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Becoming an inpatient:
a symbolic-interactionist study in a polish hospital

Abstract

This paper presents the results of a study that aimed to reconstruct the identity changes in the process of becoming an inpatient in a hospital. The notion of identity moves the focus of the study within a hospital away from the functionalist perspective and allows to center on the biographical disruption at the onset of chronic illness. Intersected with the concept of becoming a hospital inmate it illustrates a primary interactionist concern of structure-interaction reciprocity. In first step author presents the classical writings on hospitals and then attempts to reconstruct the illness narratives by employing the theoretical framework of interpretative sociology and the Łódź School of Qualitative Sociology.

Keywords: chronic illness identity, hospital ethnography, the illness narrative, symbolic interaction, qualitative methods

Stawanie się pacjentem:
studium interakcyjno-symboliczne polskiego szpitala

Abstrakt

Artykuł prezentuje wyniki badań poświęconych rekonstrukcji zmian w sposobach budowania tożsamości w trakcie procesu „stawania się pacjentem" w szpitalu. Pojęcie tożsamości pozwala odejść od funkcjonalistycznego ujęcia instytucji szpitala i skoncentrować się na biograficznym wymiarze choroby przewlekłej. Analiza dynamiki stawania się pacjentem szpitala prowadzona z perspektywy interakcjonizmu symbolicznego ujawnia strukturę wzajemnych interakcji. W pierwszej części artykułu autorka przywołuje klasyczne prace na temat etnografii szpitala jako środowiska wytwarzającego specyficzne narracje pozwalające na stawanie się pacjentem. Druga poświęcona jest rekonstrukcji tych narracji z perspektywy socjologii interpretatywnej i tradycji łódzkiej szkoły socjologii jakościowej.

Słowa kluczowe: tożsamość, choroba przewlekła, etnografia szpitala, narracja choroby, interakcja symboliczna, metody jakościowe

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Introduction: the importance of studying the illness narrative

The imperative for 'healthy' living in high-risk societies is increasingly evident in many areas of our lives. The number of activities conceptualized with relation to health is growing (Nettleton 2013). Sport and exercise are 'healthy' activities, food is categorized in terms of 'healthiness' and household products are considered 'green' if they contribute to the preservation of 'healthy' environment (Albrecht, Fitzpatrick, Scrimshaw 2003: 4). The degree of 'monitoring and self-regulation' appears to correspond with the 'risk-averse' nature of society (Naidoo, Wills 2008: 134) whereas globalization has intensified the social relations and brought together distant places and concepts. The overwhelming presence of the medical discourse disguised as the totally private and personal identity project has impinged upon individual autonomy (Cockerham 2012: 154).

Foucault's concept of the gaze illustrates continuous surveillance of biomedicine. The gaze enables control exercised through medical practices. The biomedical discourse dominated by the medical profession expertise leaves out the patients' voice. The expansion of Western culture that 'diffused biomedicine throughout the world' came to be associated with the notion of modernity (van der Geest, Finkler 2004: 1997). The explosion of medical technologies did open new possibilities of diagnosis and treatment. However, medical practice has reached out beyond 'simply' medical treatment. Additional reference encompasses areas such as health promotion and prevention (Naidoo, Wills 2008: 133). The constant process of monitoring the population has been termed by Foucault as "a bio-politics of the population" (1981: 139).

Given that the idiosyncratic concepts of health and illness are not neutral products of the clinic or the laboratory but result from the social processes – they are "shaped by, and in turn, shape the particular society and culture in which they are formed" – lay health beliefs 'are not simply diluted versions of medical knowledge' but are grounded in the socio-cultural contexts in which people lead their lives (Nettleton 2013: 35). The individual perceptions and experience of health vary significantly across the world. Indeed, apart from biological and geographical factors, these are the socioeconomic and demographic properties that shape individual responses to health problems (Albrecht, Fitzpatrick, Scrimshaw 2003: 4). This, in turn, has consequences

for the forms of help that are sought in ill-health, illness coping strategies and the degree of benefit form medical intervention (Ejsmond 1965: 123).

