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Space, time, and power in hospital health care: Contributions based on the ethnography of an obstetric center

Espacio, tiempo y poder en la atención hospitalaria de la salud y la enfermedad: Aportes de una etnografía de un centro obstétrico

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ABSTRACT This paper presents the results of an ethnographic study of an obstetric center within a hospital of Greater Buenos Aires and an analysis of the spatio-temporal dimension of hospital care. The fieldwork, carried out between 2007 and 2011, followed the everyday dynamics of the hospital and included observation in the obstetrics unit (waiting areas, the obstetric center where births and emergencies receive care, and the ambulatory care, ultrasound, and hospitalization rooms, among others) as well as spaces such as the appointments and statistics offices, the office of social services, the central hall, the pharmacy, and hallway waiting areas. Interviews were carried out with department heads, obstetricians, nurses, social workers, staff of the laboratory and the appointment and statistics offices, volunteers and patients. In this way, the article analyzes the medical-bureaucratic routines in the admission and hospitalization of women in the obstetrics center; the disputes, transactions and negotiations occurring among professionals, patients and families; the delimitation of spaces; and the temporal sequences and hierarchies involved in the passage from the "outside" to the "inside" of the hospital.
KEY WORDS Ethnography; Hospital Care; Obstetrics; Argentina.

RESUMEN Este artículo presenta resultados de una etnografía de un centro obstétrico de un hospital del Gran Buenos Aires a partir del análisis de la dimensión espacio-temporal de la atención hospitalaria. El trabajo de campo, llevado a cabo entre 2007 y 2011, siguió la dinámica de la vida cotidiana hospitalaria e incluyó la observación en la unidad de obstetricia (salas de espera, consultorios externos, sala de ecografías, sala de internación, centro obstétrico donde se atienden los partos y emergencias, entre otros) y en otros espacios como los servicios de turnos y de estadísticas, las oficinas del servicio social, el hall central, la farmacia, los pasillos de espera, etc. Además, se entrevistaron a jefes de servicio, médicos/as obstetras, enfermeros/as, trabajadoras sociales, personal del laboratorio y del servicio de estadísticas y turnos, voluntarios/as y pacientes. Se analizan las rutinas médico-burocráticas de la admisión y la internación de mujeres en el centro obstétrico; las disputas, transacciones y negociaciones entre profesionales, pacientes y familiares; la delimitación de espacios y las secuencias y jerarquías temporales en el pasaje del "afuera" hacia el "adentro" del hospital.
PALABRAS CLAVES Etnografía; Atención Hospitalaria; Obstetricia; Argentina.

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INTRODUCTION

> One may usually see this daily scene in public hospitals: dozens of people crowd together in halls and rooms. Like distrustful intruders, they are alert to the movements of employees, the voice that calls their name or number, the steps of the professionals. [...] Gaining access to health care involves [...] an itinerary of searching and obtaining appointments to deal with clinical analysis, X-ray examinations, interconsultations, referrals. We have named it "the career of the public hospital patient." Such itinerary of never-ending wait, applications for appointments, consultations, whose cycle is constantly starting and restarting, has for those having a suffering, an obvious and insurmountable mark: during the process, the initial ailment is continuously threatening to become a disease that will get chronic (or acute, according to the case) due to the trajectory imposed by the medical appointments and the bureaucratic-institutional care circuit.[1]

This fragment is part of a report on access to health care in public hospitals in the City of Buenos Aires, released in 2003 by the Argentine National Ombudsman Office [*Defensoría del Pueblo*]. Scenes like the aforementioned are recurrent in our studies on the institutionalization of the medical care of diseases, damages, ailments, and other causes in public hospitals of the Buenos Aires Metropolitan Area (AMBA) [Área *Metropolitana de Buenos Aires*], over the last 15 years.[2,3,4,5,6] For their description and analysis, time and space show up as significant dimensions.

Ronald Frankenberg analyzed the passage of those people who demand health care, from the "outside" to the "inside" of the health care institution, where new spaces and temporalities are imposed. In this regard, he states that "medicine seems, [...] in its present manifestation, [...] to be a waiting culture,"[7] in which flexibility in the management of time is proportional to the status and authority of the different actors.

This article presents some of the results of an ethnographic study carried out in an obstetric center of a hospital within Greater Buenos Aires, based on a discussion of the space-time dimension of the network of relationships, institutional practices, and itineraries of people and groups, which are developed every day in hospital care. We analyzed the organization of hospital care, the mechanisms and institutional sequences which transform people's personal problems into problems that can be medically "solved,"[8] the ways of bureaucratic implementation, the agreements, the negotiations, the disputes, the different interpretations, the ways of designation and classification, and the implicit assumptions in the definition of the subjects and their needs.[9]

After exploring the contributions of social investigations in health services in Argentina, and specifying the starting points and conceptual and methodological definitions, the organization of this text follows the ethnographic reconstruction of different moments of the obstetric care and their theoretical implications, thus interweaving a description and relevant analysis, aiming at the dialogue between ethnography and theory.[10]

Ethnography in the investigation of health services

Over the past years, in Argentina and also Latin America, researchers from the social sciences have carried out many investigations regarding health services. Analyzing this vast field goes beyond the aims of this article. Nevertheless, referring to some of those studies, especially to those that analyze health services within the Metropolitan Area of Buenos Aires, will allow us to establish in general terms the field of discussions and discoveries that is relevant to our investigation.

