THE ANTHROPOLOGY OF WAITING ROOMS: TEMPORAL HIERARCHIES AND EMBODIED PATIENCE IN PUBLIC HEALTHCARE INSTITUTIONS OF SOUTHEAST EUROPE

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Abstract: The anthropological literature on waiting has developed along two tracks. One treats waiting as an exercise of institutional power, in which the imposition of delay produces subordinated subjects; the other treats the waiting room as an atmospheric and spatial condition with its own affective properties. Neither track has examined how waiting rooms stratify internally, nor what difference it makes whether that stratification is visible to those it disadvantages. This article addresses that gap. Drawing on the published ethnographic and health-services literature, it proposes a distinction among three regimes of temporal stratification, differentiated by where the conversion of social advantage into temporal priority occurs relative to the sight-lines of those waiting: sequestered conversion, in which advantage is exercised outside the room; codified conversion, in which it is exercised inside the room under published criteria; and exposed conversion, in which it is exercised inside the room through unpublished, particularistic means. The article's original contribution is the claim that public healthcare waiting rooms in Southeast Europe are characterised by exposed conversion, and that this produces a distinctive attentional posture I term surveillant waiting: attention directed laterally at co-waiters and at the staff-door threshold rather than forward at one's own turn, because the operative uncertainty concerns not when one will be seen but who will be seen first and on what basis. The consequence for the article's second key term is that embodied patience in such settings is better understood as vigilance held in a still body than as resignation or discipline. Three falsifiable predictions follow, of which the sharpest is that reducing waiting duration should not reduce dissatisfaction under exposed conversion, whereas rendering the conversion either invisible or codified should. The study is conceptual and comparative and rests on no new fieldwork; the conclusion specifies the observational design that would test the predictions.

Keywords: *waiting, temporality, medical anthropology, Southeast Europe, embodiment, queueing, informal practices, public healthcare.*

INTRODUCTION

Anyone who has spent a morning in a public outpatient clinic in this part of Europe knows the particular quality of attention that fills the corridor. It is not the drowsy inattention of a departure lounge. Heads turn when the door opens. People count who went in and in what order, register the person who arrived after them and was called before them, and note the quiet exchange at the reception desk that preceded it. The bodies are still — hours of stillness — but the attention is working continuously, and it is not working on the door that will eventually open for

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oneself. It is working on everyone else. This article is an attempt to say what that attentional posture is, why it takes this form here, and what it implies for two concepts the anthropological literature has been using loosely: temporal hierarchy and embodied patience.

The scholarly literature offers two frames, and both illuminate part of the scene without accounting for what I have just described. The first frame reads waiting as a technology of power: institutions impose delay, and the imposition produces subjects who learn subordination through their own idleness. Recent work in this vein is strong and varied. Chakkour, Vollebergh, and de Koning (2024) analyse bureaucratic waiting and the spiritual repertoires that people develop within it; Ameso (2026) examines temporal governance in a health setting where waiting shades into waiting in vain; Drangsland (2019) treats waiting as a redemptive state in a governmental offer to migrants; Nielsen, Danneris, and Monrad (2021) analyse the temporal experience of long-term unemployment through the lens of temporal control. The second frame treats the waiting room as a place with properties. Kearns, Neuwelt, and Eggleton (2020) examine patient perspectives on space and time in general practice waiting rooms and find the boundaries between clinical and social space unexpectedly permeable; Repo, Kymäläinen, and Humalisto (2022) analyse the institutional atmosphere of a psychiatric hospital as something one can feel in the air. Both frames are productive. Neither asks what happens when the room's temporal order is unequal in a way its occupants can watch.

That question is the article's subject, and answering it requires a distinction the literature has not drawn. Every waiting room in every health system is stratified: someone is always seen sooner, and the reasons vary from clinical urgency to appointment systems to who knows the nurse. What varies across systems is not whether stratification occurs but where the conversion of advantage into temporal priority takes place relative to the perceptual field of those disadvantaged by it. In some systems the conversion happens elsewhere — in a separate facility, a different insurance tier, an appointment algorithm that sorted the queue before anyone arrived — and those waiting cannot see it. In others it happens in the room but under published criteria that everyone can in principle accept, as with clinical triage. In others again it happens in the room, in full view, through means that are neither published nor defensible in public: a phone call made in advance, a familiar face at the desk, an envelope, a nod.

The original contribution of this article is to name these three configurations — sequestered, codified, and exposed conversion — to argue that public healthcare waiting rooms in Southeast Europe are characterised by the third, and to derive from that characterisation a specific and testable claim about the phenomenology of waiting in such settings. The claim is that exposed conversion produces surveillant waiting: an attentional posture directed laterally rather than forward, in which the person waiting monitors co-waiters and the threshold between the corridor and the consulting room, because the uncertainty that matters is comparative rather than durational. From this follows a reinterpretation of the second term in this article's title. Embodied patience under exposed conversion is not resignation, and not the acquired discipline of a docile body; it is vigilance held inside a body that has nothing to do. The stillness and the alertness are simultaneous, and their simultaneity is the phenomenon.

Three hypotheses organise the investigation. The first (H1) holds that the three regimes are analytically distinct and that the published literature on waiting can be sorted by them, with the dominant Anglophone cases falling under sequestered or codified conversion and the exposed variant underdescribed. The second (H2) holds that Southeast European public healthcare settings exhibit exposed conversion, as evidenced by the regional literature on informal relations, connections, and differential trust in health institutions. The third (H3) is the phenomenological claim: that exposed conversion produces surveillant waiting, whose signature is lateral rather than forward attention and whose complaint register concerns fairness rather than duration.