Whenever in a hospital, a patient resigns from individual autonomy for the treatment to be exercised (Goffman 1961: 174; Mol 2006: 6; Sokołowska 2009: 173). We could put a question: is it because contemporary hospitals are empowered with absolutely state of the art medical technology and knowledge to apply it? Or, perhaps the fact that by posing the ultimate questions of life and death 'hospitals have claimed the domain of the beginning and end of life rites of passage' (...) and 'medical treatment is viewed as sacramental intervention and gift of grace and new hope' (Long et al. 2008: 73)?

The patients, therefore, seem to be facing conflicting expectations – that of a passive, in the least subordinate patient and a proactive self-governing individual capable of continuing treatment practices outside the hospital ward (Taylor, Bury 2007; Nettleton 2013: 44). One aspect of it is the demand of the state or medical institutions and professionals that the ill stay actively involved in their health management and disease prevention (Bergen, Stivers 2013: 221; Taylor, Bury 2007: 28). It relates to the economic aspects, mainly to the healthcare financing, structuring and efficacy (Nettleton 2013: 151-152). This article shows how the patients' identities change as they follow certain schemes of hospital admission and the realization of being ill. The research took place in a cardiac clinic of a leading multi-specialized hospital in Poland[1].

From medical sociology to sociology of illness experience

The basic assumption of biomedicine that disease is located in the body has potentially grave consequences for the ill. First and foremost an illness from the patient's perspective is a disease from the perspective of a physician. In addition, the Parsonian concept of the sick role is based on the assumption that being sick is not a deliberate and knowing choice and, as with other deviant behaviors, society accounts for its elimination by intervention of medicine. The sick are considered unable to take care of themselves and as such must seek

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[1] The study was conducted for the purpose of MA thesis *Becoming an inpatient and the social world of the hospital. A symbolic interactionist analysis* written under the supervision of Katarzyna Iwinska and defended at Collegium Civitas in March 2015.

medical advice and cooperate with medical experts. The experts are empowered by possessing necessary prerogatives with solid foundations in the scientific knowledge based on the study of biological malfunction within the bodies. The very controlling role of the 'gaze' originated in the discursive practices of 18th century Paris and the need for teaching, research, treatment and observation to be located in one place – the clinic (Foucault 1976: 83).The concept of surveillance returns in Goffman's *Asylums* in the detailed description of the institution's tools of social control (1961: 188).

The 1960s and 1970s are marked by intensive empirical work focused on exploring the experiences people have with chronic illnesses. Anselm Strauss's *Chronic Illness and the Quality of Life* (1975) addresses the problem of everyday regimen accompanying the chronic condition by reaching beyond the purely biological origin of a chronic illness. Strauss defines it as a 'negotiated reality' in line with the view of society as a product of interaction and negotiation (Gabe, Monaghan 2013: 73). Trajectory remains the crucial concept in Strauss's theory with its two distinct properties of duration and shape. None of them are purely objective entities. Instead, they are both perceived properties.

It is the temporal aspect that plays critical role in case of chronic illness. Following Kathy Charmaz argument that chronic illness poses 'more social, interactional, and existential problems because it lasts' (Charmaz 2003: 277) it becomes evident how different it is from an instance of acute illness. Charmaz points out that chronic illness models modes of everyday activities, social and cognitive activity and thus demands from an individual a reconstruction of personal identity from the newly developed self-images. "Physical pain, psychological distress, and the deleterious effects of medical procedures all cause chronically ill to suffer" (1983: 180). The medicalized view of suffering ignores or minimizes what Charmaz names *the loss of self*. As the chronically ill experience negative effects of their condition on their self-images and as positive aspects of identity are no longer available the new situation results in spiraling consequences that lead to a diminished self-concept (ibidem: 168).

Conducting research in a Polish hospital

The majority of research conducted in the Polish hospitals are clinical trials. The other frequent type are health related quality of life studies (Tobiasz-Adamczyk 2009). Though arising from different standpoints both types are conducted mostly by medical professionals with the use of standardized tools that "guarantee" the scientific objectivity of the study. The study of patients' narratives and especially in a hospital is a fairly rare empirical proposition in Poland. However, Michał Skrzypek's singular reconstruction of the sociological model of the chronic illness (2011) is a rich source of underlying theoretical assumptions.

