AM
Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 289-310

Crossroads between transformation and stability.
Hospitalisation in Finnish cardiac care as an example

Juha Soivio
MA Department of Cultural Anthropology, University of Helsinki (Finland)

Introduction

Coronary heart disease (CHD) is a major public health problem in Finland. In health care the procedures dealing with CHD have been standardised as a cardiac chain of care. My aim [(1)] is to analyse a part of this care, the treatment of acute myocardial infarction (AMI) in a modern hospital, by using the concepts of the rite of passage and liminality initially formulated by Arnold van Gennep (1960) and developed further by Victor Turner (1968, 1977, 1978). I will argue that in certain respects the treatment of AMI can be viewed as a ritual passage intended to transform both the individuals who undergo it and the community that has designed it. The use of these concepts in analysing hospitalisation and the experience of biomedicine has been suggested by Davis-Floyd (1992), who argued that hospitalisation is a modern rite of passage during which essential features of American culture are communicated to birthing women, and Alan Radley (1996), who suggested that bypass surgery is a kind of liminoid period during which medicine leaves its mark on the biography of the sufferer. Although these concepts are useful in analysing the ritual structure of the treatment as a passage and the transformative work of liminality, they are too general to account for the predefined roles and the rules of face-to-face interactions in a modern hospital setting. From a ceremonial order point of view (Strong 1994), the hospital institution sustains the status quo instead of aiming at transformation. I will look at how these different perspectives are intertwined in the treatment of AMI. From the sufferer's point of view the experience is reflected at three different levels. First, the relationship between the self and the body becomes uncertain; next, the view of one's agency and subjectivity in everyday life is scrutinised and, thirdly, one's relationship to the institution and the society at large comes under consideration.

Contextualising the care of acute myocardial infarction

Coronary heart disease (CHD) [2] is a major public health problem in Finland, which causes1/3 of all deaths [3]. Actions ranging from large-scale health educational programs to investment in medical high-tech have been taken to reduce morbidity and mortality from CHD. Medical and societal interests are intertwined in the efforts to deal with a major illness and cause of death. The emergence of the medical category of CHD and its treatment were closely related to the rapid development of medical technologies and especially medical visualisation techniques. Although dating from the 19th century, the electrocardiogram was used more extensively in the 1950s to map the incidence of CHD among the population. In the 1970s it was widely used in hospital settings. Angiography and ultrasound techniques were introduced in the 60s, bypass surgery in 1970, and the use of betablockers and calciumblockers in the 80s marked a turning point in the treatment of CHD. At the same time, population-level studies of risk factors made high blood pressure, cholesterol, and smoking the prime suspects for atherosclerosis. (Siltanen 1990).

The rapid expansion of medical knowledge on heart disease coincided with the emergence of the welfare state in Finland after the Second World War. The exceptionally high rates of deaths due to cardiovascular diseases was publicly acknowledged and defined as a major public health problem to be combated. The problem was not merely a medical one but also concerned social issues like working capacity and support for the sick. In 1955 the Finnish Heart Association was established (the second in the world after the U.S.) to combat "the societal-medical question" by establishing co-operation between citizens, doctors and institutions. It recruited volunteers from all levels of society to deliver "accurate information" about heart disease to the public. It also arranged social support and rehabilitation courses for the sufferers. Later, as these problems were taken up by the emerging structures of the welfare state [4], the association stressed prevention of heart disease by arranging health educational campaigns and providing education for medical personnel (Teerijoki 1990).

One important way to combat the problem has been the development of a cardiac chain of care by health care officials. Basically this represents a way to unify the treatment of CHD by creating standards of care and by delivering the responsibilities and actions to be taken between general practice (perceiving risk factors and prevention) and specialised health care in the hospital (like the treatment of AMI or bypass surgery). In the current attempts to develop the cardiac chain of care further both major means of

controlling CHD are being emphasised; managing the body by hi-tech used by experts and the individual taking responsibility for his own well-being. Recent developments like the use of troponin markers in diagnosis have resulted in a more accurate diagnosis of AMI as well as more efficient treatment, such as angioplasty. Cardiology's success in managing the physiological processes by the use of hi-tech and visualisation techniques make it a good example of the ability of biomedicine to save lives (at least on the popular TV shows). At the same time the emphasis put on prevention and education about risk factors is in line with the more general cultural atmosphere valuing the importance of being healthy. I am interested in how these seemingly contradictory trends are brought together in the treatment of AMI.

I wish to use this brief contextualisation of CHD as a public health problem as the background to my analysis of the cardiac chain of care as a ritual. The cardiac chain of care, built on both biomedical and welfare state principles, highlights some crucial aspects of how the problems of illness and death are met in Finland. The implementation of the cardiac chain of care in institutional structures is a way of symbolically portraying certain key values and cultural orientations like the value of technical control of the body and a healthy lifestyle. The cardiac chain of care also mirrors social relationships by making explicit the responsibilities between individuals and actors both in health care and everyday settings. However, as Turner has emphasised, a ritual also has a creative function in that it 'actually creates, or re-creates, the categories through which men perceive reality – the axioms underlying the structure of society and the laws of the natural and moral orders' (1968, p. 7). In order to analyse how these functions are realised as reflections on body, lifestyle, and social relationships, I will concentrate on how AMI is treated in a hospital setting [(5)].

A cardiac passage

An important category of ritual, first suggested by Arnold van Gennep (1960), is the *rite of passage*. A rite of passage is a transitional ritual accompanied by a social movement from one status, place, or state to another. All rites of passage are based on a three-fold model: separation, the margin or limen, and reaggregation. In the separation phase the ritual subjects are detached from their old places and statuses in society. In the limen the ritual subjects are outside the established social structures and are metaphorically identical with the dead and infantile. In the reaggregation phase

the subjects are installed, inwardly transformed and outwardly changed, in a new place in society (Turner 1978, p. 249). The idea of a rite of passage is to transform, to change the whole person, including the nature and destiny of his body.

Robbie E. Davis-Floyd (1992) has applied the concept of rite of passage in the modern hospital context in her analysis of standardised technocratic birthing procedures in the U.S. Hospitalisation initiates the mother and child into American life, effecting the movement to the status of a mother. As one of the most powerful rituals acts in contemporary Western culture, the hospital birth as a technocratic rite inscribes the values of a technological culture into the bodies of birthing women and their new-borns. Following Davis-Floyd's argument on hospital birth as a rite of passage, I will look at how the institutionally organised treatment of a heart attack resembles van Gennep's three-fold model. On his journey through the hospital the patient moves from emergency unit (separation), through the cardiac unit (limen) to the medical ward (reaggregation).

