"Stepped-on like a floor-mat": human experience of hospital violence in the Northeast of Brazil[1]

Pisada como pano de chão: experiência de violência hospitalar no Nordeste Brasileiro

Pisada como trapo de piso: experiencia de violencia hospitalaria en el Nordeste Brasileño

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ABSTRACT

Despite recent efforts to improve the quality of public health services in Brazil, inequalities and institutionalized violence persist in hospitals. This critical anthropological study investigates the human experience of hospitalization from the viewpoint of patients of a public hospital located in Fortaleza, capital city of the state of Ceará, in the Northeast of Brazil. A qualitative method, "The Patient's Pathway," was created and utilized. It blends ethnographic interviews, patient's narrative collected prospectively during the entire hospitalization – from admittance to discharge – and participant observation. The pathway of 13 key-informant patients was followed. Results reveal that our patients narrated 225 distinct hospitalization experiences. The majority (83.6%) was interpreted by patients as "degrading" and "humiliating" their sense of personhood; only 16.4% were seen as "caring" for the patient, contributing to the recovery of their health. A progressive demoralization of the "suspect patient" is revealed, beginning with his/her reception by uniformed guards and confiscation of personal belongings. Hospitalization is characterized as abandonment, loneliness and imprisonment, due to the imposition of norms, rules and procedures which ignore patients' autonomy, subjectivity and personal conditions. Despite the oppressive hospital structure, patients manage to resist, drawing upon multiple strategies: personal traits, creative imagination, social solidarity and religious faith. Humanizing public hospitalization in the Northeast of Brazil requires including the patient's voice and experience while removing harmful stigmas.

KEYWORDS: Cultural Anthropology. Violence. Hospitalization. Power. Humanization.

RESUMO

Apesar de recentes esforços para melhorar a qualidade dos serviços públicos de saúde no Brasil, iniquidades e violência institucional persistem nos hospitais. Este estudo antropológico-crítico investiga a experiência humana da hospitalização do ponto de vista do paciente

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internado em um hospital público, localizado em Fortaleza, capital do Ceará, no Nordeste brasileiro. Um método qualitativo original, "O Percurso do Paciente" foi criado e utilizado, mesclando entrevista etnográfica, narrativa do paciente coletada prospectivamente durante a internação, desde a chegada no hospital até a alta, e observação-participante de 13 informantes-chaves. Os resultados revelaram 225 experiências distintas de hospitalização narrada pelos pacientes. A maioria (83,6%) dos acontecimentos foi interpretada como "desprezo" e "humilhação"; somente 16,4% foram percebidos como "zelando" pelo paciente, contribuindo para a recuperação da sua saúde. Desvelaram a progressiva desmoralização do "paciente suspeito" desde a sua recepção por um guarda uniformizado até o confisco de pertences pessoais. A hospitalização é caracterizada por abandono, solidão e aprisionamento, em virtude da imposição de normas, regras e procedimentos que ignoram a autonomia, condições pessoais e subjetividade do paciente. Apesar da estrutura opressiva, pacientes resistem às agressões, utilizando múltiplas estratégias: traços pessoais, imaginação criativa, solidariedade social e fé religiosa. Humanizar a hospitalização pública no Nordeste brasileiro requer incluir a voz e a experiência do paciente, removendo os estigmas que o prejudicam.

PALAVRAS-CHAVE: Antropologia cultural. Violência. Hospitalização. Poder. Humanização.

RESUMEN

A pesar de los recientes esfuerzos para mejorar la calidad de los servicios públicos de salud en el Brasil, iniquidades y violencia institucional persisten en los hospitales. Este estudio antropológico-crítico investiga la experiencia humana de hospitalización del punto de vista del paciente internado en un hospital público, localizado en Fortaleza (Ceará), nordeste brasileño. Un método cualitativo original, "El camino del paciente" fue creado y utilizado, mezclando entrevista etnográfica, narrativa del paciente realizada prospectivamente durante la internación, desde la llegada al hospital hasta el alta, y observación-participante de 13 informantes-claves. Los resultados rebelaran 225 experiencias distintas de hospitalización narrada por los pacientes. La mayoría (83,6%) de los hechos fue interpretada como "desprecio" y "humillación"; sólo 16,4% fueron percibidos como "cuidado" por el paciente, contribuyendo para la recuperación de su salud. Mostraron la desmoralización progresiva del "paciente sospechoso" desde la recepción por un guardia uniformado hasta la apropiación de sus pertenencias personales. La hospitalización se caracteriza por abandono, soledad y prisión, por la imposición de normas, reglas y procedimientos que ignoran la autonomía, condiciones personales y subjetividad del paciente. A pesar de la estructura opresiva, los pacientes resisten a las agresiones, utilizando múltiples estrategias: trazos personales, imaginación creativa, solidaridad social y fe religiosa. Humanizar la hospitalización pública en el Nordeste brasileño requiere incluir la voz y la experiencia del paciente, desechando los estigmas que perjudican.