Thy study draws upon the tradition of Chicago School ethnographies, in particular on the socialization of the physicians and on making out in a mental hospital (Goffman 1961: 172). The classic ethnographic tool of participant observation, employed by Goffman in the study of *Asylums* (1961), and Glaser and Strauss's research on dying (2007). The study also reaches out to the concept of identity work with its pronounced temporal aspect over individual biography (Charmaz 1983, 1990; Bury 1982) and eventually invokes the European tradition of hospial ethnography (van der Geest, Finkler 2004). The other core influence is the Polish sociology of medicine with the groundbreaking thought of Magdalena Sokołowska (2009, 1989), and the successors to her intellectual legacy (Zakrzewska-Manterys 1995; Ostrowska 2009; Skrzypek 2011, 2012).

Hospital research is a demanding enterprise and to accomplish it the following concerns need to be addressed. Firstly, the defensiveness of hospital authorities and reluctance to let the observer enter their workplace. This is because Polish hospitals are highly structured exclusive/excluding institutional spaces with clearly hierarchical and patriarchal relationships. In addition, hospitals in Poland do not necessarily reciprocate interest in the relationship with social sciences. It requires more than what average medical schooling offers.

The doctors' opinion about the research were split. Some approved, supported, got interested in the new concepts. Others showed disbelief or negation. Clearly, to the doctors the researcher was not their kin despite the white uniform. Similarly with the nurses, they felt they were being watched and

their work was the researcher's main interest. At one point and toward the end of the week the researcher's personal belongings were left locked up in the same room as usual except one of the nurses took off with the only remaining key. The access should not have been limited as it was the only diagnostic room in the ward and very often used during the weekend.

The next concern is the methodological question. As has already been mentioned most of the research methods in Polish hospitals utilize standardized questionnaires (Tobiasz-Adamczyk 2009: 123). Consequently, medical professionals are not acquainted with qualitative research and at first consider it far from scientific. Especially since the area of illness as part of everyday life does not seem of interest to positivist academics and enjoys extensive coverage of contemporary media. The question of methodology is discussed in detail in the next paragraph.

Last but not least there are ethical concerns. The researcher has to take into account that ill people simply do not feel well. In addition, people with chronic conditions are particularly sensitive to others' opinion (Charmaz 1983: 190-191). Therefore, the research honesty and transparency, anonymity, privacy, data protection and security as well as informed consent had to be guaranteed. Privacy, and right to intimacy presented a different issue. Tackling this demanded from the researcher a certain degree of sensitivity and understanding of the hospital rules. A white uniform symbolized scientific and safe encounter with the researcher and allowed to approach the patients in their intimate situations of hospital life.

However, the main principle that respondents 'should not be harmed as a result of participation' (Bowling 2014: 183) was the source of gravest concern. How was the researcher to know the study was not harming a patient? The cardiac conditions do not always present clear symptoms to the patients. How then, a researcher could learn the participant was exhausted? To avoid unnecessary risk individual interviews' time was limited. Even though some patients enjoyed talking about their health issues the timespan did not exceed half an hour. The group interviews, however, took longer mainly because of taking place inside the rooms with the patients staying in their beds.

Still, the researcher's knowledge of the cardiac conditions proved helpful – when one of the respondents, emotionally involved in the interview, was asked if he was tired answered without delay that he actually felt very

tired already. Another patient did not participate in the study because he disclosed in an informal exchange that he had already had three heart attacks and was endangered with another one virtually any time.

The Method

The theoretical approach adopted for the purpose of sociological description of the illness process and one which takes into account patients' opinion is anchored in the humanistic paradigm. The theoretical and philosophical approaches that inform strategies adopted in the study include interpretivisim and constructivism.

Having accepted the fact that 'no single method can adequately treat all the problems of discovery and verification' (Denzin 1969: 926) and as a result of the complex and sensitive nature of the hospital setting multiple methods were used. Each method's restrictions often meant the strengths of the other. The triangulation procedure secured synchronic reliability as it implied the use of observation, in-depth semi-structured interviews and group interviews (Bowling 2014: 365).

The researcher took up the roles of an observer as a participant (Konecki 2000: 183). However, the question remained 'how can, or should the participatory aspect be realized'? According to Sjak van der Geest and Kaja Finkler the researcher who 'wants to be a »natural« person whose presence in the ward can be continuous, has three possibilities to choose from: joining the staff, the patients or the visitors' (2004: 1998).