Two disclosures belong here rather than in a methodological footnote. First, this article reports no fieldwork. I have not observed a clinic corridor with a notebook, timed a queue, or interviewed anyone about their waiting; the opening description above is drawn from ordinary life in the region and is offered as motivation rather than as data, and I will not treat it as evidence anywhere in what follows. The evidentiary base is the published literature, and where that literature is thin for this region — as it is, considerably — I say so. Second, my position is that of someone who has done a great deal of this waiting and none of this observing. That gives me a certain confidence about what the phenomenon feels like and no standing whatsoever to claim it generalises, and readers should weigh the argument accordingly: it is a conceptual proposal with a testable consequence, not a report of findings.

LITERATURE REVIEW AND METHODOLOGY

Literature Review

Four literatures converge here. The first is the anthropology and sociology of waiting as a political condition, which has expanded rapidly since 2019 and now constitutes a recognisable subfield. Chakkour, Vollebergh, and de Koning (2024) examine how people inhabit bureaucratic delay through spiritual repertoires, refusing the reduction of waiting to passivity. Vaughn (2019) analyses the waiting of migrant nurses in Norway; Naidu (2023) explores the temporal dimensions of educational migration in terms of getting used to waiting; Hansen (2020) examines who has any say over how long waiting lasts; Toumaras (2026) analyses everyday waiting under humanitarian slow neglect; Zhao (2026) proposes waiting as an epistemic-temporal mechanism for decolonising migration knowledge. Olwig (2021) treats temporariness and uncertainty in refugee life. Terzioglu (2022) examines Syrians' experiences of waiting in Turkey, which is the geographically closest case to the present one and the only item in the corpus set in the wider region. Flaherty (2022) frames the general question of negotiating temporality in everyday life, and Valkenburg (2022) connects temporality to epistemic justice.

The second literature concerns waiting and time inside health institutions specifically. Kearns, Neuwelt, and Eggleton (2020) provide the single most directly relevant study, examining how patients experience space and time in general practice waiting rooms and finding the room's boundaries permeable between clinical and social registers. Pedersen, Johansen, and Schellerup (2021) analyse the organisation of waiting time in health services through what they call colour time, challenging the assumption that waiting is a residual to be minimised. Repo, Kymäläinen, and Humalisto (2022) analyse the institutional atmosphere of a psychiatric hospital. Cogburn (2025) examines a Tanzanian maternity waiting home as a place of impossible demands where care and surveillance intertwine, which is the closest published analogue to the surveillance dimension I develop below. Vijay and Koksvik (2024) study waiting for care and the community organising that grows in its interstices in Kerala. Ameso (2026) analyses temporal governance and misalignment; Davies (2026) treats clinical time as labour under the striking formulation of watching you wear out; Bogicevic (2021) examines how cancer patients are configured as research subjects through the taming of time; Lukšaitė (2022) analyses reproductive chronicity. Diasio (2025) and colleagues develop the notion of regimes of temporality for rare disease in Europe.

The third literature is regional and concerns healthcare, trust, and informal practice in Southeast Europe and the wider post-socialist space. Pantović (2021) analyses how women navigate institutional childbirth in Serbia through social positioning and informal relations, and Pantović and Đorđević (2024) examine barriers and trust in perceptions of the healthcare system among Roma mothers in Serbia — together the strongest regional evidence available for differential access within nominally universal institutions. Basna, Pospisilova, and Bures (2025) analyse

informal payments in Czech healthcare and the blurred line among greed, need, and gratitude, a framing that captures why the practice resists both defence and prosecution. Rodrigues (2021) examines communicative trust in public healthcare facilities. Čvorović (2019) and Dobrivojević-Tomić (2019) supply regional background on health and reproduction, the latter historically. Žikić (2021) analyses attitudes to public health measures during the pandemic in Serbia, and Žikić (2024) examines wasting time as a cultural practice in contemporary Serbia, which is the only item in the corpus treating time itself as a regional ethnographic object. Blume (2021) offers a critical reflection on global health from within the regional journal.

The fourth literature is conceptual: embodiment, atmosphere, and the theorisation of institutional space. Kulenović (2021) assesses the explanatory power of embodiment in anthropology, a review that is unusually useful here because it distinguishes the senses of the term that my argument needs from those it does not. Qureshi (2023) analyses middle-aged British Pakistani women's intuition of the limits to care under the heading of patient patients, playing on the double sense of the word in exactly the way this article's title does. Čerešňová (2023) examines how the circulation systems of buildings determine social behaviour, which supplies the architectural dimension of the waiting room that anthropological accounts usually omit. Weston (2019) offers a rare direct ethnography of queueing in a public event setting. On the wider theoretical setting, the regional journal literature contributes: Cvjetić (2025) develops a triadic model of the somatic inscription of ideology distinguishing disciplinary, affective, and performative modalities; Gomez (2024) analyses the governed body; McDougall (2023) examines governmentality and technologies of the self; Akrap (2025) analyses the psychology of the fair price and the conditions under which a consumer feels cheated, which turns out to bear directly on the fairness-versus-magnitude distinction developed below; Vasconcelos (2025) offers a phenomenology of loneliness among the hyperconnected; Stojanović (2023) analyses Honneth's deformations of recognition in platform work; and Risojević (2024) treats collective trauma in post-conflict Western Balkan societies.

A fifth strand concerns who gets excluded and how exclusion is enacted at the point of contact, which is the mechanism my argument depends on even though none of these studies examines a queue. Fraser and colleagues (2020) analyse the subtle dynamics of stigma in healthcare access for people emerging from drug treatment, describing exclusion accomplished through manner and micro-interaction rather than through rules — the same modality by which particularistic advantage operates, seen from the other end. Zafer-Smith (2020) examines how wellbeing is ordered in a sheltered setting between wars. Williamson (2021) analyses obstetric racism in Brazil as something enacted beyond the body and beyond the clinic. Schaub (2024) shows how armed conflict lowers healthcare utilisation by instilling fear and eroding trust, which bears on any post-conflict setting where institutional distrust has an additional source. Lindén (2021) examines patient advocacy conducted under the pressure of running out of time, a case in which temporal scarcity becomes a political resource. Perski, Wilton, and Evans (2020) analyse the ambivalent atmosphere of a training programme, extending the atmospheric approach beyond the clinic proper. Marshall (2024) analyses the acupuncture clinic as a health-enabling place, which is instructive as a contrast case: a setting whose temporal order is not contested at all.

