

Medicine, magic and religion in a hospital ward.

An anthropologist as patient⁽¹⁾

Josep M. Comelles

Department d' Antropologia Social i Filosofia, Universitat Rovira i Virgili (Tarragona, Spain), Institut d' Estudis Avançats

Translated by Kevin Costello, Servei Lingüístic
Universitat Rovira i Virgili, Tarragona, Spain
Revised by Susan DiGiacomo and Xavier Allué

To Marta, Eduard and Pol

1. Orpheus

In the early summer of 1991, my wife, my children and I were involved in a horrific accident in the Spanish region of Alcarria. The motor home we were travelling in burst into flames. The children were unhurt but my wife suffered serious burns from which she was able to recover only after a long period of treatment and rehabilitation. On the same day we were admitted to different sections of the same burns unit. My wife was put in the Intensive Care Unit (ICU) while I was admitted to the general ward. We were separated by just over fifty metres. She remained in a pharmacological coma for six weeks and for two or three more weeks she was on that fine dividing line between life and death. She then spent five months in intensive care, a further six months in rehabilitation and for two more years she made daily visits to a rehabilitation centre. Today she leads an extremely active life. Her experience became the subject of an autobiographical text (Allué 1996).

My own injuries were more localised and needed just a couple of weeks in hospital and a month of superficial treatment outside. In the hospital ward, while trying to cope with my anxiety as best as I could, I kept a diary. Ever since the accident I had felt a compulsive urge to understand what had happened to us. While I was being taken to hospital and felt the tremendous thirst that burns cause, my brain began processing data at top speed in an attempt to explain why my vehicle had set on fire. In the hospital,

some fifty metres from my wife, my relatives and friends built up a wall of silence. «In here he isn't a Doctor» they told the doctors, «he's just a patient». Information about my wife was selected carefully. Nothing was left to chance. Visits to my wife were banned. Information was scarce. During the first couple of days my senses were dulled by tranquillisers, I was covered in bandages and I did not really know what was going on. When I had regained a certain degree of serenity I asked for some paper and a fountain pen. My writing must have followed a sort of confused process in which my two professions of anthropologist and psychiatrist fought to rebuild my identity in the anonymity of a hospital ward. I could not accept the passive role of the patient. Nor was I yet fully aware of the seriousness of my wife's condition – despite the alarming signs. In my diary a confused hotchpotch of field observations, clinical comment and personal emotions emerged. It was as if in all the confusion my various identities were battling with each other to fill the uncertainty. I was not able to take a detached view of the institution and, despite my normal curiosity, I never managed to become a systematic and aware observer. Out of these notes I began to write a personal diary.

Against the early ominous predictions of the plastic surgeons, the question of my discharge came up after a fortnight. As time went by I had guessed more and more of the truth and this awareness of the situation was, I think, a deciding factor in my leaving the hospital. I have since seen many patients with only half the injuries I suffered remain in the ward for weeks. My status as a Doctor clinched my discharge.

I had entered hospital with just the clothes I had on. All our belongings had been burnt. I asked my mother for a wallet and a photocopy of my identity card that, as luck had it, she kept. I could not leave the hospital without documentation, without an identity. I left without seeing my wife. I could not. I was not to know then that it would be another three interminable weeks before I saw her again. I went home to pick up my things. From the window of the train I could see the hospital drawing away. I shuddered, fearing the worst. I now knew the situation. I resolved my domestic situation before taking the train. When the train got into the station I stayed alone in the deserted and silent summer in Madrid. I did not have the courage to visit her. Outside the hospital, while my wounds slowly healed, nausea was eating away inside me. After the first weekend, my friends took the shuttle to Madrid to keep me company. For more than two months *Chamartín* station became the place for swapping over shifts. Days passed ever so slowly and the news was always bad. At first I thought that my diary would help me to overcome my solitude and nausea. The pact of silence at

the hospital only broke for a few short minutes every day – at one o'clock in the afternoon. The minimal information I was given was always the same. The remaining twenty-three hours and fifty minutes were a constant torture. My friends organised a strict military regime for me. My role as both Doctor and patient faded rapidly and the arrogance of the former was replaced by an unrestrained feeling of impotence, of horror at my uselessness, weakness and inability to react. I dreamt of sleeping for two whole months and made crazy plans and projects. I drew up several funeral protocols during the interminably long nights but I refused to accept that she could die. Those around me were instructed to leave no room for hope so that the final blow would be less. My instructions to myself were to go all the way without losing hope. In the worst moments I was the only one who believed that this was possible. I lived miserably. I was weak, fragile, gripped by my selfishness and the few shreds of arrogance I had left. I forced myself to bring a computer and every day I sat down to write. Nevertheless, I could not. I just switched it on and looked at the first paragraph. Nothing. I did not think then about narrating or reconstructing the process. I took on the role of the defenceless layman who tries to survive in the face of the death of a loved one and lets he go. However, I did not dare descend into hell itself.

In the middle of August 1991 the nursing staff urged me to enter the ICU to see my wife. I resisted because I could not allow myself to watch her die. I wanted to remember her as she was when she was alive, not wrapped up in a dirty shroud of bandages. The voices became more persistent. A number of signs seemed more positive. During the week of the August public holiday in honour of our Lady when Madrid, deserted by its inhabitants, becomes a ghost town, rumours of her survival grew louder. Shielded by my close friends, I finally went in to see her. She heard my voice and started to cry.

The ICU then became my home. I do not think I was ever a good companion as I was unable to fully assume the role that was dominated then by my status as a Doctor and my obsession with therapy. I struggled constantly between my roles as husband, friend, psychiatrist and Doctor, obsessed by the need to be useful after so many weeks of feeling useless. I did not understand that my idea of usefulness was not the same as hers. I failed as a companion, father, husband and therapist. I was unable to resolve the contradictions caused by my numerous identities. With a steely determination I wanted to administer a case that seemed to me to be the case of my life, without realising that it was not my life on the line but that of my wife. I did not realise that the reasons for my failure were that I had not recog-

nised the drama, or I was blinded by it, and that I had not noticed that she had taken on a strong awareness of her own independence, a strong ability to control the process herself. I wanted to be like Orpheus returning to the underworld to save Euridice. I forgot that Orpheus failed.

Two years passed before I could go back to the subject. Marta was finishing the second draft of her book but she did not know how to fill the gap left by her pharmacological coma. This was necessary for the logical sequence of her narrative. She suggested that I act as an informant but warned me that instead of an anthropological text she just wanted a written account. She used only a part of what I gave her because she quickly realised that my professional identities and my distress slanted my view at the time. She decided that this part of the story should be in a different font so that one part would be a summary of her case history and the other a neutral account in the third person that ended with an evocation of the myth of Orpheus (Allué, 1996: 21-24).

The draft I prepared helped me to begin to understand what I had not wanted to understand and at the same time to discover a new meaning for my experience. I used it partly to make a kind of self-analysis and partly to approach a world that has not been widely studied by anthropologists and clear up a few contradictory aspects of hospital care. I used the first draft, a year later, for an interdisciplinary meeting (Comelles, 1995). Now, some years later, I can reconstruct my personal moral career and take some distance from the facts.

2. Hell

Twenty years ago patients with burns on more than 50% of their body usually died. Today patients with severe burns on more than 80% of their body *pull through*. Assuring their survival is a complex clinical problem that can only be tackled by the burn units. They carry out advanced multidisciplinary research, perform experiments in therapy and train plastic surgeons, intensive care personnel and nursing staff. Ideally, they have an intensive care unit (ICU), a hospital ward and operating theatres. They are “closed” wards.