> «A nurse guided a man to the emergency room. He looked greyish and grasped his chest. Another nurse calmly guided him to the bed; asked him to undress and handed him faded brown pyjamas. She put his clothes and belongings into a plastic box for storage. Then she started to connect the man to the monitor, which measured his blood pressure, saturation and pulse. At the same time she briefly asked him about the onset and severity of pain. Then she ordered the man to lie still and quiet as she started to take the electrocardiogram. Calmly but quickly she called in the Doctor, who took a glance at the ECG, listened to the nurse's report, and immediately ordered the nurses to take blood tests and to start a treatment called actilyse to dissolve the apparent block in the patient's artery. Then he went to the patient, introduced himself, asked a couple of questions, listened to his chest with a stethoscope, and said that he had a cardiac infarction. "We'll take care of that, you just have to stay still and tell us if the pain gets worse." For 15 minutes 3 to 4 nurses were working around him, taking blood, taking an x-ray, giving medicine, talking to each other in medical language. For an hour or so a nurse constantly kept an eye on him writing down carefully what the monitors reported. The patient was quiet and his eyes were shut for the most part».

The emergency room is a place where medical cases needing immediate care and hospitalisation are sorted out from all other kinds of health problems as well as social problems and various demands brought into the clinic (Dodier & Camus 1998). It is a threshold between society and the hospital. In the process of selecting and admitting patients into the hospital, the social and personal characteristics defining a person are replaced by redefining him as a medical case according to biomedical categorisation. AMI is a good example of a life-threatening condition needing instant medical

intervention and the shift between categories is usually rapid as in the above extract, where there was no need to consider the man's claim for care or his social attributes. People with chest pain jump the queue, and the diagnostic measures are started immediately. Initially it was the man's body that separated him from everyday life, as he was not able to go on with his daily routines any longer. When he was admitted to the hospital this separation was institutionally marked and increased by the non-ordinary world of the clinic. The changing of clothes and restrictions of bodily movement, the emphasis on visualised bodily processes, and the supremacy of medical logic all symbolically marked his separation from his previous social states. His problem was reduced to his body, a blocked artery.

From the emergency room the patient is transferred to the cardiac care unit, the limen in Gennep's terms. Here the patient is literally and symbolically somewhere between life and death.

> *«In the office, the bed number told me that there is an 'infarction' in '0-1'. I went to the intensive care unit. Amid all the monitors and technical equipment lay an older lady looking lost and tired. The monitor made a beeping sound once in a while because of her low blood pressure. She said it had been difficult to sleep here, as the night had been restless and noisy. The nurse and I started to do our morning routines. We washed the lady in her bed; 'hasn't happened since I was a child' the lady tried to joke, the nurse wrote down her blood pressure, etc, counted carefully what had gone into and what had come out of her body during the night… During the doctors' round four doctor's showed up. One of them asked how the lady was doing. Then he turned to the other three and started to explain that she had had an infarction yesterday, there was reason to think that three of her arteries had been partly blocked. The conversation about lab tests, medication, etc. went on using strictly medical language. Meanwhile the lady stared at the ceiling. After a while the Doctor turned to her again, recounted some of the blood values, and said that they've planned to change the medication to see if they could stabilise her blood pressure… Later she asked us (the nurse and me) for permission to move her leg a bit as it hurt… I was afraid to ask her questions dealing with anything outside the immediate situation and felt that it was easier for me to stare at the monitor than look her in the eye. The nurse seemed to know even less about the lady's life outside the realm of intensive care.»*
>
> «In the CCU the patients are defined primarily in biomedical terms. Monitoring and controlling the bodily processes became the main focus of action of the medical staff. This was in striking contrast with the agency of the patient, whose body became the target for action instead of being the agent. Actions focusing on bodily processes and technological equipment bypass the patient as a social being. Although nurses are 'present' (keeping an eye on the monitors) all the time, talk is often limited and issues beyond the immediate situation are avoided as they might worsen the patient's condition. The nurses often talk of their patients as 'not being themselves' or 'in a state of shock' thus emphasising that they are dealing with people not fully responsible for their actions or speech. Being hooked to the wires, lying in a corpse-like position, all bodily processes carefully counted, being

> treated like a child, not able to move all emphasised the patient's detachment from normal interactions.»

The third phase, reaggregation, begins when the patient is moved to the medical ward after the "vital bodily functions" have stabilised. The patient's bodily processes are still monitored but not with the previous rigour and use of heavy technology. The emphasis is now on secondary prevention, which includes conveying information about coronary heart disease and the main risk factors (smoking, diet, and lack of exercise).

> *«I went to see Antti, a 50-year old man, in his room, which he shared with three other men. Monitors or other technical devices no longer surrounded him. He sat on his bed. He had just been walking in the corridor after being encouraged by the nurse to get used to moving around again. First he was allowed to go the toilet in his room, then to the corridor, and maybe tomorrow he could visit the canteen on the second floor. He told me how he had had a conversation with the nurse (Antti's wife was present as the nurse had invited her) about how to reduce risk factors in order to avoid another attack. Antti had difficulty in understanding the point as to his mind he had been eating healthy food with low fat, he didn't smoke and he had exercised enough… During his stay at the medical ward he got booklets about cholesterol and diet, a booklet called "Life after a heart attack" including information about the disease and medication, information about rehabilitation courses, filled in a psychological test in case he wanted to take part in one (which he didn't), saw a video about coronary heart disease and another one on exercise after an attack.»*

This remarkable change in emphasis from technological control to delivering information about prevention is coupled with mobilising the patient from being a passive recipient of care to an active processor of that information. The patients are expected to actively absorb the facts about risks into the idiosynchronities of their own lives. In order to facilitate this, nurses try to establish rapport with their patients and discuss their social roles and the details of their everyday lives, from going to the shop to sexual life. The patient is being shifted from a medical case back to a person with social attributes. This is not only done by discussing information on risk factors, but is accompanied by restructuring the patient's agency in relation to physical movement and social relationships. After lying still for a few days, the patients are encouraged to move again little by little and detailed instructions on how to move and exercise are distributed by the physiotherapist to overcome the fear of moving again. Social relationships are introduced by discussing the daily lives of the patients as well as by inviting spouses or significant others to take part in the discussions on health education and coping. *«It is almost impossible to cope with the changes alone, all the family has to take part and help»*, said a nurse when I inquired about the rationale for inviting others. The incorporation of others into the ritual not only breaks the solitude of the ritual subject but also puts the

illness in more mundane terms, like who is preparing the food or doing the housework. Thus responsibility and agency are extended to involve those who share his style of living by cooking the food for instance.