A sixth strand supplies the regional and theoretical framing that the article's later sections draw on. Matić (2022) analyses inequality, precarity, and gentrification as the underside of urbanisation; Luleva (2024) documents family strategies for coping with precarisation in post-socialist Bulgaria, describing a repertoire of informal adaptation that the health corridor also draws upon; Risojević (2024) examines identity, memory, and collective trauma in post-conflict Western Balkan societies. Cvjetićanin (2023) analyses the temporality and artificiality of museum collections, a study of how institutions construct time that transfers usefully to institutions that allocate it.

Hjärpe (2022) shows how measurable time becomes governable time in childcare services, which supplies the counterpart to my policy argument: measurement is not neutral, and what a system counts determines what it can improve. On the theoretical flank, Postolache (2025) analyses how epistemic authority is reconstituted under algorithmic mediation and Chernov (2023) applies Mbembe's necropolitics to spatial technologies of exposure — both concerned, in different registers, with how institutions distribute attention and neglect.

What none of these supplies is an account of within-room stratification and its visibility. The power literature treats waiting as something done to a population, undifferentiated at the point of imposition. The atmosphere literature treats the room as a single environment with shared properties. The regional literature documents differential access without analysing the waiting room as the site where the differential becomes perceptible. And the embodiment literature has not been brought to bear on the specific bodily configuration of stillness-plus-vigilance. The gap is at the intersection, which is where this article works.

Research Methodology

The study is conceptual and comparative and proceeds in three steps, each with limitations I record as I go. The first is corpus construction. I assembled peer-reviewed literature published from 2019 onward bearing on any of four topics: waiting as a social and political condition, time and temporality within health institutions, healthcare access and informal practice in Southeast Europe and the post-socialist space, and the conceptual apparatus of embodiment and institutional atmosphere. Identification proceeded through Crossref queries restricted by journal ISSN, supplemented by keyword searches, with inclusion requiring peer review, direct topical relevance, and a digital object identifier verified by direct resolution rather than accepted from a secondary citation. Fifty-five items met the criteria.

The second step is the construction of the regime typology. I asked of each published case a single question with a determinate answer: relative to the perceptual field of a person waiting, where does the conversion of advantage into temporal priority occur? Three answers exhausted the material. Sequestered conversion places it outside the room, in prior sorting, separate facilities, or differential entitlement exercised before arrival. Codified conversion places it inside the room but under criteria that are published and in principle acceptable to those disadvantaged — clinical triage being the paradigm. Exposed conversion places it inside the room under criteria that are neither published nor publicly defensible. The typology is exhaustive by construction, since conversion must occur either within or outside the perceptual field and, if within, either under published criteria or not. Its usefulness therefore has to be judged by what it discriminates, not by whether it can be falsified as a classification — a point I return to among the limitations.

The third step derives phenomenological and policy consequences and states them as predictions. This is where the article makes claims that go beyond its evidence, and I want the boundary to be visible rather than blurred. The published literature can establish that differential access exists in the regional health systems and that waiting rooms have describable atmospheres. It cannot establish that attention in Southeast European clinic corridors is distributed laterally rather than forward, because nobody has measured it. The predictions I derive are therefore offered as hypotheses with a specified test, not as findings, and a reader who wants to know whether they are true should read the conclusion, where I describe the study that would settle the matter. No quantitative claim of any kind appears in this article, because the sources support none.

RESEARCH RESULTS

The analysis returns findings in four blocks. The first sorts the corpus by regime and bears on the first hypothesis. Of the published studies that describe a waiting situation in enough detail to classify, the majority fall under sequestered or codified conversion. The general practice waiting rooms studied by Kearns, Neuwelt, and Eggleton (2020) operate on appointment systems in which the sorting has already occurred before anyone sits down; the psychiatric hospital analysed by Repo, Kymäläinen, and Humalisto (2022) organises access through clinical and administrative criteria that are institutionally explicit; the Danish health services examined by Pedersen, Johansen, and Schellerup (2021) are the clearest instance of codified conversion, since the whole point of their colour-time analysis is that waiting is organised by declared categories. The bureaucratic settings analysed by Chakkour, Vollebergh, and de Koning (2024), by Drangsland (2019), and by Nielsen, Danneris, and Monrad (2021) impose delay on a population without visible internal differentiation at the point of waiting: everyone waits, and the injustice at issue is the imposition rather than the ordering.

The second block records the cases that resist that classification, and it is here that the third regime becomes visible as a residual category needing a name. Cogburn (2025), analysing a Tanzanian maternity waiting home, describes a setting in which waiting is intertwined with surveillance and in which what happens to whom is negotiated rather than administered. Vijay and Koksvik (2024) describe waiting for care in Kerala as a condition around which communities organise, implying that the distribution of care within the waiting population is contestable and contested. Ameso (2026) analyses the misalignment between institutional temporal governance and the temporalities of those subject to it. None of these is a Southeast European case and none uses the vocabulary I propose, but each describes a situation in which the internal ordering of the waiting population is neither pre-sorted nor publicly codified. The exposed variant, in other words, is not an invention of this article; it is a pattern the ethnographic record contains without having named.

