Lay Values, Organizational Concerns, and the Handling of 'Social Cases' in Romanian Emergency Departments

Marius Wamsiedel

Introduction

In Romania, the existence of 'social cases' has recently been documented in psychiatric facilities[1] and tuberculosis sanatoria.[2] Healthcare practitioners in these settings tend to assign the 'social case' label to patients whose social problems (particularly the likelihood of ending up on the street if discharged) are more pressing than the medical ones. In spite of being regarded as burdensome for the functioning of the service, such patients generally receive special, favorable treatment. Thus, even though many of them are considered to be subthreshold for hospitalization,[3] doctors keep them institutionalized for extended periods of time to prevent their lapse into homelessness and to save them from the host of problems associated with the inability to assume functional roles in society. Jonathan Stillo regards this informal practice as a medicalization of social welfare devised by healthcare practitioners in reaction to the inability of the Romanian welfare system to meet the needs of some of the most vulnerable citizens. Similarly, Jack R. Friedman talks about "the moral resistance of psychiatrists to the abandonment of the poor and distressed by both families and state."[4]

The 'social case' constitutes an epiphenomenon of the dramatic social stratification that has taken place in the post-socialist countries of Central and Eastern Europe. The shift from planned to market economy involved a series of reforms (e.g., privatization of state-owned enterprises, land restitution, and welfare downsizing) that ineluctably led to the redistribution of wealth within the society. While some social categories managed to take advantage of the newly created opportunities, some others, especially the working class[5] and the Roma,[6] failed to do so, becoming "the losers of post-1989 changes."[7] The differential access to resources, albeit organized along class and ethnic lines, was not internally homogeneous. Instead, as Bruce O'Neill observed, "poverty impressed only upon those unable to succeed in a brutally competitive labor market, such as the elderly, the low-skilled, and those otherwise deemed inefficient."[8] Thus, the ideological egalitarianism of the socialist regime gave way to a savage version of social Darwinism, in which the ones unfit for the new conditions became economically dispensable.

The massive layoffs taking place in mining and industry after 1989[9] were not the only problem affecting working class people. In addition to economic precariousness and status demotion, they also had to deal with alienation from peers and a significant reduction in symbolic capital. During socialism, miners and industrial workers performed strenuous tasks under difficult and risky labor conditions. The commonality of experience contributed to the creation of strong bonds among coworkers and the development of a sense of occupational solidarity, which were reinforced by the discursive construction of workers as paragons of socialist virtue in state propaganda. In the final years of the socialist regime, the scarcity of resources and the ever-increasing demands on the part of authorities to meet ambitious yet unrealistic plans challenged this solidarity, as it "led to an overheating of social relations"[10] in general. However, it was only after the change of regime, in the context of layoffs, that the nature of workplace relations swiftly turned from cooperation to competition and conflict.[11] Those who lost their jobs also lost the opportunity to frequently interact with colleagues, and many of them decided to sever social ties with former work friends altogether[12] due to economic trouble and internalized feelings of shame.

After the demise of state socialism, the working class identity itself became heavily stigmatized. Industrial workers and miners, who had relentlessly been celebrated in the socialist media,[13] had enjoyed high wages and perquisites unavailable to other groups,[14] and had contemplated the prospect of intergenerational upward mobility,[15] came to be seen in the new regime as a residue of socialism. They were held responsible for the failures of an industry they epitomized[16] as well as for the shortcomings of the current society.[17] Even though their presumed attachment to and support for the Communist Party are questionable, at least towards the final years of the regime[18], their relatively privileged position created at the time deep resentment, particularly among the cultured yet dispossessed intelligentsia.[19] This negative view became dominant in the post-socialist society. The new media adopted a stereotypical representation of the working class, vilifying its members[20] and turning a blind eye to the structural conditions that led to their downfall.[21] Unsurprisingly, many working class people internalized the stigma directed at them, regarding failure as a matter of personal responsibility[22] and taking the blame for it.

Those recently impoverished experience not only dire economic straits, but also "a profound rupture of their expected life course."[23] Many of them are destitute of money, friends, connections, opportunity, and hope at the same time. Those lacking the safety net of social support are particularly exposed in periods of severe economic hardship to the risk of turning to a life on the street. The fall into homelessness, a prospect that was inconceivable only a quarter of a century earlier,[24] means for many Romanians who are destitute reaching a point of no return, given that extreme poverty "became entangled with near permanent unemployability,"[25] and the few jobs available to vagrants are menial, low-paid, and insecure.

Social cases and the moral evaluation of patients

IT IS in this general context, and against such a grim prospect, that psychiatrists and doctors in tuberculosis sanatoria attend to the social circumstances of patients, lengthening the stay of the most vulnerable beyond what is necessary from a strictly medical standpoint. In this paper, I extend the theoretical examination of the 'social cases' in Romanian healthcare by examining the situation as it occurs in the emergency departments of public hospitals.

