Opinion

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Softening the Medical Gaze Through Informal Economy. Towards a Resocialization of Medical Dominance

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ABSTRACT

In order to ethnographically capture the ambiguous ways in which medical informal economy is understood, legitimized or questioned, a bottom-up analysis is needed; before highlighting the systemic valves due to which these informal practices appear, we need to document the specificities of the medical act and of the way in which disease and hospital culture are internalized by the patient. In this paper I will argue that attributes inherent to the specific way of understanding, organizing and practicing modern medicine are one of the main reasons why informal exchanges are legitimate and reproduced. Informality-as-gift, i.e., the situation in which the medical act is not in any form conditioned, most often seeks to replace the "medical gaze" with a human gaze, appropriate, non-hierarchical and non-paternalistic, "forcing" the healthcare professional to a type reciprocity that takes the form of recognizing the other's humanity by personalizing the therapeutic or care relationship.

Keywords: Medical Dominance; Hospital Culture; Ethnography; Informal Payments; Medical Gaze; Conflict; Resocializing the Medical Act; Romanian Medscape; Gifts

Introduction

The widely accepted version regarding the origin of the phenomenon of informal payments (called "attentions", "gifts", "bribe", depending on the source) in the Romanian healthcare system is that they come from the communist period. In order to overcome the shortcomings of the free healthcare system, which was characterized by the limited access to medicines, modern equipment, specialized staff or quality conditions for treatments, patients resorted to cash payments or other material gifts in order to circumvent these issues. At that time, the medical staff was included in the category of civil servants, with the salary as their only source of income, a situation that continued in the first years of the transition, until the regulation of the physician's statute by the College of Physicians and the emergence of the private sector. Low wages in the healthcare field coupled with the poor economic situation of the whole country have led to the emergence of a new type of informal payments: through the "just price theory" (Babcock [1]). The patient uses informal payments as a gift to compensate for the difference between the perceived value of the medical act and the remuneration of the staff who treated them, deemed insufficient.

The informal medical economy was analysed and presented to the general public in terms of: I. political and legal implications - the establishment of patients' gestures to offer money and / or items to the medical team and the latter's gesture to accept any payment / item, outside the formally stipulated frameworks, as acts of corruption; II. economic implications - informal medical payments are one of the main factors in delaying the efficient management of public health services. The presence of a parallel economy to

the official one is a major barrier to the exercise of liberalization of the medical services market. It is assumed that these informal behaviours can only be eradicated through further liberalization and even through the privatization of the healthcare system (see the analysis of policy options and strategies for reducing the extent of informal payments); III. social implications - in terms of diminishing accessibility to health services or limiting quality by conditioning the medical act.

Thus, we noticed that the anthropological (not psychological!) dimension of the informal exchange dynamics, which brings together the particular way of organizing and socializing the medical sector, plus the cultural responses (more specific narratives and behaviours) to the disease, remains obscured. Without evading political, legal, economic or social implications, the informality must also be seen as a cultural response to the "medical gaze" (Foucault [2]) (Palaga,2020); healthcare informality should also be understood as a concern of the patient for the humanization of the medical act, in which they are most often involved as a procedural object - thus the presence of informal practices in the private health sector can be explained, the "medical gaze" being a component that runs through the medical system, be it public or private. Of course, if the biomedical approach to the disease and the management of the process of restoring the body's homeostasis were the key element, able to reveal the presence of informal practices, then they would be widespread and detectable even in those countries where studies show that they do not occur.

Without being able to empirically support my claim now, I tend to believe that gift-based informality is also present in Western economies, but it is not documented since it is theorized as reminiscent of old socialist customs or may be culturally defined in completely different terms. For example, I interviewed regarding this matter five Romanian nurses who emigrated to the UK, who were working in a "nursing home", with bedridden "residents" or with advanced forms of dementia, so they were highly dependent on the medical team. They assured me that even there the medical team receives small gifts / "attentions" from the patients' relatives, even after the patients' death, to show their gratitude. I believe that in Romania, socialization in the medical profession or the role of the "patient" operates with a "strong" version of the medical gaze, emphasizing the asymmetry between the physician and the patient, contrary to the Western space, which insists more and more on a personalized type of medicine and on establishing a relationship based on trust in professional expertise, without the specific distance created by expert knowledge.