The unit where most of the observations were made is on an asymmetrical T-shaped floor. A door divides the main wing into an intensive care unit for severe burns *on the inside* and a general ward *on the outside*. The first section occupied 40% of the space and consisted of a dozen partitioned beds, nurses’ room, doctors’ room and a large treatment room with a

Hoffman tank for baths. The general ward consisted of a dozen rooms with two or three rooms for minor injuries or for patients *who had pulled through*. It also had a treatment room with another Hoffman tank (Allué 1996: 56-64), offices and other rooms. In the wing perpendicular to the main corridor were the operating theatres. Described in this way, a burns unit is quite a complete little hospital. Staff included plastic surgeons, intensive care staff, rehabilitation staff, nurses, physiotherapists, occupational therapists, orthopaedists, ancillary staff, epidemiologists and microbiologists, and occasionally a psychiatrist and a priest.

The treatment protocol for treating major and minor burns has changed little, even since the latest technological boom. It consists of surgically cleaning the wounds, regular care and skin grafts. On admission patients are bathed, their condition is assessed and, according to the depth and extent of their burns, they are intubated, sedated with opiates, given assisted breathing equipment and monitored. The necrotic tissue is then removed from the burnt areas and the grafts that will cover the areas where it is thought that the skin will not re-grow are planned. Topical treatments and normal everyday medication are formalised, as well as general large-scale therapy every two or three days that is independent of surgical intervention. A patient may receive surgical intervention with a general anaesthetic a dozen times in the minimum two or three months of a treatment that can continue for years.

The major aim of the treatment is to put patients in a position to generate new skin by preventing infections from the environment and somatic complications. The main causes of life risk in burn patients are damage to lungs due to fumes, renal complications caused by the metabolites of the burnt skin and the side effects of the treatments⁽²⁾. The surgical protocol is designed to cover the maximum of burns quickly⁽³⁾. This depends on the availability of skin to draw from since it is still impossible to produce artificial skin. Medical care keeps patients alive until their wounds heal: *«what cures the burns victim is time, just time»*, said one plastic surgeon. This axiom has not changed.

3. *Living dead*

When a badly burnt patient is admitted, the plastic surgeons are faced with a dilemma. They know that recovery will be a long process. They know that they have excellent resources but they also know their limitations. What they do not know, however, is whether the patient *will pull through or not*,

although they might be aware of the probabilities involved. The extent and depth of the wounds, age, sex, physical condition and build can give some idea of the patient's future prospects, but his *resistance* will not be known until the end of the process. The decision about whether to let patients die or to try to keep them alive is based on the experience of the practitioner, his beliefs, social considerations and the pressures from the patient's social network. Doctors and nurses know that their decisions will be called into question for months or years, during which time they will have to share a long moral career. They know that there is a possibility of recovery, except when there are no donor regions or when there are serious somatic, respiratory or renal complications⁽⁴⁾. This possibility, however remote, which terminal cancer patients do not enjoy, is important for shaping the culture of the organisation and, together with the overall results of their therapy, justifies the units and their protocols.

However, whenever they have to make an uncertain prognosis the medical profession always expresses it as a *very* or *extremely critical* one. This means that the patient has little chance of pulling through. This contradictory position means accepting that the intensive care therapy can be performed without their requesting the opinion of a patient whom is conscious on arrival. Analgesia is induced by pharmacological coma via opiates and psychoactive drugs. This therapy needs assisted ventilation, and later tracheotomy. This protocol is followed to ensure a patient's survival but at the same time it removes his social condition. It kills a patient socially, converting him into a dead being who is unrecognisable through the windows, through which his social network can see him twice a day.

In the burns service the patient is no longer a social *being*. It is not simply a question of reification of patients by the medical world. In this arena patients become non-people irrespective of their will or decision-making abilities and they are prevented from interacting with their environment because their only outputs are their biological parameters obtained from monitoring or from analytical or microbiological protocols. This attitude to therapy and diagnosis is rationalised by saying «*it is better that he doesn't know too much about it, for his own good*». However, this view collapses under its own weight when one sees how analgesia is haggled over in the series of interventions that follow treatment.

We have gone beyond what used to be understood by reification of the body in classical clinical exploration. This examination was a non-verbal interactive language involving the Doctor, the patient and the members of the patient's social network who waited around expectantly. In the situation we are trying to describe, this interactive language is also abolished as

the body is only explored through monitors that provide information, either written or on screen, about what is happening. The patient is not a living being: he is an on-screen *representation*. Alone in the ICU the patient is almost non-human. «*Marta is a thing*», someone said. In ICU Marta, like Vicente, «*is a pipe*». A *pipe* is a patient connected to tubes who «*is waiting to be taken to "El Corte Inglés"*» i.e. to surgery⁽⁵⁾, «*one of these days. Who's that?*» Asks the visitor. «*Oh, that pipe ... he's dead*», replies the nurse, «*we're keeping him here with the pipes 'till they come to take him away*». A living dead person among the dead beings, sharing the monotonous rhythm of the ventilator. Whether the patient recovers or not is irrelevant since what is being administered are only what remains of the patient's biology: there is no wish to take on the *travail de deuil*. To *allow* the patient to *die* is apparently an exonerative process considering the limits of knowledge, a way of saving face if things go wrong and picking up medals if the patient is saved. It is to practise a kind of indifference that is indispensable for doing a job in which one contemplates horror and suffering on a daily basis, and a way of avoiding or renouncing the function of social support and sociability that existed at the birth of hospitals. However, horror cannot be sidestepped and by organising the unit along hierarchical lines, its administration is reduced. Plastic surgeons pay their visits, do their rounds early and come back from time to time if necessary. Staffs in ICU shut themselves away in the ward and discuss the laboratory data. Nurses and ancillary staff come in and go out to change drips or take samples. The more *pipes* there are, the worse the overall service, the higher the absenteeism, and the more obvious is people's irritability. To cope with all this, artificial practices of ritual sociability are drawn up. Staffs holds celebrations and parties, but outside accomplices are sought for them. Visitors who do not enter are told that they should because although the patient is in a pharmacological coma there is a field of interaction between staff and the patient.

Bringing the patients *inside* removes them from their social network and shuts them away in a secret place, in which not even the most elementary of the vital processes are controlled by the patient. This takes the idea of total institution to the limit. The idea of social death in total institutions reaches its highest degree of perfection here. Inside they try to remove all subjectivity, since clinical decisions are based on the continuous evaluation of a set of objective parameters that limit the role played by clinical intuition. The interaction that used to take place between patients, their social network and professional staff around the development of the illness is being lost, while the discussion and negotiation about whether to continue with a treatment excludes laymen and patients, who are considered inca-

pable of deciding for themselves. Information becomes unidirectional i.e. from the *inside* to the *outside* and is synthetic e.g. «*he's not very well, he's better*», «*he has a sepsis*», and «*he's not breathing too well*». It does not communicate any vicissitudes or the decisions that are constantly being taken and that are reflected by the spectacular thickness of the medical records. There is no room *inside* for the emotional support that guaranteed the traditional doctors their customers and prestige, since the patient is socially dead. Hospital practice, therefore, tries to remove the social and cultural aspects of the patient's body and relegate them symbolically to the *outside* of the hospital. However, it cannot. Sociability grows outside.

To allow the patient to die socially is a therapeutic strategy that clashes with the fact that the patient retains certain ability for perception and oneiric interpretation of the environment. He also retains an ability for non-verbal interaction that begs a number of questions about his sociability, not so much towards the doctors but towards the nurses who spend more time with him and have to make an effort in order to understand his demands ⁽⁶⁾.

They can feel that he is responding to stimuli, that he can open his eyes amid the pharmacological haze. A rather esoteric theory about this type of communication is constructed, which as such is incorporated by the nurse better in her capacity as a citizen than in her capacity as a nurse. In addition, although the dead being is not attributed with the ability to act socially, members of his social network act as his representatives ⁽⁷⁾.