PALABRAS-CLAVE: Antropología cultural. Violencia. Hospitalización. Poder. Humanización.

Introduction

State reforms and health policies do not always favor human dignity in health service practice[1,2]. Barriers to health service access, low-quality and precarious services, hegemony of the biomedical model, based on technicistic logic still persist, underestimating the complexity of factors which affect a person's health[3,4]. The user's rights, even when legally based, are still disrespected[5].

A vision and practice of integrality, however, have been emerging, allowing constitutional rights to come into effect, and the humanization of health care has gained more importance in the debate on public health in Brazil[6,7]. During the last three years, the Ministry of Health developed the National Policy for Humanization of Care and Management in Health Services (PNH: Humanizasus), a public and transversal action[5]. The proposal, which is based on sanitary reform – the foundation of the public health sector (SUS) – intends

to reinforce the principles of integrality, resolubility, and equity in a "SUS which works". It opposes the model of health exclusion and commercialization[8], therefore, contributing to "an integral and equal attention, with responsibility and bonds, which values workers and the advance of the democratization of management and participative social control[5].

Despite these efforts to improve the quality of public health, inequities continue being unveiled in hospitals[9,10] – a challenge for social transformation. The current situation is hard to change because of the resistance to fulfill human rights in Brazil, a violent, authoritarian, vertical, hierarch and oligarch society, marked by a polarization between total lack and total privilege[11].

The word "violence" comes from the Latin word *violentia*, which refers to "violent action; physical or moral constraints; use of force, coercion"[12]. Used in the common sense, it means: use of words or actions to degrade and hurt others; the abusive use of power, which results in wounds, suffering, torture or death. However, there are several forms of violence which, in comparison to physical strength, are even more aggressive, oppressive, dominating and complicated to deal with because of how subtly they are embedded into the macro structural level, institutional context, social relations and symbolic meanings[13].

"Structural violence"[14] is a macro-social force in the political-economic realm, which limits unfairly the access of the disadvantaged groups to opportunities. When the abusive power of the State is concretized in institutional spaces, we have what is called "institutionalized violence"[15], characterized by abandonment and tutelage, which controls the lives of certain segments of the population. According to French sociologist Pierre Bourdieu[16], the most insidious form of violence in institutions, exercised by agents on the working class, is "symbolic violence". It occurs when power imposes its vision of the social world and distinctions between people as legitimate, disguising the current interests and power relations to the extent it becomes accepted by both the dominators and the dominated. In health care, the hospital has become a systematized therapeutic instrument in which disciplinary norms and mechanisms have been introduced since the XVIII century[16]. Our goal, with this study, is to reveal hospitalization experiences, symbolic meanings and strategies of resistance from the viewpoint of patients of a public hospital located in Fortaleza, the capital city of the state of Ceará, in the Northeast of Brazil.

Methodology

The data for this anthropological research was collected from January to July 2005 at a tertiary general public hospital in Fortaleza (a town with around 2,200,000 inhabitants). It is an appropriate context to investigate the impact of social inequalities in institutionalized care. The metropolitan area of Fortaleza is marked by socioeconomic disparity and increasing segregation: the average distance between the richest 10% and the poorest 40% of the population increased from 13.3 to 18.7 times from 1991 to 2000[17].

By placing patients in their significant universe[18], we created an eclectic combination of techniques, "The Patient's Pathway". In the first month, free observations of the hospital surroundings and internal environment were performed and registered in a field diary. Three surgeries, three death cases, and eight women in labor were monitored. In the following two months, participant observation was performed, in every hour and day of the week, of every "moment experienced" by approximately 50-60 inpatients, including: admittance, patient transportation, barriers to treatment access, family visits, exams, care and procedures, feeding, religious rituals, childbirth, celebrations, surgeries, bad news, death, discharge, among others.