The site selection is purposeful. Whereas regular psychiatric institutions and sanatoria provide medium- and long-time service to persons with chronic illnesses, the emergency department is by design meant to give care primarily to the ones experiencing acute problems. Several consequences derive from this structural difference. First, the number of clients that staff members interact with on a daily basis is much higher at the emergency departments, and so is the variety of medical problems they ordinarily encounter. Second, the clientele tends to be heterogeneous in terms of ethnicity, class, and gender. Third, the time spent by a patient before discharge or transfer to another unit is usually very short, which hinders the exchange of medically irrelevant information between patients and staff members. Fourth, emergency departments cannot provide long-term hospitalization on their premises, which makes impossible the exact replication of the informal practice documented in the other settings. The strategy of "maximiz[ing] differences by changing the scope of […] research,"[26] which is actualized in the examination of medical organizations that have marked dissimilarities from those hitherto studied, aims towards refining the understanding of lay morality in Romanian healthcare settings.

Besides being a topic of interest in its own right, the analysis of social cases provides an opportunity to test the applicability of the theory of the moral evaluation of patients in post-socialist contexts. In its classical version, this theory posits that healthcare workers sort patients out in terms of their social value and the degree to which their health problem fits within the occupational jurisdiction of the institution. In other words, the two criteria that orient the staff's informal classification of patients are the putative social worth of the individual and the legitimacy of the case.[27] The assessment of worth derives from lay considerations about the social order and the range of moral entitlements it procures to individuals,[28] whereas the assessment of legitimacy originates in organizational concerns and serves to apportion limited resources to the ones who actually need them.[29] The 'social cases' as described by Friedman[30] and Stillo[31] fail to meet both criteria that inform the moral evaluation of the clientele. The extreme poverty and limited social connections place them towards the bottom of the social hierarchy, whereas the absence of severe medical conditions blatantly destroys the presumption of legitimacy. In other countries, individuals with a similar profile tend to be categorized as 'problem patients'[32] and treated unfavorably. Several questions naturally arise from these considerations: Is the benevolent treatment social cases receive in tuberculosis sanatoria and psychiatric facilities a peculiarity of those fields of medical practice? Or does it express a way of attending and responding to the social circumstances of the patients that is widespread in the Romanian medical practice? What does the handling of social cases in Romania say about the theory of the moral evaluation of patients?

Methodology

To answer these questions, I rely on six months of ethnographic fieldwork conducted in the spring and summer of 2013 and the summer of 2014 at the emergency wards of two public hospitals in Romania. To preserve anonymity, I will refer to them as County Hospital and City Hospital. Data collection consisted of observation, informal conversations, formal interviews, and analysis of written documents and visual artifacts. As my research project was primarily concerned with the initial classification of would-be patients, I collected most of the data at the triage. However, I also conducted shorter periods of observation at the Minor Emergency room at City, and the Monitoring and Surveillance room at County.

During fieldwork, I completed over 250 hours of observation. To increase data accuracy, I audio-recorded a few dozens of admission interviews taking place at County. I engaged in frequent casual discussions with 15 triage nurses, 3 registrars, 10 doctors, 2 nurses from the Monitoring room, and 2 nurse aides working at County, and with 5 triage registrars, 6 doctors, and 4 nurses working at City Hospital. I also conducted semi-structured interviews with 23 persons representing various categories of social actors involved in the activities at the Emergency Departments: 5 triage nurses from County Hospital, 2 triage registrars and one nurse from City Hospital, and one high-level official from the Ministry of Internal Affairs in charge with emergency situations, who also played a key role in the configuration of the emergency healthcare system.

The study received ethical approval from the Institutional Review Board at St. Mary's Hospital in Hong Kong.

Settings

The two hospitals serving as research sites are similar in terms of organization, staffing, average number of presentations, and historical development, but different with regard to location and triage arrangements. Both are located in urban areas: County in a medium-sized town of about 100,000 inhabitants, and City in a much larger municipality, which is also an important university center.

The staff working at the emergency department of County Hospital consists of 11 doctors, 62 nurses, 22 nurse aides, 22 orderlies, seven aides, six registrars, and one social worker. The emergency department at City is serviced by 14 doctors, 41 nurses, 11 nurse aides, 12 orderlies, six registrars, and one social worker whose appointment is temporary. Hospital occupations are clearly gendered. In both hospitals, female doctors outnumber male counterparts (8 vs 3 at County, and 11 vs 3 at City). Both heads of the department are females. With one exception in each hospital, all nurses are females, and so are nurse aides, aides, and registrars. On the other side, only males work as orderlies.

According to hospital records, the emergency department at County had considerably more users as compared to the one at City until December 2010, when the latter

was reorganized. Afterwards, the average number of daily presentations at the two hospitals became relatively similar (204 daily presentations at County as compared to 227 at City).

One of the most important procedural differences between the two emergency departments is related to the agents in charge with the initial assessment of would-be patients: at County, nurses perform the triage, whereas at City, where a double system is at work, this falls primarily under the responsibility of clerks (*registratori medicali*), who are data-entry operators lacking any nursing or medical training. They process all cases that have not been handled by pre-hospital emergency units, the ambulance and the Mobile Emergency Service for Resuscitation and Extrication (hereafter MESRE). Ambulance and MESRE crews generally bypass the triage and present patients directly to one of the doctors in the major emergency room, unless they consider the condition satisfactory enough not to justify fast-track admission. This arrangement is facilitated by the existence of a separate entrance to the major emergency room, which provides direct access from the parking lot.

