

Life is not Normal

Social Construction and Change of Everyday Life while waiting for one of the Family members who are hospitalized

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Abstract— The economic crisis in Southeast Asia in the 2000s has resulted in the vulnerability of its people, including in Indonesia. Within the framework of economic recovery, the government developed a pro-people health policy. Every citizen is given health insurance. If it is poor, then the government helps its dues. However, it is not fully utilized. This study shows several reasons for the ineffectiveness of the program. Not a matter of access, but rather a matter of construction about illness. Pain has a social function. Pain can disturb the regularity of everyday life. Because things are more advanced, especially when deciding to be hospitalized. This study shows that there is a different construction between patient and family of patients based on social class. Differences in construction are related to pain, decisions for hospitalization to the decision to wait for the patient. Patients construct pain as destiny and misfortune. The family understands as destiny. Consequently, the family performs waiting activities as a form of love and concern for the patient.

Keywords— *sick, illness, poor, medicare, life not normal. Social construction*

I. INTRODUCTION

The continuing monetary crisis in the political crisis of 1996 and thereafter resulted in the societal and economic vulnerability of the economy. These two sides are in a loop of poverty and prosperity, meaning that the economic crisis results in an individual and family health crisis, otherwise health vulnerability will have an impact on the economic crisis. In the economic recovery program, the government includes a *pro-poor* people health policy with *askeskin* or *askes gakin*.

From World Bank records (2006), during the Suharto government, although it was the responsibility of the government, the use of health facilities was more a private matter. Assumptions are built, the government has established various health care centers, from the village level to the city, from health centers to public hospitals, but the community must also bear the cost of services. Therefore, the government

at that time considered the policy of pro-rich people, let alone the number of poor families who use public health facilities remain low on the one hand. On the other hand, the number of health facilities and health professionals accumulates more in urban areas than in rural areas.[1]

Nevertheless, since the post-Suharto government, there have been changes in health policies. This policy is more on the side of the poor. This is evident from Bappenas (*National Development Planning Agency*) data. Data from Bappenas (2009) shows that health funding for 76.4 million poor people is allocated for 4.584 billion rupiah, while the fund for primary health centers is 2.64 billion rupiah. The government also charges the payment of health insurance claims for poor families amounting to 176 billion rupiah, and family planning activities of 500 billion rupiah.[2], [3]

From the researcher's initial observation, it is known that this opportunity is not accessible by the family. Findings in Makassar for example, a mother and child died.[4] Meanwhile, in East Java people prefer to go to a young shaman (*dukun tiban*), Ponari, from Dusun Kedungsari, Balongsari Village, Megaluh Distric, Jombang Regency. Every day Ponari who is still in grade 3 elementary school must me - serve hundreds of patients. The origin of the patient is not only from around the village, but already across districts and provinces. [5]

In the meantime, there are some notes about how the behavior of people who are forced to let their family members be treated roughly, or prefer to seek treatment instead of having hospitalization should be advised by a doctor. Observers of urban poverty see this problem as more of an excess or a result of poverty. Incapacity of the poor in accessing health facilities. [1]

However, it attracts attention when the government provides health insurance for poor families (*askeskin*), public health insurance, and requires the management of private companies to provide social security for their employees, the avoidance patterns of health facilities remain, especially if

they have to inpatient. That is, in addition to the problem of access to health services, there are other problems from the community.

The issue of inpatient costs is a major concern for all families, not just poor families. Families who are able to afford it usually have budgeted health costs in insurance, not so in poor families. Poor families prefer the fulfillment of basic living needs, such as consumption and shelter, rather than health.

Sickness conditions are not always understood the same in society. There are different constructions in each family. Can not be understood, whether it is related to socioeconomic status conditions, for example in families who are able to assume pain if the body is felt not like the previous days, or if the poor families assess the pain if not able perform social function, especially can not earn a living. Similarly, accept the doctor's decision for inpatient whether it will be viewed differently in different layers of society.

II. RESEARCH METHOD

This research takes place in Surabaya and surrounding areas (Sidoarjo Regency). In addition to technical reasons, such as compatibility with the residence of the research team, more than that changes in the economic structure of Surabaya and its surroundings have an influence on the status and condition of public health. The unit of analysis is inpatients and their families. Since social construction is contextual, depending on the type of illness (chronic and not chronic), cultural and socioeconomic background, the subject of the study is distinguished by the variant. The socio-economic conditions of the family, for example, affect the choice of health institutions, namely the classroom and the type of hospital, while the culture and the type of disease affect the construct of the patient.

