PATIENT PRIVACY:
An ethnographic study of privacy of the person in National Health Service patient care settings, with reference to human rights

by

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This research uses an ethnographic methodology to address the issues of privacy of the person, patients' expectations and the level of intrusions by health professionals within NHS hospital ward settings. Field work took place over six months in three acute wards, with surgical and medical patients, of a large district National Health Service Trust hospital, using non-participant observation, unstructured interviews with patients (n = 55) and staff (n = 12) and semi-structured interviews of patients (n = 18) and staff (n = 22). In the spirit of ethnographic enquiry, the culture and ward environment in the context of everyday life of patients and health professionals were documented. Applying the principles of phenomenology and grounded theory, the data were analysed manually and the contents organised into 11 key categories. In order to interpret the findings, the classic works of Goffman (1959, 1968a and 1968b) were adopted as interpretative tools, leading to the tentative formulation of a privacy model. The model explains the relationship between the selves of patients and staff and their behaviours on the wards. The level of intrusions by health professionals was measured against the benchmarking of the 'dignity and privacy' factors, contained in the 'Essence of Care' (DoH 2001), and Article 8(2) of Human Rights Act 1998.

Analysis of the categories established that patients and their relatives had very little privacy in the wards, being compromised by both doctors and nurses. The patients' territory and space were not sufficiently respected. They had little control and choice. The professionals overwhelmingly set the agenda of the wards. Patients were
frequently interrupted unnecessarily by both doctors and nurses and their individuality was compromised. Explanations of staff behaviours included the existence of ‘blind spots’ and habituation. In such an environment the patients were only able to cope by adopting the sick role.

Recommendations emerging from this study suggest that the patients’ privacy should be placed nearer to the centre of caring. There should be a greater emphasis on planning the care of patients by practitioners and educationalists to ensure a good role model is established to demonstrate that privacy of patients is an integral and equally important part of medical and nursing care.
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CHAPTER 1

1 BACKGROUND AND OVERVIEW OF THE RESEARCH

1.1 Introduction

In this chapter I provide an overview of my qualitative research into privacy of the person of NHS hospital in-patients. The background and motivation to this research are explained, recognising the impact of various Department of Health documents and the Human Rights Act 1998 on the issue of privacy. The aims of the research questions are identified and the structure of the thesis explained. In the last section, the findings and the intended contribution of the research to the general pool of knowledge are summarised.

Throughout this thesis, to avoid grammatical awkwardness the term ‘he’ denotes both genders. Where practitioners are mentioned, they include such health carers, as doctors and nurses. The term patient applies to those individuals who are being cared for in a hospital setting.

1.2 Background of the research

Tremendous strides have recently been made by the government, through the enactment of the Human Rights Act 1998, to empower patients and citizens generally with regard to their human rights, including their rights to privacy. The Department of Health has published various documents to reinforce this principle. The publications of ‘The Caldicott Report’ (1997), ‘The NHS Plan’ (2000), Your Guide
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to the NHS (2001) and the ‘Essence of Care’ (2001) have all contributed to raising the awareness of practitioners about the importance of respecting the patients’ privacy. Equally, the health care practitioners’ regulatory bodies, the Nursing and Midwifery Council (NMC 2002) and the General Medical Council (GMC 1998) have incorporated the principles of holism and humanism within their professional codes of conduct. Holism considers individual patients as persons with specific needs (McGee 1988). Montgomery-Dossey et al (1988) explain holism as a philosophy that views everything in terms of ‘patterns of organisation, relationships, interactions, and processes that combine to form the whole’ (p 5). Humanism emphasises the quality of existence, that is, respecting patients’ wishes, maintaining their dignity and respecting their rights (McGee 1988). It is argued that the application of the ‘nursing process’ as a decision-making pathway (Kratz 1979, Yura and Walsh 1988, Alfaro-LeFevre 2002) during the delivery of care tends to respect the individual rights of patients and their holistic needs.

The human right to privacy was clearly established as a fundamental right to be protected as early as 1948. Article 12 of the Universal Declaration of Human Rights declared that ‘no one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor attacks upon his honour and reputation’ (p 2). The problem of defining ‘privacy’ as a unique fundamental right has been debated for decades (Younger Committee 1972, Michael 1994). It was a question of whether one is discussing a state or condition, a desire, a claim, or a right to privacy. It is now established that a person has ethical and legal rights to privacy under the Human Rights Act 1998. There is no doubt that the need to privacy is culture-specific and
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The need for privacy can vary widely among individuals within a society (Bates 1964, Westin 1967, Michael 1994).

The term privacy is not clarified within the Human Rights Act 1998. However, the 'Essence of care' (2001) document defined it as 'freedom from intrusion' (p 182) thus affirming its definition by the Younger Committee (1972). Although the right to privacy was not acknowledged by English courts (Malone 1979, Gordon Kaye 1991) until the passing of the Human Rights Act 1998, its importance as a basic need to a person has always been recognised in western society (Warren and Brandeis 1890, Bates 1964, Younger Committee 1972, Westin 1967, Altman 1976). Despite the importance of privacy to a person's well being, health care practitioners, academics and patients have been concerned about whether patients' or clients' rights are properly maintained and respected during the hospitalisation process. These are concerns about their autonomy, self-determination, dignity, self-esteem and privacy of the person (Barron 1990, Bauer 1994).

Patients' rights in health care have also been the subjects of many debates within the NHS settings. There has often been a hostile reaction from those who claim to speak for the medical profession, as they argued that to adopt the language of rights leads to restrictive practice with the regrettable consequence of defensive medicine (Kennedy 1991). There is no doubt that the NHS Plan (2000) aims radically to reform the health service and represents the biggest shake up of the NHS since it was established in 1948. Besides providing acceptable standards of care to patients, NHS Trusts and health professionals have been given specific targets to meet within certain deadlines (NHS Plan 2000), such as reducing hospital waiting times for
patients to three months for outpatients and six months for inpatients by 2005. Despite this, professionals are expected to meet patients' holistic needs (Morrison and Cowley 1999). It is therefore assumed that practitioners have now moved away (or ought to have moved away) from the traditional 'medical model' of practice to meeting the holistic needs of the patients (Kennedy 1991, Your Guide to the NHS, 2001). The main focus of the 'medical model' was the physical aspects of care and the aim was to treat diseases and conditions, sometimes at the expense of meeting the patients' needs as persons (McFarlane 1977). Patients were often treated as a class of conditions like 'fractured neck of femur' or 'myocardial infarction', as if devoid of personalities (Kennedy 1991).

In the light of such conflicting demands upon the professionals, on the one hand respecting the patients' right to receive privacy and on the other meeting the government targets and reducing patients' complaints for the level of services provided, the question that I wanted to answer was, to what extent the patients' right to privacy is being respected within an NHS clinical setting. Privacy is broadly distinguished into two forms of privacy of the person and information privacy (Michael 1994). The general claim to privacy of the persons includes not to have their territory and space invaded, not to have [patients'] books read by strangers, not to have their autonomy infringed and not to receive intimate care in public (Michael 1994, Bauer 1994, Beauchamp and Childress 2001). Michael (1994) explains that information privacy is 'narrower' (p 3): strangers should not obtain knowledge of patients' data without their permission (Parrott et al 1989, Beauchamp and Childress 2001). According to Westin (1967), information privacy is 'the claim of individuals, groups or institutions to determine for themselves when, how, and to what extent
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information about them is communicated to others' (p 7). This research was primarily concerned with finding out the extent to which the privacy of the person was respected in the NHS wards in the light of various Department of Health documents, the Human Rights Act 1998 and the various constraints raised within the NHS Plan (2000), including the geographical and logistical constraints of the wards.

1.3 The concerns that prompted this research

This thesis has emerged in response to the many changes and raised expectations introduced by the government and the Department of Health into the delivery of care of patients within NHS Trusts. My post as nurse tutor at the European Institute of Health and Medical Sciences (EIHMS), University of Surrey, requires me to participate in the preparation of both undergraduate and postgraduate students for their practice in the distinct area of law and ethics. Over the last four years I have been actively involved in updating practitioners in the area of risk management. My responsibility also includes visiting allocated wards and conducting educational audits to ensure that a satisfactory educational climate for students is maintained in the clinical settings. It was during such visits that the idea of this project emerged. What my lecturer colleagues and I had been teaching in the classroom environment seemed not always to have translated into the practice settings. Certain practices concerning patients' privacy and dignity raised disquiet in me. Out of curiosity and to test the principles of the Department of Health circulars and the professionals' own codes of conduct in aspects of patients' privacy, I undertook a preliminary survey with a group of postgraduate nurses (n = 30) in July 1999 (Woogara 2000). They were asked to complete a questionnaire and describe their understanding of the
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ways patients’ privacy was respected or compromised in the clinical setting. The following comments reflected the overall concerns of the group:

‘Nurses walking in behind the closed curtains while a patient is being washed/undressed’.

‘Doctors tend to ask personal information in front of other patients’.

‘Doctors instructions workbooks are left open in the nurses’ station’.

‘While giving personal care and intimate procedures the curtain is not properly drawn’.

‘There are not enough toilet facilities on our ward. Able patients have to use the commode behind curtains’.

‘Patients are not able to sleep because of the noise level at night’.

‘Patient handover is given at the end of each bed. Other patients and visitors can hear what is being discussed’.

‘Doctors’ ward rounds have to be addressed’.

In another similar study of mine (Woogara 2001), a further group of 21 nurse practitioners (ranging from grades D to I), were asked to register their awareness of the Articles of the European Convention on Human Rights and their understanding of the Human Rights Act 1998 and to state whether or not the Convention had any influence on day to day patient care. This study showed that 60% of the practitioners had no awareness of the European Convention. Eighty percent of them had not heard of the Human Rights Act 1998 and another 80% stressed that health care was not influenced by the European Convention on Human Rights. The result of these findings motivated me to write for publications in an attempt to raise the awareness of practitioners in the area of human rights and patients’ privacy within the NHS wards.
During the literature review for this present study, it soon became evident that research in the area of the patients' privacy of the person was limited and most of the available research was from outside the United Kingdom. There is an abundance of reviews in the area of information privacy, particularly in the field of electronic and data privacy. Even the United Kingdom parliament appears to have stressed the importance of information privacy by passing the Data Protection Act 1998 and the Freedom of Information Act 2000. With the exception of Barron's (1990) study of the patients' right to personal space (discussed in section 2.7), there have been few academic works that have constructively tried to explore patients' and professionals' perceptions of privacy of the person within its contextual settings through observations of patients' and staff's behaviours. Those that have been undertaken have mainly utilised a mixture of quantitative and qualitative methods, by using questionnaires and structured interviews format. These include by Bauer (1994) in a German hospital, Back and Wikblad (1998) in a Swedish hospital, and Leino-Kilpi et al (2003) in five European countries, one of them being Scotland (discussed in section 2.7).

1.4 Research questions

A number of questions emerged from my preliminary studies, observation of ward settings during the educational audit, and the literature review. The overall aim of this research was to conduct an ethnographic study of patients' privacy of the person. This was done by using non-participant observation of patients and practitioners and their interactions over a period of six months in three different wards of a large district NHS Trust. Semi-structured interviews of patients (n = 18) and doctors and
nurses \( n = 22 \), and unstructured interviews of patients \( n = 55 \) and staff \( n = 12 \) were also used to determine the patients' and professionals' perceptions of privacy in National Health Service patient care settings, with reference to human rights. By combination of the research methods I expected to address the deficiencies highlighted in the previous research and maximize the validity of the findings. Through observation of the clinical settings, patients' and staffs' interactions, ward culture and by undertaking semi-structured and unstructured interviews of patients, their visitors, doctors and nurses, a triangulation of methods and sources of data were achieved. Denzin (1989) defines triangulation as the combination of multiple methods in a study of the same object or event to depict more accurately the phenomenon being studied. It was envisaged that by adopting such a process the validity and reliability of the study would be enhanced and contribute to the generalization of the findings. Accordingly, I searched for answers to the following questions:

1. What issues of privacy of the person arise in NHS hospital ward settings?
2. What behaviours and perceptions on the part of patients, doctors and nurses are relevant to issues of privacy of the person?
3. To what extent are there currently intrusions into the patients' privacy of the person, by the standards set out in regulatory and legislative instruments?

1.5 Structure of the thesis

This thesis is subdivided into seven chapters, including this chapter. Chapter 2 contains the literature review concentrating on Department of Health documents, the Human Rights Act 1998 and studies in privacy by Schuster (1976), Parrott et al.
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(1989), Lawler (1991), Bauer (1994), Back and Wikblad (1998) and Barron (1990). In that chapter (section 2.8) the philosophy of Goffman is evaluated as I have utilised many of his principles of interaction from his classic works *The Presentation of Self in Everyday life* (1959), *Asylums* (1968a) and *Stigma* (1968b) as interpretative tools to make sense of the data in chapter 6. Chapter 3 briefly explores the common distinctions between quantitative and qualitative methods, ethnography, grounded theory and phenomenology. In chapter 4, the design of the research and the use of ethnography, the settings and the data analysis process are explained.

During the data analysis phase, eleven categories had materialised in accordance with the significant emergent themes. These are classified as follows: a) conceptions of privacy; b) territory and space; c) control and choice; d) personal care and depersonalisation of the patient; e) privacy of patients' information; f) professional 'blind spot' and habituation; g) ward lay out and logistics; h) patients' coping mechanisms; j) visitors and relatives; k) regulatory and government standards; and category m) professional rationale for 'overriding' the patients' privacy. These categories are described in chapter 5 using quotations from the participants and the observation data. Besides Goffman's classic works (1959, 1968a, 1968b), the works of Berger and Luckmann (1966), Foucault (1982), Menzies (1988), Cohen (2001) and others are also used to discuss the data in depth in chapter 6. Through interpretation of the categories, I demonstrated that the majority of staff, patients and their relatives believed that there was very little privacy in the bays of the wards. The data revealed that both doctors and nurses compromised the patients' privacy. Based on such findings, I devised a model of privacy (see section 6.13), that reflects Goffman's (1959, 1968a, 1968b) framework of interaction within a team and
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between individuals, explaining that the selves of members of staff and patients can
be affected by various factors within the ward settings. In the last chapter the
findings of the research, in the light of the three research questions, are summarised.
Recommendations, areas of further research, strengths and limitations of the research
are also explored in that chapter. The conclusion is that this research contributes not
only to the wider discussion among health care professionals about privacy of the
person, and if implemented could lead to general improvement in patients’ care.

1.6 Conclusion

This introductory chapter explains the background to this research. It also provides a
brief overview of the main contents in the various chapters of the thesis. I believe
that the conclusion, recommendations and the formulation of the privacy model has
the potential to contribute significantly to the care of patients by challenging the
attitudes of practitioners (and, to some extent, patients) in the area of patients’
privacy of the person.
2.1 Introduction

In the previous chapter, the background and the reasons for undertaking this research were explained. This chapter reviews various literature that has defined privacy as a specific right and explores its importance to citizens at large and patients within a hospital setting. Particular attention is drawn to the legal system of United Kingdom, the Department of Health’s publications and professionals’ own guidelines that have highlighted privacy as an important right to an individual. Additionally, section 2.8 considers the classic works of Goffman (1959, 1968a, 1968b) as I have deployed some of his views as interpretive tools in chapter 6 to make sense of the data.

As I said earlier and now wish to emphasise, while there is extensive literature on privacy of information (often known as confidentiality), this proved to be largely irrelevant to my research questions with their focus on privacy of the person, such as invasion of personal space. What literature is available is reviewed in this chapter.

2.2 Privacy as a basic need

It is generally accepted that in Western Society every citizen needs some privacy, either privacy of the person and/or privacy of one’s personal information. Barron (1990) stipulates that privacy is a human need and right. She explains that it ‘allows people to maintain their individuality and it is important for the psychological well-
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being of hospital patients’ (p 28). The Younger Committee (1972) had previously
reinforced these principles. According to them:

Privacy is a basic need, essential to the development and maintenance
both of a free society and of a mature and stable individual personality
(p 34 s.113).

Both Westin (1967) and Altman (1976), in their respective writings, support
the need for privacy as a basic human right, which can be justified on moral
and legal grounds. Such a right to privacy was apparently first recognised by
Warren and Brandeis (1890) when they equated privacy with an individual’s
right to be left alone. They also suggested that privacy is the most
comprehensive of rights and the right most valued by civilised people.

2.3 Definition and meaning of privacy

The term privacy is ill defined and there is no consensus among academics in the
legal, sociological and psychological disciplines, although ordinary citizens have
little difficulty with the concept (The Younger Committee 1972). The Committee
had decided that the word privacy could not be defined satisfactorily and recognised
that ‘privacy ... a concept which means widely different things to different people
... changes significantly over a relatively short period’ (p 206). The Committee gave
two reasons for the problem of defining privacy adequately. They argued that
‘privacy’ often evokes much emotion, and the understanding of privacy is very
personal in nature. It is dependent on personal standards, fashions of the day and
cultural mores that may differ across time and space. The Committee thus concluded
at that time that a general legal right for privacy would create many problems and uncertainties. They took the view that:

The best way to ensure regard for privacy is to provide specific and effective sanctions against clearly defined activities which unreasonably frustrate the individual in his search for privacy (p 205 s. 663).

The Committee did attempt to explain the nature of privacy. According to them privacy was comprised of two main aspects. The first of these is freedom from intrusion upon oneself, one’s home, family and relationships. This definition has recently been supported by the Department of Health in the ‘Essence of Care’ document (DoH 2001:182) and accordingly ‘freedom from intrusion’ has formed part of definition of privacy. The second is privacy of information, ‘that is the right to determine for oneself how and to what extent information about oneself is communicated to others’ (p10:38). Similarly, Cantrell (1978) and Gifford (1987) argue that privacy can be explained in terms of ‘solo type’ privacy and ‘data type’ privacy. According to them, the issue of privacy very much concerns a person and his interaction with society and the containment of information about the person. This interpretation seems to have been accepted widely.

Altman (1976) suggests that one group of definitions of privacy reinforces the principles of seclusion, withdrawal and avoidance of interaction with others. He cites (p 7) the works of Bates (1964), Chapin (1951) and Jourard (1966) to illustrate this point. For example Bates (1964) states that:

A person’s feeling that others should be excluded from something which is of concern to him, and also the recognition that others have a right to do this (p 429).
Chapin (1951) values the idea of being by oneself and thereby obtaining relief from the pressures of the presence of others. On the other hand, Jourard (1966) argues that privacy is an outcome of a person's wish to withhold from others certain knowledge as to his past and present experience.

Altman (1976) offers his own definition of privacy as a 'selective control of access to the self or to one's group' (p 8). This definition emphasised that as long as the person has capacity and is mentally competent he has the ultimate decision to deny, as well as to grant, access to the self. He believes that human beings achieve the desired levels of privacy mainly by behavioural mechanisms such as verbal and non-verbal use of the body and by relying on environmental behaviours, cultural norms and customs. He suggests that privacy mechanisms are dynamic and responsive to ongoing events. He explains that if an individual is unable to achieve a certain level of boundary control, such persons can utilise additional mechanisms to ensure their privacy. For example, an intruder may be asked to leave the space or can be tossed out of the territory physically. He compares the privacy mechanisms to an automatic heating system, which uses a thermostat and a temperature gauge to maintain a desired level of heat.

The notion of individual privacy seems to derive from the principle of individual self-determination, or freedom and personal independence. According to Bates (1964), privacy is a self-related subjective experience. He compares the self with a house. The access to the rooms of a house is limited to individuals according to the knowledge they have of them. He further explains that the meaning of privacy can be
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derived more from psychological determining factors than sociological. He expands on this as follows:

'It [privacy] is less likely to be defined by overt, interpersonal behaviour, [but] more by attitudinal and affective responses of the individual' (p 429).

This definition of privacy seems to run contrary to Altman’s (1976) idea of privacy who argues that the need to privacy is primary governed by sociological factors, such as the need of withdrawal and avoidance of being with others. Altman (1976) suggests that the need to privacy is an active process that requires individuals to seek others when the need arises. Bates (1964) accepts that privacy incorporates subjective and societal dimensions. With regard to the subjective nature of privacy, he suggests that a person’s privacy is structured in three ways. Firstly, privacy is differentiated into many content areas. These can be readily distinguished by ‘the kind of things that arouse feelings of privacy’ (p 430) in a person, for example issues with one’s self, physical image, ideas, beliefs and pictures of one’s performance in a known group. Secondly, privacy is structured by the response one gives to an unwanted actual or potential intrusion of somebody and thirdly, privacy is defined by the situation in which a person finds himself in his daily dealings with his environment. Bates argues that although privacy is of a subjective nature and is flexible in accordance with one’s response to different people and situations, the structure of privacy ‘is by no means infinitely flexible’ (p 431). He explains that privacy is so intimately related to the self that it does not undergo radical changes within a short time. I have disagreed with the explanation that ‘self’ cannot change within a short period. In the formulation of the privacy model (see section 6.13), I have argued, based on evidence, that patients’ and staff’s selves can be influenced by
various factors in a ward setting in the way patients and staff behave at the privacy interface. Bates (1964) also suggests that privacy is both positively and negatively valued; the latter, particularly, when one feels undue loneliness. Much of the time, he explains further, that people take the issue of privacy for granted. They only become aware of privacy when their boundaries are violated. This has implication in the way that NHS wards are structured. For example, hospital wards have many single-bedded cubicles. It is assumed that for some patients these cubicles could be positively valued for ensuring their privacy, but equally others could view them negatively as too much privacy in a cubicle could cause loneliness.

Bates (1964) also believes that a person's society and his culture determine his perception of privacy. The issues of privacy are usually understood by all the members of a society with respect to their body and its functions generally. According to him 'society distinguishes among its members and among different situational contexts in the kind and degree of privacy recognised' (p 431). These are pertinent statements to my research. Individuals are admitted to a hospital as patients from different cultural backgrounds and according to Bates (1964) with different privacy needs. One of the issues that this research would like to show is whether the hospital with its own distinct culture is able to meet the individual privacy needs of these patients.

In his book *Privacy and Freedom*, Westin (1967:31) explains that there are four distinct states of individual privacy in western societies. He describes the first state as *solitude*, which entails the individual's separation from groups and freedom from observation of other persons. During this state, individuals feel physical stimuli like
noise, smell, heat and cold but despite all these intrusions, Westin believes that solitude ‘is the most complete state of privacy that an individual can achieve’. A second state, intimacy allows individuals to act as part of a small unit such as husband and wife, the family or a friendship circle. This state permits individuals to achieve a close, relaxed and frank relationship with others. Anonymity is a third state, which occurs when individuals are in a public place but still seek freedom from identification and surveillance from others. Reserve is a fourth state. In this state individuals create a psychological barrier against unwanted intrusions by limiting communication about themselves and by creating a mental distance. I was particularly interested in these four states of individual privacy and these are discussed in section 6.2.

Westin (1967) further identifies that there are also four functions of privacy. These are personal autonomy, which helps to maintain self-independence and self-identity. The second function is emotional release, which allows a person to relax from social roles by deviating from accepted social norms. Self-evaluation enables a person to plan and assess future actions and lastly, the limited and protected communication function of privacy provides the person with the opportunity to share confidences with others. His analysis of the components of privacy suggests that people seek a balance between either being with people or being away from them. Westin notes that too much or too little separation from other human beings is an undesirable state of affairs, thus reinforcing Bates’ (1964) sentiments.

On the other hand, Parent (1988) has defined privacy as ‘the condition of not having undocumented personal knowledge about one possessed by others’ (p 216). He
argues that a person’s privacy is diminished exactly to the degree that others possess the kind of knowledge about him. Parent (1988) suggests that the nature of undocumented personal knowledge consists of:

Facts about a person which most individuals in a given society at a given time do not want widely known about themselves. They may not be concerned that a few close friends, relatives, or professional associates know these facts, but they would be very concerned if the information passed beyond this limited circle (p 216).

Documented information, according to Parent (1988), is classified as such information that is easily available from newspapers, and court reports. Thus to discover a person’s criminal record from press reports is not invading that person’s privacy. On the other hand, information collected for special purposes, such as patients’ profiles kept in medical records, is not in the public domain and unauthorised persons must not be allowed access to such information.

It is apparent from these writers (Bates 1964, Westin 1967, Altman 1976, Barron 1990) that privacy is essential to a human being. They emphasize the notion that at times it is healthy for individuals to withdraw themselves from a crowd and avoid the added pressure of interactions with others and intimacy. In order to ensure that such a state is achieved, these writers suggest that such individuals have to be autonomous persons with full capacity to exercise their rights. Considering the geographical layout of NHS wards where it is common practice to house a maximum of six or more patients in a bay, is it feasible for individuals as patients to achieve such freedom in the bays?
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Although the purpose of this study is (in accord with the phenomenological principle of grounded theory) to clarify privacy within the perceptions of the patients and professionals in their lived experience, it may be useful to have a working definition of privacy of the person at the outset:

Privacy of the person is the sense of identity, worth (dignity), autonomy and personal space that each adult human being has; a sense of a boundary between ‘I’, ‘me’, ‘mine’ and other people and ‘the world’. In environments such as a hospital this boundary is clearly under pressure, and may be perceived as under threat or standing in need of negotiation.

I might add that inherent within this definition is that a person’s boundary and space are respected so that some sort of solitude for him or her is ensured. That a person’s modesty is protected in that his body is not exposed to the gazes of strangers and that his identity, autonomy, and individuality are respected.

2.4 History of privacy protection within the legal system

Although traditionally it has been an ethical and expected right that a person’s privacy is respected whenever necessary (United Nations 1948), the United Kingdom had not recognised privacy as a fundamental and enforced right in the British legal system. Instead of making privacy a key issue in a case, the courts have used various courses of action in an attempt to protect privacy, including malicious falsehood and breach of confidence (see below the cases of Malone (1979, 1985) and Gordon Kaye (1991).
In an effort to recognise some sort of individual privacy, it was demonstrated in an earlier section that the Younger Committee (1972) had equated privacy as a necessary component of life. However, they had concluded at that time that a general legal right of privacy would create many problems and uncertainties. They felt that the defined activities could include unwanted publicity by the press and broadcasting, misuse of personal information held by public authorities, and intrusion into home life by neighbours, landlords and the media. The common law case of *X v Y* (1988) illustrates these points very well. In this case, two doctors, who were diagnosed as having contracted the disease AIDS, were still carrying out their normal duties in general practice in an NHS environment. A national newspaper wanted to publish their names, in the public interest, in order to protect the patients in their care. This was prevented by the court and an injunction against publication was granted. It was held that the NHS and their servants had a statutory duty to take all necessary steps to ensure that any information capable of identifying patients examined or treated for AIDS should not be disclosed, except to a medical practitioner or to a person under his direction. The decision of *X v Y* clearly meant that the issue in question was breach of confidentiality and not of personal privacy.

It is a fact, therefore, that the UK legal system has been reluctant to recognise privacy as a human value that is worth protecting by statute. In the case of *Malone* (1979), evidence of Malone’s phone being tapped by the police was produced at his trial for receiving stolen goods. Sir Robert Megarry held:

‘English law did not entertain actions for interference with privacy unless the interference amounted to one of the established causes of action in tort or equity’.
Similarly, the judgement of Gordon Kaye (1991) supports the above principle. In that case, Gordon Kaye, a well-known television actor, was being cared for in a hospital following a car crash in which he was seriously injured. It was alleged that without the actor’s permission, two tabloid journalists had breached the actor’s privacy. They had burst into his hospital room, ignoring a notice prohibiting entry, interviewed him, took some pictures of his facial injuries and published them. Despite this breach of the actor’s privacy, it was held in court that the press behaviour did not constitute trespass or nuisance to his person, except perhaps a breach of Mr Kaye’s right to keep the details of his medical condition and physical appearance confidential. Lord Justice Glidewell stated:

'It is well-known that in English law there is no right to privacy, and accordingly there is no right of action for breach of a person’s privacy'.

The Calcutt Committee (1990), which was primarily concerned with the excesses of press intrusion in the affairs of Princess Diana, had concluded that ‘a general wrong of infringement of privacy ... would give rise to an unacceptable degree of uncertainty’ (Cm 1102:12.12). However, the Committee gave some support to the possibility of a tort of invasion of privacy that was specifically related to the unauthorised publication of personal information. It stated:

Personal information could be defined in terms of an individual’s personal life, that is to say, those aspects of life which reasonable members of society would respect as being such that an individual is usually entitled to keep them to himself, whether or not they relate to his mind or body, to his home, his family or to other relationship, or to his correspondence or documents’ (par12:17).
Despite the general lack of endorsement both by Parliament and by the courts of a general right to privacy, there have been some legislative movements over the years that provide protection for privacy of information in specific areas. These include: The Interceptions of Communications Act 1985, enacted following the Malone's (1985) case, Broadcasting Act 1996, The Police Act 1997 Part III, The Protection from Harassment Act 1997, Data Protection Act 1998 and Freedom of Information Act 2000.

2.5 The Human Rights Act 1998 and the right to privacy

Britain's first law protecting personal privacy on a more general basis was announced as part of the Queen's Speech on 4 May 1997, which was subsequently debated in the House of Commons and lead to the enactment of the Human Rights Act 1998. This was part of Labour Government policy 'bringing rights home to Britain' (Government White Paper 1997). The Lord Chancellor, Lord Irvine of Lairg, explained the essence of the effect of the Act in moving the second reading of the Bill in the House of Lords:

The Bill will bring Human Rights home. People will be able to argue for their rights and claim remedies under the Convention in any Court or Tribunal in the United Kingdom. Our Courts develop Human Rights throughout our society. A culture of awareness of Human Rights will develop (Hansard col. 1230).

The Human Rights Act 1998 incorporated, among others, Article 8 of the European Convention on Human Rights into British domestic law from October 2000, when
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for the first time 'a right to respect for private life' became part of British law. Article 8 of the European Convention for the Protection of Human Rights reads:

(1) Everyone has the right to respect for his private life, his home and his correspondence.

