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ORIGINAL PAPER

"Spaces and encounters in Romanian hospitals make us sicker". Romanian patients' discourses about medical system

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Abstract:
The present study aimed to identify the ways in which Romanian patients assess the last visit to the clinic or hospital as a physical "space" and as an environment of social necounters. The methodology used is a qualitative one – the auto-ethnography, an evocative and analytical form of writing which is itself an art, connects personal and cultural worlds by "writing in" these ordinary everyday experiences. The sample was made of sixteen auto-ethnographies of the Romanian patients from Bucharest collected in the period January – July 2017. The study showed that the spaces of the hospitals'and clinics' in Romania were perceived as unfriendly and hostile by the patients. On the other hand, the quality of social encounters within the medical spaces is very low. The discourses about spaces and encounters related to the medical act and illness were, as such, extremely negative as tone and the use of catastrophic metaphors was wide-spread. We can conclude that more researches are needed in order to change the way in which Romanian hospital and clinics were built and maintained in order to increase the patients' satisfaction and trust.

Keywords: *interpersonal communication; social encounter; discourse; health system; medical space.*

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Introduction

Romania has the lowest percentage of total health expenditure in Gross Domestic Product among the European Union's countries, spending only around 5.5% of Gross Domestic Product for health in 2008 (Chanturidze, 2012). The financing of the health system in Romania is considerably lower not only than the European average but as well as compared with the average expenditurs on health of the neighboring countries (Chanturidze, 2012). As regards the balance between public and private financing in Romanian health sector, as the statistics (Chanturidze, 2012) showed, in 2012, public expenditure accounted for 81% of total spending, while 19% was private expenditure. As Björnberg (2018) had noted, in 2017, Romania's system of health was placed last at the level of the European Union. The items which were taken into account in making this hierarchy were: patients' rights and information, treatment outcomes, accessibility (waiting times for treatment), prevention, pharmaceuticals and the range of services offered, (Björnberg, 2018). Despite this negative general situation, no data are available regarding the design of the healthcare built environment in Romania and its impact on medical system and on the doctor-patient relations.

The present study tried to fill a gap in the existing literature with direct connection to Romania. The aim of it is to identify the ways in which Romanian patients assess their last visit to the clinic or hospital as a physical "space" and as an environment for social necounters.

Theoretical framework

In the recent years there is a growing body of research centered on the design of the healthcare built environment which aimed to show how those buildings and amenities improved the health for patients and the working conditions for medical staff. As a 2013 study showed (Anjali & Upali, 2013), healthcare built environment can contributes at te improvement of the medical system on three major axes. First, it can grant a safe and healing environment for patients; secondly, this type of environment could lead to the creation of an environment which has beneficial effects on staff's activities. Thirdly, such an environment has a definite impact on organizational and business objectives related to the health system for a given society, since it increased the pace of activites and favoured positive work-related relations among medical staff.

Research has shown that hospitals that feature new designs and amenities send patient satisfaction scores vaulting skyward. At the same time, a better medical enviroment can have a positive effect on the medical staff's performances (Anjali & Upali, 2013).

In what can be assessed now as a "classical" work about the influence of hospital's environment of patients' physical and emotional well-being, Ulrich (1984) analysed made an important differentiation between two groups of patients: one group that stayed in a room with "tree views" (e.g. with windows) and another one which were located in a hospital amenity with no windows (e.g. the so-called "wall viewers"). Ulrich had showed that those patients who stayed in a room which had a window ("tree viewers") have improved faster their condition after surgery, have had lower scores for post-surgical complications and stayed less time in a hospital (Ulrich, 1984). In the same vein, Goldman and Romley (2010) had showed that amenities were a larger factor in driving traffic to hospitals as compared with clinics. The result of this situation, the above-mentioned authors stated, was the fact that the hospitals which have modern

design features attract more patients and this type of environment is favoured by managers from the health systems (Goldman and Romley, 2010).