There are two data collection techniques used in this study, namely observation and in-depth interviews. Observations were made to obtain a description of the role of family members in the healing process of health (inpatient), lifestyle changes and family member strategies for having to wait and care for the sick. In addition to making field notes from the observations mentioned, photography technology is used to record every event.

From medical knowledge and illness narrative obtained from in-depth interviews, this study uses Alfred Schutz's phenomenology by typifying to know the general type and personal ideal type of the patient's subjective experience and the patient's waiting family. The common and personalized built types include pain, illness, healing, the hope of post-healing relating to the patient's position in the family, the following regarding the pattern of inpatient decision-making with regard to the patient's position in the family.[6]–[8]. It is related to the *in order to* motive and *because* motives on the

patient's self and the patient's family when the decision to take care of inap. In addition, the general type and personal ideal associated with the objective conditions of individuals and families, such as ethnicity and social class, have provided socialization of that knowledge.

III. RESULT AND DISCUSSION

A. Social Construction of Illness

Of all patients, illness is defined as not performing its social role. This malfunction is characterized by physical features or conditions that do not allow a person to perform functions, such as headache, body temperature rises (heat), body weakness is not good to move, until faint and paralyzed. Richard (13 years old) who body dizzy, hot, and body limp, as well as Mr. Tumiyo (56 years old) who feel healthy. When the doctor went to practice, he collapsed and went to the hospital.

The patient and his family actually never distinguishing chronic and non-chronic disease. Chronic illness does not mean long-standing illness due to organ dysfunction, but seen from the effects it has on the body. Senyampang is still healthy, moving normally, even though it has chronic illness and can cause death, the person is considered healthy. This case occurred as happened by Mrs. Nanik (60 years old) and Mrs. Masrurroh (55 years old). They keep working as normal as if they did not experience any illness, until they became exhausted and fell ill. After the condition falls, limp and faint, new patients and families pay attention and take the option for hospitalization. That is, chronic diseases or not a choice of views of patients and family members remain the same. People are considered sick if they do not perform their functions.

Meanwhile, in less fortunate families, the illness is a disaster. Their life is barely mediocre. From time to time they work to earn additional income. Therefore, when one family member, let alone the head of the family, will be considered unfortunate. Although interesting to be observed, to the doctor or hospitalization is considered a deposit or arisan to be paid without requiring whether to return or not, as usual. They resign, but underneath it assumes that it is a disaster not only for the patient, but for the family. Therefore, it is not uncommon for sick children or family members who are not their breadwinners to misplace first. Only then, after a few days, family members would regard divine fate or trials.

TABLE I. SOCIAL CONSTRUCTION OF ILLNESS AND DISEASE

	Social Class	
	Poor/Near Poor	Not Poor/Rich
BKKBN Criterion	Pre-prosperous 1	Prosperous Grade 1 or 2
Payment to Hospital	Free by Public/Gov.	Silver/Gold/Platinum type of Health

	Health Insurance (Medicaid)	Insurance Cash via saving on Bank)
The Other Economic Resources for Paying	Family and Neighborhoud	Family, Coorparate, The Other Social Network, like as: Religious Groups
Volume	Small	Big
Disease	Infectious Disease (Non-Chronic) Chronic Disease	Chronic
Factor	Working Hard Enviroment	Working Hard Diet
Social Construction of Hospitalized	Paying to Doctor/Hospital Fate (Nasib)	Time off Contemplete / Closer to God
Patient Construction	Load	Load
Family Social Construction on Patients	Load	Time to show love
Social construction of pain/sick	Disaster (Musibah)	Destiny (Takdir)

hit too. In addition, if treated, how about my sales. Not to mention, I have to go back and forth (wira-wiri) to the the village local office, district office and primary health center taking care of health insurance for the poor. It can be done within a day." Currently, with a government policy that requires everyone to have health insurance, it really does not matter. The government will bear the fee for poor families.

Third, the doctor's actions usually explain the level of emergency of the patient if not addressed intensively. The evidence of laboratory medical records is shown in patients and families. Patient and family decide. Patients often refuse to be called sick and have to be hospitalized. With medical records, Mrs. Nanik was "forced" by family members, such as husband and son. *"If it's not like this, when will the mother want to rest"*

Finally, this is the end of the negotiation episode between doctor, patient and family member of the patient. This negotiation can last only five to ten minutes, or it may take several days, until such as Mr. Tumiyo and Mrs. Nanik that the doctor had previously advised for the hospitalization. *"Money can be found. When it hurts, what do we want?"* More or less the same, it is said by the patient and family members who wait when it finally has to be hospitalized A difficult choice and not easy.[9], [10]

B. Hospitalization: End of the negotiation episode

With health insurance for the poor, the opportunity to obtain health care is the same for all community layers. Nevertheless, the conclusion of a medical action to be performed, ie hospitalization, is not always welcome to all patients and members of family. First, the patient's condition is a major consideration in the decision of the patient or family's member. Dreadful conditions, such as Doctor Wijaya who had a sudden difficulty walking and talking after practice, Mr. Tumiyo fainted, and Richard that weak, gave no alternative to the family. When the patient goes into the ER, the physician checks and performs the initial medical action, then usually sees the family members and offers advice for hospitalization. Because the patient is in the care room, family members usually negotiate the possibility of outpatient care. When knowledge of the profound disease and the condition of the patient is severe, the family usually approve the doctor's advice.