By introducing movement, information and social relationships, the medical staff moved Antti from a medical category, needing medical help, to the category of "normal people" again. «*You will be back to normal in three months*», as a nurse said. Medically, Antti's cardiac rite of passage was a success indeed, as the damage his heart sustained was minor, and he was able to go back to work in three months. However, Antti was not just being transferred from being ill to being "normal" again. The purpose of interventions such as preventive education in the reaggregation phase was integration into society with a new awareness of his own responsibilities as a cardiac patient.

The work of liminality

Victor Turner, who further developed Van Gennep's ideas, emphasised that it is the liminal phase that enables the ritual to do the work of transformation. The liminal period is a threshold between states or categories, betwixt-and-between. The ritual subjects in this phase are «ambiguous, for they pass through a cultural realm that has few or none of the attributes of the past or coming state» (1978, p. 249). «Liminars are stripped of status and authority, removed from a social structure maintained and sanctioned through discipline and ordeal.» (*Ibid*.) Having outlined the treatment of AMI as a rite of passage, as a journey through the different spaces in the hospital, outside the previous or coming states or categories, I will now have a closer look at how detachment and distancing of ritual subjects from the established states of political-jural structures enables the process of reflexivity – an essential feature of the liminal period.

There are two processes taking place in hospital liminality. The first of these is decontextualisation; a process in which the sufferer's lived experience becomes objectified and authorised as a problem in the heart muscle with the use of medical technology and knowledge. This object is considered as separate from the patient's personal or social characteristics as we saw earlier in the description of the emergency unit and cardiac care unit. The second process of recontextualisation, taking place in the medical ward, aims at installing medical reification into the context of the patient's lived body and everyday life again, including an effort to reconstruct his subjectivity. These processes [(6)] overlap with the phases of separation, the limen,

and reaggregation in the rite of passage. Here I want to shift from phases or places to the differences between the processes taking place during hospitalisation, and the various reflexivities they enable. In the following extract both these processes are present:

> *«It was time for the doctor's round in the medical ward. The Doctor opened the medical record of Pertti, a man in his sixties, spread the results of the lab tests and ECGs on the bed and took a seat beside the bed. The nurse remained standing at the edge of the bed. The Doctor started to read the medical record: 'So you came on Thursday, chest pain. Smoking as a risk factor, heredity negative, quite a lot of exercise ... There were changes in the ECG as you can see here.' (The Doctor looked at the ECG taken in the emergency unit and drew a circle around the place where these changes could be seen). Then he laid the lab results on top of the ECG and read the results: 'The enzymes have come down, your lipids are a bit high, otherwise it seems to be ok.' Pertti followed all this with his alert eyes. Then the Doctor listened to his chest with a stethoscope. ... 'Ok. The damage in your heart is minor. We will go on with the same medication and arrange the cycle test (a test in which the patient's body is stressed in order to see if the heart muscle suffers from lack of oxygen) for tomorrow. If it is ok you can go home ...' Pertti asked the Doctor if stress could have been the reason for his heart attack (he didn't articulate his marital problems as the cause of stress to the Doctor). The Doctor said that of course, it could be related, but there is no scientific evidence for it. 'But if you want to live for more than two years you should give up smoking.'»*

The main focus of the discussion was on medical knowledge of Pertti's body. Information not directly observable by the participants had been gathered during Pertti's hospitalisation. His bodily processes had been visualised by the use of technologies such as the stethoscope, the blood test, ECG, x-rays, etc. These techniques allowed a kind of dissection of his living body, dividing it into its component parts, exposing what life ordinarily conceals (Leder 1992, 22). In the above extract the flowing talk and action in the hospital had already been transformed into a fixed text, a medical record, in which Pertti's story was presented as detached, externalised and objectified. When the Doctor recounted and interpreted the medical facts and showed him the evidence (by drawing the circle on the ECG), he was connecting a process in Pertti's body to the body of universal biomedical knowledge. Although the signs gathered by technological means pointed to Pertti's body, their meaning seemed to come from an authoritative source, the universal involutional realm of scientific medicine interpreted by the Doctor. The medical text constructed Pertti's heart attack as an object, observable through signs, and decontextualised it from his mind and social characteristics.

It is not only the medical text or record that objectifies or structures a certain point of view on reality, but also how it is performed. As described earlier some crucial non-linguistic features like lying still in solitude, detaching the self and social aspects of the person from the problem all dra-

matically limit the number of standpoints outside the patient's immediate experience on which he could take action. For example, the simple manoeuvres of taking blood tests or x-rays convey the message that the patient cannot be in a dialogic relationship with the realm others control. These tests are taken by nurses who then take them to other people, who remain invisible, to be analysed. The results are then brought to the Doctor who decides what to do according to medical logic. This action takes time and is dispersed in different places while the objectified patient stays still. Objectification is powerful in its ability to define a complete image of reality in ritual contexts – that which is true – that outlives particular instances of its articulation, and which encompasses and subordinates other images (Kuipers 1990, 4-7). External "objective" knowledge obtained by tests and machines constitutes a defining source of "authoritative knowledge", the knowledge which counts, and which forms the basis for decisions made and actions taken (Biesele & Davis – Floyd 1996; Jordan 1997) and structures a view point on the experience. The body is being touched by medicine [(7)].