4. *Living in hell*

In Spanish hospitals, as a result of a very deep-rooted cultural pattern regarding the responsibility of domestic groups in managing health/illness/care, the close family consciously assumes the role of *representing* the dead being. *Staying* with the patient may involve staying for hours in the corridor, *outside*, irrespective of the rules and timetables, and making deals. Unlike in the United States we do not have a well-established legal framework for regulating the rights of the individual patient or his legal representative. What we have are a series of uses and customs relating to the collective responsibility in matters of illness, and therefore an order of representation that is more collective than individual and based on the common laws for the social management of illness. In the Anglo-Saxon world of informed consent, the patient delegates his legal rights in writing. In our environment, his social networks are his representatives. The dead

being is *inside*, but he lives and has his voice *outside*. The *presence* of the patient in the body of his relatives is fundamental to an understanding of the fundamental contradiction between a model of a hospital that is autonomous and socially and culturally independent and a common law reality that is in contradiction with the former. Hospital staff are therefore constantly torn between their professional identity and training and their identity and experiences as citizens in domestic management of illnesses i.e. between their professional (cultural) identity and their cultural identity. Finally, since the American model delegates' legal representation, it provides professionals with a negotiated order inside a legal framework. In Spain they constantly have to negotiate new adjustments because the rule developed is the result of spontaneous and constant dialectics that cannot generate any kind of jurisprudence other than experience itself. Medical training does not attempt to sort out this contradiction between the rational and the emotional since it considers the emotional to be purely irrational, archaic or borne out of ignorance and superstition. Rationally oriented decisions are therefore always justified so as to ensure their supremacy over emotion.

Although the medical model has not solved this problem by incorporating it, it tries to do so with formal, expert practices, using the value that science has acquired in popular knowledge to protect itself. In the first place services are closed. The reason given is the risk of infection but it is mainly to provide a protected area in which to take decisions without being influenced by sentiment, to limit the supply of information to a minimum and to feel under less pressure, since pressure is a form of power. This means that doctors can walk without covering their shoes, smoke in the ICU corridor, work without rubber gloves or rationalise the lack of communication with relatives by saying *«it's better that you don't know too much, in fact it's better that you know as little as possible»*.

Then there are the rules and regulations that attempt to justify segregating areas and concealing medical activity. These rules and regulations are intended to administer the relationship between staff and the *presence* of the patient, represented by his social network. One learns about emotional indifference, the creation of hierarchical distances, how badges are used and how reserved areas are created. All of this is based on a rationalisation that stems from the intrinsic and indisputable goodness behind the decisions that are taken.

By refusing the opportunity to understand how important social and cultural aspects are to the caring process, the medical model displays its most negative side: the lack of technical resources needed to solve this problem

of communication and support leaves the door open to conflict, irregularity and dealing. Instead of understanding and learning, however, the staffs answers in a variety of ways, each of which is just as bad as the other. They accuse laymen of being ignorant or coarse. They call them *uncultured*. They apply entirely police-like criteria, thus exacerbating the conflict. They agree to *turn a blind eye* and set up a system of discretionary deals, which is obviously always unfair (in health service jargon a patient is known in such cases as a *recommended one*). However, threats and coercion are also used to create the picture of the good patient, i.e. one who keeps quiet and accepts whatever they give him, as well as that of a bad patient, i.e. one who asks what and why they are doing what they are doing.

The socially dead are still sociable people, however. «*Sometimes, when half awake he looks at us as if he's asking us something. We tell him things and he sometimes wants to reply*». The problems they cause produce contradictory responses. Nurses and ancillary staff encourage relatives to go *inside* to cheer them up and give them the will to live. They encourage them to break through the barriers of space and secrecy, to help them to *get through it* despite the attitude of medical care that advocates that «*the best thing for them is to sleep*» and «*to be awoken as late as possible*». The nurses sense the therapeutic value of sociability, or at least rationalise it because they know that the relatives who feed the patients and keep them company are less work and do not call so often.

It is this fragile patch-up theory that causes the defences of the professionals to tremble. Sometimes they tremble on a long-term basis – this is the *burnout syndrome*. More often they require the complicity of the patient's social network in the management of care. Their professional ideology has been built around care and, therefore, on shared experiences, so the horror cannot be combated with such efficient resources as those of the doctors. For this reason, female nurses sometimes weep while some male nurses become expert mini-doctors, as a form of escapism, and others turn to violence, torture or sadism.

Doctors are in a better position to cope with the horrors because the rhetoric on which their practice is based is more epistemologically sound. This is because they have rejected care and support in favour of diagnosis and therapy. Their position in the hierarchy allows them to escape and hide, without it being noticed, or be ready at midday with all the necessary information. However, they are besieged, feel criticised and go on the defensive. If we understand strategic professional aloofness as emotional indifference, it is difficult to explain it rationally in a society in which to pay attention to the patient still implies being in continuous contact with him.

Right from the outset the doctors' attitude is to try, not very subtly, to make the patient's relatives share their emotional indifference, to «*accept the harsh reality*», to «*get used to the idea of not seeing him or her ever again*», and wait for the fateful outcome by doing nothing. A positive outcome is never guaranteed. «*I saw her today. When I arrived, she was horrible. She has no skin, she's got terrible scars and she's in a bad way. She's going to die, she's almost certainly going to die*», the very nervous woman Doctor told the visitor who was pestering her, before moving away, still speaking but not looking at him. The word "almost" offers a ray of hope, gains a bit of time, and makes the waiting shorter. Professional defence mechanisms are fragile things. They work more or less well in hospital situations where there is a high turnover of patients that normally stay for between a few days and two or three weeks. In Burns we speak in terms of months, slow progress, occasional crises and how to be patient when everyone – doctors, patients, visitors – has to be patient.

The organisation is unable to resolve these contradictions. Firstly, because of the fundamentalism behind the theoretical positions on which medical discourse is based. Secondly, because of the lack of any self-criticism. Thirdly, because there are no analytical instruments to tackle problems or suggest other organisational frameworks that does not view medical care as a service for the professionals but as a complex reality, that rejects the patient's *social presence*. It is often claimed that these distancing strategies are intended to increase the charisma of the Doctor, using resources designed to increase people's admiration for them so that that they can retain their power. I agree with this view to a certain extent but I would also like to point out that the burns unit also reveals the intrinsic weakness of the position of the Doctor and other staff. This weakness stems from the fact that it is impossible to guarantee that the therapy proposed will be successful. Medical literature of the 19th century shows that doctors knew they knew very little and that at best they could make forecasts with some success. They did not claim to find cures but they knew that they had to keep the support of the social body, the *social presence* of the patient. The hospital Doctor wants to cure the patient but does not know whether he can. Both the doctors and the nursing staff want the social presence to believe that a cure can be found so that they do not have to seek their support, which would distract them from their hypothetical care work (Comelles, 1996, 1998). This turns the commonly held view of the power of the Doctor, the powerlessness of the patient and the desperation of the patient's social network into a more complex situation. Firstly, the doctor's power and the patient's desperation are reflected in their behaviour and, in our case, in the patient's oneiric production.

Secondly, the impotence and desperation of the medical staff emerge as they see the limitations of their ability to make prognoses and to cure. Thirdly, there is the power of the social network, and also its powerlessness as it sees that its opportunities for collaborating in the process are denied.

5. *The experience of uncertainty*

The critical period has no clear limits. *«If they go beyond forty days they usually recover»*, one nurse told a group of relatives. If the days go by and the patient does not die, hope is not lost. Nevertheless, the way ahead is uncertain, *«he's still poorly»*, *«he's very poorly»*, but nobody knows what makes him resist. *«They have a will to live, something within them makes them carry on, say the nurses. I don't call people when they're suffering: what's the point? When they die we'll ask their relatives to come»*, said one woman Doctor. Gabriel died alone early one morning. They called some time later. Nothing gets in the way of the logic of the institution even though Gabriel is conscious and he knows that he is going to die as he contemplates his leg that was amputated in a routine operation two weeks earlier.