Second, negotiations can continue between doctors and family members of patients. It happens when the family member has experience of caring at home with the same illness. Moreover, the main consideration is the issue of funds, as well as difficulties when taking care of askeskin, such as Mrs. Supriyatin (45 years old), Richard's mother, *"How not? If I get dengue fever I can take care of it. Her brother had been*

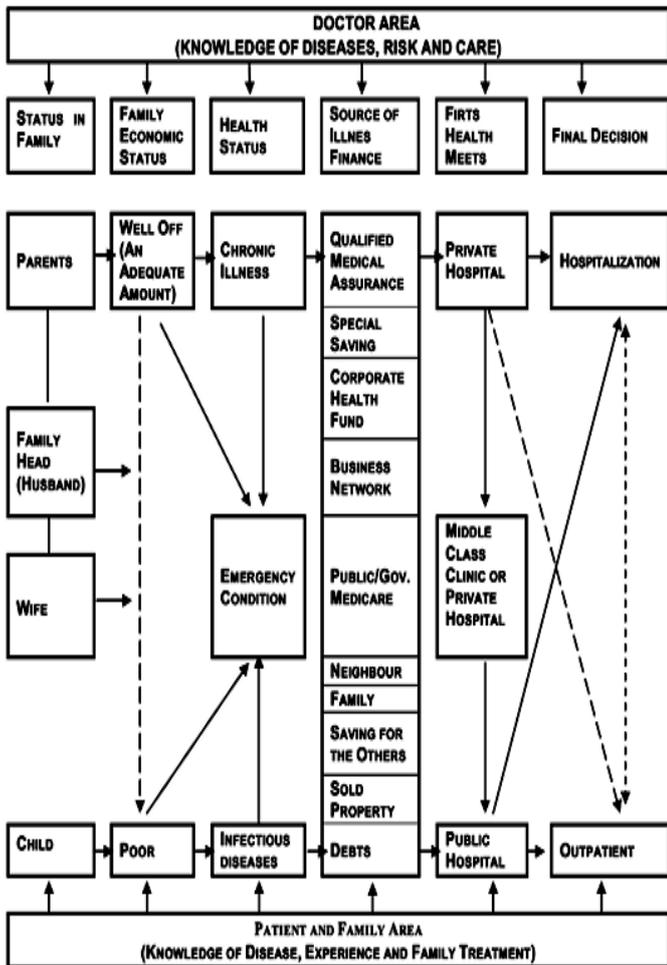


Fig. 1. Negotiating Arena between the Doctor, Patient and Their Family

C. Waiting for Patient, Replacing Nurse Function

When looking at cases in the findings of data, it appears there are certain patterns in the decision to wait or not to wait. In the patient, the first pattern is that if the patient sees it as a disaster, then it gets a sense of guilt. Supported by trust in nurses, they choose and ask family members to not have to wait for him. The reason, what suffered is enough for them, no need for other family members. The second pattern, patients with chronic illness actually already feel it as destiny. Resignation or fatalism is a coping strategy on the condition of pain that has been chronic and lasted continuously.[11]

However, they often feel guilty to family members. They feel they have involved family members on their problems. For them, it is more than enough attention and affection of family members. It's more than enough family sacrifice. Therefore, from the beginning they tend to avoid hospitalization in hospital, better outpatient. For them, it is better not to stay with the patient. For patient family members waiting, the main problem is hospital service, in this case the

nurse. With the condition of any patient, initially considered unfortunate, but when it is faced from day to day, then there is the process of adjustment (*coping strategy*). The construction of calamities then gradually becomes the word "fate" and so on until finally accepting as "destiny." Whatever its construction, as it considers disaster, if they feel guilty. Therefore, they want to give more attention and do not believe in nurses. The next action is to wait for the patient. They replace the nurse's function, except for medical treatment. This is different from those who have high confidence in hospital services. They fully surrender the nurse, except on private activities, such as bathing and defecating. Trust in nurses or precisely on hospital services is actually a consequence of early decision making and health insurance ownership. This finding is more or less the same as Michele A. Carter.[12]

