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I'D VISIT A DOCTOR, BUT WHEN I PONDER IT, I GET THE BLUES: On affective atmospheres in Russian medical institutions

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Abstract

The article deals with the issues of affective atmosphere conceptualization and atmosphere research. Using the concepts of affective atmospheres by such eminent phenomenologists as Hermann Schmitz (1928–2021), Gernot Boehme (1937–2022) and Tonino Griffero (1958), the author introduces the case of Russian medical institutions' atmospheres. The use of the "atmospheric approach" in social sciences in general, and anthropology, in particular, allows one to resist the scholars' prevailing distancing strategies that reduce social reality to mere statistical measurements or semiotics. Contemporary approaches to atmospheric design, implemented in many applied fields (urbanism, musical composition, theater, painting, marketing, etc.) give hope that medical anthropologists will soon be able to apply this knowledge for the transformation of medical institutions' atmospheres into an independent and effective therapeutic tool that not aggravates, but rather facilitates the condition of visiting patients.

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Medical anthropology, as well as socio-cultural anthropology in general, take only initial steps in the study of atmospheres as an essential aspect of everyday life. Each of us, with the exception of a small number of victims of either

deep apathy or alexithymia (a condition when a person cannot express or describe their feelings, or even experience them), or a few lucky people who have achieved satori, constantly experiences various, and often quite strong emotions that overpower us as an autonomous and awe-inspiring force. The ancient Greeks attributed the power of affects to gods and believed that human fate was in the hands of divine powers. Contemporary phenomenology of atmospheres, the foundations of which were laid about half a century ago, generally agrees with this statement. One of its leaders, Hermann Schmitz, considers affective atmospheres as *objective forces*, independent of individual will and preceding the cognitive comprehension of changing situations and events. In other words, prior to comprehending any situation in which we find ourselves, we are already immersed in its affective influence, which not only precedes, but also (pre-)forms the very understanding of the situation we are involved in. We do not think affect, but affect thinks us. To use a psychoanalytic concept, our everyday life is full of such 'post-factual rationalizations'. This formative or preforming ability of atmospheres gives phenomenologists grounds to consider affective atmospheres as factors of objective nature – or, as perhaps the most influential of the phenomenologists, specializing in atmospheric research today, Tonino Griffero puts it, – “quasi-things”.

An important property of atmospheres, which is reflected in Griffero's qualification of them as quasi-things, that is, insubstantial, but objective forces or factors, is their protean, vague, diffuse and fluid nature, the vagueness and fundamental uncertainty of their boundaries, and often their elusiveness and non-invasiveness. People usually do not find it difficult to determine the general *properties* of a particular atmosphere (perceiving them as pleasant, light, oppressive, heavy, etc.), but cannot define the phenomenon itself and find it difficult to describe its dynamics. Researchers, who develop the concept of atmosphere within the framework of aesthetics as a theory of perception, or beyond its boundaries – in social sciences and humanities, are divided into two camps – supporters of so-called 'mentalism' or 'cerebrocentrism', on the one hand, and their opponents, emphasizing the external conditionality or ecological determinants of our perception, on the other. For the former, the atmosphere is *our* affective perception of space, for the latter, it is a fundamentally indefinable phenomenon, since they see the indefinability as an affective atmospheres' ontological property. Still any atmosphere can be described as a constellation of specific or particular properties. Its antecedence to our cognitive comprehension of situations indicates that we can cognize the world *through*, or *within* a certain atmosphere, which remains itself out of focus of consideration and therefore escapes definition, although its presence and influence are quite obvious. Researchers in pursuing of objective knowledge are often hindered by their positivistic stance, which forces them to 'decontaminate' perception from subjective influences. But what Jupiter is not allowed, the bull is allowed: an anthropologist should not be led away by the stance that opposes the perceiving subject to the object of perception. Being both a social science and a part of humanities, anthropology can balance between *explanation* and *understanding*, and by virtue of its unique position is able to grasp ontologically unstable phenomena, such as atmospheres.

Since, as already mentioned, anthropologists have only recently included affective atmospheres within the subject of their interests, the answers to the questions of why and how they should explore them should be considered as preliminary. Some traditional and old objects of field ethnography, such as dwellings or rituals, are usually endowed with special atmospheres that have so far escaped anthropologists' attention. Still there is already a number of publications to prove that anthropologists are not immune to the 'atmospheric turn' (cf.: Pink, Leder Mackley 2016; Bille 2017, 2019; Edensor 2012; Kiib et al. 2017; De Matteis 2018; Eisenlohr 2018). This is a sufficient reason for other anthropologists to

pay attention to such an important aspect of everyday life that their colleagues have already looked into. Besides, the inclusion of the “atmospheric approach” into the toolkit of social sciences in general and anthropology, in particular, makes it possible to resist the well-known reductivist and distancing strategies that reduce social reality to a set of measurable parameters or semiotic assemblages, the reduction, which cannot but establish inequality and power imbalance between researchers and their subjects.