Dead beings spend their days not knowing whether they will revive or die. Others pass their time in the waiting periods any way they can. Plastic surgeons spend their time between operations, grafts and baths. In the intervening periods they wait, powerless, while the intensive care unit staff attend to the patient, while the body resists and the grafts take, and until time passes. If the operations are delayed it is because the patient would not be able to cope with the surgery or the baths, and the relatives suffer. *«Every morning when I got up I would say to myself, another day and they are not going to operate. This went on for weeks. She has no skin, they would reply, and she's got a sepsis. We can't do anything»*. Have patience. Be patient.

Waiting for something to happen is another way of avoiding questions that nobody, in a social pressure situation, knows the answers to. One sees the same faces week after week, building up their hopes and managing their waiting time by interpreting signs or magical practices. *Forty days, quarantine*. Interpreting banal signs like the calendar of the saints' feast days and converting any technical parameter into some kind of indication.

«As I couldn't bear the situation I only went at midday and did the waiting at home. It was unbearable. The daily journey to hospital was a horrendous experience. The underground never seemed to arrive. The corridors seemed interminable to me and in the lift I suffered from tachycardia. The news at one offered no hope, her fever was up, she was suffering from hypothermia, she was dying, and she was dying. I didn't want the telephone to ring in the afternoon. They told me they rang after a patient has died.

In the end my friends called me only to ask about her fever. If it had gone down it was as if she was cured. But the next day the nausea returned.»

The interpretations become more frequent because the answers provided are always terrible. Visitors get used to questioning the least bit of information, or what they believe to be information, that they have managed to gather from various snippets or from other visitors. The tactic is to penetrate the walls of secrecy surrounding the jealously guarded, seldom divulged, information. As the process is so lengthy, however, the group is able to acquire good knowledge of where to find the information and how to get it.

«When I got to the unit I knew that Eulalia was poorly again: the nurses didn't say good morning cheerfully. They looked at the ground, sloped off or made as though they hadn't seen me.»

Faced with the feeling of failure that a deterioration of a patient's condition brings, the staff invents other strategies. Some employ verbal brutality.

«This one's about to die. They took him into the theatre today and did a botched job. It doesn't matter, he's going to die anyway.»

Others use silent tears as they try with the benefit of their long experience in medicine to tell relatives not to build up their hopes. Others try as best as they can to cope with the anxiety induced by the suffering of patients of the same age or gender as they.

«When I came back off holiday I didn't dare to go into the ward and ask about Marta. When I left at the end of July I thought I wouldn't see her again. I went in and as I was passing number 12 I looked in out of the corner of my eye and there she was. I couldn't believe it.»

These are narratives that indicate the extent of the professional self-defence mechanism.

In any society uncertainty produces cultural responses that render it highly significant. The hospital becomes a place of sociability immersed in a specific cultural context in which heightening the secrecy surrounding medical practice increases uncertainty, anxiety and desperation. Laymen therefore become blindly dependent on the curer, who is unable to manage the process well if the process does not follow the guidelines on which the model was based. As soon as the power of the curer becomes clear from a rapid and effective therapeutic protocol, the desired result is obtained. In the treatment of burns this response is neither rapid nor effective. It takes a long time, uncertainty increases and there are no answers. The blind faith is slowly and inevitably eroded; the professionals start to be criticised and time reveals the limitations and contradictions of their practice. Time

also puts limits on secrecy. When in contact with the professionals, laymen begin to acquire technical knowledge that they incorporate into their own knowledge and understanding of the illness. They learn to decode and interpret medical information, evaluate clinical signs and interpret silences. Sometimes they understand the professionals, who in contrast find themselves caught in an impossible situation or trapped by their inability to share, since it is on this that they have based their practice and charisma. They still believe that if they were to reveal their secret they would lose both credibility and people's blind faith in their omnipotence, which they believe is fundamental to performing their tasks unhindered. They do not share their own subjectivity with others. Instead, they sublimate it through professionalism and scientism, believing that they do not have to admit their weakness or ignorance. The hospital Doctor does not understand that by doing this he locks himself up in solitude in a search for scientific answers that also have their limitations. In the face of an erratic and unforeseeable development his powerlessness forces him to hide behind a shield of scepticism. He accuses others of lacking emotion: *«we've seen so many husbands (and wives) abandon their partners after their discharge; children avoid their burnt parents because they are afraid of them»*, or forecasts the most negative sequelae so that at the end they are not so disappointing. His ambivalence becomes evident, however, when over and over again he asks *«the patient who has pulled through whether or not»* so much effort *was worth it*. The answer, either as a written text or as a speech in an academic or hospital context, does not serve as a mirror on which to base self-criticism *«What have you got against doctors? You're one yourself»*, they asked me. I have never rejected my identity or my training. However, faced with this ambivalence they hide behind their faith in a knowledge that is also limited. Are they trying to have their work ratified, or are they asking themselves about its meaning? The social death of the patient prevents him from deciding for himself about his suffering and legitimises an interventionist model of practice that reduces him to an instrument of science. Therefore, via the permanent or temporary donation of his body, he helps other people to survive and to unveil some of the mysteries of the human body. Nurses deduce the therapeutic value of sociability and build their professional culture around it. Doctors, on the other hand, reject it because to accept it would be to question the foundations of both their knowledge and their identity.

6. Resistance

By denying the patient, and his *social presence*, doctors can perform miracles. The treatment of burns requires cleaning and grafting *until the patient can regenerate his own skin*, i.e. allowing sufficient time for *the patient to fabricate his own skin*. «What you have to do», the plastic surgeon told Marta, «*is to eat, eat and eat because you need to make skin*». As her back was used as the source of new skin, three weeks had to pass between grafts, during which time she had to be fattened up so that she could fabricate more skin. Technical operations do not heal directly: they are intended to provide the patient with the necessary conditions for healing himself. Doctors will clearly consider this difference a philosophical one since for them the healing is a result of their intervention. It is true that severe burns do not heal without the help of doctors, but this does not remove the fact that the value they give to healing is a metaphor that puts them at the top of the process. The problem is that the body responds so slowly that they have to fill the gaps between one operation and the next, one bath and the next, with significance. These gaps are presented and perceived as *the treatment of burns*, even when this time is used just to wait for the wounds to heal. These gaps reveal the limitations of their work, «*we've done the grafts and we now have to wait for them to take, for the patient to respond*». If the patient's condition is very bad, *his grafts won't take* or his skin will be *too atrophic* to guarantee their success. Their language identifies not the limitations of the technique but the limitations of the patient. If the treatment fails responsibility lies with the patient. «*He would not survive the operation*», an operation that once again has to be postponed. This highlights their fear that the patient «*will die in the operating theatre*» and place the ball in the court of the intensive care people even though any failure would show up in their own statistics.

Medical discourse merely describes what has happened. Prognosis is not changed or given overnight. They insist on *waiting* and using the patient's *resistance so far* as encouragement. These monotonous messages, rigorously controlled and expressed after weeks of disappointing messages in a corridor near the doors of the ICU, reveal their limitations. Despite the coldness, in conversations with staff or nurses one gets the feeling that they understand and have an emotional complicity. Like traditional doctors, they know their technical limitations, that it is the patient's resistance and not so much their own technique that decides between life and death. Therefore, when the patient *pulls through*, solidarity based on the waiting, anxiety and daily disappointments has silently built a channel of common feelings. It is just like what used to happen with the good old doctors.

To explain the powerlessness experienced during the gaps in time requires the process to be rationalised, the delays to be explained and the fact that healing does not result exclusively from their action to be overlooked. The patient builds his own *resistance*, day by day, hour by hour, by not dying, by getting over infections, somatic problems, and the savagery of the therapy and its side effects. *Resistance* is verified and a confused explanation linking genetic, constitutional and psycho-physiological factors is given to relatives to justify why one patient *gives up* and *dies* while another *has a will to live* and *pulls through*. How can dead beings *give up* or *have a will to live*?

