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Between *hospitality* and the *inhospitable*: Critical judgments on the professional-beneficiary relationship within assisted reproductive technology

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ABSTRACT

In recent decades, the health sector has witnessed the emergence of social movements of patients aimed at redefining public policies on access to and provision of medical care. These changes are reflected in the conceptual models of *patient-centred care*, developed to guide medical practice towards patients' expectations and wishes. However, different patient-centred models remain eminently focused on the dimension of *solicitude* when attending to patients' specific needs: interpersonal relations based on the caregiver's attention to the patient's singularity. Namely, patients can express other moral references concerning their experiences in clinical contexts. That is the case with *hospitality*. Based on a Portuguese research project focused on the clinical experience of ART beneficiaries, this article aims to analyse hospitality as a moral orientation with specific proprieties associated with attending to patients' singularity, thus aiming to contribute to the ongoing discussion and revision of the conceptual models of patient-centred care.

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1. Critical mobilisation of patients around healthcare: Other moral semantics beyond justice and autonomy

Over the last few decades, the health sector has been a ground for the emergence of social movements, initiatives and collective organisations for the defence of patients, associated with diverse diseases/medical conditions. Health is a field of social and political mobilisation across various countries in North America, Latin America and Europe, led by formal

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and informal groups with different aims and demands regarding access policies, research and health practices (Barbot, 2002; Brown & Zavetoski, 2004; Mackenzie, 2022; Maguire & Britten, 2018).

These collective actors, which may incorporate different forms of mobilisation, constitute themselves as participating agents in the (re)definition of health policies, disputing the decision-making arena with political centres of power and expert authority (physicians and scientists) (Britten & Maguire, 2016). Their intervention covers different domains: (a) the direction of therapeutic innovations and development of (bio)medical research, to improve diagnosis and treatment of specific diseases; (b) the conditions of access to available treatments and medicines, reducing health inequalities based on social characteristics or identities (e.g. gender, sexual orientation, etc.); (c) the therapeutic processes, in the sense of an increased priority of the patient as the protagonist of the therapeutic choices (and empowered to that effect) as an alternative to a hegemonic decision-making position for professionals in their condition as experts; and (d) the public recognition of the experiences of illness and construction of identities according to specific categories of disease (Barbot, 2002; Brown et al., 2011; Gaudillière, 2002; Maurer et al., 2019; Rabeharisoa & Callon, 2002; Smith, 2020; Thompson, 2007).

Assisted Reproductive Technology (ART), as a set of medical techniques and treatments designed to assist human reproduction, within the broader process of progressive techno-scientific innovation applied to biomedicine (Clarke et al., 2003), also reflects these claims for justice in the public domain (Mackenzie, 2022). An example of this are the public controversies that have erupted around access to fertility treatments, as in the case of categories associated with states of vulnerability related to the ability to procreate without the mediation of medical technologies. This is the case of access for chronically ill patients (e.g. seropositive, diabetic or cancer patients) or by same-sex couples (Delaunay, 2014; Sastre et al., 2021; Yerkes et al., 2018). Also, the process of progressive commodification of ART encompasses the extension of access to these techniques to broader populational groups, beyond the treatment of biological infertility (Patrizio et al., 2022).

In the aforementioned context of the reconfiguration of the relationships between *lay* and *scientific authority* in healthcare provision (Rabeharisoa & Callon, 2002), the concept of patient empowerment and autonomy in the decision-making process is also progressively becoming a guiding moral framework for the professional-patient relationship (Castro et al., 2016; Thompson, 2007). In detriment of practices perceived

as *paternalistic* (Pattaroni, 2011) – perpetuating dependencies between the institution/organisation providing a given service and its beneficiary, rooted in the technical knowledge asymmetry that subordinates the lay-person to the expert – the figure of the autonomous and responsible individual, capable of projecting his or her will in therapeutic decision-making is thus morally valued.

Precisely in the specific context of ART, beneficiaries' trajectories are marked by several decision moments, framed by law as a set of publicly available options. These decisions include choices regarding clinical procedures, which also involve weighing different factors, such as efficacy, physical and emotional burden, time and financial costs (Duthie et al., 2017; Borghi et al., 2019). Moreover, the decisions extend to the destination of surplus embryos, which, unlike the decisions to donate oocytes or sperm, can also be emotionally distressing (Huele et al., 2020; Samorinha & Silva, 2016). In contrast to decision-making models in which the patient is limited to the passive position of receiving technical information and consenting to treatment, the professional's ability to reduce the asymmetry in technical expert knowledge with the patient and to incorporate the patient's preferences/options in the decision-making processes is assessed (Thompson, 2007).

At the same time, other types of normative references may also guide patients' critical operations and demands regarding the functioning of healthcare organisations and professionals' conduct. Specifically, claims associated with different moral frames also emerge when they concern the functioning of institutions. These include a central morally invested category: *care* (Gilligan, 1995; Laugier, 2011; Paperman, 2010). This notion refers to demands – when actors express themselves critically on the functioning of healthcare institutions – that are not limited to conceptions of justice with universal validity, oblivious to the recognition of patient's singularities (Boltanski & Thévenot, 2006; Pattaroni, 2011; Thévenot, 2007).

Indeed, the notion of care, developed as a concept of moral and political philosophy associated with feminist currents, refers to an attention to the other in different spheres of society beyond the familiar/domestic one (Chatel, 2011; Furstenberg, 2011; Laugier, 2011). This is the case of the field of medical care, where the concept qualifies a practice oriented towards the comfort and singular needs of the patient, in parallel with medical acts aimed at healing (Chatel, 2011). Indeed, *cure* and *care* are distinct but complementary concepts concerning the way clinical treatment is provided: cure refers to a result-oriented medical intervention;

care refers to a broader universe of healthcare practices (Chatel, 2011; Guérin, 2016).

Moreover, care has in the concept of *solicitude* the cornerstone of a relational sphere in medical practice that is far from individual autonomy and large-scope conventions as moral references (Fleury, 2018; Loffeier, 2015). Instead, this concept concerns practical knowledge in the field of interpersonal relations based on the caregiver's attentive willingness to adjust to the patient's singularity (Furstenberg, 2011).

Solicitude refers to the interpersonal ability to be attentive to the fragility/vulnerability of the other, in the sense that the decision-making capacity may be affected. It therefore describes the capacity to anticipate and listen to the patient's needs, through attentive observation and benevolent gestures. Hence, it involves a sensitivity of the caregiver towards the patient that requires personal vigilance (Fleury, 2018; Loffeier, 2015).

However, solicitude does not aim to reinforce the patient's vulnerability, but to promote resilience and empowerment (Fleury, 2018). Indeed, it requires a bond of benevolence towards the patient, yet without limiting the space for individual decision-making (Furstenberg, 2011). Rather, it aims to restore and support that autonomy. Solicitude rests, thus, on a paradox between proximity and distance: it implies closeness/proximity from the caregiver (when welcomed/desired by the patient), through a supportive presence, but without monopolising the patient's decision-making space. Proximity is calibrated with a distance in the relationship that reflects respect for the patient's alterity (Furstenberg, 2011).