Urban anthropology, the anthropology of music, the anthropology of organizations and, finally, the main object of our current discussion – medical anthropology, need atmospheric phenomena research no less than the studies of material culture or customs and folk festivals. In the specific case of medical anthropology, the atmospheric turn, which has been developing in the social sciences for a couple of decades under the influence of ideas formed in philosophical phenomenology, has so far been practically ignored: among the already extensive literature on affective atmospheres, there are only a few articles that refer to the phenomenon and its relations with medical anthropology issues, such as health, diseases, doctors and patients relations, or medical institutions management. This is a rather strange situation, since affect and its influence on the human psyche and body have been the objects of medicine since its formation. I think that the borderline position of medical anthropology, a significant part of whose intellectual resources are spent on mastering the results of the rapid progress of medical knowledge and practices, leaves insufficient time to cover other areas of knowledge, which as a result suffer from neglect.

The atmosphere of medical institutions I believe that due to such properties as the elusiveness of the atmospheres, their evading of exact descriptions, and the facelessness of atmospheres prevailing in our medical clinics, emergency rooms or hospitals, the conversations with my interlocutors (I avoid formal surveys and interviews, as I believe that they mainly reproduce the content of the questions posed), furnished relatively poor and undifferentiated set of data. To find out what stands behind this paucity of expression, I had to decompose the impressions of my respondents into several classes, each of which corresponded to one of the main perception channels.

If we assume that the events of the world unfold for us mainly in the visual, acoustic and olfactory channels of perception, and that atmospheres are influenced and perceived primarily through these channels, then this is what can be told based on the impressions of my interlocutors. The overall impression of the atmosphere of medical spaces and institutions was, without exception, unfavourable. My interlocutors described it as “agonizing”, “boring”, “unpleasant” or “dreary”. A more detailed analysis, taking into account different aspects and channels of perception, revealed the following.

Information on the *acoustic landscape* of reception and consulting rooms and hospital corridors offered little insights. My interlocutors mentioned coughing, complaints and groans of patients, as well as brief and grunting, poorly intelligible remarks of the medical staff (especially from the registration office employees – one of my vis-a-vis called them all together “ungracious retirees”). Three of my interlocutors, evidently basing more on their childhood memories than on their impressions of the present day, recalled their awe in front of the dentist's office, from which came the clang of instruments, the howl of a drill and the screams of those unfortunate who were in the hands of the Aesculapius before them. From such accounts I have made perhaps premature inference that the acoustic background of the dentist's reception room dominates and determines the atmosphere that influences and pre-adjusts the patient to the upcoming torturing procedures. This atmosphere of fear and awe (as, indeed, the dominance of acoustic perception in its creation), however, became rather an exception, and it was only in the case of a dental office or clinic that it was mentioned. For the

medical spaces of other types, acoustic dominance turned out to be atypical, and instead of awe, the atmosphere was described more often as “dreary”.

Unlike the pleasant music familiar from sanatoriums and dispensaries with their “relaxation rooms”, the acoustic landscape of other medical spaces, such as corridors and reception rooms was described, rather, in terms of sound absence – as silence, interspersed with the sound of shuffling feet on linoleum, or questions about the queue and the nurse's exclamation “Next!”, creating the impression of a machine, or conveyor, grinding the ailing bodies. However, there were exceptions here, since the digital generation generally ignored the acoustic impressions of medical institutions, creating with headphones and smartphones their own sound capsules that unfailingly separated them from other sound sources, and supplanted the acoustic poverty of hospital spaces with musical impressions.

The *visual* impressions associated with medical spaces also did not shine with expressiveness: bare walls, occasionally decorated with information stands and posters with medical propagandist texts (private clinics turned out here to be an exception, since in addition to posted price lists, licenses and diplomas, their walls were often decorated with paintings, and window sills with flowers, the latter, however, were also found in hospital or clinics' corridors and offices). In the case of the newly built clinical centers' interiors, one could speculate on their ‘color scheme’, whereas in the case of the older clinics and hospitals, this phrase was hardly present: the paint used in the repair of these spaces corresponded only to the sanitary norms, but not to the color of furniture or other painted surfaces, so the overall ‘color scheme’ and visual impression acted more as an irritant than as an aesthetically pleasant interior.

