

Chapter 37

The Care Facility in Central Europe as a Form of Shelter: Implications for Women

Carolyn Thompson

Carolyn Thompson is an assistant professor in the College of Architecture and Design, Kansas State University. In 1990, she was sent with three other faculty members of the college on a fact-finding tour of Central Europe to explore opportunities for exchange, professional development, and research. This paper offers some of the observations from that tour. She has a Bachelor of Arts in the History of Art from Mount Holyoke College and a Master of Architecture from Columbia University, with twelve years of professional practice in architecture and interiors.

In November of 1990 four faculty members of the College of Architecture and Design of Kansas State University (KSU) were sent by the College to Central Europe to explore opportunities for exchange, professional development, and research. As a member of that group, among my personal interests were facilities which offer care: relatively short-term in the form of the hospital, or long-term in institutions such as orphanages or nursing homes. As the only female member of the group, I made a point of observing the status of women in the society at large, and the degree to which policy and cultural attitudes affecting them also influenced the care facility.

The classic Soviet conception of its citizens is best depicted in Social Realist art, where human forms are idealized, as in ancient classical sculpture. In this depiction of humankind, there is little place for the concept of uniqueness or diversity, which has led Western cultures to the notion that "special" populations deserve special attention, so they may participate fully in the life of the community. Many of the social developments of the last three decades in the West have dealt with the fact that economic distinctions, which Soviet regimes initially purported to remove, are not the only limitations which may hinder equality. Viewing social realist images of the family, one does not perceive, for example, the ethnic differences to which Central Europeans have clung for decades; nor does one see the traditional family roles which women are obligated to fulfill despite full-time employment; nor is it evident that many citizens of formerly Soviet regimes are physically and/or mentally disabled. The *denial* of these phenomena is painfully evident to an observer from the West, where these issues have been addressed continuously for a generation. The inattention which they have received in these formerly Soviet countries suggests that in Central Europe, as in the West, ethnics, women, and the disabled may share a common cause.

The previous Soviet regimes in the region were committed to the provision of care, for as long as possible, to anyone requiring it. In the limited exposure to these facilities which our 1990 tour provided, it seemed that there was more reliance upon the care facility than is conventional by current Western standards. Stays are longer, and confinement to such a facility seems to be the physician's solution of choice more frequently than in the West. The average stay in a Polish hospital, for example, is 28 days (Niemiowski, 1990); such a lengthy stay could thus accord the facility the status of *shelter*. The care facility is of special concern to women, who are frequent recipients of health care

services due to their reproductive capability, and because they or their children may be born with disabilities, which in these societies could confine them to an institution for the duration of their lives.

The inclusion of this paper in this conference is based on the premise that (1) the care facility in Central Europe is a form of shelter; (2) women are strongly affected by the facility and policies surrounding its delivery of services, and (3) those policies do *not* facilitate women's personal control over their bodies or their lives.

In the view of current Western concepts of care, the heavy reliance upon the care facility may be seen to contribute to a dependency that Americans, at least, would view as inconsistent with the change in economic structure that we presume to be taking place. This perception, however, may be based not on a Western vs. Eastern economic dichotomy, but rather on a European vs. American cultural one. In a 1988 article in the *Journal of Aging and Human Development* (Gelfand, 1988, 57-65), the author compares the character of German social services to those of the United States. German services, like those in Central Europe, are almost always performed by professionals, and supported by government funds, available on an *unlimited* basis. The idea of a time limit, such as one finds in the U.S., on government-supported health care to those who need it is not paramount in Germany, as it is not in countries of Central Europe.

An article describing Czech psychiatric care in the *International Social Science Journal* (Vencovsky, 1973, 547-554) mentioned no programs that were *not* the creation of the government, and none that was operated without the supervision of a psychiatrist. By contrast, women's self-help and support groups in the U.S. and chemical dependency groups, such as A.A., adamantly reject professional help. Even many federally sponsored programs in the U.S. are simply grass-roots initiatives, such as meals-on-wheels, which have eventually received funding, due to the demands of aggressive interest groups. Both illustrate a strong cultural bias toward voluntarism and community control, rather than the more traditional European assumption that the professional's decisions, whether those of physicians or planners, are always best (Gelfand, 1988, 60). To the American mind, influenced by social movements of recent years, especially feminism, this policy suggests a type of patriarchal control, however protective and benevolent, that remains basically inattentive to specific human needs.