In the last fourth months, we performed a more in-depth ethnographic study, with close monitoring of 13 patients, from admission to the hospital until discharge, which varied from 7 hours to 60 days, depending on how long was the patient's hospital stay. These 13 key-informants were selected randomly according to the following criteria: 1) identification upon admittance; 2) first person in line at the hospital reception; 3) inclusion of at least one patient from different hospital sectors; and 4) diversity of cases. From the 13 patients selected, four are men and nine are women, with ages varying between 16 and 93 years old. The majority of the patients (61.5%) are married; 23.1% are single and 15.4% are separated. The majority (84.6%) live in the suburbs of Fortaleza and 15.4% come from other cities of the State. Almost half (46.2%) is illiterate or has not finished elementary school; 7.7% graduated from elementary school and 46.1% are in or graduated from high school. Most of the patients (53.8%) are economically inactive, i.e., unemployed, house wives or retired; 46.2% have a low-income or work on their own. More than two thirds (77%) were first-time inpatients and 23% had been hospitalized before two or five times. Patients with serious mental disorders, incapacity to express themselves verbally and under 16 years old were excluded from the study. The monitored cases include: preeclampsia, normal delivery, premature and high-risk childbirths; uterine and pulmonary biopsies; vaginal aesthetic surgery, bariatric surgery, hysterectomy, thyroidectomy and extraction of a node from the patient's foot; rheumatological problems and a case of cutaneous leishmaniasis.

In order to unveil hospitalization experience from the viewpoint of patients and to capture their interpretation of the experience during their pathway at the institution, a combination of techniques was used: ethnographic interviews[19], patient's narrative[20] – collected during the entire hospitalization, and participant observation. The challenge was to understand the patients' moral experience context, which "is always changing and usually uncertain"[21], in their current world: the hospital environment.

The in-depth and open-ended ethnographic interviews took place during the entire hospitalization time and were very flexible. The interviews were oriented, but not limited, by guiding questions which favored the description of situations, the revelation of lived experiences and meanings, and were modified according to the context of the interview: 1) Tell me about your stay in the hospital; 2) Describe what it was like to be hospitalized; 3) Describe a memorable event which made you feel better/worse in the hospital; 4) From your admission to the hospital and your experience, what do you think could be done to have made your hospital stay more humane? 5) What else would you like to say about your hospital stay? At the right moment, the patients were encouraged to freely narrate their version of the incident at the time it was happening. Therefore, the narrative of 13 real patients (only the pseudonyms are fictitious) stimulated the formulation and spontaneous expression of criticism towards their current situation. The data was collected prospectively in the presence of the researchers with an initial phrase or question: "tell me what is happening", "how are you feeling now?", connecting the patients with their senses. As the trust in the researchers increased, the narratives started occurring spontaneously. The interviews and narratives were recorded and later transcribed, producing a voluminous text of 331 single spaced pages.

After initial and repeated readings of the statements, 225 distinct narrations, or meaning units, were identified on hospitalization experience, and were grouped into 23 categories, used to codify transcriptions according to the Categorical Content Analysis[22]. Six themes were analyzed in-depth in this article: poverty scenario, suspect patient, hospital imprisonment, power, stigma and patients' strategies of resistance. We reconstructed the experience of getting ill, and the pathway of

hospitalization, admittance, hospital stay and discharge of each of the 13 patients, focusing on their way of thinking and acting. We were inspired by the "contextualized semantic interpretation" of anthropologists Bibeau and Corin, who interconnect the individual experience of different people, in this case the patients, to their systems of meaning and evaluations, and to their reaction or not to the structural constrains of the institution[23,24]. Finally, the data collected was interpreted according to the theoretical references of Medical Anthropology[14,25,26,19,20,27,1,28], which establish the patients' viewpoint and explanatory models; Health Sociology[29,13,30], from the perspective of the social phenomena of exclusion; and the humanization of care[6,7,31], which consider the patient a leading character and a citizen of rights.

In this article, the patients' voice entwines with the researchers'. However, each one's voice is carefully indicated. Ethics in research was guided by Resolution 196/96 of the National Health Council – Ministry of Health (CNS-MS-Brasil), which regulates researches involving human beings[32].

Results

According to the viewpoint of patients hospitalized in a public hospital located in Fortaleza, the capital city of Ceará, in the Northeast of Brazil, the experience of hospital stay is marked by suffering, degradation and stigmatization. From the 225 distinct experiences on hospital stay narrated by our informants, a multiplicity of senses was identified. The majority of experiences, 188 (83.6%), was interpreted by patients as "degrading" and "humiliating". Only 37 (16.4%) of the experiences in the hospital were considered "caring", i.e., the patients felt they were being treated "as people", contributing to the recovery of their health.

Poverty scenario and the suspect patient

Before arriving to the hospital, the patient had to cross the historical town square of Lagoinha, the *Praça do Malandro* ("Scoundrel Fair") and the *Beco da Poeira* ("Dust Alley"). There, gold chains, watches, electronic devices and guns, which were stolen in robberies at the noble neighborhoods of Fortaleza, are sold illegally "for a song" in order to "get rid" of the stolen goods before the police discovers the crime. Among the hawker stalls, pirated CDS and counterfeited products from China and Paraguay are sold without invoices.