As a central element of medical care, the moral concept of solicitude is embedded in various conceptual models of *patient-centred care* (PCC). These are frameworks designed to guide medical practice towards the expectations and wishes of the patient (Brickley et al., 2021). Several conceptual models have been developed, both for the broader clinical context (e.g. McCormarck et al., 2011; Medina-Artom & Adashi, 2020; Mourad et al., 2019) and the specific context of fertility treatment (e.g. Aarts et al., 2012; Dancet et al., 2011, 2012; Shandley et al., 2020; van Empel et al., 2010; Webair et al., 2021).

These conceptual frameworks, built inductively from patients' reported experiences in clinical contexts, include solicitude as a normative expectation of patients about how they receive healthcare by highlighting the importance of clinicians' interpersonal skills in responding to patients' capacities, perspectives, and preferences. However, the patients' discourses can also reveal other moral domains related to

attending to their singularity – which can be insufficiently captured by these conceptual models (Gagliardi et al., 2019). Indeed, in addition to the importance of further improving conceptual clarity regarding the different dimensions of *care* (Scholl et al., 2014; Zeh, 2019), different patient-centred models remain eminently focused on the dimension of solicitude when it comes to attending to patient's singular needs.

Namely, patients can express other moral references concerning their experiences in clinical contexts. This is the case of *hospitality* (Stavo-Debauge, 2018). The latter also consubstantiates a mode of accommodating patients' idiosyncrasies but with specific properties compared to solicitude.

Therefore, attending to patients' particularities can encompass different (and complementary) moral spheres that can be conceptually differentiated, favouring medical institutions that can provide care more effectively in its plural dimensions (Pattaroni, 2011). Hospitality, as a concept developed within the *French Pragmatic Sociology* (Boltanski & Thévenot, 2006; Thévenot, 2006; 2019), can bring to light this plurality that goes beyond solicitude, thus contributing to the ongoing discussion and revision of the patient-centred care conceptual models (Brickley et al., 2021; Gagliardi et al., 2019; Kitson et al., 2013).

Based on a Portuguese research project focused on the clinical experience of ART beneficiaries, this article aims to analyse the specificities of hospitality as a normative orientation associated with attending to the patient's singularity. The central concepts mobilised are presented in the next section, followed by the methodological underpinnings. After presenting empirical examples of different manifestations of hospitality as a normative orientation expressed by patients, the results are debated in the discussion section and summarised in the conclusions.

2. Different domains within familiar engagement: The conceptual premises of hospitality

The paper draws on the *regimes of engagement in action*, conceptualised by Laurent Thévenot (2006; 2019), as the theoretical framework guiding the analytical trajectory. Each regime concerns distinctive formats of actors' involvement with the surrounding environment, through different forms of cognitive and evaluative appropriation (Thévenot, 2007; 2014). Namely, the regimes differ by the type of socially valued good aimed at when engaging with the environment. Thus, each mode of engagement relies on different kinds of normativity in terms of how a given situation is perceived according to a desired good.

Three regimes of engagement are conceptualised: *public justification*, *engagement in a plan* and *familiar engagement* (Thévenot, 2006). These regimes differ according to an analytical axis that goes from the general to the particular – i.e. from engagements backed on collective conventions (such as customs or legal rules) as normative references for acting in the public sphere to engagements that are more intimately personal (Thévenot, 2019).

In the *regime of public justification*, the good aimed at corresponds to participation in the common good of a political community, expressed by different *orders of worth* (Boltanski & Thévenot, 2006). These moral orders constitute publicly consolidated conventions that actors mobilise to qualify (i.e. classify and hierarchise) the different situations composed of *beings* – individuals, objects, and relational formats. That is the case of *efficacy* as a concept of the common good associated with *industrial worth* (Boltanski & Thévenot, 2006) and central within healthcare. This convention is supported by beings that express this worth – e.g. *experts*, *patients*, *technicians*, *technical instruments*, *procedures/protocols*, etc. It is thus in reference to this notion of the common good – *efficacy* – that different clinical situations can be evaluated/judged (by patients or other actors).

In the *engagement in a plan*, the environment is perceived in reference to individual objectives, having the *satisfaction of the action performed* as the aimed good. The environment is thus functionally formatted for fulfilling the will of an individual endowed with autonomy, capable of projecting oneself successfully into the future and forging contracts. The autonomous project/plan takes place according to publicly available choices – thus, standardised options, independent of a person's singularities/idiosyncrasies (Thévenot, 2019; 2006).

Within healthcare, *informed consent* constitutes a central device mediating the patient-professional contractual relationship within this regime of action. This legal document defines the terms of a common (clinical) plan of action, according to standardised norms for clinical protocols/treatments legally available (Thévenot, 2009). Also, it establishes a set of reciprocal rights and obligations and safeguards the patient's decision-making autonomy within a symmetrical relationship with the professionals (Pattaroni, 2011; Thompson, 2007).

In the *regime of familiar engagement*, *comfort* and *ease* are the aimed good. The action develops through proximity, supported by a familiarisation dynamic of the person with the environment. This type of engagement differs from the previous ones in that it rests on local, customised references for grasping the surrounding environment. Thus, it does not

favour extended coordination with actors unfamiliar with these localised/personalised references (Thévenot, 2006; 2019).

This regime of engagement can encompass different moral domains in terms of attending to *ease/comfort*. In addition to solicitude (Breviglieri, 2008; Pattaroni, 2011), other normative references emerge with specific pragmatic proprieties. That is the case of hospitality (Breviglieri, 2006; Stavo-Debauge, 2014; 2018).

The grammar of hospitality is based on the accommodation of practices with a view to the *ease /comfort*, within the regime of familiarity/proximity, in the way of participating in a space or organisation, so as to ensure that actors engage and achieve their projects. Therefore, hospitality arises from asymmetries in the forms of appropriation of places and objects, and in the ability to participate, being its goal the integration of the individual. It thus manifests itself in an attention to intimate bonds (forms of action and intimate meanings, outside conventions and standardised norms) and vulnerabilities (which constrain engagement exclusively through those regimes of action characterised by greater generality) in their various possible manifestations (Breviglieri, 2006; Stavo-Debauge, 2014; 2018).

As a moral framework, hospitality presupposes an openness to the other (in this case, the patient) through a continuous presence and availability throughout the succession of events that constitute the therapeutic path. It is through the development of familiar attention in the interactions that this performance is undertaken (Thévenot, 2006). Manifesting itself in the most diverse contexts (Stavo-Debauge, 2014), in the specific case of beneficiaries in ART units/clinics, the grammar of hospitality is therefore oriented towards the openness to the other (the beneficiary) in his or her participation in these organisational contexts, which are characterised by technical-scientific devices and standardised norms that provide the basis for the cognitive and evaluative appropriation of situations (Thévenot, 2019) and of the individuals (and objects) in them.