In a recent talk to the Forum on Environmental Issues in Central Europe at KSU, Lech Klosiewicz, a Polish architect specializing in housing, demonstrated that plans for housing and population growth were conceived on a nationwide basis by planners, and implemented from above, with little consideration for micro-level issues such as the occupants' desires, or even their health. The physical organization of a certain housing estate, which Dr. Klosiewicz presented, followed a Beaux-arts formal prototype which is balanced and artful as a two-dimensional plan drawing. However, the plan in application, downwind from a factory, could not have more effectively drawn the factory's atmospheric pollutants into its inner court area, thus seriously affecting the health and comfort of the residents. This housing estate thus symbolized the frequent contextual inappropriateness of housing and health care policies on a larger scale.

Decisions concerning the location of health care facilities in Central Europe seemed also to be the product of a plan for the health care infrastructure imposed from above. This observation is confirmed by the article on Czech psychiatric care previously mentioned, in which the nation's definitive Medical Act of 1966 is described in the following terms: "(Its principles) constitute *directives for establishing the network of hospitals and health centers* Medical care is a fundamental duty of the State, and it must have a *scientific basis*" (Vencovsky, 1973, 548). Similarly, the network of hospitals and health centers is "scientifically" planned, which seems to mean without any interaction with user groups. Thus the Central European attitude toward care, so much a product of Soviet policy and culture, has implications which were evident in the organization of the public environment, and in the location and internal arrangement of care facilities themselves. Examples presented will follow the chronology of the tour, beginning in Poland.

1. The KSU group had the privilege of a review, provided by the Director of Design and Construction of Hospitals in Poland, of drawings and photographs of many major hospitals constructed in the nation since 1970 (Niemiowski, 1990). This was the first evidence we encountered that many facilities were dedicated to only certain specialized functions, such as oncology, and none other, and that these facilities were limited in number, and located according to a master plan. As a consequence, patients had to travel far from home and family to receive treatment for the more serious illnesses. The holistic support that could be offered by a more general facility, and a sense of community context during treatment, were in these cases evidently not available.

The decentralized care facility, with its emphasis upon the patient remaining in the home and in her/his community—such as the community hospital, the out-patient clinic, the half-way house—seemed relatively rare in this overview of Polish hospitals. If a diagnostic test must be performed, the patient must use public transit to access a large hospital, where diagnostic and out-patient services are located near the entrance, as opposed to freestanding facilities throughout the community. Before we become complacent about the superiority of American care, we should recall that our data are drawn from our experience with the private sector. The scenario just described is not limited to Central Europe, however: it is well-known to any poor person in any large American city, who needs to use the services of the city hospital.

Reports by Dr. Charles Bascom and others of Romanian health care are similar: here antibiotic treatment is given largely by injection, not taken orally. Thus one travels to the hospital to receive several injections, which must be dispensed over six-hour intervals (Dr. Charles Bascom, KSU Student Health Services, 1991). This method of treatment, one would imagine, reinforces the dependency of the recipient upon the services of the institution; antibiotics taken orally obviously permit a patient greater control over her/his care.

2. At the Institute for Industrial Design in Warsaw, an atelier of designers of textiles and garments was composed exclusively of women. The group presented "a line" of garments for bedridden patients; the garments were designed to facilitate care-giving—the turning and moving service provided by an aide or nurse—rather than to improve the mobility of the patient. Again, the status and control of the caregiver is reinforced through design: the patient is characterized in this transaction as essentially passive.
3. The tour of Central Europe by the team from the College of Architecture and Design included many discussions with faculties of academic disciplines similar to our own—in the Department of Interiors at the Technical University of Brno, Czechoslovakia, the faculty presented a student's thesis project, which offered a view of the social context of Czech long-term care facilities. The project involved the renovation of one of the two extended care facilities for the handicapped in the entire nation. Placement in the facility obviously required separation from family and community. Physically and mentally disabled were confined to the same institution, with no recognition of their disparate needs. While the students' proposal stressed improved mobility of patients within rooms and through corridors, there was no evident intent to use the configuration of the facility to nurture independence or reintegration into society—this was evidently a setting in which patients were cared for virtually indefinitely. The absence of handicapped accessibility in the public environment at large seemed to play a major part in the retention of

persons, even those with a relatively minor disability, in these facilities.