Some investigations aim at analyzing the organization of the public health system, from the perspective of the territorial management and the different rules for the implementation

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of the local policies. This field of studies analyzes the historical process regarding the conformation of the health sector in different municipal districts of Greater Buenos Aires, from a perspective that is focused on the processes of sectoral decentralization and local political and institutional scenarios. In this way, it is propounded to reconstruct "the particular architecture of the sector at a local level, to shed light on the actors, the local dynamics, the decisions made and their relationship with more general processes."[11] The studies address local policies and provincial co-participation on health[12]; practices for supplying medication to the public hospitals within the city of Buenos Aires[13]; funding, resources, and administrative structure of hospital management in four hospitals of the province of Buenos Aires[14]; population's accessibility to medical attention at municipal health care centers in two municipal districts of Greater Buenos Aires[15,16]; to name just a few. In one study, the researchers highlight the differential conditions of accessibility to pregnancy control and birth attendance in different health care centers within the province of Buenos Aires.[17] In general, these research works articulate the analysis of different information sources such as home surveys, inquiries of directors and professionals from health care centers, in-depth interviews with public officers and directors from the health sector, and hemerographic, legal, and sectoral statistic sources.[18]

Ethnographic studies in health care institutions generally focus on the analysis of professional categories and knowledge, as well as the personnel-patients interaction and their attention experiences. Here we include studies about therapeutic trajectories and health care practices in specific populations: individuals who suffer from migraines,[19] individuals affected by HIV/aids,[20] migrants who suffer from tuberculosis,[21,22] users of illegal drugs,[23] native peoples,[24,25] among others. A significant number of these ethnographies explore the therapeutic perspectives, the diagnostic categories and hospitalization criteria, and/or usual aspects of the institutional life in psychiatric hospitals and mental health services.[26,27,28,29,30] In particular, ethnographic studies in obstetric and/or gynecologic services address professionals' practices and representations, the dynamics of the programs, women's experiences, discrimination processes and medical construction of women's bodies.[31,32,33] The process analysis for local implementation of public policies, especially in policies aimed at both the mother and the child, is in the spotlight of Pozzio's ethnographic study[34] about the usual interactions between State agents and women within a health center in Greater La Plata (province of Buenos Aires). The aim of her work is to understand "the different ways of conceiving women, motherhood and genre from the perspective of the different social actors that bring public health policies to life."[34]

The spatial and/or temporal dimensions of health institutions are the central topics of some research works. Crivos[35] analyzes the spatial layout, the general organization, routine practices, and interrelations between the staff members of a teaching hospital, to conclude that the vertical structure of the hospital and the transformation of the sick person into a patient cause what the author calls an "inversion of the service relationship" in which the patient ends up being "at the hospital's disposal."[35] Based on the idea of a "routinized work," Ferrero[36] looks into "the role that time assumes" and "the social ways to regulate it" in the organization of medical attention at a primary care center in the city of Buenos Aires. The author focuses on the ethnographic analysis of the proceedings necessary to take an appointment, saying that it is "as a kind of ritualized activity, since it presents a formal, conventional and symbolically expressive nature in terms of the social relationships that are produced within the context of that institution."[36] Visacovsky[37] analyzes the ways in which professionals' psychoanalytic identity is built from the uses of space in mental health services at "a hospital in Lanús." Apart from the biomedical institutions, Auyero's work[38] should also be mentioned. He analyzes the concept of waiting, its normalization, and the perception of time from potential recipients of social

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welfare from the State, in the province of Buenos Aires, during their frequent encounters with State officials and politicians. Based on a concept that he describes as a "tempography" of domination,[38] he argues that the experience of waiting in State institutions creates and recreates the subordination of the "urban poor," who "learn" to be "patients of the State" based on the production and reproduction of uncertainty and arbitrariness, which are factors already existing in their daily lives.

METHODOLOGY

To start with, we used the notion of "heterology"[39] in the processes of health-illness-attention[40] and, therefore, of the need for an ethnographic approach when studying these processes. This means that both illness and treatment are built from a plurality of voices, practices, and perspectives and they are produced as a *whole*, and they are defined in the intersection of relationships among institutions, actors, biographies, and daily interactions.

On the basis of this approach, the institution is presented to us as a process in which relationships are constantly built, questioned, kept, and transformed. Within this framework, we adopt the perspective developed by Menéndez[41,42] regarding his descriptive and analytic prioritization of individuals' and groups' practices. The author states that:

> ...it is their activities that connect in a specific way the different health services and it is these individuals – and their "patient trajectories," their "survival strategies" and so on – which establish a network of health service relationships and not each of the health services in themselves.[41] [Own translation]

We propound a theoretical-methodological approach that, borrowing Petryna's[43] expression, we call "prismatic" as a reference to an "insertion angle."[44] This approach, focused on the daily practices and itineraries of individuals and groups, and their own and collective ways of perceiving, interpreting, demanding, and receiving medical attention for diverse ailments, seeks to understand the processes of "reflection," "refraction," and "transformation" of health policies, forms of government for the people, and inequality conditions within health institutions.

From this perspective, we analyzed the relations between institutional practices and the daily routines and itineraries of the women that receive medical attention, get into labor, and give birth at the obstetric center of a general hospital in a district of Greater Buenos Aires. Between 2007 and 2011, we visited the place in an attempt to follow the dynamics of the daily life at the hospital.[45] The fieldwork included observation in an obstetric unit (waiting rooms, outpatient care, ultrasound rooms, hospitalization rooms, and the obstetric center, among others), and other spheres such as the statistical and appointment service, the social welfare offices, the central hall, the desks where appointments are assigned, and the waiting areas in the hallways. It further included interviews with heads of service, obstetricians, nurses, social workers, personnel from the laboratory and the statistical and appointment service, volunteers, and patients. The interviews followed a guide with open-ended patterns and they were digitally recorded, subject to the consent of the interviewed person. The investigation project and the informed consent forms used with the health personnel and the patients were reviewed and approved by the Ethics Committee of the hospital under review. In order to preserve the anonymity of the participants of the investigation, their names are omitted or replaced with fictitious names.