Thus, hospitality is understood as the capacity of institutions to open up to users, welcoming the other, through a plasticity of action that is aimed at the accommodation (albeit always partial and conditional) of singularities (Stavo-Debauge, 2018). In the forms of action in which it is materialised, hospitality aims, through these different openings to an engagement of proximity, to obtain from the other a full participation in that space (Stavo-Debauge, 2014) – ensuring, in this case, their engagement in the therapeutic trajectory as a project (Thévenot, 2006) and, more specifically, the achievement of pregnancy.

Hence, solicitude consists of practical knowledge in the field of interpersonal relationships that relies on the attentive disposition of the caregiver through a *professional tact* in the form of attentive listening to personal needs and concerns (Fleury, 2018; Furstenberg, 2011; Ricoeur, 1990). In turn, the grammar of hospitality, as a moral framework, is used to evaluate the arrangement of physical spaces, organisational procedures, and configuration of interactions – specifically, concerning an organisation's plasticity in terms of its ability to accommodate users' particularities and vulnerabilities.

It is on this latter grammar in particular that this article focuses on, analysing how it arises in the judgements made by ART beneficiaries. Using empirical data from a research project conducted in Portugal, we intend to explore different moral judgements conveyed where the grammar of hospitality – in multiple combinations with other grammars – emerges as a normative reference structuring assessments made about the interaction with professionals and the functioning of ART units/clinics.

With the purpose of mapping these moral judgements, in their different manifestations, the analysis is divided into four themes that emerge from the respondents' utterances:

(a) *Singularising accommodation to the patient when engaging in the therapeutic plan.* It refers to the accommodation of informational asymmetries between users, aimed at empowering them to engage in the therapeutic plan, which involves decisions of technical and scientific complexity. This theme also includes attention to the emotional experience associated with moments of failure and uncertainty of the therapeutic path (Delaunay, 2017).
(b) *Accommodation of personal/intimate bonds.* This encompasses the respondents' expectations in terms of the plasticity of the functioning of the organisations that enables them to encompass intimate meanings produced by the beneficiaries.
(c) *Attention of organisational functioning to the patient's ease / comfort.* It includes perspectives concerning the arrangement of spaces or the configuration of situations beyond conventions and norms, encouraging a greater accommodation to the patient's singularity.
(d) *Protecting the patient from inhospitable situational settings.* It includes situations that may affect the beneficiary in terms of a positive self-understanding, that is, situations that represent a denial of forms of recognition (Honneth, 2004) associated with the regime of proximity (Breviglieri, 2009; Martins & Delaunay, 2016) – such as denial of emotional care – and consequent experiences of humiliation.

Therefore, the analysis is structured around these four themes. Specifically, it is the ability of professionals and organisations (ART clinics/units) to ensure the engagement of the patients in their therapeutic processes for good hospitality (Stavo-Debauge, 2014; 2018) that the performances and situations in these clinical contexts are likely to be evaluated by ART beneficiaries.

3. Methods

The empirical data presented in this article results from a research project conducted in Portugal, based on a *mixed methods* approach, involving semi-directive interviews and an online survey questionnaire. The study population includes both ART beneficiaries and professionals working in the sector, either in public units or private clinics – namely physicians, clinical embryologists, nurses and psychologists. However, the present analysis is based solely on data from interviews with ART beneficiaries.

A total of 69 interviews were conducted by the same researcher, between September 2019 and January 2021. Initially, the interviews were held face-to-face in locations chosen by the respondents. However, the development of the fieldwork protocol coincided with the eruption of the COVID-19 pandemic, determining that most interviews were done through videoconference.

Interviewees were recruited through the Portuguese Fertility Association, social networks and online infertility forums, as well as through informal contacts. We used non-probability sampling techniques: snowball and convenience sampling. No quotas were applied; thus, no maximum number of interviews was set. The aim was to obtain a diverse sample in terms of variables that could potentiate different experiences and perspectives: gender, sexual orientation, level of education, type of parental project (couple or solo) and therapeutic trajectories of the interviewees (i.e. number of treatment cycles, resort to public/private ART units, etc.).

When considering the issue of multiple trajectories, it is important to contextualise and point out that, in Portugal, the first law regulating assisted reproduction techniques, approved in 2006, restricted access to couples in a stable, heterosexual, marital union who had health problems (either infertility or the risk of transmitting a genetic disease). However, a subsequent revision of this legislation (Law 17/2016) gave all women access to ART, regardless of whether they had an infertility diagnosis,

their marital status, or their sexual orientation. Access for male homosexual couples remains prohibited under the current legal framework. Furthermore, the healthcare network in Portugal for ART comprises public units (integrating the country's National Health Service) and private clinics, with the current legislation in Portugal allowing a maximum of three funded second-line treatment cycles (*in vitro* fertilisation and/or intracytoplasmic sperm injection) in the public sector.

Thus, based on this methodological protocol, the sample obtained is mostly composed of female interviewees – approximately 92%. The majority of interviewees (87.8%) were also in some form of conjugality – either marriage or non-marital partnership. In addition, 90.5% of the cases in which interviewees had sought access to fertility treatments for the accomplishment of the parental project were framed within a heterosexual relationship; only five interviewees associated their project with a homosexual relationship, while two with a single-parent project.

With the exception of five foreign-born interviewees, all were of Portuguese nationality. There were also only three interviewees who had accessed ART treatments abroad. Most of the interviewees had completed higher education (78.4%), with approximately one third having a postgraduate degree, master's or doctorate (33.8%).

In terms of data processing, interviewees were assigned *pseudonyms* to ensure anonymity. The full transcripts of the interviews were subjected to a thematic content analysis using MAXQDA (2018 version). The category-based analysis undertaken aimed to compare the respondents' discourses so as to highlight associations and variations in their perspectives, according to a set of themes covered by the research project and related to the therapeutic experience in the context of ART.

The interview script for the ART beneficiaries included several topics, aiming to cover the different stages of the therapeutic process, both before and after the end of treatments: formation of the parental project; the impact of the diagnosis of infertility and the decision to seek specialised medical help; prior knowledge about ART; description of the therapeutic protocol and lived experience; decisions about surplus embryos (if applicable); conceptions and forms of attachment to the created embryos (moral status attributed, moments of change in these conceptualisations, beginning of the construction of an emotional bond, etc.).

Considering these different topics, the thematic analysis of the interviews followed an inductive process of category building (Bradley et al., 2007). The analysis was carried out collectively by the core project

team, namely, the principal investigator and the researchers recruited to carry out the fieldwork and analysis of the empirical material. To this end, regular meetings were held to discuss and progressively refine the categories (themes and coding).

First, a preliminary list of themes was generated through an open coding process. Here categories emerged based on patterns derived from the raw data rather than preconceived theories. A code tree reflecting the key ideas expressed by the participants was developed in MaxQDA. The themes and coding were then discussed to develop a richer and more nuanced reading of the data, rather than necessarily to reach a consensus (Braun & Clarke, 2019). Next, the initial list of themes was progressively shortened and refined as the interviews were analysed. The code tree was continuously adjusted until theoretical saturation was reached, i.e. when no additional codes were found in the interviews.