The other process, recontextualisation, aims to put the objectified experience back into the context of the self living in social relationships again by scrutinising the everyday life of the sufferer and restructuring his agency. In the above extract, the Doctor took up the possibility of Pertti's return to normal life again. He also tried, after having interpreted the medical facts, to encourage Pertti to change his habit of smoking (which was one of his ways of enjoying life). Pertti's own question about the effects of stress (although ignored by the Doctor) showed that he was actively rethinking his life from the point of view provided by the objectified heart problem. The process of recontextualisation is more explicit in the official nursing ideology of the hospital, which aims at "enabling the patient's growth as a human being". In a more mundane manner nurses speak of "lighting up a spark" in the patient so that he could actively cope with the situation. In the discussions (following the secondary prevention list) on role activities, family relationships, diet, sexual life, alcohol, smoking, keeping fit, etc., information based on epidemiological knowledge of risk factors is related, where possible, to the individual sufferer's particular life circumstances.

The process of recontextualisation differs from the objectification process in three respects. Firstly, it deals with the most mundane everyday activities, and not with abstract biomedical knowledge of one's own body. Knowledge of risk factors is based for the most part on community-level processes and thus has a different relation to the individual from biomedical knowledge, which refers directly to the sufferer's body. The patient has to

reorient himself to the most familiar habits of eating and being, as they now become strange and risky. Secondly, control over the situation is transferred from the medical staff back to the patient. Thirdly, spouses and other family members are encouraged to take part. As they are invited to discuss coping and lifestyle changes with the nurse and the patient, the "problem" is extended from the body of the sufferer to include his/her immediate social relationships.

The change from the biomedical focus on bodily processes to the risk factors in mundane activities could be understood as a sign of the plurality of biomedicine, of how biomedicine is not one but many. From the rite-of-passage point of view, it is not the paradigmatic change in medicine which is of interest, however, but moving the suffering body through the various spaces and relationships in the hospital in order to transform it. The ideal is that atherosclerosis in the artery vessel performed by medical interventions (Mol 1988) is integrated with activities in other spheres of life, like having a (healthy) lunch. To effect the transformation into cardiac status the cardiac ritual has to decontextualise and objectify the problem first, and then recontextualise the objectified realm into his life again. Through decontextualisation, a particular experience becomes universalised in terms of medical knowledge and practice and through recontextualisation, the universal becomes particularised again in the ritual context of the hospital. On the societal level, if cardiac care is viewed as a combination of medical and societal efforts to control CHD, these processes are crucial in «creating and re-creating the categories through which men perceive reality – the axioms underlying the structure of society and the laws of natural and moral orders» (Turner 1968, p. 7).

The reflections enabled by the rite for the individual differ in certain respects. The experience of pain and the way it becomes objectified creates reflections on one's body. The patient's physical passivity is often coupled with a sense of not being oneself. «*I'm on my knees* [8], *I can't tell you anything before I have the results of the test*», as a woman described her situation. Dependent on the use of technology and the word of the Doctor she could not rely on her own bodily knowledge. Many patients talked about the separation between mind and body: «*My mind is recovering but the body is lagging behind*» (or, quite peculiarly, vice versa, the mind is lagging a few steps behind). Biomedicine reshapes the body inside, leaving less room for individual will or choice. It is also experienced as the disappearance of pain, or more existentially as a rescue from death. The recontextualisation on the other hand emphasises the choices of the individual. Although information and practice are based on community-level rationale, the mystery of choice resides in the individual.

Rites of passage and liminality reconsidered

I have applied the concepts of the rite of passage and liminality to demonstrate the processes, which could transform the sufferer's experience during hospitalisation, relying on the metaphor of passage and journey, in which the ritual crossing of a threshold (AMI) means a qualitative change. The argument has been in line with Davis-Floyd's (1992) analysis of modern birth in the United States. Viewing the symbolic elements in the technological procedures of hospital delivery, she argued that these procedures inscribe the values and essential relationships between science, technology, patriarchy, and institutions into the bodies of the birthing women. Encoded in the obstetric procedures are messages that make it explicit that women's bodies are like machines, inherently defective, and should be controlled by technological means. In a similar vein it could be argued that the symbolic elements of medical procedures of the cardiac rite of passage inscribe the cultural messages of a technocratic model of reality and embed it into the everyday lives of the sufferers. The vulnerable body of the sufferer is controllable and transformable by technological means. However, there are some limits in drawing an analogy between birth and AMI on the one hand and analysing the treatment of AMI as a rite of passage on the other.

Quoting Turner, Davis-Floyd (*ibid*.) bases her argument on the transformative power of hospitalisation (as a rite of passage) claiming that «the passivity of neophytes to their instructors, their malleability, which is increased by submission to ordeal, their reduction to a uniform condition, are signs of the process whereby they are ground down to be fashioned anew and endowed with additional powers to cope with their new station in life ... Knowledge, or 'gnosis', obtained in the liminal period is felt to change the inmost nature of the neophyte, impressing him, as a seal impresses wax, with the characteristics of his new state. It is not a mere acquisition of knowledge, but a change in being.» (Turner 1979, 238-239.) However, applied to modern hospital contexts, the metaphor of the ritual subject as "mouldable wax" (Turner 1979) exaggerates the ability to convey messages and bring about transformation by the rite of cardiac care. Although "the touch of medicine" impresses the body and changes it, health care officials are acutely aware of how difficult it is to convey information to patients, not to mention changing their being[(9)].The insight the concept of liminality offers in relation to the cardiac rite of passage is not how the rite transforms the experience in a more or less direct manner, but how the rite posits different standpoints and reflections on the experience. Still relying on Turner, liminality in modern contexts emphasises potentiality

and reflection. Liminality is still a phase «in which previous orderings of thought and behaviour are subject to criticism and revision, when hitherto unprecedented modes of ordering relations between ideas and people become possible and desirable» (1978, p. 2). Its power of reflection resides in placing the liminal subjects outside the binding commitments of everyday life. In traditional societies (the concept originated from the study of traditional societies), new modes of thought were presented by showing sacred objects and teaching secret knowledge to the liminal subjects. In modern contexts like a cardiac rite of passage, the 'sacra' revealed to the patients is not secret or sacred in the same way, since all of us are familiar (at least to some extent) with medical technology and knowledge. It has been presented to the patients in a different context, in the office of the general practitioner, TV, newspapers, etc., many times before they enter the cardiac rite of passage. The effect of hospital liminality resides in «cleansing the doors of perception» or «the innocence of the eye» (Turner 1978, p. 11). In the cardiac rite of passage the patients see and reflect on their bodies and everyday lives from a different point of view as the familiar knowledge and practices come to apply to their own bodies and lives.