The third block assembles the regional evidence bearing on the second hypothesis, and here the finding must be stated with care because the evidence is indirect. No study in the corpus observes conversion happening in a Southeast European waiting room. What the regional literature establishes is the existence and the mechanism of differential access within nominally universal systems. Pantović (2021) documents how women navigating institutional childbirth in Serbia mobilise social positioning and informal relations to obtain better treatment, which is precisely the conversion of social advantage into institutional priority. Pantović and Đorđević (2024) document the obverse: Roma mothers' perceptions of barriers and their differential trust in the healthcare system, describing a population on the losing side of the same mechanism. Basna, Pospisilova, and Bures (2025) analyse informal payments in Czech healthcare and characterise the practice as occupying a blurry zone among greed, need, and gratitude — a characterisation that matters for my argument because it explains why such conversion is neither codified nor concealed: a practice that participants themselves cannot classify as either corruption or courtesy will not be written down, and will not be hidden either. Rodrigues (2021) examines how communicative trust is built or lost in public facilities. Taken together these support the inference that conversion occurs and is particularistic; that it occurs within the visual field of other patients is an inference beyond what they establish, and I mark it as such.

The fourth block sets out the phenomenological consequence that constitutes the article's central claim and that the third hypothesis states. If conversion is exposed, then a person waiting faces an uncertainty of a particular structure. Under sequestered conversion the question is when: the order is fixed and unknown, and attention is directed forward, at the door and the clock.

Under codified conversion the question is also when, with the added information that certain others may legitimately precede one, which is absorbable because the criterion is acceptable. Under exposed conversion the question changes form. It becomes who and why, because the order is not fixed, is being made continuously in the room, and can be altered by events one may be able to observe. Attention accordingly turns from the door to the room. That reorientation — from forward and durational to lateral and comparative — is what I call surveillant waiting, and it generates the article's three predictions: that attention in such settings is distributed laterally, that waiting-room talk is comparative rather than durational, and that complaint concerns fairness rather than length.

A supplementary observation qualifies all of this. The corpus is dominated by studies set in Northern and Western Europe, sub-Saharan Africa, and South Asia. Southeast Europe is represented by five items, of which two concern healthcare directly (Pantović, 2021; Pantović & Đorđević, 2024) and one concerns time as a cultural category without concerning health (Žikić, 2024). This is a thin basis for a regional claim, and the reader should hold my regional characterisation more lightly than my conceptual one. It is also, I think, a finding in its own right: the region's ethnological output has concentrated in recent years on heritage regimes, identity, and post-conflict memory, and the everyday institutional texture of public services has attracted comparatively little attention (Risojević, 2024). Somebody should be in those corridors with a notebook, and largely nobody is.

A sixth observation concerns measurement and belongs with the results because it explains why the phenomenon has stayed invisible to health-services research. What health systems count is duration: minutes from arrival to consultation, days from referral to appointment, months on a list. Hjärpe (2022) shows how measurable time becomes governable time, and the corollary is that unmeasured time is ungoverned. Nothing in a standard waiting-time metric records the order in which people were seen relative to the order in which they arrived, and nothing records whether that ordering was explicable. A system could therefore reduce mean waiting time substantially while leaving the grievance untouched, and would register the intervention as a success. Pedersen, Johansen, and Schellerup (2021) argue that treating waiting as a residual to be minimised misses what waiting does organisationally; my point is adjacent but distinct — the metric misses not only what waiting does but what patients are actually watching.

THREE REGIMES OF TEMPORAL STRATIFICATION

Begin with what the three regimes share, since the differences only matter against a common structure. In each, a scarce good — the practitioner's attention — is distributed over a population larger than can be served at once, and the distribution has an order. In each, that order is produced by some combination of arrival time, clinical need, administrative entitlement, and social advantage. And in each, the people waiting have some model, accurate or not, of how the order was produced. The regimes differ in one variable only: whether the operation of social advantage is perceptible to those it disadvantages, and if perceptible, whether it is justified by a criterion they can be expected to accept.

Sequestered conversion is the modal arrangement in the systems the literature describes best. An appointment booked three weeks ago by someone with the flexibility to telephone during working hours, a referral obtained faster through a well-connected general practitioner, a private consultation that bypasses the queue altogether: all of these are conversions of advantage into priority, and none of them is visible from a chair in the corridor. Kearns, Neuwelt, and Eggleton (2020) describe waiting rooms whose social texture is rich precisely because the competitive question has been settled elsewhere; the room can host sociability because it is not hosting a contest. This is worth emphasising because it is easy to read the presence of sociability as evidence that a

system is humane, when it may equally be evidence that its inequalities have been successfully removed from view.

Codified conversion keeps the operation inside the room and legitimates it. Emergency triage is the paradigm: a person arriving later is seen sooner, visibly, and the reason is announced and generally accepted. Pedersen, Johansen, and Schellerup (2021) analyse how health services organise waiting into declared categories, and their central insight is that such organisation does normative work rather than merely administrative work — it tells people what kind of waiting they are doing. The condition of its success is that the criterion be one the disadvantaged party can endorse from their own standpoint, and clinical urgency satisfies that condition unusually well, since anybody can imagine needing to be the person who jumps. Codification does not eliminate resentment, but it changes its object: one resents the system's parameters rather than one's neighbour.

Exposed conversion keeps the operation inside the room and does not legitimate it. Someone greets the nurse by first name and is admitted between two scheduled patients; someone makes a call in the corridor and is subsequently called; someone's file moves to the top of the pile after a conversation nobody quite hears. The conversion is visible in its effects and often in its performance, and it is defensible by nobody: the beneficiary will not claim it, the institution does not acknowledge it, and the disadvantaged cannot contest it because nothing has formally happened. Basna, Pospisilova, and Bures (2025) capture the normative ambiguity precisely in describing informal payment as suspended among greed, need, and gratitude. It is the same suspension that makes exposed conversion durable: a practice too small to prosecute and too consequential to ignore.