The organization of triage at City hospital departs from the official procedures, which specify that only nurses or doctors are allowed to assess the condition of the patient at the moment of presentation (Romanian Ministry of Health).[33] My informants regard the arrangement as a pragmatic adaptation to local work conditions, particularly to the shortage of nurses. They consider that the practice involves low risks, because registrars have been instructed to refer all cases that appear to be potentially severe to nurses and doctors.

Social cases at the emergency department

Oana

Soon after beginning fieldwork at County Hospital, I assisted to the admission interview of a would-be patient retrospectively labelled by nurses as a 'social case:' Oana, a woman in her late 20s, who makes an appearance at the triage room on an early evening of March. The verbal exchange with the nurse is succinct:

Triage nurse:	Hello, Oana!
Patient:	Nurse, can you send me to K. [a psychiatric hospital]?
Triage nurse:	I cannot…
Patient:	So what can I do? I will stay here!

Triage nurse Nina raises her elbows with a grimace of understanding and regret. She does not say another word. Oana takes a seat in a corner of the triage room. Another nurse, who happened to be in the triage booth at the time, tells me that she would stay there overnight. Nina describes Oana as "the social case who is not a social case." She has a family and receives a disability allowance, but her mother, who is remarried, takes her meager income every month and then orders her out of the house. From time to time, she gets admitted to one of the two psychiatric hospitals in the county. After discharge, she often comes to the emergency department, and occasionally sleeps there.

"We don't want to admit her because it's hard to get rid of her afterwards," Nina tells me. Even her stay in the waiting room is not devoid of problems. Oana's erratic behavior, due to mental instability, is well-known to the staff. Nurse Nina shares with me some stories to make her point. One night in the waiting room, Oana suddenly cried for help, rushed to the exit, and jumped right in front of an approaching ambulance. It was only the driver's presence of mind that averted an accident. Another night, she unexpectedly started doing prostrations.

Without any prompting, Nina goes on, telling me how she has made sense of the current situation. Oana has a child with hydrocephalus, who is currently institutionalized at K., and "that's probably why she wants to go there. She must be longing for him. But what can we do? If we send her to K., they are not going to admit her. She's been discharged from V. [another psychiatric hospital] today."

Oana is, like many patients deemed 'social cases,' a frequent visitor at County.[34] This status grants her the privilege of escaping admonition for the inopportune visit, and makes any attempt to frame the problem under medically relevant terms utterly unnecessary. The triage nurse knows in great detail Oana's situation, and displays towards her tacit, yet unequivocal sympathy. She cannot agree with the request for transfer by ambulance to the psychiatric hospital because Oana does not show any episode of mental illness that would warrant such a move, and her passage through three institutions the very same day may raise a suspicion of inappropriate transfer, or turfing,[35] to those who monitor electronic patient registries.[36] The unexpressed agreement to let the patient sleep in the waiting room appears as a sort of compromise solution to Oana's housing problem.

The long-haired young man

The second ethnographic vignette that I introduce here refers to a brief exchange between a triage nurse and a nurse working in another sector of the emergency department:

Nurse:	The one with long hair [sitting] on the radiator is a drug user from my apartment complex.
Triage nurse:	And why should we care? He didn't ask for anything.
Nurse:	He didn't ask. All he wants is to stay inside because it's warm.
Triage nurse:	He likes us, that's why he came here!
Nurse:	But there's not only one, but two [persons].
Triage nurse:	Leave them alone.

The waiting room is a loosely regulated place, where people are generally ignored by staff unless they act in a disturbing way. Triage workers, who have unimpeded visual access to it and constantly monitor what is going on out of both professional interest and personal curiosity, only exceptionally interact with the people in the waiting room. The major exception to this rule takes place when a patient in poor condition comes and there is no seat left. However, this occurs rarely, because more often than not the companions give their seat to the ones in apparent distress.

Unlike Oana, the biography of this story's protagonist is unknown to the triage nurse until a co-worker brings forth the discreditable information about drug use. While the triage nurse's decision to cut her colleague short may be read as an indication of professionalism, preventing information that is clinically irrelevant from biasing her and influencing the handling of the person, this is inconsistent with her curiosity towards other patients. By limiting the amount of discreditable information, the triage nurse does not need to account to the other nurse for her decision to let the person sit in the waiting room in violation of the organization's code of conduct.

The two cases introduced here give insights into the peculiarities of the emergency department when it comes to the categorization and handling of social cases. The staff-devised category membership criteria are the object of the next section. For the moment, it suffices to mention a few notable specific traits of the emergency departments. First, the label of 'social cases' is attributed to a heterogeneous public, which includes patients, would-be patients (individuals who make, explicitly or not, a claim for admission), and persons who do not aspire to patient status. Second, the amount of information about the person's biographical trajectory varies and is contingent upon the frequency of that person's visits. In the case of regular users, like Oana, the stock of information can be remarkably detailed. In other cases, the information can be limited to the appearance of the person and the demeanor within the waiting room, as with the long-haired young man. The former situation is more common at County, which holds monopoly over the emergency services in the administrative unit in which is located. The latter is encountered more often at City, which is only one of about a dozen hospitals providing 24 hours emergency service. Third, the emergency department can only provide social cases with momentary relief from the complex problems they experience. Unlike psychiatric institutions and tuberculosis sanatoria, the emergency departments admit social cases or let them use the facility for sleep or rest for a period ranging between a few hours to one day.