The interviewees' discourses were then subjected to further analysis, particularly about the clinical experience in terms of the relationship with professionals and the clinical environment (procedures, physical settings, etc.). At this stage, the analysis was developed using the *Sociology of engagements* as the theoretical approach – with a particular focus on the conceptual contributions around normative expectations based on familiar engagements as a cognitive and evaluative format. Due to space limitations, the focus was placed on hospitality as a specific normative reference within the familiar engagement. The topics that emerged from the interviews were then condensed into the four structuring themes described above and presented in the results section of this article.

4. Results

a) The singularising accommodation to the patient when engaging in the therapeutic plan

Analysing the evaluations that the respondents make of their ART experience reveals expectations related to forms of action of greater proximity (Thévenot, 2006). In particular, if hospitality designates a specific form of relationship with the other that presupposes the partial suspension of judgement based on the regimes of conventions and norms so as to attend to their difference, beneficiaries' judgements can be based precisely

on an expectation of a singularising appropriation in the relationship with professionals. This is what the following excerpt illustrates.

> **Helena:** The hospital [hospital name], in principle, is a good hospital for this type of treatment, but I didn't feel very well supported, no … I felt it was a routine … […] Parents, when they are in this process, I think they should have other support in the sense of sometimes finding the best words, how they're spoken to … […] I don't know, I don't feel that sensitivity … […] I thought I should have more attention, care, feel more tenderness […] A person is fragile […]. The process is very well explained. But then there's another follow-up that I think … There isn't sensitivity … […] Like, I felt … 'I went *there*, I did *that*, such and such. It worked, it didn't worked … you're leaving … (1IVF; 1OE;0ST;0CE)[1]

The term used by the respondent to describe the process of treatment by the professionals – 'routine' – refers to an inflexibility and depersonalisation that she identifies in the organisational procedures, in the sense of an action exclusively anchored in standardised norms and conventions, with no openness to engagements of proximity, of attention to singularity ('more attention, care'). It is also important to take into account that this attention, within a regime of proximity, is not exclusively an end in itself. In particular, it is her *fragility* from the point of view of her ability to be involved in the therapeutic trajectory, resulting from the situation of *uncertainty* associated with the accomplishment of the parental project (Delaunay, 2017), that was brought up by the respondent. In this sense, the singularising engagement also contributes to the maintenance of the therapeutic trajectory as an engagement in plan (Martins & Delaunay, 2016).

Thus, care as an expectation in terms of hospitality to meet the situation of vulnerability ('you're fragile') at the moment of failure in the therapeutic trajectory – providing the confidence in oneself to maintain the engagement in the plan (Martins & Delaunay, 2016) – clashes with the inhospitable nature of the predominant format of action that the respondent identifies in professionals. Indeed, as she specifies, her critical judgement of her clinical treatment does not result from the work of empowerment in terms of the information given about treatments ('The process is very well explained'); rather, it lies in the deficient articulation of this procedure with the capacity for a singularising engagement, in the form of the different morally invested categories mobilised: 'support', 'sensitivity', 'attention', 'tenderness' and 'care' (Dancet et al., 2012; Gameiro et al., 2013).

Another dimension relative to this hospitable ambience in the acts of communication has to do with the *emotional labour* (Hochschild, 1983)

performed by the professionals – management of their emotional states according to the situation – and the way that this is integrated and assessed in the beneficiaries' judgements about the professionals. This is illustrated in the following excerpts.

> **Ana:** 'I really liked the team I had there. We are followed-up by several doctors. We have one that always keeps our clinical file, but we are followed-up by many nurses … And even at the time of transferring the embryos everything was very … It was all very funny and amusing. They didn't want anyone crying or sad and … They had amazing nurses there … 'Look, your little child is here' … They explained everything to us … 'It's inside this little tube, let's put it in now'. And they showed us … on the ultrasound … a bright dot that was there … I have no reason to complain about the commitment of that team. Always very positive.' (3IVF;7OE;0ST;0CE)

> **Laura:** 'Every time we had an ultrasound I had to go to Porto. We're from Lisbon. But it was very funny because was like this: when we arrived in Porto they would say 'Here come the Benfica[2] fans. What are they doing here!?' Boy, it was a completely different contact … that I never felt at *[name of an ART unit]*. Never. Maybe because they also have a lot of people. But they also had there. It was a contact … It was different. It was … It was more human, it was … And just this … this icebreaker was funny because we got there and we felt good.' (1IVF;5OE;1ST;1CE)

In both descriptions, *humour* emerges as a device for hospitality (Cai et al., 2014; Dancet et al., 2012; Poli et al., 2021), also revealing its importance to make up for the lack of a comforting and reassuring physical and emotional environment of the domestic/private space, resulting from the rupture with the usual intimate and social environment (home, family, friends) associated with the immersion in the clinical space. It is through this device for action that the professionals also undertake a progressive effort of constituting a basis of trust and constructing a familiar proximity (as an 'icebreaker') within their interpersonal relationships with the beneficiaries.

While the continuous rotation of professional staff ('We are accompanied by many doctors') is likely to generate experiences judged inhospitable – in the sense that they favour an engagement with the figure of the *patient* based only on conventions and standardised norms (therefore, an appropriation in generality) – *humour* emerges integrated precisely as a way of building an *emotional atmosphere* (Livet & Thévenot, 1993) associated with proximal space (Breviglieri, 2008). Hospitality, as openness to the other, as a guarantee of a continuous presence and availability throughout the succession of events and trials that

constitute the therapeutic trajectory ('commitment of that team'), is therefore also assessed in the respondent's discourse on the basis of its importance in maintaining an engagement in this action plan.

a) Accommodating personal/intimate bonds

The second theme that emerges from the interviews relates to the ability to attend to the differences from the point of view of the intimate/personal meanings that the beneficiaries construct in relation to the surrounding environment and which, as such, diverge from appropriation formats supported by conventions and norms (Thévenot, 2019). This is illustrated in the following excerpt, in which the grammar of hospitality is mobilised specifically concerning the information provided about the fate of surplus embryos (that is, dissociated from the parental project that led to their creation after the completion of pregnancy and consequent termination of the parental project).

> **Sandra:** That was an answer like 'No, we make the embryos' elimination'. And I even asked if it was possible that we could keep … after the elimination, right? … […] if we could eventually keep the straws, and then do a farewell ceremony, anything. They also thought that it made no sense. […] But I feel that it could be important, […] that somehow it was important to consider this emotional side that people … how should I say … Because I think a person never forgets the embryos one has there. (1ICSI;9OE;1ST;7DE)

The discourse focuses on the ART clinics organisational malleability for acknowledging intimate meanings concerning the embryos generated, namely the possibility of performing farewell rituals (Dancet et al., 2012). Thus, the critique made by the respondent does not focus on the ability of embryologists to provide information aimed at empowering the beneficiary to make an informed decision regarding the options available on the fate of surplus cryopreserved embryos. Rather, the judgement made focuses on the evidence given in the act of communicating and on the attention to the 'emotional' dimension, that is, to the affective bond that the beneficiaries can build with the embryos.

