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The Nurse and the Rural World

A Successful Relation for Biomedicine

"I didn't know who helped us, maybe God!"

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Biomedicine has been thriving in Romania since the middle of the 20th century. What was it that made this possible? That was the question underlying the argumentation in the present article. As the title suggests, this article aims at outlining the very fine connections between a special category of personnel within the biomedical system and the beneficiaries of this system, the patients, in a particular place—the Transylvanian rural area. In other words, we shall talk about the relation between the people living in the rural area in Cluj County, Transylvania, and the biomedical system—with reference to the special category of medium level personnel, the nurse. The biomedical system had been imposed on them before the beginning of the communist regime in Romania, but definitely not at such a large scale.

In a few previous articles[1] I was concerned mostly with the negative side, or indeed with what might be called the issues that generated a rejection of biomedicine by the people living in rural areas. It had not been my

purpose to seek the negative, this just came out from the interviews I had with the villagers. In order to restore the balance, but mainly because it was hard to believe that the negative image is the only one possible, in this article I became more interested in bringing arguments favoring the positive[2] side of the relation between biomedicine and the rural areas.

My entire argumentation was based on the interviews with with people living in eight villages of Cluj County, conducted in 2009, 2010, and 2014, and it was intended as a qualitative research, assuming that if key members of a community spoke of holding to certain beliefs and practices, many others would act similarly. The villages chosen were at variable distances from the city of Cluj-Napoca, a major biomedical center—with plenty of clinics, private or government-funded, and a prestigious medical university. Accordingly, some villages were peri-urban to Cluj-Napoca, some at the farthest distance from Cluj (on the fringes of the county), and others were villages at a median distance between the two categories. This item—distance—has proved irrelevant for our research because, surprisingly, it has not brought differences regarding the acceptance or rejection of biomedicine. People living in the most remote parts of the county, that is, very far from Cluj-Napoca, have presented the same perception of biomedicine as the people living in the villages next to the city. The distance was calculated according to the administrative limits of the county, and thus the farthest village would be at approximately 60 km from Cluj-Napoca, and the nearest at about 12 km. We interviewed people of different ages—the youngest born in 1975, the oldest born in 1922—about their illness and healing experiences over an extended period of time: from 1948 till the present day. A part of this research was financially supported through a grant,[3] the rest was done in the framework of the institution where I currently hold a position as a researcher.[4] This item of age has also failed to present differences at a general level, but some of these can still be noted in some extraordinary cases. We interviewed people of both sexes, without factoring in how a woman's perception of biomedicine and her relation to it would be different than those of a man. This remains to be investigated in a new project. Summing up, the people living in the studied rural area had a strong tendency to perceive and relate to the biomedical system in a similar way, regardless of the physical distance to a biomedical center or the age of the people having health troubles.

The core of this article consists of the local[5] situation of a particular space and timeframe. Still, we could find similarities for some of the biomedical policies discussed in this article, and I would mention here Samuel Ramer's article referring to the same program of schooling the nurses in Russia, long before a similar program was implemented in Romania.[6] The main focus of my article remains, as initially intended, the possibility to bring forward a particular way of

life, in a particular space and a particular timeframe, with *powerful* social implications. Accordingly, we acquired a certain *local* knowledge that mattered, and performed an in-depth analysis of an important topic regarding the relation of a citizen with the state, in the light of one aspect that in recent years has become one of the most important fields of debate: *human health*. In this context, it is also definitely important that in Romania, according to the Census of 2012,[7] still only 54% of the population lives in urban areas, giving the rural population important weight in the overall picture. Thus, the (bio) medical practices, used by almost half the population of the country, become even more important.

