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# L'hôpital en Asie du Sud. Politiques de santé, pratiques de soin. Introduction

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## Introduction

In the social sciences, researchers have been particularly focused on studying hospital dysfunctionings—caregiver violence, corruption, medical negligence, discriminatory practices. Indeed, their work often reports on the forms of tension established between patients from underprivileged backgrounds and auxiliaries, nurses and doctors from public hospitals faced with budget cuts, lack of staff and equipment shortages. This observation is particularly documented in West Africa (Jaffré & Olivier de Sardan 2003), Central Africa (Hours 1985), South Africa (Fassin 2008). Brauching out from reflection on the bureaucratic burdens of hospital institutions, on local professional cultures or on structural social inequalities, these researchers reveal the forms of frustration, resentment and contempt felt by caregivers and patients.

The emphasis is then placed on a paradox: the fact that public institutions—supposed to guarantee the health of all reproduce social cleavages. Conversely, initiatives for free health care and hospital improvement policies are being driven into the background.

This is particularly salient on hospital ethnographies carried out in South Asia and in India in particular (Jeffery & Jeffery 2008; Jullien 2016; Varley 2015; Zaman 2004). Historically, in India as elsewhere, the hospital was a place that welcomed and cared for the poor and where there was a high mortality rate among patients and deplorable hygienic conditions until the end of the 19th century (Jaggi 1979; Arnold 1993; Kumar 1998; Speziale 2012). Today, the image of patients sitting on the floor in the corridors or halls of public hospitals, well-known problems of maternal and infant mortality, waiting times, understaffing, outdated medical equipment, corruption or even verbal and physical violence give the impression that Indian healthcare institutions are solely characterized by their dysfunctions. Similarly, the Indian media frequently highlight scandals about poor hygiene and ill-treatment

of patients, calling hospitals a “national disgrace”. This adds up to regular reports in the local press of altercations between hospital staff and a patient’s disgruntled relatives.

However, with the increase in life expectancy, the rise in degenerative diseases, the development of health insurance—including for poor patients (for example the Rashtriya Swasthya Bima Yojana programme launched in 2008)—and the implementation of new health policies, the Indian hospital sector is being used more frequently than in the past. Recent surveys conducted by the National Sample Survey Office (NSSO) show that 4.4% of the urban population and 3.5% of the rural population were hospitalized during the year (NSS round 71st, 2014) compared to 2% and 1.3% respectively on the basis of similar surveys conducted in 1995-96. In the absence of a national registration system, it is difficult to know the exact number of hospitals in the country, but the World Bank and the Insurance Regulatory and Development Authority of India (IRDAI) estimate their number at nearly 100,000. From luxury hospitals to small neighbourhood maternity wards, the hospital system is developing with a multiplicity of offers and services in line with the strong fragmentation of Indian society. Focusing on health policies or on the system of values mobilised by carers makes it possible to realise that concern for patients’ well-being persists despite the difficulties mentioned. In other words, taking into account the perspective of different stakeholders at various scales, from the most informal to the most institutionalized, allows us to nuance the picture of an Indian hospital marked by social and health distress.

## **Hospital (Re)compositions**

Thus for several decades, we have observed in the hospital sector, a progressive dissemination of practices and models of care where the well-being of patients is emphasized. Since the era of the “five-star hospitals”, which spotlighted a better quality of care and service compared to public hospitals (Lefebvre 2008), similar concerns have emerged in smaller private hospitals that want to attract newly solvent patients from an expanding middle class since the 1990s (Lefebvre 2010). These initiatives, through the rhetoric employed, are similar to the activities of the “wellness industry” (Smith & Puczkó 2009): from New Age practices that divert from their original context body techniques such as yoga or ayurvedic massages, to thalassotherapy offered by luxury hotels. Its recent emergence could give the impression of a marketing strategy effect and it might be tempting to neglect the study of this phenomenon based on the pretext that it constitutes a simple fashion, a current trend.