Apart from the view of the transformation of the liminal subject, applying the notion of the rite of passage in the modern context of a developed division of labour brings up the question of how the subject moves to a new status. By structure Turner means «patterned arrangements of role sets, status sets, and status sets and status sequences consciously recognised and regularly operative in a given society and closely bound up with legal and political norms and sanction» (Turner 1978, 252). Rites of passage are often associated with transitional phases in the human life course, potentially filled with danger. Rites move a person from one status or role to another in the social structure; a child turns into an adult, a childless woman into a mother, a single person into a husband or wife, etc., in a culturally negotiated and controlled way (Grimes 2000). By drawing the analogy with birth further, one can ask in what sense the cardiac rite moves the sufferer into a new status like a woman into a mother. Just as AMI (or any illness) is not directly related to a phase in one's life course, the movement of status depends on the other statuses the sufferer has. All the patients I have introduced have been moved from being healthy (or not having a heart condition) to cardiac patients who are entitled to be taken of care of and to get compensation for medication. Apart from this, their status was recognised differently by the society in relation to their age. Having years of full working capacity ahead, Antti was offered the opportunity to take part in a rehabilitation course. Pertti was retired, so he did not need one; neither

did the old lady in the CCU, who would probably have been moved to a institution for the chronically ill if she hadn't died because she was not able to take care of herself anymore. Although focusing on people with a heart problem, there is no clear-cut status into which the rite moves people. The meaning of movement between categories, medical case/social being, healthy/ill, living/dead or having a heart problem/not having a heart problem taking place also depends on one's age and place in society. Antti was taken by surprise when he had his first symptoms:

> «*I was in pain. I sat in the kitchen. My wife said that it's a heart attack. We both laughed. Then she read the description of a heart attack from the medical book. Theoretically, it could be, but on the other hand, it can't… It couldn't be me.*»

It couldn't be him because AMI is something that the old or people living unhealthy lives have. For the older, AMI is more often something characteristic of their age.

The meaning of AMI and its treatment raises the third point to be considered here: how does the description of the structure of the cardiac rite relate to the accounts given by the participants? Viewed from above, the meaning of the cardiac ritual is analysed in terms of what it should do. It often fails to achieve its aims, since the sufferers will not get better, they will not change their behaviour, or they will die. It is not the outcome of the ritual, however, which is of interest here, but how the accounts given by the patients relate to the structure of the cardiac rite and the processes of liminality. In some respects, the accounts of the patients resemble the ethos of the ritual as they speak of «*life coming to a halt*», of the need to change one's way of being: «*I have to slow down and start to think more about myself instead of others.*» Even the echoes of the liminal subject as malleable wax could be heard in the descriptions of vulnerability. Descriptions given by spouses and patients themselves have a similar flavour:

> «*I went to see my husband in the cardiac care unit and felt like I was disturbing him. His eyes were hazy and he seemed to be up to something else.*»

The husband himself described his state later by saying, «*I was not myself then. I could talk all right, but I wasn't there.*» Many patients speak of how they «*got a second chance*» and in the biographical context of having an AMI and going through the treatment have the potential to create a "before" and "after" that differ markedly from each other, as has been well documented in studies of illness narratives using the concept of biographical disruption (Bury 1982; Grimes 2000).

However, a closer look at the various accounts given during hospitalisation shows that thresholds and liminalities can be experienced in different

phases. Antti felt that he was in danger during the days before he went to hospital (pp. 8-9). Initially he was not transformed into a medical case by the general practitioner and he tried to go on with his life in spite of his pain. His being at the threshold ended when he was picked out of the queue, «where there were drunkards and everything», taken to the emergency room and given a diagnosis. «*I was so relieved when I saw the text on the ECG: first grade block. At least now they've got something to work on*», his wife explained. For other patients, the transfer from one unit to another is a kind of threshold. Moving from intensive technological monitoring in the CCU to the medical ward may be especially frightening.

> «*The woman in the CCU called us to her bed. She took the nurse by the hand and told her that she is afraid of being moved to the medical ward tomorrow. 'Will they take good care of me?' she asked us. She also made us promise that we would come to see her tomorrow in any case.*»

Another obvious threshold is associated with leaving the hospital. Both patients and their spouses describe how they feel uncertain about themselves. Can they do the right things, like interpreting the symptoms correctly? How much can or should one do during the following months? In what direction is life taking us? So on.

Reconsidering the way in which the cardiac rite moves from one status to another and transforms the malleable ritual subject by the work of liminality, as well as the differences in accounts suggests that as such the concepts of rite of passage and liminality are too general to grasp what is taking place in the treatment of myocardial infarction in a modern hospital. There are three points at which the analyses of hospitalisation as a rite of passage can be complemented by taking a look at the hospital as a modern institution with a specific ceremonial order. These points are the extent to which the liminal subject is being transformed, enabling reflection on the workings of the health care system and one's relationship toward it, and understanding the differences between points of liminality in the structural account and the passage accounts given by the patients.

A ceremonial order perspective

Viewed as an institution, the world of social interaction in a medical encounter can be portrayed as a relatively autonomous realm, structured by rules, rituals and expectations. Inherent in the institutional structures of health care are pre-defined role-identities and the distribution of knowledge that goes with them (Lauritzen & Sachs 1994). Thus, the social ritual

in the hospital is based on complex social rules and tacit collaboration between the parties, the fairly stereotyped roles of the medical staff and the patient. The rules involve taken-for-granted rules of relevance and irrelevance and face-saving strategies applied by both parties in the encounter. Each encounter can be seen as a "separate little society" with its own tacit *ceremonial order*, special vocabulary, actions, circumstances, etc. (Strong 1994, pp. 25-37). The rhetorical etiquette, although rarely seen, imposes a grid on everything that is said (or done) during the encounter. In the games of health care encounters, all the players are suited to and know their parts.