The first study that looked at the specific type of physician-patient relationship was conducted by L.J. Henderson in 1935. He showed how this interaction takes the form of mutual feedback, in which both the physician and the patient affect each other's behaviour (Henderson, et al. [3,4]). The basic task of the physician is to "listen": "When you talk to the patient, you have to listen in particular: firstly, you have to listen to what he wants to tell you, secondly, you have to listen to what he doesn't want to tell you, and thirdly, you have to listen to what he can't tell you." (Henderson [3]). Parsons' sociology of roles assigned to the generic typology of the "patient" has been strongly influenced by Henderson's pioneering analysis (Bury [4]) (Monaghan). The disease, as theorized by Parsons, is a form of deviance, a departure from the "normal" sequence of daily life, which will be managed by a specific social institution: Medicine (Varul [5]). Remaining in the Parsons' paradigm, the disruptive potential of the disease, understood as a deviation from the organic functionality of the social, is contained by the recognition and social internalization of two roles: the role of the patient, on the one hand, and the role of the physician, on the other.

The role of the patient is tripartite: they must accept the idea that being ill is an undesirable status and should want to restore their health. Then it is necessary for the patient to address the medical institutions and submit to them, strictly following the "recommendations" made by the medical specialist (Parsons [6]). Both Henderson and Parsons describe a consensual model of organizing the physician-patient interaction, in which the paternalistic authority of the physician must be 107 uncritically accepted, as it is legitimate in that

(i) The physician knows more than the patient

(ii) The physician will always follow the patient's best interests. Subsequently, Szasz and Hollender (1956) captured three categories of relationships that can develop between the physician and the patient.

1. A type of relationship similar to that between a parent and a child, based on the dual opposition between "active" and "passive".

2. A relational style similar to that built between a parent and a teenager, based on "guidance" - "cooperation", with less symmetry compared to the relationship described in the first section.

3. Mutual participation, a relationship between "adults".

To remain in the analogy proposed by Szasz and Hollender, the physician who works today in the Romanian healthcare system, both public and private (!), is like a parent who breaks down under the weight of daily tasks, accumulated stress and fatigue, continuous pressure, which has a relationship with a child who fails to keep up with the mature and punctual explanations of the parent, but who

is afraid to ask for further clarifications, so as not to cause another nervous episode. I should not be understood that I antagonize medical staff, on the contrary: I think that they are themselves victims of systemic pressures, and the doctor-patient dyad is, in fact, shaped by many other mediators: socialization in the profession, protocols, increasing use of medical technologies (Frank, et al. [7]), plus, of course the systemic problems of the healthcare system, which I have presented extensively in the previous chapters. The physician of the period described by Henderson is completely different from the one that a patient will meet today in a specialist outpatient clinic or in a hospital unit. Even the asymmetry and paternalism captured by Parsons in his attempts to theorize the roles assigned to the patient or physician are soft compared to how current technologization and excessive bureaucratization rewrite the interactions within the current biomedical system.

If the type of medicine that organizes the socio-medical system described by Henderson relies on "listening" to the patient and figuring out what they want to hide from you or, moreover, even what they cannot tell you, if Parsons' physician "trains" their patient, who must listen to them in order to recover, today physicians interact much more frequently with the results of paraclinical investigations than with the patient's narrative about the disease. Currently, the patient continues to incorporate the role of the patient, but the physician is less and less present in the interaction. The patient is asked a series of specific questions for the completion of the anamnesis. The answers, always punctual (the treating physician / resident physician / nurse will ensure that the patient does not stray unnecessarily) are quickly noted in the patient's "Observation Chart", after which the medical team's attention is refocused on certifying the symptoms by gathering objective evidence, able to certify a correct diagnosis.

There are types of medical care, such as cancer surgery, in which the physician disappears completely after the intervention, monitoring and "talking" with the patient through resident doctors or through the intermediary staff: "You had no one to ask. The nurse said that she was not allowed to tell you, that the doctor would explain to you, but the doctor was nowhere to be found, he was still in surgery or at the clinic, who knows?! (The physician mentioned here also owned a private clinic, n.n.). (...) He had seen me before the discharge and then he told me that it was okay to come for an exam in three months. (j, F, 51, cancer patient). The major problem with this type of doctor-patient relationship is not the inherent disciplinary and asymmetrical nature of the interaction - it is not difficult for the patient to accept that someone knows more than they know about the illness that is causing them suffering. The doctor-patient dialogue often turns into a monologue, in which the patient ends up self-addressing their fear caused by the uncertainty of the presence of the disease and its evolution.