This would be forgetting that in the aftermath of the Second World War, the World Health Organization (WHO), then responsible for leading global health action, relied on well-being to define health. In 1946, institutional definitions of health shifted from a purely disease-free approach to promoting a more holistic perspective (Levin & Browner 2005). The preamble to the WHO Constitution defines health as “a state of complete physical, mental and social well-being”. This definition, signed by representatives of 61 states, has not necessarily succeeded in transforming the vision of the disease or in transforming biomedical practice. However, it has made an unprecedented turn in the way health is approached and still seems relevant: health remains linked to the notion of well-being in the Sustainable Development Goals decided under the leadership of the United Nations in 2016 (cf. Objective 3: Ensure healthy lives and promote well-being for all at all ages).

The well-being of patients in South Asia is mainly addressed from fields on traditional medicines and alternative care practices (Županov & Guenzi 2008). But what about the biomedical system that is widely used by patients? This interdisciplinary volume, empirical in its ambition, has a double objective. On the one hand, it aspires to rebalance the critical point of view that characterizes a number of hospital ethnographies. On the other hand, it aims to understand the contemporary transformations of hospitals based on the study of care policies and practices.

The hospital institution has long been presented as a place apart, governed by its own norms and social structures (Fortin & Knotova 2013: 10). Although hospital institutions attracted the attention of sociologists of the time (such as Parsons or Freidson), they seemed too homologous and familiar for ethnologists to be interested in (Long, Hunter & van der Geest 2008).

In recent years, the publication of thematic issues devoted exclusively to hospitals has been a turning point in anthropology (Fortin 2013; Long, Hunter & van der Geest 2008; Chabrol & Kehr 2018). In a reference article on hospital anthropology, S. van der Geest and K. Finkler (2004: 1998) recommended viewing the hospital not as isolated but shaped by external social life. The hospital is now conceived “as a microcosm of society” (Zaman 2004, 2013), “as a window on the locality” (Sainsaulieu 2003) or, to use the Foucauldian term, as a “heterotopy” (Street & Coleman 2012). Researchers report on diverse “hospital cultures”. And since awareness of death is often attached to hospitalization, hospital life is often “a condensed and exacerbated form of life in general” (Long, Hunter & van der Geest 2008: 73).

Our work builds on the more nuanced reflections of Long, Hunter and van der Geest (2008) who see in the hospital both the effect of a common biomedical culture and local particularities. Due to the professional hierarchy, clothing, language or medical devices, the hospital environment

brings together a certain number of particularities. But the hospital also concentrates and crystallizes gender, class or power relations specific to the territory in which it is located.

This volume is an opportunity to offer an interdisciplinary panorama in social sciences on the contemporary Indian hospital. While collective books and journal issues abound in studies on Ayurvedic, Unani and Siddha medical systems (Leslie 1968; Quaiser 2001; Sujatha & Abraham 2012; Zimmermann 1992) or on other levels of the health care system (Jeffery 1988), the hospital has remained relatively unstudied, except by historians (Arnold 1993; Harrison 1994; Ramanna 2002; Sehwat 2014; Speziale 2012). It is on the basis of this observation and with the will to encourage interdisciplinary exchanges that the workshop “Patients, Practitioners and Walls: Thinking Well-Being in Hospitals in India and Elsewhere” was initiated. It was organized by Clémentce Jullien, Bertrand Lefebvre and Fabien Provost in September 2015 at the Centre d’études de l’Inde et de l’Asie du Sud (CEIAS). Bringing together five presentations, and chaired by J.-P. Olivier de Sardan and A. Vaguet, this gathering aimed to think about well-being in hospitals in India in a decentralized way by comparing it with other countries (France and Morocco in particular).

The present volume is born from this day, rich in debates and ideas. With developments, the ten articles in this thematic issue are in line with the initial orientations: to maintain the focus on South Asia (India and Pakistan) and adopt a multidisciplinary perspective (anthropology, geography, sociology, political science) on the hospital environment, comparing approaches (quantitative, qualitative) and varying levels of scale (micro-macro).