Low-income patients and their families already arrive at the hospital under suspicion – they could be one of the scoundrels of the fair, a "criminal", "thieve" or "robber" from one of the gangs in the city. Before being institutionalized, patients are filmed by a security camera; suitcases and bags are inspected and personal belongings confiscated by two uniformed guards; personal objects are not allowed. At the hospital, we witnessed a companion open his suitcase, retrieve the patient's belongings and place them in a transparent plastic bag while the guard kept a vigilant eye. The receptionist handles questions and requests, but is not friendly. There is a sign with a picture of a nurse indicating to keep it quiet, while the noise of the buses out on the streets invades the environment through the iron bars. At the obstetric emergency ward, a sign on the wall informs the patients of their rights: *As taxpayers, you have the right to a dignified health care in public service. DEMAND YOUR RIGHTS!*

Hospital "imprisonment": an experience of confinement

The hospital is seen by patients as a *prison*, a form of confinement, as if they were *"inside a box"*. It causes claustrophobia, *"agony", "depression"* and even *"loss of mind"*. It is an unfamiliar place, where feelings of abandonment and loneliness "*worsen as the days*

go by, especially at night and on Sundays". There is little freedom and the patient's identity is ruptured with the imposition of norms: striped clothing with large numbers on it, guards at the entrances, iron bars on the windows, prohibitive signs, closed environments and limited contact with family. Patients who are *"imprisoned"* on the second floor *"catch a breath of air"* at the window with iron bars, while they watch the movement out on the streets: a dear one passing by, the smell of *tapioca* pancakes being cooked, the sunlight. It is the window of life, *"the magical corner…the corner of longing!"* Paradoxically, "*we come to the hospital looking for life*".

The participants' discourse is a portrayal of *"hospital prison"*. Matias, 42 years old, unemployed, complains about the imprisonment: *"You spent the whole time feeling bad because you're not with your family…there isn't anywhere for you to catch some air, walk around, see movement, you know? This isolation is the bad part"*. Guiomar, 83, hospitalized for 30 days, does not notice *"anything good about being in a hospital"*. While waiting for her surgery, she exclaims: "*It's easy to get in the hospital, the hard part is getting out!"* After 48 hours in labor, a mother asks: *"Why do they lock us up here? My baby is normal. I want to go home. There's no place like home*". When the patients need to leave the hospital for treatment, they are easily confused with prisoners from jail because of the striped hospital clothing.

Therefore, being discharged from the hospital is the dreamed freedom, the return to the patients' world: their house, family, friends, work and leisure. Home is a place of comfort where "*I'm well taken care of"* with "*dedication, and where I receive total attention*", there *"I cook my own food, well seasoned beans… making little balls with my hands!"* (Mano, 93 years old, illiterate). For José, an agriculturalist with cancer, who is "*tied"* to parenteral feeding bonds, being hospitalized is like wearing an unbearable "*halter*". He could not wait to leave the hospital, and dreamed of "*after surgery, eating fish (...) there's nothing better than your own house!"* Longing for life outside, another patient laments: "*My goodness, if I were at home now, I would be with my baby, eating bread and drinking coffee*". Mano, retired, 93, yearns for his freedom: "*Thanks God, I'll be leaving this prison...we feel imprisoned, you know? We don't see anybody, just the door; at least there was a small TV for us to know what was going on in the outside world*".

Institutionalized hegemonic power

At the hospital entrance, patients are received by a gallery of plaques honoring the instituted power of politicians and former directors. A sign on one of the walls of the ambulatory warns: "*Treating a civil servant on duty with disrespect is considered a crime punishable by up to 6 months or two years in jail or fine (Article 331)*".

At the emergency ward, a chain and a policeman block the entrance of "unauthorized" persons. An ambulance driver stresses the "*dreadful authority*" of the hospital: "*We're humiliated almost all of the time. It's already hard to get things done around here, and they make everything even harder*". The professional attendants' attitude is perceived as arrogant, because it "*degrades"* the patient: *"when they put on those white clothes, they feel all-powerful*".

All institutional power is concentrated in the appointment scheduling center. A glass wall separates patients from attendants; communication happens only through a microphone. There is no one to hold responsible. An impersonal *"center"* makes decisions which affect people's lives, deciding where women will have their baby, if they will be hospitalized or sent to another hospital: "*the people at the center do the work…just the girls there know*".