Here emerge the contradictions behind the logic of the institutions that we have already seen trying to abolish cultural and social aspects. These explanations project the values of the members of staff and the doctors themselves, but their reasoning cannot be proved clinically, or else there is very little proof, or it can only be supported by their intuition. Resistance is measured by the indicators and the patient's response to treatment but such is the diversity of patients that one begins to think that some sort of communication may be established with their dead beings or that there may be some way of allowing them to communicate with the world. Again there begins a discourse of esoteric dimensions about influences. As there are no scientific data to justify such assertions the discourse is based on a strange combination of factors deriving from scientific positivism and animal magnetism and other, less visible factors that have their distant roots in the oriental religions depicted in Hollywood science fiction films. «*May the force be with you*».

With *resistance* described in this way and defined in terms of the ability of the dead being to fight and the magical influence that those who are present can pass on to him, the biomedical community, imperceptibly, finds an alibi for the limitations of its knowledge and practice. If the patient does not resist and dies «*he didn't respond or didn't resist the treatment*», but if he resists and pulls through, «*the technique (or treatment) is good, it has produced good results with this patient*». To perceive the sovereign body, he who is dead socially, as the fundamental agent of his healing, albeit assisted by a series of external influences that include the whole paraphernalia of biomedical therapeutics, is to rethink the whole view of magical thought and practice. This is all the more true if we add the strong ritualisation of the process, the oneiric trip associated with the pharmacological coma and that excursion to the fine line between life and death to which the patient is submitted. This process may go unnoticed in a general ICU because the stays are shorter but in burns the oneiric trip is a painfully slow process. Nothing is ever decided and nobody can guess the final outcome. The patient resists

but so too must the plastic surgeon, the intensive care worker, the nurses, the ancillary staff and the patient's relatives and friends. Because of the characteristics of the process, which is a long and uncertain road, all the actors, without realising it, are constantly interchanging their roles since the emotional crisis they are involved in challenges the conventional and rational instruments that govern normal life. Finally, the notion of resistance traps the patient's whole professional and social network in the need to participate as one block in the process of influencing and encouraging the patient's resistance. However, how can one mediate in this process?

7. *Magic and technology*

How to mediate, how to influence the body somehow, is about how to influence the inner strength of the patient so that he can withstand his horrendous daily suffering. Therapeutics, antibiotics, fluid therapy, and I.V. nutrition nourish the body but the idea of resistance is concerned with the soul and in biomedicine the soul does not exist, although everyone believes that it does. There may therefore be a place in medicine for the religious idea of the miracle as the intervention of a saint or the esoteric idea of irradiation from the minds of those nearby who are capable of magically transmitting the strength that the dead beings need in order to *resist*.

Segregation of the *inside* and the *outside* becomes a symbolic limitation, with the patient located in a liminal space. For this reason the process will not be interpreted in exclusively biomedical terms but by constructing specific cultural forms in the interactive space that allow invisible communication between he who has gone to the other side and the others that are here. This space for sociability, a meeting point for knowledge and medical practices on the one hand and knowledge and popular practices on the other, was the operating theatre corridor. Every day dozens of people converged as they waited for one operation to finish or for news of another, and the orderlies made up rooms and attended to the patients' needs. Because the epidemiology of burns is erratic, people of many different origins converged on this area, sharing their experiences over long chats. Although the regulations do not allow visitors into the operating theatre corridor, they often entered anyway or *slipped through* into the hospital ward during the morning rush in the hospital services. Outside, the hospital staff never tired of repeating «go home, there's nothing you can do here», one never stopped hearing «I don't want to go, I've got to stay with him, I can't go

home, my place is here». If the pressure is too great, they retire to the cafeteria but return later to the seats in the hall. It is a physical presence but more than that it is a social one. The patients who are admitted to the hospital may come from a long way away. In addition, in the most serious cases their relatives want to stay close to them «*in case something happens*». They cannot be convinced otherwise because they have been taught that they have to be there to share the experience of the illness with their family and they cannot go back on this principle without feeling guilty. Physical proximity is explained not only as a moral duty but also as a *presence* that directly influences the morale of the dead being. In the technological hospital this presence is a continuation of a domestic mobilisation against illness and suffering, but the hospital is not designed or organised to cater for such an area because in individualist societies with Lutheran roots this presence does not work in the same terms. As the characteristics of high-risk groups mean that most of the patients are from poor working class backgrounds, and as many of these come from hundreds of kilometres away, assuring and maintaining this presence becomes an odyssey for them, especially if the patients are burns patients. Where should they go? How should they live and how can they endure unlimited waiting that could go on for months, a long way from home and with nowhere to stay? They cheat the security regulations and sleep on the armchairs in the corridors. They do what they can to be near their loved one, challenging their own impotence, misfortune, anger and pain with their presence. Silent, unmoving, wrinkled faces in the corner. «*That's Andrés' mother, that's Ernesto's fiancée*», people explain in low voices. Atilano, Gabriel or Eulalia «*are very poorly*». These are the unknown patients half seen from the corridor through the windows that surround the ICU. They resist day after day and remind the relatives of those who are pulling through of the time when Ernesto or Andrés were Eulalia or Gabriel. If someone dies, like Gabriel, they go downstairs to hold the wake. If they pull through they talk about it quietly, almost ashamed because other patients have just been admitted. There is no need for surnames or addresses: people on the inside will hardly ever be seen again. His wife is out now, she's suffered so much, but «*Miguel is still inside. He's getting better, though. How courageous his wife has been, they are saying here that nobody can work out how she survived. We've prayed a lot for her*». The only information people have are first names or the number of the patient's bed. The number of anonymous experiences gets bigger. The experienced ones approach the "newcomers" who look despondently at the floor and feel jealous of those who come out smiling. But the latter look for an opportunity to say hello to them, to break the anonymity and privacy to engage them in conversation and encourage them, «*you must be*

Eulalia's husband, I know how your wife is, here bad news gets around fast. I know she's in a bad way but have faith, keep your chin up». Then they recount their own story to show that some people do pull through, or speak about Eugenio who was in two years ago, or Atilano, as if they were legends for pulling through. *«Don't lose faith, keep your chin up»*. Stories with a moral to fill the void left by the uncertainty and show that there is light at the end of the tunnel beyond the doctors' cold assertions and their lack of prognoses. At the same time the stories become lessons in how to behave when one day they may be able to do the same for those who are admitted in a critical condition a week later. Local myths, legendary people, short personal stories; the small, miserable odyssey of one on the outside so that newcomers may know what they must do, how they must resist, how they got through the days and nights of frustration despite the absolute powerlessness of waiting. In desperation nausea invades the body. It becomes a shield that prevents one from thinking rationally. Sometimes it leads to nihilism.

«I didn't want to see her like that, I wanted to remember her as she was when she was alive. Everybody said she'd die, but I never accepted that. The worst thing was my feeling of impotence, everything I knew was useless, and I could only use it on myself. I must resist so that I can be of use later. I didn't know then how useless I was going to be.»

Nothing can rationalise the situation and one begins to believe in the comfort that religion brings to people.

Professionals and lay people regard the resistance of the dead being as a conscious struggle against death – a struggle that allows those waiting to live in hope. The crisis situation therefore creates imperceptible communication links between all the social actors, the *social presence* of the patient must not be just a symbolic one: it needs to form part of the therapeutic process. Presence alone is not enough: action is needed. To accept this implies a discourse regarding the patient that hides the work that the patient's relative does for him and creates a scenario in which the social network must be aware of doing something for the patient without accepting that they are doing it. The bells toll for you.