At a multi-purpose lounge of an acute psychiatric clinic in the United States, injections of antipsychotic drugs were used to manage patients who exhibit "aggressive and agitated" behavior. According to Anjali and Upali (2013) if the walls of a hospital were decorated with realist scenes taken from nature that could lead to an important decrease (around 70%) in the daily administration of dugst designed for this type of illness. As Zimring, Joseph and Choudhary (2004) had pointed out, the benefits derived from a direct connection between nature and medical settings lead to a lower level of stress for patients and medical staff, a better general health conditions (reduced blood pressure, reduced pain and increased pain tolerance) and a lower number of days for patients' recovery after the medical intervention.

In their research about bipolar disorder, Benedetti, Colombo, Barbini, Campori and Smeraldi (2001) pointed out that the positioning of patients' rooms within the hospital had have an influence on their general well-being. Thus, patients who stayed in rooms with morning sunlight spent fewer days in the hospital than others. In addition, for the same type of illness (dipolar disorder) even the simple image of real nature within their room could have positive effects on their general health-related condition (Benedetti, Colombo, Barbini, Campori and Smeraldi, 2001).

In the same vein, psychiatric patients studied by Nanda, Eisen, Zadeh and Owen (2011) displayed different level of agitation and anxiety when they lived in various hospital environments. Thus, when photos of landscapes were placed on the room's walls, the patients had displayed lower levels of anxiety and agitation as compared with the situation when abstract art objects were placed in the same medical environment. According to the same study (Nanda, Eisen, Zadeh and Owen, 2011), even the simple movie taken in the nature and presented to the patients can also positivel influence their general conditions, leading as such to the decrease in the blood pressure and a higher tolerance for pain.

The study made by Teltsch, Hanley, Loo, Goldberg, Gursahaney and Buckeridge (2011) showed that the transformation of massive and commonly shared intensive care units into private rooms within a Canadian hospital have lead to a drop by half of the bacterial infection in this medical building. In addition, the fact that intensive care units were private rooms had influenced the time of staying of patients in the hospital after the medical treatment or/and intervention (Teltsch, Hanley, Loo, Goldberg, Gursahaney and Buckeridge, 2011).

On the basis of positive effects showed on the patients' general health condition, the redesign of intensive care units into private rooms is now a common standard, generally accepted in the medical world, its main benefits being the important drop in the infectious organisms' transmissions within the medical settings (Chaudhury, Mahmood and Valente, 2016).

At the same time, apart from the physical space it could provided for medical activities, an hospital or a clinic would offer the space for social and communicational encounters between patients and doctors. As Hunter (1991) eloquently noticed, at the heart of the medical act one would find the doctor-patient "dialogue". In this way, medicine is fundamentally communicative at its esence. This is especially true for evidence-based medicine that is usually practiced in hospitals and the most important communications the physician must take into account are those which occur just at the beginning of the interaction with their patient. In a study on physician-patient

communication, Keating, McDermott and Montgomery (2014) had stressed that this is the key element in achieving the goals of the medical act. In their view, this communication has as its main aim to enable the patient to assign real symptomatology. The process in circular, since the information provided by the patients became central in establishing a treatment by medical staff (Keating, McDermott and Montgomery, 2014).

Methodology

Given the exploratory nature of the present study, no research hypotheses were stated, even in the form of qualitative ones. The analysis presented in this article is only descriptive. The methodology used for this study is the triangulation of the methods applied for the same set of research data. From a strictly methodological point of view, we have chosen the analysis of discourse and auto-ethnography. Both methods were qualitative and no satistical data were employed. Understanding the meaning of context is critical in healthcare environments research since the environments are designed for a system that keeps changing. From this standpoint, participant observation is preferred over non-participant observation, although the distinction between the two frequently blurs (Atkinson and Hammersley, 1998; Cohen and Crabtree, 2006).

The auto-ethnography is considered as an evocative and analytical form of writing which is itself an art, connects personal and cultural worlds by "writing in" those ordinary everyday experiences. The auto-ethnography does not have a very long history and, instead, represents a more recent shift to include the researcher within the context of culture (Boylorn and Orbe, 2016). According to the existing literature in the field (Peterson, 2015), the auto-ethnography is the product of an introspective anthropological movement which attempts to include the viewer inside the culture which he or she is exploring. From here, as Young and Meneley (2005) had pointed out, the accent is placed not on the externality of the object of research, but on the redefinition of it (Young and Meneley, 2005) according to a more complete methodology. The observer is, at the same time, the external (the "Other") and the internal (The "Same") researcher of the reality. The sample was made of sixteen auto-ethnographies of the Romanian patients from Bucharest collected in the period January – July 2017. The structure of the sample is presented in Table 1.