The emotional bonds built with these in-vitro entities, based on a familiar engagement, are formats of action distant from grammars that sustain appropriations of the embryo as a technical object and from a functional perspective (within an action plan supported by objects expressing *industrial* worth). Beyond a limitation of the publicly available options regarding the fate of such embryos, it is also the communication management, in the sense of an accommodation of the emotional impact regarding the

prospect of destroying embryos, that is highlighted in the assessment made of the professionals' conduct (in this case, embryologists).

Regarding this tension between distinct regimes of engagement in clinical settings – in particular, between broad conventions and the familiar engagement (Thévenot, 2004b) – the next excerpts provide another dimension where this same tension may occur: the definition of the onset of pregnancy and the respective intimate meanings that may be built by the beneficiary.

> **Alba:** When they put the embryo inside me, I asked if I was pregnant … […] I asked if I was pregnant and they said no … I founded that frustrating … If I have an embryo inside me, even if he doesn't develop, I'm pregnant. But they say no. Medically, I'm not considered pregnant … A bit ridiculous, but OK … […] It's one of the flaws of the clinical centre, they are very cold. (1IVF;18OE;1ST;10CE)

The tension between grammars is glimpsed in the dissonance between the subjective dimension of the interviewee's experience of pregnancy ('If I have an embryo inside me […] I am pregnant') and the medical criteria that underpin the professionals' judgement which postpone the confirmation of pregnancy to a later stage of the therapeutic trajectory. The *coldness* that the respondent mentions in this way of action translates this mode of engagement grounded in local references, far from the *industrial* convention that guides professionals' action and clinical gaze. In fact, it is precisely in this inhospitality that resides the judgement made by the interviewee about the way the ART clinic operates ('it is one of its flaws'), in an observation that thus extends beyond the conventional orders – in particular, beyond the effectiveness of the clinical work, as a conception of the common good (Boltanski & Thévenot, 2006).

Furthermore, implicit in the observation is also the issue of the emotional management of the beneficiary in their engagement in the therapeutic trajectory. Meaning that an acknowledgement of pregnancy, even if not supported by clinically defined protocols and criteria, also constitutes a factor of motivation from the point of view of her involvement in the therapeutic trajectory and belief that pregnancy can be achieved. The category 'frustrating' is used by the respondent in that sense: the representation of the embryo transfer as a stage attained in the action plan aiming at a pregnancy ends up being disqualified as such by the professionals.

Moreover, this expectation of attention to patients' intimate meanings, parallel to the biomedical criteria that guide professional's judgments,

also extends to the optimism about achieving pregnancy (Dancet et al., 2012), as expressed by another interviewee:

> **Lisa:** We went back to the hospital and had another ultrasound and *[the doctor]* said 'This is not moving forward, let's wait another week. […] In the afternoon I did a *[pregnancy]* test. It was positive. And in the evening they told me 'No, don't get your hopes up, this will not go ahead'. […] There are moments that are a bit … sad … And then they're already so … so hardened by experience, dealing with it every day that they don't have … Well, the way they talk sometimes … it's not the most appropriate, right? (5IVF;7OE;0ST;0CE)

c) Attention of organisational functioning to the patient's ease / comfort

Another theme of analysis relates to attention to privacy issues, and which modes of action based exclusively in the *industrial* worth, in an appropriation of the patient as a *clinical object*, are liable to neglect. The next excerpt illustrates precisely how the configuration of a medical consultation situation is likely to be assessed from the point of view of the *discomfort* caused, comprising a moral perspective on this moment of interaction associated with a familiar engagement.

> **Lia:** Later, at the medical appointment, I also feel that in terms of privacy, for example. […] I even understand, I really understand. But sometimes it's strange that you're in an appointment and you have three doctors on the other side. […] Suddenly you feel like a little girl with a very serious problem, who needs all those gentlemen doctors there. […] In the private sector you have your doctor who follows you and that's it, that's all. Eventually, a nurse comes if you need to do an ultrasound, if you need anything extra. A nurse or an assistant. And it's an intimate, private thing, it's not a … 'LOOK … [laughs] TCHARAN!' (1IVF;2OE;0ST;0CE)

The issue of 'privacy' takes centre stage in the respondent's view when comparing the experiences in the public and private sectors that make up her trajectory. Within this category, related to feeling at ease with the surrounding space (Breviglieri, 2006), the focus is on the configuration of the situation, namely the simultaneous presence of several medical professionals in the various follow-up consultations. This situation is an oppressive configuration (Thévenot, 2009) of what the respondent stresses should be, within the grammar of hospitality, an 'intimate, private' ambience – which she experiences in the private sector – and a good that should also be taken into account in the way interactions between patients and professionals are organised.

In other discourses, the focus is also placed on inhospitable ambiences, but specifically arising from the configuration and arrangement of the physical space:

> **Diana:** The preservation of people's privacy is very important and the way services are organized does not guarantee people's privacy … People are making ultrasounds, for example, to monitor the evolution of an ovarian stimulation, and there are several people in the same corridor … So as to be quicker, sometimes, there are two people … inside an office changing clothes while another is having an ultrasound separated only by a folding screen … and the other is having the consultation … […] I'm not supposed to be listening to medical instruction […] 'You're going to take this now to trigger the ovulation. Don't have sex in the hours before that'. These are issue of the private sphere. (5IVF;7OE;1ST;0CE)

> **Cecília:** For example, I was going to do a monitoring ultrasound. […] The room was very narrow … The hallway door was sometimes open. […] We undress behind this folding screen. When you move to the examination table you come out of the folding screen. So, people who are passing in the corridor … It's a corridor where not only medical personnel or nurses or auxiliaries pass, but also some couples who are leaving other appointments. And, therefore, you do this little show off for the people who are passing by. (5ICSI;8CE;0ST;0CE)

As a moral orientation of the judgement that both respondents make about the way ART unit where she received treatments operates, the grammar of hospitality stands out in the sense of an organisational functioning that also assures comfort – particularly in the form of safeguarding 'privacy' (Dancet et al., 2011; Webair et al., 2021). Aiming at an interaction that assures this moral imperative when providing clinical care, the layout of the space should thus take into account matters of the 'private sphere,' avoiding spaces prone to publicise the intimacy of the beneficiaries. *Efficacy*, within the *industrial* worth, as sought by the configuration of space and organisational functioning ('so as to be quicker'), is thus presented as having to be combined with attention to this moral demand.

d) Protecting the patient from inhospitable situational settings

The grammar of hospitality as a moral framework is identifiable in the respondents' discourse also from the point of view of the effects arising from an appropriation of the figure of the patient in generality, through standardised conventions and norms that govern clinical/hospital organisations (Thévenot, 2006). Illustrating this theme is the experience reported by another respondent. The context relates to the

performance of a surgical procedure – an ovarian puncture – by a medical professional other than the one who had accompanied the interviewee since the beginning of her therapeutic process. From the grammar of hospitality, the description focuses specifically on the subtraction of the patient's singularity in the way that the technique is performed.

