hospitals and cities in Bangladesh exemplify their commitment to maintaining social bonds and reinforcing the hierarchical structure within the broader community.

The cultural dynamics inside a ward are shaped by the individuals who reside and labor within its boundaries, in addition to the circumstances they are compelled to confront. The hospital provides medical care to individuals situated at the lower end of the socioeconomic spectrum, and the limited availability of resources sometimes leads to professional dissatisfaction among the physicians and staff members. The hospital depends on the assistance and provision of care from family members in order to support and attend to their hospitalized relatives. Patients provide young males and domestic workers with little remuneration in exchange for their assistance in fulfilling their daily needs. Remarkably, patients construct a microcosm of their own by engaging in humorous banter concerning senior physicians and fellow patients, so mitigating their sense of powerlessness and affording them respite from the tedium associated with their hospitalization.

Kaja Finkler carried out a substantial amount of research in the area at a hospital in Mexico. In spite of the fact that biomedicine is practiced all over the world, the author provides examples of medical professionals at an outpatient facility that is affiliated with a well-known hospital in Mexico City who demonstrate their capacity to adapt biomedical approaches in order to make them appropriate for the cultural environments in which they work, thereby localizing medical practice. The author emphasizes that the usage of the same medical terminology for diagnosing patients does not necessarily suggest that these diagnoses surpass the cultural knowledge of the patients' individual situations. This is one of the main points that the author makes. In order to investigate the theoretical ramifications of medical professionals redefining diagnostic categories, the author explains how the practice, albeit being conducted on a global scale, is impacted by elements specific to individual locations. In addition, the author discusses the practical implications of developing epidemiological profiles that are dependent on the diagnoses provided by medical professionals.

The author believes that therapeutic decisions are not made in accordance with norms that are either generally acceptable or that are culturally particular. In her research, Lucia Tanassi highlights the value of customized treatment within the framework of obstetrics within an institutional setting. More specifically, she focuses on St. Mary's Hospital in Rome, which is located in Italy. The use of anecdotal evidence provides as an illustration of the way in which obstetrics stereotypes continue to prevail and reinforce cultural ideas on the passivity of women. Tanassi argues, however, that even in situations in which women are treated as objects because of hospital laws, these individuals nonetheless display agency, despite the fact that they may appear to be submissive. Women who are expecting children report feeling a sense of fulfillment



from following the recommendations made by their doctors, despite the fact that doing so may require them to make significant sacrifices or to persevere through a variety of challenges. These women are motivated to become mothers by their desire to have children of their own.

The scientific work "The Allocation of Life-Prolonging Interventions to Newborns in the Neonatal Ward of Amsterdam University Hospital: Ethical Considerations," written by Eric Vermeulen, investigates the ethical considerations surrounding the allocation of life-prolonging therapies to newborns in the neonatal ward of Amsterdam University Hospital. The research investigates the difficult decision-making process that must be undertaken in order to establish which newborns are qualified to get particular care and which are not. The author argues that the process of making these decisions should involve conversations between parents and healthcare experts, in which the Dutch cultural concepts of compromise and negotiation are taken into account. These discussions should take place before these judgments are made. In the academic work that they have produced, Hans van Amsteland and Sjaad vander Geest investigate the political and legal repercussions that are related with a hospital that is located in the Highlands of Papua New Guinea. It is interesting to note that this modern institution, which provides more than just medical services, also respects ancient cultural ideals of justice by evaluating claims for compensation due to bodily harm that was caused as a result of acts of aggression or accidents.

This is something that should be taken into consideration. Marcia Inhorn is concerned about the ethical implications that come with conducting research in hospital settings, in particular when the primary subject of the investigation is an illness that has a negative social connotation, such as infertility. In this case, Inhorn is particularly concerned about the potential for discrimination. The author investigates how politics of patronage, privatization, and privacy affected anthropological research carried out in in vitro fertilization (IVF) clinics based in hospitals in Egypt and Lebanon. Individuals who pursue in vitro fertilization (IVF) typically seek isolation and may even want sexual anonymity while pursuing these therapies. This is primarily owing to the cultural stigmatization of infertility treatments, especially in the context of male infertility. As a result, it is absolutely necessary to address the ethical concerns that are associated with the method of getting informed assent.

In addition, as a consequence of the commercialization of medical services in the Middle East, both patients and anthropologists have fewer alternatives available to them when it comes to gaining access to private IVF clinical settings for the purposes of receiving treatment or conducting research. The ideals of medical privatization and the requirement of protecting patient privacy have a significant role in determining the extent to which anthropologists are able to get entry to the domain of IVF secret. It is our hope that the collection of papers that are being presented in this special issue of Social Science and Medicine will act as a catalyst for additional scholarly inquiries into the field of biomedicine and hospitals, with a particular emphasis on different cultural points of view.

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