Making the 'social case'

THE 'SOCIAL case' represents a patient category of widespread use in both settings, although the criteria for its membership are not clearly agreed upon by all members of the staff. By and large equated with homelessness and the absence of acute medical problems, it admits, however, a variety of understandings. They range from a minimalist representation, which attributes the label of 'social case' exclusively to patients lacking shelter and having meager or no income, to a more encompassing one, which extends its use to incorporate all patients in a situation of extreme vulnerability, regardless of their actual housing status.[37] Various intermediary points exist along this continuum, as the following interview excerpts indicate:

> NURSE: A social case is someone who has no house, no means of subsistence, [and] no income whatsoever. (Interview nurse Jenny, County, 20130425)

NURSE: A social case is a person who has no house, no income, and no first-degree relatives to provide her with shelter. (Interview nurse Andra, County, 20130426)

NURSE: These street people, social cases as we call them, have no sort of income, no house, they live on the street. (Interview nurse Lucia, County, 20130430)

REGISTRAR: First and foremost, social cases have no housing […], but there are also poor people who have a tiny house and come here because they don't have a family doctor, but these are social cases that…
INTERVIEWER: …Are they still considered social cases if they have a tiny house?
REGISTRAR: As a rule, the ones without housing are considered social cases. [After reading the subcategories of the 'social case' entry in the electronic registry, which include 'housing status' and 'domestic violence,' she adds that battered women who have left home are also entitled to membership of the 'social case' category, but mentions that the incidence of such cases is so rare, that they become practically irrelevant.] (Interview registrar Crina, City, 20140729)

INTERVIEWER: I would like to ask you what you mean by social case.
NURSE: Street persons. […]
INTERVIEWER: How about persons who have a shelter, but are very poor and, say, have nobody [to care for them]?
NURSE: [Persons] in an advanced state of filth, of illness… [if] there is no one to care for them, nobody to help them, to feed them, they are, indeed, considered social cases. (Interview nurse Florica, City, 20140731)

Although triage nurses at County appear to be more inclined than staff at City to adopt a restrictive understanding of the category, their interpretation is situationally flexible. One day, during chitchat, Nurse Nina told me about an outstanding 'social case.' It concerned a middle-class woman aged 69 claiming to have recently sold one property and to have deposited part of the money from the transaction, 100,000 lei [roughly 22,800 euro] in a bank. The woman had senile dementia, lived in a different city about 100 km away, had no close relatives, and came to the emergency department with visible signs of aggression. She explained that some neighbors beat her in an attempt to make her sign a contract whereby she agreed to donate them her house. She asked to be hospitalized in order to stay away from the neighbors she feared. Staff members complied with the unusual request, and arranged for her temporary hospitalization in another healthcare facility. Meanwhile, they alerted the authorities in order to find her an elders' nursing home. What is remarkable in this story is that the patient was neither in lack of shelter nor economically deprived. Instead, it was her extreme vulnerability, due to a combination of advanced age, mental illness, lack of social support, and external threat, that made her a fit candidate for inclusion into the 'social case' category. Various other situations of a similar sort suggest that patients whose problems fall under the occu-

pational jurisdiction of social workers tend to be labeled as 'social cases,' a point that has also been made by Friedman[38] in the context of psychiatric practice.

The typification of 'social cases,' albeit related to some objective condition, be it homelessness or extreme vulnerability, goes beyond the situation itself. Staff members use complex narratives to make sense of the origin of the problem and the degree of personal responsibility for it. Although there are notable interpersonal variations among indigent persons seeking shelter in hospital emergency rooms, these narratives explain their condition through a combination of unfavorable external circumstances and personal flaws. Homelessness or vulnerability is not something that just happens, the ineluctable outcome of a string of bad luck and personal misfortunes, but rather something to which the individual has contributed over time in some way or another. Hence, all persons labeled as 'social cases,' with the notable exception of the mentally ill, are to some extent held culpable for their misfortune. The degree of personal responsibility, however, can vary greatly.

Generally speaking, triage workers distinguish between two types of 'social cases.' The first one refers to ordinary people whose entry into the career is accidental, unanticipated, due to structural factors, and whose stay is explained through some sort of defective will. These are persons who have performed ordinary social roles for extended periods of time until they were affected by a serious crisis. Some of them became homeless during the turbulent period of post-socialist transition by losing jobs, contracting loans from banks or pawnbrokers they were unable to pay back, or making poor investments. Others got on the streets following a divorce. They lacked the strength to recover, and in many cases medicated their grief with alcohol, which made their recovery even harder.

The second type refers to people whose inability to assume functional social roles creates the predisposition for a life on the streets. Their career is linear rather than sinuous, and thus less dramatic. Resembling up to a point the vagrants described by Nels Anderson,[39] they seem to enjoy the bohemian lifestyle and do not contemplate getting out of it. Therefore, they adamantly refuse any opportunity provided by state agencies and non-governmental organizations to get formal employment or social housing, because "they're not accustomed to living in a community or abiding by the rules" (Interview nurse Lucia, County, 20130430). In their case, homelessness is seen as a permanent status.