Two clarifications forestall misreadings that I have found myself needing to guard against while writing. The first is that exposed conversion is not a regional pathology. It occurs wherever institutional formality is thin relative to the density of social ties, which includes rural practices in wealthy states, small-town institutions everywhere, and any setting where staff and patients belong to the same social world. What may be distinctive about the Southeast European case is prevalence and matter-of-factness rather than existence, and even that is a claim I cannot establish from the present corpus. The second clarification is that the three regimes are properties of situations rather than of countries. A single hospital may run its emergency department under codified conversion, its specialist clinics under exposed conversion, and its private wing under sequestered conversion, all in one building — and the architectural literature suggests that the building's circulation system will itself shape which regime obtains where (Čerešňová, 2023).

The architecture of the corridor is not incidental to which regime obtains, and this is a point the anthropological literature on waiting has almost entirely left to others. Čerešňová (2023) argues that a building's circulation system is a key determinant of social behaviour, and the observation applies with unusual force here. A reception desk placed in the sightline of the seating produces exposed conversion by default: every negotiation at the desk is a performance before an audience that has nothing else to look at. A desk placed around a corner, or an intercom system, or a numbered-ticket display, does not eliminate particularistic advantage but relocates its exercise out of the visual field, converting the regime toward the sequestered type without any change in who actually gets preferred. Kearns, Neuwelt, and Eggleton (2020) note the permeability of boundaries in general practice waiting rooms; the present argument suggests that permeability cuts both ways, since a room open enough to host sociability is also open enough to host observation. Marshall (2024), describing the acupuncture clinic as a health-enabling place, describes a setting in which the practitioner-patient interface is not visible from a waiting area at all, and the contrast is instructive precisely because that clinic's calm has an architectural component that no amount of staff courtesy would supply.

The regimes also differ in what they do to those on the advantaged side, which is worth a paragraph because the literature on waiting almost never considers them. Under sequestered conversion the advantaged party need not experience their advantage as such: booking an appointment feels like ordinary competence, not like queue-jumping, precisely because nobody is watching. Under codified conversion the advantaged party is publicly marked but publicly justified, and the emergency patient wheeled past a full waiting room bears no social cost. Under exposed conversion the advantaged party is marked and unjustified, and must therefore manage the exposure — hence the studied casualness of the greeting at the desk, the brevity of the exchange, the avoidance of eye contact with the seated. Fraser and colleagues (2020) analyse how exclusion is accomplished through manner and micro-interaction rather than rule; what I am describing is the same modality operating in the inclusive direction, and it requires the same interactional skill. There is a small ethnography waiting to be written about how people who use connections comport themselves while doing so.

The typology also does something the waiting literature has not, which is to specify what exactly is unjust in a given case. Under sequestered conversion the injustice is distributive and structural, located in the prior allocation of the resources that let some people book and others not; the room itself is innocent. Under codified conversion the injustice, if any, lies in the criteria, and the argument is a policy argument about how urgency should be defined. Under exposed conversion the injustice is relational and immediate: it is not that the system is arranged badly but that this person, here, is being preferred over me, now, for a reason that would not survive being stated. Valkenburg (2022), connecting temporality to epistemic justice, provides the closest existing conceptual resource, though his concern is with whose temporal experience counts as knowledge rather than with the ordering of a queue. The distinction among kinds of injustice matters practically, because remedies that address one do nothing for the others.

One might reasonably ask whether the three regimes are stable or whether systems drift among them, and the question matters because a typology of static types is less useful than one that specifies transitions. The drift I would expect, on the evidence available, runs from exposed toward sequestered as institutions formalise: appointment systems, electronic queue displays, and physically separated reception areas each remove conversion from the visual field without necessarily removing it from practice. Pedersen, Johansen, and Schellerup (2021) describe health services actively organising waiting into declared categories, which is drift toward codification and is the rarer and more demanding path. What I would not expect, and what no case in the corpus displays, is spontaneous drift from sequestered or codified toward exposed conversion — formality is asymmetrically sticky, which is a familiar finding in institutional analysis and holds here. If that asymmetry is real, then exposed conversion is a residual condition of under-formalised institutions rather than a stable equilibrium, and its regional prevalence would be a symptom of institutional thinness rather than of any cultural disposition. I state that as a conjecture, since establishing it would require the longitudinal comparison nobody has done.

SURVEILLANT WAITING AND THE BODY THAT MONITORS

What does a person do with attention that has nowhere useful to go? The waiting literature has generally answered by describing what waiting people do with time — endure it, fill it, resist it, sanctify it. Chakkour, Vollebergh, and de Koning (2024) show people building spiritual repertoires inside bureaucratic delay; Nielsen, Danneris, and Monrad (2021) analyse attempts at temporal control among the long-term unemployed; Naidu (2023) describes the acquired competence of getting used to waiting. These accounts share an assumption that the waiting subject's problem is duration. Under exposed conversion the problem is different, and so is the activity. The

person's problem is not that time is passing but that the order is mutable, and their activity is not endurance but monitoring.

Monitoring has a bodily form, and describing it is where the concept of embodiment earns its place in this argument rather than decorating it. Kulenović (2021), reviewing the explanatory power of embodiment in anthropology, distinguishes uses in which the body is a site on which culture is inscribed from uses in which bodily comportment is itself a mode of practical engagement. Surveillant waiting belongs to the second. The comportment is specific: the trunk still, the posture arranged for indefinite duration, the gaze mobile, the hearing tuned to the reception desk, the head turning at each opening of the door, a readiness to rise that never quite discharges. It is the posture of a person doing something while appearing to do nothing, and the appearance is not incidental — visible vigilance would be socially costly, since it would announce that one suspects one's neighbours. So the vigilance is performed as patience. That is the sense in which patience here is embodied: not as a virtue cultivated but as a presentation maintained over a state that is its opposite.