The perspective of a visitor does not allow for participation in patients' everyday activities, long term observation, especially of patients other than the person being visited. It may also potentially interfere with the ethical aspect of research legitimization. Research carried out from the patient's perspective is challenging practically and ethically and researchers admitted as patients in a hospital would not necessarily be able to conduct any research. Research on the part of the staff counteracts the possibility of interaction with patients that is a prerequisite of an insight into their symbolic worlds.

The Study

The hospital in which the study was done is popular among the inhabitants not only of the city it is located in but also the whole country for academic, technological and professional merits. The turnover of patients reaches 60 000 a year. The cardiology ward in which the study took place has a turnover of 400 patients a month which amounts to nearly 5 000 a year. The choice of the ward coincided with the researcher's personal experience and the fact that cardiovascular diseases are the most frequent cause of death in Poland[2].

The hierarchical nature of relations[3] within the hospital was the main reason why the researcher wore a white uniform throughout the whole study. Its primary function was to protect the patients (both medical and academic staff in Polish hospitals wear uniforms) as she could instantly be categorized as a professional i.e. not harming the patients and authorized to enquire about intimate issues. The uniform did also protect the researcher – to the staff it signaled permission to stay with the patients in their rooms as is the case with medical students or clinical psychologists.

The continuous movement of patients in and out of the ward (including both acute and routine care 'cases') made it very difficult to predict the inpatients' length of stay. That is why arranging an interview in advance turned out to be virtually impossible (except for two cases – one of a young man who felt assertive enough to find out from the personnel, and one lady with a chronic condition who knew how much longer she would stay as hers was a consecutive visit to the hospital).

Otherwise, the researcher had to deduct from the observation and other data, how much longer a patient was to stay in the hospital. Therefore, an interview needed to be arranged ad hoc, most of the time. Convenience sampling was used both by reasons of high patient rotation (12-15 new patients daily in a 42 bed ward meant a significant fluctuation of patients) and

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[2] *Sytuacja zdrowotna ludności w Polsce*, Narodowy Instytut Zdrowia Publicznego, http://www.pzh.gov.pl/stan-zdrowia-ludnosci/sytuacja-zdrowotna-ludnosci-w-polsce/.

[3] An example of the doctors' position in the hospital materialized itself in a canteen: while the researcher (without the uniform) was queuing for the sandwich her turn came when suddenly a doctor (in a uniform) rushed into the canteen and snatched the last available sandwich without any consideration for the que. Trying to protest the researcher heard from the cashier that the doctor has priority because he "is saving people's lives whereas ordinary people must wait".

ethical aspects. This is an approved method in healthcare research methodology as well qualitative research (Bowling 2014: 209).

In the course of the research, it was possible to differentiate four groups of patients from which respondents could be recruited. First group consisted of the oldest patients and those with gravest conditions whose participation in the study was not possible. Second group consisted of patients with advanced cardiovascular conditions and aged 65-85. Third group consisted of middle age patients aged 40-65 with either initial stage of illness or congenital heart defects. The fourth group comprised the youngest patients again with congenital heart defects and/or cardiovascular incidents. The first two groups were most numerous so the individual interviews had two persons from the third and fourth group and three from the second group. In group interviews the largest number – four – also recruited from the second group and three from the third group while one from the fourth group.

The study took place between March 20th and July 9th 2014. The times of observation were irregular and depended on the many factors that had to be taken into account such as a possibility of conducting an interview during daytime routine activities. In the course of the research it was possible to identify the best moment for engaging the patients in the discussion – right after noon and shortly before lunch or sometime after lunch (the researcher had to bear in mind that after eating a lunch the inpatients required some rest). Definitely the weekends when family and friends would visit limited the possibilities of researcher – patient interaction.

The strategy employed for collecting data meant each instance of data collection would begin with overt observation to understand the dynamics and priorities of interactions in the ward and later on – the meaning of the events that have taken place since the previous visit. Apart from being the source of observation it served as a preparatory stage and introduction to the interview in that it familiarized the patients with the researcher's presence and the researcher with the patients. That is how the individual semi structured interviews were done. The group interviews were possible because the patients acquainted with the researcher's presence were keen to discuss. While asking to take part in an interview it would sometimes turn out that a specific person was either too tired or had to remain in his/her bed. In such a case a conversation in a room would turn into a group interview.