## **From “Health for All” to Quality of Care: Hospitals Facing New Expectations**

Although health is not explicitly a fundamental right enshrined as an article in the Constitution, many health-related investments and projects are initiated by political authorities in the two decades following independence with the objective of guaranteeing access to health care for the entire population, in accordance with the principles of a universal health system. Indeed, while life expectancy at Independence was only 32 years, and in a vision of public policies influenced by socialism and fabianism (Frankel 2005), the planned development of care services accessible to all is a central axis of Indian government health policies (Banerji 1985). According to the various government reports (Government of India 1946; Ministry of Health and Family Welfare 1962, 1985), hospitals would be more numerous, better deployed,

better equipped and therefore contribute directly to the well-being of the population. In this inclusive approach, which falls within the WHO definition of health (1946), the hospital is a centre of excellence in a health system that should contribute, according to the Bhore Committee, to “the positive state of well-being in which the body and mind can function to their full capacity” (Government of India 1946). The health and well-being of the population are still considered inseparable from India’s economic and social development (Ministry of Health and Family Welfare 2002, 2015, 2017): “An aspiration to be ranked amongst the most developed and civilized of nations requires a commitment to improving the health and well-being of its citizens. Health and happiness is not only a driver of economic growth, it is its very purpose” (Ministry of Health and Family Welfare 2015).

If in the past, the hospital was intrinsically perceived as a place of healing, the demands of patients and institutions have gradually increased. Various transformations in the hospital sector have contributed to the emergence of well-being designed in terms of quality of care. The recognition of patients’ rights, through the extension of the Consumer Protection Act (COPRA) to the medical sector, has brought to the fore the issue of the quality of care received and the many failures of the medical sector to regulate bad commercial and medical practices. The increased use of private hospital services also poses problems when hospital charges push households into poverty. Following the neo-liberal turn of the 1990s, and faced with the increased commodification of hospital care (Connell 2011; Hodges & Rao 2016), national hospital policy is now part of very prosaic dimensions of health care improvement and public coverage of health expenditure (Ministry of Health and Family Welfare 2015, 2017).

Moreover, with the expansion of private hospital provision, and increased competition between institutions, the quality of care and services offered by hospitals have become important elements in attracting patients (Baru, Qadeer & Priya 2000). By developing a wider range of services, by drawing inspiration from the practices of other service industries (hotels) and by better integrating the diversity of patients’ expectations in the use of hospital services, private hospitals are dealing with new normative sources in their organization and practices.

The rise of medical tourism has been particularly important for the restructuring of the hospital sector. Many social science publications have focused on the economic, legal and logistical reasons why patients travel abroad to treat diseases (Bookman & Bookman 2007), to become parents (Inhorn 2007; Pande 2016; Rudrappa 2010) or to make therapeutic cures (Naraindas & Bastos 2011). A large number of studies agree on one point: India and the private hospital sector have positioned themselves on this global market and are now

leaders in medical tourism (Bochaton & Lefebvre 2010; Connell 2006). This is due to several factors: attractive prices, renowned specialists, modern infrastructures, advanced technologies and a therapeutic pluralism well-known worldwide with ancestral medicines: “To become the most important global destination it has upgraded technology, absorbed western medical protocols and emphasised low cost and prompt attention” (Connell 2011: 1095). This success in the surgical care sector is also due to the structural weakness of hospital systems in neighbouring countries (Afghanistan, Bangladesh, Nepal), from which a large majority of foreign patients coming to India for treatment originate (Lefebvre 2010). The rise of medical tourism has undoubtedly accelerated the emergence of high-level hospital services in the private sector and has incidentally contributed to the emergence of the quality of hospital care as an important issue in Indian hospital policy.

Beyond the hospital sector, India’s “wellness industry” is particularly characterized “by a strong potential for innovation in the therapeutic field and by a claim to the age of these new therapies” (Pordié 2011: § 22). With its transnational dimensions, this wellness industry has also participated in the redesign of therapeutic practices and, more generally, in the reconfiguration of the health landscape in India. For example, yoga is a practice that has gone “from an ‘Indian knowledge’ to a ‘global knowledge’, then declining by following an infinite variety of social norms relating to the body by complex associations, borrowing from different fields of so-called complementary or alternative medicines” (Hoyez 2014: 58). Finally, and although this aspect is still little studied, the welfare industry also influences the expectations of Indian citizens. Hospital services, like other service industries, are now the subject of online patient reviews, while health insurance companies are developing inter-hospital comparison tools to guide patients in their choices. Even in the context of public facilities with limited human and financial resources, in the face of large patient flows, improving patient well-being can lead to innovations that improve the quality of care. In his ethnography of *Mumbai Cancer Hospital*, a cancer reference centre, Macdonald shows the important role volunteers play in monitoring and welcoming patients and how beyond biomedical care, religious practices (*seva*) can improve the well-being of patients and their families (Macdonald 2016).