Norms are incontestable, authoritarian and coercive: visits outside hours are not allowed, nor is bringing food into the hospital or wearing shorts or mini-skirts, for example. Routine

institutionalizes obedience to power – there is no respect for the singularity of patients and their families. On a certain occasion, a security guard kept a husband from seeing his wife out of visiting hours despite the seriousness of her condition; an imaginary line, which could not be crossed, separated them, forcing them to talk to each other from afar. It is mandatory to take a shower, independently of the time, the patient's will or physical condition. Companions receive a mattress in the afternoon and have to return it by 8 o'clock in the next morning, even if they still might need to use it. The presence of a companion during labor is not allowed, although enacted by law. Patients are also not allowed to use their own clothes. Pregnant woman have to wear "Barbie clothes", a pink, striped, standardized gown, with the name and number of the unity printed on it in large letters; sometimes they wear yellow gowns, which they compare to the uniforms of street sweepers.

The physical deterioration of the hospital environment is perceived as an act of personal degradation. The hospital bed is broken, the mattress worn out, the bathroom dirty, several equipments inflict pain, the patients and their families feel abandonment and rejection: "e*ven my bed is aggressive, broken, the mattress is worn out…the bathroom doesn't have a light…to get in the bathroom at night, there are cockroaches, you know, that kind of stuff?"* These bad conditions are considered extreme *"bad luck"*. Matias, 42, obese, had been waiting for a stomach reduction surgery for three years, with no luck: *"I had a little bit of bad luck, the equipment was broken…Oh! Poor people suffer!"* The precariousness of the situation sometimes forces the patient to plead: "*My God, have mercy on this hard bed!"*

The lack of organization of the service system causes patients to feel "*like a chicken with its head cut off, not knowing what to do*", they are disoriented and lost because of the difficulty in scheduling exams, appointments or surgeries. The sensation of "*not knowing*", during hospital stay, leads to insecurity, tension, anxiety and impotence, making patients feel fragile. Miriam, 21, with a high-risk pregnancy, complains: "I *was frantic, like a chicken with its head cut off, because it was a great shock to have to stay here, without telling anyone, without knowing anything…I felt alone and abandoned*". With labor pains, she was forgotten on a stretcher inside the bathroom: "*I know the beds were all taken, understand? They had to put me inside the bathroom; I felt so rejected…I don't know… because they didn't give me a blanket*". *After that, she was taken to a "closed delivery room with no lights...I just curled myself all up*".

Institutional stigma and demoralization of patients

The feeling of unworthiness is common between patients who feel like *"nothing, very small"*. Discriminated because they are poor, metaphors which refer to poverty, criminality and unwanted social status are associated to the patients' identity, reducing them to the condition of victims. They are stigmatized as being *"poor little things", "babies", "scoundrels", "criminals", "street sweepers", "bathroom cleaners", "African folkloric figures full of tricks", or even "objects", "toys", "floor-mats, on which everyone steps on"*.

Amélia, a grown-up woman, is "*discriminated*" by gestures and words of a nursing assistant. She is treated like *"a poor little thing, a useless creature, a little baby; the worst words to refer to someone, because it means they can't do anything by themselves!"* Even though her name is written on a sign beside her bed, a patient, who was willing to change her own bed sheets, is interrupted by the nursing assistant: "*Baby, let me do that!"* In tears, a daughter blurted out on the *"violence"* suffered by her mother: "*They say my mom is abandoned… that no one looks at her! I was already stepped on a lot…treated badly. I was doing what I could. I didn't study to know everything (…) what hurts the most is the aggression of seeing someone we love suffering!*" During the study,

we also witnessed a nutritionist comparing one of the patients with a bandaged foot to Saci (a Brazilian one-legged folkloric creature) when she had to hop to her bed on one leg: "*That's right Saci, keep on hopping!*" Then, the nursing assistant commented on the absence of the patient's mother: *"She's like a hummingbird…I don't like mothers like that!"* Estevão, semi-illiterate, who was recovering from his fifth surgery, compares himself to a puppet, without a will: "*They move us here and there, make toys out of us*". He felt discarded when he was discharged from the hospital the night before Christmas: "T*hey were going to clean that part of the hospital, and I was sent away with everyone else, even though I wasn't feeling well*". A woman with a high-risk pregnancy refers to her "*inferior*" social class, as if it were a floor-mat: "*(…) we leave our house and everything's okay…then we get to a place like this and we're treated like a floor-mat, stepped-on by everyone. They're the ones who know everything, or think they know. Just because they are better off… because it's not from equal to equal, you know?*" Family members are also unqualified for care. The companions receive a list of "*domestic*" tasks to do at the hospital: "*They're almost asked to clean the bathroom!*"