THE RELATIONAL APPROACH OF SPACE AND TIME IN HEALTH SERVICES: SOME CONCEPTUAL CONSIDERATIONS

This paper examines the space-time dimension of hospital care, paying attention to both the materiality, distribution and uses of space,

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and the organization and management of institutional times. Some conceptual considerations should be first explained. As Foucault stated,[46] one of the major processes that characterized the "take off" of medicine starting at the end of the 18th century was the transformation of hospitals into "mechanisms of collective medicalization."[46] Foucault attributes the development of hospital medicine to the development of urban medicine and the introduction of mechanisms of disciplinary power, a power that involves surveillance and control of the individual bodies of the sick people, who are already separated from domestic life. Hence, the hospital space becomes the central object of medical intervention through the study of localizations, distributions, and movements. Visacovsky[37] highlights, based on his analysis of *The Birth of the Clinic*, that the "spatial dimension is crucial in the constitution of medical knowledge" because the emergence of the medical view, from the 18th century onward, is consubstantial with the development of the medicalized hospital space.[37] Nevertheless, it is important to highlight that this central theoretical place assigned to the medical knowledge and practices, and the processes of medicalization, tends to analytically displace the institutional processes and relationships, and the experience of the sick people, by subsuming their prominence and activity into the conditions established by the professional view. A significant contribution to this matter has been made by historian Armus,[47] who discusses the "alleged passivity" of people suffering from tuberculosis in Argentina between 1870 and 1940, revealing their different actions and claims and the ways in which they "managed to deal with knowledge and medical practices."[47]

In her ethnographic study in a university hospital in Brazil, Recorder[3] uses Simmel and the symbolic interactionism to address how the activities and practices of the subjects and social groups are configured in their relationship with space, a space that at the same time they create by giving it meaning. Recorder notes that the possibilities of the hospital space define the variability of existing temporalities and the characteristics of the interrelations that happen there. The hospital *produces*, through its different spaces, the timing, the forms, and the meanings of the set of interactions and practices that, inside this institution, are created and recreated. But also, these spaces *are produced* by the interactions of the different actors that take part in the process of hospital care, the ones who talk and listen, who make and watch differentially in each space and in front of different people.

In his research study, Visacovsky[37] resorts to "the assistance of a constructivist view of space in which its practical experiences [are] at the same time a dimension of its constitution." He partially recalls De Certeau and distinguishes four operations through which the actors appropriate the space and create it "as they use it."[37] Those operations involve naming, establishing an order, creating a language, and creating narratives.

In our study, we recall De Certeau's distinction between "places" and "spaces." According to this author, a place "is the system (of whatever kind) in accord with which elements are distributed in relationships of coexistence," that is, an instantaneous configuration of stable positions. A space exists, he asserts, "when one takes into consideration vectors of direction, velocities and time variables."[48] Space is a "practiced place," the effect of multiple practices that orient it and temporalize it, being, therefore, ambiguous, polyvalent, and mobile. Hence, the space entails a determination that operates through the actions of the historical subjects. Within this framework, in our ethnographic studies, the map and its *coordinates of place* are accompanied by itineraries, in other words, by the signifying operations which "create" space. In turn, these itineraries "temporalize" space, establish sequences, and indicate the separation between social time and hospital time.

Thus, we characterize space and time through the processes which define them. Therefore, it becomes necessary to focus on "the relationality of space-time rather than of space in isolation."[49] In this way, we follow the ideas developed by Harvey, who, based on Lefebvre, introduces the triple dimension

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of space: material, represented and lived, opening it to the sensations, emotions, and meanings integrated into our everyday lives. Thus, he asserts, "the physical and material experience of spatial and temporal ordering is mediated [...] by the way space and time are represented" and by how "these spaces of representation are part and parcel of the way we live in the world."[49] In our framing, the hospital spaces and times are, then, at the same time material, symbolic, and social, and substantive places in the processes of conformation of the experiences of illness.[20]

The local health system

The main socioeconomic indicators of the municipal district under review revealed the presence of social contrasts and a strong spatial segmentation. According to the results of the Argentine Population, Households, and Dwellings Census carried out in 2010, 11.2% of households showed at least one indicator of Unsatisfied Basic Needs (NBI) [*Necesidades básicas insatisfechas*]. Such value was 9.3% at the national level, 8.2% in the province of Buenos Aires, and 9.3% in the 24 districts of Greater Buenos Aires. Among the inhabitants of the municipal district, 46.2% were covered by the public health system.[50]

At the same time, the data of the statistical system of the province of Buenos Aires about the local health services revealed – at the time the fieldwork was carried out – a shortage of physical resources in relation to the amount of population, and an intensive use of the available resources. If we take the year 2011, we will possibly notice that the number of inhabitants per institution that did not offer hospitalization, such as primary health care centers (CAPS) [*centros de atención primaria de la salud*], was 3735 in the province and 12,635 in the district. Additionally, a ratio of 0.4 beds (acute and chronic) per 1000 inhabitants was registered that year, this value being 1.8 in the province; the bed turnover reached a value of 50.5, while in the province of Buenos Aires it was 32.8; the estimated percentage of bed occupancy was 81.6%, this rate being 75.8% in the province, and the average hospitalization days were 4.5 days, a number lower than the provincial value, estimated in 8. The latter values indicate shorter hospitalization periods, which might be associated, principally, with the predominance of birth attendances (which generally require between two and five days of hospitalization) compared with the district health care centers. In 2011, this was the second municipal district of the province with the highest number of births, this rate representing 5.3% of the provincial total (144,961). The vaginal delivery/Cesarean delivery ratio was 21.2 in the municipal district, below the provincial average estimated at 30.6.[51]

Between 2007 and 2011, the operation of health care centers was regularly interrupted during variable periods by strike actions of health care workers, shortage of human resources (especially, anesthetists), or beds available for hospitalization and/or due to building improvements which lasted indefinitely. Furthermore, there was a high concentration of centers of primary or hospital care in a few areas of the municipal district, along with the ensuing problems of geographic accessibility suffered by the inhabitants of other areas.