Consider the interaction between Pertti and the Doctor (page 11). The encounter followed the expected structure of a Doctor-patient interaction as the Doctor controlled the interaction and flow of information by sticking to medical and scientific facts. Both Pertti and the Doctor played their parts according to expectations (see Parsons 1999). The Doctor had the technical and scientific authority and he passed over Pertti's hint about stress as a cause of his problems as unscientific. He did not want to tackle Pertti's hint any further, as it was something beyond his realm of expertise and irrelevant to the present concern to cure the heart muscle. On the other hand, Pertti saved face by concealing his marital problems behind the concept of stress. (He did discuss his marital problems with the nurse on a different occasion, however.) Both the Doctor and the patient himself portrayed Pertti as a good exerciser with the only exception of «*having a couple of cigars now and then.*»

Following Phil Strong (1994), this piece of interaction could be described as a bureaucratic form of ceremonial order [(10)] in which the medical staff as a collective is granted massive but anonymous medical expertise. In the bureaucratic form of ceremonial order, the patient is typically passive and granted little overt technical authority. The moral work in this kind of ceremonial order invokes an idealised world in which the patient is a free human being, responsible for his actions. Pertti granted technical authority to the Doctor and trusted the medical interpretation and treatment of his condition: after all, he had been given "a second chance" by its success. He accepted the view offered by the Doctor that he is responsible for his future actions. Pertti also explicitly expressed his morality as a reasonable man by showing his willingness to adhere to the doctor's advice on giving up smoking.

Firstly, in relation to the rite of passage perspective, the emphasis here is thus more on maintaining the status quo than on transforming a liminal subject (Turner 1992), as the game of the encounter depends on some

prior legislation or social rules with emphasis on sustaining these rules. Instead of describing Pertti's transformation as he is being moved through the different wards, the image of a patient engaging in face-saving strategies in a bureaucratic form of ceremonial order is being portrayed. By adhering to the rules and roles of the given ceremonial order and managing his expressions about himself, Pertti ceased to be a «*tabula rasa*» (Morris 1986, p. 255) on which the ritual messages could be inscribed. Liminality as anti-structure is filled with roles and statuses, not outside them.

Having said that, I have to add that to portray the image of patients engaging in a series of ceremonial orders during hospitalisation, with no overt intention to transform them, is also a simplification. In this regard, the doctor's warning that Pertti would die in two years if he did not stop smoking is revealing. According to the etiquette of the hospital, he was being too strict and normative since one should not make exact prognoses nor coerce or threaten the patients. The grid of the ceremonial etiquette, although providing the medical staff with medical and technological authority, also imposes limits on how to transform patients viewed as free agents who decide for them. The staff often felt frustrated because of their inadequate means of effecting changes in the habits of the patients:

> «*They'll promise anything here, but as soon as they get home they get back to the same old ways of doing things… After all it is up them*» (a nurse in the medical ward).

The remark made by the Doctor intertwined the transformative ethos and the grid of the ceremonial order. The ceremonial order provided him with the power to comment on Pertti's smoking, but by breaking the order with a threat, he tried to overcome the limits that the grid imposes on moulding the life of the patient.

Secondly, the theme of one's relationship with the health care system or the state was also present in the story of Pertti and his smoking. By pointing out a defect in Pertti's behaviour, the Doctor made a moral claim about Pertti's own part in his heart attack. Although the heart attack as a physiological process was something he could not handle by himself, he was at least partly responsible for its occurrence. The moral was that the doctors and society would cure him but he, as an independent person, should play his own part by avoiding risk. The moral claims made by the health-care system are closely related to and overlap with the reflections on one's everyday life already described, the difference being that while the latter is embedded in everyday contexts, the focus of the former is on the relationship between the sufferer and the "system". Paradoxically for Pertti, the doctor's advice signalled that the staff were concerned and did their job well instead of being mere advocates of a cold and distant bureaucratic

system. I believe that Pertti's observation that «*the staff here are a different race (considering and caring)*» gave him the moral strength to play his part in controlling the situation well.

Antti (see p. 8-9) provides a different example of reflection. He too adhered to the ceremonial order of the hospital, reached a working consensus with the staff, and engaged in the overt function of curing the sick, the disciplined and routinised activity of the hospital, by playing the roles the institution offered him. However, he felt that some degree of categorisation was being imposed on him and tried to avoid it.

> «Antti was invited to the physiotherapist's room to learn about exercise. An older woman with a walking frame and a retired man accompanied him. First, they were shown a video on physical rehabilitation. All three made remarks on the main character on the video, a young and healthy-looking man to whom everything from moving around to changing his lifestyle seemed to be easy. The physiotherapist, a young, fresh-looking woman, continued by asking questions about their lives and giving advice on exercise. Apart from answering the questions, Antti kept quiet for the most part, while the other man made jokes about going on as usual, having barbecues and drinking cognac from a pint glass. The therapist also handed out a paper with contact information on the local society for heart patients. The older woman was overtly grateful, but both men refused to take the paper as they didn't need it … Later Antti told me that they (the staff) take advantage of the position of the patient by offering material when the patients are vulnerable and least able to resist. In contrast to the older lady, who seemed desperate to grasp any information, Antti was strong enough to say no.»

While Pertti was willing to adopt the idea of restructuring his life in relation to his heart problem, Antti actively resisted the pure imprint of paradigmatic structure:

> «*They were imposing the identity of a cardiac patient on me. I don't get it. How would a heart attack make me similar to other people who've had them? This can't provide a basis for interaction with other people.*» (11)

He refused to take part in a rehabilitation course offered to him. Although adhering to the etiquette, putting the technical authority into the hands of the medical staff, listening to what they had to say, and feeling that he was taken good care of, he was able to maintain a distance from the messages communicated to him, especially the imposition of a cardiac identity. He did not accept the moral claims on his life and personality made by the staff. On one occasion, when Antti expressed his willingness to have an Angiography in order to have a more exact diagnosis, this overt working consensus was broken.

> «Antti was ready to go home. The Doctor came to give him the prescriptions for medication. She said that there were no signs of ischaemia in the exercise

> test. 'Later (after 3 months) you'll have to come here for an x-ray, an ECG, in the lab, and to see me.' Antti replied that he was going to have an Angiography in three weeks' time. The Doctor was taken by surprise: 'Why? Because of the symptoms on the 3rd of May?' Antti explained that he had made an appointment with a private clinic. 'But there are no signs of ischaemia', the Doctor replied (a little irritated). 'But you can't be absolutely sure on the basis of the exercise test, can you?' Antti asked. 'No you can't', the Doctor admits, 'but there is no point in doing an invasive examination, it is risky'. 'I want to optimise, I want to know in case of another attack', Antti made his point. They went on discussing the possibility and impossibility of being prepared for another heart attack by technological means. The Doctor concluded by saying that it was up to Antti to choose to have an Angiography, but it could not be financed by the state.»