> **Sandra:** […] and it was also the person who performed the ovarian puncture. I was sedated and I never spoke to him, not before nor after. […] Because who came to see me afterwards was the doctor who accompanied me. But that doctor who performed the puncture, while I was sedated, I never spoke to him directly. We had interactions over the phone or by email … But that special touch was lacking … […] And I remember that … when I woke up from the sedation I was already in the room, I was no longer in the place where the puncture was performed … I started to cry a lot. […] And then later I even talked to *[husband's name]* about this, about the feeling of rape. […] It's the feeling of someone having done something to my body. (1ICSI;9OE;1ST;7DE)

The expression used by the respondent ('that special touch was lacking') summarises the grammar of hospitality that orients her judgement. At issue is not the obligation that the intervention be performed by the doctor in question, but rather the absence of a previous contact favouring openness to this singularity. Moreover, as the respondent specifies, contact with the doctor who carries out the procedure takes place at a distance (by email and telephone) and is therefore incompatible with engagements of proximity (Thévenot, 2006). It is thus also through a familiar engagement, in a dynamic of hospitable openness on the part of the doctor, that the horizon of mutual consent associated with the engagement in a plan is attained in the execution of the aforementioned surgical procedure (Breviglieri, 2008).

The weeping reported by the respondent reflects precisely the emotional experience coupled with the moral judgment produced about the situation – affecting the positive understanding of herself (Honneth, 2004). The final expression used – 'it's the feeling of someone having done something to my body' – also refers to one of the models of intersubjective recognition, based on socialisation through emotional attachments between close persons (Honneth, 2004), associated with the regime of familiar engagement (Thévenot, 2006). The humiliation in the light of this model of recognition resides specifically in an offence against the physical integrity of the individual, as a form of degrading treatment resulting from an indifference to the personal dimension in the relationship, from the failure to build trust

(Breviglieri, 2008; 2009). More than a physical pain associated with bodily mistreatment, it is the feeling of exposure, without a context of proximity, that underlies the denial of recognition. It is precisely in this sense that the inhospitable experience felt by the respondent is equated with a 'rape'.

A different example of an inhospitable configuration of a situation in a clinical context is given by another respondent. The situation relates specifically to the system of identification (the hospital user card) that she carries as a patient, in accordance with the standardised norms of the hospital where the ART unit is located (Thévenot, 2009). As she describes, this same object – as being of a qualifying nature – has collateral effects from the point of view of her experience as a patient in this treatment unit.

> **Diana:** The service was called 'Sterility Service'. So just for that there is a very big stigma. […] My card, which has my hospital user number, has a giant label … with my name and it says 'Sterility Service' underneath. Therefore, I will present that card at all other services where I eventually have appointments. […] They are always looking at the card. 'Oh, poor people, they are those who've been there for I don't know how long' *[laughs]* 'And who don't have children' … 'Poor things, they can't have children' … And then there's that story: 'So, is the problem yours or your husband's?' *[laughs]*. (5IVF;7OE;1ST;OCE)

The hospital user card – an object expressing *industrial* worth included in an environment functionally prepared for the identification of the patient according to the respective hospital service ('Sterility Service') – emerges as a focus of criticism based on the grammar of hospitality as a moral framework of evaluation. The stigmatising and so inhospitable effect associated with this qualifying object is highlighted (Boltanski & Thévenot, 2006) – publicising the respondent's clinical condition both to the medical staff and to any other actor present in that space. As information belonging to the intimate sphere, her pathology acquires a hegemonic role in her identity in that territory.

This stigmatising effect materialises in indiscreet glances ('they are always looking at the card') or in intrusive dialogues and enquiries in that same hospital space ("Is the problem yours or your husband's?"). Such acts constitute an invasion of her intimate sphere – an excess of proximity that, as such, appears *unbearable* (Breviglieri, 2009) to the respondent, to the extent that it prevents any form of distancing from others, thus entangling them in her intimacy. In this case, the decision-making autonomy (of whether or not to disclose the information) within the engagement in a plan is also restricted as a moral framework

at the service of hospitality – that is, as a format that, in parallel with the regime of proximity, also allows the different vulnerabilities of each beneficiary to be taken into account (Stavo-Debauge, 2014).

Moreover, the hospitable qualities of clinical units also extend to spatial configurations that are cable of attending to patients' well-being:

> **Ema:** It's a maternity hospital … You see pregnant women everywhere and that had a very, very negative impact. It was painful. […] Or to see … For example, I once went for an exam in the hallway where I heard that an abortion had been done … . (1IVF;17CE;0ST;0CE)

The perspective conveyed by the interviewee refers to the hospitality in the arrangement of the clinical environment, in the sense of the ability to take into account the vulnerability of the users. That is the case of patients' exposure to the coexistence in the same hospital space of users with different – and contrasting – clinical purposes ('an abortion had been done'). The arrangement of physical and socio-functional settings does not raise criticisms from a functional perspective; it's negatively evaluated because of environmental elements that fail to pay attention to situations of vulnerability associated with the impact of infertility and, therefore, the patient's well-being (Dancet et al., 2011).

5. Discussion

Patient-centred care is a widely used model in current healthcare systems, with an increasingly prominent position in terms of legislation and regulation of clinical activity (Scholl et al., 2014). However, as mentioned by several authors, the implementation of patient-centred care is conditioned by an ambiguity/lack of clarity in terms of its definition and conceptualisation (Zeh, 2019; Scholl et al., 2014; Pelzang, 2010), as well as how further features of patient-centred care can be integrated (Kitson et al., 2013). Considering this limitation, several proposals for integrative conceptual models have been developed (e.g. McCormarck et al., 2011; Scholl et al., 2014; Gagliardi et al., 2019; Brickley et al., 2021).

Concerning the aim of developing comprehensive conceptual frameworks for patient-centred care, the analytical proprieties of Pragmatic Sociology have the potential to contribute to a more nuanced understanding of how the patient-professional relationship can be built to achieve the goal of 'responding to patients' needs and preferences' (Pelzang, 2010) in its multiple manifestations. In particular, this framework has the potential to allow for a more detailed conceptual

differentiation of distinct normative expectations based on the familiar engagement (Thévenot, 2006) that patients produce regarding the healthcare they receive.

Indeed, this regime of action encompasses different moral spheres of practice, each with their own pragmatic consistency in terms of the relational modality between caregiver and care receiver – which can, therefore, be conceptually disentangled (Thévenot, 2006). It is this internal diversity concerning the singularising relational modalities in care that can be improved in current proposals for conceptualising patient-centred care.

In particular, when examining the different conceptual models/frameworks of patient-centred care, several dimensions specifically aim at recognising the patient's singularity. That is the case of *Fostering healing relationships* and *Addressing emotions* (Gagliardi et al., 2019; McCormarck et al., 2011), *Emotional support* (Scholl et al., 2014; Zeh, 2019), or *Whole person* (Brickley et al., 2021).