Resisting the *"dreadful authority"*

Patients and their families resist institutional power and condemn the "absurd" aggression. They openly denounce what is happening by shouting in hallways to receive news on their dead mother, calling the attendants at the scheduling center bad names, registering complaints at the ombudsman office and threatening to call a popular TV program, *Barra Pesada*. They also rebel against the waste of public money, criticize political corruption and embezzlement. Patients feel wronged and robbed by the lack of ethics, as Cláudio, 67, retired, comments: "*The biggest waste is the sewer rat, the thieve, the rodent; doesn't the rat come into our houses and take what's ours? That's what the politician, the hospital administrator does, and nobody is punished (…) half of the money used to buy saline solution goes to his pocket!*

Subtler protests, in between the lines, protect the patients' anonymity, so they run less risks of being punished: "*If we want to be healthy again, we've got to stand everything. If we complain it's worse!*" In this study, four forms of resistance to subordination were identified: a) personal traits; b) self-protective forms of thinking and acting; c) support from family and friends; and d) religious faith and spiritual transcendence.

Patients use personal traits to overcome the aggression suffered. Some "stand everything" with patience, conforming themselves to long lines, lack of information and uncomfortable situations: *"I'm drinking, eating, sleeping, I can take it"*. Others fight against the unfairness "*on their own*". Elvira, 50, waited three years to set a date for her hysterectomy, "*going from door to door*", until she found a doctor who was able to go around the barriers to her treatment. Escaping the current situation in thought, fleeing the experience by sleeping, fantasizing or "*making belief"* is another strategy of resistance. One of the patients protests subtly against a nurse's lack of interest: *"I can't even say it, but I notice she isn't doing it willingly… we don't like it, but we have to accept, faking we like it!"* Another patient compares himself with people in worse conditions to accept his own situation. Matias, 42, at the surgical clinic, uses irony to criticize: *"I'm going to invite Lúcio [the governor of the state of Ceará] to come see my apartment. This narrow little bed is 'beautiful'... Imagine, a guy like me with almost 400lbs lying on this small bed!...It's of the latest generation!*" Some patients prefer not to follow any of the imposed rules: "*the TV can only be turned on at certain hours, but no one obeys*". Others leave anonymous complaints in the suggestion boxes.

Patients also resist dominant power by creating solidarity bonds with other patients, family members, friends and companions. Affection "*gives us strength*" because it opposes the "*impersonal and cold*" treatment we receive.

Miriam, 21, single mother, feeling abandoned, counts on her roommates' help: "*We were there with the same problem…when one of us was sad, we all cheered her up!*" A net of social solidarity is created within the conversation circles, favoring the sharing of life stories, difficulties, information on diseases and alternative treatments. Daily visits and phone calls from family and friends make hospital stay bearable.

Finally, the belief in God, prayer, and reading the Bible help patients to make it through moments of uncertainty, pain and loneliness, as Eva, house wife, 56, points out: "*If I don't have faith in God, in whom will I have faith? He helps me to get up, to get better, feeds my soul…We don't feel so lonely here…He doesn't abandon anyone*". In the high-risk nursery hallway, desperate mothers put their babies' identification bracelets on the image of Our Lady asking for healing.

Discussion

The expectation of hospitalization for patients in a public hospital in the Northeast of Brazil, most of them poor, sick and vulnerable, is to be "blessed" with the improvement of their health. In their pathway to cure, they leave behind their house, family and cultural way of living to confine themselves from everything and everyone, "*searching for life in the hospital*". They expect to receive professional help, a *"zealous"* care, which is welcoming. The experience of hospital stay, however, in the metropolis of Fortaleza, is paradoxically marked by aggression, humiliation and disrespect of the patients' personhood and rights. Instead of promoting health, hospital stay usually results in suffering, because of power abuse, discrimination and demoralization. Patients "*are there because they have no other choice*", they need care, but, in theory, it is their right as citizens. In human complexity[33] and contradictions, discharge from the hospital represents a relief from institutional violence. The patients' return home is considered the end of *"imprisonment"*, the recovery of their freedom and reunion with those who wish their best.

The disillusion with hospitals as a place of miraculous cure is substituted by the idea of a prison and, consequently, hospital stay becomes a forced imprisonment – against the patient's own will. According to popular imagination, the hospital's physical structure, clothes, form of communication, etc. conspire to create the image of a *"hospital prison"*: iron bars on windows, blocked entrance, inspected bags and confiscated belongings, scheduling center, striped gowns and signs with rules and prohibitions. In fact, the person who is locked up behind bars in this metaphor is not the sick, fragile person who needs care, nor a patient with no name, but a "*scoundrel from the fair"*, who invaded the hospital. Transformed into a criminal, the suspect patient deserves to be confined and punished, justifying, therefore, the indifference, disregard and maltreatment in hospital stay.