The moral evaluation of social cases

'SOCIAL CASES' are considered, without exception, as illegitimate users of the emergency department, even though their health status is believed to be generally poor. Nurses and clerks typify social cases as carriers of various illnesses, including tuberculosis and sexually transmitted diseases. Similarly to the very elderly patients, they are considered to have various chronic illnesses that require lengthy examination, which cannot be provided in the emergency department. Unlike the very elderly, however, social cases seldom make an appearance due to disturbing symptoms. More often than not, they only accuse a general state of weakness, tiredness, lack of energy, headaches,

or simply mention the need to get some rest. The resources consumed by admitting them do not match the severity of the condition, which makes staff firmly dismiss the legitimacy of their claim for care: "We are not meant to admit social cases" (Interview nurse Vera, County, 20130513). As in the French hospital studied by Jean Peneff,[40] nurse aides at both emergency departments are the most vocal opponents of their admission because their workload is much higher with social cases than with other categories of patients, and it involves 'dirty work' (e.g., cleaning filthy bodies, removing bed sheets after their discharge, and cleaning the room). During fieldwork, I encountered several situations in which nurse aides refused to care for social cases and fiercely argued with doctors and head nurses about this.

In terms of worth, social cases do not fare any better: they tend to occupy extremely low positions in the informal staff-devised hierarchy. However, this does not mean to imply that they are all the same. As compared to other categories of patients, the social cases are the object of intense scrutiny and interest. Were the emergency ward a tabloid, social cases would undoubtedly be its heroes. In their case, the admission interview departs a lot from the questions of bureaucratic interest. Triage nurses and clerks inquire or attend to any available cue about the person's life before getting on the street, the length of the homeless career, the family status, and the lifestyle. Information of this sort is later on exchanged with co-workers who handle the social case after admission. They can fill in the blanks of the triage admission interview and add to it novel information that would make the social stature of the person clearer. The range of communicable information is virtually unbounded, but things that might change the inclusion in a particular type have the highest value. For instance, the discovery that a homeless person has obtained a college degree and has worked for many years as a teacher before falling into alcoholism, getting divorced and losing the house through the partition lawsuit spreads quickly among staff members and becomes one of the main topics of gossip for the day. Patients of this sort, even though their overall social worth is perceived to be very low, are more esteemed than those about whom no precise information is known, and much more than those whose bio-psycho-social makeup or prior history allegedly predisposes them to a life on the streets.

In other words, the assessment of social worth depends to a certain extent on the career type to which they are assigned. Patients regarded as ordinary derive some worth from the status they had before the misfortune that caused or precipitated their decline. Patients for whom, on the other hand, no favorable information can be mobilized are degraded in the hierarchy of worth. All in all, in spite of the differences, the perceived worth of social cases tends to be extremely low.

The negative moral evaluation of social cases is unambiguous, and so is their undesirability. Nurses and clerks complain that they drain the resources of the department unnecessarily, delay the admission of the so-called 'real emergencies,' and disturb the flow of activities and the comfort of staff and patients because "they act like a tribe" (Nurse Lucia, County, 20130430). In spite of the harsh discursive representation and the various sorts of trouble that their presence at the emergency department generates, social cases tend to be treated sympathetically. While ordinary patients failing to meet both

the legitimacy and worth criteria are commonly chastised and subjected to unwarranted delays, this almost never happens with social cases.

Moreover, staff members accept to admit social cases provided that the staff is sufficient to cater for them and the department is not overcrowded. At times when the demand for emergency care is low, the homeless are admitted to the monitoring and surveillance room, where they receive an intravenous perfusion containing glucose and vitamins. After about an hour or so, they are discharged. Rarely, they are allowed to spend the night in the department. In case the patient has a mental illness, she is referred to a psychiatric hospital. If the emergency department is overcrowded and the person has no mental illness, she is generally allowed to rest in the waiting room provided that she is not disturbing, violent, or extremely dirty. It is only seldom that known social cases are refused any sort of favor.

To the theory of moral evaluation, in its classical formulation, this way of handling problem patients constitutes an exception. However, its incidence in various medical settings and different cultures suggest that this is not an exception, but rather an adaptation to changing structural conditions. Patients like Oana find themselves in a situation of extreme vulnerability that is potentially life-threatening, when neither their families, nor the state can properly tend to their needs. Even though shelters for the homeless exist in both municipalities in which the emergency departments are located, the admission criteria are sometimes difficult to meet,[41] the spaces are overcrowded, and the environment is deemed unpleasant. Those who are left out, or who cannot adapt to the rigors of the shelters, find in the medical system one of the few viable alternatives to the street. Emergency departments, psychiatric hospitals, and sanatoria for tuberculosis create an informal welfare system that compensates for the malfunctioning and care gaps of the official one.

So far, I have discussed the social dimension of the visits made by these patients at the expense of the medical one. This does not mean that social cases never have healthcare problems that demand professional assistance. Occasionally, their visits are triggered by genuine concerns with their state of health. As a rule, when health problems are on-going or expected manifestations of a chronic disease, patients are admonished for bypassing the family medicine system or the polyclinic. Even though they are not denied access, the visit is deliberately turned into an unpleasant one through moralizing discourse, use of irony and sarcasm, and extended delays in order to discourage return. This is not the case with social cases, and the logic is similar to that of the socially-motivated visits. While it is true that the patient has the possibility to access other healthcare institutions that are appropriate for her problems, the practical access to those settings is difficult because of the cost of examination and the discriminatory practices that constrain access. In these circumstances, the emergency department becomes the only reliable option for diagnosis. The admission of patients failing to meet both the legitimacy and worth criteria because of lack of practical alternatives has also been documented in French emergency departments recently,[42] which suggests that this might be a general response to the increased demand for healthcare from the most vulnerable members of the society.