The contributions of this special issue are divided into three thematic areas. The first axis, entitled “Breaching standards on behalf of patients?”, examines the rationale for replacing formal standards with informal and widely shared sets of professional practices. The second axis “Hospital spaces: towards the complementarity of cares?” questions the plurality of spaces and stakeholders involved in patient care itineraries. Finally, the contributions of the third and final axis “Well-Being in question: care experiences” puts into perspective

the discrepancies between care services and patients' experiences. Thus, by varying levels of scale, combining institutional perspectives with ethnographic studies, and addressing local conceptions, methods and practices, this issue aims to foster more integrated approaches to the hospital sector.

## Breaching Standards on Behalf of Patients?

As mentioned, a growing number of national and international standards designed to frame and improve the quality of hospital care and patient safety has been articulated over the past few decades. B. Lefebvre thus returns in his contribution to the challenging beginning of the Indian hospital accreditation system, often presented as a solution to the public authorities' failures to control the hospital sector. This corpus of standards, although co-constructed by private and public stakeholders, is having a very difficult time gaining a foothold within hospitals and in a hospital sector marked by strong fragmentation.

In this context, many researchers favoured top-down approaches to assess the extent to which new resolutions were then translated and implemented within hospital institutions. But the proliferation of conventions and arrangements—which may be difficult to put in place or poorly adapted to the local context—should not overshadow the existence of less visible but equally decisive informal and shared practices.

In his work on the hospital, T. Parsons identifies the respective social roles of patients and physicians. His model is based on the idea that physicians' actions are related to their official duties (Parsons & Shils 1951). The relationship between a doctor and his patient is purely “affect-neutral” (*ibid.*), ideal-typical of *Gesellschaft*-type societies (Weber [1921] 1978), in which state representatives have no emotional or personal ties with the users they meet. As a result of Parsons' work, the social sciences have documented the deviations physicians make in hospitals from the institutional definitions of their role.

The interest of the exploratory concept of “practical norms” is precisely to analyse the existing gaps between official norms and practices (or attitudes) shared collectively by state agents, be they bureaucrats (Blundo 2015; Olivier de Sardan 2015) or public-sector caregivers (Le Marcis & Grard 2015; Olivier de Sardan 2013). Forged by J.-P. Olivier de Sardan in reference to an African context, this concept has the merit of not conceiving deviations from norms exclusively in terms of deviance or social disorder. As the latter specifies, “practical norms” refer to the “various informal, tacit or latent regulations that underlie the practices of stakeholders that do not conform to official or formal norms, that explain by their very existence the relative

convergence of these practices, and that make it possible to understand the gaps or the ‘game’ with official or formal norms, whether professional or social” (personal communication).

At the hospital, these practical standards may be essential in identifying cases that deserve the attention of health care staff from “rubbish cases” (Jeffery 1979). But the determinants of differentiated patient treatment are not exclusively biomedical and moral. The research conducted by H.M. Andersen (2004) in Ghana and by D. Gibson (2004) in South Africa are salient examples: despite the ideal of equal access to care, the working conditions in hospitals and the value systems specific to each healthcare provider do not allow them one and the same and unique treatment. As such, understanding the professional culture of caregivers and taking into account the environment in which they work is essential to avoid hasty judgments. “Many [doctors] only become that way because of the way of life they have been expected to lead, to survive as doctors in sometimes harsh, even brutal environments” (Hemmings 2005).