Village life suffered a great deal of changes during the period chosen for study and mentioned above. Two of these changes have had major effects upon the general life of the population, and in particular upon the relation with biomedicine: the first was the advent of communism, and the second was the fall of communism, both bringing significant macro-level changes. Were those changes affecting the micro-level and, if they did, what would that process look like? Did a new system replace the old one for good? According to the communist statistics, the answer would undoubtedly be a definite "yes." Going into details, the answer might be a little more ambiguous, even though the great success of communism in Romania was incontestable. Still, shifting our interest towards the individual level, the truth was that people did not change overnight, and regardless of the restrictions applied they still kept some knowledge, habits, and emotions, preserving *oases* of specific ways of life inside the system, but away from its vigilant eye. I would place the medical and healing beliefs in this category. The new humanist literature on that topic has a name for it: *resistance* (to the communist system), from the armed resistance of the groups in the mountains to the largely publicized phenomenon of abortion. As to the past twenty years, after the fall of communism, the reality has shown some similarities with the one sixty years ago, also developing a pattern of resistance: resistance against capitalism.

According to the interviews, about more than fifty years ago and even more recently, the rural area was a success story without physicians or biomedicine, relying only on its *old* medical systems based on religion and nature. Even though the first healthcare law was passed in 1874, setting in motion the organization of the healthcare system Romania, it looked like communism was the one that made the rural world *swallow* biomedicine, willingly or not. In its battle with the 'retrograde' mentality of the peasantry, the medical system was entirely organized on biomedical principles and firmly imposed on the population. Biomedicine thus became the authoritative knowledge[8] in all that referred to health and healing practices, and also the *only* medical knowledge accepted in Romania (by the state), all other types of knowledge in the field of healing being

dismissed. Due to the long distance between theory and practice, the implementation of the biomedical system took years and proved to be a far greater task for the fragile emerging regime: too many things to do in too little time. Similarly to the general situation, the medical system had its ups and downs throughout the second half of the 20th century. For the people interviewed, in retrospect the communist biomedical system seemed much better than the present one. Twenty years ago, it fell apart just when it was finally starting to get some trust from the people. Recently, the biomedical system has become just one facet on the medical market, facing massive competition from all sorts of medicines and practitioners. The hegemonic place it held before 1989 has faded away, leaving behind a vulnerable and nostalgic rural population. Population ageing has been a general trend in Europe and Romania is no exception, but that phenomenon has been more acute in the rural area, due to demographic factors like the very low birthrates or the migration towards urban areas and other countries. With few exceptions most of the villages under study had an aged population. In the overall picture, these were still the fortunate cases, since most of them were retired people[9] living off a pension, and medicines or consultations were offered for free. Their social position kept them as clients for biomedicine. The most vulnerable segment was that of the young people in the villages, because they did not have a steady revenue and therefore no social or medical insurance of any kind. At the same time, they could not afford constant private medical care. Somehow they ended up in-between the measures intended to reform the biomedical system. Biomedicine was still reaching them at a theoretical level, through mass media, family members or acquaintances. That system of social connections has always functioned, only the agents have changed: before communism they used to go to priests, chanting women, monks, witches etc., during communism they moved towards medical representatives: clinics, physicians, nurses. Nowadays they resort to a diversity of systems, like a Babel tower of healing practices. Medical pluralism[10] has reached a significant peak in both urban and rural areas. Biomedicine has continued to be in the center of general attention, both public and official (state policies), in all that concerns healing measures and techniques, but the pre-modern healing has turned into a post-modern one, catching up fast and competing heavily against biomedicine. This fact also brought a slight change in the way biomedicine and its representatives treat the patients. If during communism the authority of the state also encompassed the authority of biomedicine, *outlawing* other types of medical knowledge—and so the authority of the physician undoubtedly shaped an unequal healer-patient relation—presently the patient has become a *client* and is therefore more empowered in the healing decisions than before. That change has still not been fully understood by the rural people. Some continued to believe in the biomedical power until that

was proven wrong. Having spent most of their mature life under the communist regime, the biomedical system became more familiar to them. That situation also brought a certain vulnerability for those aged rural people who could not question or had limited knowledge to question the biomedical system and its representatives. The situation in the field revealed a whole range of attitudes, from total rejection to the full acceptance of biomedicine.