Concluding remarks

The handling of social cases at the emergency department is largely consistent with that taking place in other medical institutions in Romania, such as psychiatric hospitals[43] and sanatoria for tuberculosis.[44] Staff members display a protective stance towards those patients who are unable (or, in a few cases, unwilling) to get socially integrated into the mainstream, even though their presence is burdensome and raises various problems for the functioning of the department.

The category membership as well as the subsequent handling is adapted to the institutional design of the emergency department. Thus, the 'social case' label is most often attributed to persons who are already homeless, as compared to the healthcare settings studied by Friedman and Stillo, in which homelessness existed only as a future possibility, albeit very likely. Also, the emergency department cannot temporarily prevent the lapse into homelessness, as the psychiatric facilities and the sanatoria do, because of their limited resources and high flux of patients. Therefore, while they cater for the needs of the social cases, they do so in a distinct way, by providing short-term admission, transfer to another medical institution, or (tacit) permission to spend the night in the waiting room.

Triage workers at the emergency department, like healthcare practitioners in other institutions, attend to the structural conditions that have configured novel forms of social exclusion during the post-socialist transition. Although there is no perfect agreement with regard to the allocation of blame between the individual and the society, structural conditions are not discounted as an explanatory factor for the existence of social cases. Triage workers take them into consideration when making sense of life trajectories departing from ordinariness, and when accounting for the illegitimate use (or attempted use) of the emergency service.

These findings indicate that the classical version of the theory of moral evaluation fails to accurately interpret the informal categorization and handling of patients in a post-socialist context. The staff-devised criteria for deciding the moral entitlement to use the emergency service include the social worth of the individual and the legitimacy of the visit, but also go beyond them. Thus, even though the moral evaluation takes place at the intersection between lay values and organizational concerns, it is not centered exclusively on the individual and the medical organization, but also takes into account the existence of alternative ways of receiving healthcare or social assistance.

Further research is necessary to decide whether this situation is peculiar to Romania (and, in a general sense, to countries that have experienced a rapid and major change in social stratification and have been unable to provide a safety net to the downwardly mobile), or it expresses a new ethos governing healthcare delivery nowadays. The theory of moral evaluation can be reassessed by examining the handling of the extremely poor and the homeless in different post-socialist medical contexts, as well as in Western ones, where an "informal system of positive discrimination,"[45] apparently similar in nature and content to the one encountered in Romanian emergency departments, has already been documented.

The provision of care to the refugees in Western countries can provide a useful opportunity and case study for assessing the applicability of the theory of moral evaluation, given that the high migratory flow has created additional pressure on the existing medical and welfare systems in the countries of destination.

❑

Notes

1. Jack R. Friedman, "The 'Social Case:' Illness, Psychiatry, and Deinstitutionalization in Postsocialist Romania," *Medical Anthropology Quarterly* 23, no. 4 (December 2009): 375–96.
2. Jonathan Stillo, "'We Are the Losers of Socialism!' Tuberculosis, the Limits of Bio-Citizenship and the Future of Care in Romania," *Anthropological Journal of European Cultures* 24, no. 1 (2015): 132–40.
3. Friedman, "The 'Social Case:' Illness, Psychiatry, and Deinstitutionalization in Postsocialist Romania," 387.
4. Ibid., 391.
5. Bruce O'Neill, "Down and Then Out in Bucharest: Urban Poverty, Governance, and the Politics of Place in the Postsocialist City," *Environment and Planning D: Society and Space* 28, no. 2 (April 2010): 254–69; Gerard A. Weber, "'Other Than a Thank-You, There's Nothing I Can Give': Managing Health and Illness among Working-Class Pensioners in Post-Socialist Moldavia, Romania," Human Organization 74, no. 2 (2015): 115–24.
6. Michael Stewart, "Deprivation, the Roma and 'the Underclass,'" in *Postsocialism: Ideals, Ideologies and Practices in Eurasia*, ed. Chris Hann (London and New York: Routledge, 2002), 133–55.
7. David A. Kideckel, "The Unmaking of an East-Central European Working Class," in *Postsocialism: Ideals, Ideologies and Practices in Eurasia*, ed. Chris Hann (London and New York: Routledge, 2002), 128.
8. Bruce O'Neill, "Bored Stiff: Sex and Superfluity in a Time of Crisis," *Public Culture* 27, no. 2 (May 2015): 391.
9. Kideckel, "The Unmaking of an East-Central European Working Class."
10. Steven Sampson, "All Is Possible, Nothing Is Certain: The Horizons of Transition in a Romanian Village," in *East European Communities: The Struggle for Balance in Turbulent Times*, ed. David A. Kideckel (Boulder, CO: Westview Press, 1995), 169.
11. Other reforms produced similar consequences. For instance, the restitution of land generated in many a rural community interethnic enmity (Katherine Verdery, "Nationalism and National Sentiment in Post-Socialist Romania," *Slavic Review* 52, no. 2 (1993): 184–85), opening up historical wounds.
12. Kideckel, "The Unmaking of an East-Central European Working Class," 125–27.
13. Florentina Andreescu, "The Changing Face of the Other in Romanian Films," *Nationalities Papers* 39, no. 1 (January 2011): 81–82.
14. Kideckel, "The Unmaking of an East-Central European Working Class," 114.
15. Jack R. Friedman, "Shame and the Experience of Ambivalence on the Margins of the Global: Pathologizing the Past and Present in Romania's Industrial Wastelands," *Ethos* 35, no. 2 (2007): 243.
16. Kideckel, "The Unmaking of an East-Central European Working Class," 114.
17. Alison Stenning, "Where Is the Post-Socialist Working Class? Working-Class Lives in the Spaces of (Post-) Socialism," *Sociology* 39, no. 5 (December 2005): 983–84.