(2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

According to Wadham and Mountfield (1999), victims of human rights have generally three distinct types of rights within the Human Rights Act 1998 against the public authorities, for example the NHS Trusts. These are: absolute rights (Articles 3, 7 and 12), limited rights (Articles 2, 4 and 5) and qualified rights (Articles 8, 9, 10, 11 and 14). With regard to privacy, therefore, patients have no absolute right when they are being cared for in clinical settings. Health practitioners may interfere with this right if it appears to professionals that it is necessary to breach this right in the best interest of patients. However, any such breaches have to be justified in the interests of national security, for the prevention of disorder and crime; for the protection of health or morals, or for the protection of the rights and freedoms of others (see Article 8.2). Awareness of these exemptions was crucial to my research. Article 8.2 implies that professionals could only compromise patients' privacy if the exemptions had existed at the time of the breach. In this research these exemptions were used as benchmarks to determine whether the professionals had breached the privacy of their patients (see section 6.11).

The case of Regina v Ashworth Special Hospital Authority and Another, Ex Parte N [2001] confirms the view that breach of an individual's privacy can become a legal
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issue, despite the fact that, in this case, violation of the patient's privacy was held justified on public interest ground. Ashworth Special Hospital had been randomly monitoring the telephone calls of mentally ill patients classified as having dangerous, violent or criminal propensities. N (patient) complained that such a monitoring process breached his right to privacy under Article 8 of the European Convention on Human Rights. It was held by Justice Newman that interference with such a right by a public authority was permitted under Article 8.2 of the Human Rights Act 1998.

2.6 Patients' privacy in relation to Department of Health and professionals' guidelines

The publications of the Patients' Charter (1995), Caldicott Report (1997), Your Guide to the NHS (DoH 2001), and the Essence of Care document (DoH 2001) have all strengthened the principles of humanism. These documents have stressed the notion that patients are deemed to possess the right to privacy when they are being cared for in a NHS hospital. They have equally helped to define the accountability of the practitioners and their obligations in respecting the privacy of the patients.

Under the heading of 'personal consideration and respect', the Patient's Charter (1995) stated that 'You can expect the NHS to respect your privacy, dignity and religious and cultural beliefs' (p 6). The Caldicott Report (1997) has stressed that all 'information identifiable to individual patients concerned with their medical care, and medical research' (p 2) and any information that passes between the NHS and
other NHS or non-NHS bodies is to be kept confidential. The booklet, 'Your Guide to the NHS' (2001), under the title of 'What standards of care can I expect?' reads:

We will respect your privacy and keep your health records secure; NHS Staff will respect your privacy and dignity. They will be sensitive to, and respect your religious, spiritual and cultural needs at all times (p 28).

The importance of respecting patients' privacy is also recognised in the 'Essence of Care' (2001) document. This document is written for health care practitioners to be used as a toolkit in benchmarking and improving the quality of care of patients/clients. The eight aspects of care, including 'privacy and dignity' (p 182) identified within the document, are described 'as the fundamental and essential aspects of care' and are seen as 'crucial to the quality of patient's care experience' (p 8). The document has defined the term privacy as 'freedom from intrusion' (p 182) thus affirming the definition of privacy first highlighted by the Younger Committee (1972). The Department of Health envisages that the benchmarking process outlined in the document will enable health practitioners 'to take a structured approach to sharing and comparing practice, enabling them to identify the best and develop action plans to remedy poor practice' (p 8). With regard to respecting the patients' privacy and dignity, the Department of Health identifies seven factors (components) that may be used for benchmarking activity. These factors were found very relevant to my research. In section 6.11, I have analysed each of the factors and compared them against the behaviours of the professionals, as they emerged from the data, to determine whether or not the practitioners had met benchmarks for best practice. The 'factors' are illustrated under the heading 'Privacy and Dignity' as follows:
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<table>
<thead>
<tr>
<th>FACTOR</th>
<th>BENCHMARK OF BEST PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes and behaviours</td>
<td>Patients/clients feel that they matter all of the time</td>
</tr>
<tr>
<td>Personal world/ Personal identity</td>
<td>Patients/clients experience care in an environment that actively encompasses individual values, beliefs and relationships</td>
</tr>
<tr>
<td>Personal boundaries/space</td>
<td>Patients/clients personal space is actively promoted by all staff</td>
</tr>
<tr>
<td>Communicating with patients/ clients</td>
<td>Communication between patients/ clients takes place in a manner which respects their individuality</td>
</tr>
<tr>
<td>Privacy of patient-confidentiality of client information</td>
<td>Patient/client information is shared to enable care, with their consent</td>
</tr>
<tr>
<td>Privacy, Dignity and Modesty</td>
<td>Patients/clients care actively promotes their privacy and dignity, and protects their modesty</td>
</tr>
<tr>
<td>Availability of an area for complete privacy</td>
<td>Patients/clients/carers can access an area that safely provides privacy</td>
</tr>
</tbody>
</table>

Figure 1: Privacy and dignity factors (Essence of Care, DoH 2001: 182)

Following the passing of the Human Rights Act 1998, the Department of Health (2003) has also published guidelines to all NHS Trusts highlighting the importance of understanding and respecting the human rights of patients by all health professionals. Within the guidelines there are examples of case studies that highlight the key points of the specific Articles of the Convention and the ways in which violations of the patients’ rights can be avoided by practitioners. For example, with regard to Article 8, the right to respect for private and family life and correspondence, the case study explains that ‘health and social services inevitably have an impact on people’s private and family life’ (p 3). It cites the case of *TP & KM v UK* (DoH: 2003), which is concerned with the removal of a child from the mother into care. The case study identifies that the European Court of Human Right upheld a violation of Article 8 when the mother was not provided with a proper, fair or adequate opportunity to participate in the decision making process.
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Similarly, the Nursing and Midwifery Council's (2002: clause 5) and the General Medical Council's (GMC 1998) codes of conduct have both stressed the importance of respecting the privacy of patients. The GMC's document, entitled 'Good Medical Practice: Protecting patients, guiding doctors' states under the heading, 'Maintaining trust', that 'Successful relationships between doctors and patients depend on trust'. To establish and maintain that trust, the document explains, 'Respect patients' privacy and dignity and treat information about patients as confidential' (p 5).

When undertaking this research, I had therefore assumed that since the incorporation of the Articles of the European Convention on Human Rights within UK domestic law, and particularly since the publication of the 'Essence of Care' document (2001), nursing, midwifery, medical and paramedical professionals would pay attention to issues such as patients' feelings, respecting the patients' privacy and their identified individual needs and rights when planning their care. It was also assumed that such carers would have moved away from the concept of medical model, that is 'condition focused' care to meeting the holistic needs of their patients (Walsh and Ford 1989).

2.7 Studies in privacy

Privacy and the individual's right to privacy has been a subject of increasing concern to many researchers. In this section I review the works of Schuster (1976), Parrott et al (1989), Lawler (1991), Bauer (1994), Back and Wikblad (1998) and Barron (1990) on privacy in order to further understand the nature of privacy of hospitalised patients.
In a phenomenological analysis, Schuster (1976) derives an understanding of privacy from her data, involving the interview of 21 'recently-hospitalised' Caucasian adults in an American hospital. According to her:

Privacy is a comfortable condition reflecting a desired degree of social retreat on the part of the person seeking it. It represents a valued, meaningful and purposeful withdrawal whose dimensions and duration are within the control of the one seeking privacy. (p 245)

Data from her investigation led Schuster (1976) to identify three aspects of privacy. 1) Privacy of life style, which refers to the individual’s preference in day-to-day living. 2) Privacy of event, which Schuster explains, that for a specific activity, like ‘showering’ (p 246) privacy is necessary. The need for this form of privacy is of short duration only and 3) privacy of personality. This aspect of privacy is not transient in duration and 'entails that which is the innermost part of self and the domain of autonomous activity' (p 246). She found that her patients attached significant importance to privacy of personality. This was most evident when the patient’s ‘self’ was threatened, particularly when the individual patient was not in control of events. Within the three aspects of privacy, Schuster explains that the ability to maintain and control one’s boundary is of crucial issue.

Schuster (1976) elucidates that privacy frequently entails some form of distancing, which can be psychological or physical in nature. She cites four major variables that strongly influence the patients’ ability to control or protect their boundary. These variables are (1) mobility, (2) level of consciousness and awareness, (3) the specific character of patient-to-patient relationships and (4) perception of role. With regard to the third variable most of her patients thought that since hospital provides 'a singular
situation’, and a ‘one-time encounter’ (p 247) with other patients, the ‘camaraderie’
feeling within a hospital serves to mitigate the restrictions of ‘ordinary day to day
socialisations’ (p 247). As to the fourth variable, she explains that perception of role
refers to the view that individual patients have ‘as patient’ and that such a role is
largely formed from previous personal experience as a patient and orientation to the
illness. She found that many patients tended to rationalise the breaches of their
boundary by the notion of member of staff’s ‘legitimacy of entry’ with comments
such as ‘it’s their job’ (p 248). She concluded that the care and comfort of patients
can be improved and unnecessary discomfort avoided when the needs for distancing
and boundary control are recognised by members of staff.

My main criticism of Schuster’s (1976) research is that she obtained her data by
interview technique only, the form of which is not explained. If she did use an
interview schedule then its format is not clear. The type and number of participants
that she used is also an issue. Although she states in the preamble that the issue of
privacy is of increasing concern ‘among citizens-at-large’, the population of her
study was limited and was conducted with middle-class Caucasian adults only.
Accordingly one is left wondering that, had she used other groups of society whether
her findings would have been any different. In a hospital there are many groups of
patients. Since she conducted the study through interview techniques only it is
assumed that her participants were all competent adults according to clinical
standards. Nevertheless, I found Schuster’s research very informative. She explains
what privacy is and what it means to individual patients. She stresses the importance
of respecting the patients’ boundary through distancing control on the part of
practitioners. She advises us of the factors that may influence the ‘self’ of an
individual patient and the 'interactional' (p 248) nature of privacy, which requires respect when individuals seek distance from others as a form of comfort. Her study also provides an insight into the ways that patients often rationalise the violation of their privacy by practitioners.

On the other hand, a study on privacy by Parrott et al (1989) was undertaken to examine patients' perceptions ($n = 427$) of the meaning of privacy within the doctor-patient relationship. The participants in this study were mainly adults and were recruited locally on a voluntary basis in a large southeastern United States metropolitan community. A 10-item questionnaire was used to determine the patients' perceptions of the invasiveness of privacy of certain questions, comments or certain practices by doctors. A 5-point Likert-type scale was used to determine the participants' responses. Having divided privacy into physical, social and psychological dimensions, the researchers concluded the multidimensional and situational nature of privacy. With regard to their physical privacy dimension, overall 34% of the respondents agreed or strongly agreed that having to undress before seeing a physician was a violation of their privacy. 48% considered undressing when a nurse was present to be invasive of their privacy and 58% thought that undressing parts of their body that was unrelated to the reason for a medical visit to be a violation. On the other hand, issues related to the social dimension of privacy showed that 31% of the participants thought that remarks made about their general physique was a violation of their privacy and 28% viewed questions about their use of leisure time as violations. In terms of the psychological dimension of privacy, 54% of the participants considered reference to morality to be a breach of their privacy and 40% considered being told that they were irresponsible about their health to be invasive.
The research of Parrott et al (1989) shows that exposure of the body or any part of it can be viewed as a violation of privacy. They found that younger and female participants were more likely to regard such exposure as invasive. Accordingly, the researchers hoped that health practitioners would evaluate their methods of practice and would take the feelings of patients into account when delivering care. They concluded that ‘patients may become socialised’ to many aspects of care, but that ‘does not say that they are happy or comfortable in the situation’ (p 1384). They further suggested that loss of privacy could lead to feelings of stress, which in turn might lead to the patients’ failure to understand a doctor’s instructions or recommendations. In my study I did not pay specific attention to gender issues and how these impinge on the issue of privacy. The main reason I did not attend to this particular issue is that the wards I observed were single-sex, not mixed, so I was unable to make useful comparisons. However, it is an important issue for further research.

Like Schuster’s (1976) research, the study of Parrott et al (1989) was undertaken in America where health care is private. While Schuster conducted her research with the aid of interviews, Parrott et al (1989) utilised questionnaires to gather their data. They had no contact with the participants and therefore had no opportunity to verify the findings as I intended in my research. Although the research raised the important multidimensional nature of privacy, which has undoubtedly increased the knowledge level of privacy, questions could be asked about whether quantitative research was the correct methodology to seek answers about the situational nature of privacy. It is therefore argued that the findings as perceived by the participants reflected a social reality that was external to them. This argument is also supported by May (1994).
I found Lawler’s (1991) study very informative for my research in the ways professionals define and view patients’ privacy. Through observation and interview techniques of nurses (n = 34) about the body and the way it is managed by nurses as part of their daily activities, she argues that the body is problematic in our society and examines the intellectual background to the problem. She explores the pattern of relationships between theoretical concepts of the body, body care, privacy, dirty work, women's work and sexuality. With regard to privacy, she explains that the ‘notion of privacy, as nurses use it, is difficult to articulate’ (p 165). During the body care of their patients, she found that nurses utilised the term privacy to mean either a lack of audience, no unnecessary exposure of the body, minimising the possibility of embarrassment and maintaining a person’s dignity. She comments that nurses generally needed to protect the patients’ privacy, but in doing so went beyond the patients’ need for privacy. She calls one of the methods that nurses tend to use as ‘minifisms’; that is techniques whereby nurses deliberately and overtly understate the situation or minimise the extent of something. For example, she explains that nurses often use such words as ‘Don’t worry about it. It’ll be alright’ (p 167). This statement consolidates the findings of Smith (1992) that nurses ‘work emotionally on themselves (emotional labour) in order to appear caring at all times’ (p 18). Another method that nurses seem to use in respecting the patients’ privacy is by asking relatives and visitors to leave the area or the room while nurses assist the patients with body care and when a patient had a need to vomit. She explains further that, besides considering the patients’ privacy, nurses utilise such methods in order to ‘(1) minimise their own potential embarrassment; (2) manage their dirty work by having it hidden from view; and (3) feel less exposed to potential criticism or interference from relatives’ (p 170). This observation is of importance because it signifies that
nurses and doctors have feelings and are involved in maintaining the ‘aura’ of caring beyond the sight of other patients and strangers.

Lawler’s (1991) study shows that she had conducted her research with a certain rigour. Instead of conducting her research with one method only, as was undertaken by Schuster (1976) by the use of interviews and Parrott et al (1989) by questionnaires, Lawler utilised two distinct methods to gather her data. Through the observation process she was able to assess the social reality of the situation as perceived by her and the nurses. The use of both observation and interview techniques allowed Lawler (1991) to make ‘taken-for-granted aspects of nurses’ (p 11) work explicit. By a combination of research methods she was able to achieve a level of triangulation to maximise the validity and reliability of her findings and the ability to generalise from it. However, Lawler’s (1991) research only reflects the nurses’ perspectives. It is argued that had she interviewed the patients, she might have obtained different types of data and would have reached different conclusions. It is suggested that this omission could have tarnished the validity of the findings.

Bauer’s research (1994) into patients’ privacy in a 502-bed acute German hospital setting has reinforced Westin’s (1967) explanation that human beings are generally concerned about the ‘four distinct states’ of individual privacy (see section 2.3). In this study, through the use of semi-structured interview and questionnaires, Bauer found that some of her participants were very concerned with the exposure of their personal identity. Since most of the participants were from a local village, they expressed great fear of violation of their anonymous position while they were being cared for in the hospital wards. They also showed concern with particular regard to:
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- Exposure to full view of strangers and the probability of recognition
- Patients’ data at the bed or door
- Questioning and discussion of private matters in front of others
- Privacy with visitors
- Privacy when answering the telephone

Bauer’s research (1994) generated a vast amount of rich data, which clearly illustrates how patients perceive privacy in hospital. During the categorisation process she noted the following themes that summarise the patients’ concerns about their privacy:

- Privacy in the hospital environment in contrast to home
- Fear of exposure or personal identity (as discussed above)
- Fear of failure of others to respect personal autonomy
- Fear of physical exposure of the body
- Invasion of personal territory
- Invasion of personal space
- Violation of intimate distance
- Effect of invasion of privacy on the individual
- The individual as part of a patient community
- Patients’ coping mechanisms/reactions to invasion of privacy (p 45)

The main findings of Bauer’s (1994) research show that certain groups of patients were most concerned about exposure of their body and personal identity rather than intrusions into their personal space or their territoriality.
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Bauer (1994: 138) concluded that every patient needs some sort of privacy, for his or her physical, mental, emotional and spiritual well being. She questioned whether the intrusions into patients’ privacy by health professionals that she found were always due to thoughtlessness. She found instances of deliberate invasion of individual privacy and argued that the reason for such intrusion was a way of expressing the staff’s power at the defencelessness of ‘normal’ patients. She also found that private patients tended to have more privacy than patients being cared for in public facilities. Her research rejects the notion that women and elderly patients are more sensitive to the invasions of their privacy. Instead, she concluded that individual patients differ in their need for privacy and the way they express themselves of this need. She further argued that when patients are very ill and weak, their privacy threshold is low because they need help, and she accepts the notion that such a process may involve invasion of their privacy. However, Bauer stressed that when a patient’s condition improves, the privacy threshold changes accordingly and any potentially intrusive nursing action has to be renegotiated.

In the evaluation of Bauer's (1994) research, it is admitted that her study was mainly concerned with the gathering of data from patients' individual perceptions. She conducted the interviews with those patients who were more able to express themselves and those who were better educated. This meant that these patients were more effective in their expression of the violation of their privacy. Those patients who were unable to express themselves well were ignored. She herself showed some disquiet about the use of the questionnaires even though the overall aim of their use was to examine whether any emergent trends during the interviews also applied to a larger sample of the population. She admitted that the use of the questionnaires was
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not a productive way of eliciting honest opinion. She expressed concern about various issues with regard to the responses that she had received. For example, when there were several items on one topic she found that the first question was generally answered 'in a more indifferent way'. On the other hand, since many patients needed help in the completion of the questionnaire forms, it is fair to say that they might have been influenced by the presence of the researcher. However, despite these reservations, Bauer's (1994) is the first researcher whose findings have given a good insight into aspects of privacy of the person and the issues that might emerge in my research.

Back and Wikblad (1998) carried out their research into patients' privacy in a Swedish hospital. The aims of their study were to explore patients' \((n = 120)\) and nurses' attitudes \((n = 42)\) towards privacy and to study whether nurses' perceptions corresponded with the patients' own reported needs. Two questionnaires were used for the data collection. Attitudes towards privacy in general were measured by use of a questionnaire partly adopted from Marshall (1974). A multi-trait scaling of the results was performed and it resulted in a final tool consisting of 20 items rated on five-point Likert scales. Attitudes towards privacy in hospital were also measured by use of a questionnaire that was constructed and tested by Arciero et al (1993). The questionnaire included 13 items on environment, physical care of patients, communication with relatives and care providers. Patients and nurses were asked to score each item on a 4-point scale, ranging from not important to very important.

Back and Wikblad's (1998) findings indicate that patients and nurses generally agreed in the ratings of the major components of privacy, but privacy in hospital was
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estimated more highly by the nurses than by the patients themselves. Females had higher overall scores for privacy than males, and younger patients had higher privacy preferences compared with older patients, thus supporting the findings of Parrott et al (1989). Being allowed to talk to doctors in private and having toilet facilities were given the highest preference. Patients receiving long term care compared to those patients receiving care in the acute setting also showed higher privacy preferences. With regard to personal property, the patients showed high privacy preferences value for having access to a locked locker/cupboard where personal items could be kept safely. On the other hand, low privacy preferences were indicated for having meals in private and the selection of their own visitors. The patients also showed low privacy preference values to the importance of being cared for by a nurse of the same sex. The researchers concluded that patients were socialised to expect low privacy during a hospital stay, but ‘it does not mean that they are comfortable with the situation’ (p 945), thus supporting the views of Parrott et al (1989). They recommended that a more explanatory study approach was needed to clarify the effects of lack of privacy in hospital.

Barron (1990) studied ‘the patients’ right to personal space’. She compared Swedish and British nurses’ attitudes to offering privacy to elderly hospital patients and the extent of privacy availability in each country. Her study involved the use of questionnaires, a checklist and participant observation. In each country four wards participated in the study, involving patients ($n = 80$), relatives ($n = 61$) and nurses ($n = 76$). During the participant observation, she specifically made notes of the following activities: use of bed-side curtains, use of commodes, extent of door closing, knocking before entering, and nurses’ attitudes towards maintaining privacy.
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In both countries, Barron found that nurses had generally failed to ensure the patients' privacy by not drawing the bed curtains around the patient during micturition or defaecation, by not giving verbal warning before re-entering the patient's side of the curtain, by not closing the door once the patient was in the toilet, and by not maintaining the patient's dignity when assisting them with washing. She also found that the relatives were not provided with privacy during their visit to the hospital. She concluded that despite the evidence 'of sometimes slipshod practice' (p 30), maintenance of patient's privacy was rated highly by the nursing staff, thus supporting the finding of Back and Wikblad (1998). Although the nurses were aware of the importance of maintaining the patients' privacy, they had generally failed to protect it in practice.

I found Barron's (1990) study very informative for my own research. This seems to be the first study that had been seriously undertaken in a General Hospital Unit in England compared with the previous studies that were carried out in different countries. Since privacy perception may vary across the cultural boundaries (Younger Committee 1972), Barron's study gave me a litmus paper against which the findings of my research might be judged. My main criticisms of Barron's (1990) study are that she is very reserved in explaining her methodology. For example, it is not clear how long she spent observing the participants. Equally, it is unclear at what stage of her observation period the nurses were asked to complete the questionnaires. Like Lawler (1991), she concentrated her study on observing nurses and their attitudes to privacy. Had she observed and interviewed patients and members of the medical team, the richness of the data and the validity of the research would have been enhanced.
In their comparative study of elderly patients’ and staff perceptions of privacy in the care of elderly patients in five European countries (Scotland, Finland, Greece, Spain and Germany) Leino-Kilpi et al (2003) found some interesting results. Having at first described privacy in terms of physical, social and informational dimensions, their results demonstrated that overall perceptions of privacy were strongest in Scotland and weakest in Greece. On the other hand, perceptions of privacy by patients and nurses were quite similar in Finland, Scotland and Germany compared to Greece and Spain. In the latter two countries nurses believed that they had respected the privacy of their patients more often than the patients themselves felt this was the case. The researchers also found a clear association among patients in Spain and Scotland, showing that a low level of independence of the patients lead to the perception that their privacy was less likely to be respected. On the other hand, in Scotland they found that patients with a higher independence level were twice as likely to perceive that their privacy was rarely respected.

Although it is interesting to note the findings of Leino-Kilpi et al (2003), it is argued that certain omissions in the study might have affected the quality of the research. Since the study was mainly conducted with the aid of questionnaires, the lack of observational methodology meant that the reality of the situation was not fully tested. There is also a question about the apparent selection of only those elderly patients with capacity in the completion of the questionnaires.
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2.8 Erving Goffman (1922-1982): An overview of his classic works and their impact on the formation of self

Following the emergence of my categories, I sought guidance from the works of Goffman (1922-1982), *The Presentation of Self in Everyday Life* (1959), *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates* (1968a) and *Stigma* (1968b) as interpretive tools to make sense of my data in chapter 6. Accordingly, this section analyses his classic works, as they were found relevant to my study.

Without doubt, Goffman was one of the leading sociological writers of the post-war period. He was a great observer as an ethnographer of every day interactions and was able to describe them in ways that no other writers had previously done. Through the use of extended metaphorical and systematic and unsystematic naturalistic descriptions, he portrayed day to day behaviour in a way that makes one think of daily mundane every day performance, not only from a novel angle, but he gave to sociology an approach for analysis of social interactions (Manning 1992).

In his early work, *The Presentation of Self in Everyday Life* (1959), Goffman uses six dramaturgical principles: performance, the team, the region, discrepant roles, communication out of character and impression management, to explain the way in which individuals or members of teams interact in the presence of one another. He explores the methods that either individuals or members of a team use during such interactions, attempt to control and guide each other’s impressions, sustain their performance and the kinds of things that individuals or members of a team might do.
Goffman views interactions as performances that can take place regardless of the mental state of individuals and their beliefs of reality, which they stage as long as they sustain a viable front. An individual’s front can add ‘dramatic realisation’ to his performances that help to highlight those aspects of his performance that otherwise might remain undetected by his audience. Individuals do this by deliberately manipulating those aspects of their performance with which they want to impress their audience. In order to impress their audience, individuals attempt to present an ‘idealised’ version of the front that is more consistent with the culture’s general norms and values of society than the actual behaviour of the actors when they are not in the presence of the audience. Sometimes individuals play down their intelligence by ‘negative idealisation’ in order to impress their audience. Such idealised behaviours are only achieved by concealing their own norms and values that are incompatible with an idealised version of themselves.

Goffman also explores the concept of group dynamics through a discussion of ‘teams’ and the relationship between performance and audience. He explains that for a team to function effectively, the members of the team co-operate in performance in order to maintain the definition of the situation that is sanctioned by the group. The team continues to maintain unanimity in the ‘front’ region where they are visible to the public. In such settings they are likely to be polite and show respect to each other. Each team-mate relies on the good conduct and behaviour of fellow members to maintain the accepted front of the team. Together, they develop an attitude of protectiveness to each other and are bound by rights of the team, which Goffman has labelled as ‘familiarity’ (1959: 88). Thus, he argues, the necessity of maintaining the desired front during a performance reduces the possibility of dissent among the
members of the team. Each member of the team feels a strong pressure to conform to
the desired front in the presence of their audience, as any deviant behaviour can
damage the credibility of the entire performance.

In *The Presentation of Self in Everyday Life* (1959), Goffman has given an insight
into the formation of self during an interactive process. The self of an individual is
seen as the product of the various means by which it is produced and maintained. In
such an interaction process, if the self is damaged it is more likely that
embarrassment would occur. In such circumstances an effort can be made by both
parties to rescue the situation to maintain the creditable selves. However, in certain
circumstances, the dignity and value of the self cannot be rescued. In *Asylums*
(1968a), Goffman demonstrates how in the total institution of a mental hospital,
inmates were subjected to a series of abasements, degradations and humiliations of
their selves and a withdrawal of all the physical and social supports that once
sustained them (p 24). Through such treatment the inmates’ ‘self is systematically, if
often unintentionally, mortified’ (p 24). In certain cases their humiliation became
intensified by an absence of privacy. Despite the continued assault on the inmates’
self, he asserts that for most inmates a radical and permanent change does not occur.
This is partly because they are able to defend themselves from the mortification
process by playing a detached role.

On the other hand, in *Stigma* (1968b), Goffman shows us how the self can be deeply
discredited if not completely destroyed, which is quite different from the ‘self’
portrayed in *The Presentation of Self in Everyday Life* (1959). He poignantly
demonstrates that the selves of crippled individuals can be totally changed if others
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react to or view them as part of the accepted norms within Anglo/American society. For example, 'Desperate' who was born without a nose, cripple and minority groups are forced to be marginalised by the presence of idealised conduct.

Throughout his early works Goffman has implicitly tried to demonstrate the impact of power and influence during an individual or team performance. He has implied that individuals can be calculating in obtaining a desired response during any interactions. He uses such words as 'design' (1959: 4) on the part of the actor to ensure that an acceptable performance took place. He explains how glances, verbal statements and positioning could bring a desired effect. He also shows how individuals can utilise knowledge and their positions in a team to wield power over their colleagues or inmates in an institution that can lead to the stripping of their identity, as was shown in Asylums (1968a). His concern with information control in Stigma (1968b) and misrepresentation and possession of secrets in The Presentation of Self in Everyday Life (1959) gives an indication that individuals can exercise control over others through the use of power.

Giddens (1987) said that Goffman would not be ranked as highly as Foucault, Habermas or Bourdieu as a theorist but his works have been given enough credence to describe him as an ethnographer of the self. As a writer of micro-sociology, he has shown the way in which the interaction in aspects of social life can be analysed. He has also warned of the danger of possessing too much power and control over disadvantaged people. Analysis of his works gives us great insight into the nature of social interaction and the psychology of the individual that are so easily overlooked in daily life.
Although tremendous progress has been made in the care of patients and respecting their rights since Goffman's writings, within the NHS clinical settings, I wanted to find out whether the principles discussed in this summary could still be relevant in my research. I particularly wanted to find out whether the concepts of 'front' and 'back' regions were applicable within a ward setting. Nurses and doctors worked within the principle of team concepts and I was interested to determine the extent to which the influence of the lead consultants and nurses had had an effect on the notion of solidarity on the members and its impact on the privacy of the patients. These are discussed in detail in chapter 6.