For most of the communist period, the rural areas were more or less *covered* by modern medical institutions. Some of them were inherited from the previous period—going back to 1912. The first major re-organization of the medical system during communism took place in 1948, and it had considerable impact, involving the *nationalization* of facilities and the transition from private to state funding. The second re-organization took place in 1974—curiously[11] for me, in the same year when the UK also re-organized its medical system—but with a less significant public impact than the one in 1948, probably due to the fact that the communist regime was in a period of stability. One interviewed nurse talked about a state project in the 1950s and 1960s—a successful one—to train people from the villages for medical positions and then send them to work in their native villages.[12] Still, this effort was not enough, as trust took a longer period to build up. People did not trust institutions, they trusted other people, and they did not trust people generically, they trusted people they *knew*. The intuition of some party leaders (or just some directions sent from the USSR)[13] was correct, when they thought of a way to educate villagers into biomedicine, as a successful method for implementing modern medicine in the rural areas. Using community members in spreading and using medical knowledge was not without its troubles, but in the end it yielded good results, as one female nurse remembered:

I lived here, here I… It is my first job and the… last one.
But how did you get…?
You know how it was? In… 1965, they… selected some youths from the village, whom they knew for sure would come back here, to do… actually we went to school with a contract. We graduated the vocational school in the city…
[It was] The nursing school…
Nursing and… after graduation I had a contract with the hospital that sent us to the villages where we were from. I wasn't, we were… we were two from here. One of us was sent as a midwife and the other as a nurse. The other left after five years, after she…
The contract was for five years?
It [So] was the contract. And I remained here, I got married, I had my family, and I remained here. Well, she left. When we came here, in 1967, when I graduated,

> *the dispensary had moved to the new premises, this was pretty new… I don't recall what year exactly… I don't know, it was in 1961 when it was ready. You see, the old dispensary was there and the flood took it. Before that, there was a bridge, and there was a house, a house where the dispensary was, and a flood came and took it. It wasn't exactly by the water but there was a flood and… There is a new building now on that lawn. We remained here… in charge. There were one physician, one nurse, not a nurse, a disinfector… (that's what he was called), a nurse for obstetrics and gynecology; everyone did pediatrics because this was the way in those times. Then came a period, another system, probably at that time the new, younger physicians graduated, and they were compelled to do one year of internship in the countryside. Well, there was a period when there were five physicians here… five. Yes: there were dentists, pediatricians, two GPs.*
> (Nurse, born in 1947)

The nurse above was trying to convince us that she and her colleague (who eventually left) were part of the *change* of the system back then. Metaphorically, in her discourse nature came to *wash away* the old knowledge, flooding the old hospital in her village. From then on the stage was set for building a new society, new knowledge.

When talking to the nurses that held such positions in the villages (as in the case above), we acquired a very dynamic picture of their duties: they were always running from one patient to another, establishing connections, helping with births, vaccinating the children etc., but most of all, *spreading* knowledge and *convincing* the members of the village community that biomedicine was the best way of healing, that its purpose was always good and that there was no room for mistakes. They were true followers of what they had been taught in school, and they were part of something 'big', greater than what they had previously known. But there was also a very important psychological component: everything was *new*—new regime, new jobs, new premises… They had the deep conviction that they were *building* a society. And so it was! The nurse above also referred to a second program, in the years of stability for the regime, when indeed young physicians were sent to the villages as interns. The program was less successful since physicians were usually sent to places far from their own families or native towns, and more importantly very far from their expectations regarding their future professional life.

Indeed, especially in the second part of the twentieth century the progress of biomedicine was huge, and not only in Romania. Nurses talked about how their usual workdays were, and what perils and obstacles they faced, but also about the successes that made them keep going:

> *We were doing permanent ward shifts, there were maternity wards, rooms for children. . . . There were hard times. . . . The maternity wards were the most difficult… and we were just a few, just a few and someone always had to be on duty. Day and night. . . . You had to be (t)here. . . . We provided round-the-clock service in the field, too. . . . It was very hard. We got training, very good training, and we did practice, too… We knew the theory, but we had little practical experience. I tell you… I lived many nightmarish moments… many times . . . I didn't know who helped us, maybe God! . . . I didn't have any problem so big that I couldn't solve!*
> (Nurse, born in 1947)[14]