Generally speaking, the municipal district was responsible for the low-complexity hospital care, the primary care strategies, and the efforts for health promotion and prevention. The province of Buenos Aires was responsible for guaranteeing hospital care of higher complexity. This labor division between health services did not consider ways of joint intervention, referral and counter-referral systems, or potential communication channels between the health care centers in the municipal district and the province. In this way, as indicated by other research studies on the health system in Greater Buenos Aires,[11,16] there was an overlapping of two public health jurisdictions and, between them, no kind of articulation was expected. Thus, the local health system exhibited fragmentation and a lack of articulation between

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jurisdictions, levels of medical care and health care centers, characteristics that are globally shared with the health care system of Argentina.[52,53]

Space-time dimension and its materialization: the obstetric center

The hospital obstetric and gynecology service was made up of three units: the outpatient gynecological and obstetrics care; the obstetrics center, where the emergency service operated; and the hospitalization room. Each unit was coordinated by a head of staff, occupied different and separate areas within the hospital and had their own resources and agendas. Although the units shared the medical staff, each of them worked with relative autonomy from the other units.

In the obstetric center, the staff assisted with natural and Cesarean deliveries, some surgical procedures (curettages, among others) and other emergency consultations. Ten medical residents were accountable to the head of the obstetric center. They worked 36 hours a week, 24 of which had to be consecutively devoted to emergency care. On a daily basis, two of them coordinated daily activities, establishing routines and work guidelines that used to change according to the professional in charge. Twice a week (generally on Saturdays and Sundays) the shifts in emergency care had to be covered by means of other hiring systems (internships, for instance). Every day at 12 o'clock noon, after finishing the daily activities of outpatient care or hospitalization rooms, a medical resident joined the obstetric center's staff. A staff doctor was in charge of the medical residents' supervision at the emergency care. Two nurses, which were accountable to the nursery department, also were part of the personnel. Frequently, in the afternoon, medicine and nursery students joined the personnel. After 20 years of operating with a staff that was exclusively made up of physicians and nurses, on December 2008, an obstetrician joined the emergency staff. Furthermore, staff doctors and medical residents from the neonatology service also worked at the obstetric center and performed the first maneuvers on the newborns in an adjacent area to the delivery room and the operating room.

Spatially, the obstetric center was on the first basement level of the hospital. One could access through two doors that only opened from the inside. Patients were given access through one of the doors of the waiting area. The emergency and hospital staff could enter through another door located in a lateral hallway that was exclusively reserved for them. In general, it was the nurses that opened any of the two doors and controlled who entered and through which door.

The general access door led to the "admission office," an area of approximately 1.5 x 2 meters with two gynecological beds that were separated by a fabric curtain. If, after the consultation, the physician or the obstetrician decided that the patient needed to be hospitalized, they carried her to one of the five rooms in the center. Inside every room, apart from a little restroom, there were also two beds with mattresses without sheets, and woolen blankets.

"Practiced place" I: the admission

On arrival, women had to knock on the door located in the waiting room and wait there to receive medical attention. The waiting time on the "outside" would vary, depending on the activity which was being carried out on the "inside." In the interim, while waiting, there was no way of knowing if the knocking had been indeed heard or if there was someone inside.

Normally, women were admitted by a nurse who would open the door, just letting the woman in without companions inside, and would enter in the "nursing register" some information such as name, place of residence, age, date of last menstrual period, number of pregnancies and births, and blood pressure. Then, the nurses would call a doctor or an obstetrician in order to carry out the "admission examination." Only occasionally, and in very specific situations, were the staff

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doctors in charge of this task. Once on the "inside," for the woman, a new waiting period would begin to await the arrival of the doctor or the midwife.

The admission examination would always start by asking for the same information that the nurse had already entered in the nursing register: this time they were entered in the "emergency care register." The hospitalization of women in the obstetrics center would be decided based on different reasons. All the women who arrived with a "water breaking" or a miscarriage in process were immediately admitted. The waiting period for curettages would vary and depended primarily on the availability of the hospital anesthetist doctor on call (such wait could be from 6 to 36 hours). If a woman arrived with contractions, the response would also vary depending on the estimated stage of labor and also – as we will see below – on the insistence of the woman and the predisposition of the obstetrician or the medical resident. When the woman had contractions with a frequency of one per minute, at least seven centimeters of dilation of the cervix, and the baby was "low," she was hospitalized because she was considered to be in labor. If the woman had contractions with that frequency but without the necessary dilation, she was recommended to go home and return to the emergency room in a few hours. Nevertheless, most of them would go through labor in the small waiting room because, given the distances across the municipal district, they feared that they would not be able to return to the hospital in time.