2.9 Conclusion

This chapter reviewed the literature on the subject of privacy. As outlined, privacy is a basic need, which has been explored in the works of Barron (1990), Westin (1967), Altman (1976) and the report of the Younger Committee (1972). Privacy was defined and its meaning explained by analysing the works of Bates (1964), Westin (1967), Altman (1976), Parent (1988). In the section, 'History of privacy protection within the legal system', it was argued that the English Courts have been reluctant to acknowledge a person's privacy, using the case laws of Malone (1979, 1985), Gordon Kaye (1991) and X and Y (1988). However, since the passing of Human Rights Act 1998 and its incorporation in October 2000 into UK domestic law, for the first time a right to privacy of the person was conceded by the legal system. Section 2.6 explored the importance of various Department of Health documents, and the nurses' and doctors' own codes of conduct that have stressed the need to respect patients' privacy within NHS settings. In section 2.7 the studies in privacy of
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Schuster (1976), Parrott et al (1989), Bauer (1994), Back and Wikblad (1998), Lawler (1991), Barron (1990) and Leino-Kilpi et al (2003) were reviewed in order to understand the previous research in privacy. Finally in section 2.8, the classic works of Goffman (1959, 1968a and 1968b) were briefly analysed to demonstrate their relevance to my research and how individuals normally interact in social performance and how their selves can be affected by the behaviours of others.
CHAPTER 3

3 RESEARCH APPROACHES AND METHODOLOGICAL CONSIDERATIONS

3.1 Introduction

The preceding chapters provided an account of the background underpinning this research. This chapter outlines the research approaches and methodological considerations. Research methods are classified and the common distinctions between quantitative and qualitative methods are briefly explored. Since I have adopted an ethnographic approach to conduct the research and the principles of grounded theory and phenomenology to gather and analyse the data, these approaches are explained further. As patients’ and staff’s perception of privacy are also looked at in this research, this subject is examined in section 3.4.

3.2 Quantitative research

Quantitative research methods were originally developed in the natural sciences to study natural phenomena. These approaches have been described by the term empiricism (Leach 1990) and positivism (Duffy 1985). The quantitative research approach is said to be an objective, formal and systematic process, in which numerical data are used to quantify or measure phenomena and to produce findings. It examines the cause and effect relationships using a deductive process of knowledge (Duffy 1985). Variables are carefully controlled to ensure validity and reliability of the research. The fact that the findings are viewed to be the direct result
of the observable processes and can be verified and replicated, they are considered to
be knowledge (May 1994). The aim of quantitative research is therefore to search
out generalisable laws that can then be applied to a larger population. Examples of
quantitative methods that are now well accepted are laboratory experiments and
surveys in the field of social sciences.

The common criticism that is leveled against quantitative research is that the internal
processes, whereby mainstream scientists arrived at knowledge, are ignored and only
the external (observable and describable) processes are considered to be important
(May 1994). Such research has very little contact with the participants. Social reality
is seen as external to the participants; hence it is seen as a poor method of studying
people (Parahoo 1997), for instance the behaviours and perception of patients and
staff with regard to patients’ privacy in NHS wards. This concept is supported by
Leininger (1994) who believes that quantitative methods have limited benefits when
discovering and interpreting the central domains of nursing phenomena, ‘especially
as [they are] related to human care, health and well being’ (p 98).

3.3 Qualitative approach

As the aim of my research was to explore the concept of privacy within a NHS
setting, I adopted a qualitative approach to seek answers to my research questions.
Qualitative research methods consider that the experience of individuals is important
and valid and bring to light much data that were previously averaged away or simply
never considered by the quantitative method. The aim of qualitative research is not to
measure, but to gain knowledge and understanding of phenomena (Leininger 1985).
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She also explains that generalizations are not the goals of qualitative paradigms (1994:103).

According to Field and Morse (1985), a qualitative study is well suited when the purpose is to gain insight into an area that cannot be broken down into smaller pieces without losing sight of the whole. Similarly, Bockmon and Riemen (1987) believe that the qualitative approach explores the meanings that people assign to their aspects of the social world. The understanding of such principles was crucial in this research. I believed that patients' privacy could not be studied effectively in a laboratory. In order to understand the elements of privacy, and build the distinct issues of privacy, I had to look for the meanings that patients and staff gave to their social world.

As this research had adopted the principles of grounded theory, phenomenology and ethnographic approaches, these are now explored in the following sections.

3.3.1 Grounded theory

Grounded theory is an alternative to the hypothetico-deductive approach of positivism. It is an inductive approach to research whereby hypotheses and theories 'emerge out of', or are 'grounded' in data (Parahoo 1997:45). This method was initially publicised by Glaser and Strauss following their sociological study on the experience of dying in a hospital (Glaser and Strauss 1966). Data are mainly collected via participant observation and interviewing. Researchers tend to go to the participants in an attempt to discover their view of a particular situation. This notion of discovery is central to the philosophy of grounded theory. It is grounded by the
assumption that people order and make sense of their environment. This order is derived from their shared social and symbolic interaction (Chenitz and Swanson 1986). According to Nusbaum and Chenitz (1990) data are analysed systematically in four stages:

The first stage is that of generating substantive codes. In this stage, beginning categories are generated and their properties delineated from the data. During the second stage, theoretical coding occurs. Data is ordered, and linkages are established between the categories. The third stage is that of delimiting the theory. The theory is reduced in bulkiness and the boundaries of the theories are established. The fourth and final stage is that of writing the theory. (p 220).

The principles of grounded theory appealed to me. Since I was determined to study patients’ privacy at close range, I adopted, besides the ethnographic methodology of observation and interview techniques, the principles of grounded theory to discover the world of patients and staff that allowed me to make sense of their environment. One of the weaknesses of grounded theory is that it does not allow personal assumptions and expectations to form part of the data. This issue is explained further in the next section. Since, according to Burawoy et al (1991), grounded theory allows theory to emerge from the field, they argue that such emergent theories can only treat ‘the social situation as the confirmation of some theory’ (p 9). The formulation of my ‘privacy model’ confirms the view of Burawoy et al as I showed the way that the existing factors of the ward influence the selves of patients and staff. This is explained in section 6.13. Accordingly, it is argued by Burawoy et al (1991) that in pursuing generalisations, grounded theory has remained at the same level of reality.
During the data analysis phase, the concept of grounded theory was also very useful, particularly when generating codes, themes and categories. It also allowed me to utilise the 'constant comparison methods' to compare and contrast the emergent themes, categories and issues of privacy that Glaser and Strauss have described. However, instead of a new theory emerging from the data, as Glaser and Strauss (1966) have suggested, I had to 'drag out' (May 1994) various explanations for the findings in order to formulate the privacy model in the light of the emerging themes and categories. These are explored in detail in chapter 6.

3.3.2 Phenomenology

Phenomenology is a philosophy and not a research method (Giorgi 1997). The purpose of this approach is to study the lived experience from the perspective of the experienced person. Unlike grounded theory, the goal here is to describe the experience of the phenomenon under study, not to generate opinions or theories (Parse et al 1985). This method is not concerned with explaining, predicting or controlling the 'lived world' of the subject. The essence of the phenomenon is captured through a rigorous process of disciplined reflection and identification of common themes. The end product is a description of the essential structure of the phenomena.

According to Husserl (cited by Bauer 1994), phenomenology is 'the rigorous and unbiased study of things as they appear so that one might come to an essential understanding of human consciousness and experience' (p 34). According to Husserl, phenomenology is:
If I put myself above all this life and refrain from doing any believing that takes the world straightforwardly as existing - if I direct my regard exclusively to this life itself, as consciousness of the world - I thereby acquire myself as pure ego, with the pure streams of my cogitations. (Husserl cited by Crotty 1996: 61).

This quotation summarises Husserl's approach to the study of phenomena. His goal was to analyse the original primordial phenomena, the immediate data of our consciousness that has not been subjected to pre-reflective conscious rational processes (Crotty 1996). Husserl believed that in order to achieve an unbiased understanding of phenomena, it is necessary to set aside (bracket) our own presuppositions and preconceptions. Once this bracketing is achieved, the participants are left with pure ego (natural human ego, not worldly ego) and consciousness which do not assume the existence of an independent external world. He alleged that the process of bracketing is the foundation for rigorous science. He suggested that it is possible to encounter an object with pure consciousness by transcending our everyday surroundings. Many Husserlian phenomenological researchers have used bracketing differently. They have stopped short at transcendentalism and applied Husserl's philosophy of 'descriptive phenomenology' to their research methodologies. These researchers (Thomas et al 1998; Giorgi 1997; Crotty 1996; Benner 1984) claim to suspend their own knowledge and experience of the phenomenon to ensure elements of objectivity.

Heidegger did not agree with Husserl's view. He ascertained that pure consciousness and awareness were not always necessary for human beings to relate to objects (Dreyfus and MaGee 1987). He recognised that individuals could not separate themselves from the world in which they live. This philosophy supports the notion that individuals cannot bracket their knowledge and experience of the phenomenon
under investigation in order to be impartial. I have utilised Heidegger's principle in this research and have explored the notion of bracketing further in this chapter, in the section 'ethnography and reflexivity'.

The principles of phenomenology were very valuable, particularly when interviewing patients and staff to explore their 'lived' experience of privacy in the clinical settings. However, since my research was aimed at exploring the cultural climate of the wards and the perception of practitioners and patients, Husserl's approach to the study of privacy as the main method of gathering data was rejected. Despite all my attempts, I knew that it was impossible to 'bracket' all my previous presuppositions. Nevertheless, in order to gain understanding of the patients' and practitioners' values, meanings and beliefs to privacy from their 'lived' experience, I found the phenomenological principles useful during my reflection and identification of themes and categories. According to Colaizzi (1978), phenomenology seeks to know the phenomenon under study as it is experienced. I used the principles of Colaizzi during my content analysis process and these are explained in section 4.16.

3.3.3 Ethnography

The ethnographic approach was adopted to conduct this research on privacy. Its relevance to the study is explained in section 3.3.3.3 under the heading, 'choice of ethnography in the study of privacy'. In this section I examine ethnographic approach to research generally.

Werner and Schoepflie (1987) have attempted to describe 'ethnography' as a 'description of the folk' from the terms ethno (folk) and graphy (description).
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Fetterman (1998) explains that ‘ethnographers assume a holistic outlook in research to gain a comprehensive picture of a social group’ (p19). Ethnography is a type of qualitative inquiry that involves the description and interpretation of the cultural behaviour of a group (Polit and Hungler 1999). It is based on the assumption that culture is learned and shared among members of a group and, as such, can be described and understood (Morse 1994). It involves collecting, describing and analysing the ways in which human beings categorise the meaning of their world. In other words, ethnography attempts to learn what knowledge people use to interpret experience and mould their behaviour within the context of their culturally constituted environment (Aamodt 1991).

The main objective of an ethnographer is to learn from members of a cultural group and to comprehend their world as they define it in context. This is sometimes known as the ‘emic’ perspective, which refers to the way the members of the culture perceive their world (Polit and Hungler 1999). ‘It is the insiders’ view’ (p 245), their language, modes of expression ‘that are used by members of the group under study’ (p 245) to express themselves. In this research I collected the ‘emic’ perspective data by formally and informally interviewing patients and staff. Ethnographers strive to acquire an ‘emic’ perspective of a culture under study (Boyle 1994, Polit and Hungler 1999). By contrast, the ‘etic’ perspective is the outsiders’ interpretation of the experiences of that culture. This type of data (etic) was obtained by observing the behaviours of patients and staff in the clinical setting over a period of six months. Boyle (1994) believes that both type of data are necessary ‘in helping the ethnographer understand why members of a particular group do what they do’ (p 166). Hammersley and Atkinson (1983) suggest that the context within which the
behaviour of the participants can be understood includes far more than the physical environment, as ‘any account of human behaviour requires that we understand the social meanings that inform it’ (p 9). To do that, they suggest that the ethnographer needs to do more than just describe behaviour; she or he must understand why the behaviour takes place, and the circumstances that produce the behaviour. This is what I have done during the interpretation of the data in chapter 6. By formulating the privacy model (see section 6.13), I have explained the circumstances that produced the behaviours of the participants. The emergence of this model also allowed me to explain the social culture of the NHS ward background and the many activities that influence the privacy interface of the ward environment.

3.3.3.1 Ethnography and participant observation

I chose non-participant observation method to conduct this research and the reasons for this choice are explained in chapter 4 at section 4.2. However, participant observation is the method of choice in many ethnographic studies (Parahoo 1997). According to Layder (1993), researchers may derive many benefits from participant observation. For example participant observation allows closest scrutiny of the research field. It represents an ideal form of research strategy as this method enables the researcher to become a ‘native’ of the group being studied.

Davies (1995) argues that the ethnographic approach allows observational skills to be used that people normally use in their everyday lives. The purpose of participating is to obtain an insight into the subject’s feelings and behaviour. It combines participation in the lives of the people under study while maintaining some
professional distance that allows for adequate observation and recording of data (Boyle 1994).

However, Millman (1976) suggests that an ethnographer can never fully participate in the action in the same way as those being studied. She explains:

Every social world has its own rules about what is to be attended, and how. To be a participant or insider means that one is guided by this socially shared definition of reality. (p 330).

In her study to obtain an understanding of the world of doctors, Millman (1976) argues that a researcher cannot do what the subjects (doctors) can do, but she felt that a researcher can be close enough to obtain sufficient data to get an understanding of the world of doctors. She explains how she was able to spend sufficient time with individual doctors and by accompanying them through their rounds, she was able to ‘get a feeling for the texture and quality of staff life in the hospital’ (p 331). This was one of the reasons for my choice of non-participation observation method. I knew that I would never be able to undertake all the activities that the doctors and nurses could do. As an observer I was still able to observe how the various groups of doctors and nurses viewed and gave meaning to the situations that arose, and how they chose to pay attention to some things and not to others.

3.3.3.2 Ethnography and health care practice

The core of the medical and nursing professions lies in the delivery of their practice. In order to understand the professions, it is necessary to study them within the contextual setting. There are some distinguished nurse researchers who have used the
ethnographic approach to explain nursing practice. Field (1983), in her study of public health nurses’ perspectives of nursing, followed four nurses in the community for a period of five months. In this study, Field placed herself in the nurses’ environment, taking a limited role in nursing activities and observed the informants from many vantage points. The informants were volunteer participants. Their clients’ consent was sought in the participation of the study before their interaction with the nurses. The researcher took the role of participant-observer, utilising observation technique, formal and informal interviews and client records. Data were recorded either on tape or in field notes. The data were analysed concurrently to identify relations within the data that would merit further study. Final analysis was undertaken after the completion of the fieldwork. While she accepted that it would be inappropriate to generalise from her four case studies, she found that the studies proved very significant in relation to the beliefs and practice of these four nurses. While there were common elements across the models used by the four nurses, she found that the ‘organisational relations were unique to each individual’ (p 9). She also observed that the major influence on the model that the nurses were utilising appeared to be guided by the nurses’ own life experience and priorities. When the employers’ policies conflicted with the nurses’ beliefs, the nurses devised strategies for circumventing the policies.

Similarly Savage (1995) used the ethnographic approach to study the dynamics of the nurse-patient interaction as a crucial element in the effectiveness of nursing care. She studied the ward culture of two ward teams, ‘Jones’ and ‘Smith’ wards, over a long period. She concluded that ward ideology, the nature of a ward team, support received from management and the type of interaction with the medical staff all play a vital part in the effectiveness of nursing care. Most importantly, the study looked at
the way in which nurses experienced relationships with patients. She found that nurses who were prepared to use closer relationships with patients therapeutically, through the use of touch, humour and body posture, did not find the relationships as stressful as might be assumed. Although she had utilised an ethnographic approach, she admitted that she had 'limited success in making use of participant observation' (p 18). She explained that her participation was limited by ethical and legal considerations, as she 'had not practised as a nurse for some time' (p 18).

3.3.3.3 Choice of ethnography in the study of privacy

Privacy is a very sensitive subject. The patients' and the professionals' perception of privacy may not be the same. I considered therefore (as explained in chapter 1) that quantitative methods, such as the use of questionnaires and structured interviews, were inadequate for the study of privacy as the reasons for certain personal actions or inactions required explanation.

In support of my choice of the ethnographic approach for this research, I concluded that social actions and interactions would be better understood following a detailed examination of the way in which individual patients and health professionals defined and interpreted the situation in which they found themselves. The research by Savage (1995) reinforced the choice of methodology as she explained that ethnography is 'a way of accessing beliefs and practices, allowing these to be viewed in the context in which they occur and thereby aiding understanding of behaviour' (p 4).
3.3.3.4 Ethnography and reflexivity

Boyle (1994) has pointed out that ethnography has a reflexive character, which implies 'that the researcher is a part of the world that she or he studies and is affected by it.' (p 165). This principle is supported by Ratner (1997) who suggests that subjectivity guides everything in qualitative methodology, from the choice of topic that one studies to selecting methodologies and interpreting data. In explaining reflexivity, Hammersley and Atkinson (1995) suggest that both positivism and naturalism have held extreme views in that it is possible:

In principle at least, to isolate a body of data uncontaminated by the researcher, either by turning him or her into an automaton or by making him or her a neutral vessel of cultural experience (p 14).

Boyle (1994) suggests that a good ethnography is somewhere between the two extremes:

The ethnographer does not take data at face value, but instead considers it as a field of inferences in which hypothetical patterns can be identified and their validity tested (p 165).

In this research I have followed Boyle's (1994) and Heidegger's principles. I acknowledge that the subject of this research arose because of my personal interest in patients' human rights and respect for their privacy. It was impossible to 'bracket' personal experience from my consciousness (Dreyfus and MaGee 1987). Hence, realising the reflexive character of ethnography (Ratner 1997), I made every effort to take a non-judgemental view of the data and describe the activities of the participants as objectively as possible and the contexts within which they were interacting. Throughout the research, albeit sometimes with difficulty, my personal experience as a lawyer and a
nurse has been set aside and the data looked at objectively and purely within the contexts in which the data were obtained. I made every effort not to privilege the nursing or legal point of view. That is, I had not used either perspective to judge behaviour or events when recording or analysing the data. Although it was not possible to ‘bracket’ all experiences totally, I obtained solace from the writing of Savage (1995), who had observed by citing the work of Sapsford and Abbott (1992), that reflexivity can be important for three reasons; ‘it acts as a form of self-monitoring and helps to minimise errors. It represents a form of data analysis, that is a way of understanding the data; and it helps to show that the interpretations of the data are reasonable ones’ (p 22).

3.3.3.5 Limitations of ethnographic approach

Like all approaches to research, ethnography has limitations. Even the most rigorous experimental study is subjective in light of the researcher’s theoretical stance, questions asked and interpretation of findings (May 1994). Since the self is the major instrument for data collection in an ethnography study, I had to ‘tune’ (Lipson 1991) my ‘self’ so that valid data were collected. I am a male and with Asian background. I was conscious that my cultural stance should not ultimately affect the gathering and interpretation of my data. According to Freilich (1970):

The internal mental state of the anthropologist is a prime determinant of his presentation of self in the research community. His presentation of self leads to a public image that attracts or repels valid data. (p 35)

De Vaus (1991) suggests that ethnography has a great weakness in that it relies mainly on subjectivity and is not open to scientific analysis. There is always the
danger that researchers may immerse themselves to such an extent in the particular culture they study that they become ‘unable to have an objective view of the situation’ (Parahoo 1997:152). Hence, it is argued that since ethnography methodology does not lead to generalisable findings, funding bodies are poorly receptive to such research (Savage 2000). However, Fetterman (1998) believes that biases serve both positive and negative functions. He explains that when biases are controlled, they ‘can focus and limit the research effort. To mitigate the negative effects of biases, the ethnographer must first make specific biases explicit’ (p 1). This was precisely my aim during the discussion of ‘ethnography and reflexivity’ in the previous section 3.3.3.4.

Qualitative research is therefore often criticised for lacking scientific rigour, reproductively and generalisability (Mays and Pope 1995). However, Murphy et al (1998) argue that the process of generalisation is not the purpose of qualitative research and point out instead the in depth understanding that ethnography gives to research. Since ethnography is not experimental research by its very nature and does not require manipulation of the independent variable, internal validity is not a goal for qualitative research (Brink 1991). Lincoln and Guba (1985) reject the framework of validity in qualitative research that is commonly accepted in more quantitative research in the social sciences. They reject the basic realist assumption that there is a reality external to the perception of it. Murphy et al (1998) accept that since observation is one of the main approaches of ethnographic study, it tends to generate large amounts of data and can become very time consuming during the data analysis phase.
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Awareness of these limitations of ethnography helped me to plan the research in a systematic way. Besides understanding my 'self' and its influence on the whole process of the research, I ensured that ample time was always allocated during the planning phases of the research as it was expected that large amounts of data would be generated.

3.4 Perception

One of the questions of this research (question 2) was to determine the perceptions of privacy on the part of nurses, doctors and patients. As a researcher, it was therefore important to understand, the principles of social perception so that the data could be analysed from a knowledge base and any conclusions reached objectively.

The social psychologist King (1962) has defined perceptions as the outcomes of cognitive processes that are used to obtain, organise, and utilise information about stimuli. Both objective and subjective factors affect these. The latter include such attitudinal factors as preconceptions and stereotypes. According to Allport (1935), attitudes can also influence the way in which people perceive and respond to the world. Atkinson et al (1990) explain that our abilities to perceive, besides being derived from innate ability, are learned through experience with objects in the world about us. We make use of auditory, visual, verbal and non-verbal information to perceive people and surroundings. Argyle (1983) believes that perception involves:

The whole process of interpreting and making sense of other people and the social events in which we are involved. This is important, because the way in which a person perceives (and interprets) events affects how he will behave (p 97).
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He explains that perception of people is quite different from the perception of physical objects. While physical objects 'are seen as being pushed and pulled by physical laws, people are seen to some extent as being responsible for events and initiating action' (p 97). He suggests that inadequate social performance is often due to faulty perception resulting in inaccurate interpretations.

Literature has also shown that factors like one's cultural background (Davitz et al 1969), gender (Hill 1978), socio-economic status (King 1962) personal experience (Jennings and Muhlenkamp 1981) or the specific role one holds in society (Biddle 1979) can be the major determinants of perceptions. For example with regard to cultural background as a determining factor on perception, Hill (1978) found that 70% of patients on a rehabilitation unit reported a problem in communication with medical staff because of differences in race. In addition, a majority of the white patients highlighted their resentment to black nurses. In their study of experience on perception, Jennings and Muhlenkamp (1981) found that when oncology caregivers were more experienced, they were better able to perceive the emotional state of the patients. On the other hand, Lauer et al (1982) have indicated that the nurses' length of work experience did not correlate with their perceptions of importance of various types of educational items.

It is also important to understand how individuals form impressions of other people. Kelly (1955) explains that people usually tend to behave differently towards males and females, old and young and other divisions of people through the process of construct formation. Argyle (1983) argues that people generally use three kinds of construct to
form opinion of others. These are roles (eg class, occupation), personality traits (intelligent, extraverted) and physical characteristics like attractiveness and height.

As a researcher, it was therefore important that I should be aware that a person's perception might be affected by the way individuals perceive the situation, the roles they have adopted and whether they are in a dependent or subordinate position. Patients are commonly in a strange environment and in a dependent position when ill, and may adopt an ingratiating attitude and undue politeness in order to receive care (Argyle 1983). According to Argyle ingratiating behaviour and politeness are two of the main sources of error in judging a person's attitudes and behaviour. This issue of perception is especially illustrated throughout the interpretative stages of my data in chapter 6.

3.5 Conclusion

This chapter explored different research approaches so that I could make an informed decision in the ultimate selection of ethnography as the main methodology for this research. The differences between quantitative and qualitative methods were also explained so that the overall aim of qualitative study is recognised as not seeking generalisation but to describe the data as it is found. As the research questions had also attempted to determine the perceptions of patients and staff in their understanding of privacy, this notion was briefly explored so that its awareness would enrich the data collection and interpretation.
4 THE DESIGN OF THE STUDY AND HANDLING OF DATA

4.1 Introduction

In the previous chapter it was stressed that ethnography was the main methodological approach for this research. In this chapter I shall explain more fully the reasons for choosing ethnographic methodology for this research, non-participant observation and various interview techniques in the gathering of the data. The research arena is described in detail, illustrating the process of gaining entry to the research field. Emphasis is also placed on explaining the sampling methods of the participants, their profiles and the methods used in the organisation and analysis of the data.

4.2 Ethnography and non-participant observation

The choice between qualitative and quantitative research methods is influenced primarily by the research questions that have been set (Henwood and Pidgeon 1993). This research aimed at exploring both patients’ and health professionals’ perceptions of privacy within a clinical setting, and any intrusions into patients’ privacy by the standards set in regulatory and legislative instruments. Accordingly, it was decided that ethnographic methodology was the most appropriate to use in the light of the answers that were sought. This allowed me to adopt a multi-faceted approach comprising of non-participant observation, semi-structured interviews and ad hoc conversations with patients and staff (Field and Morse 1985). Cohen and Manion (1994) suggest that the preferred method of observation, that is, non-participative or
participative, is to a large degree determined by the nature of the setting. According to these authors participant observation is more suitable to unstructured and natural settings such as the study of a village culture, while non-participant observation tends to work best in structured, artificial settings, such as the present study of a ward setting within the National Health Service. The differentiation of ethnography into 'classical' and 'focused' types by Morse and Field (1996:126) also aided the selection of my methods. Within classical ethnography, the researcher spends a longer period of time as a participant-observer in the naturalistic setting. On the other hand, 'focused ethnography' allows a limited participant observation to take place. Morse and Field (1996) explain that 'focused ethnography' is more appropriate in health context studies as it allows the subject matter to be selected before the commencement of data collection. The selection of the non-participative observation technique was in part due to personal concerns about legal, ethical and professional implications in this study. I had left the active practical field of nursing in 1980 and was not fully confident to participate as an active member of the ward team to undertake the roles of a participant observer. Savage (1995) has succinctly highlighted the weaknesses of ethnographic study through participant observation in her study of 'Nursing Intimacy':

I had only limited success in making use of participant observation. This was partly because the extent of my participation was limited by ethical and legal considerations; as I had not practised as a nurse for some time. I restricted myself to those practical tasks that posed no risks to the patient (p 18).

Besides the above rationales for selecting non-participant observation as the main tool for data collection, the view of Millman (1976), as explained in the previous
chapter, also influenced the selection of this methodology in that an ethnographer can never fully participate in the same way as the informants being studied.

4.3 Ethnography and interview techniques

By combining observation and interviews (semi-structured and unstructured), it was intended to grasp a near-complete understanding of the subject of privacy being studied. Through the interview techniques, validation of observed evidence was sought and clarification of any inconsistencies that arose between what was observed and what was said at the interviews. According to Fetterman (1998):

> The interview is the ethnographer's most important data gathering technique. Interviews explain and put into a larger context what the ethnographer sees and experiences (p 37).

Parahoo (1997) states that ethnographic interviews can take the form of normal conversations. Fetterman (1998) notes that informal interviews are the most common in ethnographic work. Such interviews are useful throughout an ethnographic study in discovering what people think and 'how one person's perceptions compare with another's' (p 38). Another important aspect of this approach is that the participants can ask questions of the researcher. Frankenberg (1982) believes that the questions that the participants ask of the researcher are sometimes more important than the questions that the field worker raises with the participants.

Interviews in a qualitative study may be formal, in that they are prearranged with the key players for the purpose of detailed conversation, or they may be informal, in that the interview is unplanned and data are gathered during day to day conversation as
the field is being observed (May 1991). The format of such interviews can also be unstructured or semi-structured. Unstructured interviews are those interviews that do not reflect preconceived ideas about content and flow and are done with little or no organisation. Semi-structured interviews are also known as focused interviews and these are defined as those organised around areas of particular interest, while still allowing flexibility in scope and depth (Polit and Hungler, 1999).

It is common for ethnographers to regard solicited accounts as less valid than those produced spontaneously. Thus, Becker and Geer (1957) argue that it is important to ensure that conclusions about the perspectives of participants are not entirely reliant on solicited answers, otherwise we can be misled by reactivity and the effects of the researcher's questions on what is said. Similarly, there is a tendency among ethnographers to favour non-directive interviewing in which the interviewee is allowed to talk at length in his or her own terms, as opposed to more direct questioning. The 'aim here is to minimise, as far as possible, the influence of the researcher on what is said, and thus to facilitate the open expression of the informant's perspective on the world' (Hammersley and Atkinson 1993:129).

In this study, besides a lengthy period of non-participant observation, I used both formal and informal interviewing techniques. All formal interviews were pre-arranged and semi-structured, although ethnography advocates that an unstructured interview process is better suited (May 1991). The latter view was rejected in this study. Unstructured interview implies that it is conducted without utilising any of the researcher's prior information, experience or opinions in a particular area. In this study I was to investigate the participants' behaviours and perceptions with regard to
patients’ privacy within the NHS and it was difficult to ‘bracket’ these conceptions.

May (1991) supports this view as follows:

Since human interaction is based on a culturally derived structure of meanings that is shared to some extent, it would be extremely difficult for the investigator to approach any interview as a completely neutral element. Investigators have some area of interest in mind at the outset, and their goal is to discover and understand the informant’s perspective on that particular aspect of life (p 191).

4.4 Ethical Issues

One of the most important functions of Research Ethics Committees is to protect the individual rights of the patients. Application for ethical approval was submitted to the Local Research Ethics Committee on 30 March 2001 for consideration of the research proposal. The proposal was considered on 1 May 2001 and verified on 24 July 2001 (Appendix 1). The first point of concern at the first meeting was:

'You should provide a consent form to accompany the patient information sheet to enable patients to agree to you observing the interaction between them and staff. The Committee would like to see a copy of that document'.

This comment created a dilemma for me. I wondered whether only competent patients (according to clinical standards), with capacity to understand the process could be involved in the research. It seemed that those patients who were unable to consent, such as very old or unconscious patients would not become participants for data collection. In order to seek answers to the research questions, it was felt that all patients being cared for in a bay of a ward should be equally observed. The law is very clear in this area. If a patient is deemed incompetent in law, health practitioners can apply the principles of
'best interest's or 'the doctrine of necessity's principle' (Health Service Circular 1999) and give care accordingly. In the clinical setting I was an outsider and a researcher and was not involved in the direct care of the patients. Following discussions with my supervisor, nurse manager, sister in charge of the ward and the Research Ethics Committee, it was decided that, in the case of incompetent patients, permission of the nearest relative of the patients would be sought, either retrospectively or directly during their visits. This principle was rigorously tested throughout the study and in all cases consent was obtained from the nearest relative of the deemed incompetent patients. The second key issue of concern of the Research Ethics Committee was:

‘What mechanism will you use for your initial approach to patients? The initial approach about the study should come from the nurse involved in the patients' care who could then, with the patients' agreement, introduce you’.