«I don't know if you are religious but I spend all day praying for my husband. It's the only thing I can do for him. I have great faith in saint Gemma Galgani, many people here in Achúcarro are devoted to her. She's performed miracles and intervened for many patients, says Vicente's wife. I'm agnostic, you know, an old agnostic rationalist, but many nights I have prayed and prayed, relatives of other patients gave me religious pictures and I kept them at my bedside⁽⁸⁾»

In this context of human intervention, belief in miracles does not arise from superstition or ignorance: it is an instrument that takes on a new meaning in a context in which the limits of what is human or natural ap-

pear to come into focus. It is important to believe in them because doctors, attempting to get away from the pressure of relatives, can be seen rushing along the corridor saying something like *«he's going to die, he's going to die, he's got some terrible scars. One can only pray and hope for a miracle»*. Why a miracle in this temple of reason? The word does not crop up in the treatment of burns only occasionally. One always hears it. It is at the forefront of the process. It expresses the chance that all burns patients have when they are admitted but that is not formally invoked. The miracle is present. The doctors not only utter the word: it is embodied in the corridors and in the wards. Healing the badly burned patient is a miracle that challenges the very limits of science. The social actors, whether professionals or non-professionals, think or sense that they can participate, that they can intervene. The social body merges with the individual body.

«We don't really know why he pulled through. Everything was against him. We didn't even dare to do some things because we never thought he would resist. Sometimes it happens, it just happens, says the head of the unit. I'm an agnostic and an apostate, but I don't know how many times in desperation I asked for forgiveness and tried to say prayers I only half remembered from my childhood. I collected religious pictures and made vows. I had to try it, I just had to, both for my patient and for myself.»

The belief in miracles is the consequence of the long waiting, the time of uncertainty, the time without answers, the feeling that one can do nothing. All this means that there is nothing left to do but search desperately for something to hold on to in order to feel that one is taking part in the process and limit the effects of the nausea in oneself. In these contexts the social network of patients, even those who are not religious, openly rebuilds belief in the symbolic efficiency of religion and magic. This sometimes leads to a blind faith in new technology (which often borders on science fiction), promises to our Lady or the saints, magnetism and the effects of electromagnetic radiation from the brain, telepathy and telekinesis. Look, Juan's wife tells me in the corridor leading to the operating theatre when I tell her that I do not want to go in to see my wife because if she dies, I want to remember her as she was when she was alive.

«I go in every day and touch my husband's bed, strongly, very strongly. I know that in this way I transmit all my energy to him. When I'm here I do the same. I know he receives it and it helps him.»

Juan's wife is a devotee of saint Gemma Galgani. She has given me pictures of her, she prays every day, and she is a believer and regularly practises religion. However, she does not realise that she has incorporated the ancient resource of thaumaturgical touch into her religious practice, which is based on requesting intervention, and that she has reinterpreted this in terms of telepathy and energy. She prays in the hospital chapel, far from

her husband, but she needs the physical contact to say to the dead being: I resist so that you may too, and my resistance, my will to live, is my will that you live. The metaphor they use is a biological one that in the sophisticated hospital reveals the strange relationships between medicine, religion and magical thought. This energy is transmitted telepathically or physically (it is therefore necessary to be present) by touching the patient or his bed or, sometimes violating internal regulations, by bringing objects into the room.

«As I'm a rationalist with medical training I preferred the classical resource of religion, prayer and vows. I couldn't get to grips with all this paraphernalia connected with telepathy. I suppose I'm too radically positivist and too sceptical. However, I still don't understand why I took up the old religious discourse of my childhood again. Perhaps at one time in my life I believed in it and it seemed now, in my desperation, easier to accept than parapsychology.»

An innocent observer may think that the magical and ritual practices that hospitals follow are a consequence of the divide between knowledge and ignorance, that they are secondary adaptations on the periphery of the hospital. In the first draft of this text, I fell into the same trap. Later, however, I realised that religion and magic did not represent the boundary between the *inside* and the *outside*. Neither were the product of people's superstitions or ignorance, but rather the output of dialectics between scientific and popular knowledge located between the organisational culture of the scientists and the social presence of the patients. Magic and religion were therefore fundamental to structuring the organisational culture of the hospital as a product of the interaction between the staff and the patients and their social network, between the hegemonic culture and the subordinate cultures. The culture of magic and religion is built around experience and characterised by dialogue. Because the ability of the technological hospital to fulfil the purposes for which it was designed is limited, it has been impossible to exclude this culture from it.

What I was able to deconstruct, as an observer, made me realise that the dividing line between magical thought and religious thought is not the one that separates the *inside* from the *outside*. Professionals themselves have, in their own way, incorporated these thoughts into their own practice, their own management criteria, and their requests for help and mobilisation. Also, behind their shield of technical knowledge, they have channelled them and re-fed them. Otherwise, how could a professional remain for years and years in this service, witnessing all this horror, when most of the resident doctors escape after their compulsory working period to pursue their careers doing breast and nose jobs in the private sector? Why else would they stay there if not out of a subjective confidence in their mission?

It is because they themselves recognised and invoked those miracles in which they could claim to be mediators.

Both magic and religion are participants in the process because the process implies the emergence of a shared logic. While the magical and ritual practices play an important role in the process of enduring the waiting, their effect is to improve the relationship between the *inside* and the *outside*. For this reason, from the inside the miracle is invoked and practices to support it are encouraged. I am not saying that invoking the miracle is a conscious strategy on the part of the professionals but it is the product of the *external* condition of specialist that emerges in a crisis situation. The miracle is invoked because many doctors and nurses are believers and they believe in them and because they are not fully able to give a reasonable explanation for the differentiating factors behind the *resistance* of the patients. However, whether they are believers or not, when a seriously injured patient *pulls through*, they rationalise their therapy and cannot explain with assurance what it was that allowed the patient to survive. In the annals of the burns units there are constant reminders of cases of mythical proportions of patients who have survived. Singular cases when no hope was left. Cases that, in a cultural context like the one I am describing, take on the same structural function as those that were resuscitated or cured of fatal illnesses in the miracles. Both types of narrative are designed to establish the symbolic existence of hope in an environment in which, rationally, there is none.

In these circumstances religion and magic acquire a highly significant role in the logic of the institution. They become incorporated as subordinate practices in therapy and care, set up an area of sociability and turn the patient's social network into actors in the therapeutic process. This is why the professionals, when the situation takes them beyond their condition as professionals and their human dimension emerges, propose or resort to the metaphors of magic and religion or think about them without mentioning them. To a certain extent, in the area of non-sociability, they also express a desire for sociability that allows a degree of participation.

«As they knew I was a Doctor, although they would have always denied that I was, that night they asked me to give them a hand with Angela, the dressmaker from Vallecas. She was the daughter of one of the patients and didn't want to leave the hospital. That day I felt particularly useful. I managed to convince the girl to go home: I told her what had happened to me and other stories people had told me. I didn't have to make it look as grim as the doctors had always made it look to me and to her. We spoke for a couple of hours. She went home then without the feeling of guilt that had at first prevented her from leaving her father alone in the ICU.»

However, the resources of magic and religion have some obvious limitations. They become more and more apparent as the relative, extending his knowledge of the process, begins to understand that all the doctors' efforts are worthless if the patient does not resist. This point highlights the failure of the institutional model and the need to find an explanation for what has happened. The relative, besides praying and transmitting energy, begins to perceive the Doctor as someone who is unable to provide answers, because he has none, and who, like the family doctors of other eras, can at the best of times only make predictions. He therefore asks the doctors to do what they did at the patient's bedside in the 19th century i.e. allow the patient to die well, share his suffering or share the waiting. Moreover, the Doctor can only offer partial answers.

Doctors have abandoned their role of providing social support for patients and their relatives but they have not resolved the questions surrounding uncertainty. Popular knowledge to fill this gap is built up not through medical discourse, but through occasional botches created by the syncretism between magic, religion and science, or by legendary stories of patients that prove that survival is possible, that there is a future. This is why, when the patient is about to pull through, the staff oblige the relative to enter, «*you must go in, you must, he's waking up and he needs you*». The patient needs the final push to resist, the relative needs to transmit to the socially dead the stimulus of society, a reason to be reborn and end his odyssey at any price. «*The sad thing is that when we on the outside cheer because he's pulled through, his own drama will be only just beginning*», said someone, with the strange lucidity that the desperate waiting brings.