Table 1. Structure of the sample used in the analysis

Gender	Age	Marital status	Occupation
14 respondents – female; 2 respondents – male.	7 respondents - 20-35 years old; 9 respondents - 36-55 years old.	12 respondents – married; 4 respondents – single / unmarried.	4 respondents – students; 1 respondent – IT expert; 1 respondent – architect; 2 respondents – economists; 4 respondents – employe in a private company; 3 respondents – owners of a small company; 1 respondent – housekeeper.

Source: Author' own set of auto-ethnographies – January-June 2017

The discourse analysis had been applied on the sample of the auto-ethnographies. As the starting point was taken the fundamental hypothesis that discourse analysis is a method that allowed us to identify the way in which reality is reconstructed by language, in the sense of Sancho, Paniagua, Lopez Garcia, Cremades and Serra Alegre (2003). Discourse analysis was understood as (Deacon, Pickering, Golding and Murdock, 1999: 147):

"…an attempt to understand the systematic relations between texts, discursive practices and socio-cultural practices."

On this basis, we attempted to discover and clarify the ways in which the power relations and structures are built into the daily language and the way in which language contributes to the legitimation of the social relations that exist (Deacon, Pickering, Golding and Murdock, 1999).

Analysis of the results

From the total sixteen (16) autho-ethnographies analised twelve (12) were made in state-owned hospitals and clinics and only four (4) were made in privately-owned ones. As regards the medical specialities where the euto-ethnographies were made their distribution is presented in Table 2 from bellow:

Table 2. Medical specialities where the auto-ethnographies were made

Medical specialities	Number of auto-ethnographies made
Dentistry	1
Medical tests	1
Otorhinolaryngology	1
General (Family) Medicine	2
Neurology	1
Pulmonology	1
Gynecology	4
Pediatric surgery	1
Orthopedics	3
Gastroenterology	1

Source: Author' own set of auto-ethnographies – January-June 2017

Fourteen (14) hospitals and clinics where the auto-ethnographies were made had agreements with Romanian National Health Insurance House (CNAS) and two (2) did not have this kind of agreements (they were privately-owned ones). In the case of two (2) state-owned clinics which had agreements with National Health Insurance House requirements

A-E 4: I must say that, with the exception of the admission fee, all the procedures were free of charge. Even in those circumstances the doctor asked me for 50 lei for analyzes, because, as he said "I have to bring some substances from my home". Oddily enough for me, but I have to pay...

A-E 8: Well, I'm registered with CAS if I work and also if I do not work on the basis of the handicap certificate. The problem is that I have to be careful when going from the work contract to the right to have health insurance on the basis of

my disability. The bureaucracy is killing us, so if I do not go to submit my request for health insurance I automatically lost my health insurance. Ohhh!!! This it's not an automatic process, as usual. Theoretically I did not have to pay in the hospital. OK, this is only "theoretically" because in fact, basically, I bought all my drugs, I paid cesarean operation, give money to nurses, doctors, midwives. The total ammount of money was quite impressive.

The majority of buildings – twelve (12) – in which auto-ethnographies were made had been old buildings, only four (4) being new clinics. Also, the majority of those buildings were big ones – thriteen (13) – and only three (3) were small location for medical services. As some of the authors of the auto-ethographies described those buildings, they were mainly huge spaces with various medical specialities within them:

A-E 3: The hospital is a building with several floors, quite large. It's an old building, but it seems it had been improved. As a hospital I found that there are 496 beds, of which 36 are for day-time ambulatory hospitalizations. The building is divided in different departments such as emergency medicine, various medical specialties, several surgical specialties, paraclinical investigations and other specialties.