As the quote above explicitly says, nurses were always in motion, always present, having very good qualifications that needed practice. They combined their training with experience into something that brought significance to their lives: their *work*. The whole work situation engendered a powerful sense of self-esteem. They did fulfil their role in society, and their contribution counted in the bigger picture.[15]

After hearing what nurses in the rural area had to tell about their lives at work, my curiosity was piqued by the official program that might have guided them in doing what they did. I looked at the legislation and I was surprised to see that in the most recent Healthcare Law,[16] nurses were mentioned just once in the chapter that defined the notion of medical staff, while for the categories of physician, dentist and pharmacist, there were pages and pages defining their status and other things connected to the respective position, some even explained in minute detail. The previous Healthcare Law was the one of 1978,[17] where there were more provisions concerning the nurses, such as what type of schooling was needed in order to become a nurse, but also which were the job requirements, in art. 75, and also in art. 76 that defined the category of auxiliary staff, also important for our demonstration here, since the connection between the ordinary people and the modern medical system was also done through this auxiliary staff.

> *Art. 75.*
> *The secondary healthcare personnel perform their activity under the direct control and guidance of a physician and have the following obligations:*
> *a) Participate in the actions of prevention and elimination of diseases, in the activity of healthcare education;*
> *b) Ensure the individual hygiene and the permanent care of the sick people, administer food and the medicines prescribed;*
> *c) At a physician's indication they provide treatment and medical care, carry out laboratory analyses and other medical tasks;*

d) Permanently supervise the status of sick people and inform the physician on the evolution of the disease, respond promptly to patient requests, being forbidden to receive or demand amounts of money or other material advantages from the sick people in their care;
e) They are responsible for the good maintenance of devices and other materials and they prepare and sterilize the instruments in full compliance with the technical-sanitary norms.

Art. 76.
The auxiliary healthcare personnel consists of orderlies, caretakers and suchlike that ensure cleanliness and hygiene in medical units, the preparation of materials needed for medical activities, the accompaniment of the hospitalized sick people; they fulfil the tasks stipulated in the regulation concerning the organization and functioning of the unit.[18]

It appears that the new law of 2006 forgot about this type of personnel and the contribution it brought to the good functioning of the medical system, although it was incredibly thoughtful with other categories of the system: physicians, dentists, and pharmacists. What the 'officials' have forgotten was there, in the stories of illness of the village communities. Interviewing the rural people highlighted that contribution, when we performed an in-depth analysis on how the villagers *actually* got connected to the medical office or hospital. Their work was of twofold importance: for the patients and for biomedicine, at many levels but mostly in making biomedicine *acceptable* to people who knew nothing about it.

IN MY interpretation there were two types of relations of the rural people with biomedicine. The first is a formal, *exteriorized* one—in the sense that they resorted to biomedicine and its representatives in case of necessity, within a relation marked by distrust. The interviews showed that they didn't do it directly, but usually through *mediators*. And… they did it because they had to, not because they wanted to!

The second is an *interiorized* one, based of the 'emission center' of medical knowledge, always someone from the family. The relation was not necessarily grounded on the 'efficacy' of the remedy but on the status of that particular member within the family. That situation functioned in both directions, that is, it might be that the status in the family was ensured precisely by the profession of nurse.

Regarding the first type of relation—the exteriorized one—an interesting outcome when reviewing the interviews has been that the villagers accepted biomedicine if it was *mediated* by somebody. They were the ones who chose the mediator, and most often it was someone from the family, but that someone

was either a nurse or worked in a different position in the medical system, or had a relation with a representative of the medical system. There were also situations—rare cases—when the connection was done directly through a physician. According to the interviews, that was the case when the physician had worked for a number of years in their village and then moved to a clinic in the city. That situation was highly dependent on the relations that a physician established with the village community. Usually the educated people (teachers, administrative staff) in the village resorted to a physician as a mediator. Otherwise, obviously, the *recommendation* was done again through a *nurse* that was working alongside that physician. Certainly, that nurse was a member of the village community.