8. *Pulling through*

Sometimes a critically ill, badly burned patient *pulls through*. This does not mean that he comes *out*, as he may remain *inside* for months and even die. *Pulling through* means that the patient crosses a symbolic threshold beyond which his survival *seems* assured. Those who *pull through have resisted, have turned the corner*. It is the result of changes in clinical indicators, improvements in biological parameters, intuition, experience and subjectivity. It means that the living dead revive or are reborn, that they can return to a social life, although they are still not cured.

«*I was envious whenever anyone pulled through and I wondered when it would be my turn. It was for me that the bells tolled, not for her. Will I be able to forgive myself one day?*»

In a context in which the border between life and death is not clear, those who pull through acquire a charisma. The whole unit has taken a gamble that will link them to the unit forever. Quite apart from their inclusion in overall survival statistics, the singularity of these exceptional cases inscribes them in the annals of the institution's culture. They become its points of reference, prove its efficiency, cement its prestige and are presented at professional meetings. However, for the journey towards pulling through there are no explanations. It just happens.

«Halfway through the month she was dying. They hadn't bathed her for a fortnight. The nurses told me she smelled. Friday was the public holiday in honour of our Lady of La Paloma and you know what public holidays are like in hospitals, staff is off and, well, you know. The nurses said that the more sedatives they gave her, the lower her temperature got. They bathed her on the Sunday because they thought that if they didn't she would die. They couldn't wait any longer. They took a gamble. Her hypothermia after it was incredible. I was told her temperature was 29° and that she had a pulse rate of 250. By Monday her temperature had increased a little. They took away her sedatives and her temperature seemed to go up. That week it was the procession. Her friends had gone to see it. Luisa carried the candelabra of the Virgin and pinned a brooch of our Lady to her chest. She wore it all night. They brought the brooch to me in Madrid on Thursday and I gave it to the nurses to put in her room. On Thursday they bathed her again. One nurse told me that it had done her the world of good. On Friday, her temperature was being back to normal and the nurses insisted she was getting better; she was better, and she was waking up. The doctors began to speak in a different tone of voice. On the Saturday we went to see her. When I went in and she saw me she started to cry. She knew who we were. On Sunday for the first time the nurses said amongst themselves that she was pulling through, she was pulling through. And she did.»

Nobody asks why someone pulls through. As the answers are unclear it is better not to look back. The gods forbade Orpheus to look at Euridice until they got out of hell. Here hardly anybody looks back. Hospital statistics do not explain the reasons why. They are diluted among all the patients in the unit and reduced to statistical correlation of biological and sociological variables. *«She simply didn't want to die. It was fate. It wasn't her time»*. Again they talk about genetics, constitution, the will to live and resistance but after this period of uncertainty they feel sure of the practice once again and pulling through is seen less and less as a thing of the patient and more the result of the technical measures deployed. There is no more talk of waiting or of miracles, but of being patient, of being a good patient, of following doctor's orders. Once the patient has recovered his leading role, his social network abandons its vigil.

The story of the brooch of the *Virgin* is only told to the closest friends.

«You never know how to explain these stories because some people would look down on you, my God, miracles in the 20th Century! You think some people will have a good laugh behind your back.»

Lay people, while congratulating the relative on his happiness, talk about «fate» or say that «nature is an unfathomable thing», or that «it wasn't time», others reply that «this kind of thing makes my hair stand on end», while others think the story is «beautiful». Patients prefer not to speak about it. It has nothing to with them: it is all about the work of others.

The point at which patients pull through is on a symbolic line that divides life and death and has different interpretations for the different social actors. For intensive care staff and nurses it means that their work has been a success. For close relatives it means the end of a period of uncertainty and distress and their return to a world of care and conventional hospital support and a chance to help the patient physically. More distant relatives feel that all has ended well, so they can be demobilised. For the plastic surgeon, who recovers complete control over a patient he had previously shared with the intensive care specialist, nothing visibly changes. For him, pulling through means that his job is done and that the last ulcer has healed: «you are no longer a burns victim, right now you are a patient of the plastic surgeons».

For the patient it means nothing (Allué 1996: 17). He does not know that he is entering a new stage in his life from which there is no escape. The New Testament teaches us about the resurrection of Lazarus, but it does not tell us what became of him. The burns patient does not know what future lies in store for him either because nobody tells him. The plastic surgeons have lost track of their old patients and have done their part of the job. Now the patient is shared among rehabilitation staff, orthopaedists and occupational therapists. Relatives are also in the dark. The club of severely burnt patients is a select group of *revenants* who do not know each other and whose later stories, in so many social arenas and with so many different sequelae, have peculiarities that are difficult to share. The badly burnt patient who survives is a special case. Fire is a capricious thing. Sequelae manifest themselves progressively, sometimes months and even years after they have *pulled through*. Rehabilitation may last years and may be a life-long thing for some parts of the body. Aesthetic sequelae change and diminish with time, but the functional sequelae and disabilities mean having to learn to eat, walk, dress, or put on make-up. They mean taking on a new identity. These are permanent areas of uncertainty for which the patient has no previous experience.

For the hospital service the patient who pulls through is another success to add to its list of triumphs. It justifies the goodness of its therapy and organisation. They present their slides at conferences, write a few articles that may guarantee them future successes. The life of the patient is no longer a matter for them. For a few years some will be landmark references

until their names are forgotten and replaced with others. They will then become clinical records in some storeroom until the papers are destroyed or read by some medical historian. After five years these articles are no longer read, they are the scientific prehistory of treatment. The patient, *who is no longer a burns victim*, begins a long journey of rehabilitation and plastic surgery, during which his singularity is lost. Now he is another elbow or contraction or a few more tendons. Out of professional curiosity they will explore the whole body. As usual they will touch and pinch the skin and evaluate what their predecessors have done and, if necessary, criticise their work.

The story of the Virgin also is forgotten: it is just a private anecdote that has no interest for religion. In the burns unit, just as psychiatrists behave like surgeons or intensive care staff, the priest goes around dressed in a doctor's coat and behaves like a psychiatrist. The Church is not interested in these miracles. It is as reticent about them as it is about the healing that takes place around apparitions. The matter is not even remotely discussed within university hospitals. Our Lady and the saints do not need to be legitimised further. To argue about it would mean reopening the old controversy between science and religion. The Vatican accredits miracles based on post-mortem medical reports and beatification requests, which in recent years have been particularly frequent and quick. The miracles performed by the apparitions of the *Virgin Mary* and the saints had some meaning in the fourth century. Today they do not perform miracles. Miracles are performed by men and women who the Church wants to beatify in terms of the new meaning that it attaches to the word to defend itself against the generosity with which saints were beatified in the beginning (Woodward, 1991; Ziegler, 1999). The relationship between religion and medicine also requires accepting scientific discourse and using rationalism to administrate some of the educational or sanitary measures without creating any conflict with medicine. In exchange, the Church does not question the healing ability of the doctors because its strategy today depends only marginally on this as an instrument of faith. The theological miracle today is no more than what medicine is prepared to accept it cannot explain. Religion has also taken on board the medical model: the priest does not take part in the ritual and magical practices we have previously referred to.

However, while the relationships between medicine, magic and religion can be understood in terms of their respective organic roles in modern society, they become especially significant in the hierarchical hospital. Here, the social use of believing in miracles allows the limitations of science to be

exonerated without its overall validity being questioned. It also allows the professionals and their institution to be made unaccountable. This is also true for the patient's social network, which is allowed to play the symbolic game of supporting and contributing to therapy although they are not told that this symbolic and ritual game is being played especially on itself. For religion this no-man's-land highlights the strong influence that it still has on popular culture and represents an area in which people's faith, which is minimal when compared to other eras but not insignificant, can be restored.