A-E 11: The clinic's building is separate, but there are many other buildings on the same campus, such as the Emergency Institute for Cardiovascular Diseases, or sections located in some stand-alone buildings, such as the Gastroenterology Department. We can speak about an entire hospital campus. The clinic is an old, partially renovated building. The corridors are long and the doctors' offices are located on the same floor with the salons where the patients are hospitalized or/and with the nurses' offices. I think there are there are around six rooms on each side of the corridor. Physicians (specialists in gastroenterology) have two offices, one of which is used jointly with the other gastroenterologists, and the other seems to be only for the head of the Department. Also, on the same floor – 2nd floor – there is a mini-room, which is used as a cabinet by one of the doctors from the same section. The Parasitology Section is located at the basement. Here the doctor has his own cabinet next to the lab for analysis. Although located in buildings linked through a passageway, it would be impossible for any patient to travel alone from the gastroenterology section to the parasitology one. Well, the reason is there are no signs to guide this travel. On my first visit, I was accompanied by one of the doctors to the middle of the road, then he had explained to me how to continue my journey alone "lower a floor, turn left, then find a long hall, go to it, make first to the right, find a door, move it, then not the first cabinet, the second …". From tmy third visit (not from the second) I was alone. I have met several times patients who did not know how to get to one of the sections I already knew. We formed a group of three-four (3-4) patients and we were going together from one point to another.

A-E 14: The Hospital Church is located in the courtyard of the hospital and near to the University of Medicine and Pharmacy. This is the place where the Holy Mass is celebrated and where spiritual assistance can be obtained by the patients. The hospital has eleven (11) floors but the building is an old one. There are about

37 cabinets within the building. The Emergency Receiving Unit is located on the ground floor to provide an easier access for the emergency cases. This is open to all patients, either they came with ambulance or by themselves. At the 1st floor there is the Large Amphitheater of the Hospital, on the 2nd floor there are located Anesthesia and Intensive Care Clinic, on the 3rd floor there are Orthopedics and Trautamology, at the 4th and 5th floors are the Sections of Obstetrics and Gynecology, on the 6th floor is the Clinic 1 of General Surgery, on the 7th floor it is the Clinic 2 of General Surgery, at the 8th floor it is otorhinolaryngology, on the 9th floor it is Neurology, on the 10th floor it is Cardiology and at the 11th floor there is Neurosurgery. Well, this can be a rather accurate description of the entire building since I am not good at drawing the plan.

Almost all buildings had offered an easy access for the patients and their attendants. Some exceptions mentioned "narrow-scale access" or "darker and long corridors between parts of the same buildings".

A-E 14: The access in this building as extremely strange - either on a ladder, and then through the entire access hall in the lounges, or on a very narrow staircase and you arrive in the same place.

As regards the dominant colours of the medical spaces included in auto-ethnographies the dominant colours were white (eleven – 11 – buildings) and blue (four – 4 – clinics and/or hospitals). It is a sort of "trademark" of the Romanian hospitals and clinics. Sometimes those two colours were used in the same building but in different rooms:

A-E 15: I stood in two reserves in the hospital. My first reserve was white, with the more dirty tiles, it had to be renovated. Well it was dirty but not unimaginably dirty, I've seen much worse. But it was a brighter room. The second salon was recently renovated. Here the blue color predominated. Also, it was much darker than the first one.

The furniture in all hospital buildings was minimal, all auto-ethnographies mentioning only the existence of chairs, sometimes of the sofas. In privately-owned clinics there were sometimes (two – 2 – times) alsp a television-set as a device where the programs of a Romanian generalist television station were broadcasted:

A-E 3: Upstairs there is a sofa for two people, and at the entrance to the salons there are chairs for maximum four or five (4 or 5) people. Most patients are standing, being prepared to be the first their doctor saw. This is that way because there was made no appointment based on time-attendance of the patients. There is no playground for children, or anything else with any aesthetic or decorative function. But there is a buffet with an outdoor patio with chairs and tables, where the patients' companions can take a snack or something to eat.

No auto-ethnography mentioned spaces for children or internal decration with green plants. Instead everyting was presented as minimalist, white-and-blue dominated spaces.