This reading revises the concept the article's title borrows. Patience in the waiting literature usually appears either as institutionally produced docility or as an achievement of the waiting subject. Qureshi (2023), analysing middle-aged British Pakistani women's intuition of the limits to care, plays on the double meaning in patient patients and finds something closer to a considered accommodation than to either. What I am describing is a third thing: patience as concealment. The body is still because stillness is what the setting requires and because there is nothing to do with a body in a corridor; the attention is elsewhere entirely. Cvjetić (2025), distinguishing disciplinary, affective, and performative modes of somatic inscription, provides useful vocabulary here — the stillness is performative in her sense, a presentation maintained for an audience, while the vigilance is affective, an ongoing state of low-grade arousal that leaves the body tired after a morning in which nothing happened.

The surveillance framing has a precedent worth acknowledging, though it runs in the opposite direction. Cogburn (2025) analyses a maternity waiting home in which institutional surveillance and care are so entangled that the waiting women are the objects of watching. What I am describing inverts the vector: the waiting person is the subject of surveillance, not its object, and what they watch is one another and the staff. The two are not alternatives; a corridor can easily contain both, with staff monitoring patients for compliance while patients monitor staff and each other for signs of the order being altered. Gomez (2024) and McDougall (2023) analyse how contemporary institutions constitute watched bodies, and their frameworks handle the first vector well. Neither addresses lateral surveillance among those subject to the same institution, which is a gap in the biopolitical literature that this case makes visible.

The complaint register follows from the attentional structure and gives the argument its most testable consequence. If the operative uncertainty is comparative rather than durational, then dissatisfaction should track perceived unfairness rather than elapsed time, and reducing the wait should not reduce the grievance. There is indirect support for the general mechanism in an unexpected place. Akrap (2025), analysing the psychology of the fair price under dynamic pricing, identifies the conditions under which a consumer feels cheated rather than merely charged more, and finds that the perception of having been treated worse than a comparable other does work that the absolute magnitude does not. The parallel is not exact — a queue is not a market — but the underlying structure is the same: a comparative judgment about treatment generating a grievance that magnitude alone would not produce. If that mechanism operates in corridors as it does in pricing, then shortening queues is the wrong intervention.

Who is exempt from surveillant waiting? Two groups, and identifying them sharpens the concept. The first comprises those who possess the relevant ties and know they will be

accommodated; for them the corridor is a formality and the attentional posture is unnecessary, which is one reason accounts of these systems differ so sharply depending on whom one asks. Pantović (2021) describes women deploying social positioning competently in Serbian maternity settings, and competence of that sort dissolves the uncertainty that generates the vigilance. The second group comprises those who have concluded that the mechanism will never work for them and have stopped watching for it — a resignation that is genuinely resignation, unlike the vigilance I have been describing. Pantović and Đorđević (2024), documenting Roma mothers' perceptions of barriers and their diminished trust, describe a population plausibly in this position; Fraser and colleagues (2020) describe an analogous withdrawal among people stigmatised in healthcare access, and Schaub (2024) documents utilisation itself falling where trust has been destroyed. The concept therefore picks out a middle band: those for whom the mechanism is neither reliable nor foreclosed, and who must therefore keep watching. That band may well be the majority in the settings I am describing, but it is not everyone, and any observational test would need to sample across the three positions rather than treating the corridor as a single population.

There is also a temporal depth to the posture that a single morning does not reveal. Waiting under exposed conversion is not one event but a genre of event, repeated across every institutional encounter in a life — the clinic, the counter, the office, the certificate. Luleva (2024) documents the informal repertoires families develop to cope with post-socialist precarisation, and those repertoires are precisely what a person carries into the corridor: a working knowledge of whom one might call, an estimate of one's own position in the local web of obligation, an expectation about how the morning will go. Matić (2022) analyses precarity as a structural condition of contemporary urban life in the region. What accumulates is not merely distrust of a particular institution but a general theory of how outcomes are produced, and the corridor is where that theory is tested and confirmed on a weekly basis. Risojević (2024) analyses collective trauma in post-conflict societies at a register far more severe than anything under discussion here; I mention the work because the mechanism is formally similar — repeated small confirmations sedimenting into a durable interpretive frame — while insisting that the phenomena are not comparable in magnitude.

One objection should be met here rather than deferred. It might be said that I am describing ordinary queue-monitoring, familiar from every bus stop and supermarket, and dressing it in unnecessary vocabulary. The reply is that ordinary queue-monitoring has a resolution: the queue's order is visible and violations of it can be named, so the monitoring is brief and terminates in either confirmation or protest. What distinguishes the corridor under exposed conversion is that the order is not visible, violations cannot be named because nothing formally happened, and the monitoring therefore has no terminus. It runs for the duration of the wait and produces no actionable output. That is a different phenomenon from watching to see whether someone cuts in front of you in a shop, and the difference is exactly the unavailability of protest — which is also what makes the resulting affect so distinctively corrosive.

IMPLICATIONS FOR POLICY AND FOR THE ANTHROPOLOGY OF TIME

If the analysis holds, the standard policy response to waiting-room dissatisfaction is aimed at the wrong variable. Health systems measure waiting in minutes and treat reduction as the improvement; the reasoning is intuitive and, under sequestered and codified conversion, probably correct. Under exposed conversion it should fail, because the grievance is not generated by duration. Three interventions would be predicted to work instead, and they are worth stating concretely so that they can be tried and found wanting. The first is codification: publishing the criteria by which order is determined, including the legitimate exceptions, converts the regime into the second type and gives resentment a legitimate object. Pedersen, Johansen, and Schellerup (2021)

show that declared temporal categories do normative work, and that work is exactly what is missing here. The second is sequestration: removing the conversion from view, whether by separating the interfaces at which it occurs or by redesigning circulation so that the reception desk is not a stage (Čerešňová, 2023). The third and most demanding is elimination — but a system that could eliminate particularistic conversion would already be a different system.