The interviews made it obvious that not a single aged man or woman went to a physician by himself/herself, even at the time when there was a dispensary in their village. There was a major reason for that situation, completely expressed by the word *distrust*. There was a major distrust both towards the staff and the methods. Regarding the medical practitioners, there were two major levels of distrust: age and origin. For a population that was thinking in the terms of a monotheistic religion, and consequently had a collective mentality—that is, reaching out and accepting a remedy only after its efficacy had been proven on a community member—resorting to new, untested methods was inconceivable. Biomedicine was a new and untested healing method within their community. *The pills were bitter and the shots were invasive*… On the other hand, the new system came with *new* and… *young* people to a society grounded on the idea of acquiring knowledge and experience by growing old. The order of things was reversed: how could old people learn anything from the young ones?

> *They refused the shots. Because they hurt the children and they cried, and we scared them with the shots and with vaccines. Because after that the children fell ill… how to vaccinate them, because afterwards they would not sleep, and they cried and that place became swollen and for other reasons.*
> (Nurse, born in 1947)[19]

> *We were women, but it did not count. There were many old women that helped with the births. We could collaborate with the young ones, but the [old] ones… we being like their children, they did not pay attention to us… because what do these young girls know? Did they give birth? Do they know what a birth is?*
> (Nurse, born in 1947)[20]

A second aspect was related to origin. Except for a few people, usually holding secondary positions in the dispensary or hospital (nurses), the rest, especially the doctors, were not natives of that particular village. This aspect had and still has

a major impact on the social life of the villages where the research took place, in general and also in particular in relation to the topic under discussion. Not knowing anything about the *healer* became a greater risk than the illness itself.

That is one reason why the GPs that had surgeries in the villages, according to the new organization of biomedical services, had nurses/assistants from the respective villages. There was also a financial reason, as an employee from that village was cheaper than a commuter. Still, in a system that changed after 1989 towards the idea of a patient-client, a local villager nurse could bring more patients, using the relations and the reputation he/she had in the community. This situation was encountered in the villages were the nurses educated during the communist regime were still active, albeit retired. Almost each village had one of these. For those who did not have them, the solution was again the family: they were registered with the same GP as their children in the city. The third case was of those who were not registered anywhere, not paying contributions to GPs or the Healthcare Directorate, and who solved their health problems in a private clinic and only when an emergency occurred.

Metaphorically speaking, the healer-patient relation presented similarities with the 'orthodox' one, and it had its origin in the monotheistic type of religion that is common in Europe, as pointed out many years ago by Arthur Kleinman.[21] That situation, transposed to our micro-level, would look like this: the physician—*God*—is rarely reached, through the intercession of nurses—*saints*—who put in a word for the 'sinner,' recte the patient. Certainly, the triangle rural world-nurse-biomedicine was not necessarily one lacking in tension, as not everything went smoothly… Obviously, most of the tensions were due to the failure of the treatment, but there could have been other causes as well. Among the other causes, the social image the nurse or her/his family had within the community, good or bad, was of utmost importance. At the end of the day, the nurse was still 'one of us.'

The most important *other* cause of tension non-related to treatment was the intrusion of biomedicine into the *way of life* of the patient, with directions regarding total or partial changes to it. In these cases, the physician, the nurse, and biomedicine itself became the main enemy of the patient. This is the unfortunate outcome of a relation going in a negative direction.

> *Now the lady doctor is asking them, an old woman comes in… well, many of them have high blood pressure. They should not eat fats, salty food, and they ask: "But what should I eat?" "What did you eat?" the lady doctor asks. "What do you usually eat?" She says: "In the morning I have a mug of milk with bread." "And in the afternoon?" "Yes, I make a soup." "And in the evening?" "In the evening… potatoes and I make a cheese soup."*
> (Nurse, born in 1947)[22]