Almost every one of my interlocutors complained also about the incomprehensibility of the clinics' topography with its many corridors, and unpredictable locations of various offices and specialists. The visual image of these spaces was dominated by long, intricate and poorly lit corridors (a Freudian image, reflecting the anxiety of the patient), by numbered office doors and benches or chairs covered with leatherette, and by tables and cabinets (with medical instruments or papers) in the doctors' offices, piles of papers on the doctors' desks, decorated only with an outdated computer. The closest analogy to this image were bureaucratic spaces, and the figure of a scribbler and a bureaucrat turned out to be closely associated with the image of a doctor at a clinic reception. As one of my interlocutors stated: “They write more today, than they look and listen.” This ‘blindness’ and ‘deafness’, attributed to the medical staff, supports the general feeling of being lost and abandoned, of being at the mercy of alien and uncontrollable forces, which cannot but support the general atmosphere of hopelessness and longing noted by most of my interlocutors.

However, the strongest component of this atmosphere turned out to be its *olfactory dimension*. The smell of disinfectants and medicines (and in hospital wards of urgent and intensive therapy – of unattended bedpans, as well) – all this in a complex way influenced and supported the impression of powerlessness and hopelessness. As one of my interlocutors put it: “You should run away from this stench, but you must endure and wait until you can finally leave.” Smokers in queues in reception offices react to this olfactory pressure unconsciously: they run outside with the words “I'll be back soon!” and thus arrange a break in this seemingly endless session of olfactory violence. The non-smokers sit patiently, attending to their inner feelings, which the long passive waiting usually aggravates, and if they do not find a way out to their annoyance, they fall into a stupor, from which they are awakened only by the exclamation “Next!”. These impressions of my interlocutors seemed very convincing, until I accidentally stumbled upon a series of publications by a Danish researcher of atmospheres and affects Anette Stenslund (Stenslund 2012, 2015), including her article on the

exhibition of contemporary art. In her study published in the collection "Exploring Atmospheres Ethnographically" (the chapter is titled "The harsh smell of scentless art: on the synaesthetic gesture of hospital atmosphere"), she describes an interior installation that was exhibited at the National Gallery of Denmark in September 2014 (Stenslund 2018). The installation consisted of several interconnected spaces and objects (Stenslund designates it "a corridor"). It turned out that museum visitors associated this art object with a hospital space, and when asked about the atmosphere of this space, many of them mentioned an unpleasant hospital smell. The authors of the art object, who called it "Biography", the artists Elmgreen & Dragset, whom Stenslund also interviewed, did not intend to associate their creation with a hospital or with any particular smell, seeking only the impression of a "complex and chaotic version of some public institution"; the "corridor" did not have any olfactory effects, and when creating this installation, they did not think about smells.

Stenslund's interviewing of museum visitors (150 interviews) made it possible to draw a non-trivial conclusion that the (affective) atmosphere as a phenomenon not only relies on *multisensory perception*, but also always manifests itself as a *synesthetic whole*, which underlies the atmospheric nature of perception and makes it difficult to describe and define atmospheres. It can also be noted that personal history and biographies have a significant influence on the perception of these phenomena: a person who had no experience of medical spaces would hardly have any associations with a hospital when visiting an exhibition of contemporary art, and even less in the case of smell perception in an odorless "corridor".

Let's return, however, from our excursion to the National Gallery of Denmark to domestic medical institutions. I might have exaggerated the importance of the olfactory component of these atmospheres, due to my own biography and impressions. It is worth mentioning here that Gernot Bohme not only noted that odors are essential elements of atmospheres, but also considered them 'the most essential' among all other characteristics, since by their very nature odors, in his words, turn out to be "the most atmospheric" (Böhme 2006: 128). It is also worth clarifying that among my interlocutors there were many elderly and not too healthy people – three of them had pacemakers, another suffered three strokes, many were seriously ill during the recent Covid pandemic, several times getting into intensive care wards. In other words, their biographies were oversaturated with impressions of hospital atmospheres, *synesthetically merging* into a common image of 'a vale of woe'. I wouldn't be surprised if, instead of perfumery smells of modern disinfectants, they still catch the smells of bleach and carbolic acid of the hospitals of their youth. I suspect that if among my respondents there were more young people with headphones, who only occasionally wander into medical clinics to get their health certificates for study or work, the 'average temperature in the hospital' I measured would be more optimistic.

So, why is it necessary for medical anthropologists and other representatives of the medical profession, who are engaged in health planning, prevention and socio-hygienic research to pay attention to affective atmospheres? I will put forward a not overly bold hypothesis that pleasant atmospheres attract people to a greater extent than painful ones. Current research on the design of atmospheres with specified properties, the results of which are already implemented in many applied fields, such as architecture, urbanism, musical composition, theater, painting, marketing, etc. provides hope. It is hoped that medical spaces will also attract researchers' attention, and the accumulated knowledge could then be used for transforming medical atmospheres from an environment that aggravates the patient's condition into a truly therapeutic and regenerating one. In the meantime, from my point of view, the existing atmospheres, at least in the case of Russian

medical spaces, if we focus on the comparison of the atmospheric side of healing, remains inferior even to a shamanic healing session.

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