Although a necessary sign of medical profession medical uniforms of doctors and nurses were all only white, a colour that is general associated with cleaning and the antiseptic environment.

> *A-E 4: They have uniforms, but, hmm…, there is no clear distinction between doctors and nurses about that or it is not clear for me. They look all the same; I cannot make any difference among them.*
> *A-E 8: The physicians have white gowns, and nurses, either they wear white gown or white blouse and colored pants (mainly blue).*
> *A-E 15: Oh, the uniform differentiates medical staff from all the rest of the people, but for me it is quite unclear, it is difficult to understand who is a doctor and who is a nurse.*

In all autho-ethnigraphies analysed one can notice the fact that the Romanian medical spaces were overcrowded, full of patients waiting not so much on the chairs or sofas but standing beside the walls. As such, inter-personal communication was made only among the partients and their attendants. No auto-ethnography mentioned any interaction between the medical staff and the parients plus their attendants during the attendance times.

> *A-E 6: Oh, there were many chairs in the waiting room ... but the there were much more people than chairs, so they stood still, because many children were also sitting in the chairs. People communicate one to another or they remain silent all the time while they attend the doctor Well, the major problem discussed was the illness or the disease they came to see the doctor ... then about the health of the children, and about the children in general.*

> *A-E 10: Sitting near the halls there are always more than ten people, most of them with their attendants. Those who stand on the (insufficient) waiting chairs are the elderly / seriously ill patients; the rest, patients / patients, most often seek their doctor on corridors, wandering, or staying still. Most of the patients were over fourty years old or seniors. And many of them were from the province, many retired. No hipster / corporatist seen there. Most of them are standing still but some of them (or their attendants) are constantly moving. They communicate quite a lot: "what did you think the doctor will gave you", "what will be this 'something'", "for what kind of problem you came here". I have never entered immediately; I waited for hours (three – 3 - hours or maybe even more!!!). There was no "tail", it was important who would "slip" faster to the doctor. Certainly, those with the doctor's mobile number entered before us.*

The interaction with the medical staff (doctors, nurses or technicians) was minimal in all auto-ethnigraphies analysed. When it appeared it was based either on the fact that patients knew the doctor (or nurse) directly or on the "bribes" offered directly by the patients and/or their attendants.

> *A-E 7: The staff was friendly only if it is rewarded, for any information you have to pay (as much as you should). In fact, the nurses first looked to see what you put*

in their pocket …well...envellope…and then answered the question addressed to them.

A-E10: *It is a precarious situation. There is no good communication in the system. What should make ease the lives of doctors and patients in fact put a burden on them. And I refer here at the bureaucracy, at the health cards that do not work, and the payments that are not done in time for the suppliers of different services….*

A-E 16: There is no concern for the patient's well-being and for the creation of a well-functioning system in which both those who work within it and those who benefit from it to be satisfied. I must add that, generally, good health systems are not cheap.

In the case of some auto-ethnographies there are long and detailed descriptions of their social encountering in the medical setings.

A-E 1: I got there due to an unfortunate and unpredictable event in my life ..... a motorcycle accident… I could draw a parallel to my experience for a few hours at XXXX Emergency Hospital where I was taken first date. Such a terrible experience it was.... A hospital that has no orthopedist, a hospital that has not been given any kind of soothing, and that had lasted until my relatives get something in order "to be friendly with the employees from the Emergency Room". I had a rather severe fracture in my leg, and they only wanted to do me worse, moving my foot in several ways ....Nobody said anyting to me, I know nothing. I felt like a corpse, a body and not like a person. It was terrible, awfull. After that I was transported with an ambulance to Bucharest, in the place described above. And YES, I can say that I was lucky enough to enter contact with professional people here. But this was not the case of the first hospital.