There was, though, an increasingly strong recognition and dependence on medicines for the aged people in the rural area. They did take pills, if not regularly at least occasionally, deeply convinced that they knew better than the doctor… leading to a secondary but nonetheless important fact: the self-medication that created situations ranging from hilarious to dangerous. Many aged people gave their pills to their neighbors, based on quick assessments of the similarity between symptoms. The results brought tragicomic outcomes when the side effects occurred. On the other hand, most of them had real trouble in understanding the indications or even the name of the medicine. One peasant woman, after getting frostbite on her hands, got scared and looked at the indications for Algocalmin[23]—a very popular analgesic in Romania. Since the name on the box was different, but on the box was written in small letters "Antibiotice SA" [Antibiotics PLC, the name of the company that produced the medicine], she became deeply convinced that the GP had gotten her prescription wrong and given her an antibiotic instead of an analgesic. The hilarious part was that none of her neighbors, young or old (more or less educated), could accurately understand what was written on the medicine box. Certainly, the fact that she had mixed the analgesic with alcohol was of no importance to anyone… Nor that they all knew how to read but they had deep troubles in understanding the meaning. Literacy proved helpless or quite dangerous (since they all read the word *antibiotics* on the box).

The second type of relation with biomedicine, the interiorized one, became extremely visible when the interviewed people resorted to biomedicine *primarily* in an illness situation, and it was at its peak when it was used as a *referential* system in the healing process. When analyzing the interviews, I noticed that rural people resorted primarily to biomedical healing of any sort (pill, shots) if they had a personal connection with the biomedical institution and/or representative: they had a family member (brother, daughter in law, daughter, son, cousin) who worked in the medical system—usually a *nurse*; or one of their family members had a close relation with a medical professional, again usually a nurse. One reason for this situation was the orientation of rural people towards jobs that require a short period of schooling, of medium difficulty and with a rapid integration into the workforce. The cases when the relation was with a physician were extremely rare and generally regarded the educated people in the village—the priest, the teacher, those with higher positions in the local administration.

Generally, if the aged people had a nurse in the family, the healing methods they primarily resorted to were the biomedical ones. They did respect the authority of that person, as Professor Robert Cialdini proved with his experiments on the rules of persuasion: one of his six rules is the one of authority, which could be applied to our demonstration.[24]Authority refers to the tendency of people to be convinced by those they believe have knowledge and credibility

regarding a certain topic. In our interviews, their family members demonstrated enough authority and credibility in the medical field. In case they did not have a family member working in the biomedical system, they resorted firstly to herbs, religion, magic, and turned to biomedicine only when the situation was acute and the other remedies failed.

The best example of using the biomedical system as a *referential* one was the case of a bike accident, when the grandparents had at home only biomedical remedies to treat the wounds of the grandson who had fallen off the bike. The grandson had injured multiple areas of his body.

The way the whole situation was presented and also the attitudes of protagonists vis-à-vis the methods involved in healing shows an acute process of internalizing the biomedical system per se and also as a source of *prestige* inside the community. It is a complicated, twisted relation, showing that the formal education necessary in order to become a nurse offered prestige to the respective position. Hence, by diffusion it came to offer prestige to the ones that propagated it—magic by contact. The direct contact with biomedicine and at the same time with a representative of the two worlds—biomedical and family—transferred the prestige towards the last components in the system—the grandparents who administered the treatment to the child. This combined with the accidental presence of an urban mentality powerfully dependent on biomedicine. How else? In the cities, who could have created or at least preserved a healing system based on plants, in the confines of an apartment located in a building surrounded by concrete. For the grandparents mentioned above, resorting to pills and not to old remedies meant a sui generis source of prestige, of access to a 'superior' world. The urban mentality proved its importance for our research, since most of the people living in rural areas were either former commuters or neo-rurals, having spent the past twenty years in the villages under research.

A few of the people belonging to the old generation, as active consumers of biomedical drugs, started to have second thoughts when the effect of one drug was counteracted by another drug and so on… That was the moment when questioning the efficacy of biomedicine became acute.