The patient's questions rarely find an expert interlocutor, and when the physician is available to listen to them, problems arise related to the inability of the latter to set aside the hyperspecialized language, both medical and administrative-bureaucratic (diagnostic codes, example): "(…) technology does not talk to the patient, but exclusively to the doctor. And insofar as they have full confidence in the accuracy of technology, they really don't see why they should waste time talking to the patient as well" (Mihăilescu [8]). The unique narratives of the unique individuals facing the disease become completely irrelevant and are perceived even as impediments to the identification of objective, measurable and therefore "visible" markers of the disease: "The psyche is therefore part of the patient's clinical picture, but more as a "noise", as a "neurosis", as a psychopathology. Suffering must also be considered, but only to free the "actual disease" (somatic!) from the expressions of this "subjective element", which can take the physician "on the wrong path", preventing them from finding out the "key to diagnosis". (Mihailescu [8]). Of course, we can ask ourselves: how current and problematic is the reduction of the patient to a symptomatology? Following the ranking of dissatisfaction factors among patients, a study by Popa et. al.

In 2017 concluded that the main source of dissatisfaction mentioned by patients is the fact that medical staff in Romanian hospitals adopt a type of behaviour in which communication with the patient is increasingly restricted. The members of the medical team do not consider it important to explain to patients the specifics of the medical treatments and procedures to which they are to be subjected, nor about their duration or consequences, although these would give patients a sense of security, emphasizes the study. A review of 12,000 patient complaints showed the emergence of the following two characteristics of medical professionalism - communication problems and lack of respect - as the main sources of dissatisfaction for patients. Lack of respect refers to all this tacit behaviour: either the physician does not introduce themselves to the patient or ignores them, talking to the medical team as if the patient were not there. In fact, according to the biomedical model, it is not a patient who is physically there, but a pathology that needs to be discovered and combated. The limitation of medical interest in aetiology, symptomatology and the result of paraclinical investigations has been the subject of strong criticism since the 195072, but their reverberation on the professionalization of medicine is almost zero.

The hospitalized patient, facing a serious pathology, which requires a complex medical care and which is totally dependent on the medical team, feels the strongest alienating effect of the "medical gaze". Hospitals are liminal spaces, in which patients are removed

from their daily routine, passed through intermediate filters (tests, examinations, drug treatments, surgeries) and redefined as identity: they "lose or receive limbs" and become part of categories such as "cancer survivor"," awake from coma", etc. (Long, et al. [9]). Similar to the personal experience of acclimatization to the rigors and routine of "life in ward", which I briefly summarized as self-ethnography in the beginning of this study, also patients, as they adapt to the inpatient space, feel the need to reduce the impersonal and standardized character of wards, asking their family members to bring them items reminiscent of a familiar environment (bedding, small decorative items, board games that do not overload them, etc.) and even the need to personalize the relationship with the treating physician, with the nurses and the EMTs, with the people serving the food and, of course, with the other patients. I also believe that the increasing frequency and number of payments.

I would also like to mention the position of the Hungarian psychoanalyst Michael Balint, who advocates a psychodynamic approach to the disease and medical examinations, which could both facilitate the addressing of the patient's psychological and social problems and the diagnosis and treating their condition. Informality in the hospital environment are reactions generated in response to the unfamiliar, closed and strongly regimented social order of hospital life. Hospitals are standardized, regular and orderly places, according to the biomedical model and modern bureaucratic requirements, so as to allow the interaction of medical technologies, therapeutic areas, specialized medical staff and patients, in order to diagnose and treat bodies affected by the disease (Parry, et al. [10,11]). One of the first observations made to highlight the multiple dimensions and meanings assigned to hospitals dates back to 1930 from Michael M. Davis: "For the sick and their caretakers, the hospital is a battlefield between life and death.

For doctors, the hospital is an institution where medicine is practiced and a centre for study, research and training. From the point of view of the businessman and the taxpayer, the hospital is a financial enterprise." (Davis, et al. [12,13]). The same medical institution is invested with different cultural meanings, depending on the position and situation that generates the appreciation: for the healthy individual, the hospital is the "home of disease and suffering" (S., M, 28, caretaker of a terminally ill cancer patient), a space of dissociation "from life, with all the small things that give it flavour" (W, F, 40, patient hospitalized for a gynaecological surgery). For the sick individual, the hospital is a place that generates re-evaluations and prioritization of things that are "really important in life, (...) a place where one suffers a lot, but where even the most intense joys can occur" (Lz , M, 38; participated in the birth of his own child at a private clinic). In Western societies, the hospital has become the place where life begins and ends (Long [9]). Overall, the hospital becomes a place where questions are raised, and answers are given about the purpose, nature and significance of human life at a much more intense level than we are used to in our daily lives.