In the admission examination women usually insisted on being admitted as soon as possible. Some of them would do it telling stories of women who had had their childbirths on a bus or a hall. Others would go out, but they would hit the door several times to remind them of their presence and demand attention. Others would be firmly insistent and threaten not to leave the stretcher until they were admitted. In addition, some companions would demand a woman's hospitalization every time a doctor, obstetrician, or nurse appeared. These ways of insisting and putting pressure had different results:

> *In the office, the staff doctor seemed to be hiding from someone. When she saw the obstetrician, she asked her to go to the admissions section because there was a "fierita"* [pejorative term meaning "wild animal"] *and she didn't want to "see her or touch her." In the admission offices, the young woman was waiting in a stretcher, with contractions and evidently scared. She was 22 years old and this was her second child. She was 38 weeks pregnant. Her companion had been left outside; another "fierita," according to the doctor. She didn't have documents of her prenatal controls, although she "had done everything right," she insisted. The documents remained at the penitentiary where she had been imprisoned the previous month. The obstetrician performed a pelvic exam and explained to her that she had yet to go into labor, and told her to go home and wait a little longer. The young woman did not seem so convinced. She repeated that with her last baby, she hadn't had contractions and pain, and asked why they wouldn't admit her to have the baby. In a warm but firm tone the obstetrician insisted that it wasn't time, that she only had "five centimeters of dilation" and explained that if she was hospitalized, she would have to be alone. More or less an hour later, the young woman knocked on the door again. This time, she got in saying that she wasn't going to leave, even if they told her to do so. The obstetrician let her in, performed a pelvic exam again and told her once more that it wasn't time yet. The young woman said that she was going to stay there because, if not, she would give birth in the hall. Her insistence and determination made her win the dispute. The obstetrician started to prepare the documents to hospitalize her.* (Field report, March 24, 2009)

An initial approach to the admission processes shows discrepancy between the times that are established by the institutional

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routines and the times lived in the process of labor, the expectations, the concerns and agreements of the family, and the distances and the available offering of resources of the local public health system.

In the emergency room, it was common to find women who arrived from different parts of the district referred from other health care centers. Without further explanations and lacking a formalized referral system and support for transfer, women needed to move different distances, in most cases, in public transport, while having some contractions or during labor. In some opportunities they were referred, in turn, to a health care center in the city of Buenos Aires. Throughout the fieldwork, there were several occasions in which the obstetric center did not have anesthetists on call, or that it was the only health care center of the municipal district that had this kind of professional. The same happened with the beds available in the neonatal intensive care. In view of these situations, the answers of the heads of the emergency staff varied from the closure of the obstetrics center to the limitation of the care to specific affections or the continuity of the regular assistance.

> *Gabriela arrived at the emergency room of the obstetrics center with contractions. She was in her eighth month of pregnancy; she had five children and had lost two late pregnancies, as she said. She was welcomed by Ana, a committed and affectionate obstetrician who had recently started to work at the hospital. Gabriela was 34 years old, but she looked much older: her skin was cracked and she had a tired look. She would speak timidly and slowly. When Ana asked her where she lived, she answered "in the countryside." As she didn't have an exact address she gave her some indications to locate her house. The obstetrician asked her for more details, but Gabriela made it clear that, actually, she lived "deeper" from where she had informed. Her description and gestures seemed to indicate it was a long distance. Gabriela gave the obstetrician a pile of papers and analyses carefully arranged in a folder with drawings, among which there was a positive Chagas disease test, an echo-Doppler qualified as "pathological" and a referral letter from a doctor of a maternity hospital located closer to her house. Ana was surprised to see that referral. She asked if she knew why she had been referred. Gabriela shrugged her shoulders and just said that they "sent me here." Ana asked her to wait* [...] *When the doctors saw the referral letter they remembered the physician as an old acquaintance from their "times as medical residents" and explained to the obstetrician that on that Thursday the hospital was the only one in the district that had anesthetists, and that was the reason why patients were being referred, even from the "maternities."* (Field report, June 18, 2009)

The definition of inside and outside, of distant and close, is always and inevitably relational. The hospital becomes the "inside" when it admits and provides medical attention to people who go through distances and do not manage to receive care in other health care centers. It becomes the "outside" again when it fails to meet the care demands and refers them to another care center. Thus, looking from the relational perspective of the trajectories and demands of the patients and their close relatives, the space is amplified in reference to what happens in the neighborhoods, in other health services, in the territories in which everyday life takes place. And it is the people in the territory that eventually become patients in the hospital, who articulate spaces and temporalities in quest of solving or taking care of their health problems and diseases.

"Practiced place" II: the admission to emergency care

The medical-administrative routines for admission outlined the distance between women and the "outside." From the moment of the admission, their bodies ceased to be private;

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it was at disposal for medical interventions and exposed to the examination of everyone who was, whether by chance or not, at the obstetric center.

After entering their data, the first stipulated step for women that arrived with contractions was a pelvic exam, for which every woman would have to undress and lay down in a stretcher without a disposable rope or a curtain that may reduce their exposure. After the pelvic exam, the fetal heartbeat was monitored. This procedure was done either with Pinard's stethoscope or with a monitor. Using a Pinard requires the necessary training to know where and how to place it, and then one must strain one's ears to be able to hear the fetal heartbeat. Both patients and students practiced this form of monitoring on patients innumerable times. In general, they would not be able to hear the heartbeat on the first attempts, and this would concern those women who were offering their bodies as if they were learning objects. With the monitors, women could hear the heartbeat, but either one of the two machines in the center would be frequently out of order.

In order to hospitalize the patient, it was necessary to draft a clinical record that always implied, in the first place, the execution of an informed consent. With this document, the woman would agree to her hospitalization and also to a non-specified procedure, and this section was left blank. During our observation period at the obstetric center, only one woman asked to read the document before signing it.

This access to the medical-institutional world of the obstetric center was linguistically marked by the adoption of a technical term, "primigravida," "secundigravida," "PRM" ("premature rupture of the membranes"), "metrorrhagia," "DF" (dead fetus), among others, that was used from that moment onward to describe the woman. Occasionally, and when the woman's clinical history would not fit within any of these names, they would include her last name or an improvised nickname. The use of these terms helped to separate a particular woman from the outside world and, at the same time, established the world of the emergency care[54] as the new order of truth. Only obstetricians would call the women by their first names when they were assisting them during labor.