18. Eszter Bartha, "Welfare Dictatorship, the Working Class and the Change of Regimes in East Germany and Hungary," *Europe-Asia Studies* 63, no. 9 (November 2011): 1591–1610.
19. Michele Rivkin-Fish, "Bribes, Gifts and Unofficial Payments: Rethinking Corruption in Post-Soviet Russian Health Care," in *Corruption. Anthropological Perspectives*, ed. Dieter Haller and Cris Shore (London and Ann Arbor, MI: Pluto Press, 2005), 90.
20. Stenning, "Where Is the Post-Socialist Working Class?," 983–84; Don Kalb, "Conversations with a Polish Populist: Tracing Hidden Histories of Globalization, Class, and Dispossession in Postsocialism (and Beyond)," *American Ethnologist* 36, no. 2 (May 2009): 213.
21. Kideckel, "The Unmaking of an East-Central European Working Class," 125–27.
22. Charlie Walker, "From 'Inheritance' to Individualization: Disembedding Working-Class Youth Transitions in Post-Soviet Russia," *Journal of Youth Studies* 12, no. 5 (October 2009): 542.
23. Friedman, "The 'Social Case:' Illness, Psychiatry, and Deinstitutionalization in Postsocialist Romania," 392.
24. Homelessness itself is a recent creation (Martin Lux and Martina Mikeszova, "The Role of a Credit Trap on Paths to Homelessness in the Czech Republic," *Journal of European Social Policy* 23, no. 2 (May 2013): 210.) both as an experience and as a cultural frame of reference (O'Neill, "Down and Then Out in Bucharest," 257.). During socialism, the phenomenon was largely invisible, and talking about it as a social problem was taboo. The state engaged in vigorous attempts to preserve its ideological front by building houses and institutionalizing those who refused or were incapable of living according to the standards of the socialist society.
25. O'Neill, "Bored Stiff," 391.
26. Barney G. Glaser and Anselm L. Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Chicago, IL: Aldine de Gruyter, 1967), 57.
27. Julius A. Roth, "Some Contingencies of the Moral Evaluation and Control of Clientele: The Case of the Hospital Emergency Service.," *American Journal of Sociology* 77, no. 5 (March 1972): 839–56; Alexandra Hillman, "'Why Must I Wait?' The Performance of Legitimacy in a Hospital Emergency Department," *Sociology of Health & Illness* 36, no. 4 (May 2014): 485–99.
28. Barney G. Glaser and Anselm L. Strauss, "The Social Loss of Dying Patients," *The American Journal of Nursing* 64, no. 6 (1964): 119–21.
29. Hillman, "'Why Must I Wait?"; Carine Vassy, "Categorisation and Micro-Rationing: Access to Care in a French Emergency Department," *Sociology of Health and Illness* 23, no. 5 (September 2001): 615–32, doi:10.1111/1467-9566.00268; James M. Mannon, "Defining and Treating 'Problem Patients' in a Hospital Emergency Room," *Medical Care* 14, no. 12 (December 1976): 1004–13.
30. "The 'Social Case:' Illness, Psychiatry, and Deinstitutionalization in Postsocialist Romania."
31. "'We Are the Losers of Socialism!' Tuberculosis, the Limits of Bio-Citizenship and the Future of Care in Romania."
32. Niels Buus, "Categorizing 'Frequent Visitors' in the Psychiatric Emergency Room: A Semistructured Interview Study," *Archives of Psychiatric Nursing* 25, no. 2 (April 2011): 101–8; Ruth E. Malone, "Whither the Almshouse? Overutilization and the Role of the Emergency Department," *Journal of Health Politics, Policy & Law* 23, no. 5 (October 1998): 795–832; Ruth E. Malone, "Heavy Users of Emergency Services: Social Construction of a Policy Problem," *Social Science & Medicine*, 40, no. 4 (February 1995): 469–77; David Sudnow, *Passing on: The Social Organization of Dying* (Englewood Cliffs, NJ: Prentice-Hall, 1967); Mannon, "Defining and Treating 'Problem Patients' in a Hospital Emergency Room."
33. Romanian Ministry of Health, *Ordinul Nr. 48/2009 Privind Aprobarea Protocolului Naţional de Triaj Al Pacienţilor Din Structurile Pentru Primirea Urgenţelor* [Order 48/2009 Regarding

the Approval of the National Protocol for the Triage of Patients in Emergency Units] (Bucharest, Romania: Monitorul Oficial [Official Journal of Romania], 2009).