In order to remedy this omission the following section was inserted on page 6 of the Ethics Committee form:

‘In order to increase the validity of the data collected, a third party will be contacted initially to select the patients and the health care participants, namely the named nurse and the ward sister respectively, in the distribution of the information sheet and the seeking of the consent of the participants. By employing the help of a third party, undue pressure is not placed on a participant to take part in the study. This will no doubt increase the objectivity of the study’.

Adhering to this principle was difficult owing to the individual caseloads of staff on the wards. However, I always ensured that patients and staff would only participate in the study on an informed basis (see appendix 8, information sheet).

The issue of confidentiality was another factor of concern to the Local Research Ethics Committee. It was assured that all data, on tapes or hard copies, would be
Chapter 4: Design of the study and handling of data

stored safely within a locked cupboard, which was provided specially for this purpose by the University. I also ensured that throughout the research, with regard to the handling of the data, the issue of confidentiality was respected in accordance to the principles of the Data Protection Act 1998.

4.5 Access to the field

Gaining entry to the field was not a straightforward procedure. It required patience and negotiation skills on my part. It was natural that nurse managers, doctors and all concerned in the well being of patients would ask questions about every aspect of the research. Some key workers had no knowledge of ethnography. My legal and nursing backgrounds might have created an added sense of unease, rather than ease, when I approached the gatekeepers for the first time. Suspicion had to be dispelled. I followed Fetterman’s (1998) advice:

*An introduction by a member is the ethnographer’s best ticket into the community. Walking into a community cold can have a chilling effect on ethnographic research (p 33).*

Being a regular visitor to the chosen area of the field of study as a nurse tutor helped me in the choice of the research arena. I felt that the choice of an acute surgical setting, including an orthopaedic ward, for the study was relevant to the research as it comprised a range of patients from the ages of 18 to 80 years old and various stages of legal competence. I was already familiar with Ward A (appendix 2) which I chose for my pilot study. Many nurses (now qualified) knew me as their personal tutor. One of the sisters had been a personal student when she undertook her orthopaedic course. Srinivas (1966) discusses the advantages and disadvantages of studying in a
Chapter 4: Design of the study and handling of data

familiar setting. An ethnographic approach is suited to someone having a detailed knowledge of the culture of the particular universe of enquiry (Srinivas 1966, Firth 1981, Fielding 1993). A balanced approach was adopted in the selection of the field. I selected Ward A which was very familiar to me and Wards B (appendix 3) and C (appendix 4), where I knew neither the staff nor the ward environment.

After having identified the field, written consent was sought from the key players. This included meeting personally with the Unit Nurse Managers of the three wards, the Director of Nursing of the acute hospital, and the Lead consultants (a total of five persons) who had patients in the clinical settings. Since I personally knew the Unit Nurse Managers quite well, they introduced me to other key players and also facilitated various meetings. Many other informal meetings were also held to give further explanation about the research, although by this stage the research was already approved by the Local Research Ethics Committee. At these meetings the aim of the research, its process, the contents of the information sheet (appendix 8) and consent form (appendices 9 and 10) were fully discussed. I also had a formal meeting with the Research and Development Co-ordinator whose responsibilities included monitoring all research in the NHS Trust. A seven-page questionnaire was completed and the project details were counter-signed by the Director of Nursing Services who was specifically appointed by the hospital to oversee my well being and the state of the research. The form was also signed by the Finance Officer, Care Group Manager and the Clinical Director of the Trusts. An honorary contract was arranged and thereby the issue of liabilities and indemnity insurance in case of negligence on my part was clearly agreed. I was issued with a hospital NHS Badge, showing my name and identity as a researcher, thereby confirming the lawfulness of
my presence in the area. I was specifically advised not to wear a white coat or any uniform that could easily confuse me as a health practitioner in the minds of the participants.

4.6 Pilot study and structure of Ward A

Pilot studies are small preliminary studies carried out in order to test the feasibility of the larger study (Atkinson 2000). I carried out the Pilot study in Ward A of the general hospital in which the main study in Ward B and Ward C was to be undertaken. Ward A was a standard type Orthopaedic ward that housed 28 patients. The ward consisted of four bays for six patients and four individual cubicles each (appendix 2). At the time of the study, the ward was full. Fourteen of the patients were male and the rest were female patients. Although most of the male patients were mobile, the majority of the female patients were elderly, bed-bound and recovering mainly from operations on their hip joints. The ward was usually staffed with a G grade sister and a complement of four or five staff nurses and health care assistants. During the night the ward was normally staffed by two registered nurses and two health care assistants.

As part of this pilot study it was decided to undertake the field observation for a period of four days. At first it was planned to observe only six patients located within one of the bays of the ward. However, because of the movements of patients from one six bedded bay to another or from a one-bedded cubicle to another, or to the main bay as patients were recovering from their illness, it became necessary to spread the observation to 16 patients over two bays and four individual cubicles (a
one bedded room). Each observation period lasted for an initial continuous period of five hours, separated by one one-hour gap, which was used for reflection and scrutinising the field records that were made during the observation. The observation period was mapped out as follows:

Day 1 (Thursday) 05.00 - 10.00 and 12.00 - 17.00
Day 2 (Friday) 16.00 - 23.00
Day 3 (Saturday) 07.00 - 14.00
Day 4 (Sunday) 12.00 - 17.00

During the four days, any staff working in the consenting bays and cubicles were observed, but the main focus of observation was nursing and medical staff. All patients who were being cared for in the consenting bays and cubicles were also observed. Non-participant observation, semi-structured (formal) interview techniques and informal conversations were mainly utilised to gather the data and add to the richness of the data. During this period, three patients and two staff (one nurse and one junior doctor) were formally interviewed with the aid of interview schedule (see appendices 5 and 6). All interviews were conducted with the full consent of the participants, and consent was sought from the relatives for the incompetent patients. Data were also gathered by the use of everyday conversation with patients and staff. All formal interviews were recorded on audio-tape. All field notes and tapes were subsequently transcribed, coded and themes determined manually by utilising Boyle's (1994) and Colaizzi's (1978) principles of content analysis. It was always ensured that all data were carefully stored in accordance with the Data Protection Act 1998. The data obtained during the pilot study later became part of the final analysis.
as it was felt that the data were significant enough to warrant inclusion. Although some lessons were learned from the pilot (see section 4.10), the weaknesses of the pilot in no way vitiated as appropriate and adequate for the main study.

4.7 The research arena and the participants of the main study

This section addresses the geographical structure of the main field work settings, the type of patients cared for in the wards and the recruitment of health practitioners in the study.

4.7.1 The structure of Ward B

The main study was commenced at the beginning of January 2002 in Ward B and Ward C and was completed at the end of June 2002. During this six-months period all data were collected by non-participant observation of staff, patients and their visitors, informal conversation with staff, patients and their relatives, and by semi-structured interviews with staff and patients with the aid of an interview schedule (see appendices 5 and 6). The interview schedules were the same that was used during the pilot.

Ward B was a surgical arena but in contrast to Ward A it also included medical patients. Seventeen of the twenty-nine beds were allocated to patients suffering from urological conditions, for example, cancer of the prostate and conditions of the kidneys were common at the time of the study. Nearly all the male and female patients had indwelling catheters in situ after their operations. After their surgery,
these patients remained in the hospital for a period of five to seven days. The other
twelve beds were occupied by patients suffering from vascular conditions. Peripheral
vascular disease of both feet, leading to amputation of one or both feet, was a
common occurrence. Many of these patients were also suffering from the added
problems of diabetes and heart conditions. This meant that most of this group of
patients had mobility problems.

At the time of the study one of the orthopaedic wards in the hospital was being
refurbished, with some of the orthopaedic patients (both male and female) transferred
from that ward to Ward B. These patients were also accompanied by an extra full
timed registered nurse, although the complement of beds in Ward B remained the
same throughout the study. The transfer of these patients meant that there were
always at least four or five more patients with orthopaedic conditions than urological
or vascular conditions.

The structure of Ward B was very similar to Ward A. It comprised of 29 beds. It
consisted of four main six-bedded bays and five one-bedded cubicles (appendix 3).
The ward had a sitting room for patients and their relatives, which was the size of a
one bedded cubicle, situated between rooms 6 and 4. The sitting room had a colour
television and was furbished with comfortable chairs.

As in all other wards in the hospital, there was a white board on a wall located next
to the nurses’ station. The nurses used this board to record daily the names of all the
patients, their consultants and the patients’ bed location in appropriate coloured inks.
During the changeover of shifts, the board was the main point of reference for
checking the patient’s profile by doctors, nurses and other paramedical staff. Visitors and relatives also used the white board to check the whereabouts of their friends and relatives. During the time of the study, one of the rooms of the ward was also used as a urology clinic, run by a G grade sister. The attendance of these patients meant that very often the patients’ sitting room was occupied by patients who were waiting to see the clinic sister. This also meant that during most mornings the sitting room could not be used by the residents of the ward.

The daily nursing duties of the ward were shared between two main teams. Each team was headed by a ward sister and was supported by staff nurses and health care assistants. Team nursing tends to operate within a hierarchical management structure (Norman and Cowey 1999) and is popular in many practice settings (Thomas and Bond 1990). At the time of the study the ward was largely staffed by Philipino and agency nurses because of a high number of vacancies (see table 1, Nursing staff: 37% and HCA: 24%). As with all the wards of the hospital, the workload of the nursing staff was divided between three main shifts. These were as follows:

- 07.30 - 15.30
- 13.00 - 21.15
- 20.45 – 08.00

The full time staff nurses worked in rotation between night and day shifts. The nursing staff establishment of Ward B is shown below in table 1:
Table 1: Nursing establishment of Ward B

<table>
<thead>
<tr>
<th>Funded establishment, Whole time equivalent (WTE)</th>
<th>In Post (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day/Night</td>
<td>Day/Night</td>
</tr>
<tr>
<td>Qualified</td>
<td>16.0</td>
</tr>
<tr>
<td>Day/Night</td>
<td>10.13</td>
</tr>
<tr>
<td>Health Care Assistant (HCA)</td>
<td>10.7</td>
</tr>
<tr>
<td>Day/Night</td>
<td>8.1</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 1 showing the number of nurses and HCA in post in Ward B compared with the funded establishment.

It was apparent during the study that the ward did not have an overt philosophy of care in place although I was informed by several nurses that such a philosophy did exist and was located in a file somewhere in the sister’s office.

4.7.2 Reasons for choosing Ward B as the main field of study

There were many reasons for choosing Ward B as the main fieldwork of the study. Primarily, it was an ordinary ‘bread and butter’ type of ward. There were at least three different types of patients, suffering mainly from orthopaedic, urological and vascular conditions. I was particularly interested in observing the care of the patients suffering from urological conditions. Since post-operatively most of them required very intimate care during the management of their indwelling catheters, the issue of how their privacy and dignity were maintained by staff was of particular interest to me. The patients with vascular conditions, had their mobility affected, stayed in bed for longer, and were quite ill, providing me once more with an appropriate arena for the study of privacy. The ward also had both male and female patients aged between 18 and 95 years and offered a unique opportunity to sample a wide range of the
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population. Most importantly, compared to Ward A, I was a stranger here. Most of the staff had never met me prior to the study and I had no knowledge of their personal profiles.

4.7.3 The structure of Ward C

Ward C was very different from Wards A and B. This ward was known as an 'overflow ward', housing patients from the Accident and Emergency Department until a bed was found for them in the main wards of the hospital. The ward comprised of three main bays (appendix 4). The size and diameter of these bays were very similar to the bays described for Wards A and B respectively. However, two of the bays of Ward C had eight beds each and the third bay accommodated six patients. In theory, patients were supposed to stay for a short duration only. In fact, during the study it was found that many patients remained there until they were discharged home after a period of 10 to 20 days. The nurses on this ward were all dressed differently from other wards. As the staff were part of the Accident and Emergency Department, all were dressed in pale blue operating theatre style uniforms. This ward was well staffed compared to Wards A and B. The lead nurse of the Accident and Emergency Department managed Ward C.

4.7.4 Reasons for choosing Ward C for the study

It was not planned to use Ward C as part of the main study. At the beginning of the study it had already been decided to complete the study on Wards A and B only. However, during the initial period of observation study on Ward B, I had an informal meeting with one of the lead consultants who, despite giving his initial assent to
conducted the study, was still wary of my presence. The consultant could not understand the reasons for choosing 'his ward' when other wards, according to him, were better suited to such a study. He suggested that I should also explore the opportunity of studying aspects of privacy on Ward C. He indicated that Ward C 'will open your eyes'. Following this conversation, I visited Ward C informally to see for myself its geographical structure. It was not realised until then that Ward C's complement of patients was very different from Wards A and B. Following a discussion with my supervisor, I approached the Local Research Ethics Committee, the lead consultant of Ward C and the nurse manager and ward sister for their permission to spend a period of one month in Ward C. Aside from the lead consultant, I did not have any difficulty in obtaining permission to conduct the extended study on Ward C. Although the lead consultant eventually consented to the study, he made clear to me of his dissatisfaction with a qualitative approach. He felt that a qualitative study has no place in medicine and argued that only a quantitative study should be encouraged. The encouragement of the consultant of Ward B and the polite protestation from the lead consultant of Ward C, ultimately helped me decide to devote at least one month of my time simultaneously on Ward C without changing any aspects of my methodology, thus maintaining the validity of the study within the defined approaches. Extending the research to Ward C also gave me an opportunity to triangulate the study so that evidence from a wider perspective could be utilised in the final analysis of the data. Extension of the study to Ward C also added challenging hurdles, such as seeking further consent from the Local Research Ethics Committee, the lead consultant, and all other key parties concerned in the running of that ward.
4.8 Time spent in the field

It was decided that all patients being cared for on Ward B and Ward C would be selected for observation. During the six-month period (see table 2), a minimum period of at least three days a week was spent in Ward B. During the last month of the observation period a similar amount of time per week was spent simultaneously in Ward C. For example, if Monday was spent in Ward B, it was always ensured that Tuesday would be spent in Ward C. Each observation period had lasted three hours instead of five, a change from the pilot study because during the pilot study I experienced difficulty in maintaining my concentration while also recording the findings manually. As during the pilot study, I scattered the observation time equally among the morning, afternoon, evening and certain periods at night in both the wards. Table 2 summarises the time spent in the three wards:

Table 2: Time spent in the clinical setting

<table>
<thead>
<tr>
<th>Research arena</th>
<th>Time spent</th>
<th>Observation of patients in one period</th>
<th>No. of patients formally interviewed</th>
<th>No. of staff formally interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward A</td>
<td>4 days</td>
<td>16 patients: 2 six-bedded bays and 4 cubicles</td>
<td>3</td>
<td>1 doctor, 1 nurse</td>
</tr>
<tr>
<td>Ward B</td>
<td>6 months</td>
<td>29 patients: 4 six-bedded bays and 5 cubicles</td>
<td>12</td>
<td>5 doctors, 12 nurses</td>
</tr>
<tr>
<td>Ward C</td>
<td>1 month</td>
<td>22 patients: 2 eight-bedded and 1 six-bedded bay</td>
<td>3</td>
<td>3 nurses</td>
</tr>
</tbody>
</table>

Table 2: showing the time spent, patients observed at one span and the number of patients and staff formally interviewed in the respective wards
4.9 Sampling of participants

It was initially planned that 15 patients and at least 12-14 staff ranging from all grades of medical and nursing staff would be formally interviewed. In fact, at the end of the study, I formally interviewed (semi-structured interview) 18 patients, 6 doctors and 16 nurses (table 2) with the aid of respective interview schedules (appendices 5 and 6). During the observation phase 55 patients were also informally interviewed in day to day conversation, mainly by sitting by the patients' beds, and several grades of staff (n = 12) either by the nurses' station or in the staff coffee room as the opportunities arose.

Although initially the help of ward sisters was utilised to recruit patients and staff for the formal interviews, it soon became apparent that this system could not be continued. The lead nurses always seemed to be very busy when I required them. It was therefore decided to resort to opportunistic sampling of both patients and staff as had already been done during the observation phase of the research. I wanted to recruit a range of patients, nurses and doctors, but it depended very much whether they were willing and available.

4.10 Profile of the formally interviewed patients

Eighteen patients were formally interviewed (table 2), of which only three women consented to be interviewed on audio-tape (appendices 9 and 10). However, many female patients were quite happy to be informally interviewed as part of day to day conversation with me on the ward. For unknown reasons the female patients showed
great reluctance to be formally interviewed on audio-tape. Prior to interviewing the patients formally, a conscious effort was made to ensure that all patients would be given time to adjust themselves to the ward routine. Hence all the newly admitted patients were interviewed from day 2 onwards. Table 3 shows the hospitalised length of stay of these patients at the point when they were interviewed.

Table 3: Profile of the formally interviewed patients

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Stay in hospital in days</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
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<tr>
<td>3</td>
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<td>2</td>
<td>7</td>
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<td>1</td>
<td>8</td>
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<tr>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>1</td>
<td>26</td>
</tr>
</tbody>
</table>

Table 3: illustrating the point when in-patients were formally interviewed in relation to their stay in the hospital

All processes of the research remained the same as during the pilot study, except that the technique utilised for the formal interview stage of the semi-structured process was slightly adjusted. More attention was paid to maintaining a balance between flexibility and consistency when interviewing the participants (staff and patients). Although flexibility is essential in eliciting the individuals' personal stories with regard to their perception of privacy, I felt that during the pilot study I did not pay sufficient attention to consistency of approach while interviewing the staff and patients. A special effort was made to ensure consistency by concentrating on the
types of questions asked, the depth of detail, and the amount of exploration in order to allow comparison between the participants (May 1991).

4.11 Profile of the formally interviewed staff

During the study 22 health professionals were formally interviewed (semi-structured interview) with the aid of an interview schedule (appendix 6). These comprised six doctors and 16 nurses (table 2).

Of the six doctors, one was a consultant, two were registrars, one senior house officer and the other two were house officers qualified six and nine months respectively. In general, the medical staff were very reluctant to be formally interviewed. Many made themselves unapproachable and were very quick to point out that they were very busy people. The main rationale for such reluctance was pressure of work, too many forms to fill and too many patients to see. Every time when a member of the medical team was approached, I was advised to bleep the doctor at a set time. When I subsequently managed to get hold of the doctor by bleep, I frequently was told that he or she was busy doing certain things at that time and I was politely advised to bleep the person at another time. I gave up the idea of pursuing these doctors after four or five attempts, having to utilise various other techniques to accommodate them. This meant waiting for them for hours either on the wards or in the clinic until they could free themselves from what they were doing. At one point the support of the consultant was sought to facilitate the process, but still the plea remained unanswered. At times, it was felt that there was a deliberate attempt on their part to frustrate the research.
I did not face as many difficulties with the nursing team although it was still very frustrating to fix a set time to interview them. In the end 16 nurses of different grades were formally interviewed as follows:

1 nurse manager
1 G grade sister
1 G grade specialist nurse (stoma nurse)
8 E grade nurse
3 D grade nurse
2 fourth year student nurse (These nurses were undertaking their BSc Health Science course and were in their last week of completing their training)

While seeking the consent of the participants, at all times a philosophical stance was taken. It was accepted that participants had the right to refuse or accept my request to interview them. At no time was undue pressure put on them even after receiving a negative answer to be interviewed.

4.12 Data Collection

During the study data were obtained in three distinct ways: by the use of non-participant observation and formal and informal interview techniques.

4.12.1 Non-participant observation data

An important part of the research design was to decide what to observe. According to Berg (1988), it was important to familiarise oneself with the environment and develop relationships with participants in the field and observe and ethically
‘eavesdrop’ on the main characters of the study. This ethos was applied throughout the study. Every effort was made to build a working relationship with all staff and patients equally. I was very apprehensive at first that my presence would cause some sort of ‘Hawthorne effect’ (Roethlisberger and Dickson 1939). In order to cement relationships with all grades of staff conscious effort was made to spend time with them in the coffee room, share with them their jokes and participate in different ward activities, like making coffee while maintaining a degree of distancing. During these informal meetings many staff took the opportunity to ask further questions about the research and many were very willing to share their experience of events with regard to any aspects of patients’ privacy. All such data gained were carefully recorded at the earliest opportunity during the reflection phase.

The non-participant observation involved spending time over a selected period observing the interactions of the participants. In this research this meant all who came in contact with the patients: doctors, qualified nurses, student nurses, care assistants, physiotherapists, occupational therapists, pharmacists and the cleaners. They were observed from a comfortable distance and notes were kept manually and contemporaneously in a A-5 size hard-back notebook, either in long hand or sometimes in coded form, which were later expanded at the earliest opportunity. The observation position was frequently changed from a sitting position in a bay nearest to the window to sitting by a consenting patient and talking to such patients and scanning the field at the same time. The use of this strategy ensured that staff and patients were not made unduly uncomfortable by being stared at. Very often such a planned observation strategy was interrupted because of doctors’ or nurses’ ward rounds and I had to reposition myself in another bay. All the observation data were
personally typed, usually within the first two days of gathering the data to prevent distortion of the information. This type of data, as explained in section 3.3.3, is also described as the ‘etic perspective’ data, which ‘is the researcher’s abstractions and explanations of reality’ (Boyle 1994:166).

4.12.2 Interview data

The other method utilised in gathering the data was ‘emic’; through the use of formal and informal interviews with the full consent of the participants. The ‘emic perspective’ (Boyle 1994, Polit and Hungler 1999) is that in which data that are obtained directly from the participants themselves, either formally or informally. According to Boyle (1994) and Polit and Hungler (1999) such data are ‘the insider’s view of reality, or the informant’s perspective which is the heart of ethnographic research’ (p 116). Boyle (1994) supports the notion that an understanding of the insiders’ view of their world is crucial in describing situations and participants’ behaviours.

All the formal interviews were undertaken in a semi-structured way with the aid of an interview schedule (appendix 5). It was soon discovered that the majority of women and a minority of men patients, for reasons known to themselves, were very reluctant to be interviewed on tape. In one instance, a lengthy arrangement was made with a patient for the formal interview to take place at a certain period of the day. When I arrived it became apparent that the patient did not want to be interviewed at that time. The patient was quite willing to talk to me freely then and there, but for the formal interview he asked me to come after lunch. When I then arrived, he asked me
to come back after tea and then the next day. While it was possible to have gone along with his plan it was decided on ethical grounds to give up the idea of interviewing this patient altogether. It seemed that the patient would have been pressurised. Other patients were quite willing to participate in the formal interview process and share their experience with me on tape. In fact it emerged that during the formal meeting, many patients were quite relieved to talk and share their experience. As a result of this difficulty, great care was taken when gathering data informally from patients by informal interviews. All data were recorded in long hand in a A-5 size hard-back notebook in conversation format as the patient was talking to me. These notes were recorded word for word and at times in coded form and expanded during the typing phase (see appendix 11, an example of a formal interview of a patient).

Fortunately, the same difficulty did not arise with the nursing staff. The main issue with the nursing staff was availability of time and a quiet place to be interviewed without interruption. Because of this difficulty, certain formal interviews with doctors and nurses took place in a corridor. Although such an environment was found unsatisfactory at the time and in itself in danger of breaching confidentiality of the patients’ information data, there was no alternative available. When interviewing patients and staff in such an environment, the questioning format was compromised and questions of sensitive nature were not pursued in depth.
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4.13 The participants’ interview schedules

The formal interview was semi-structured using a differing interview schedule for staff and patient participants (appendices 5 and 6). Each interview schedule consisted of ten questions. Although both interview schedules had similar themes, the staff’s schedules included questions that required testing the knowledge of the participants’ understanding of Department of Health protocols and specifically of the Human Right Act 1998. Having an interview schedule was a starting point only, as this method allowed the participants to influence the content of the question. The use of the interview schedule also enabled invitation for discussion and facilitated the exploration of the participants’ experience (McLeod 1993).

4.14 Organisation of the data

As I explained in section 4.7, each ward had a white board, two meters square in diameter, cited by the sister’s office. By looking at the board I could tell who was where on that ward. Generally, for example in Ward B, patients on the white board were referred as patient 1 (1) or as patient 10 (5). This meant that patient 1 (1) was known as patient 1 who was located in room one. Similarly, patient 10 (5) was identified as patient 5 in room ten. This method of identification created some confusion in my mind and lead to an ethical dilemma. These patients were frequently called as patient ‘1 (1)’ or ‘10 (5)’. I noticed that most of the time, they were not called by their names. This arrangement meant that, even if a patient was being internally transferred from room one as patient 1 (1) to another room as patient 10 (1), that patient would still be identified by his location number as patient 10 (1)
although he was the same patient. To overcome this confusion, it was decided to
identify all the patients by a unique number. To start with I designated all the patients
as ‘patient 1’ to ‘patient 29’ and so on. Accordingly, patient 1 (1) was given number
1 and patient 10 (1) became patient 23. If a patient was internally transferred, that
patient would still carry his unique number with him from one room to another.
Similarly, on the discharge of a patient, any newly admitted patient to that bed was
given his own unique number. Thus, during the observation period, patient 1 (5) was
discharged home. The new patient who occupied this bed was subsequently called
‘patient 29’ and not ‘patient 5 in room one’.

Identifying the staff was not so straightforward. The ward was staffed normally by a
core of permanent nurses and doctors. However, every day it was noticed that the
ward was being visited by a group of outside doctors who wished to see patients with
specialised conditions. It was very difficult to track these personnel. Similarly, owing
to shortage of staff, the nursing staff was supported by different agency nurses every
day. Apart from identifying the permanent staff, it was quite difficult to follow an
individual doctor or nurse to make any value judgements. Accordingly, it was
decided to identify the nurses or doctors generally rather than give each of the staff
an individual number or a code.

To keep track of all the formally interviewed participants (patients and staff), a strict
interview profile sheet (appendix 7) was kept. This personal profile sheet enabled me
to revisit the interview scenes frequently and check any comments that I had made at
the time of the interview.
4.15 Analysis of the data

In this section, I shall explain the strategy that I had utilised in the analysis of my data in as judgementally free manner as possible. Although an ethnographic approach was employed as the main research design, I also used the conceptual principles of Grounded Theory and phenomenology, to develop key concepts from the raw data to seek patterns and themes during the formulation of categories. The interpretative framework of Goffman (1959, 1968a and 1968b) and others were included at a later stage. Owing to the confidentiality of the data involved the help of my supervisor was sought to externally validate the process involved during the content analysis. Many hours were spent with the supervisor checking the emergent themes and whether the key concepts reflect the named categories.

The management and analysis of qualitative data involve lengthy and complex processes (Pollock 1991, Savage 1995). Despite this complexity, concrete guidance is not provided to support a researcher (Pollock 1991). Although many books are written about the processes of qualitative data analysis (Hammersley and Atkinson 1995, Silverman 2000, Morse and Field 1996), I had difficulty in finding a particular framework from any of this literature that could be applicable to this area of study. This is a real issue, since analysis and interpretation of data are dependent on the researcher’s perceptions, personal experience and cognitive processes. It also depends on the methodology, adopted by the researcher, which can influence the overall analysis process. According to Stern (1991) ‘the task may seem laborious, but we must now translate qualitative language into common English for our
methodologically different colleagues. If others fail to understand, they will also fail to accept the [findings]' (p 148).

Many writers have noted that qualitative data analysis is undertaken simultaneously with research design and data collection (Pollock 1991, Bryman and Burgess 1994). Hammersley and Atkinson (1995) have also stated the importance of data analysis at a very early stage. They stressed:

\begin{quote}
The analysis of data is not a distinct stage of the research. In many ways it begins in the pre-field work phase, in the formulation and clarification of research problems, and continues through to the process of writing reports, articles and books. (p 205)
\end{quote}

I commenced the preliminary groundwork for the analysis during the conceptualisation and clarification of the research's aims when I conducted my pilot study. Understanding of my data analysis was also enhanced by publication of an article that explored a) the different forms of privacy invasion that might occur within an NHS hospital, and b) other current research in the area of privacy (Woogara 2000).

I conducted an ongoing analysis through reflection on my field notes, the contents of the diary based on field observation, and the interview texts of patients and staff. At the completion of data collection, following an observation phase or a formal interview, the aim was to have the hand-written notes typed within two days and the verbatim interview texts transcribed word for word with the aid of a transcribing machine by a designated secretary within a week of completion of each interview. However, due to the size of the data produced, I also undertook some of the
transcribing tasks. All texts transcribed by the secretary were later checked for any errors or omission against the audiotape. This process did not reach a satisfactory completion until six months after leaving the actual field. It would have been easier to transcribe all the tapes myself rather than to allocating this task to a person who had no vested interest in the research.

Once the observation phase and formal interviews were completed, a comprehensive analysis of the data commenced. According to Bernard (1988), the word analysis has two meanings:

On the one hand, it means making complicated things understandable by reducing them to their component parts. This is descriptive analysis. On the other hand, it means making complicated things understandable by showing how their component parts fit together according to some rules (p 317).

Boyle (1994) suggests that ethnographic data can be analysed into three general headings: ethnoscience, content analysis and descriptive analysis. Ethnoscience emphasises the emic perspective and gives prominence to interview data. As the result of the analysis, for example, taxonomies, decision models and causal chains are produced. Boyle notes that content analysis is a 'catch-all term covering a variety of techniques for making inferences from text data' (p 179). According to her, content analysis involves the categorising of each word, phrase or sentence in a text with labels that reflect the emerging concepts. Content analysis may also involve the counting of emerging concepts, which, according to Downe-Wamboldt (1992), improves both the precision and the completeness of the research. In this study, this principle was implemented by counting the positive and negative replies of the formally interviewed participants to determine their perception of privacy (see
section 5.2.6, figure 2). With regard to the descriptive analysis of ethnographic data, Tesch (1991) explains that its purpose is to:

Achieve deeper insight, to search for commonalities across the study participants or sites, to explore uniqueness, and to interpret the meanings of the discovered patterns (p 319).