The data gathered in the course of the study consisted of the field notes, the diary and recordings of the interviews. The approach adopted to sorting, categorizing and interpreting the data was the framework approach which consists of five stages: (1) familiarization (2) identification of a thematic framework (3) indexing (4) charting (5) mapping and interpretation (Bowling 2014: 402).

Familiarization equaled reading the interview transcripts and the notes, next identification of a thematic framework which reflected the *a priori* aim of the study and developed into an index, indexing which equaled annotating the text with the help of CAQDAS, and finally charting to rearrange the data to the appropriate thematic areas, mapping and interpretation. The data gathered and the consecutive stages of analysis resulted in a chart that disclosed more themes than the main one. They included the doctor–patient relationship, informing strategies and various body related issues such as intimacy or physiological changes.

The Rituals of Identity Transformation

Admission through ER – Acute Care

Emergency room is one of the pathways of getting into the hospital (it was not possible to conduct an observation inside, only an observation of the ER entrance was possible). Analysis of the inpatients' stories shows that all the inpatients with the ER experience see the place as full of chaos and people: *mass of people*. Indeed, there are people constantly waiting at the ER entrance and long waiting hours are accompanied by extreme congestion:

> "You know, here in ER it is quite usual, you wait, more or less, when you get here at nine, then if they place you in the ward at noon, that's a miracle (WI3) I was twenty four hours in the ER ... I mean, from 3pm till 2am, and from 2am till 3pm, I was in the observation/diagnostic area and then I came here" (WG1).

The moment before getting into the hospital is learning that something is wrong. It is important for the process of becoming a patient because a person subject to an illness related event does not know in most cases how to describe what is going on. Therefore, he/she attempts to find explanation for what is happening using the lexicon at hand. It lacks relevant terms as well

as norms of adequate action. The analysis of interviews shows that an ill person's cognitive apparatus develops in the process of „familiarizing" with the illness. It appears the participants are not aware the changes they are experiencing are symptoms of an illness:

> "Well, I did know because you could feel it, you know, I started getting more tired, and so on, but I kept going, somehow"(WI1).

And:

> "Simply, I was thinking, that because I was a plumber. I thought I just caught a cold, maybe the joints, maybe something similar"(WI3).

Those who possess specialized knowledge recognize and name the symptoms and the disease itself. Hence the importance of an expert with specialized knowledge who is either a physician in an outpatient clinic or an emergency room employee to provide a sense of guidance through the myriad of fearful experiences:

> "Later a lady told me that there exists such an illness and it does not depend on anything"(WI3).

The principal functional role of the ER is getting to know what is the medical need of an individual person, and whether the symptoms legitimize treatment in the particular hospital. In that sense the ER functions are to structure, divide and assign the future patients to respective wards. To achieve this patients are categorized according to the severity of their condition:

> "Even I do not know how I, I do not remember, if I had..., it seems to me..., I had exactly ... the orange color... the orange badge. But how... I if that was thirty minutes, in the meantime, true, ECG they did it instantly, I remember..." (W11).

However, this does not necessarily shorten their waiting time. In addition, the ER is the place where "fear and hope mount" mix and interplay which does not make it a more serene place. It is all about change and movement and the narratives evoke the image of Styx.

It may be for that reason that patients with some previous experience choose a different and faster pathway. Instead of spending long hours at the ER they get there in an ambulance, which allows for initial diagnosis already before reaching the hospital. There is no sense of discomfort accompanying their decision to call an ambulance even though they are aware it is not justified:

> "I am not going to wait couple of months to see the doctor; I call the ambulance instantly".

The prevailing problem is that of long waiting hours and insecurity of being admitted and that is what they want to avoid. This situations demonstrates the person's determination to have things done his way.