Drawing upon detailed ethnographies, several contributions to this volume show that these differences are numerous and diverse in Indian hospitals. Such disparities can be observed in relation to national health policies (Jullien), laws relating to forensic medicine (Provost) or good clinical practice (Varley). In each of these three cases, the violations of established policies, laws or protocols, and its justification by health professionals, make the existence of alternative informal standards aimed at the well-being of others, all the more obvious. For example, in obstetrical settings, health-care workers have shown little interest in ensuring that the adoption of contraceptive methods respects the “informed and voluntary choice” of individuals, as advocated by health policies. In practice, hospital staff deviate from the official standard by favouring definitive contraceptive methods, considered more suitable for populations from underprivileged backgrounds and therefore more effective (Jullien). Similarly, many medico-legal experts knowingly omit evidence when writing autopsy reports, thereby derogating from the Indian Evidence Act. Doing so allows them to guarantee the insurance premium or to preserve the reputation of a deceased’s family (Provost). Many caregivers at the *Gilgit-Baltistan District Hospital* in Pakistan do not follow the recommended dosage of oxytocin. This breach of protocol is also fully owned. Given the lack of resources and personnel, the administration of oxytocin is dictated by practical logic, or even by the financial interest of the caregivers (Varley). In each case, the discretionary power of agents is based on a critique of state policies or laws deemed irresponsible (Jullien), ethically difficult (Provost) or unrealistic (Varley). In sum, on the basis of ethnographic cases attentive to the interactions between state agents and users of care services, several of

the works gathered here show how caregivers' conceptions influence their interpretation of the rules. In other words, the contributions of C. Jullien, F. Provost and E. Varley reveal how public sector caregivers are—like teachers, the police, courts or legal services—“street-level bureaucracy” (Lipsky [1990] 2010), “policy makers” (*ibid.*: 13).

Like J.-P. Olivier de Sardan with his concept of “practical norms”, these texts highlight the existence of parallel standards (or protocols) and reflect the logic at work. The various contributions clearly show that deviations from the established standards “do not indicate a lack of standards, but rather an excess” (De Herdt & Olivier de Sardan, 2015: 4). As previously stressed, taking these standards into account is central to going beyond whistleblowing logic, understanding the uses and operations of the hospital sector and better discerning the attitudes and behaviours of hospital staff. Hospital ethnographies often list implementation problems and in doing so provide a critical picture of caregiver-patient relationships and the quality of care provided. Research, particularly in sociology, is an exception to the rule: in her work on the disease-caregiver relationship in France, S. Fainzang shows that doctors' lies are mainly considered to benefit patients (Fainzang 2006: 73). This is particularly notable in the precautions that European and North American hospital staff take to announce the approaching death or to inform family members of a loved one's passing. “The doctor finds himself torn between conformity to his social role, allowing him not to say everything, or even to lie, and the concern not to appear to contravene the new values laid down by health democracy, advocating the autonomy of the patient” (Fainzang 2006: 150; cf. also Glaser & Strauss 1965).

Like this research, the contributions of this volume show in an original way how the concern for patients' well-being remains relevant when official standards are supplemented by another set of practices and logics. While violations of policies, laws or clinical protocols by hospital staff have often been viewed as infringements of patients' rights, this volume demonstrates that they can also be motivated by the public interest, patients' well-being or the appropriate care delivery.

## **Hospital Spaces: Towards the Complementarity of Cares?**

For a long time work on the hospital focused on the way in which the spatiality of hospitals participated in their normativity. For E. Goffman, spatial configuration and rules of life are closely linked to the hospital, “A total institution may be defined as a place of residence and work where a large

number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life” (Goffman 1961: 11). Barely fifteen years later, Foucault forged and developed a substantially similar concept, that of “disciplinary institution”. According to Foucault, the hospital constitutes an “instrument of medical action” which is “in its very materiality a therapeutic operator” (Foucault 1977: 172). Despite different theoretical concepts and methods, the two authors agree on the impact of spatial layout and internal organization on the intrinsic effectiveness of the hospital institution.

In their analysis of the discourse, practices and activities within psychiatric care services, Bayetti, Jadhav and Jain show the porosity of these spaces and the circulation of practices that are organized there. In contrast to the concept of a “total institution” (Goffman 1961), the presence of family carers is mandatory in certain services, for material and practical reasons, creating a link with the outside world, continuity with the home space, and helping to maintain the patient’s social identity. Through the study of a community mental health program, the authors also expose how the concepts and practices produced in these spaces, notably with regard to the use of psychotropic drugs, are reinterpreted outside by patients and their families.