A-E 12: The staff brutally addressed pregnant women; they said harsh replies to them. Frequently they talked as if you were a cow sent to a butcher, not a person. It was probably the most humiliating and lasting experience in my life. Especially a university professor, called to attend the surgery, who discusses issues that could scare anyone in front of me as if I were not present or I would not have been able to understand. The nurses lifted your feets; they broke them apart brutally, without warning you, as if you were just a body on a table. And even now I get embarrassed when I remember. It was horrible when I was felt treated simply as a body lacking autonomy and soul, manipulated by everyone as if it were dead. I was waiting for anesthesia with my soul, I felt like I was doing a panic attack on that table (I do not know if it's a real memory that I was tied up or something delicate, but I subjectively felt drunk), with all the hands on my body. When I got back from anesthesia I was extremely sorry for about five, six hours, and the doctors said only that it was normal that they would pass. I'm not afraid of the pregnancy, but I'm terrified of fear of having a baby in a hospital in Romania and spent a lot of time in various hospitals. You can ignore misery, poverty in hospitals, but violence and emotional, psychological abuse from the medical staff were unprecedented. I have not felt in my life so much as a simple

body, refined, devoid of any human quality like there. It's a trauma that you usually remember in the cold, you can even amuse yourself on it afterwards, but I'm crying even now when I remember.

As the above two examples showed the lack of communication between doctor and patients can lead to extremely negative opinions of the patients about the medical system and health professionals.

Conclusions

In the last decades the health system can be assessed as a specific topic in Romania due to it under-financement mixed with bad management and frequent accusations of corruption (Suciu, Stam, Picioruş and Imbrişcă, 2012). Romanian medical system it is a centralised and weak one, almost incapable to react to present demands in the health domain world-wide (Suciu, Stam, Picioruş and Imbrişcă, 2012).

The present study was centered on the Romanian patient's assessments of the design of the healthcare built environment in Romania and of the medical space's impact on the doctor-patient communication.

As the autho-ethnographies analysed had showed, the spaces of the hospitals' and clinics' in Romania were perceived as unfriendly and hostile by the patients. There was no attempt to reduce the patients' stress, to faster recovery times, or, simply, to offer a pleasant escape from stressful situations, as the study made by Zimring, Joseph and Choudhary (2004) already showed. The Romanian hospital and clinics were not designed and built to contributes at a safe and healing environment for patients and a positive environment for staff, as other studies (Anjali and Upali, 2013) showed that it is possible. Instead, they are old buildings, overcrowded with people, painted almost exlusively in white and blue colours and where the patients seemed to be compelled only at a certain type of behaviour – that of a sick person.

An interesting aspect noticed was related, also, to the relationship between patients and medical uniforms. In general (Castledine, 2004) it is assumed that the uniforms derives a clear legitimacy to the surrounding world and it allows a person or group to engage in socio-cultural associated activities specific to the occupation to which a particular uniform is associated. In medical professions this legitimacy, on the one hand, allows the doctor or nurse to approach patients and enter their physical and psychological space, and, on the other hand, it sends a clear message about the medical expertise they have acquired through education and training (Castledine, 2004). Those elements were obvious in the case of auth-ethnographies analysed in the case of the present paper.

Also, as our data showed, the quality of social encounters within the Romanian medical spaces is very low. The discourses about spaces and encounters related to the medical act and illness were, as such, extremely negative as tone and the use of catastrophic metaphors among patients was wide-spread. Much more, due to the lack of communication with medical staff, the Romanian patients which completed the autho-ethnographies often had experienced feelings related to body's objectification and rejection of the medical system as a whole.

Although this is only an exploratory and descriptive study one can conclude that the lack of trust in Romanian medical system and medical staff which is noticeable nowadays could be directly linked not only to the economic and logistic conditions (lack of proper financing, massive migration of doctors, etc.) but also to other factors. One of

those various factors could be the improper use of medical space and the "neutral", impersonal general medium in which the medical act took place. This space could also have some influences on the lack of interpersonal communication between the patients and the Romanian medical staff. On the other hand, we could agree with Stewart's (2005) thesis that the practice of healing medicine involves emotional and rational change. From here, we asses that the "communicative gap" presented withn the auto-ethnigraphies analysed would requests new strategies and plans for improving interpersonal communication among patients and medical staff.

We can conclude that more researches are needed in order to change the way in which Romanian hospital and clinics were built and maintained in order to increase the patients' satisfaction and trust towards the medical system in general.

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