4.16 The content analysis process

After having assimilated the unique principles of ethnoscience and descriptive analysis, it was decided to utilise the content analysis format because it involves identifying the significant statements in each phrase or sentence of the text and giving certain labels to them (Cavanagh 1997). Colaizzi (1978) has supported this process. According to Colaizzi (1978), the first step is to read the transcripts in order to gain a general feeling and understanding of the content. The second step is to identify the significant statements that describe the phenomenon under investigation, in my case the area of privacy of the person and thirdly, the researcher should explore the meaning of the significant statement to obtain a creative insight and meaning. This analytical process had already started when I entered the field and during the typing phases of the observation and interview data. This process of data analysis was quite different from certain grounded theories, where the researcher begins with no preconceptions and perhaps with a less clear statement of the research aims.

As soon as the observation data was typed and the formal interview audio-tapes of staff and patients transcribed and checked, I commenced the process of content
Chapter 4: Design of the study and handling of data

There are many methods that can be used in the coding process. Stern (1991) believes that the coding process can be done by hand (manually). She states:

As for coding alone, I maintained that there is no reason why any reasonably bright, trained, mature individual cannot code the data accurately, coherently, and solo (p147).

I considered using the NU*DIST software programme as an aid to the coding process. However, it was soon realised that despite its advantages, it lacked the flexibility and constant overview that was needed. It was therefore decided to code manually in a way that would keep me in touch with the data as a whole. In the end, although it was very taxing and time consuming to code the data manually, I was satisfied because the active process had enabled me to become fully immersed in the data.

4.17 The key stages of coding process

Four distinct stages were involved in the coding process, and identification of themes and formulation of categories. First I decided to organise my formal interview and observation data into two distinct groups.

The formal interview data were in turn subdivided into two main domains: patient data (an example at appendix 11) and staff data (an example at appendices 12 and 13). The transcribed text of the 18-patients’ data were sequentially numbered from pages 1 to 104. Similarly, the staff data (doctors and nurses) text was also sequentially numbered from pages 1 to 167.
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The observation text comprised two forms of data: data obtained from observation of Wards A, B and C and data gathered informally when interviewing patients and staff (see an example at appendix 14). These data were also sequenced and numbered from pages 1 to 140. In the light of these descriptions, different forms of data were labelled as follows, thus ensuring that the distinct forms of data obtained from a recipient or through observation are correctly identified during the content analysis phases:

a) UIP Unstructured interview data of patient  
b) SIP Semi-structured interview data of patient  
c) UID Unstructured interview data of doctor  
d) SID Semi-structured interview data of doctor  
e) UIN Unstructured interview data of nurse  
f) SIN Semi-structured interview data of nurse  
g) GO General observation data

Besides numbering the text pages, every line of the data texts was numbered from 1 to 50 with the aid of the ‘page set up’ function on the computer. Giving a line number to each sentence made the coding process easier. Thus, when a theme was identified in a text it could be immediately cross-referenced by the type of data obtained, its page number and then the location of the data by its line number. For example UIP-1:1-11 was identified as follows: The three upper case letters ‘UIP’ signifies that the data was obtained informally from an unstructured interview of a patient. The first number is the page number of the text and following the colon, the
second group of numbers are the line numbers from line 1 to line 11 where the data could be located.

The second stage of the analysis process was the most laborious phase of the coding process. This involved reading and rereading the texts several times. Once satisfied with the meaning of the phrase or the sentence, its significance was noted on the right hand side of the page with a pencil, either using the letter of the category or the name of the theme. I also decided to highlight the sentence with a coloured pen for easy identification. For example, at page 56 of the staff interview transcript I wrote ‘No privacy in the main bay’ opposite the lines 6-10 or I could have written just the letter ‘A’ to signify category A. It was always ensured that once the themes were identified, these were immediately transferred to the specific category sections. This meant that I was frequently shifting from the interview or observation data texts to the category file in the word document. This process was very time consuming but very satisfying once the end of an interview data was reached. This process was continued until the coding of all the text data was completed. During the second or the third reading of the texts the previously identified themes were frequently changed or subsequently replaced by the previously rejected themes.

The third step in the analytical process of the content analysis was grouping the themes into specific categories. Wilson (1985:408) explains that one of the main techniques for content analysis is developing a set of categories. Wilson (1985) advocates devising a set of categories in advance and then coding the theme into the existing categories. I only partially adopted Wilson’s process of categories formation. During the analytical process, at first 13 categories had emerged. The
names of these categories were changed several times during the content analysis phases and following further discussion with my supervisor, these were subsequently reduced to eleven. The final eleven categories are not listed in order of priority, nor is it intended to do so. These are listed into distinct headings. Next to the main heading, a significant letter of each identified category, for example A, B, C etc are entered, and next to each letter the name of the category is written, thus 'A - Conceptions of privacy', 'B - Territory and space'. Labelling the categories synonymously with a letter next to the name of the actual category literally simplified the process of discussion during the analytical phase of content analysis.

The key categories are labelled as follows:

A  Conceptions of privacy
B  Territory and space:
C  Control and choice
D  Personal care and depersonalisation of the patient
E  Privacy of patients’ information
F  Professional blind spot and habituation
G  Ward layout and logistics
H  Patients’ coping mechanisms
J  Visitors and relatives
K  Regulatory and government standards
M  Professional rationale for ‘overriding’ patient’s privacy

The fourth step in the coding process involved cross-referencing the themes between different categories (Morse and Field 1996). This was a very lengthy process and
required a tremendous amount of patience and mental gymnastics. At times it was
difficult to place an identified theme within one category. For example with regard to
the emerging concept 'choice of carers', I had a dilemma of deciding its position.
The question was to decide whether it should be placed within category A
(conception of privacy) or category C that encompasses the principle of 'Control and
choice'. In the end it was decided to place those words within category 'A' because
it was apparent from the interview that for this patient, 'choice of carers' was
important to the meaning and conception of privacy. In such a situation I always
sought the guidance of my supervisor who was helpful in specifying themes within
certain categories more objectively.

4.18 Exit from the field

At the entry to the field I had provisionally arranged with the nurse managers and
lead consultants that I would be spending a period of at least six months in the field.
However, after spending nearly six months in the field, the observation data were
becoming very repetitive. It was obvious that a 'saturation' point had been reached as
recurrent patterning of events had started to occur. During the last days in the field
there were times when barely nothing was written in the field notes. As Fetterman
(1998:10) had said 'when the general picture reaffirms itself over and over again, it is
probably time to wrap things up and return home'. Besides, all the staff whom I had
formally interviewed had started showing signs of different caring attitudes towards
the patients. Nurses who barely drew the curtain during nursing activities were now
very conscious of my presence and started drawing curtains completely by the
bedside. The ward culture changed to a large extent. Doctors were more conscious of
my presence, too. It was noticed that the lead consultant had suddenly stopped having conferences by the bedside where other patients could overhear. It seemed that a wind of change had blown through the ward with regard to respecting patients’ privacy and dignity. Since I started obtaining completely different data, I decided that it was time to leave the field.

4.19 Conclusion

In this chapter the choice of the ethnographic approach has been justified as the main research design for data collection. Reasons have been outlined for adopting non-participant observation and formal and informal interview techniques for gathering data. The research field has been described in detail and the ethical issues I had to consider prior to entering the arena for the pilot and main studies. After having given a clear profile of the participants in the study, I explained at length the methods I used in organising the data and the principles I applied during the data analysis phase. I defined four distinct stages of the content analysis. These were: the labelling process of the texts and formulation of the components of the key, identification of significant themes, grouping themes and concepts into specific categories, and cross-referencing stage of the concepts and themes within each category.
CHAPTER 5

5 DESCRIPTIVE ANALYSIS OF CATEGORIES

5.1 Introduction

Following the field work all data were carefully arranged in three separate documents. These were headed as 'patient data', 'staff data' and 'observation data'. During the content analysis the emergent themes were transferred to each of the most appropriate categories. In this chapter the emergent data findings of each of the eleven categories are described in detail. However, since this chapter is descriptive, I try to limit my explanations and interpretations of the data here as far as possible. In describing the data verbatim quotations from the participants are used to stress the themes. At the end of each statement I have identified the source of the quotation, page number of the document and the actual lines where the quotation can be found.

I realise that, while describing the findings of individual category, themes from other categories sometimes overlap. At all times an effort is made to recognise such overlaps. In order to make sense of each category and simplify the data findings during the descriptive phase, some of the categories have been subdivided under different sub-headings as groups of themes emerged in each category. Not all the emerging themes of a category have been recognised during the descriptive phase. The themes that are put aside at this stage are recognised within the discursive sections of the next chapter. Since my research focuses on staff and patients' perception of privacy of the person these data have been graphically presented (see
section 5.2.6) to emphasise its importance in the light of the overall findings. However, I did not feel that further statistical or graphic representation of my findings would be relevant or helpful, since my study is qualitative in nature, and statistical representation could detract from consideration of the human relations and understanding.

5.2 Category A: Conceptions of privacy

Having critically analysed the data within category A, the conceptions of privacy as perceived by the participants are now described under the following headings:

- Definition of privacy
- Meanings of privacy
- Having neighbours of choice
- Privacy of information
- Importance of privacy
- Privacy within the NHS wards

5.2.1 Definition of privacy

Individuals had different perceptions of privacy, for example, to some patients privacy meant freedom from intrusion of their personal space and territory by the health professionals, respecting their personal autonomy and freedom from unexpected interruptions of their daily routine. To others privacy meant to have their personal data respected from other patients and strangers. Taken as a whole the data
gathered showed that both the staff’s and patients’ definition of privacy to be very similar to the working definition outlined in section 2.3. Clearly, patients were expressing their feeling and ideas about relinquishing, negotiating or being threatened by pressure on their boundary of ‘self’, that is, their identity, worth, autonomy (or control) and space (or territory).

It is apparent from the findings that, as might be expected, the notion of privacy differed from individual to individual. A wide variation of the definition of privacy had emerged. Definition and weight given to privacy were different depending on the mobility of the patients for their care and their experience of being a patient and other factors.

For example, on asking patient 44 who was being cared for in the main bay with five other patients, to explain what privacy meant to him, at first he found it very difficult to articulate. He replied:

*I don’t know. Sharing this room with people is definitely not privacy. A word does not come in my language. In such a hospital you have privacy of your thoughts only (UIP-50: 3-5).*

Although most patients acknowledged that the study of privacy is important, when they were asked to define it, this statement shows, they had never thought of privacy as a real issue in hospital. Similarly when patient 69 was asked the same question, he too had great difficulty:

*I don’t know. It was a mixed ward when I was here before (UIP-67: 15).*
Patient 69 had carried on explaining that on his previous admission to the ward he was nursed in a very different set up. He tried to suggest that in a mixed ward, where female and male patients were nursed together in the same bay, there was no privacy. When the same question was raised with patient 207, his reply was very illuminating:

*It is difficult to define. It is very personal (UIP-120: 18-19).*

It is apparent therefore from the above statements that patients found it difficult to conceptualise privacy. The understanding of privacy was very personal, as highlighted by patient 207. This was again reinforced by patient 312 who was being cared for in one of the 8-bedded bays of Ward C. According to patient 312:

*Privacy is difficult to explain (UIP-134: 43-44).*

Similarly, as far as patient 157 was concerned:

*Personal privacy does not exist on this ward. On this ward only nurses define privacy... But most of the times patients remain in the gaze of other patients. For me privacy is when I draw my curtain around me. But there is no privacy up here, others can hear me even if the curtain is drawn (UIP-102: 38-41).*

According to patient 157’s statement, privacy did not exist in the main bay of the wards. He felt that it was the staff who defined privacy for the patient. This was done by either closing the curtains around the patient’s bed in the main bay or placing the patients in the side room.

Similarly, when staff were asked to define privacy, they too had difficulty. According to Nurse 10, since patients are individual beings, privacy means doing
simple things for them like drawing the bed curtain and respecting their confidential information \((SIN10-115:11-19)\). With the help of analogies, nurse 10 expanded that a human being has two forms of privacy: physical privacy, which can be maintained by closing the bed curtains; and information privacy, which should be kept confidential whenever possible.

The format of defining privacy was stressed by doctor 5. He explained:

*What privacy is, it has two things: one related to the notes, patients’ information with regards to their medical condition and the other is related to privacy in conducting a history and examining a patient* \((SID-34:3-5)\)

In one way or another, it was clear from most staff and patients that they understood the differences in the two forms of privacy: privacy of the person, and information privacy. At first, although they had difficulties in conceptualising the term privacy, they found it easier to explain the definition of privacy through the use of various analogies.

**5.2.2 Meanings of privacy within the NHS setting**

During the formal and informal phases of the interviews, patients were asked to elaborate on their understanding of the term privacy. As a researcher I was interested to find out what privacy meant to them while they were being cared for in the NHS wards. In order to facilitate this process, patients were first asked to explain the difference between being at home and being a patient within a ward setting. To this question, without exception, patients noted a huge difference between their own home and a NHS ward. For example for patient 1:
Chapter 5: Descriptive analysis of categories

Well it's totally different. You are with people [in a hospital] you don't know. That's the big difference. You are living at very close quarters with people that you don't know (SIP-1: 19-20).

When I asked the same question to patient 4, he replied with a broad smile on his face:

Freedom [at home]. [In a hospital], it's like a set time when you have to have your medication or whatever and you have to ask permission to do almost everything (SIP-26: 31-32).

For patient 6, the difference between being at home and being in a hospital was:

Well there is quite a difference, I think. At home you are more relaxed in your natural surroundings even when you are not feeling too well. At least you feel safer at home (SIP-38: 19-20).

In short, all the patients agreed that there is a difference between being at home and being in a hospital. According to these patients, they did not have freedom within the NHS wards. To a large extent it appeared that their personal autonomy, even when they were competent, was taken away from them. Their daily activities were based on routines. They had to get up and received medication and meals at certain times of the day.

One of the common examples that the patients used to elaborate on the meanings of privacy was the importance of having their own space, in the form of having a side room with all its added facilities, like having their own sink, toilets, shower units, radio and television. These features were strongly scored by nine patients. Thus, when patient 1 was asked to explain her understanding of privacy, she replied:
My idea of privacy is really having my own little space and I suppose inviting people into it but I put that aside when I come in to hospital (SIP-7: 20-21).

For patient 1, privacy meant having her own space and territory in which she could do whatever she wanted away from the gazes of others. To this patient having physical walls and barriers were important to keep away unwanted individuals from her territory. She indicated that, in her precious space, the final decision of inviting people remained with her and the length of time they were to stay there with her.

This notion of privacy was reinforced by patient 2, to whom privacy meant being in a side room and being in control of his territory and space where he could invite the number and type of visitors whenever he liked, and be involved in any activities within reason. According to patient 2, who was being cared for in the side room, privacy meant:

Well in this private room I can have as many visitors as I like within reason. My visiting times are not as strict. They stay as long as you don’t make too much noise late at night or anything like that, my friends are allowed in. It’s a lot more private in here (SIP-8: 33-36).

To patient 2 the concept of privacy was also receiving intimate care in private without any physical disturbance from strangers and staff. He explained:

For instance, my fiancée comes in and half of the time now I will let her give me a bed bath... I just have a little bit more care and attention from my fiancée and it’s just nice that we are in a private room. We can shut the door and basically people knock on the door before they come in and if we are busy doing something or filling out forms for insurance we can say ‘sorry, can you just wait a little while’ ... It’s a lot more private (SIP-8: 40-46).
Similarly, when patient 207 was asked to elaborate on his understanding of privacy, he said:

*It is very personal. But I think it is largely to do with having one's own space. It is again a mental thing. To me privacy means having own space so that I can move around freely (UIP-120: 18-20).*

Patient 207 supported the subjective nature of privacy. According to this patient, it depended on the individual's upbringing and his psychological and social make-up. This was supported by patient 42 when he said:

*To me privacy means not to be exposed. It all depends how private you are. It depends on your comfort level and what you feel comfortable with. You reflect more on privacy when you think of your condition. The older you are the more private you want to be (UIP-48: 35-38).*

It is apparent from patient 42's description of privacy that he normally did not think of privacy as a basic need as society generally thinks of food in everyday activities. To him the issue of privacy only became important when one is ill or has more experience of life. It appears that when patients are in hospital they have plenty of time for reflection and the meaning of privacy becomes more important when one is ill and whenever one has lost one's own space and territory. To patient 42, not to be exposed to strangers was important, as the features of one's body are a very private matter.

### 5.2.3 Having neighbours of choice

To certain patients, privacy meant being in the company of individuals who have similar characteristics as their own so that interactions and interrelationships can take place without any undue friction. A hospital bay allowed a congregation of six
(Wards A and B) or eight patients (Ward C) to take place without their wishes or direct control. For example, to patient 321 (Ward C), privacy meant, besides having the facilities of a private side room:

To me...privacy also means being in the company of your own choice; not being lumped with everybody as here, with due respect to these patients. As a private patient you tend to have different groups of patients as company (UIP-131: 49-50 and 132:1-3).

It is obvious that this patient was not very happy ‘to be lumped together’ with other patients in the same room. She was rather displeased with the company she was forced to keep. She would rather be with patients of her choice and hold conversations with individuals who were ‘on the same wavelength’ as herself. However, not all patients showed overt dissatisfaction when they were being ‘lumped together’ with others. For example, when patient 348, who was being cared for in Ward C with seven other patients in the same bay, was asked to enlarge on her feeling of being with strangers on the same ward, she replied:

It is OK if you are not desperately ill. It will be very disturbing when one is very ill. When visitors come, it can be very disturbing because of the overcrowding. They can be noisy. I like the companionship though. It would be better with four people. It gets airless and very stuffy (UIP-137: 29-32).

It is evident that patient 348 liked the company of others, albeit with certain reservations. According to this patient, such companionship is only tolerable as long as a patient is not very ill. In illness, the presence of many strangers could lead to experiencing uncomfortable feelings owing to crowding effects and noise levels within the bay.
5.2.4 Privacy of information

To some, privacy meant respect for their confidential information. This issue tended to be more emphasised by staff than patients. For instance, according to Nurse 1:

> We have to make sure that other patients in the same room are not actually aware why these patients are in, like suicide attempts, psychiatric problems, because I am pretty sure that these patients or clients would not want everybody else to know why they are in there (SIN-48: 22-25).

It is very interesting to note that for this nurse, information with regard to mental illness or suicidal attempts is seen to be very private, whereas information with regard to physical illness is seen in a different light. For example she went on to say that:

> But if you have got, for example, a fracture like a femur it's more likely that somebody else will find out in the room. But with something like schizophrenia and if you have had a suicide attempt, I feel that is something quite private that the patients really don't want other people around them to know (SIN-48: 23-30).

This aspect of information privacy is explored further when data from category E is presented in detail.

5.2.5 Importance of privacy

Nearly all patients and staff had agreed that the respect for personal privacy was important. When this question was specifically raised with patients 5 and 10, they replied:
Yes, yes, after all you are still an individual when you come into the hospital, aren’t you, and you still want to be treated as an individual and with respect (SIP5-35: 41-43).

I certainly think it is important (SIP10-58: 44).

For some, particularly staff, respect for privacy was seen as a basic need and it is as important as nutrition and sleep. That is what nurse 2 implied when she said:

Well I could say that. I feel it should be like that (SIN-59: 38).

Receiving intimate care, for example using a bedpan in bed, using a commode by the bed side, being given a bed bath or visiting the bathroom were viewed by both staff and patients as a very important private matter. For example, according to nurse 1:

I’m more than certain about privacy when I can actually visit the bathroom or do what I need to do, you know in private. That is something I would consider quite important for myself actually (SIN-50: 11-14).

We saw earlier on that to patient 2, the use of a bedpan was a very personal thing and according to him it should only be used in private. When he was very ill and could not exercise any control, he could tolerate the help of staff with his intimate body functions. But when his condition had improved he was adamant that:

They don’t put me on it [bedpan] any more or they haven’t put me on it since I’ve been here. I would not let them. I would put myself on it. I would ask them to just get me the bed-pan and then leave and I would sort it out from then on (SIP-16: 7-9).
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To this patient the presence of a catheter was not as personal as the use of a bedpan. He maintained that the use of a bedpan was a very private matter. He reflected:

* Whereas with the catheter, I don't think it is very personal; but I don't think it's as personal as going to number two [using a bedpan] in the toilet ... I think that is probably the most personal thing I could think of in my view to me that is like number one personal (SIP-16: 13-16).*

He went on to say:

* I will maintain that as long as I am able to lift myself off this bed with one or two arms and slide something under me I will do it myself (SIP-16: 20-21).*

It was very interesting to note that when patients and staff (nurses and doctors) were asked to place privacy on a scale of importance, compared to receiving medicine or any other medical and nursing care, nearly all patients and staff stated that receiving medicine was more important than having personal privacy. For example, when nurse 1 was asked how she would equate privacy with maintaining personal hygiene or giving medicine to patients, she made it clear that nurses generally never considered the issue of privacy as a top priority:

* I have never thought of it (SIN-54: 27).*

When she was questioned further as to where she would place a patient's privacy on a scale of 1 – 10, if number 1 on the scale was more important than number 10. She stated that:

* I would put it probably 4 or 5 (SIN1-54: 39).*
When she was asked the same question with regard to patients receiving medication, she was very confident in her answer:

*Well I would have to tell you, [number] 1. (SIN-54: 6).*

This nurse's main reason for placing privacy at a lower priority was, according to her, because medications were prescribed by a doctor, whereas privacy was not. She explained:

*Yes, yes because it's a priority [giving medication]. I have to follow, you know, doctors' orders and in order for patients' safety they might need the medication (SIN-54: 10-11).*

When a house officer was asked whether he had ever thought of prioritising the patients' privacy compared to giving medicine when treating his patients. He replied:

*I have not thought of that. I don't know. Of course, if the patient is very ill, for example, with multiple PEs [pulmonary emboli], his medication will come first (UID-55: 37-38).*

On pressing the same house officer further if he had ever thought of prescribing privacy and dignity for a patient to the nursing team, it was noted that he became very quiet before replying:

*No. I have never prescribed maintenance of dignity and privacy for a patient. I have not thought of that (UID-55: 42-43).*

When patients were asked to indicate what aspects of care that they were most concerned about in relation to the issue of privacy, many patients thought immediately of their medical condition, cancelling of their operation and the quality of food in the
hospital. To many patients the issue of privacy was not seen as important as having safe medical treatment. For example, according to patient 2:

I'm most concerned about them making mistakes, which has happened since I have been in here (SIP-I1: 25-26).

Similarly, when patient 157 was asked to explain the importance of privacy to him, his reply was rather blunt:

I do not regard my life as private. Of course, my thoughts and my religion are private to me. I have no desire to be private (UIP-102: 13-14).

It was obvious that to patient 157 the issue of privacy was not an important issue in a hospital. He was adamant that patients did not come to hospital for privacy but to receive physical treatment. It is clear that to this patient receiving his medication was more important than having privacy in a hospital, because as he later explained:


Similarly, patient 5 was also supportive of the argument that receiving medication was more important in a hospital than the maintenance of one's privacy. He said:

I think it got to be medicine really, because that's got to be the crux of it. That's what you come into hospital for: to receive treatment (SIP-36: 32-33).

It was not surprising to receive a similar answer when patient 13 was asked to comment on the importance of privacy in NHS wards. This patient was being cared
for in Ward B, as one of six patients in the main bay. He was very forceful in his explanation:

Oh yes, I mean, if you come into a hospital you know you are giving up a significant chunk of your autonomy and dignity ... and your privacy for a period of time because that's the price of getting yourself treated and the judgement is whether you need to give up so much of it to get treatment... (SIP-74: 43-50).

It is evident from patient 13's answer that overall patients were prepared to sacrifice their privacy for the price of receiving their medical treatment. Does this statement imply that privacy would not be able to compete on equal footing with medical treatment as the latter was perceived more important than privacy in the mind of these patients? It appeared that this was the very question that patient 13 was trying to ask himself: 'should patients have to give up so much of it to get treatment?'

On the other hand, when staff were asked to comment on the importance of respecting the patients' privacy in relation to them receiving their medical treatment, it was very fascinating to find that many staff thought that the concepts of medical treatment and privacy are of equal importance. For example, according to doctors 4 and 5:

Ehm, privacy, and medicine too, they are both are equally important (SID-28: 4-5).

I think they are both as important as each other. They are both important (SID-39: 40).

Although both medical staff stated that the issues of privacy and prescribing medicine were of equal importance when caring for their patients, there was a hint of
hesitancy in both answers. This is because while the first statement started with ‘Ehm’, the second speaker was not sure of his answer and started with ‘I think ...’.

A similar type of answer was received from the nursing staff when they were asked to comment on the importance of privacy. Most felt that both privacy and medicine were of equal importance, yet with the same degree of hesitancy as the medical staff. For example nurses 14 and 9 replied bluntly:

Yes, in a way (SIN-152: 38).

Yes (SIN-109: 34).

5.2.6 Privacy within the NHS wards

Although most of the patients and staff concurred in many instances that respecting the patients’ privacy was important in a hospital, the majority of the formally interviewed patients (77%) and the staff (92%) accepted that patients had little privacy within the NHS main wards (figure 2).
These findings were also supported by observations. Patient 32 who was transferred from a single-bedded side-room to the main bay with five other patients, explained to me during an informal interview:

*There is no privacy up here. You can hear each other's conversation. When I want to talk to my relative I have to whisper, same thing on the telephone: you cannot talk about other things apart from being just short (UIP-42:15-17).*

Patient 32 stressed that patients did not have information privacy in the main bay. Although each patient had a personal telephone on his or her locker, the privilege of having this luxury meant that patients had to pay the price in privacy. Similarly, the following sample of patients' replies reinforces the points that when patients were being cared for in the main bay there was no privacy:
Not really. The staff have no time for niceties up here. They are so busy (UIP-86-79: 3-4).

There is no privacy at all in such bays. The place is made for nurses so that nurses can see all the patients. We had [it] like this in the army... (UIP107-81: 37-38).

What privacy? The answer is no. Most intimate things are talked about and I can hear everything. It can be very embarrassing sometimes. We do not expect any privacy in this place (UIP109-95: 39-41).

It is clear from patient 109's answer that many patients did not expect any privacy when they entered a NHS hospital. The reasons for such expectation will be expanded in the next chapter. Generally patients assumed that staff were too busy for such 'niceties', as indicated by patient 86 above. According to this patient, respect for one's privacy was a luxury that could not be afforded in the present NHS climate.

Patient 1 was very pragmatic about her expectation of privacy in a hospital. She said:

Well, I think, you can't really expect to have very much privacy on a public ward in a public hospital even with only six patients. You know the beds are reasonably close together. I don't think anybody can really expect there's going to be an enormous amount of privacy (SIP-1: 49-50 and 2: 1-2).

Patient 157 was very lucid in his answer when he was asked whether patients had privacy in the main bay of Ward B. This patient was being nursed with five other patients. According to patient 157:

Personal privacy does not exist on this ward. How can it be?... They come along and draw the curtain without asking you. But most of the time patients remain in the gaze of others. For me privacy is when I draw my curtain around me. But there is no privacy up here. Others can hear me even if the curtain is drawn (UIP-102: 38-43).
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Like many other patients, patient 157 was very adamant that as far as personal and information privacy was concerned, such things did not exist on a ward. It was the hospital staff who decided when a patient’s curtains should be closed and the level of privacy that should be maintained on a ward. This finding was also supported by my own observations that have been enlarged in other sections.

When patient 44 was asked to explain whether privacy existed on a ward, his answer was very illuminating. According to him, certain patients deliberately gave up their privacy on admission to hospital. He explained:

> You give up your privacy when you come to the hospital. You have to let down your barriers (UIP-49: 49-50).

Similarly, when staff were asked whether patients had privacy in NHS wards, many of the responses received were mixed but mainly holding a negative stance. For example when nurse 1 was asked to comment about patient privacy on NHS wards, she simply replied:

> On the ward there is no such thing as privacy, is there? And as I was saying earlier I know it's only a little point but there is nothing worse than having to toilet yourself with all these people around you and we nurses tend to forget that it is not normal doing it in surroundings like that ... because of smell (SIN-56: 8-11).

Nurse 1 was adamant that patients did not have personal privacy on the ward. She cited a very common example to stress this point. According to her, since personal toileting is a very private matter, the bedside could not provide the extent of privacy that a patient deserves during such an activity even when the bedside curtains were fully drawn. According to her, other patients in a bay would know what was
happening behind the curtain and the pervading faecal smell was bound to affect other patients in the bay.

Similarly, nurse 3 reinforced the point that when patients were admitted to the ward, they tended to lose their personal privacy. She reflected this issue in the following way:

*I would say generally when somebody comes into hospital ... privacy that is enjoyed at home ... in many respects it is gone out of window when they are on the ward because there are so many people grouped together (SIN-66: 42-45).

According to nurse 3, patients did not have personal privacy on the ward because it was unnatural to have so many individuals together, either six or eight patients in a bay. This nurse’s comments reflect the viewpoint of patient 321 (Ward C) who said that there was no privacy for patients in the bay because they were ‘being lumped with everybody, as here, with due respect to these patients’ (UIP-131: 49-50 and 132: 1-3).

Nurse 6 was concerned that dying patients were not given the intimate privacy that they deserved. Being cared for in the main bay with other patients, albeit with the curtain drawn, was not very conducive for the well being of either the dying patient or other patients on the ward. This nurse felt that such patients, when they reached ‘the last leg’ of their lives, should be given a side room where ultimate privacy could be provided. Nurse 6 stressed:

*And it’s hard to move round her because with all care we have to turn her and also there’s not a lot of privacy for her in some ways. You see, they
tend to put people who are dying in the side wards which I don’t necessarily agree with but when it’s so close like this it’s sort of... I’m not sure how it’s affecting the other patients or how good it is for her (SIN-78: 44-48).