Once they were admitted, women would have to wait again inside a room of the obstetric center. The labor follow-up method would differ a lot depending on whether the medical attention was in charge of a medical resident or an obstetrician. While the first ones would focus on pelvic exams to measure the dilatation of the cervix, and on the fetal heartbeat monitoring, without having any other form of interaction with the patients, the obstetricians, while taking into account the same indicators, sought to accompany the woman during the process. They would alternate measuring processes with conversations, waist massages, words of encouragement or consolation, instructions on how to strain or when to push, explanations about the labor process, and so on. The staff doctors would rarely participate in that task and would just listen to the news that the medical residents or the obstetricians may have on each hospitalized woman. These routines and the role distribution were defined, reinforced, and reproduced by the highly hierarchical professional relationships that, on their day-to-day implementation, established the terms for institutional operation and validated, at the same time, the adopted guidelines.[39]

The proceeding would change when it was estimated that a woman could be a candidate for a Cesarean delivery and therefore needed a closer follow-up. The Cesarean deliveries were carried out by a staff doctor or by a medical resident under the supervision of one of them. In those cases, they would have to wait for the anesthesiologist, who usually attended the obstetric center twice a day. "Inside," women would wait for their child's birth all by themselves, separated from their affective support, in medical and administrative procedures.

"Practiced place" III: the waiting area

Once a woman was hospitalized, she would lose contact with the persons that may have

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been accompanying her, who were left "outside," in the waiting area.

> *Obstetric center, at about 10:30.* [...] *In the small waiting room, the women who were waiting to receive care were mixed with the family members who were waiting to receive news: a man with a girl was trying to answer all her persisting questions about the newborn "baby brother;" he had not been able to see his son yet, he only knew he had been born on the previous night. Another man was walking down the hallway, while talking on his cellphone, alternating from commercial transactions to conversations about his girlfriend that was inside; she had entered at eight, but he did not know anything yet. A group of people had set up a "camp" in the hallway, with beach chairs, thermos, sandwiches; it was a group of 6 people who, as they said, had been waiting since the day before for any piece of news regarding the first child/grandchild of the family. Meanwhile, every so often a woman would arrive asking who the last one in queue to receive attention was. Time seemed to be frozen. From the outside, it was impossible to know if there was someone inside, any movement, or when the medical attention would be received, or when there would be any news. The man, impatiently, started knocking on the door every five minutes, but he did not get any answer. Many women that were still waiting to receive attention imitated him* [...] *People's movements seemed to be taking place in a vacuum. Some women who had arrived for the emergency care left* [...] *At 12:50 the door opened, and behind it came a nurse, the people quickly crowded in on the door, but only two women could enter, the two who were first on the list from the waiting area that was tacitly agreed on, "unaccompanied." The nurse told the other people to wait for the "medical report."* (Field report, April 15, 2009)

"Outside" the waiting for the news would be deployed on the grounds of uncertainty, without knowing the approximate time it would take before receiving any news, without a referential figure from the institution that could indicate the steps to follow, without a face to appeal or to ask to. This uncertain space of the waiting area was full of emotions at stake regarding the medical attention of the beloved ones, the joy of welcoming a child, the fear that something could go wrong during labor. Different feelings were suspended in the silent atmosphere of the waiting area, emotions that would only find the channel for the expression of opinion or relief when they received news from the medical staff.

"Inside" the ways of communicating with the family members and companions of the patient varied. The waiting process on the "outside" could be very different depending on the day and the mood of each professional. This would be especially noticeable in the communication to the companions immediately after birth. In some cases, communication with them after birth was not stipulated. At some emergency rooms, the neonatologists would go out with the baby so that the family could see them, although this proceeding was not systematized, given that if they decided not to go out for any reason, the family would not be able to see the baby until the woman was transferred to the hospitalization room, a process that could take up to two days. Just on one of the weekly emergency shifts it was agreed that, upon the decision of the physician in charge, the obstetrician or the medical resident would introduce the baby to the family and give them information about the woman's general state of health.

Regardless of the methodology adopted, the dialogue with the people that were waiting "outside" would usually concern the emergency staff, especially when the knocks on the door became very persistent. Every time the door of the obstetric center opened, it was common that many people would crowd in at the door asking for their relatives. In general, as time went by, the tone of the

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questions would change, as they would be formulated more anxiously and, sometimes, even in an intimidating or threatening tone. On occasions, these situations turned into arguments and confrontations involving the patients' companions and the hospital staff.

When the insistence and the knocks threatened to disturb the "inside" environment, a medical resident would be frequently sent with a list of the hospitalized patients so as to provide a short "medical report." In other opportunities, "the medical report" could be replaced with a handwritten list that would hang from the door, enumerating the surnames of the hospitalized women, assuring that "they were all okay" and asking not to knock on the door.

On occasions, the companions played the card of kinship or affinity and neighbor relationships with a member of the hospital staff to access the obstetric center through the staff's door or to be able to contact the doctors. They were mostly nurses or administrative officers and, only in one opportunity, the intermediary was a doctor that did not belong to the hospital who knocked and had access through the staff's door.

The administration of the relationships between the staff and the women's social network implied institutional strategies like space segregation and information restriction. The arguing, the shouting, and the repeated knocking on the door did not represent an incidental aspect but a regular part of the center's tasks, causing a permanent discomfort to which the staff would react by blaming family members and companions for the chaos or by applying discretionary mechanisms.