In hospitals, medicalisation has not brought about a process of demystification but a reordering of hegemony and subalternity. The hospital practices we have described show this. The difference lies in the subordinate position of religious discourse in the institution. Its fundamental role is to administer sociability at the heart of the institution. Praying for a miracle is relegated to the intimate, to an occasional role in making more tolerable those situations that institutional care, having reduced illness to a biological dialectic between patient and professional, has not foreseen. In most societies this dialectic is wider and biological illness is included in a social and cultural experience that extends invalidity beyond the biological patients to their social networks. Therapy and care take care of both groups. In the traditional model this was one of the functions of the social support: it wished the population to accept science rather than pure faith, to replace the religious interpretation of illness involving the mystery of God with a naturalist one that offered the immediate and perceptible support of men.

This support does not exist in the hospital model so the patient's social network and the hospital workers themselves use religion and magic as instruments to bear the personal and collective crisis and to combat uncertainty. They resort to the miracle to express what they cannot explain rationally. The miracle becomes a functional tool, in the sense that it helps resolve uncertainty, the lack of answers, ignorance and anxiety. The hospital staff uses the miracle as a resource that is not foreseen in their therapeutic arsenal.

The limitations of this magical practice and its link to those *on the outside* and to the hospital staff can be seen when those on the inside, the patients who are pulling through, are unwilling to accept the hypothesis. They have not resorted to magic because it is not one of the expectations that they see from their perspective. The patients learn very quickly that such a miracle does not exist, although they may wonder one day what it would be like. In Lourdes there are crutches, but no prostheses. Their functional and aes-

thetic sequelae are going to shape their new identity. They have died and they have been reborn but they are not the same.

This is why one can also understand both my agnostic and rationalist informant and my informant who has prayed for his family offer candles: they make pilgrimages or cling to lucky charms to keep the promises they have made to their relatives and friends. The bells toll for them, not for the patient who may now be handicapped for life. This is why we can understand the patient, in as much as he accepts his new identity, considering various scenarios that fluctuate between depression and suicide. Why does he bemoan his misfortune? Why does he say «*now it's up to them to keep me?*» Why does he embark on a struggle and personal resolution to completely restructure his life and, in a new form of civic responsibility, take on a new identity that is neither better nor worse, just different?

9. *Euridice*

I do not believe in miracles, but they do exist. I shall conclude this ethnography at the point where Euridice recovers her *presence* and affirms her social being and her freedom. Her own ethnographical narrative describes the facts of the latter stages of her journey because pain and physical suffering cannot be shared and we probably do not have the right to share them anyway (Allué, 1999). Between the moral suffering of the staff and relatives and the physical suffering of the patients, staff and relatives always come off better. It is the tortured ones who must talk about it. For this reason I do not want to talk in terms of concluding my account. I have attempted to put forward an ethnography based on a *tranche de vie*. It is the story of a couple of months in the life of an observer who in hospital changed his role of temporary patient to those of husband and witness of a great drama. This observer is also a psychiatrist. Only the distance that time provides allows him to take up the role of anthropologist.

I have not attempted to be objective in the naturalist or positivistic sense of the word. What I saw, what I lived, may be perceived as the revenge of an ingrate or the settling of scores by a traitor to his profession. Perhaps it will be read and will allow similar scenes and similar situations in other small units of other enormous hospitals in other parts of the world to be relieved. Either way would mean that the consciences of its readers will have been moved in one way or another. If I achieve this, I will have met my objectives. An ethnographical account can never claim to be an objective representation of reality. It is the reader who awards veracity if it fits in with

his own perceptions, emotions or intuition. An account wishes veracity to stem from the embodiment of another person's experience: *«that was my experience too, just as you describe. When I looked after my mother, or my father, or my friend»*. On the other hand, when someone spits out: *«so that's why we pay you, is it?»* I do not feel like a traitor to the medical profession that I have never abandoned. My position in all this has been extremely ambiguous. In my narrative, my identity as an anthropologist has come through. My function in the hospital was more than that of a companion, or that of a Doctor who fails to understand why he is living with the subjective and undying awareness of his mission in the world. In the first draft of this text I may have been obsessed by the need to keep a distance, to remain objective. These needs meant that I had to hide the part I played in the events (and my misdeeds).

Five years later my position has changed. I intend to hide neither the part I played nor my misdeeds. However, I can comprehend and explain the Orpheus myth. I understand now why Orpheus looked at Euridice and why she comes back to hell. The Euridice he went to find and who died under his gaze was the woman he desired so intensely to see. However, it was a different Euridice who left hell with Orpheus and it is she who now tells us the story from her point of view. She is the myth's real heroine, not Orpheus. She defeated hell. Both she and Orpheus left it and were able to live together once Orpheus had understood the greatness of Euridice's new identity and accepted that his failure guaranteed their future and was the means to fulfil his uncontrollable desire that led him to go back to hell for her. The importance of the myth and of this story, therefore, are not its heroes but the way in which men and women build their own versions of hell and are reluctant to leave them.

Roxanne: *«Ces pleurs... c'était vous?»*

Cyrano: *«le sang était le sien»*.

(Edmond Rostand 1912, *Cyrano*, Act V)

Notes

⁽¹⁾ This article is part of an ongoing investigation into the relationship between medical practice, self-care, institutionalised care and religion. Fieldwork was carried out between July 1991 and February 1992 in the burns unit of a hospital in Madrid. Other observations were made over periods of no longer than two weeks when accompanying my wife to a burns unit in Barcelona between 1993 and 2000 and to a plastic surgery department of a hospital in Galveston, Texas (United States), in 1993. A first draft was published in Comelles, 1994. This paper is more enlarged English version of the Spanish text (Comelles, 2000).

- ⁽²⁾ The skin makes up 15-20% of body weight and, in an adult, has an area of just under 1.5 m². Infection of a seriously burnt patient is essentially caused by opportunistic flora in the hospital.
- ⁽³⁾ A graft is a layer of skin extracted with a dermatome and applied to the debridement area, either as a complete graft or as a mesh to stretch the skin over large areas. Grafts are not intended to become new skin but to act as anchorage points or as a “catalyst” in the granulation process.
- ⁽⁴⁾ Not all donor skin is of the same quality. The good skin is found on the thighs, the back and the pubis. It is better in men as it is more robust; in women it is thinner. In the initial evaluation the plastic surgeons always touch and pinch the skin. The relationship between the plastic surgeons and their patients is a constant game of touching and pinching. These physical relationship forms the basis for clinical experience, «*stabilised skin is skin that can be pinched*», they say, but it is also a part of the interactive game between the plastic surgeons and their patients. There are strong elements of reification, however: «*tell me what you think of this ear*», says one doctor in front of a patient who is conscious. Or, «*that nose will be very bad*». It is not often that one hears, «*his nose might not be very good*», for example.
- ⁽⁵⁾ The idea of *El Corte Inglés* – the biggest department-store in Spain –, comes from the mesh-type grafts. To cover large areas it is not necessary to apply full skin. An extendable mesh of skin obtained with a dermatome can suffice. This can increase the area to be covered three- or four-fold. This type of graft is identified in the healed skin by its appearance – it is like a wide gauze mesh.
- ⁽⁶⁾ While doctors never concern themselves with this matter the nursing staff, who are much more frequently in contact with the intubated patient, are much more sensitive to the patient's condition as a living being. It must be remembered that pharmacological coma is maintained through synthetic opiates and is subject to peaks of maximum drowsiness and troughs due to the kinetics of the drugs. Moreover, the dreaming that opiates usually generate contributes both to this fluctuation between deep sleep and semi-conscious daydreaming and a certain perception of the body being handled (see Allué, 1996: 24-40).
- ⁽⁷⁾ There are clear differences between Spain and the United States in this respect. The need for the informed consent of the patient demands that the patient be able to designate a representative who can take decisions in certain circumstances on his behalf. In Spain this is not completely regulated. What we may call the common right of the opinion of the social network is in operation.
- ⁽⁸⁾ Gemma Galgani was an Italian member of a religious order at the beginning of the 20th century. She died after a long and painful illness and was later beatified for her ability for miraculous intercession.

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