The response that doctor 6 gave was typical of the answers I received when I asked other doctors whether patients had privacy in the main ward. This doctor’s reply was:

We unfortunately only have the curtain and that is insufficient. I mean you cannot guarantee privacy and intimacy when the neighbour can hear exactly what you have told the patient. You can at least try to do the curtain business, although the curtains as you well know are very insufficient because they don’t close properly and they don’t allow sufficient privacy really (SID-42: 43-47).

It appears that certain staff tried to create a climate of privacy. However, it was obvious from previous comments that although both patients and staff knew that such a physical climate for ensuring privacy could not be maintained, a perfunctory gesture of drawing the bed curtain was carried out by the staff, like the ‘curtain business’, as doctor 6 put it.

Nurse 14 reinforced the previous statements, that generally patients did not have much privacy in the main bay. According to her:

Well I wouldn’t say there’s much privacy, ...I wouldn’t say so, because of the environment because of the situation really, if only it was one room. In a single room I would say there is privacy. We are trying to maintain privacy by drawing the curtains but there is no privacy really because whatever they say another person can hear you on the other side even if you draw the curtains... there’s no privacy at all (SIN-147: 1-8)

Nurse 14 stressed the point that patients had limited personal and information privacy on a main ward. Even if the curtains were closed, because of the closeness
of beds, any private matters being discussed would be heard by other patients. In short, it was impossible to keep anything within the private domain of a patient. She reckoned, though, that to a large extent privacy could be maintained in a side room where patients were usually cared for in a single-bedded room with all its modern facilities.

However, not all patients had agreed with the above comments that patients did not have privacy in the main bay. Some patients were prepared to accept the fact that despite the physical state of NHS ward, there was certain privacy in the bay. This group of patients categorically believed that closing the curtain had the effect of ensuring privacy from the main ward. For example, when patient 9 was asked whether patients had privacy, he replied:

*Up to a point I think yes ...well if you want privacy you can draw the curtains around the bed* (SIP-50: 45-49).

When a similar question was asked of patient 16, he was very philosophical in his reply. He said:

*Ehm yes, I suppose in the environment that it is at the moment, I don't suppose you do too bad for privacy really when there's only just 6 beds in a ward. I suppose everybody's fairly independent, aren't they, of each other. So nobody interferes with you that much unless you get into trouble* (SIP16-85:41-45).

According to patient 16, patients generally had privacy because all the six patients in his bay were mobile and each patient behaved independently of the other patient. In fact this patient believed that he was fortunate in a way to be placed with only six patients in a ward.
Many patients were convinced that there was more privacy in the side room where patients were cared for in a single-bedded room with individual toilet, sink, shower room and usual audio-visual entertainment facilities. For example, according to patient 2:

"Well in this private room I can have as many visitors as I like within reason. My visiting times are not as strict. They stay you know as long as you don't make too much noise late at night or anything like that, my friends are allowed in. It's a lot more private in here (SIP-8: 33-36)."

In many respects this patient could do as he wished in the side room. He was allowed as many visitors as he could have and most importantly, he could enjoy the company of his visitors without the glaring gazes of strangers around him, as was highlighted by patient 157 that in the main bay ‘patients remain in the gaze of others’ (UIP157-102: 39-40). Again the comments of patient 160 confirmed the majority views of patients that the side room provided more privacy than being in the main bay. Patient 160 was recently transferred from the side room to the main bay where he was being cared for with five other patients. According to patient 160:

"Last time I was in the side room, there is more privacy there ... It is much better being in the side room. I could conduct my own business there. It was very private for me. If you are ill I suppose the main bay is a good idea where people can keep an eye on you. On the other hand you still want peace and quiet. So the private room is a good idea UIP-104: 14-21)."

To patient 160 the side room was like being at home or in his office. In the side room he was able to conduct his own private business which he could not do in the main bay in the company of five other patients. The side room was very satisfactory to him because he could continue with his business affairs in the hospital.
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However, to certain patients, being a patient in a side-room meant that they had to face different problems. Patient 2 explained:

*Being in a side room gives you a lot of privacy and after 26 or 24 days I suppose a lot of privacy during the day, it gets a bit much and you would like to be with people or seeing things move, watching the world go by...I am bored stiff, there's no movement, there's nobody walking around. There's no life. It's just me and four walls. (SIP-12: 36-42).*

Although having privacy is important, patient 2 thought that too much privacy was unhealthy to the well being of an individual. At times he became very lonely and staff tended to forget his existence in the side room. He missed the company of others and felt isolated within the four walls of the side room.

5.3 Category B: Territory and space

Category B is about the patients' space and territory. This section is divided into two parts. The first part of the data illustrates the ways and the various mechanisms that staff and patients had utilised to maintain the patients' personal space and territory during their stay in hospital. The second part of the data shows the extent to which the patients' space and territory were deemed to be invaded by the staff.

When patients enter a NHS hospital they were either housed in a single-bedded room, or in a bay with six (Wards A and B) or eight patients (Ward C) whom they had never met. Generally patients were given no choice as to where they would be located and they were hardly introduced to other patients by the staff. The introduction to other patients was left entirely to the patients themselves.
The patients' only private place around them was the bed, which was roughly 72 inches from the next bed in Wards A and B. In Ward C, that comprised of eight patients in two of the bays, a distance of 36 inches separated these beds from each other. Patients were allocated a small unlockable cupboard, the bottom shelf of which was usually occupied by a personal bowl that was used by nurses for washing facilities for the patients should they require this. This locker was usually positioned on the right hand side of the patient. There was also a bed table on four wheels and a comfortable upright soft chair, which was always positioned by the bed. Each bed had the facility to be screened by a railed curtain that was made of colourful cotton fabric. The purpose of the curtain was to provide some personal space and territory for the patients within which any intimate activities could take place in the privacy of the fully drawn (closed) curtain. On each locker a personal telephone was located that could be used by patients at any time with the aid of pre-paid facilities organised by the hospital. The location of so many beds in a bay gave the impression of overcrowding, particularly in the morning when the beds were being made and linen trolleys were being wheeled about by the nursing team. At one such occasion, the following activity was noted:

*Patient 305 had gone to the toilet. Since the space is occupied with two linen trolleys, the patient could not go to his bed on his way back from the toilet. He had to wait for at least five minutes for his bed to be made and enough space for him to sit by his bed. I do not think that the nurses noticed the dilemma that the patient was in, nor did the patient raise any issues of concern (GO-127: 6-10).*

This observation statement shows that in the main bay patients did not have any set territory of their own. They could not say at all times that the bed space around them was their own. It was apparent that it was the hospital staff who defined space and
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territory. When patient 312 was asked to reflect on the environment of the eight-bedded bays, she was quite sincere in her reply:

_You do feel squashed a bit as the beds are so close. After a while I suppose you tend to become used to it. It does not bother me though (GO-134: 27-28)._ 

Although this patient felt ‘squashed’ in the ward environment, she was very philosophical about it. The closeness of the beds did not ‘bother’ her too much as after a while in the hospital she managed to orientate herself to the routine of the ward.

Nurse 7 explained the state of the ward environment (Ward C) quite well when she declared:

_Its just too crowded basically, there’s not enough space for all the chairs. There’s not enough space for lockers for everyone either. So they don’t have anywhere to put their things so basically they end up putting them in big bags, and when you pull the curtains round they are so close that they can hear everything anyway; so it makes no difference really pulling the curtains round (SIN-90: 46-50)._ 

This statement graphically explains the state of the bed environment of the patient. For example, the closeness of the beds made the ward appear overcrowded. The space was so limited that very often patients did not have enough space in their own lockers to store their personal belongings. Hence, they resorted to placing their belongings in bags. According to this nurse, in such an environment, the drawing of the bedside curtain made a mockery of the attempt to maintain privacy as the patients were physically so close to each other.
5.3.1 Maintenance of territory and space for patients

During their stay in hospital patients normally regarded the allocated bed, locker and the bed table as their own. This was clearly highlighted by patient 157 when he was asked whether he ‘regard[ed] the bed, locker and the bed table as his own during his stay in hospital’ (102: 16-17). He simply replied:

Yes I do (UIP-102: 19).

While patients were in bed or sitting by the bed, various mechanisms were utilised by staff to ensure some sort of space and territory for patients. One of the main ways was for the staff to close the curtains around the patient. This was reaffirmed by patient 1:

I don't think you can have privacy on a hospital ward. I mean you know a little bit of privacy with the curtains drawn (SIP-7: 13-14)

While patients had a choice of closing their own curtains to ensure their personal privacy, it was very interesting to note that I rarely observed this activity in any of the wards. Drawing the bed curtains was mainly left to the hospital staff. This was reinforced by nurse 7 when she was asked whether she had noticed it patients close their own curtains to ensure some sort of privacy (SIN-92:26-27). To this question the following reply was received:

I haven't. No (SIN-92: 29).
It was noticed that bed curtains were regularly closed on certain occasions by staff, particularly when giving intimate care to their patients. For example, certain doctors undertook the ritual of closing the bed curtains when they wished to examine their patients physically. On the other hand, nurses would attempt to close the bed curtains when giving such personal care as allowing the patient to use the commode facilities by the bedside or bed bathing the patients or when changing the patients. On these occasions, the closing of the bed curtains was automatically carried out by the nursing staff without ever asking the permission of the patients. For example nurse 1 explained:

Depending obviously, if they can walk to the toilet, I will walk them to the toilet if that can be done. Otherwise, we are talking of course by the bedside or in the bed, all I can do is draw the curtain around (SIN-50: 24-26).

On one another occasion, the following activity was noted during a doctor's round:

The team moved to patient 5. Before the doctor could examine the patient physically, the nurse shut the curtain (GO-23: 46-47).

This observation statement clearly illustrates the point that the nursing team made some sort of gesture in drawing the curtain to maintain the personal space and territory for the patient. For example, before the doctor could examine the patient physically, the flimsy physical barrier was drawn around this patient. Again on another occasion the following activity was observed:

Something is wrong with patient 124. The health care assistant went to him and drew the patient's curtain straight away (GO-93: 13-14)
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This activity shows that at least all grades of staff made an effort to ensure some sort of privacy for the patient. For example, as soon as it was noticed that something could be wrong with patient 124, the health care assistant (HCA) immediately drew the curtain to create a physical barrier from other patients. By barring other patients’ view, the HCA hoped to provide some privacy for this patient.

Even the medical staff were prepared to follow this unwritten code of drawing the bed curtain when they felt it was appropriate to do so. On one of my observation periods, I noted the following activity of two doctors:

*Patient 55 is sleeping on his back ... Two doctors walked to this patient. They tried to shut the patient’s curtain, but it remained half opened (GO-57: 14-17).*

It was a common occurrence that when staff wished to perform intimate activities at least, they always made an attempt to draw the patients’ curtain. This was seen during the doctors’ ward rounds, bed bathing of patients, use of the commode by patients at the bedside and other intimate activities undertaken by the staff by the bedside.

However, on odd occasions, it was noticed that certain patients’ curtains were left closed either fully or partly although no overt activity seemed to be taking place at that time. On one such occasion, the following observation was recorded:

*Patients 2 and 5’s curtains are fully drawn. No staff are around. Where are they I am wondering. No nurse came into this bay for nearly 10 minutes (GO-24: 34-35).*
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It later emerged that the nurses who had closed the curtains of these patients had completely forgotten that they had done so. When the nurses arrived on the scene they continued the bed making activities as if nothing had happened. It was interesting to note that none of the patients made any comments about the closed curtains. On another occasion the following activity was observed:

Patient 169 is lying on top of his bed. He is listening to his own radio and reading a book. His bed light is on and the curtain is half drawn, thereby separating the view from patient 182 (GO-114: 22-24).

It was apparent that patient 169 had intentionally closed the curtain between patient 182 and his own bed to ensure some degree of privacy while he was reading his book and listening to the radio. Although the patients lying opposite him could see him, he was quite deliberate in the maintenance of a barrier between himself and his neighbour.

On Ward C, during one of the observation periods, the following scene was observed. An elderly Muslim woman was being cared for in one of the eight-bedded bays. She was dressed in a Muslim costume and was lying on top of her bed. All other patients were attired in their night dresses or hospital gowns. At this point the following observations were recorded:

Patient 345 (patient 9) is sitting on her bed. She is wearing her own clothes. She is of Asian origin and is dressed like that. I am told that she cannot speak English ... The curtain between beds 9 and 10 are drawn so that the view of patient 345 is completely blocked from patient 346 who is in bed 10 (GO-136: 17-21).
What was puzzling about this case was the presence of the half-drawn curtain between patients 345 and 346. Was the curtain drawn to ensure some sort of privacy for patient 345, or for patient 346 from patient 345? When I enquired later about this drawn curtain I was informed by one of the nurses that the curtain was drawn to ensure privacy for the Asian woman. This raises the issue of ethnicity, culture, religion and privacy, which is clearly a very important one. I do not specifically address this issue in my study. Since this particular hospital is located in an area that is not very diverse, it would have been difficult to study this issue with proper comparators. Further research in a more diverse environment would be very useful. In this case there is some ambivalence about the action of drawing the curtain. Was it to give some special protection to the Asian woman, and if so on what grounds? Had her views been sought? Was it to segregate this woman from the other patients, that is, to protect their 'privacy' rather than hers? This would have been questionable. (I come back to this woman, and the issue of culture, on p. 215) Issues such as this should be treated in further research.

5.3.2 Invasion of patients’ territory and space

It had been observed earlier that many patients regarded their allocated bed, locker and bed table as their own while they were in hospital. This was typically highlighted by patient 157 (UIP-102: 19). It was also noted that certain patients expected that their space and territory would be respected by staff by closing the bed curtains around them when they received intimate care (SIP-46: 47-50). Most importantly on such occasions, I assumed that access to the patients’ space and territory within the closed curtain would be sought by staff prior to entering. This assumption of mine
was found to be incorrect in the majority of my observation periods. For example, it was noticed on many occasions that, although an intimate care was being carried out within a closed curtain, certain staff did not forewarn the patient prior to entering the patient’s space. The following recorded observations typically exemplify this point:

_A washing bowl with water was soon presented to the patient. The flimsy curtain is drawn around him by a nurse... She [nurse] is moving in and out of the curtain. While the patient was being washed a House Officer (lady doctor) without any prior warning opened the curtain and wanted to see the patient (GO-21: 6-10)._  

This scenario is a typical representation of the number of occasions that were witnessed when a patient’s privacy was deemed to be compromised. Patient 4 was being washed within a drawn curtain. However, the House Officer wanted to see the patient then and there, and the only way she could achieve this was by walking through the closed curtain. Another observation scene illustrates a common occurrence of the above perspective:

_Patient 4’s curtain is closed. His dressing is being done (by a nurse). A doctor called and she started peeping through the curtain without prior warning. She went in and immediately came out, walked to the nurses’ station and asked another doctor for his opinion. They both then walked to patient 4, walked in through the drawn curtain and together completed the procedure of taking the patient’s blood (GO-40: 1-5)._  

It was very obvious from the above description of the observation that despite the fact that the patient’s dressing was being conducted by a nurse within the closed curtain, the doctor felt that taking the patient’s blood was her priority. By peeping through the drawn curtain she assessed the priority of the occasion and she was able to overrule the nurse in the completion of the patient’s dressing. However, sometimes, on the invasion of a patient’s privacy by peeping, a doctor having
realised his mistake, would withdraw from the scene having interrupted the nursing activity. The following statement of nurse 7 typically reinforces the above points:

Well, for example, yesterday I was doing a dressing on a patient with pilonidal sinus on a gentleman, yes, and he was kneeling and obviously bottom towards the edge of the curtain and a doctor just came in and said 'oh you're not ready yet'. I said, 'oh', ... no warning at all and that poor chap, I mean he was only 20 or 21 I think, he was already embarrassed anyway because it was myself and another nurse doing it ... If the curtains are pulled then there's obviously something going on so (SIN-93: 27-39).

This observation summarises the key points I have discussed so far, that certain members of staff compromised the patients' space and territory without thinking of the patients' dignity and privacy. The patient was having a very intimate care. His pilonidal sinus at the anus was being dressed. This was being done in the presence of two nurses in the intimate privacy of fully drawn curtain. Yet without prior warning this climate was shattered by the intruding doctor. The patient was already embarrassed. According to nurse 7, it was obvious that if a curtain was closed, it was human courtesy that permission should be sought prior to entering.

It is important to record that it was not only doctors who attempted to 'intrude' into the patients’ territory, nurses were equally at fault. Nurse 13 attempted to explain such a scenario quite well:

But I think on some occasions perhaps, yes, staff [nurses] do enter curtains without saying before they are actually inside the curtain (SIN-139: 16-18).

This statement was supported by observations on several occasions. It was noted that invasion of the patients’ territory and space was in fact a common occurrence by
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both nurses and doctors. In one such instance, note was made of the following activities:

*Patient 5's leg is being re-bandaged. The nurse saw me and hurriedly drew the curtain. Another nurse is moving in and out of the curtain without any prior warning. All conversations can be overheard. Another nurse walked in and I could see what is happening inside (GO- 5: 22-25).*

In the above scenario it was obvious that my presence had some sort of effect on the staff. What was subsequently recorded was found to be an important issue. For example, although the patient’s dressing was done within a drawn curtain, the other nursing staff were quite happy to walk in and out the patient’s territory without the patient’s permission.

It was also a very common occurrence that nursing staff hardly ever warned patients prior to entering a drawn curtain. On one such occasion, the following records were made:

*The patient is using a bedpan in bed although she could sit out of bed. The bed curtain is only partly shut. I can see all the activities of the patient from where I am sitting. When the patient finished using the pan, she buzzed twice before a nurse could come. The nurse walked in the drawn curtain without forewarning the patient (GO-13: 19-24).*

The use of a bedpan by a patient within a closed curtain can be described as a very intimate activity. The nurse had made an effort to draw the curtain to ensure some privacy for patient 2. However, the observation showed that proper care was not taken to draw the curtain fully. Beside myself, other patients and visitors could see through the partly drawn curtain. What is equally important to note is that the nurse failed to give any sort of warning prior to entering the closed curtain.
In order to check that my observation had recorded the correct version of events, patient 154 was asked to confirm the observation (GO-106: 12) when she received intimate care within a closed curtain. The following reply reinforced the above findings that patients’ territory and space can be invaded at any time at the volition of staff:

 Ngô, the nurse did not ask my permission before coming in (UIP-106: 14).

However, when nurse 1 was asked a similar question as patient 154, as to whether she personally warned a patient prior to entering a drawn curtain, particularly when a patient was using a bed pan, she replied:

No, because you see, if a patient rings you, I normally approach the curtains and say ‘I’m coming Mrs so and so or Mr so and so’, and then they know I am on my way and then I open the curtains. Very few will actually stand in front of the curtain and say ‘it’s me, the nurse, I’m coming in now Mrs so and so’ (SIN-51: 10-14).

Nurse 1 intimates that, as far she was concerned, she alerted a patient prior to entering a fully closed curtain, although this was not evident during the observation. According to nurse 1, prior to entering the closed curtain she normally said quite loudly, ‘I am coming in Mrs so and so or Mr so and so’. This nurse was also quick to point out that as far as other nurses were concerned, very few of these nurses would ask a patient’s permission prior to entering a drawn curtain.

On two occasions it was noticed that when a curtain was fully closed, certain staff did respect the patient’s privacy. Prior to entering within the drawn curtain, they made an
attempt to warn the patient and seek his permission, albeit without waiting for consent. For example, on one occasion, the following activity was noticed:

Patient 12 [Ward A] has asked for a bedpan. The nurse closed the curtain fully. 'Can you lift your bottom up?' [I heard]. 'Give us a buzz when you have finished.'... At the sound of the buzzer, the student nurse walked to the curtain and said, 'Knock knock,' and walked in without waiting for a reply (GO-2: 39-45).

The above activity was carried out by a third year student nurse who was nearing the completion of her training. Prior to entering the closed curtain, the nurse attempted to forewarn the patient by pretending that the closed curtain was a door.

Again, during the same observation period, it was noticed another student nurse overtly alerting a patient of her entry into the closed curtain. I had recorded the following data:

Patient 19's curtain is partly closed. He is having a wash and shave. 'Knock knock', a first year student said, before going in through the curtain (GO-4: 29-30).

On another occasion, it was observed that a care assistant had made the effort of waiting for the patient’s permission prior to gaining access into the closed curtain. For example the following recording supports this finding:

The care assistant is passing around fresh jugs of water. He approached patient 3 whose curtain is fully drawn and said aloud 'can I come in?' and waited. 'Come in,' came the reply from within the curtain. It was only then that the care assistant walked in and served the jug of water (GO-4: 8-12).
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This activity was observed for the first time. It is very interesting to note at this stage that the forewarning signals described above was only observed during the first three days in the clinical field when staff were getting used to my presence.

Another activity that was commonly observed was the habit of some staff of leaving the bed curtains fully opened during certain personal care of the patient. On another occasion, I noticed that staff had left the curtains ajar or half-closed while undertaking personal activities with the patient in the full view of other patients or passing visitors. On one such observation periods, the following notes were recorded:

*It is nearly 9 p.m. A doctor walks into the ward. Nurse informed the doctor that patient 20 is not drinking and that a drip should be started. The doctor saw the patient's notes and strolled to the patient, having collected certain items for the drip set. I followed her from a distance. She was in a hurry. She went to the patient, selected his right hand and without further ado started placing the venflon. No curtain was drawn and no consent was sought. Within a few minutes she was gone (GO-29: 33-38).*

This observation was a common occurrence that at times staff did not attempt to close the curtains when carrying out a personal activity for the patient. It was quite in order for staff to undertake such activity in the full view of other patients.

Another record reinforces the findings that certain activities were carried out in the full view of other patients:

*Patient 4's venflon [a venous canulla] is being removed by a student nurse. She is sitting on the patient's bed. She is wearing gloves and explaining all the procedures very carefully. Patient 69 is intently watching the activity since the curtain is not shut (GO-74: 11-15).*
As explained earlier patients commonly regarded their beds, bed-table and their locker as theirs during their stay in hospital and this was confirmed by patient 157 and many other patients when they were questioned on this issue. It is therefore assumed that the space and territory around the patients' beds were theirs. If this assumption is correct, it is then presumed also that staff would always ask the patients' permission prior to sitting on their bed. As the above statement shows, although a chair was nearby, the nurse chose to sit on the patient's bed in order to complete the activity of removing the venflon from the patient's arm. Sitting on the patients' bed by staff was a routine occurrence, particularly when feeding patients, talking or during any activities that required closeness of proximity. This observation data reflects the above comments:

Patient 22 is being fed... She [HCA] is leaning over the patient and trying to feed him. She stopped after a while, then picked up a red blanket belonging to the patient, spread it on top of the bed and sat on it and continued the feeding process. (GO-7: 36-39).

In another instance, the following activity of a nurse was observed:

Patient 26 is being admitted by a nurse. The nurse is sitting on the bed. The patient is 31-year old young lady ... She has a visitor who is sitting by the nurse on the chair. Her curtain is not drawn (GO-9: 45-48).

Besides the nursing staff, the medical staff were also frequently observed sitting on the patients' bed, particularly when explaining certain things to the patient, although a chair was often found vacant nearby. For example, on one of my observation periods the following activities were noted:
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Two doctors walked into room 1 and went to see patient 37. The consultant sat on the patient's bed and started talking to the patient (GO-52: 14-15).

Besides interacting with patients while sitting on their beds, it was also observed that the patients' beds were used for other purposes. Sometimes a patient's bed was being used as a linen trolley, for example, on one occasion, the following statement was noted:

*The HCA has left a pile of bed linen on patient 109's bed, using the bed as a bed linen trolley (GO-107: 46-47).*

On another occasion, it was observed that the ward sister was seen using the patient's beds as a platform for teaching purposes while the patient was sitting on his chair by his bed. This event was recorded as follows:

*I notice sister and a student nurse are sitting on patient 65's bed while the patient is sitting by his bed. Sister is teaching the student with regard to a procedure (GO-66: 6-8).*

I wanted to find out whether sitting on a patient's bed constituted breaching the patient's privacy. Accordingly, I asked many patients, nurses and doctors for their feelings on this subject. The majority of staff and patients felt that sitting on the patients' beds was a good thing and did not constitute violating the patients' space and territory because they always asked the permission of the patients' permission prior to sitting on the patients' beds (SID-21: 41-47; SIN-94: 20-30). Although the statements from a doctor and a nurse were rather contradictory from what had been observed, the nurse reinforced the doctor's statement that staff often asked the permission of patients before sitting on their beds as follows:
Doctors don’t tend to sometimes ... but, they don’t tend to. I usually say, ‘alright if I sit down,’ and they always say, ‘fine fine’ or they sometimes say to me, ‘do sit down,’ if I’m sort of working or something; but if I do admission I say, ‘is it alright if I sit?’ and I think that the majority of the nurses I think do that (SIN-94: 21-24).

It is interesting to note in this statement that nurse 7 believed that doctors did not usually ask permission of the patients prior to sitting on their beds. On the other hand, nurse 7 was adamant that as far as she was concerned, she always sought the permission of the patient. She also indicated that the majority of nurses would ask the permission of patients prior to sitting on their beds. However, when patients were asked whether staff did seek their consent prior to sitting on their beds, the following reply was received from patient 16:

Huh, huh, good question, ehm, I suppose invariably thinking over all the times I’ve been here I don’t suppose I’ve probably had that happen to me more than once or twice (SIP-89: 23-25).

According to patient 16, it is apparent from his reply that both nurses and doctors had sat on his bed without asking his permission. When I asked him further: ‘Do you think doctors and nurses should sit on our patients’ beds without their permission?’ his reply was very philosophical:

Well, I think if there’s enough chairs around then they should use the chairs uh-huh (SIP-89: 42-43).

Patient 16 suggests that as a matter of routine, staff should not sit on patients’ beds. He reckoned that there were enough chairs about the ward for them to use these rather than choosing the patients’ beds. On the other hand many patients felt that sitting on their beds by staff was not a problem (UIP-80: 30-32), UIP-93: 32-40).
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Similarly, many staff argued that sitting on the patients’ beds would comfort certain patients (SID-7:5-45, SIN-58:25-27) and cement the nurse/doctor/patients relationship. When doctor 6 was asked whether sitting on the patients’ beds by staff constituted invading the patients’ space and territory, his reply was as follows:

No. I don't feel that I do that. I usually sit towards the end of the patient's bed and rather feel that I establish a doctor/patient relationship when I do so (SID-43: 11-12).

According to doctor 6’s reply, sitting at the end of patients’ beds was quite in order. He felt that by sitting on the bed he was maintaining a therapeutic relationship with the patient. Similarly, nurse 4 supported doctor 6’s reply when she said:

Get down to their level and whether that involves a chair or sitting on their bed I think that's fine. Concerns that we had in the past about infection control issues are not there anymore (SIN-70: 18-21).

Nurse 4’s reply is a broad representation of many staff’s mode of thinking that sitting on the patients’ beds was beneficial to both parties. Nurse 4 argued that the gesture prevented staff being in a threatening position and that, moreover, it was no longer a threat as a mode of infection spread.

At frequent intervals it was noticed that certain staff members could freely move patient’s personal items from their bed table or their locker without seeking their prior permission, even when such patients were competent. In one instance I noted the following activity:

Although patients are still eating their lunch, a cleaner moved into the bay and started cleaning their bed tables and locker. She is handling the patients’ personal items without asking their permission. The cleaner moves to patient 5. She started cleaning one half of the table while patient 5 is eating on the other half (GO-5: 48-49, 6:1-2).
This scenario raises the question whether cleaners and staff should ask the permission of a competent patient before moving their personal items. Although many patients thought that this was not necessary, others thought that staff should generally seek their permission before undertaking such activities. For example, patient 3 thought that it was politeness that staff should ask their permission before moving their items:

> It was on the bedside-cabinet and they moved the bedside-cabinet with the things on it. ... I was sitting there and watching them what they were doing and I saw every move they made ... On the etiquette side I suppose, I could just say, 'do you mind if we move your belongings over here while we do this side of the floor and then move them back?' (SIP-20: 48-50, 21:1-4).

The evidence also suggests that for patients, their lockers were very personal because they stored valuable items in them. Observation showed that staff did not give second thought to accessing the patients' lockers. The following example illustrates this point quite well:

> Nurse is accessing the patient's locker without his permission. She is looking for something. Could it be that she is looking for the patient's washing bowl? During this activity the patient is fast asleep (GO-3: 46-48).

It is evident from this description that nursing staff were too ready to delve into the patients' lockers without their permission. Should the staff do this? Another observation data documents the following behaviour of a nurse:

> The male staff nurse came to patient 83 and said, while opening the bottom of the locker, 'can I borrow your bowl? Patient 84 has no bowl and I want to wash him'. Patient 83 looked at him and said 'yes' (GO-79: 38-41).

In this example the nurse attempted to ask the permission of the patient while he was already in the process of opening the patient's locker. It is clear that the patient had no choice but to give an affirmative reply.
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When nurse 14 was asked whether staff respected privacy of the patients with regard to the contents of the patient’s locker, the following reply was received:

>Nurses ... open it[locker] and see what’s inside, there’s no privacy in there; I wouldn’t say there is (SIN14-146: 36-37).

According to nurse 14, since the patients’ lockers were not lockable, staff could access them at will. She felt that patients did not have privacy of their property in their locker, although most of them believed that the locker was theirs during their stay in the hospital.