The obstetric center was, in this way, built as a closed space. The specific proceedings of a woman's "admission" guaranteed her medical attention, but also deprived her of her social network, given that she would be isolated and forced to go through the process by herself, separated from her family, who would not know anything about her until the professionals made such decision. Parents, siblings, partners, and friends were left outside and, with them, the everyday feelings and meanings of common sense, regarding life, birth, care, and the need for emotional support. In this way, a different space was created: a space that protected the professionals and allowed them to make decisions without being influenced by everyday rationality, and emotions and feelings of those who were waiting. This space organization would contribute to creating distances and hierarchies and, at the same time, to the learning of the professional role and what we could call emotional indifference, during the processing of the relationships between patients and family members.

As Comelles[55] showed in his research study about a major burns unit in Madrid, when the presence of "the social and cultural aspects of the health care process at a hospital" is denied, "the medical model shows its most negative face" precisely opening "the doors of conflict, irregularities and transactions." Comelles highlights, in this regard, that "the inability of the corporate culture of services" to resolve this tension "comes from their fundamentalisms" and from the difficulty to "accept that the *social presence of the patient* is also part of it."[55] In this case, it refers to the presence in the space-time dimension at the emergency obstetric center of the notions, knowledge, feelings, and experiences of women and their companions.

The represented space: *"the trenches"*

In informal conversations and interviews it was common for the doctors, nurses, social workers, obstetricians, and authorities to refer to the conditions of their everyday work. On several occasions, they depicted, using humor, the complaints, indignation, difficulties that – they considered – appeared in their daily work: the lack of certain professionals (especially anesthetists and nurses), low salaries, a lack of job tenders and appointments, and an insufficient number of medical residents.

In particular, shortage and deterioration of the material resources necessary for hospital care was a recurring topic: from the lack of chairs for sitting in the doctor's lounge, to

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the only electric scalpel constantly sent for repair; from a monitor of the "*Pleistocene*" in the hospital emergency room to the only fetal heart rate monitor "*from when Marie Antoinette got pregnant*" for the whole outpatient care section; from "*scissors that don't cut as they should*" and "*forceps that don't grasp as they should*" to the lack of an ultrasound scanner for emergency diagnosis in the obstetrics center. They would also mention problems in the design, use, and maintenance of some of the service places, the lack of disposable robes and bed linen, and the uncertain provision of drugs for outpatient patients ("*sometimes you don't have buscopan, but you have a very expensive antibiotic*"). Those who occupied management positions would also mention difficulties in the purchase or reparation of damaged material. Every problem that arose, they say, posed a new difficulty and opened a chain of negotiations, a "struggle," as one of them described. "*Please, don't let one single light bulb burn out,*" would pray another one. "*We are always at the mercy of the events,*" as stated by a third one. Staff doctors, physicians, or chiefs would mention the exhaustion, the fatigue of working in such conditions, although some of them asserted that daily effort of working at the limits of the possible, was redeeming – in their own terms – that "*practice of medicine using medicine,*" without technology and resources.

During one of the shifts, an obstetrician introduced herself as a "*doctor of the trenches.*" In fact, it was usual to overhear the same expression being uttered by doctors every time they addressed the professional practice in that hospital. The hospital space, introduced that way, referred to what was highlighted above: the building conditions, the shortage of resources, the deterioration of the instruments, the unpredictability in the operation of the institution, and what they felt as a "desertion" by the authorities.

The expression "the trenches" also referred to the population of users whose social presence characterized the service. The characterizations and appraisals of the patients were not uniform, and the judgments of the same person were not always equal. However, the stories and comments tended to organize around countless "leading cases" that were strongly stereotyped. In this argumentative strategy, the "cases" would confirm or ratify preliminary judgments, and the stories, when they were generalized to a larger population, they would lose their singularity. Thus, we found accounts about teenagers who were mothers at a very early age, women who had a disproportionate number of children that they failed to support, women who arrived without prenatal controls, violent women or "*malandras*" [crooks]. Some professionals were moved by some of the stories; others would utter permanent complaints, always outraged because of them; others chose to establish a cold and distant doctor-patient relationship, in which nothing seemed to be worth of interest.

This discursive form falls within the set of meanings, senses, and positions which, even with variations, permeated the set of institutional practices and routines, including the organization and distribution of the spaces and time sequences. In this context of meanings, the precarious working conditions in the public health system and the alleged ignorance, incompetence, and even dangerous nature of the population receiving care might also be considered an "excuse"[19] to establish and validate the creation of hierarchical distances, the enclosure of spaces of care and the rejection toward the presence of the patients, and their relatives and emotional supports.

In this "metaphor of the trenches" there was an evident medical representation of a type of professional practice that combined a perception of the deterioration and unpredictability of the presence of the State with a marginality notion regarding the population and their forms of sociability. That metaphor also implied a vision of the hospital space as a margin or territorial, institutional, and social border in which the State was dissolved or weakened.[56]

Attention should be drawn to the contribution of a now classic paper in which Ferguson and Gupta analyze the metaphors of "spatialization" or "verticality" of the State,

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associated with a center-periphery model. These authors find that the strength of these metaphors "results [...] from the fact that they are embedded" and at the same time are produced "in the everyday practices" of creation of "spatial and scalar hierarchies" in the "multiple, mundane domains" of the state institutions.[57] From this perspective, the image of "verticality" is called into question, and the so-called "peripheries" emerge as significant spaces in which the State is permanently shaping its ways of governing, building, and regulating the population.