If the spatial configuration of hospitals has been considered for its continuities and ruptures with biomedical practice, patients in South Asia turn to medical traditions and places of great diversity during their therapeutic itineraries. The Indian government encouraged the development of indigenous systems of medicine in the 1970s to increase medical coverage among more isolated rural areas (Dejouhanet 2009), however it would be wrong to conclude that Indian patients are turning to AYUSH due to deficits in biomedical infrastructure. There are various reasons why individuals choose more inclusive medical approaches or combine different approaches—jointly or successively—for the same disease. Therapeutic itineraries reflect both the quest for meaning (“why me?”) and the willingness of individuals to approach illness in a holistic way.

With the official recognition of Ayurveda, Unani and Siddha medicines, yoga, naturopathy and homeopathy (AYUSH) in 1973, India leads the way. Indeed, not only are therapeutic itineraries and medical pluralism a widespread and well-documented phenomenon in Asia (Leslie 1976, 1980; Minocha 1980; Županov & Guenzi 2008; Bourdier, 1996; Naraindas, Quack & Sax 2014) but many Asian states have the particularity of officially recognizing several health systems. Thus, in Bhutan, patients have a choice between two formal and institutionalized health systems (biomedical medicine or national traditional medicine), plus a range of alternative practices (shamanism, possession, oracles, etc.) (Tae 2017). In India, six state-supported health systems

coexist alongside biomedical medicine: Ayurveda, Yoga, Unani, Siddha, naturopathy and homeopathy (Hoyez & Schmitz 2007). And these systems are not compartmentalized: several very recent private hospitals adopt the principles of traditional Hindu architecture (Vastu Shastra) and care protocols integrating biomedical care and traditional therapies (Ayurveda) have been created. The C. Van Hollen, S. Krishnan and S. Rathnam's article specifies the dual contribution of traditional healers in therapeutic itineraries. Not only do they provide the necessary response elements for patients' relatives, but they also contribute to maintaining the social and moral integrity of individuals suffering from stigmatising diseases.

In addition to policy makers and healthcare staff, the contributions in this issue reflect a diversity of non-hospital stakeholders involved in shaping patient well-being. In India, NGOs often take over primary care activities in the most deficient areas. Non-resident Indians (NRI), professional organizations and international organizations (WHO, World Bank) have supported the development of a hospital accreditation system in India to improve standardization processes and ensure a certain level of care. Some Indian hospitals (*Apollo Hospitals*) go so far as to align themselves with transnational standards defined by the American accreditation body, Joint Commission International (Lefebvre). Similarly, S. Banerjee's article shows that the standards of care for Indian surrogate mothers stem from the expectations expressed by the intended parents, often from abroad. During gestations for others, not only are the precautions taken during pregnancy higher than those taken when women are pregnant with their own child, but the reception conditions are much better (Banerjee).

In short, the standards implemented in healthcare institutions are also based on standards defined by heterogeneous stakeholders based outside national borders. Whether it is a question of ensuring access to care, guaranteeing a high standard of care, participating in the therapeutic dimension or even taking into account the social and moral aspects of the disease, a whole range of institutional stakeholders contribute, on different levels and with different skills, to the well-being of patients.

## **Well-Being in Question: Care Experiences**

In parallel with the multiplication of stakeholders producing standards of well-being, we are also witnessing a multiplication of tools designed to identify, take into consideration, and measure the aspects that contribute to patients' well-being. This new trend in the hospital sector is attracting

interest from the social sciences. The literature review shows a shift in the disciplinary power of hospital space towards new questions about the benefits of spatiality and materiality for patients.