For the medical staff, the hospital "becomes home or, let's say, my main home, because I spend my days and nights here" (I., M, 28, resident surgeon), facilitating a continuous professional training and, at the same time, constituting an arena of continuous measurement of one's own skills, both by patients and peers: "(...) I saw here (in the hospital, n.n.) the peaks of success, but also the biggest disappointments. (...) The hospital is a very cruel friend!" (Fr., F., 46, General Surgery Specialist). For government decision-makers, the hospital is a strategic resource, but also a hotbed of major social imbalances, fuelling "big" or "small" corruption. How does a patient with severe pathology feel when they arrive at the hospital? In a foreign world, torn apart by all routine, familiarity, control, and predictability, comes to cling to the only thing they recognize, that "something" that resembles them: the humanity of the other. In the hospital, the other takes two forms: the other sick, the "fellow sufferers", as the other patients with whom one shares the room, the ward or the department are often nicknamed, and the other who has a superior expertise to you, knowledgeable of all the secrets of the medical act, from the bureaucratic ones to those related to the therapeutic conduct, but at the same time, like you, the one before the disease and the one to which you tend to return after the disease itself is tamed.

In the context of pathologies involving a major rupture in the patient's life, drawing a clear demarcation between "pre-disease life" and "post-disease life" and whose cure literally involves total renunciation of the control over one's own body and often complete dependence on the medical team, informality must be understood as an act close to the most easily recognizable element - the humanity of the other. For the physician, the patient is most often a "typical case", but for the patient, the whole experience is particular and personal. The physician will apply a generalized set of knowledge to one case among many other cases, while the patient will struggle for the physician to recognize their human particularity (Freidson [14]). Against the background of this type of conflict, inherent to the way of conceptualizing the disease according to the biomedical model, informality based on gifts is used to claim the dose of humanity that the physician learns to excise since their professional training (Kleinman).

The gift, through the kind of sociability it creates when accepted, is one of the main reasons why the informal economy is present especially in environments where the "medical gaze" is more strongly manifested. I will insert here one of the most evocative and beautiful cries against the medical gaze that I "picked up" during the ethnographic approach. It comes from a particularly reflexive

cancer patient who has closely analysed all the changes she had gone through since she "found out about her diagnosis" - her diagnosis, which she found out and was not just made." From the very way she formulated the idea, it emerges once again how the disease becomes unique for each patient who comes to incorporate it. "(...) You feel like you don't belong to anybody. You are there, lost among other patients, each with their own illness and suffering. You're scared, you don't know anything... what's next, if it's going to hurt, what they're going to find (doctors during the surgery, n.n.). And all these people are new to you (the medical team, n.n.) and they don't know you either.

And you want to tell them about you, as if that would save you. You want them to hold your hand and tell you it's okay, as if that would save you. You want to be told a bad joke, as if that would save you... (Y., F, 38, cancer patient). How does the logic of the gift work and how does the patient claim their humanity? The gift is "deeply personal. It is special. The gift is even magical. As the great anthropologist Marcel Mauss first pointed out, the gift contains both the capacity of the giver and the recipient" (Appadurai, 2006:20). The gift can surpass the medical gaze because the gift and this particular relationship that it solidifies melt into a crucible, ending up having one and the same identity. I now quote from my field diary: "I don't know how to explain it. You feel pity when you remember that the patient is human, just like you. No matter how hard your day may have been, no matter how stressed you may be, when you receive something, you stop everything you do. You can't receive mechanically, like if you remove the infusion after it terminated. You stop.

You look at them and you have to thank them. Even if you want to do it only formally, you can't... it's an emotion put into the gesture of giving and this emotion contaminates the recipient as well. It's emotional even in that standard phrase: "Oh, you shouldn't have. I'm just doing my job, you know…" (Field diary, 2018). Even if informal practices are widespread in the hospital space, every gift, every "attention", every little manifestation by which patients ask to be treated in their entirety, which involves accepting the uniqueness of their drama, their trial, is not completely routine, the acceptance of each new gift has a surprise element: "I think I received hundreds of bouquets of flowers, chocolates, coffee, perfumes and I don't know what else! But, you know, I am still happy when a patient tells me that they are satisfied with me, with my work or maybe they even remind me that I can do more and be better, to give one hundred percent." (N., F, 35, Surgical Nurse). "Of course, I'm happy for every (gift, n.n.), it's also a measure of the quality of my work and my involvement" (U., F, 40, Nurse in an Internal Medicine department treating patients with cirrhosis and other serious liver conditions).