4. Romania was not on our itinerary, but a discussion of Central European care facilities, especially with a focus upon the status of women, is not complete without reference to this country. Western journalism has recently documented the orphanages and Ceausescu's pronatalist policies, instituted in 1966, designed to increase the nation's labor force. Under the plan, each family was obliged to produce five children, contraceptive devices were impossible to obtain, and legal abortions were so limited that self-induced procedures became the norm. According to an article which used data collected in 1976, police were placed in hospitals to enforce the ruling during the first two years, causing the birthrate to increase dramatically. However, clandestine abortion procedures became so common that the birthrate eventually returned to its pre-1966 level (Moskoff, 1980, 602). This remained true until the end of the regime in 1990: thus Ceausescu's desire to increase the labor force was never realized (Kruh, August 19, 1990, 22A). One result of this policy was large numbers of normal as well as physically and mentally deficient children—often the products of unsuccessful abortion attempts—whose families could not provide for them. Their numbers included children with disabilities as minor as cleft palates and club feet, which can be corrected with current orthopedic surgical techniques. The state's solution was to create institutions to house these children. The Ceausescu regime ultimately did not have the resources to continue to maintain the facilities nor to provide adequate care—thus most of these children, even those with any initial degree of ability, languished into physical and mental deficiency.

The conditions described above received the most notable press attention in the U.S. through a feature story on *20/20* in 1990. Another example of popular although excellent coverage was a series of articles by Nancy Kruh, journalist with the *Dallas Morning News*; Kruh was sent to Romania to investigate not only the poorly maintained facilities and their residents, but the policies and social context responsible for this phenomenon. Her conclusions support the view that Ceausescu's policies imposed their greatest burden on women. To review some of her data: punishments for women convicted of having abortions consisted of fines of as much as two years' salary, or five years imprisonment.

Over the 23 years of Ceausescu's rule, some 15,000 women died of abortion complications; this estimate is considered conservative. The orphan population is now estimated at 100,000; this means that 1 in 60 Romanian children is housed in one of the 500 state-run facilities. Since conditions of life were so severe, many women

would risk death rather than have another child. After the ban was lifted in 1990, deaths resulting from abortions were immediately reduced by 80%; the rate will probably be seen to decline further by the replacement of dilation and curettage by the safer technique of aspiration (Kruh, 1990).

Dr. Charles Bascom of the Student Health Service of Kansas State University has labored in the orphanages and hospitals of Romania each summer to improve facilities and to provide care as a physician. Bascom brought plumbing supplies from the U.S. to install additional showers in one orphanage; previously one shower head served 200 children (Bascom, 1992). Walter Bacon of the faculty of political science of the University of Nebraska in Omaha, and of the Midlands Aid for Romania organization, reports the current condition of these facilities since Kruh's articles and the 20/20 feature of 1990: many, but not all of the 500, have been upgraded to model institutions, at least for the time being, through assistance provided by voluntary groups such as World Vision (Bacon, 1992).

Romania's large orphan population and its conditions apparently resulted from women's inability to choose contraception, let alone abortion, but contraceptive methods, mostly supplied by relief organizations, are now more available. Education in the use of the devices and the creation of a more positive attitude toward them are now being supported by the state. Still, the majority of women of child-bearing age suffer from side-effects of illegal abortions, obtained before the lifting of the ban; these complications seriously affect the methods required in the prescription of contraceptives for them (Kruh, August 24, 1990, 3C).

The earlier article, using 1976 data, asks why Ceausescu did not consider other means of increasing the labor force, employed by Romania's neighbors Czechoslovakia and Hungary, such as raising the retirement age, or positive methods of increasing the birthrate, such as substantial financial incentives for the birth of additional children, and 2 to 2 1/2 years paid maternity leave. The amount of leave permitted in 1976 in Romania was only 112 days (Minskoff, 1980, 612-613). Why, indeed, is the question: perhaps the control of human beings, particularly females, is for some individuals wielding power a far more compelling priority than the achievement of any stated objectives.

The above examples offer evidence of the rootedness of care facilities in the total approach to planning that characterized previous Central European regimes. They

also suggest that the resulting concept of care itself, and the environment in which it is offered, should be re-examined in the light of policies which foster personal independence, regardless of the degree of disability. The development of living skills and the creation of sources of support and accessibility in the environment could render the services of the care facility as a provider of long-term shelter unnecessary.

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