5.4 Category C: Control and choice

The formulation of ‘category C: control and choice’ was the end product of field observations and patients’ and staff’s interviews to show the extent to which patients had control and choice over any aspects of their care, including their treatments in the NHS wards. For example, it was observed that patients were frequently moved from one position of the ward to another without their permission. This was typically highlighted in the case of patient 9 who was suddenly moved from one bed position in the bay to another. This patient had already developed a lasting friendship with some of his patient neighbours and was ‘not very happy’ (SIP-50: 18-19) to be displaced from his bed position to another in the same bay. Patients were often asked permission without waiting for an answer and were hardly ever given the choice of refusal. When patient 9 was asked whether he was given any choice of staying in his previous position, he simply replied:
Similarly, when a patient was being cared for in the one-bedded side room, such patient could be moved at short notice from the privacy of the side room to a bed in the main bay with five other patients in Wards A or B. There was no one-bedded side room in Ward C. Very often the explanation that the staff gave to these patients was that the bed was required for another needy patient. A good illustration that supports this finding was the case of patient 5 who was suddenly moved from the side room to one of the beds in the main bay. Patient 5 explained to me as follows:

Well ... They came and said, 'I'm sorry you know, we are going to have to put somebody else in here. You're going to have to go back into the main ward'. I thought, oh well fair enough, I've had it a couple of days; I've been lucky. I didn't particularly want to go back to the main ward; but you know it's a privilege in a way to have a chance to come in here because basically you can pay extra for a side room ... I regarded it as a bonus (SIP-32: 9-15).

Although patient 5 was reluctant to leave the side room, in fact she had no choice but to move on to the main bay. At first she thought herself fortunate to be placed in the side room. According to her it was a 'privilege', a 'bonus' to be cared for in the side room that only private patients deserve following the payment of certain fees.

When patients were asked to explain the difference between being at home and being in a hospital environment, a unanimous response was received that generally patients did not have the same level of freedom as being at home. For example, when I raised with patient 103 the question 'what is it like being in hospital?' the following answer was received:
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At home, I have my own privacy. I can do whatever I want. I can watch my TV if I want to or I just listen to the radio. Here, we don’t have that freedom. It is a long day up here (UIP-82: 28-31).

To patient 103 it is apparent that he had no control over many aspects of his leisure activities in a hospital. For example, he could not listen to the radio or watch his favourite television programmes as and when he wanted to. Similarly patient 191 stated, ‘There is no comparison. At home I am in full control’ (UIP-116: 15). He explained further:

I am not in control here. I have to rely on the experts to tell me what to do, when to do and sometimes how to do it (UIP-116: 21-22).

According to patient 191, it is clear that while patients were in hospital they adopted different roles. They abdicated their control and power over many of their activities and health care to the professionals. Patient 218 reinforced patient 191’s thinking:

We have no control over our own affairs up here, while we are in hospital. I have certain control, but I doubt I would be able to exercise it. In a hospital you become a patient. Outside I am an accountant. You take different roles (UIP-124: 1-4).

Patients not only lost their independence in the hospital (UIP-105:23-26) but started to rely, as in patient 191’s case, totally on the expertise of health professionals. Patient 191 was adamant in his explanation that he ‘accepted at face value any advice they gave me’ (UIP-116: 22-23). This implies that he never questioned any aspects of his care. According to patient 218, on admission to the wards patients tended to adopt different roles and become ‘patients’ in the hospital (UIP-123: 48-50). Although patient 218 felt that he possessed certain control over his own affairs, he doubted whether he could exercise it, bearing in mind the ward culture.
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It was also generally noticed that certain patients lost their control and freedom over many things that citizens outside the hospital would take them for granted. On admission to hospital many patients were quick to discard their outdoor clothing and dressed in their own pyjamas or night gowns even though these patients were fully mobile (GO-48: 8, 50:15). Other patients, particularly elderly women patients, were made to wear the hospital gown (theatre gown) even though these patients were not going to theatre in the near future.

Nearly all hospital activities were routine based. Patients had to get up at a set time in the morning. All the ward main lights were switched on at 6.00 in the morning. Patients had no choice but to be wakened at this time, sometimes with a cup of tea. In fact many patients had no control over their sleep patterns. For example, when patient 7 was asked the sort of night that she had, her reply was:

*I again got up at 5 am this morning with a cup of tea. But that drip machine of patient 13 kept me awake all night. It kept bleeping every few minutes. That's one of the things you have to put up with in the hospital I suppose (UIP-24: 11-13).*

Patients not only lose their freedom and control over their waking-up time from sleep; in a hospital environment patients had to put up with different types of noise level at night, like the presence of the regulating sound of the automated drip machine and the constant sounds of ripple beds that had great bearing on patients' sleep. During the day, it was frequently observed that when patients tried to replenish their sleep or had a quiet time to rest, their sleep or restful periods were constantly disturbed by various demands placed upon them such as doctors' ward rounds. During one of my observation periods, I noticed the following:
Patient 84 is a younger patient. He came last night. He has his hospital gown on. His bed light is still on. He is snoring quite loudly. Suddenly, he is surrounded by six doctors. He is wakened by a tap on his shoulder by one of the doctors. ... They did not introduce themselves. The lead doctor started to explain to the patient what he had done to him and his progress to date (GO-77: 35-42).

It is evident from this illustration that patient 84 was fast asleep, as he was snoring quite loudly following his major operation during the night. Yet he was wakened by a tap on his shoulder. It was interesting to note that when the group of doctors left patient 84, he immediately went to sleep and restarted snoring. Within a few minutes, this patient's sleep was again disturbed, this time by two physiotherapists. At that time the following was recorded:

After a few minutes, this patient is being visited by two physiotherapists. 'Sorry to wake you up,' one of them said. They drew the curtain and started exercising his legs (GO-77: 44-45).

The above data clearly reinforces the statements that generally patients had limited freedom and control in hospitals over affairs with clinical implications. Patient 84 was desperately wanting to sleep, yet in the space of 10 minutes his deep sleep was disturbed twice, first by the doctor's ward round and secondly by the physiotherapists.

Patients' perceived lack of control over their own affairs was also noted in other areas. They were often seen to be interrupted by staff even when the patients were involved in a very personal matter. For example, while patients were eating their food, they were frequently seen to be interrupted by various personnel. On one such occasion it was noted that a health care assistant interrupted the meal-time of patient 176 in order to take his pulse, blood pressure and temperature. The following observation was recorded:
Patient 176 is in bed ... he is eating his dinner. At the same time he is looking around him and looks rather alert. The HCA came to this patient and started doing his observation (GO-111: 23-25).

It was quite clear that this was not an emergency case. The patient was alert, yet the HCA thought to disturb his meal and record his observations.

Many patients frequently remarked that it was very difficult to have peace and quiet for oneself because of constant interruptions by staff and patients. On one such occasion patient 109 was watching his favourite TV programme in the day room when a cleaner shattered his privacy. The patient made the following observation:

There is not even privacy in the day room. Yesterday I was watching grand prix on the television. Even there, one of the cleaners started talking to me when I was concentrating on who is going to win. It is so difficult to have peace and quiet (UIP-95: 41-44).

The patients' perceived 'lack of freedom and choice' was also observed in other areas. My observation data demonstrated that patients had no control over their meal times. For example, patient 12 displayed his unhappiness when he found that his breakfast was taken away while he was in the toilet (GO-24: 37-44). Meals frequently did not arrive on schedule and by the time they arrived, the food had become cold. In one of the observation periods I recorded the following interview data with patient 61:

The people who serve food up here are awful. The food is not bad. By the time the food and tea comes to us they are cold. This morning, the tea was cold. So I refused it but the waiter was rude to me and refused to serve a fresh one (UIP-61: 21-23).

It is interesting to note that when patient 61 attempted to exercise certain control over his own affairs, that is his refusal to be given cold tea, he was met by a confrontational
attitude on the part of the waiter. It appears that patient 61 had upset the ward equilibrium and attempted to shift control on to himself. Is this what patient 218 meant when he said that ‘I have certain control but I doubt I would be able to exercise it’? (UIP-124: 2-3).

Similarly, patients generally did not have much control over their personal hygiene (GO-24:2-5) or toileting facilities, particularly when such patients were bedridden. Although some of these patients were able to use the ward toilet facilities, such patients were hardly given the choice of using them. Instead, patients were placed on a commode by the bedside and left there within a drawn curtain with another patient sitting one yard away. It was also noted that following the usage of a commode or a bedpan, not once did I ever observe that patients were given water to wash their hands. This is illustrated by the following observation data:

*Patient 4 wants to go to the toilet. Two nurses are seen pushing a hoist. One of the nurses is leaning over one of the bars. This patient could have gone to the toilet. Instead she is using a commode by the bed. Water is not provided to wash her hands (GO-9: 18-20).*

When I explored the issue of patients washing their hands following the use of commode or urinals with Nurse 11, She replied as follows:

*No. They should do. But, no, that is very rarely done on this ward (SIN-127: 43).*

When patients were mobile and with full capacity, they could meet their personal hygiene needs. However, when they were bedridden and too ill to care for themselves,
dependence on the staff meant loss of control over this aspect of their own affairs. Patient 63 represented the feelings of many patients when she observed:

*When you are sick you are vulnerable. You lose your control (UIP-63: 4-5).*

5.5 **Category D: Personal care and depersonalisation of the patient**

'Category D: Personal care and depersonalisation of the patient', concentrates on the data finding that summarises the extent to which patients' dignity as an element of privacy was maintained or compromised during their stay in hospital. The data of this category is presented under several subheadings.

5.5.1 **Introducing oneself to the patients**

It is a general requirement in western society that when one approaches another human being one should introduce oneself to others as a prelude to enabling an interaction to take place. During my observation periods, I hardly saw such introductions during the many doctors' ward rounds in the wards. Most major ward rounds were undertaken by a group of doctors and very often these were led by either the consultant or his or her deputy – the senior registrar. On such occasions, the house officer, senior house officer, the registrar and a nurse often accompanied the consultant. On other occasions the group was joined by other health professional such as physiotherapists or a pharmacist. During such ward rounds I often noticed
that patients were rarely informed about the presence of other individuals around the bed. For example, on one such round it was observed that:

While I was sitting by patient 7, a group of six doctors accompanied, by the ward sister, appeared on the scene. They are visiting patient 8. They stood around the patient and were all looking at her. The consultant, without any preamble, started explaining the progress she has made to date and the medication she is to be on. All the remaining patients in the bay are trying to follow the group's interaction (GO-21: 46-50).

In this scenario I observed that the consultant failed to introduce himself and the other members of the team to the patient. While the consultant was explaining patient 8's medical progress, the curtain was fully opened (GO-22: 1-2) at all times and this meant that other patients could see all the movements and hear precisely what was being said to the patient. When I later asked patient 8 what it was like being surrounded by so many people, the patient showed more concern about other patients listening to her than being surrounded by so many professionals. In fact their presence did not 'bother' her (GO-22: 13). In another instance I made the following observation in my field notes:

Another group of seven doctors has just visited patient 68. I went to patient 68 and asked whether he knew the name of the lead doctor/consultant. The patient knew his name and told me he is a famous man. I then asked whether he knew the names of the other doctors who had accompanied him. He replied in the negative. I checked with him whether any of the doctors were introduced to him. He said emphatically 'no'. 'They did not tell me their names' (GO-66: 15-20).

This scenario was repeated almost every time when a ward round was conducted. It was a rare occurrence when patients were introduced to other members of the group. To some patients this issue was of no importance. Although patient 68 was adamant that the consultant did not introduce him to other doctors, it did not bother him at all.
He rationalised that ‘if they were to tell me their names I would forget their names any way’ (UIP-66: 20-21). However, other patients felt that during a ward round doctors should introduce themselves to patients. This was reinforced by patient 125 and many others. According to patient 125, doctors should introduce themselves. ‘It makes you think you are human beings. It gives confidence’ (UIP-92: 23-27). Patient 157 was very forceful in his reply when asked about whether staff should present themselves to patients:

*Yes. In principle they should do so. The doctors are obtaining private information from patients and patients have the right to know with whom they are talking (UIP-103: 13-15).*

Many patients felt that it was their right to have an introduction. They stressed that doctors should introduce themselves to their patients. Patient 191 emphasized that he would have liked to have an introduction. According to him, ‘I would have liked to know whether the other two doctors were students or not. Or whether they were experts in the field I am suffering’ (UIP-116: 45-47). Patient 191 reiterated that he had nothing against students. He accepted that students have to learn, ‘but it would be nice to know who they were’ (UIP-116: 48-49).

When the subject of ‘introducing oneself and members of a team’ was raised with a lead consultant during a structured interview session, he was at pains to point out that on his ward rounds he always introduced himself to his patients and shook their hands. He stressed that he often felt offended if during a conversation he noticed that patients did not recognise him or recall his name. He thought that it was very wrong not to introduce oneself to a patient (SID-3: 28-32). When the same consultant was
asked whether he normally introduced the members of his team to his patients during a ward round, he replied in the negative and made the following remarks:

_I think that’s a very astute observation. It’s something that hasn’t crossed my mind before; because I think you will find that with most consultants, who think about it, they always assume that because the juniors are always on the ward, the patients know them already. That is something that would be very useful to highlight to consultants ...and that’s something I will instantly put in my ward round (SID-4: 16-22)._ 

This consultant accepted the fact that at times patients were not introduced to other doctors in the team. According to this doctor it was a general assumption that patients knew the names of regular doctors on the ward. In fact this was found to be untrue because during the weekends house officers and senior house officers often covered the patients of several different consultants.

Although the majority of staff felt that patients would expect to be introduced (SIN-91: 32-41), others were adamant that this was not necessary. Nurse 13 thought that it would consume time if a consultant would introduce every member of his team to the patient. According to her, if a patient is confused it is more likely that he would not remember the doctor’s name. She thought that junior members of the medical team do introduce themselves to the patients and this has led to a general assumption that patients do know the names of the doctors (SIN-141:10-18). Doctor 5 thought that the introduction of one’s name to a patient is not ‘the most important thing’. According to this doctor:

_I don’t think that that’s the most important thing. You know patients often don’t remember everything you tell them. I think its more important for them to understand what’s being said rather than start remembering names and things that aren’t going to be beneficial to them (SID-35: 22-35)._
It is quite obvious from the above explanation by doctor 5 that introducing oneself to a patient is not an important factor in the agenda of a doctor’s daily activities. According to him, such explanations of other aspects of care are more important than introducing oneself to a patient, when most of these patients would forget their names anyway.

5.5.2 Hospital (theatre) gown and exposure of the body

Another aspect of care that emerged strongly in this category was the patients’ habit of wearing a hospital (theatre) gown and its impact on the privacy and the dignity of the patients. In both Wards A and B both men and women patients tended to wear these gowns on a regular basis even when not required. The hospital gown was made of white cotton material that could only be tied at the back of the neck with the aid of two thin white straps. Since all the gowns were uniformly produced to the same length, in an average patient they normally reached just above the knee. The design of the gown had many advantages in the operating theatre. During an operation a patient’s frontal part could easily be exposed without unduly disturbing the patient. In theory, once the operation was over, patients were supposed to revert to wearing their own pyjamas or nightgowns. However, in both Wards A and B the majority of the patients tended to wear these gowns well after their operation had been completed. Some elderly women, as a matter of routine, were made to wear these gowns on admission until they were discharged home or transferred to another hospital. Certain nurses felt that the presence of the gowns made it easier to nurse the patients, particularly when changing and turning patients in bed. Nurse 7 explained to me that generally women look quite comfortable in their hospital gowns (SIN-96:
25-27). According to this nurse certain women patients preferred wearing these gowns in bed instead of wearing their own nightgowns. She explained to me as follows:

_The men, I don't think they like the gowns very much. They're not very comfortable, but to the women, ehm, we say to them, what I've said to a lot of patients. 'Do you have anything to wear or would you like to wear something of ours?' And they say, 'oh I wear something of yours and not mess up my own' (SIN-96: 19-23)._

It appears from this description that patients, particularly women, preferred wearing the theatre gowns so as not to soil their own. This was true in some cases. For example, when patient 71 (a male patient) was asked about his impression of the hospital gown that he was wearing, he simply replied, 'the gown is ok. Nobody can see me apart from the staff' (UIP-69: 33). However, in the majority of cases, my findings did not substantiate that. Many patients stated that wearing the gowns made them look like fools (UIP-57: 5-9). Others thought that wearing the gown dehumanised them and made them look dreadful (UIP-17: 13-14). Patient 10 thought that:

_The gown itself is one of the most degrading things ever invented (SIP-S7: 36)._ 

Patient 92 felt a deep revulsion at wearing the hospital gown. He described his inner feelings as follows:

_It is terrible. I suppose you lose your dignity. We have to conform to institution rules. You just become one of them (UIP-80: 36-37)._
According to patient 92 he was given no choice but to wear the hospital gown and with that he lost his dignity. By making him conform to the hospital rules he strongly felt that his individuality had been usurped and he had become dehumanised.

Another significant aspect about the wearing the theatre gown was that it made patients feel very vulnerable, particularly in the presence of male doctors and nurses. Patient 154, who had experienced of wearing the gown for a period after her surgical operation confirmed this. According to her:

*The gown makes you very vulnerable. You are so exposed with it. You have to keep holding it at the back* (UIP-105: 36-37).

The feeling of vulnerability arose because when a patient had started mobilising, the back and buttock were totally exposed as the gown had only one set of ties and that at the back of the neck (UIP-91: 11-12). This led to complete exposure of the back and embarrassment to a patient. Patient 154 attempted to describe a situation when a young woman patient had to walk backwards to maintain her decency when she met a group of male doctors on her way to the toilet (UIP-105: 37-41). According to patient 154, wearing the gown ‘takes you back when you were a baby. You lose your identity’.

When the issue of wearing the gown was raised with patient 170, he laughed and confirmed by pointing at patient 171:

*I don’t think much of the gown. We both can see that [patient 171] is totally exposed ... It is difficult to do it at the back. [Pointing to patient 171, he shook his head laughing]. He kept saying ‘he looks silly, don’t he?’* (UIP-108: 21-24).
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My own observation confirmed the fact that patient identity was lost once that gown was worn beyond usefulness. Patients looked absurd and were placed in a very embarrassing situation (SIN-96: 34-45). In many of the observation periods it was noted that patients' back and buttocks were totally exposed (GO-19: 6-8, 99: 10-15). Since the gown only reached to knee height, on several occasions it was noticed that when a male patient was sitting by his bed, his genitals were exposed to the public (GO-108: 32-35). In one of the observation periods I made the following notes:

*Patient 4 is sitting by his bed in his hospital gown. His legs are exposed as far as his upper thighs. In fact his genitals could be seen. Just opposite him the visitors of patient 3 are sitting (GO-28: 32-34).*

Such sights were observed so frequently in male patients that these data are representative of many such findings (GO-37: 30-32, 39: 23-24). Women patients were no exception. As the gowns were rarely tied at the back of the neck, their breasts and genitals were also exposed frequently (GO-101: 1-2). In another of the observation periods the following was noted:

*I am observing patient 7 ... She is lying on two pillows. She has her hospital gown on which is very loose in front of her. The upper part of her breast can be seen (GO-56: 32-35).*

With regard to patient 7, I also made an addendum note. Before this patient reached this debilitated state, she was always observed immaculately dressed in her own nightgown. On another occasion the following data was entered in my field notes:

*While I am talking to patient 154, I am also observing patient 10 (a woman patient) who is lying on top of her bed. Patient 10 is wearing a hospital gown. Every time when she lifts her legs her private parts can be seen (GO-106: 33-35).*
When the issue of the hospital gown was raised with the nursing and medical staff, they agreed that there were many problems with the gowns and they could lead to many embarrassing situations (SIN-67: 13-19, SID-6: 17-43). According to nurse 3:

There are generally problems with hospital gowns; because if a patient is wearing a hospital gown ... there is always the risk that they will expose themselves without meaning to and it could be very embarrassing for the patients (SIN-67: 14-19).

When the same issue was raised with a lead consultant, he reinforced what nurse 3 had said. He enlarged on the issue as follows:

I see no reason at all for the hospital gown. I think it is a disgrace and I would support its abolition instantly (SID-5: 36-37).

According to this consultant, the wearing of the hospital gown made patients lose their dignity (SID-5: 43-45). He related his own personal experience when he was made to wear a hospital gown when he was admitted as an emergency. He added the following points:

I can see no reason in 99% of patients why they can't be given pyjamas ... If you go to a long stay ward, they [patients] are given pyjamas. If you go to a geriatric ward, on the whole, in most hospitals they’re given much more dignity ... you would feel a lot less vulnerable when you are wearing that [pyjamas] because you are covered (SID-6: 35-43).

It is clear that the consultant was at a loss as to why in most cases patients were made to wear hospital gowns. He thought that in 99% of cases patients could wear their own pyjamas and thus maintain their dignity. He thought that patients would feel less vulnerable if they could be adequately covered.
5.5.3 Disposal of patients' excreta

In this section, I intend to show that the male patients' urine was not disposed of as frequently as one would have liked. It was noticed on many occasions that in both Wards A and B, full urinals were left on the patients' bed tables and lockers many hours after their use. Sometimes more than two urinals were left lying about. In some cases even when the patients were mobile, they themselves could not dispose of the urinals because all urine output had to be carefully measured by the nursing staff. In Wards A, in one of the bays for male patients, at about 17.30, I noted the following observation data:

I am noticing something that I have not noted before. Nearly all the bed tables have full urinals on them. For example, patient 18 has one, patient 19 has one, patient 20 has one, patient 21 has two, patient 22 has one on his locker and patient 30 has none (GO-10: 11-17).

In Ward A, most of the men patients were bedridden. However, they could have gone to the toilet had they been wheeled there. Instead, urinals were provided for the patients' use and once they were used the full urinals were left behind and removed after many hours at the discretion of the nursing staff. On many occasions patients were eating their lunches with full urinals on the bed table. On one such occasion the following data was recorded:

I am observing patient 19's surroundings. He is sitting by his bed. Three urinals are lying on his bed table, one jug of water and five books. On one side of this table, a nurse placed the patient's lunch tray and without hesitation, the patient started eating his food. One of the urinals is full (GO-7: 30-33).

Patient 19 had just had his operation. His mobility was very limited. Therefore he could not have disposed his own urine. The nurse ignored the presence of the urinals
and served the patient’s lunch while a full urinal was on the bed table. On another occasion, it was noticed that patient 28 was sitting by his bed in his hospital gown and reading his newspaper. Two urinals were noticed on his bed table. Just to ensure that the urinals were full, I went to the patient and while talking to him checked that the urinals were in fact full. Full urinals were also observed on the patient’s bed table or sometimes on their locker during visiting times (GO-27: 30-31).

When the issue of full urinals lying about on bed tables was raised with nurse 1, she was alarmed. She just stated:

\[ I \text{ have noticed it} \ldots I \text{ have put my foot down in placing urinary bottles on the bed table} \ldots \text{That is appalling} \ldots \text{That should not happen} \ (\text{SIN-52: 12-19}). \]

Another aspect of personal care that could be viewed as embarrassing for patient was how certain patients were noticed walking about on the wards with their urinary bags in their hands even in the presence of visitors. On Ward B this was noticed at frequent intervals (GO-66: 9-10, 69: 5-7). When patient 6 was asked to share his feelings with me about the bag, he explained that carrying the bag in his hand gave him mobility. He was not embarrassed at all. He further explained:

\[ I \text{ was quite surprised how I did feel [about] it. When I first came in and I saw people with the bag I did not like it. I thought I don’t have to go about with that thing around. But it is surprising from my point of view how it turns out. I did not feel embarrassed} \ (\text{SIP-40: 34-37}). \]

When patient 61 was seen by patient’s 66’s woman visitor walking about with his urine bag in his hand, she was heard remarking with a smile: ‘You all have your hand bags up here’. Patient 61 had replied to this, ‘I suppose so’ (GO-70: 4-6).
5.5.4 Use of names

Another aspect of care that stood out most prominently in this category was the staff tendency to call patients by their first names or using words like ‘darling’ or other endearing expressions without first seeking the permission of the patients. The use of such expression was noted at frequent intervals. In fact it was the norm that patients were addressed in this fashion. In one of the observation periods it was noticed that patient 22, a 77-year old man, was repeatedly called by his first name by a first year student nurse (GO-7: 36-41, 24: 49-50). In another instance I made the following notes while the sister was giving personal care to a patient:

This sister keeps calling patient 213 by his first name and also using the word ‘darling’ quite often (GO-119: 32-33).

When the subject of the nurses’ habit of calling patients by their first name was raised with nurse 15, she explained that she ‘preferred calling her patients by their first names’ as long as their permission was first sought (SIN-162: 27). This evidence was not substantiated by my findings. According to patient 103, calling a patient by his first name was quite in order when one was ill. However, he guardedly explained:

But I am here for a couple of days only. So it does not matter to me. Had I been here longer I would have liked to be called by my surname (UIP-82: 47-48).

The lead consultant was adamant that patients should not be called by their first name. He thought that it was offensive and disrespectful, particularly when patients on the ward were usually in their 70’s and 80’s. He emphasised:
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I hate that. I think if somebody called me by my first name, who I didn't know, without me asking them to in the first place, I would be offended. To call them by their first name is just disrespectful, and it should never happen (SID-3: 38-42).

The consultant and many patients felt that they should not be called by their first names. In my observation period I noticed that the medical team was more likely to call patients by their surnames or 'Mr' (Go-21: 20-21), whereas the nurses and other paramedical staff preferred to address patients by their first names or by certain endearing names.

5.6 Category E: Privacy of patients' information

The data shows that although many staff understood the importance of keeping the patients' personal data confidential within the bays, this did not happen in practice. This was particularly observed during the doctors' and nurses' rounds. It was noted that ward rounds became occasions when other patients were found eagerly awaiting each other's diagnosis. However, many patients shared with me their great trepidation of the fact that such ward rounds became the vehicle whereby the knowledge of their personal profiles would not only going to be known by themselves but by their neighbours as well. In one of the observation rounds the following was noted:

A group of six doctors, accompanied by a nurse, is visiting patient 5 ... The curtain is open. Every word that is uttered by the consultant can be heard. Patient 3's wife keeps looking towards the group and is intensely trying to follow the conversation (GO-21: 20-23).

This illustration is a representative sample of many such occurrences. This ward round was taking place in a bay of six patients with the relative of patient 3 also present. If I
could follow the conversation from a distance of ten yards, surely it can be assumed that patient 3's wife and other patients could also follow the gist of the conversation. Following this ward round it was interesting to note that the consultant carried on his conversation with his group of doctors about patient 5 in the corridor where various other personnel were sitting. In another instance, the following observation was made when it was noticed a doctor questioning a newly admitted patient by his bed:

Patient 31 is sitting by his bed. A doctor is explaining to him what is going to happen to him. The discussion is rather loud. The patient is asking certain very personal questions and the doctor has replied without hushing her voice. At no time was the curtain closed (GO-36: 24-28).

All patients' admissions were carried out by the patients' bed by both doctors and nurses. It was inevitable that other patients would overhear such conversations. Doctors and nurses, including the paramedical staff, were in the habit of speaking loudly with their patients, although most of these patients were quite rational and were not hard of hearing. This evidence was corroborated by patient 160 when I asked him whether he had any knowledge of the diagnosis of other patients. He said:

Yes, I know what is wrong with them. When a group of doctors visit the patients, they speak quite loudly and you can hear what they are talking about and you can tell what is wrong with the patients (UIP-104: 43-46).

It was apparent that patient 160 had a very good awareness of other patient's profiles because of the way the health professionals spoke to their patients in loud voices without thinking of the effect on information privacy for the patient. Patient 1 also supported such evidence by venting her frustration with me when she declared rather angrily:
Yes. *I mean doctors turn up with a whole gang of people and just bawl in a very loud voice* (SIP-4: 43-44).

When the nursing staff were asked whether other patients in the bay could hear about a patient's profile during a ward round, nurse 15 made the following comments:

*Yes, yes. I am often aware of that ... and it's not a thing that you can do* (SIN-162: 12-15).

It is obvious, according to nurse 15, that other patients could overhear the staff conversation during a ward round. Yet she thought that owing to the lay out of the ward and the type of curtains around each bed, such breaches of information privacy could not be avoided.

However, not all ward rounds were carried out in the open ward in the presence of other patients. At other times doctors and nurses made an extra effort to close the patients' curtains when discussing personal matters with the patients. The presence of curtains in fact created a false climate of information privacy. Any conversation that occurred within the closed curtain was still heard by other patients. Such closing of curtains no doubt ensured privacy of the person to a large extent, but with regard to maintaining information privacy it was a vain endeavour (GO-23: 47-48, 77: 19-20). For example, when patient 5 was asked whether a fully drawn curtain could ensure a certain level of privacy to a patient, her reply was rather blunt:

*It's only a pretty flimsy curtain. It doesn't stop any sound. You can hear exactly what's going on. I mean, I haven't forgotten the doctor coming to the lady next door and saying she was going to take her leg off* (SIP-33: 1-3).
This interview data supports the view that a fully closed curtain could not create a barrier against any sort of sound unless professionals had decided to lower their voice considerably while conversing with their patients. Such attempts were noticed on odd occasions when nurses were seen speaking in a lower volume (GO-38: 36-39, 115: 45).

On another occasion I also noticed, that even a doctor’s ward round was being conducted in a deliberate climate to maintain the information privacy of patient 169. It was noted that the consultant was taking great care in speaking in an unusually soft tone to his colleagues. I recorded the following observation:

> At this moment a group of four doctors are visiting patient 169, accompanied by the ward sister. The curtain is half closed. They are talking in soft voices and taking great care that their conversation is not overheard. The consultant kept looking at me (GO-111: 40-43).

It must be added though that with regard to both instances they were observed after I had already interviewed the nurse and the consultant concerned.