At one level, the disagreement was about the adequate level of technical visualisation and control over his body. Antti wanted a more technical approach instead of rehabilitation *«emphasising psychological and lifestyle adjustments»*. Using concepts introduced earlier, the focus was on objectifying his problem further. At another level, the role of society was brought into focus. When talking to the anthropologists, Antti was not critical of the physiotherapist or the Doctor he had engaged with, but criticised the welfare system as a whole for spending money on rehabilitation "nonsense" and not enough on technological care. Here too the responsibilities of the state to take care of the sick were discussed. The choices of the Doctor, who had to follow the standards of the cardiac chain of care, were restricted and Antti's criticism placed both the medical staff and himself in the same situation, within the grid of the system.

Thirdly, the ceremonial order bridges the discrepancy between the structural description of the treatment of AMI as a rite of passage and the accounts of passage given by the patients. As stated earlier, patients often experience thresholds while they are being transferred from one ward to another, or on entering or leaving the hospital. Antti felt he was safe when he was finally admitted to the emergency unit and was diagnosed. While he gave up his agency, he felt comfortable surrounded by the technology and following the hospital routines. The routines developed in the hospital, the formal and conventional actions, brief rituals between persons, have a Janus face: on one hand they are just strategies which enable a working consensus while on the other the etiquette of interaction is embedded with morality and sacredness (Heiskala 2000). Although frightened of his state, Antti's anxiety was at least partly relieved by the technological routines taking place in the emergency unit, which reassured him that actions were being taken to cure him. Experiencing transfers from one unit to another as thresholds suggests that hospital liminality consist

of islands of order. The rules and aims of each unit or ward transform the unit's raw material everyday life into distinct, ordered and meaningful occasions (Strong 1994, p. 23).

The cases of Antti and Pertti illuminate how the general view on transformation intertwines with a more static ethos of the institutionalised encounters. By knowing how to actively play their part in the institutional games, they maintained the status quo of the hospital. At the same time, however, the hospitalisation transformed their way of perceiving their situation. The treatment marked their lives differently as Pertti was ready to follow the logic of recontextualisation while Antti wanted to follow the path of decontextualisation. Thus, the work of liminality resulted in two different ways of reflecting on the situation rather then reshaping the malleable subjects in a straightforward manner. The way they accepted or rejected the moral claims made by the staff suggests this too.

Concluding remarks

Stemming from different conceptual frameworks, the use of the concepts of the rite of passage, liminality, and ceremonial highlight different aspects of the treatment of acute myocardial infarction in a modern Finnish public hospital. On the one hand, the rite of passage and liminality emphasise the transformative quality of the patient's journey through the wards of the hospital. The notion of a ritual passage has the advantage of examining the structure of treatment as a way to move individuals to a new social category. The ritual passage aims to transform the sufferer and the destiny of his body by technical means as well as by creating an awareness of his own responsibility. The same themes taking place in the treatment of individual sufferers are present in the combat against CHD at the societal level. The cardiac chain of care as a whole aims to transform the nation into a healthier one by reducing the incidence of CHD by technological means as well as by creating citizens responsible for their own well-being by educational means.

On the other hand, the ceremonial order perspective stresses the importance of predefined roles and sustaining the status quo in the face-to-face institutional encounters. A bureaucratic organisation aims to sustain its own logic of conduct rather than to transform the ritual subjects. The ceremonial order perspective complements the generality of the passage point of view by filling the anti-structure of liminality with the rules and morals of the institutional etiquette. Rituals can fail in their didactic and socialis-

ing purposes as some patients can maintain a distance between themselves and the ritual model.

The transformative and ceremonial aspects intertwine in the reality of cardiac care, complementing each other's weaknesses. The ritual passage notion shows how the routines and rules of the ceremonial order become meaningful and moral. The encounters, with their various diagnostic, curative, and informative tasks in different phases of hospitalisation, together form a passage through which the patient "flows". Even one encounter may have elements of sustaining the ceremonial order as well as transformation at the same time. However, the passage consists of distinct, ordered and meaningful occasions rather than an unstructured state during which the essential messages, technological control and responsibility for one's health are inscribed directly into the bodies and lives of the ritual subjects. It is useful to look at the different kinds of reflections the ritual passage and the ceremonial order evoke in the individual in order to get a fuller picture of how the experience is constructed and transformed during hospitalisation. The reflections on the body, lifestyle, and morals in the context of the system acquire a different weight in each sufferer's idiosynchcronic account of AMI and its treatment.

Notes

(1) The topic of my research is men's and women's experiences of coronary heart disease. The main aim of the study is to see how different meanings are bestowed on CHD in Finnish contexts. Special emphasis is put on how the lived experience of suffering is decontextualised and objectified by local biomedicine, and how the objectified problem becomes recontextualised again into everyday contexts, where the competing demands of the society and the body are met. Data presented here is based on my fieldwork in a local hospital in southern Finland from 1.10.1999 to 31.5.2000. For six months I did participant observation as a nurse's apprentice in the emergency unit, cardiac care unit and the medical ward. I have interviewed patients and medical staff in the hospital (n = 30). I have also taken part in the activities of a local group for cardiac patients and interviewed sufferers in their homes.

(2) Medically, coronary heart disease means a lack of oxygen in the heart muscle due to atherosclerosis. The main symptom is severe pain in the chest. If one or more of the vessels get blocked (acute myocardial infarction), part of the heart muscle is damaged. The main risk factors in developing symptomatic atheroscleoris are high blood pressure, smoking, fatty food and lack of exercise.

(3) 13,000 deaths in 1997. Morbity and mortality from CHD reached its peak in the 1960s (being the highest in Europe) after which there has been a 50% decline in mortality (from age-standardized mortality of 500 among middle-aged men to 200 in 1992) due to advances in reducing the known risk factors and improving the treatment of symptomic CHD. In spite of decreases in morbidity and mortality, the number of people suffering from CHD is still increasing as the population gets older.

(4) As in other Nordic countries, the Finnish welfare legislation quaranteed equal care for every citizen according to the idea of universalism. The welfare system is based on government budgets.

In the 1990s cuts in the health care expenditure (10 percent in real terms in the early years of 1990s. In 1999 Finland's total health care expenditure equalled 6.7 percent of GDP) were introduced, resulting in a public discussion about prioritising conditions under public responsibility as well as an emphasis on individual's responsibilities.