On the other hand, the prestige of biomedicine also lost in importance when the side effects of the pills troubled the patients. They still went to the physician, but he or she either remained deaf at their complaints, or offered another pill to counteract the effects. Neither situation was fully accepted by the patient. Consequently, they still got the prescriptions and bought the pills—most of them were 90% or 100% free of charge—but did not actually take them. They reserved their own right to do whatever they wanted at home—the famous duplicity Gail Kligman[25] pointed out in her book, which was successfully employed during communism and later. Nevertheless, most aged people have come to take almost *a fistful of pills*, as they put it, for various illnesses and the side effects of

medication, in the strong belief that they would die without them. In this case "the human body is introduced in a power machine that is examining, disarticulating and recomposing it." These people have become docile bodies doing what the system wants them to do.[26]

> ***Do they take their treatment, do they keep the diet?***
> *No. Not even now. Even though they could. And they take their treatment wrongly. They say: "I didn't take the pills because I didn't feel ill. If nothing hurts, why should I take them?" "Well, the device says that you are not well." "Well, when I die, I won't be!"*
> ***Then why do they take the prescriptions?***
> *To have the pills at home. "Well," they say "I would take one once in a while, when I feel dizzy, but then it goes away and I no longer take them for two or three days."* (Nurse, born in 1947)[27]

As the demonstration above has shown, the biomedical system was slowly accepted, but it had its tensions, with bright days when the medicines worked and awful days when the side effects tormented the rural patients. Still, one biomedical character—the nurse—was smoothening the path of acceptance, through the *trust* built day by day with her work, and through her social image inside the village community. Always seen as secondary members of the medical staff, we notice that only the healthcare law issued during communism had special articles defining their status and work. This was not the case with the law passed in 2006, even though the role of this position in the overall context of biomedicine has remained pretty much the same, if we were to listen to the beneficiaries of the modern medical system. Recently, the position of the nurse in the system has been reconfigured through the creation of institutions of higher education for nurses. That brought about a wholly different perspective on the actual status of the nurse in the medical system, from the official point of view. Still, it is not the title that makes the nurse important to patients, but the way in which she takes care of them.

Notes

1. Elena Bărbulescu, "The Illusion of Health: Convergent Discourses," *Transylvanian Review* 19, Supplement no. 5 (2010): 251–259; id., "From My Body to the Body," *Caiete de antropologie istorică* (Cluj-Napoca) 9 (2010): 151–156; id., "We and They: Family, Illness and Physicians in Transylvania (1940–1990)," *Transylvanian Review* 19, 3 (Autumn 2010): 62–72; id., "At the Edge of Modernity: Physicians, Priests and Quacks (1940–1990)," *Philobiblon* (Cluj-Napoca) 16 (2011): 549–561.

2. Since my position regarding the healing systems is a neutral one, I would use the words 'positive' and 'negative' in the sense of accepting and respectively rejecting biomedicine, and not in the sense that biomedicine is positive per se.
3. CNCSIS tip IDEI–2008–2011, "The Perception of the Modernization of the Sanitary System in Communist Romania by the Rural World (1948–1989)."
4. Folklore Archive Institute of the Romanian Academy, Romanian Academy, Cluj-Napoca Branch.
5. I use the term here with the same meaning used by Clifford Geertz in his works—the idea of local worlds and local knowledge: *Local Knowledge: Further Essays in Interpretive Anthropology*, 3rd ed. (New York: Basic Books, 1985).
6. Samuel C. Ramer, "Childbirth and Culture: Midwifery in the Nineteenth-Century Russian Countryside," in *The Family in Imperial Russia: New Lines of Historical Research*, ed. David L. Ransel (Chicago: University of Illinois Press, 1978), 218–235.
7. Census 2012, http://www.recensamantromania.ro/wp-content/uploads/2013/07/Comunicat-de-presa-nr-159-_REZULTATE-DEFINITIVE-RPL2011.pdf (accessed on 29 October 2014).
8. Brigitte Jordan, *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*, revised and expanded by Robbie Davis-Floyd (Long Grove, Ill.: Waveland Press, 1993).
9. This mass of retired people encompasses a wide range of situations. The most frequent is when one or both members of a couple used to work in the factories in the county. The other situation is when the men worked in the industrial system and their wives worked the land in the cooperative farms. Some of the women that worked in the cooperatives do not get a pension due to administrative problems. As the communist system did everything to keep the workforce employed, most of the elderly population in Romania has received a pension, however small.
10. Term taken from Arthur Kleinman's works: *Writing at the Margin: Discourse between Anthropology and Medicine* (Berkeley: University of California Press, 1995).
11. This curiosity has led me to the idea that Romania was not that isolated after all, at least not at that time.
12. Elena Bărbulescu, ed., *Ţărani, boli şi vindecători: Mărturii orale*, vol. 1 (Cluj-Napoca: Mega, 2010), 393–419.
13. See Ramer.
14. Bărbulescu, *Ţărani, boli şi vindecători*, 394–396.
15. For the relation of the people with their work see also the introduction and the first chapter in David A. Kideckel, *Getting By in Postsocialist Romania: Labor, the Body, and Working-Class Culture* (Bloomington: Indiana University Press, 2008).
16. Legea 95 din 2006, http://www.cdep.ro/pls/legis/legis_pck.htp_act_text?idt=72105 (accessed on 22 October 2014).
17. Legea nr. 6 din 1978, http://www.cdep.ro/pls/legis/legis_pck.htp_act_text?idt=1367 (accessed on 23 October 2014).
18. Ibid.
19. Bărbulescu, *Ţărani, boli şi vindecători*, p. 400.
20. Ibid., 401.
21. Kleinman.