34. Regular users tend to occupy a special status within emergency departments. On the one hand, their frequent return suggests inappropriate use of the service (Margaret McArthur and Phyllis Montgomery, "The Experience of Gatekeeping: A Psychiatric Nurse in an Emergency Department," *Issues in Mental Health Nursing* 25, no. 5 (January 2004): 491; Peneff, *L'hôpital En Urgence: étude Par Observation Participante [The Hospital in Emergency: A Study by Participant Observation]*, 91–93; Mannon, "Defining and Treating 'Problem Patients' in a Hospital Emergency Room," 1007.), which carries deleterious consequences for the staff—it unnecessarily increases the volume of work and reduces the opportunities to expand knowledge and skills. On the other hand, their return provides staff members with a momentary break from the impersonality of clinical and bureaucratic encounters. Therefore, it is common for the personnel to acknowledge familiarity and express a certain degree of sympathy towards regular users by assigning them nicknames (Malone, "Whither the Almshouse?," 806.) and names of endearment (Mannon, "Defining and Treating 'Problem Patients' in a Hospital Emergency Room," 1011.), and by treating them more leniently than other patients with similar health conditions and contexts of presentation.
35. Terry Mizrahi, "Getting Rid of Patients: Contradictions in the Socialisation of Internists to the Doctor-Patient Relationship," *Sociology of Health & Illness* 7, no. 2 (1985): 214–35; Catherine Caldicott, "Sweeping Up after the Parade: Professional, Ethical and Patient Care Consequences of 'Turfing,'" *Perspectives in Biology and Medicine* 50, no. 1 (2007): 136–49.
36. Electronic records have recently been introduced to monitor the use of resources in hospitals (Sabina Stan and Valentin-Veron Toma, "High-Tech Romania? Commoditisation and Informal Relations in the Managerialist Informatisation of the Romanian Health-Care System," *Anthropology in Action* 16, no. 1 (2009): 56–71.). The data-entry operators at the two emergency departments in which I conducted fieldwork were genuinely preoccupied with the reasonableness of the information introduced in the computer system, because the content was intensely monitored and any inconsistency had to be accounted for.
37. Staff members at both hospitals also commonly use the category to designate (1) patients whose motivation to make an appearance to the emergency department is related to non-medical considerations, such as lack of healthcare insurance, and (2) patients possessing very low social status. For example, one nurse made sense of some patients' inclination to revise their statements in encounters with various hospital workers by blaming it on their alleged "lack of culture" and "low intellect." She ended the explanation by saying "That's how it is! This is a hospital for social cases, if I can put it this way" (Discussion nurse Tatiana, County, 20130325). However, the use of the category in such contexts is mainly rhetorical, since atrocity stories recounted by nurses serve, inter alia, as "mechanisms for communicating shared difficulties" (Davina Allen, "Narrating Nursing Jurisdiction: 'Atrocity Stories' and 'Boundary-Work,'" Symbolic Interaction 24, no. 1 (February 2001): 77.)
38. "The 'Social Case:' Illness, Psychiatry, and Deinstitutionalization in Postsocialist Romania," 360.
39. Nels Anderson, *On Hobos and Homelessness* (Chicago, IL: University of Chicago Press, 1998).
40. Jean Peneff, *L'hôpital En Urgence: étude Par Observation Participante* [The Hospital in Emergency: A Study by Participant Observation] (Paris: Métailié, 1992), 61–62.
41. Bruce O'Neill's (2010) ethnographic study of a Romanian NGO providing temporary accommodation to the roofless points out that the organization operates a "functional discrimination against those homeless persons who refuse to, or otherwise cannot work" (2010, 265) by imposing small monetary payments for accommodation. While this practice is by no means

specific to Romania and is intended to reinsert the person into the economic circuit (Rachael Dobson, "Conditionality and Homelessness Services; 'Practice Realities' in a Drop-in Centre," *Social Policy and Society* 10, no. 04 (October 2011): 551–53), it also discriminates against the most vulnerable of the homeless.

42. Nicholas Dodier and Agnès Camus, "Openness and Specialisation: Dealing with Patients in a Hospital Emergency Service," *Sociology of Health & Illness* 20, no. 4 (1998): 413–44; Vassy, "Categorisation and Micro-Rationing: Access to Care in a French Emergency Department."
43. Friedman, "The 'Social Case:' Illness, Psychiatry, and Deinstitutionalization in Postsocialist Romania."
44. Stillo, "'We Are the Losers of Socialism!' Tuberculosis, the Limits of Bio-Citizenship and the Future of Care in Romania."
45. Vassy, "Categorisation and Micro-Rationing: Access to Care in a French Emergency Department," 629.

Abstract

Lay Values, Organizational Concerns, and the Handling of 'Social Cases' in Romanian Emergency Departments

Patients whose social problems are more pressing than the medical ones, the so-called 'social cases,' constitute a challenge for healthcare institutions. This paper documents the staff-devised membership criteria for the 'social case' category and the subsequent handling of clients to whom the category applies at the emergency departments of two public hospitals in Romania. The handling of social cases attests to the decline of the working class in post-socialism and the failure of the social welfare system to meet the needs of the most vulnerable members of the society. At the same time, it gives insights into the permeation of lay morality in healthcare practices and reveals the limited applicability of the theory of moral evaluation of patients in post-socialist medical contexts.

Keywords

social case, moral evaluation of patients, Romania, social categorization of patients, post-socialist healthcare, working class.