Routine Admission

Routine admissions have a shorter time-span, though they also require some waiting. Labelled by the patients 'through the secretary' in fact mean regular admissions. The admission's office administrative hours overlay with the time of highest activity in the ward. They start with a visit in the admission where their referral to the hospital is verified. Afterwards, they are asked to go the ward and wait. They change their clothes only when their bed is ready. So, once the patient has been through the admission process he/she still needs to wait long hours for his/her bed; the rotation is unpredictable because the demand for medical services exceeds the supply. Not all the going home patients have yet received the discharge instructions or there is another situation that has put them on hold. Very often these ill people are asked to stay seated on chairs while waiting for the bed. Sometimes, a problem occurs when the person 'is not on the list". A further discussion leads to a tension in communication:

> "I tell them – I do not care, you here.., the professor needs to make a note for me, here, why I am not on the list, when will I be admitted, and so on... So they postponed my admission for another week and when I got there the secretary did not remember so I reminded her that the professor told her to take down the date because she herself is not authorized..."

In this case, some kind of technique has been developed to evade the limitations of routine admission. The patient is again actively involved.

In the ward

After the person has been allowed in the ward they notify the nurses of their arrival and the registration process takes place with all paperwork

that accompanies it. Once officially admitted he/she becomes the patient by virtue of the legal procedure. Next, the waiting in the corridor begins.

As routine admissions require taking samples for blood tests the patients are asked to abstain from food before the hospital and until the samples have been taken. Changing clothes into the pajamas might take place either in the ward or 'downstairs'. Very often beds are not available until midday or lunch time (1 pm).

Once in the room and with their bed, there takes place the next stage. It is the familiarization with other inmates within the particular room. Through exchanging accounts about one's condition, family and the manner they got into the hospital the patients follow the phases of group merging.

> "Initially, I was the person who actually was not saying anything – just listening. But after already some time I began to participate" (WG3).
> "Because, since we are all in this together then if I tell them how it all … how all this happened and the colleague tells us what him in which case, then a man changes his perspective on that what with him, what bothers him" (WG3).

An important aspect of joining the patient community is the nature of the relations with the nurses and the doctors. They demand complete obedience and availability. Even the simplest activities expect from the inmates to fall in line, whether this means taking the drugs/medications or allowing to examine the body (see also Goffman 1961: 28, 339). Waiting and listening 'is it my turn, now?' a kind of lethargy (ibidem: 10) are the required modes of behavior.

However, not all inpatients are ready for such compliance. Those who are among the eldest, less self assured or feel left out for any other reason nurture high expectations towards the staff. Protest takes the form of defiance and very often leads to a row. As one of the inpatients recalls:

> "The nurses bring at four, five am, they come in, turn on the light, bring the medication for you to take, even when for one person, only… and they wake up everybody and 'if you do not like it we can come at 3 am" (WI1).

Although this appears ruthless and unhuman the purpose of such behaviour may potentially be to impose social control.

It is further perfected by the daily routine. The day begins with administering drugs, checking the temperature. The early morning routine differs from

ward to ward and is closely related to a particular condition. Very often it includes weighing the patients, morning hygiene, the first meal. Those who have tests are taken for blood samplings so that they do not eat breakfast. Those assigned for a particular intervention like a surgical one wait for their turn. Others wait for the results of their tests. Yet other ones wait for the doctors' visits start. Once a week there is the Chair's visit. The prevailing atmosphere of waiting accompanies the hospital experience of inpatients. All the waiting has one common denominator – it is the diagnosis.

Into the Illness

The moment of diagnosis is a turning point in one's biography. The hitherto life is about to change.

> "And so it all finished. And the trouble began, Too little exercise, I started gaining weight. Because there was not enough motion. Because…I can't move on" (WI1).

Medications are prescribed, the patients need to learn to control the symptoms and adjust to changes in the functioning of their bodies. The illness becomes an overwhelming reality. It is very often linked to a 'loss of self' ("the illness weakens" [WG3] psychologically) as well as loss of productive ability, financial resources that add up to increasing restrictions in an everyday activities. It encapsulates the patients within its routines and physical consequences so that there seems to be no escape:

> "So up till now, all this, if one was active, one did not have to depend on anyone, anything [any help] and now with all the indications this will change dramatically" (WG3).

The illness often means dependence on others, usually the family. This has serious consequences for the patients' self-images; the former identity loses its foundations so the ill have to construct a new one from the resources that are available.