22. Bărbulescu, *Ţărani, boli şi vindecători*, 407–408.
23. On the other hand, this drug is highly controversial. In European Union countries it is forbidden, for causing severe side effects. In Romania, after few years of total withdrawal as a consequence of the general European policy, it showed up again in pharmacies, this time only as a prescription drug, most probably at the patients' request. This drug was very popular in Romania during the communist regime and the people prefer it and press for its continuing use.
24. http://www.descopera.ro/stiinta/12818224-care-sunt-secretele-persuasiunii-cele-6-instrumente-psihologice-de-convingere (accessed in October 2014).
25. Gail Kligman, *The Politics of Duplicity: Controlling Reproduction in Ceausescu's Romania* (Berkeley: University of California Press, 1998).
26. Michel Foucault, *The Birth of Biopolitics: Lectures at the Collège de France 1978–1979*, ed. Michel Senellart, transl. Graham Burchell (New York: Palgrave MacMillan, 2008).
27. Bărbulescu, *Ţărani, boli şi vindecători*, 408.

Abstract

The Nurse and the Rural World: A Successful Relation for Biomedicine

The article aims to bring into light the relation between some of the actors involved in the process of healing in rural areas based on the duality patient-healer. It has been more than one hundred years since the first healthcare law was passed (1874) and the progress of biomedicine has been quite obvious, even though it has lagged behind that of Western Europe. My main interest within this topic was to see what it was that made this system work. In a few previous articles I focused on the problems that the implementation of biomedicine in the Romanian rural areas had during the second half of the 20th century, particularly on why and how the system was rejected. With this article I focused on the reverse—what was it that made the biomedical system work? Consequently, I would bring forward a hypothesis on one of the key elements that led to the acceptance of the biomedical system in the rural areas. The idea emerged from the interpretation of the results of a few sessions of interviews done in the rural area of Transylvania, in 2009, 2010, and 2014. People of both sexes were interviewed and there was no age limit. The villages were situated at a variable distance from Cluj-Napoca—an important biomedical center. The results were convergent for all the studied villages, meaning that for our purposes physical distance could be discounted as a variable. One outcome, beside the others already approached in the previous articles—rejection of biomedicine, persistence of pre-modern healing systems, etc.—was that the role of the nurse was crucial in the acceptance of the biomedical system. Even though they hold a secondary place in the biomedical system, the main character being the physician, the nurses have played the major role of *actually* connecting the patients to biomedicine, thus building a core of *trust* which lay at the foundation of this relation.

Keywords

nurse, biomedicine, rural world, Transylvania, education, healing