Our interpretation should not be surprising, since Foucault[34],[16] has already described the hospital, from its origins, as a place of the impoverished and of disciplinary power, established by medical order, evolving to the depersonalization of hospitalized patients[35]. Goffman[15,36] also considered the mental hospital and prison total institutions, because people were segregated from society for an undetermined period of time – being locked up, isolated and formally administrated. By entering an imprisonment establishment, the condemned is submitted to six types of mutilations: 1) separation from the outside world; 2) deprivation of identity; 3) spoliation of social role; 4) threatened personal safety; 5) demeaned personhood; and 6) violation of privacy. Together, these aggressions humiliate, degrade and mortify the imprisoned *self* [36].

All these forms, which segregate the patients' social being, were identified in the study's narratives: confiscation of personal belongings by security guards; confiscation of ID cards;

family members kept away by an imaginary dividing line; standardized clothing – gown or pajama; controlled schedule, and body exposed with gowns open in the back. It makes perfect sense for patients to consider this experience a form of imprisonment: their subjectivity is disregarded, their human needs are controlled, they are forbidden to leave at will, and their social bonds are broken. Patients, therefore, lose their autonomy and freedom of coming and going, their way of life, of expressing themselves and even controlling their own body, space and time. They are forced to submit themselves to an unknown professional's care, independently of their will.

Luz[13] highlighted that institutional power divides individuals into commanders and obedient subordinates. Social relations become a form of tutelage, dependence and favor; increasing the current power and knowledge through obedience to the dominant hierarchy. In institutions, such as hospitals, patients are not seen as an autonomous self, a citizen with rights[37]. Regardless, they still report institutional violence in public service using the popular metaphor of hospital-prison – a portray of human oppression. The narratives in this study confirm this.

In the monitored hospital, hegemonic power is instituted and crystallized by at least four distinct forms of imposition over patients: 1) authoritarian institutional ideology; 2) norms, rules, routines and protocols which regulate and define behavior; 3) decaying physical conditions; and 4) discriminatory stigmas. These types of violence are particularly harmful, since they are part of the legal and institutional hospital order, reproducing inequality as something *natural*[13]. The hospital and its professional agents use authoritarian practices of management as an end itself, trivializing violence by the unjust use of power. Patients are submitted to this dreadful authority, embodying inequality[13]. The authority may be exercised by successors in administration, with rigid hierarchy and centralization, or by the doctor's power-knowledge[38], but its absolute imposition is necessary to maintain institutional order. After all, it is easier to dominate the patients if their freedom of thought and expression is limited.

Although the imposition of norms, rules, routine and standardized protocols may theoretically facilitate patient flow, speed up work processes, and improve comfort and quality of services, during field work we observed that this regulating function is frequently used as an instrument of domination[39]. It is the bond between institutionalized power relations and regulations, which ensures the continuity of institutionalized domination[13]. When it predominates in bureaucratic and techno-scientific rationality, the results are rigidness, barriers, long wait and chaos, instead of efficiency[30].

From our point of view, it is understandable that hospitalized patients live in a constant state of "not knowing anything", like a "chicken with its head cut off", wandering through hospital hallways; in order to exercise control, it is necessary to weaken, place patients in a situation of ambiguity, in the limbo, leading to a sensation of vulnerability and liminality[40]. "Disoriented", having lost their sense of personhood in society, patients are easier to manipulate and control.

Hegemonic power is also instituted in the public hospital when patients are submitted to subhuman physical conditions. In this study, precarious health care conditions and physical structures were unveiled, despite constant reforms and environmental improvements. It is shocking how inanimate structures and objects – a glass wall, a high counter, and a worn out mattress – can also be a form of aggression, and depreciation of human beings. For patients, a dirty bathroom with no lights, broken equipments, an "aggressive" bed are the result of their social status of being "poor". The lack of State funding to invest in hospital infrastructure goes beyond empty state coffers

– for low-income patients it means they do not deserve better, they are second class people, unable to pay for the services offered to the elites of Fortaleza.

This study indicates that hospital power is established by distinct stigmas of people – authorities and patients – reinforcing submission and the exclusion of anyone who is judged as being socially inferior or undesirable. The metaphors used by patients to express this discrimination are based on language, code systems and cultural references[41]. As researchers, we observed that patients are stigmatized as thieves, bandits, criminals, scoundrels, an image enhanced by the hospital, raising doubts on the patients' moral character and honesty. The "floor-mat", "street sweeper" and "bathroom cleaner" metaphors associate patients to something filthy, disgusting, and repugnant. It raises connotations of someone "unclean", "smelly", who transmits diseases. Symbolically, patients are transformed into something offensive and dangerous that deserves to "be stepped on by everyone". These metaphors are a form of criticism to the condition of being a disadvantaged social class.