However, how these dimensions are conceptualised can limit the diversity of expectations that patients express about familiar engagements (Thévenot, 2006). Indeed, in different proposals for conceptually integrated models of patient-centred care, it is precisely the distinction between the different domains of familiar engagement that can highlight the difficulty of these models in accounting for the multiple ways in which patients evaluate the healthcare they receive (Gagliardi et al., 2019).

As a first example, the categories *Fostering healing relationships* and *Addressing emotions* are dimensions of an integrative conceptual model developed about addressing patients' singularity in the context of medical treatment (Gagliardi et al., 2019; McCormarck et al., 2011). In the case of *Fostering healing relationships*, it involves 'Patient-clinician relationships that provide emotional support and understanding can help patients adjust better to their illness' (McCormarck, et al., 2011, p. 1088); as for *Addressing emotions*, it refers to 'Identifying, exploring, and expressing emotions involves helping patients identify and articulate their emotions' (McCormarck, et al., 2011, p. 1090). Therefore, these are two dimensions eminently restricted to a relational frame of solicitude.

However, when compared to other efforts to build conceptual frameworks for patient-centred care, patients' discourses reveal additional moral domains that are not captured by these dimensions (Gagliardi et al., 2019). This is the case of the theme defined as *Humanisation* (Gagliardi et al., 2019). The latter refers to patients' assessment of

organisational flexibility/malleability (thus, covering a wider configuration of spaces, procedures and interactions) to meet the patient's singularities – in the sense of 'feeling seen and heard as a person and receiving individualised communication and treatment that fits their personal needs' (Gagliardi et al., 2019, p. 10). To this extent, this dimension goes beyond the close monitoring of a professional, as described in *Fostering healing relationships* and *Addressing emotions*. Namely, it concerns the organisational plasticity to accommodate different intimate meanings, needs and vulnerabilities of patients – i.e. hospitality.

Extending the analysis to other PCC frameworks, the same limitations can be identified. The category of *Emotional support* is a dimension associated with the ability to care for patients in their singularity (Scholl et al., 2014; Zeh, 2019). However, the construction of this dimension, as 'Recognition of the patient's emotional state and a set of behaviour that ensures emotional support for the patient' (Scholl et al., 2014, p. 5), is thus revealed to be eminently oriented towards the professional's attentive listening and support (i.e. solicitude), neglecting other moral spheres linked to familiar engagement. The same extends to the category of *Whole person* (Brickley et al., 2021), described as the capacity of clinicians 'to use their skills to fully understand patients' characteristics, values, capabilities, perspectives and preferences' (Brickley et al., 2021, p. 3) – therefore, converging with *solicitude* as a moral sphere of familiar engagement, with its specific pragmatic properties.

Moreover, integrative conceptual models of patient-centred care for infertility treatment have also been developed (Dancet et al., 2011; 2012; van Empel et al., 2010). These frameworks show a more developed differentiation between different spheres of familiar engagement. Nevertheless, some dimensions can benefit from a conceptual improvement through a more nuanced differentiation between the different spheres of proximity – particularly, solicitude and hospitality.

On the one hand, these multiple moral spheres can be presented in a syncretic manner, i.e. without differentiating the various forms of familiar engagement (e.g. Shandley et al., 2020; Verkerk et al., 2022). That is the case of categories whose dimensions they measure can encompass different spheres of familiar engagement: '*Were you treated like a number or a human,*' covering different spheres of proximity oriented towards patients' singularity (Thévenot, 2006); 'Do you feel your doctor was trustworthy', which may include technical skills (i.e. *efficacy*) and the ability to build a relationship of trust through solicitude; 'Did your doctor show compassion', which can range from compassion associated with attentive

and empathetic listening to the more hospitable capacity to adjust procedures or decisions to the specific needs of the patient (Shandley et al., 2020). Likewise, *Caregivers take the time* can encompass different forms of engagement with the patient, from capacitation for decision-making to more familiar engagements, such as emotional support (Verkerk et al., 2022).

On the other hand, more conceptually elaborated models can encompass patients' different normative expectations associated with recognising their singularity. That is the conceptual model by van Empel et al. (2011), built on the general patient-centred model developed by the Picker's Institute, and applied in different studies (Aarts et al., 2012; Gameiro et al., 2013; Pedro et al., 2013; Cai et al., 2014; Mourad et al., 2019; Medina-Artom & Adashi, 2020). A more nuanced conceptual differentiation of the dimensions concerning familiar engagements can highlight fundamental elements related to organisational functioning and patient-professional interactions. This is the case with the dimensions of *Communication*, *Respect for patient's values* and *Continuity and transition* (van Empel et al., 2010).

In the case of *Communication*, the various items reveal limitations regarding the ability to capture the diversity of normative expectations that patients express within familiar engagements. Namely, the indicators that measure this dimension (e.g. 'Physician listened carefully,' 'Physician took enough time') are associated with an action in proximity anchored in solicitude, that is, referring to a professional's ability to listen and attend to patients concerns and doubts involving the clinical treatment. Communication issues anchored in a perspective of hospitality are, to that extent, clouded. This is the case of the ability to create a welcoming/relaxed environment through, for example, conversation and humour (Dancet et al., 2011; Poli et al., 2021).

In the case of *Respect for patient's values*, indicators such as *Physician had empathy with your emotions and actual situation*, *Physician took interest in you as a person* or *Staff paid attention to the emotional impact of infertility* (van Empel et al., 2010) are also anchored in solicitude as a sphere of familiar engagement, referring, therefore, to the ability to listen, pay attention, grasping vulnerabilities (emotional or otherwise). However, issues associated with hospitality, such as the ability to accommodate situational configurations, procedures and spaces to the patient's singularities and ease appear equally obscured. That is the case of organisational malleability as acknowledging intimate meanings concerning the embryos generated (e.g. the possibility of

performing farewell rituals) or the staff's optimism concerning the achievement of pregnancy (Dancet et al., 2012).

Finally, in the case of the dimension *Continuity and transition*, the indicators focus on the issue of the importance of continuity and regularity of contact with the same doctors/health professionals, but from a perspective of technical coherence in the decision-making process (e.g. *Having a lead physician for evaluation and decision-making*, *Having contradictory information or advice* or *One caregiver as a central point for problems or questions*). Nevertheless, the concept of hospitality can encompass other aspects valued by patients in the context of rotation and continuity with professionals. For example, procedures that allow building familiarity between professional and patient before a technical procedure, within a hospitable action, in case this clinician is distinct from the one that follows the patient's clinical case.

In the case of the conceptual model by Dancet et al. (2011), the dimension related to *Continuity and transition* is also present. Likewise, this dimension is described in terms of 'absolute continuity' or 'need for a lead physician' to obtain a 'consistent medical policy and shared information within their team' (Dancet et al., 2011, p. 830). Therefore, it is built solely on a perspective of coordination effectiveness and transparency in the decision-making. Again, a supplementary sphere emerges in patient's discourses, as is the case of hospital opening for familiarisation between professional and patient before performing technical procedures, ensuring, thus, a hospitable transition between physicians/professionals.