The patients' narratives include descriptions of their strategies that counteract numerous difficulties accompanying either the contact with the medical institution, or the interactions with its personnel. I refer to them to show that certain people, if faced with situations that leave little if any space for

their agency, still manage to come with ideas that help them win their way through.

> "I had a clash during the night, and today half of the hospital is upset with me" (WI2).
>
> "When I shouted that I was going to call an ambulance and that they will deliver me in an ambulance the cardiologists appeared instantly" (WI1).
>
> "She says: I have here, next to me, she says. She has diabetes, and keeps opening the cupboard over and over again and eats sweets and candies" (WI4).
>
> "Because I must see the doctor … if you use the primary care does not necessarily get here" (WI3).

The reasons behind these proactive behaviors may not be very ethical yet they show that there is some willingness and capability on the part of the patients to pursue their goals.

Conclusion and discussion

The criticism of biomedicine has its roots in the realization that the ideas thereof 'were considered to be congruent with the patriarchal and capitalist society in which they were located' (Nettleton 2013: 16). The idea of the study of illness narratives originated from the realization that neither medical world nor clinical psychologists' discourse account for the social aspects of illness experience. In addition, the functionalist perspective seeing the hospital as a structured system did not include the patients' voice. Therefore, a new paradigm had to be adopted. What followed was an 'ideological shift towards a patient's role in healthcare and a corresponding shift in perspective on the importance of the patient's voice in healthcare' (Bergen, Stivers 2013: 221).

The principal point for discussion – the question how to conduct a hospital research – remains a challenge due to scarcity of similar studies in Poland. This one may potentially answer the question what methodology is most satisfactory. The most serious concern refers to the realization of the participatory aspect and the use of uniforms. The second concern is that the results of the study may seem banal. After all there is nothing new in the stories of conflicts in the hospitals. For medical staff it is slowly becoming obvious that the

patient's perspective needs to be taken into account as the voice of the customer. The feeling of being evaluated and the right to judge the quality of service does not help release the tension between the medical world and the patients. Given the hierarchical structure of the hospital and expert power of doctors they are not yet at ease with patients' narratives.

The image of healthcare in Poland is that of persistent conflict between patients and medical staff. The worst functioning aspect of Polish healthcare is insufficient access to specialized care across all age groups. It explains why people literally 'invade' the hospitals in search of specialized advice (*Opinie o funkcjonowaniu systemu opieki zdrowotnej A.D. 2014* 2014: 1). Therefore, utilizing the results of such a study may help address the themes hitherto explored and augmented by the media.

Apart from methodological concerns the study yielded other results. One of them is a categorization of inpatients into total of five groups with relation to the service and care provided. The types are:

(a) passive and waiting person,
(b) grateful and quiet,
(c) informed client,
(d) rebellious enemy of the hospital,
(e) opponent of the system.

The validity of the types and their applicability in improvements of patient–doctor communication have yet to be tested.

A final and serious conclusion refers to the type of care in Polish hospitals. If biomedicine is centered on acute care and the hospital is biomedicine's foremost institution then Polish medical care as centered on acute care is essentially a biomedical one. One of the defining aspects of the 20th century has been that large sections of the world 'increasingly expect longer lives during which positive health can be largely assumed and anticipated' (Charmaz 2003: 287). Consequently, a growing number of people are "more likely to be living with a chronic condition" (Naidoo, Wills 2008: 131). Some 36% of the population (according to *Polacy o swoim zdrowiu oraz prozdrowotnych zachowaniach i aktywnościach* 2012) are living with a chronic condition. The result is a growing need for a change of focus in the type of hospital care. The prevailing model of acute care that dominates in Poland fails to account for the increase of chronic illnesses of the ageing European population. A new

model of medical care could potentially mean greater patient involvement (Charmaz 2003: 288). That has become one of the priorities in face of visible shortage of healthcare funding.

Finally, the themes identified in the course of analysis prove that hospitals are ultimately liminal spaces (Long at al. 2008: 72), that identity change takes place in a sequence of stages, almost like a ritual. The social consequences of the change may be varied, numerous and harsh, especially if they include difficulties in adjusting to new situation (also in face of material deprivation), difficulties in keeping up with the daily regimes, and body related issues. These are potential areas for further research if further understanding of the patients' world is at stake.

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