From the quotes above, I understand that it is, in fact, a matter of mutual recognition of the other's humanity: through a gift, the patient accesses the man behind the profession. Not only the patient is dehumanized in the biomedical model, but also the physicians, the nurse and the EMTs; they are reduced to their professional quality, often lacking an understanding of how work in the hospital environment erodes, consumes, hits hard on the physical and mental health of the medical team. We are talking about a dual rehumanization: 113 "Now you're going to say that I'm self-centred (laughs, n.n.). Yes, the patient becomes a diagnosis, as you say, but what is the doctor reduced to? A book of diagnoses and a robot who doesn't need to eat or sleep? It's not easy for us either, you know." (Wf., M, 33, urologist). Humanity is resected by the constitutive type of organization of the biomedical model, and the gift aims to achieve a dual rehumanization: the patient demands humanization through the gift, and humanization becomes possible precisely because the gift conveys to the medical staff that their own human quality is recognized and celebrated.

What do you rehumanize in the other through the anthropological category of the gift? The patient regains their name, the medical staff making an effort to memorize it, even if, when discussed in the medical team, the patient will also be identified by the number of the room and the bed occupied in the room. Often kept in the dark by a language too specialized, sometimes due to the distinction made by some medical staff73, other times due to the large number of patients and the effective compression of time, which does not allow a personalized relationship with the patient, also translating into colloquial, "secular", non-medical language the changes produced by the disease, its evolution or prognosis. The gift also has this ability to force time to expand, reminding the healthcare professional that it is necessary to speak the "language" of the patient. This aspect is admirably captured by anthropologist Vintilă Mihăilescu, in a book in which he ethnographically self-documents his relationship with the disease and the medical staff, "technology alone, by itself, only offers "statistics" of diseases (…) risking losing the patient and their particularity" (Mihăilescu [8]). The gift reminds that both sides of the patient - medical team dyad need to hear a story "about nothing" (Ş., M, 52, lung cancer patient), beyond the hospital routine, about plenary life, about everything that confronting the disease (or living in its vicinity) steals, supports, warms, encourages. Informality based on gift must also be understood as a way for the patient to regain some of the control lost over their own body, and the medical team regains the faces beyond the duties and skills expected of them at work.

In the face of these systemic disorders, the only thing left for the individual to do is to reduce the double state of uncertainty - caused by the disease, on the one hand, and the acute lack of confidence in the health system, on the other, by resorting to the informal exchange system. The bureaucratization of primary medicine, the small number of physicians that the population can

turn to, the underpayment of medical staff and the inability of the State to provide minimal medical resources have acted like a catalyst, boosting the motivation to provide decent medical care, in an informal way. In order to correct the underpayment in the public health system, more and more medical staff resort to the so-called "dual medical practice", thus generating a conflict of interest as a result of which the patient / potential patient is severely disadvantaged. Of course, the irregularities that arise as a result of economic imbalances produced as a result of the implementation of changes in the organizational and institutional healthcare framework allow the creation of a valve, conducive to informal exchanges, but this valve is not the basic reason for the emergence of informal practices and their reproduction. In the Romanian public system, the traditional relationship between the physician, the patient and the other members of the medical team is often structured on rigid hierarchical relationships and on an extremely strong "medical gaze".

Located at the top of this hierarchical pyramid, the physician often interacts with patients through mid-level medical staff (nurses), the patient's identity being assimilated almost entirely by the medical case they represent. The hospital acts like a "social island", in which class relationships or social status outside it lose their strength. The patient's identity, regardless of their position in society, becomes a parameter of a clinical case. By minimizing the being to a series of anatomical and morphological dysfunctions, the medical gaze creates a conflict between seeing and hearing. The patient experiences acute dehumanization and reductionist behaviour from the physician, who interacts more often with the results of paraclinical examinations than with the patient facing the disease itself. The patient does not conform to the "medical gaze", identifying in the initiation of informal exchanges a way to take the physician out of the professional paradigm in which they are confined. When the physician institutes the payment, forcing the patient to engage in informal payments, the exchange ends up strengthening the "medical gaze," reiterating a position of authority based on the practical skills of the medical staff and placing the patient in a lower position from a hierarchical point of view.