The idea of quality and the use of its indicators were originally applied to the evaluation of care with a view to monitoring and reducing the risk of infection and medical errors. They were then gradually extended to all hospital functions, particularly from the 1950s in the United States, in an effort to standardize practices on a national scale (Luce, Bindman & Lee 1994). Today, the development of hospital quality is articulated through the organization of the establishment, care, non-medical services, communication with patients, staff training, etc. These standards impose an objective, quantifiable and measurable perspective on quality. This vision is not always shared by physicians, especially when it comes to the relationship with patients. It is also sometimes not shared by patients themselves, whose expectations and needs for health and services can be very different within the same hospital. Banerjee's contribution exposes such a glaring gap: surrogate mothers notice that their pregnancies are monitored very differently depending on whether it is their own child or a surrogate child. Similarly, the issue of waiting time, for example, does not arise in the same way depending on the type of therapy or patients' past experiences, as described in S. Bärnreuther's article on India's context. Indeed, in the case of patients undergoing a medically assisted procreation protocol, the question of waiting is inseparable from highly personal therapeutic itineraries, be they repeated failures, entries on waiting lists or transitions between private and public hospital sectors.

This openness towards the more subjective dimensions of well-being is particularly pronounced in psychiatric care services. While aiming to ensure that patients are disciplined, many psychiatric centres and hospitals intend to contribute to the well-being of their patients by working towards their autonomy and empowerment. "Care rather than control". This is, for example, the motto of community psychiatric care centres which, according to C. McCourt Perring (1994), try to take the direction opposite to conventional hospital institutions. By establishing centres on a human scale where staff are recruited more by innate arrangements than by degree of training, the objective is to improve the caregiver-patient relationship and ensure a greater sense of freedom, autonomy and privacy for patients. In this volume, A. Gagnant de Weck's paper reports on the introduction within a psychiatric hospital in Delhi of methods specifically directed towards individual happiness, autonomy and the free expression of patients. However, her ethnographic work highlights the multiple discrepancies that can exist between the expectations and the discourse of health professionals in relation to their ideals of well-being and its modalities of application.

This gap between norms and practices in understanding patient well-being is not limited to measures of quality of care, but is sometimes found more fundamentally in medical knowledge itself. A. Strauss' work, based on the study of the case of a schizophrenic patient, shows how the discourse about the psychiatric institution held by a patient can be invalidated in the name of the objectification of his pathological condition. In contrast to this approach, A. Strauss's collection of "mad narratives" reveals that studying patients' speech enriches our understanding of hospital well-being and the factors that constitute it.

## Conclusion

This volume is an important contribution to the study of the circulation and implementation of professional standards, medical protocols and applicable regulations in hospitals. In this endeavor, the hospital acts as a reference point to define the scope of the standards, behaviours and interpretations that we propose to analyse. The collected articles illustrate several possible levels of apprehension in understanding the norms that apply to the hospital, from the transnational circulation of standards of care to the discussion of patient expectations on a case-by-case basis by medical staff. Whatever perspective is retained, the development and implementation of hospital policies only take place in accordance with local interpretations of this normative framework. Yet, while the hospital is a critical space in the development, interpretation and challenge of health standards, moving away from the hospital can also be enlightening to better understand changing patient expectations in India at the beginning of the 21st century. Additional research could be undertaken, in an interdisciplinary and comparative logic, to complement scientific knowledge of health production sites in India.

A better understanding of the reconfigurations of hospital practices and standards requires multi-site approaches that compare care from "traditional" therapeutic systems in their original production sites (temple, ashram, etc.) and in hospitals. This also involves looking at caregivers and patients outside the hospital: patients' responses to telephone satisfaction surveys or researchers' questions vary considerably depending on whether they are asked during the hospital stay or outside the hospital, once patients return to their relatives. In relation to the biomedical field, several stakeholders, such as health insurance companies and quality consultants, who do not belong to the hospital environment as such, are nevertheless playing an increasing role in the production of standards and their application in hospitals. Their interactions and mediations with patients and medical

professionals certainly deserve to be better explored. Like hospitals, the judiciary system is not simply a place for discussing norms, but also a place for interpreting and producing rules. The explosion of complaints of “medical and commercial malpractice” has led to increasing intervention by judges and medical experts to establish what constitutes “good medical practice”. In addition, Indian courts are seeing an increase in the use of judicial motions (Writ Petitions, Publics Interest Litigations) to decide issues related to public health debates. Finally, expectations and standards for health services are also discussed on social media. The multiplication of participatory platforms and the development of wide access to web tools for Indian patients constitute a new site to explore the expectations and aspirations regarding the hospital environment and the medical world.

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