I want to be careful about the second of those, because recommending that inequality be hidden is not obviously a recommendation at all. There is a real argument that visible unfairness is preferable to concealed unfairness, since what is seen can eventually be contested while what is sequestered becomes invisible even to critique. Anyone who has followed debates about the ethics of two-tier health provision will recognise the shape of the problem: sequestration purchases calm in the corridor at the cost of removing an injustice from public perception. My analysis is neutral between these positions and I do not think it should be otherwise, since the choice between them turns on political commitments the analysis does not supply. What the analysis does supply is the observation that the two interventions work through different mechanisms and should not be conflated in evaluation, and that the currently dominant intervention — reducing minutes — works through neither.

For the anthropology of time the implications are conceptual. The subfield has developed a rich vocabulary for waiting as duration: chronic waiting, suspended time, temporal governance, the politics of the meanwhile. Ameso (2026), Toumaras (2026), and Nielsen and colleagues (2021) all work within this vocabulary productively. What the vocabulary lacks is a way of handling waiting as position rather than as extension — waiting understood not as a length of time occupied but as a place in an order held against competitors. Position and extension are different objects: one can be far along in a queue that is moving slowly, or near the front of one that is being continuously reshuffled, and the experiences have almost nothing in common. My suggestion is that the subfield's concentration on extension follows from its empirical concentration on settings where position is fixed by administration, and that attending to settings where position is contested would require new terms.

The proposal also bears on how the anthropology of time handles collective waiting. Most of the literature treats the waiting population as either an aggregate — a queue, a caseload, a category of persons subjected to delay — or as a set of individuals whose experiences are then compared. Vijay and Koksvik (2024), who examine community organising among those waiting for care in Kerala, are an exception in treating the waiting population as internally structured and capable of acting. Under exposed conversion the waiting population is internally structured in a specific and unpleasant way: its members are each other's competitors for a good that is being allocated in front of them, and the sociability of the corridor is conducted across that competition rather than in its absence. This is why, I suspect, the register of waiting-room talk in such settings is so often a shared complaint about the institution — it is the one topic that reconstitutes as a collective a group that the allocation mechanism has set against itself. Žikić (2024), analysing wasting time as a cultural practice in Serbia, offers a regional treatment of time as something that can be assigned social meaning rather than merely endured, and a study of corridor talk would be a natural extension of it.

A methodological implication follows for how waiting is studied, and it concerns instruments rather than theory. Most research on patient experience of waiting asks about duration and about satisfaction, and the two questions between them cannot detect the phenomenon this article describes. A person who waited ninety minutes and was seen in arrival order and a person who waited ninety minutes while three later arrivals were admitted before them will give the same answer to a question about how long they waited, and quite possibly similar answers to a general satisfaction item, while having had entirely different mornings. What would distinguish them is a

question nobody asks: was the order of admission explicable to you? Diasio and Laiacona (2025), developing the notion of regimes of temporality for girls and women with Turner syndrome, show how much analytic purchase is gained by treating temporal experience as structured rather than as a quantity, and the same move is available in health-services measurement at very low cost. One item would do it.

A further consequence concerns the sociability that waiting rooms are often praised for. Kearns, Neuwelt, and Eggleton (2020) describe waiting rooms as socially permeable spaces where conversation and mutual recognition occur, and there is a policy literature that treats such sociability as an asset to be designed for. The present analysis suggests a caution rather than a contradiction. Under exposed conversion, corridor sociability is conducted among people who are simultaneously each other's competitors for the morning's scarce good, and it therefore carries a structural ambivalence that a design brief will not capture. The most common conversational move — the shared complaint about the institution — is generative precisely because it converts a competitive relation into a solidary one for the duration of the exchange. Stojanović (2023), analysing Honneth's deformations of recognition in platform labour, describes a comparable structure in which workers who are structurally set against one another nevertheless build recognition horizontally; the corridor is a low-technology instance of the same problem. Whether that solidarity survives the moment when one of the two is called first is an empirical question I would very much like to see answered.

There is a further dimension I can only gesture toward, which concerns what accumulates. A person who waits under exposed conversion once has had an irritating morning. A person who has done it for thirty years, for every specialist referral and every document and every counter, has acquired something more durable: a working model of institutions as places where outcomes depend on whom one knows, and a set of dispositions appropriate to that model. Pantović (2021) documents women deploying exactly such dispositions competently in Serbian maternity settings, which is the same phenomenon seen from the side of those who possess the relevant ties. Pantović and Đorđević (2024) show the corresponding effect on trust among Roma mothers, who do not. Between them these two studies describe a mechanism by which a queue produces a political sociology, and I would put the point more strongly than either does: the corridor is not merely where institutional distrust is expressed but a place where it is manufactured, repeatedly, in small increments, over decades.

Two further connections deserve brief mention because they identify where the argument could be extended by others better placed than I am. Rodrigues (2021), analysing communicative trust in public healthcare facilities, examines the encounter between user and provider; the present analysis suggests that a considerable part of what the user brings to that encounter was formed in the corridor beforehand, which would make the waiting room a determinant of the consultation rather than its antechamber. And Vasconcelos (2025), writing phenomenologically about being-with without encounter among the hyperconnected, describes a structure that the waiting room instantiates in an older and more concrete form: dozens of people co-present for hours, mutually attentive, and almost entirely unaddressed. The corridor may be one of the last settings in which strangers spend long stretches in one another's presence with nothing to do and no script for interaction, and that alone makes it worth more ethnographic attention than it has received.

CONCLUSION

The first hypothesis is supported. Sorting the corpus by the location of conversion relative to the perceptual field of those waiting produces three classes that the material populates unevenly: most studied settings fall under sequestered or codified conversion, while a residual group

of cases — Cogburn (2025), Vijay and Koksvik (2024), Ameso (2026) — describes situations in which the internal ordering of the waiting population is neither pre-sorted nor publicly codified, without naming that as a distinct configuration. The typology is exhaustive by construction and therefore not falsifiable as a classification; what it can claim is that it discriminates cases which the existing vocabulary runs together, and I would rest its defence on that.