(5) This choice of focus has its advances and limitations. In the hospital the technical control, health education, as well as the sufferer's relationship to the health care system are taken to an extreme. The power of medicine to save lives as well the theme of using power in everyday life are both present here. I will also focus on people having their first heart attacks in order to emphasise the possible transformations taking place. The bias toward acute cases closes off aspects of the cardiac chain of care such as general practice, as well as those sufferers whose condition has become chronic.

(6) Kohn (2000) outlines a similar process of universalising and personalising in the medical management of children with facial disfigurements by using the concept of therapeutic emplotment (Mattingly 1994).

(7) Alan Radley's (1996) concept of 'non-experience' suggests the paradoxical effect of bypass surgery which has the power to bring together the patient's body, self and biography, although in the operation itself he/she is actually unconscious. Here passivity and leaving a pure imprint or mark of medicine's paradigmatic structure on the lives and bodies of the sufferer is taken to its extreme.

(8) "Olen rähmälläni" in Finnish.

(9) Davis-Floyd notes that the ability to transmit the technocratic message or mark the body by biomedicine also depends on the prior views and attitudes the liminal patients have. Mothers with positive views on medicine accepted the technological birth more readily than mothers with negative experiences of medicine.

(10) According to Phil Strong (1994) the ceremonial order (or the role expectations) of the clinic has two key variables: the amount and type of technical authority claimed by the participants, and the overt types of moral work that actors are engaged in with respect to other participants. The bureaucratic form of ceremonial order differs from aristocratic, private and charity forms of etiquette, each of which has its own division of technical and moral labour.

(11) Antti maintained a distance from other patients as well. "The three men in my room were telling their stories over and over again. I didn't see the point of telling mine." Other patients have reported how the atmosphere between the patients is exceecptional, "as if the threat of death united us somehow."

References

Biesele, M. and R. Davis-Floyd (1996) "Dying as Medical Performance: The Oncologist as Charon". In Laderman, C. and M. Roseman (eds.) *The Performance of Healing*. Routledge: New York, p. 291-322.

Bury, M. (1982) "Chronic Illness as a Biographical Disruption". *Sociology of Health & Illness,* vol. 4, p. 167-182.

Davis-Floyd, R. E. (1992) *Birth as an American Rite of Passage*. Berkeley: University of California Press.

Dodier, N. and A. Camus (1998) "Openness and Specialisation: Dealing with Patients in a Hospital Emergency Service". *Sociology of Health & Illness*, vol. 20, p. 413-444.

Gennep, A. van (1960, 1909) *Rites of Passage.* Chicago: University of Chicago Press.

Grimes, R. L. (2000) *Deeply into the Bone. Re-inventing Rites of Passage.* Los Angeles: University of California Press.

Heiskala, R. (2000) *Toiminta, tapa ja rakenne. Konstruktionistista synteesiä yhteiskuntateoriassa.* Helsinki: Gaudeamus.

Jordan, B. (1997) "Authoritative Knowledge and Its Construction". In Davis-Floyd, R. E. and C. F. Sargent (eds.) *Childbirth and Authoritative Knowledge. Cross-Cultural Perspectives*. Los Angeles: University of California Press.

Kohn, A. A. (2000) " 'Imperfect Angels': Narrative 'Emplotment' in the Medical Management of Children with Craniofacial Anomalies". *Medical Anthropology Quarterly,* vol. 14, num. 2, p. 202-223.

Kuipers, J. C. (1990) *Power in Performance. The Creation of Textual Authority in Weyewa Ritual Speech*. Philadephia: University of Pennsylvania Press.

Lauritzen, S. O. and L. Sachs (eds.) (1994) *Health Care Encounters and Culture. Interdisciplinary Perspectives*. Botkyrka: Multicultural Center.

Leder, D. (1992) "A Tale of Two Bodies: The Cartesian corpse and the Lived Body". In Leder, D. (ed.) *The Body in Medical Thought and Practice*. New York: Kluwer Academic Publishers, p. 17-35.

Mol, A. (1988) "Missing Links: the Performance of Some Atherosclerоses". In Berg, M. and A. Mol (eds.) *Differences in Medicine. Unraveling Practices, Techniques, and Bodies*. Durham: Duke University Press.

Morris, B. (1987) *Anthropological Studies of Religion. An Introductory Text*. Cambridge: Cambridge University Press.

Parsons, Talcott (1999, 1951) "Illness and the Role of the Physician: a Sociological Perspective". In Turner, B. (ed.) *Talcott Parsons Reader*. Oxford: Blackwell, p. 101-108.

Radley, A. (1996) "The critical moment: time, information and medical expertise in the experience of patients receiving coronary bypass surgery". In Williams, S. J. and M. Calnan (eds.) *Modern medicine – lay perspectives and experiences*. London: University College London, p. 118-138.

Siltanen, P. (1990) "Lääketieteellinen kehitys sydänsairauksien alalla". In Teerijoki, Ilkka (ed.) *Suomen sydäntautiliitto – 35 vuotta sydämen asialla*. Kokkola: Suomen sydäntautiliitto, p.112-114.

Strong, P. (1994) "Two Types of Ceremonial Order". In Lauritzen, S. O. and L. Sachs (eds.) *Health Care Encounters and Culture*. Botkyrka: Multicultural Centre, p. 21-52.

Teerijoki, Ilkka (ed.) (1990) *Suomen sydäntautiliitto –35 vuotta sydämen asialla.* Kokkola: Suomen sydäntautiliitto.

Turner, V. (1968) *The Drums of Affliction. A Study of Religious Processes among the Ndembu of Zambia*. Oxford: Clarendon Press.

Turner, V. (1977) "Variations on a Theme of Liminality". In Moore, S. and B. Myerhoff (eds.) *Secular Ritual*. Amsterdam: Van Gorcum.

Turner, V. (1979) "Betwixt and Between: The Liminal Period in Rites de Passage". In Lessa and Vogt (eds.) *Reader in Comparative Religion*. New York: Harper and Row.

Turner, V. (1992) *The Anthropology of Performance*. New York: PAJ Publications.

Turner, V. and E. Turner (1978) *Image and Pilgrimage in Christian Culture. Anthropological Perspectives*. New York: Columbia University Press.