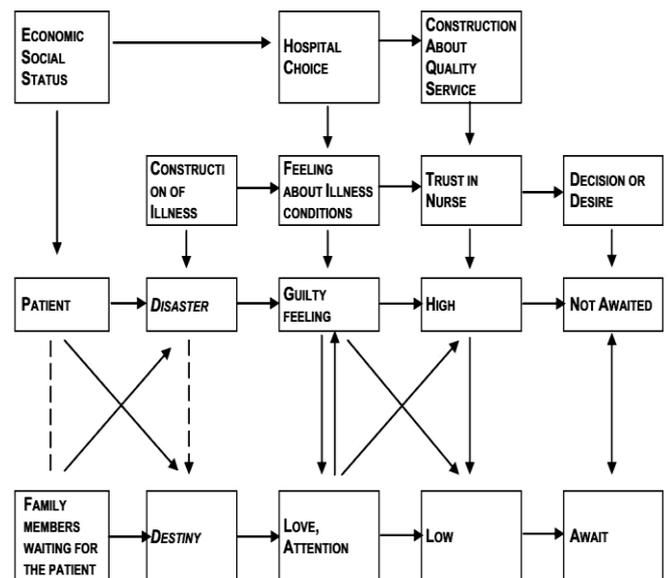


Fig. 2. Social Construction on Hospital and Patient Waiting

Family members waiting for patients not only function "replace" (in quotes) nurses. Moreover, after completing the financial administration and buying medicine, they have motivated and shared spirituality with the patient. Spirituality occurs as a coping strategy of patients and family members. Inside that spirituality, they reflect, reflect and then reconstruct the illness and condition of the patient's pain. Dana Bjarnason sees it as a genuine religiosity related to the belief system that exists in society. The nurse can serve as a secular priest who provides a religious explanation of his condition.[12],[13] Apparently, this does not happen predominantly in the care institutions in Indonesia.

Problems are less the same when asked why patients should be waited on. The first time, when conducting observations and interviews with Doctor Wijaya and his family, the research team analyzed that handing over to hired professionals was a Chinese (*Tionghoa*) way of serving

patients. Or, at least the nearest member of the family waits in the morning until 12 a.m. (the time of the morning visit ends) and the afternoon when the afternoon is late. Apparently the pattern is more or less the same is also done by other families of the Javanese with upper middle class social status, such as Mrs. Nanik and Mr. Tumiyo.

IV. CONCLUSION

What can be concluded from this research is that the decision for hospitalization is not an instantaneous decision, short and without any calculation. The decision was not just based on the gravity of the patient. If the patient gets sick until he / she is unconscious or when he is immature (still dependent on the parent), then the decision is made by other family members. If the patient is in serious condition or life threatening, then the negotiation process does not last long. The patient's family members are in an inferior or subordinated position of the medical personnel (in this case the doctor). Their choice is to accept any doctor's decision. After that, they will think and collect all their capital for the cost of patient treatment. But not so in patients suffering from chronic illness, patients themselves will negotiate with family members and doctors. Family members also negotiate. In the process of negotiation, there are a number of objective conditions and constructions of ill participating. Negotiations can take place in the old process, and ends when the patient undergoes the emergency process.

This process does not stop at the time of decision to be hospitalized. The process continues in the event of waiting for the patient at the time of hospitalization. Who and what reason the patient should wait for is the continuation of the construction of the ill and continues on the feeling or self-assessment of pain, that is guilt and/or love/ attention. The construction of hospital services and the trust of the provider (in this case the nurse) also determines whether the patient asks to be awaited or not. Patients are actually stronger driven by guilt and a desire not to be troublesome. Already hospitalized is considered by the troublesome and guilty patient for it. The burden of this feeling becomes even greater when awaited by family members, even more sick if sick.

These things must be considered by the provider. First, there is a construction difference about pain. For ordinary people, it is considered sick if it can not perform its social function. As long as they are healthy, they tend to avoid health service centers. Secondly, there are a number of objective conditions involved in decision making. Third, the objective condition also contributes to the patient's waiting activity. These conditions are often overlooked by the hospital. As a result, the number of patient waiters is often encountered more than the number of patients, especially in government hospitals.

These findings provide feedback on hospital promotion and agreed terms for the patient's family. That is, they are

expected by taking into account the patient's objective conditions and their construction. They should arrange and organize the inpatient room, so it is not shabby. Slum conditions can bring illness to patient waiting. The one patient recovered, the family members following the hospitalization. If these conditions continue, then no doubt sickness became one of the factors causing poverty.

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