The "Barbie doll" stigma, a toy no one takes seriously and manipulates, degrades the Northeastern woman, already a known target of domestic violence and murder by abusive partners[42]. Male domination not only oppresses women in the Northeastern society, but is replicated in gender relations in the hospital. Conducts of professional attendants which despise women are observed at every instance: a pregnant woman abandoned in labor in a bathroom with cockroaches, a woman giving birth in a dark room, another young woman forgotten after delivery, bleeding, with no pads or underwear etc. A citizen woman can never be a "Barbie doll", "baby" or *"Saci"*. This image violates their dignity and reinforces submission. Therefore, this study confirms how power uses stigmas to differentiate between the patients' class, gender, race, ethnicity, age etc. to discriminate and dominate them more[43,25]. Thus, this "dreadful authority" reinforces social inequality in a public hospital in Fortaleza, a city which is already marked by the disparity between economic classes and by social segregation[17].

Finally, we agree with political scientist James Scott[44] when he declares that, while facing intolerable repression, the oppressed never totally submit, without protesting, to the injustice which insults them. As oppression increases, "the weak" (impoverished patients) create subtler "hidden transcripts" to resist domination. Without running the risk of direct confrontation with power, patients show their indignation between the lines in narratives, metaphors and ironic declarations etc. which escape punishment. These are considered prudent protest tactics.

To resist the administrative order and knowledge-power of professionals and transform the hospital into a tolerable environment, patients, as well as other oppressed people groups in Ceará[27], surmise a micro-power[34]; a legitimate resistance to the prevailing power. According to Scott[44], the more intense the oppression, the more harmful and subtle are the acts of resistance. Patients create "hidden transcripts", called "weapons of the weak" to resist institutional power, a form of criticism which could never be openly expressed.

Patients also establish social networks of support to receive news from home, words of comfort and affection, which strengthen them to deal with the isolation, loneliness and confinement in the hospital. Strong faith in God and religious rituals practiced in hospital wards are a diffuse resistance to the authoritarian medicalization of the patients' bodies[34].

In face of institutional violence, unveiled in rich detail by our informants, it would be naive to think that isolated or contingent humanization programs and actions would be capable of transforming the reality of domination. Luz[13]

emphasizes that "none of these resistances dislocate or even scratch the surface of the dominance of hegemonic discourse; quite the opposite, they tend to subordinate themselves to domination". At the same time, the author admits that "institutions are a privileged place for political fight"[13].

However, this is not a fair fight; it is fought with different weapons of power. The humanization of this battle field, of this "prison", called hospital, should base itself on actions which promote human dignity. It is necessary to empower[45] patients, listen to their voice, ensure their rights of personhood in hospital stay, and recover their status of person and self[7]. Finally, it is important to value popular resistance as a legitimate protest against instituted hegemonic power. These political raw materials are indispensable for the construction of a humane hospital.

Final Considerations

The public hospital in the Northeast of Brazil, which was object of the study, is constructed as a *total institution* which reproduces prison, with restrictive norms and rigorous rules. The stigma is rooted in structural violence and introjected by patients, mortifying them. The transformation of the prevailing paradigm into a humanistic and inclusive one is challenging, because of the difficult task of eradicating social determinants of this magnitude and minimizing their effects on patients' lives.

Given the complexity of the context of socioeconomic inequality and authoritarian hospital culture, how far can the humanization process go? Will patients be able to demand dignified health care despite impositions and violations of their rights?

Transforming the hospital into a favorable environment for a person's well-being requires much more than a physical reform (new decoration, leisure areas, and different colors on the walls). A change in the deep structure of the institution is necessary: acting on the social determinants which produce iniquities in health care, on internal power and knowledge relations, and on the oppressive and discriminatory management model, establishing a professional critical and reflexive practice in every day behavior, based on democracy and on a human ethics of care, which dignifies the human being. Health education needs to contemplate a social and humanistic vision, integrating contents from social and human sciences. Professional attendants, who are also affected by hospital violence, need to understand the meaning of their work, know how the public health system operates and nurture a generosity which does not disqualify the person who they are caring for.

In conclusion, it is necessary to re-politicize patients, ensuring their rights and free expression. Claims and acts of resistance against ill-treatment, which explicitly and implicitly label and stigmatize, need to be seen as legitimate protests against institutional violence; not as mere or unmerited complaints. The "Patient's discontent" can, in fact, be valuable evidence in the process of making the "humane hospital" possible in the Northeast of Brazil.

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