Women, family members, and the space-time layout they lived

The processes of hospital care are not peripheral spaces beyond State action, or "islands" with separated culture and rationality. These processes are shaped from social conditions producing a disease, contexts of differential vulnerability, and power relationships related to politics, economics, and technical ideology involved in the institutional responses of the State. These processes exceed the hospital limits and temporalities; however, in the hospital, and through the specific institutionalization ways of the biomedical attention, they shape the set of transactions among professionals, patients, and family members while they create distances and asymmetries.

The "hospital system" is presented as a "negotiated system" in which this transacting process is carried out from relationships of social, technical, and ideological subordination of the patients and their companions, who are undergoing the transition of a "social body" into a "hospital body" from a position of disruption and uncertainty.[7] Based on the bibliography and our ethnographic analysis, we maintained that such relationships express and produce spatial and temporal hierarchies. These hierarchies, despite being put into question, are organized as routines, a set of actions that – although the staff and professionals do not always adhere to or act according to them – are carried out in a repetitive way, without explicitly reflecting on them and without the need of legitimating the decisions in every occasion.[8]

As we have shown on the ethnographic vignettes, during the "production" of the patient of the obstetric center, the key points were the establishment and adequacy of the institutional times and the control over the body processes in order to subsume them into the technical times of the obstetric intervention. As we said, for the women, this process involved waiting by themselves between medical and administrative procedures. This biomedical removal of the patients' "normal" temporalities "to a space where the time view of others [could] be imposed upon them"[7] had significant effects on the women and their companions, which were not only therapeutic but also existential and pedagogical. The implications were therapeutic regarding the loss of opportunities for a proper attention, according to the standards agreed under federal and provincial legislation on obstetric care regulations. The implications were existential and "pedagogical"[20] if we take into account the everyday attention experiences from the people's point of view and as spaces in which to learn about the differential value of their times, bodies, and lives. As pointed out by Frankenberg,[7] this is

> ...an integral part of the modus operandi of biomedicine as at present practiced, [which] iatrogenetically produces a situation of enhanced power for the healers and reduced autonomy for the patients, notwithstanding the latter's attempts to negotiate their own reconstituted temporalities.[7]

"Thrown" to the institutional operation, some women and their companions would accept care interventions and commands; others, on the contrary, attempted to tighten up the situations to improve the circumstances and obtain a more sensible answer to their requirements. In the transition process from the "outside" to the "inside," we observed silent consent and subordination, but also different transactions based on complaints

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and protests, which on many occasions were full of anger. Therefore, the women and their companions would not necessarily submit in a passive way to the conditions of attention. Faced with the hospital strategy to control and regulate the circumstances and times, we can understand these practices and transactions in terms of tactics[48] that do not have their "own area" in the power field but, even from a position of subordination and taking advantage of the "occasions" and possibilities available in the institutional power field, co-produce the hospital time and space in pursuit of answers that are closer to their own temporalities, senses, and care needs.

FINAL THOUGHTS

In this article, we made a presentation of the hospital care in an obstetrics center of a public hospital within Greater Buenos Aires, using an ethnographic analysis of institutional practices, daily routines, and the itineraries of women and their companions, which is organized around a relational approach of space and time. From the acknowledgment of space as a practiced place,[48] we recall the distinction Harvey makes of the triple dimension of space: material, represented and lived.[49]

We introduced the spaces of the obstetrics center as "practiced places" based on the processes which orient and temporalize them. Thus, we analyzed the processes of admission and entrance to the emergency room of the patients as well as the waiting periods of their families and close relatives. In that regard, we observed the following:

1. In the outside-inside distinction, the outside of the hospital is resignified if we pay attention to the relational perspective of the trajectories and demands of the patients and their close relatives, who make domestic arrangements, travel distances, and articulate the offer of institutions of the State in quest of solving or taking care of their health problems and diseases. In this way, it is revealed that the hospital care processes are shaped based on the social conditions of production of the ailment, the contexts of differential vulnerability, and the ways in which subjects and groups make their demands.
2. The implementation of medical-administrative routines would set the separation of women from the "outside" and their insertion into a new system of truth: the obstetrics emergency care. Waiting and uncertainty would seal the experience of women and their close relatives. From that point, we highlight the discrepancy between the technical times of the obstetric intervention and the times lived by women and their companions in the process of birth.
3. The obstetric center was built as a closed space. The administration of the relationships between the staff and the women's social network included the space segregation and information restriction and gave rise to conflicting situations that turned into an everyday constituent of the center. In this regard, we establish the denial of the social and cultural presence of the patient[55] as a central component of the biomedical institutionalization processes.

From the analysis of the discursive form "doctor of the trenches," a recurrent expression among professionals, we propose an interpretation of the space as represented by the physicians. In this metaphor, the hospital space and the trenches are identified by the combination of a perception of the deterioration and unpredictability of the State presence with a notion of marginality of the population and their ways of socializing. The metaphor is further associated with a kind of professional role and with the validation of their everyday practices.

The ethnographic perspective allowed us to grasp the continuous production of spatial and temporal hierarchies and, simultaneously, the everyday transactions, negotiations, and resistances through which the women and their companions, even from a position of subordination and uncertainty, would co-produce

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the time and space of the hospital and tighten up the institutional power field in pursuit of answers that would be closer to their own temporalities, senses, and care needs.

In the end, we would like to acknowledge the contributions of ethnographic studies on health services to the knowledge of collective health. Thanks to their anchoring in the local aspects and the everyday practices, we found highly valuable means to grasp the multiple processes of health-illness-attention and the complex ways in which the micro and the macro aspects of it melt together. When they reveal the local density of the State and health policies, when they add flesh and blood to the processes of medical-institutional production of the disease and the sick people; when they transform the epidemiological variables into stories and practices, they can bring to the surface not only the subordination processes, but also the people's negotiation, resistances, efforts, and creativity.

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