The second hypothesis is supported indirectly and I would not claim more. The regional literature establishes that social advantage is converted into institutional priority in Southeast European health settings, through informal relations and social positioning (Pantović, 2021), with the corresponding disadvantage documented among Roma mothers (Pantović & Đorđević, 2024), and with an analogous mechanism analysed in the wider post-socialist space under the heading of informal payment (Basna et al., 2025). What it does not establish, because no study has looked, is that this conversion is perceptible to other patients in the room. That is the inferential step my regional claim depends on, and it is currently unsupported by observation.

The third hypothesis is a prediction, not a finding, and this is the point at which the article's ambition exceeds its evidence by the largest margin. Surveillant waiting — lateral rather than forward attention, comparative rather than durational uncertainty, vigilance presented as patience — is derived from the structure of exposed conversion rather than observed in any setting. I believe it is correct, on the strength of a great deal of ordinary experience that is not evidence, and I have tried to construct the argument so that the belief is separable from the analysis and can be discarded without taking the typology with it.

The principal original contribution of this article is the distinction among sequestered, codified, and exposed conversion, together with the concept of surveillant waiting that the third regime generates and the reinterpretation of embodied patience as vigilance concealed by stillness rather than as docility or achievement. Secondary to that stands the analytical separation of waiting-as-position from waiting-as-extension, which I take to identify a genuine gap in the vocabulary of the anthropology of time, and the policy consequence that duration reduction should be ineffective where the operative grievance is comparative.

Five limitations bound all of this, and the first is fundamental rather than technical. This article makes a phenomenological claim about a region on the basis of no observation in that region, and no amount of careful hedging changes what that is. I have marked every inferential step, distinguished derivation from finding throughout, and declined to supply the illustrative detail that would have made the argument more persuasive and less honest — but the reader should understand that the central claim is a conjecture. The second limitation is corpus imbalance: five of fifty-five items concern Southeast Europe, two of them healthcare directly, and the regional characterisation rests on that. The third is that the typology is exhaustive by construction and can therefore be judged only on usefulness, which is a weaker property than truth. The fourth is that I have treated the waiting population as though its members experienced the room similarly, when the regional evidence itself shows that they do not — the person with connections and the person without are in the same corridor having incommensurable mornings, and my account describes the second better than the first. The fifth is that I write about institutions I have used but never studied, and the confidence that gives me about the phenomenon is exactly the confidence a researcher should distrust.

The study that would settle this is not difficult and I would like someone to do it. It requires structured observation in at least two clinic corridors under contrasting regimes — an emergency department operating under posted triage and a specialist outpatient clinic operating without one — coding three things: the direction and duration of gaze among those waiting, the topical content of spontaneous talk classified as durational or comparative, and the register of complaints made at reception. The predictions are specific enough to fail. Lateral gaze and comparative talk

should predominate in the second setting and forward gaze and durational talk in the first; complaints should concern fairness in the second and length in the first; and a natural experiment created by any shortening of waiting times should move satisfaction in the first setting and not in the second. If the coding comes back the other way, the typology may survive but surveillant waiting does not, and I would rather that were established than that the concept circulated unexamined because it sounded right.

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ANTROPOLOGIJA ČEKAONICA: TEMPORALNE HIJERARHIJE I UTJELOVLJENO STRPLJENJE U JAVNIM ZDRAVSTVENIM USTANOVAMA JUGOISTOČNE EVROPE

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Sažetak: Antropološka literatura o čekanju razvijala se dvama kolosijecima. Jedan čekanje tretira kao vršenje institucionalne moći, u kojem nametanje odgode proizvodi podređene subjekte; drugi čekaonicu tretira kao atmosfersko i prostorno stanje s vlastitim afektivnim svojstvima. Nijedan nije ispitao kako se čekaonice raslojavaju iznutra, niti kakvu razliku čini to da li je raslojavanje vidljivo onima koje stavlja u nepovoljniji položaj. Ovaj članak popunjava tu prazninu. Na osnovu objavljene etnografske literature i literature o zdravstvenim službama, predlaže razliku između tri režima temporalne stratifikacije, razgraničena prema tome gdje se konverzija društvene prednosti u temporalni prioritet odvija u odnosu na vidno polje onih koji čekaju: sekvestrirana konverzija, u kojoj se prednost ostvaruje izvan prostorije; kodificirana konverzija, u kojoj se ostvaruje unutar prostorije po objavljenim kriterijima; i izložena konverzija, u kojoj se ostvaruje unutar prostorije neobjavljenim i partikularističkim sredstvima. Originalni doprinos članka jeste tvrdnja da su čekaonice javnog zdravstva u Jugoistočnoj Evropi obilježene izloženom konverzijom, te da to proizvodi osobit pažnjni stav koji nazivam nadzornim čekanjem: pažnja usmjerena bočno, na sučekaoce i na prag između hodnika i ordinacije, umjesto naprijed, na vlastiti red — jer neizvjesnost koja je na djelu ne tiče se toga kada će neko biti primljen, nego ko će biti primljen prije i po kom osnovu. Posljedica za drugi ključni pojam iz naslova jeste da se utjelovljeno strpljenje u takvim okolnostima bolje razumije kao budnost zadržana u mirnom tijelu, nego kao rezignacija ili disciplina. Slijede tri provjerljive predikcije, od kojih je najoštrija ta da skraćivanje trajanja čekanja ne bi trebalo smanjiti nezadovoljstvo pod izloženom konverzijom, dok bi činjenje konverzije nevidljivom ili njeno kodificiranje trebalo. Studija je konceptualna i komparativna i ne počiva ni na kakvom novom terenskom istraživanju; zaključak precizira opservacijski nacrt kojim bi se predikcije provjerile.

Ključne riječi: *čekanje, temporalnost, medicinska antropologija, Jugoistočna Evropa, utjelovljenje, redovi, neformalne prakse, javno zdravstvo.*