Moreover, if the separation of the system factors from the human factors can hinder aspects of patient-centred care (Cunningham & Cunningham, 2013), hospitality as a moral expectation reinforces that articulation. It accomplishes it by focusing on situational configurations that integrate how interactions, procedures and physical spaces are arranged (Stavo-Debauge, 2018).

Nevertheless, additional dimensions conceptualised in this model are more overarching in terms of the plurality of moral spheres associated with familiar engagement. This is the case of *Physical Comfort*[3], which refers to the hospitable features in terms of spatial configuration (thus, beyond solicitude): 'waiting rooms and consultation rooms to be exclusively used by infertile (not obstetric) patients' and the capacity to ensure 'privacy' (Dancet et al., 2011, p. 830).

Furthermore, concerning the *Attitude of and relationship with staff*, in addition to the listening ability associated with solicitude (described in

Emotional support), relational abilities that rest on hospitality are also covered. This is the case of the capacity for welcoming relational ambiences through relational skills – e.g. 'being friendly' (Dancet et al., 2011, p. 830) –, which may also include humour (Poli et al., 2021).

6. Conclusions

The present article sought to explore the judgments of ART beneficiaries about their experiences in clinical settings – in particular, their interaction with professionals and how different clinical situations are arranged. Specifically, the aim was to highlight the importance of differentiating the plural moral spheres through which patients express their normative expectations on recognising their singularity in a hospital context. This purpose was pursued by exploring different angles of the clinical experience in which hospitality can manifest itself as a specific moral domain.

Hence, this conceptual thoroughness is a valuable objective to avoid obscuring patients' different understandings concerning how care is provided, which in turn hinders the construction of institutions whose functioning recognises that moral plurality. A greater analytical detail, by conceptualising different forms of patients' expectation based on the familiar engagement – not limited to solicitude, but also encompassing hospitality – can favour the construction of more pluralistic and nuanced patient-centred models.

In addition, a more detailed conceptual differentiation allows that, regardless of the dispersion of indicators between different models of patient-centred care (Webair et al., 2021), they can be more effectively organised conceptually according to the different spheres of familiar engagement they represent. Therefore, the conceptual models (and the measurement and evaluation tools built upon them) can benefit from greater consistency and scope.

To this extent, the present article aims to contribute to greater conceptual clarity in the integrative patient-centred care models and, consequently, to a more nuanced evaluation of patients' experiences. Also, this paper seeks to contribute to the existing literature on medical care in the context of ART (e.g. Roberts, 2012; Thompson, 2005) that explores the different grammars that can shape clinician-patient relationships.

This is the case of national contexts where, in ART clinics, the clinician-patient relationship takes on a *paternalistic* nature (Roberts, 2012), with relational dynamics characterised by their often familiar, informal

nature, with ongoing conversations and agreements built *ad hoc* and not mediated by binding legal documents (Roberts, 2012). Therefore, this type of interpersonal interaction predominates to the detriment of impersonal and bureaucratic relational formats aimed at empowering the patient for autonomous medical decisions, according to an *engagement in a plan* (Thévenot, 2014).

On the other hand, other ethnographic incursions explore how entering the clinical space – and, in this particular case, the process of turning infertility into a medical problem to treat – entails a process of *objectification* for patients (Thompson, 2005): the suspension of their multiple social roles that make up their social identity along the different clinical moments (e.g. a medical exam); their *generic bureaucratisation* according to the operational parameters of the clinic (e.g. patient number, time slot for an appointment, etc.), which aims at the efficiency of the clinical procedures but threatens the patients' singularity; or also their *epistemic disciplining*, with the medical staff managing the clinical information transmitted to the patient in the different moments, before and after the informed consent (Thompson, 2005). In turn, this objectification entails a dual relationship with agency. While it aims to enhance agency – namely, the effectiveness of the patient's participation in clinical procedures and decision-making processes – it can also constrain it by obscuring the recognition of aspects of the patient's singularity (Thompson, 2005).

Furthermore, the success of the treatment cycle impacts how the process of objectification is retrospectively evaluated by the patient (Thompson, 2005). If the treatment fails (i.e. an unsuccessful pregnancy), the alienating and dehumanising effects of the treatments tend to be emphasised; if it succeeds, the same ontological dynamic tends to become irrelevant or secondary to the patient. In this sense, ART is a particular clinical context that can intensify patients' reflections on the objectification inherent in the clinical experience. The high failure rate in achieving pregnancy, which is a central feature of this medical field, can have implications for how the clinical experiences are perceived by the beneficiaries. This makes it a particularly relevant clinical area for analysing the different dimensions that the patient-centred care can encompass – which includes hospitality.

Finally, it is important to point out the limitations of the analysis carried out. First, as this paper is based on a research project focused on the ART context, this clinical context (as in all medical fields) can present particularities that influence how the grammar of hospitality

emerges in patients' discourses. That is the case with how intimate meanings concerning certain aspects of the treatment are recognised (or not) – such as the clash of personal meanings given to the embryos with standardised procedures (e.g. destruction without the possibility of performing a farewell ceremony).

Secondly, the empirical context of analysis is limited to the Portuguese context. The grammars evoked by actors – and, in this case, by the patients regarding the received healthcare – are always culturally situated. Also, these different conceptualised grammars, as cultural repertoires for evaluating situations, stem from the Western historical and cultural contexts (Thévenot, 2014). Nevertheless, conceptual models of patient-centred care from cultural contexts beyond Western societies also reveal the presence of items that, for example, express hospitality as a moral sphere – such as physical spaces that preserve privacy (Webair et al., 2021).

Moreover, the sample of interviewees presents limitations in terms of social diversity. With respondents recruited through a non-probabilistic sampling (snowball and convenience methods), and using primarily social networks as a contact platform, the final sample displays a reduced variability in terms of sociodemographic variables that allow exploring possible differences in terms of the incidence of different grammars according to the social profiles of the interviewees (e.g. gender or social class). Nonetheless, the objective of this article is to emphasise the plurality of moral spheres that can be evoked by patients concerning the recognition of their singularity in a clinical context, focusing in particular on the pragmatic specificities of the grammar of hospitality.

Notes

1. To clarify the clinical context of each interviewee, each interview excerpt presented in this article is accompanied by a matrix of acronyms describing the participants' therapeutic trajectory (at the time of the interview). The acronyms refer to five variables and their respective values: (i) type of treatment (IVF or ICSI) and the number of treatment cycles completed; (ii) number of obtained embryos (OE); (iii) number of successful treatments (ST), i.e. full-term pregnancies achieved during ART treatment; (iv) number of cryopreserved embryos (CE); and (v) number of surplus embryos discarded (DE). For example, '2IVF; 4OE; 1ST; 0CE' means a clinical course consisting of two completed IVF cycles, with a total of four embryos generated, one pregnancy achieved and zero existing cryopreserved embryos at the time of the interview.

2. A Portuguese football club based in Lisbon.
3. Note also for the expectation that the rooms provide a 'homely environment' (Dancet et al., 2011) – convergent with a perspective of habitability (Breviglieri, 2006), as another domain of familiar engagement.

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