The gift is a specific socio-cultural reaction to the disease and the way of restoring health, to the occurrence of which economic, political, social and cultural factors contribute. Informal medical exchanges based on gifts embed the ability to produce a hiatus between the "medical gaze" and a more humane way of looking at the disease - affective neutrality turns into an illusory act of alignment with the humanity of the person requesting the expertise (a sincere look is not desired, but a mimetic look, able to convince); once the gift is accepted, the doctor undertakes to give up the professional rigidity, exhaustively approaching the patient through an apprehension of the multiple dimensions that the role of the patient implies (biological, social, cultural). The patient experiences acute dehumanization and reductionist behaviour from the physician, who interacts more often with the results of paraclinical examinations than with the patient facing the disease itself, and the gift redeems the singularity of the human face (Levinas [15]), surpassing the "medical gaze" by the sociability it propagates.

Thus, the fundamental explanation meant to clarify the dissemination of informal practices, in prolonging the macrostructural explanation [16], lies precisely in the medical ethos, in the patient's attempt to establish a human gaze, in counterbalancing the emotional neutrality (Parsons [6]) proper to the medical model (biomedical). Informal medical exchanges based on gifts embed the ability to produce a hiatus between the "medical gaze" and a more humane way of looking at the disease - affective neutrality turns into an illusory act of alignment with the humanity of the person requesting the expertise[17] (a sincere look is not desired, but a mimetic look, able to convince); once the gift is accepted, the doctor undertakes to give up the professional rigidity, exhaustively approaching the patient through an apprehension of the multiple dimensions that the role of the patient implies (biological, social, cultural). The gift redeems the uniqueness of the human face (Levinas [15]), surpassing the "medical gaze".

References

1. Babcock P (2019) Paralyzed by Prices: An Analysis of Price Theory within the Context of Health Care În The Linacre Quarterly 86(1): 89-102.
2. Foucault M (1975) The Birth of the Clinic an Archaeology of Medical Perception New York Vintage Press.
3. Henderson LJ (1935) Physician and Patient and a Social System În New England Journal of Medicine 212: 448-495.
4. Bury M (2013) Medical Model. In: Gabe J And Monaghan LF (Eds.)., Key Concepts in Medical Sociology. London Sage, pp. 111–115.
5. Varul M (2010) Talcott Parsons the Sick Role and Chronic Illness. În Body & Society 16(2): 123-144.
6. Parsons T (1975) The Sick Role and and the Role of the Physician Reconsidered. În Milbank Memorial Fund Quarterly 53: 257-278.
7. Frank AW, Corman MK, Gish JA, LawtonP (2010) Healer-patient Interaction New Mediations in Clinical Relationships. În: I. Bourgeault, R. Dingwall and R. De Vries (Eds.)., The Sage Handbook of Qualitative Methods in Health.Research.London: Sage.
8. Mihăilescu V (2019) În căutarea corpului regăsit. O ego-analiză a spitalului. Iași: Polirom.
9. Long D, Hunter CL, Van der Geest S (2008) When the Field is a Ward or a Clinic: Hospital Etnography. In Anthropology & Medicine 15(2): 71-78.
10. Parry K (1984) Concepts from Medical Anthropology for Clinicians. In Journal of the American Physical Therapy Association 64: 929-933.
11. StreetA Coleman S (2012) Introduction: Real and Imagined Spaces. In Space and Culture 15(1): 4-17.

12. Coser RL (1962) Life in the Ward East Lansing Michigan State University Pres.

13. Freidson E (1970) Profession of Medicine: A Study of the Sociology of Applied Knowledge. New York: Harper & Row.

14. Levinas E (1979) Totality and Infinity. An Essay on Exteriority Hague: Martinus Nijhoff Publishers.

15. Appadurai A (1986) The Social Life of Things: Commodities in Cultural Perpective. Cambridge: Cambridge University Press, p. 3-61.

16. Peerson A (1995) Foucault and Modern Medicine. In Nursing Inquiry 2: 106-114.

17. Szasz TS, Hollender MH (1956) A Contribution to the Philosophy of Medicine: The Basic Models of Doctor-Patient Relationship. In Archives of Internal Medicine 97: 589-592.

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