Another issue that emerged strongly in this category was the patients’ use of the bedside telephone and its impact on information privacy of the patient. Every time when a patient was seen speaking on the telephone, the other patients appeared to be transfixed at their specific spots. It was blatantly obvious that most of the other patients were following the patient’s conversation and any information shared was becoming public (GO-21: 1-4, 38: 22-23). However, when the subject of privacy was raised with patient 125 and whether he was comfortable with its usage in the presence of so many patients, he simply replied without hesitation:
The telephone is fine ... There is no problem of confidentiality. It does not worry me. Here we are all suffering the same thing. So it does not worry me if they can hear what I am talking about (UIP-92: 42-46).

Patient 125 knew well that his conversation was being heard by other patients and visitors. Yet such breaches of his privacy did not worry him. According to him, since all patients in that bay were suffering with the same condition, there was no need to maintain one's individuality. Many patients suggested that the advantages of having a telephone by the bedside outweighed the risks attached to it, namely the fact that his conversation became public knowledge. According to patient 19 such exposure did not worry him. He felt that the use of the bedside telephone was just like using a mobile phone in the street (UIP-110: 7-10).

The subject of keeping the identifiable information of a patient confidential was another issue that emerged strongly in this category. In all the three wards it was as a matter of routine that patients' names, their consultants and their location on the wards were clearly identified on a white board (GO-9: 10-14). Everyday and as the need arose, the board was updated following the movements of any patient so that reference to the board was a fair indication in the location of any patients. At times prior to a ward round, the consultant held a primary conference with the members of his team in front of the white board. Any staff sitting at the nurses' station or visitors walking along the corridor could normally hear the gist of such meetings. For example, in one of the observation rounds the following activity was noticed:

The nurses' station is very busy. A consultant, three doctors, one pharmacist and a nurse are talking among themselves in front of the board. A visitor is standing by. Nobody is paying any attention to him. They are all discussing the patients' cases. It is quite loud (GO-53: 5-7).
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This illustration is a good example in support of the case that patients' profiles were normally discussed publicly without due regard to the confidentiality of information. In this instance, although a rare occurrence, it appeared that a visitor was following the flow of the conversation. Yet at no point did any members of the group feel sufficiently constrained to halt their discussion.

Improper filing of patients' case notes became an issue of concern to me. Patients' notes were often found lying about open on the nurses' station rather than being stacked in their respective files giving no thought to the fact that such files could be read by other patients or their visitors. For example, in one of the observation periods, the following entries were made in my field notes:

There are many activities in the corridor. Strange faces are walking up and down the corridor. There are notes lying about on top of the nurses' station (GO-23: 25-27).

This casual positioning of the patients' case notes was the normal occurrence in the three wards. When this issue was raised with nurse 12, she thought that it was wrong for patients' notes to be lying about. In fact she indicated an occasion when she had witnessed a patients' notes lying on his bed following his return from the operating theatre. She thought that any strangers or patients could have accessed the opened notes. She gave the following example:

It is wrong. It is wrong. I've noticed worse. I have noticed notes being left by somebody's bed ... because of [staff] being so busy... they are just there and anybody could just walk past and look at them, really (SIN-131: 29-35).
However, according to doctor 5, notes were never left lying around. He stressed that doctors had stopped carrying notes outside the ward area keeping them carefully in their allocated places by the nurses' station (SID-34: 15-20).

5.7 Category F: Professional blind spot and habituation

In this category I present those data that imply that the care delivered to patients by the health professionals was institution-driven rather than patient-driven. Many aspects of care that directly affected the privacy of patients seemed to be rooted in traditional rituals.

During the observation periods it was noticed that the patients' day started at around 05.30 despite the fact that their pressing personal need of sleep may have dictated otherwise. For example, in most instances patients in deep sleep had to be woken so that professionals could complete the recording of their vital signs. By 06.00 irrespective of the fact that many patients might still be sleeping, all the ward lights were switched on simultaneously. This meant that patients had to be woken up and subsequently prepared for their breakfast, even though their meal was not going to be served until 08.00. This ritual preparation process also included enabling certain groups of patients to sit by their beds away from the comfort of their own beds. The night staff were always in a hurry as certain activities had to be completed prior to the start of the day shift. This meant that certain patients had to receive their medicine well before 08.00 even if their drugs were prescribed to be given for that time. The beds had to look tidy, although the occupiers were still in deep sleep. In one of the observation periods the following notes were made. It was 05.30:
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All patients are asleep except patient 2. All the window curtains are wide open. The ward is well lit by all the ceiling lights (GO-1: 24-26).

Reflecting on this scenario, it was obvious that the ward activities had started at 05.30 although most of the patients were fast asleep. The ward radio was switched on quite loudly (GO-1: 28) and the management of patients' pressure areas had already began by a group of nursing staff (GO-1: 31-35). When patient 1 was asked to confirm the time that she was woken up that morning, she replied:

Well, it’s always early being in hospital. It’s always six o’clockish [or] thereabouts (SIP-1: 29-30).

When the issue of ward routine was explored with patient 42, he thought that the ward routine was specifically designed for the staff rather than for the patients (UIP-49: 6). According to patient 13:

It’s their routine not mine ... It is designed to let them get through the work, so they start you off at 6 in the morning. If you are a natural sleeper and if you want to wake up at 8, that’s your hard luck (SIP-72: 12-14).

Both patients in the above examples were adamant that the ward routines were made for staff, irrespective of the needs of the patients. Patients were required to adapt to the routine and the expectations of staff. Patients had to meet the requirements of ward rounds. If medical staff wanted to see a patient, this had to be done even though the patient was busy doing something else. Patient 13 accepted that such routines are designed so that practitioners are able to complete their tasks in time.

Another issue that stood out prominently in this category was the number of times it was noticed that patients had to be interrupted to meet the routine requirements of the
staff. At frequent intervals it was observed that patients were interrupted in the midst of their conversation on the telephone by health professionals in order to raise issues of a routine nature. The following activity was noted:

*I can tell patient 4 is talking to somebody close to him on the telephone. I can hear every word and follow the gist of the conversation very clearly. At this point he is interrupted by a nurse and is asked whether he wished to have a wash. He said 'yes' (GO-21: 3-5).*

In this illustration the nurse could not wait for the patient to finish his telephone conversation. It was clear by following the telephone conversation that patient 4 was having an intimate conversation with somebody who was very close to him. But the nurse could not wait. It was also very interesting to note that while patient 4 was washing himself in his bed within a fully closed curtain, a woman doctor walked within the drawn curtain and wanted to see this patient without any prior warning (GO-21: 6-10). On this occasion the doctor withdrew herself from the scene, perhaps realising the inappropriateness of the occasion. On another occasion, I observed the following activity:

*While I am talking to patient 163, I notice a doctor is trying to take the blood of patient 165 (bed 6). At this time patient 165 is eating his lunch. He is rather annoyed that the doctor wants to take his blood when he is eating his food (GO-110: 19-21).*

Despite the fact that it was lunch time and all patients in that bay were eating, this doctor thought fit to take blood from patient 165. It appeared that the doctor had failed to pay any particular attention to the patient's needs. Her objective of taking the blood had to be achieved then and there. The patient showed his anger by
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retorting 'why do you want to take my blood when you took it yesterday?' (GO-110: 23).

As a researcher on the ward, one of the ways of collecting data was by talking to patients either formally or informally. It happened many times that while I was conversing with patients on an informal basis we were interrupted by nursing and medical staff. On one such occasion while deep in conversation with patient 125 our flow of conversation was suddenly interrupted by a group of doctors (GO-91: 48-49). It was obvious that the patient had to be seen then and there. The patient had no choice and the fact that he was deeply involved in conversation with me was of no importance.

In the afternoon patients often took the opportunity to snatch some rest and sleep. Because of the hustle and bustle of night admissions, many patients were unable to obtain their full complement of sleep. Even on such occasions nurses or health care assistants tended to disturb the patients' sleep to raise issues of a routine nature that could have waited had they thought it through. On one such occasion I made the following notes:

"Patient 170 is sleeping on top of his bed. He is snoring. The HCA approaches him and wakes him up because he wanted to take his vital signs. He taps his shoulder first and starts taking his vital signs (GO-108: 10-12)."

It was obvious that patient 170 was fast asleep. Yet the health care assistant could not wait. The completion of the task of taking routine vital signs was seen as more important than allowing the patient a good rest.
During my periods on the wards it became clear that many tasks were being performed by the staff without giving much thought to the implications of their actions. Many tasks were performed in a ritualistic way. On many occasions some bizarre actions by staff were noticed. For example, it was noticed that meals were often served and left at such a distance that the patient had to struggle to reach it. On one such occasion the following notes were made:

_The tea lady asked the patient (95) whether he would like sugar in his tea. ‘Yes please,’ he replied, and she left the cup of tea at least two yards away from the patient on the bed table (GO-83: 36-38)._

It was clear that the patient would struggle to get his cup of tea. Yet the tea lady carried on serving tea to others while the patient was seen struggling with the bed table just to obtain the cup of tea. The struggling action made the patient spill his tea without any further help from the tea lady. Similarly, while serving water, the jugs were left at the far end of the bed table instead of placing the water jug by the patient (GO-33: 1-2). On one occasion it was noticed that a doctor, having removed the indwelling catheter of a patient, was giving instructions to the patient that he must drink plenty of fluid. Yet the jug of water was left on a bed table that was positioned at the end of the bed. It was very interesting to note that the doctor made no attempt to move the bed table within easy reach of the patient who was bedridden. On another occasion I noticed that a patient was served a meal when the ‘Nil by Mouth’ sign was seen overtly placed at the head of the patient’s bed (GO-36: 40-43). On several occasions I noticed that ‘Nil by Mouth’ sign had not been removed from the bed even though the patient’s operation had been cancelled. On one such occasion the following note was made:
Patient 35 said that his operation had suddenly been cancelled when HE HAD been waiting all day ... The patient carried on and remarked, 'but this "nil by mouth" sign has not been removed yet. I am fed up. I have had nothing to eat all day' (UIP-41: 29-32).

Patient 35 was obviously very angry because of the cancellation of his operation and the continuing presence of the 'Nil by Mouth' sign exacerbated his annoyance. Its presence meant that he was still not allowed to eat his food when he had had nothing to eat all day.

There were many other issues that could be listed under this category. For example nurses were seen making patients' beds while they were still eating their food (GO-33: 40-41). Patients were frequently ignored during bed making with the staff talking among themselves about issues of a very personal nature (GO-83: 43-47). Ignorance of the patients' presence was also noticed on other occasions. For instance, I made the following entry in my notes during a ward round by two doctors:

The doctors then approached patient 2 and his wife. They started talking about the patient as if he was not there. After a long discussion one of the doctors said, 'sorry it is very rude talking about you in front of you.' And without explaining any further, they moved on to patient 6 (GO-45: 32-35).

On this occasion one of the doctors had realised that ignoring the patient was at least wrong and he tried to apologise for his behaviour. However, it was very interesting to note that even after such a realisation, no explanations were given.

Another issue that came to my notice was the way in which staff tended to leave the bed curtains half drawn after leaving the bed side of a patient (GO-28: 39-41). They might not have realised that such practice could hinder the full view of other patients.
In category H it was noted that many patients were inclined to spend their time observing the activities of other patients to obtain relief from the oppressive boredom of the long day. On one such occasion the following records were made during a ward round:

They left the patient [5], leaving the curtain half shut, blocking the view of adjacent patients completely for duration of nearly five minutes GO-23: 49-50).

During the examination of patient 5 by members of the medical team, it was noticed that the patient’s bed curtain was fully shut. However, as had happened on many other occasions previously, following the patient’s examination, the team of doctors and nurses left the patient, leaving the bed curtain ‘half-shut, blocking the view of adjacent patients completely for the duration of nearly five minutes’ (GO-23: 49-50).

5.8 Category G: Ward layout and logistics

Category G reflects the findings about privacy in relation to the general layout and logistics of the wards in which this research took place. The structure of the ward and staffing composition have already been explored in chapter 3. In this section they are depicted from the perspectives of the wards’ lay out and their logistics on the maintenance of the patients’ privacy.

Appendices 1 and 2 demonstrate that both Wards A and B were roughly of a similar layout, with four main bays in each ward. Six patients usually occupied each of these bays. Ward C (appendix 4) had two main bays with eight patients in each bay and a third bay for six patients. There were also five single bedded rooms in Ward B and
four such single rooms in Ward A. There were no single rooms in Ward C. All the
bays in Wards A and B had one purpose built toilet and sink. Ward C did not have
this facility. Besides a sink in each of the toilets, each bay in all the three wards had
also a sink for use by both staff and patients. The shower unit in all the three wards
was located across the corridor and this meant that patients had to walk or be
wheeled to the shower in the presence of other patients or strangers.

Owing to the general lay out of the bay, the observation data shows that at most
times of the day the bay looked very crowded, particularly in the morning and during
ward rounds. On one such ward rounds the following observation was made:

A group of doctors walked in. There are four of them accompanied by a
nurse. They went straight to patient 122 who is sitting by his bed in his
hospital gown. In the meantime, patient 109 has now returned from the toilet
and sat next to patient 122 while the doctors continued their conversation
with patient 122 (GO-94: 19-22).

This scenario is typical reflecting the atmosphere in which most patients found
themselves at times. In this case patient 122 was sitting by his bed and he was being
seen by a group of doctors, led by the consultant. There was no doubt that issues of a
personal nature were being discussed with patient 122. However, despite the nature
of the discussion, patient 109 had nowhere to go but to sit practically next to patient
122 as his chair was positioned by patient 122. The atmosphere was more pressing in
Ward C where two of the bays were occupied by eight patients respectively. The
beds were so close to each other that it was impossible to hold a conversation with
one patient without the neighbouring patient being dragged into the discussion (GO-
126: 11-13). According to patient 1 in ward A:
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Even with only six patients, you know, the beds are reasonably close together. I don’t think anybody can really expect there going to be an enormous amount of privacy (SIP-1: 49-50, 2: 1-2).

On another occasion the following notes were made:

In the meantime, patient 305 had gone to the toilet. Since the space is occupied by two linen trolleys the patient could not go back to his bed on his way back from the toilet (GO-127: 6-7).

In this illustration it was nearly 08.00 and the beds were being made by members of the nursing team prior to the patients’ breakfast. The central space was fully occupied by the linen trolleys and because of the cramped space of the bay and the presence of the linen trolley, patient 305 could not get to his own chair.

Another issue that emerged strongly in this category is the extent to which facilities that are normally taken for granted at home were not available for the patients on the wards. According to patient 61, although his bay had a television and a radio set, they were not connected to the main power supply. He found the arrangement very frustrating when his bedside radio was also out of order (UIP-61: 27-30). Patient 181, who had previously been in the side room, summarised the state of the ward facilities as follows:

I told you last time what it is like being in a main bay. There is no TV. My bed side radio’s head phone is missing and I am sitting here all day surrounded by patients who are not talking to me (UIP-115: 4-6).

Patient 181 had previously enjoyed the facilities of a single bedded room, mainly of television, radio and individual toilet facilities, now missed these facilities. His frustration was rather exacerbated as he could not listen to the communal music due
to the ear piece missing from his bedside radio. More importantly, from his point of view, he could not talk to other patients, because the rest of the patients were not in a state to hold a rational conversation. Patient 181’s statement reinforces the fact that patients want to interact with others in the ward.

Another missing element in the bay was enough space for the patients to keep their personal belongings. All the patients had the use of a bedside locker, but the space within it was so cramped that patients’ personal items and clothing were seen scattered around their chairs and on their bedside table. Patient 54 raised the importance of this issue quite well when she said the following:

*Patient 54’s clothes were lying crumpled everywhere. She said, ‘I wish I could fold these and put them somewhere but there is no place’. I tidied the clothes and left them on her locker (GO-58: 45-47).*

There is no doubt that patient 54 was rather concerned about the state of her personal clothing. They were lying crumpled on the chair and she wished that she could place them somewhere, but unfortunately such facilities were very limited in the bays. At times even if some space could be found in the locker, the patients’ clothing was forced in within a limited space in a crumpled state (GO-63: 50, 64: 1-3). On the other hand, patient 352 was most concerned that she could not find an appropriate place to hang her personal towels. This patient did not attach any importance to the issue of a lockable locker where her personal belongings could be locked. Other patients thought that they could not cope with a lockable locker because it was most probable that they would lose the key. Patient 352 made the following observation:
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But there are no facilities to hang one’s towel. There is not even a bracket anywhere. I don’t think there is a need for a lockable locker (UIP-139: 39-40).

Besides the obvious lack of facilities in the bay, as far as certain patients were concerned, it was disconcerting to note that some of the patients on admission had not been informed of existing ward facilities that they could use to occupy themselves. When patient 54 was asked whether she had tried to relieve her boredom by listening to the bed-side communal radio, she replied:

*I did not know there is a radio up here. Nobody told me* (UIP-58: 42).

Similarly when patient 74 raised the importance of having room on the ward where patients could go and relax, away from the hurly burley (UIP-73: 47-50), it was blatantly obvious that he had no idea of the existence of the day room. He replied:

*No. I did not know there is one ...Nobody told me the existence of that room* (UIP-74: 1-6).

Other area that emerged strongly from the data in this category was the state of the bed curtains that had direct impact on the privacy of the person. When certain staff attempted to shut the curtains, they could not always be fully closed. This meant that very often gaps could be seen between the curtains through which any activities being undertaken could be observed by other patients and visitors (GO-50: 30-32).

For example, on one observation period the following notes were taken:

*Certain nurses try to close the bed curtains fully, but the curtain is never closed completely. There is something wrong with these curtains* (GO-50: 33-35).
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Sometimes it was noticeable that, because of the cramped space between the beds, the bed curtains could not be closed adequately due to the presence of chairs or the sitting position of neighbouring patients between the beds. At other times these obstructions led to the uneven closure owing to the various splits within the curtains. On one such instance, the following data were recorded:

Both doctor and sister then moved to patient 66. Sister closed the bed curtains sufficiently to bar me from observing the patient. However, ... the curtains have splits in the middle and through the split I can see what is happening to the patient (GO-85: 7-11).

In this illustration, the sister (trained nurse in charge of the ward) tried to prevent me from observing patient 66 while he was being examined by the doctor. But this was a vain gesture because of the splits within the curtain I could follow all the actions of the doctor and the patient. I made an addendum note that the sister closed the curtains in such a way to bar my view but the clear views of patients 106 and 73 were left unhindered (GO-85: 7-9). The presence of gaps within the closed bed curtains was often a source of jokes by staff and patients. On one such occasion the following remarks that were made by a health care assistant were noted:

In this hospital the sight of the drawn curtain is like being at a pantomime. You just wait and see when the gaps in the curtain appears (GO-112: 39-41).

When the presence of gaps within the fully closed curtains was raised with the ward manager, she informed me that she was not aware of any mechanical defects, as nobody had reported that fact to her. However, she admitted that:

But I agree. I mean the bed spaces are actually rather small in this hospital, and if you have the curtains drawn and have a number of people behind the
curtains and someone moving from one side of the bed to the other side of the bed around the patient, the curtains do come apart (SIN-70: 50, 71: 1-4).

The ward manager agreed that staffs' movements within the drawn curtain could cause the occurrence of gaps because of the closeness of the beds and such circumstances could make the patients quite vulnerable as she experienced this herself while she was a patient (SIN-71: 5-6).

The existence of many varieties of noise in all the three wards could be viewed as impacting on the privacy and well being of individual patients. For example, many patients felt that, generally at night, the wards were very noisy due to their logistic structure and that such noises affected their sleeping patterns (UIP-49: 22-26). According to patient 12, he could not sleep on the night in question because it was 'noisy as usual' (UIP-49: 26). There were many sources of noise in the ward. It was noted that patients and staff tended to switch their radio on quite loudly when other patients were still sleeping (GO-2: 10, 61: 49, 62: 1-2).

Another type of noise that had tremendous impact on the sleeping rhythms of the patients were the noises from the variety of ward machines that were devised to help the patients. For example, the automated drip machine was irritatingly noisy and their intensity was magnified at night. Patient 7 displayed her irritation when the issue of sleep was raised with her. She replied:

*I again got up at 5 am this morning with a cup of tea. But that drip machine of [patient 13] kept me awake all night. It kept bleeping every few minutes. That's one of the things you have to put up with in the hospital I suppose (UIP-24: 11-13).*
It is apparent from this description that patient 7 found the continuing noise of the drip machine rather annoying, particularly when she was trying to sleep. Similarly, patient 15 had real problems with sleeping due to the constant noise of the drip machine. He exclaimed:

_The drip machine kept making a special noise every 10 seconds ... How can anybody sleep with such a ... noise? (UIP-25: 27-31)._ 

It is interesting to note that when the patient complained about the noise level to the nurse he was told that it was the movements of his arm that initially triggered the noise (UIP-25: 28-29). Patient 18 also had great difficulty in sleeping due to noise level of the hourly ‘blood test monitor’ to which he was attached. He explained:

_As soon as you start sleeping the machine goes off, and I wake up (SIP-97: 24)._ 

Another variety of noise that annoyed patients was the continuous humming of the small machine of the ripple beds. Patient 74 had real problems with while patient 4 was being cared for on this type of bed. Patient 74 summarised the reason for his lack of sleep as follows:

_That ripple bed machine (pointing at patient 4’s bed) kept me awake all night (UIP-73: 31)._ 

There were many other sources of noises. There were noises generated by the laundry wagon (GO-84: 23-25) that made its rounds at about 08.30. There were noisy trolleys whose wheels tended to squeak every time the nursing staff moved them to conduct ‘back rounds’ or collect urinals (GO-30: 20-22). There were noises
generated by the cleaning machine that was often used at inappropriate time, like during meal times and early morning when patients were still sleeping (GO-122: 25-28). The intensity of the noise in each of the bays was not helped either by the way in which the sink was positioned in each of the bays. Every time the staff washed their hands the pressure of the water seemed to disturb the patient whose bed was positioned half a metre away from the sink (GO-1: 34-35). On one such occasion, while the tap was being used, I asked a HCA whether the location of the sink had any effect on the patients at night, she gave the following reply:

Yes. Very noisy. Many patients have complained. But nothing has been done about it (UIP-130: 26-27).

It was not surprising, therefore, to hear such remarks from patient 86:

I like to stay up during the day so that I can sleep at night. You can never get rest in hospital, let us face it. For two nights I have not slept at all (UIP-87: 43-45).

It is apparent from this statement of patient 86 that the variety of ward noises could impact on the sleeping patterns of patients.

Another issue that could be viewed as impacting on the dignity and privacy of the patients was the architectural structure of the bays in the three wards. All the bays were separated from the corridor with large transparent glass windows. Although the importance of these large glass windows cannot be overlooked as they facilitated easy viewing of patients by the staff, their existence compromised the dignity and privacy of the patients. I collected part of my observation data scrutinising the
behaviours and activities of both patients and staff by looking through these large glass windows. By sitting by the nurses’ station and looking through these glass windows I could follow all the activities of the patients, doctors and nurses in room 1 (GO-9: 9-16, 45: 8-18). Equally visitors, other patients and strangers, could also not help glancing through the windows and seeing patients in their night gowns, hospital gowns, using commodes, and seeing unconscious patients.

5.9 Category H: Patients’ coping mechanisms

In this category I am presenting the data about the mechanisms that the patients adopted in a busy ward to cope with breaches of privacy in the light of the findings of the previous categories. Since this is mainly descriptive, some interpretation is unavoidable.

On admission to the ward the majority of patients had adopted a general culture of acceptance and a compliant attitude. Such patients had accepted from the beginning that privacy did not exist in hospital because of the strange environment they were suddenly thrust into. According to patient 5:

*I think you can be a very private person out of hospital and somehow things just change when you come into hospital. You just accept the fact that you are not going to be as private as you have been before (SIP-33: 28-31).*

Patient 5 acknowledged that when patients come to a hospital they start to adopt different roles. He further explained that patients come to hospital to receive good physical treatment and ‘certain things you have to accept and one of them is a certain lack of privacy’ (SIP-33: 41-42). According to patient 13, when patients are admitted
to a hospital they automatically become part of the production line and the process dictates that one should give up some privacy as a patient. He made the following comments:

\begin{quote}
At home you’re completely able to do whatever you want ... The opposite is in hospital where you are part of the production line going through the ward and out the other end ... There is a balancing act ... between your needs as an individual or a patient and the ward needs. You have obviously to give up some privacy ... the issue is how much privacy you should give up (SIP-70: 28-38).
\end{quote}

Patient 13 accepted the fact that the health professionals undertook a balancing act between the needs of providing effective care to each individual patient and efficiently running the ward. The process of being a patient meant that patients had to give up their privacy in order to receive their medical treatment. Patient 13 wondered whether it was a good idea to give up the level of privacy that was expected of them.

Certain patients had adopted a non-questioning attitude and were happy to conform to institution rules. When the issue of the hospital gown was raised with patient 92, he simply replied:

\begin{quote}
It is terrible. I suppose you lose your dignity. We have to conform to the institution rules. You just become one of them (UIP-80: 36-37).
\end{quote}

Similarly, when the subject of privacy during toileting activities was raised with patient 160, particularly the use of a bed-pan in bed, he replied in resignation:

\begin{quote}
It is very difficult to use a bedpan on the ward when other people are around you. I suppose when you are in hospital you expect to lose privacy. You have to put up with it. You have no choice. It is my experience (UIP-104: 25-27).
\end{quote}
Patient 160 summarised the views of many patients that generally patients had no choice but to accept the loss of their privacy on admission to the ward. Accordingly, it was observed that many patients tended to assume that generally health professionals, particularly nurses and doctors, were busy people and they had no time for niceties (UIP-79: 3). For example, in one of the observation rounds it was noticed that patient 14 had to interrupt her shower activity in order to meet the demands of the doctor's round. When this patient was later interviewed and asked to share her feelings with me she replied:

Well, I had finished anyway ...I mean they are busy people (SIP-78: 27).

On another occasion, it was observed that patient 19 was in an agitated state. He explained to me that he had been waiting to be washed for nearly two hours. He was lying in a wet bed, as his indwelling catheter had been dislodged for a while. He had been advised that he must stay in bed. Yet he was quick to point out that he did 'not want to interfere. They are busy people. I am not complaining' (UIP-32: 34-35).

A minority of patients indicated that the activities of the ward did not worry them unduly. The hospital routine, wearing the hospital gown and conceding their own privacy did not bother them (UIP-123: 42-44). In one of my field notes I entered the following data when patient 218 was asked to comment on his hospital gown. Prior to this interview he was wearing a gown which totally exposed the lower parts of his body:

It is ok. It does not bother me (UIP-123: 43-44).
When patient 3 was asked to comment on the aspect of information privacy when a group of doctors openly discussed his case within the earshot of other patients, he commented:

*I don't know, if I am honest about it. It did not worry me. I did not get any feeling that I would rather people didn't hear about it* (SIP-19: 22-23).

Patient 3 seems to suggest that in a NHS hospital the issue of information privacy was not important. According to him, patients were in a hospital ‘to be put right’ (SIP-19: 24). He reckoned that it would be very expensive to have a side room for every patient. He accepted that ‘there is too much pressure on the service as a whole’ (SIP-19: 25-26).

Another issue that emerged strongly in this category was the way that patients appeared to insulate themselves. Many patients were found sitting quietly and passively on or by their bed staring at each other (GO-89: 40) or following the activities of other patients and staff with great interest (GO-83: 22). When I asked patient 71 how he occupied himself in the ward, he replied:

*I keep myself occupied up here by observing around me* (UIP-69: 42-43)

On several occasions patients were seen occupying themselves by reading books and newspapers. They appeared to have blocked out all activities around them (GO-5: 15-16). When the issue of privacy was raised with patient 103, he replied:
At home I have my own privacy ... Here we don’t have that freedom. It is a long day up here. I spend my time reading books and observing what goes on in this place (UIP-82: 28-31).

Many patients were reluctant to make any complaint against doctors and nurses. In fact they thought very highly of doctors (GO-67: 32). Patient 12 explained that he was so touched by the care that he received in the intensive care unit that he thought of his consultant as a god. (He was not on any medication at this point when he shared this information). He accepted that doctors could make mistakes because they were not infallible. He felt that if their actions were questioned at every point it would lead to anarchy (SIP-68: 44-50). He explained as follows:

When I was in intensive care downstairs, there was a very eminent doctor who gave me such trust. He made me feel as though I was a small child that got lost in a maze ... It was like, you know, the nearest I’ve ever come to contact with God, it was unbelievable (SIP-66: 38-45).

It was generally noted that patients were very reluctant to express their concerns. This was typically highlighted when patient 54 was asked to comment on the occasion when a doctor was sitting on his bed without his permission. He replied:

It was naughty, wasn’t it? It did not bother me though (UIP-55: 17-18)

It was apparent that patient 54 was not very happy about the doctor sitting on his bed without his prior permission. Yet, he quickly tried to retract his initial accusation and immediately became defensive by rationalising that it did ‘not bother’ him. Other patients felt that by complaining they could become labelled as they could be readmitted to the same ward under the same consultant and nursed by the same
personnel. I thought that patient 111 made a clear case of accepting the status quo and not complaining against the staff as follows:

\[
\text{You can't tell bad things about this place if you have to come again as is in my case. I have been here three times. The nurses have been excellent, excellent (UIP-88: 28-30).}
\]

According to staff nurse 5, the majority of the patients conformed to the rules of the hospital. She stated that she had hardly ‘seen anybody made any complaints’ (SIN-76: 19-21). Nurse 12 summarised the majority of the patients’ feelings as follows:

\[
\text{I think they are very quiet. They can become very withdrawn, to some extent embarrassed (SIN-133: 9-10).}
\]

5.10 Category J: Visitors and relatives

It was obvious that patients generally welcomed their visitors and enjoyed spending time with them. In all the three wards visiting time was very relaxed, although the ward notice stated that only two visitors were allowed to visit a patient at a time. The data show that during visiting time the visitors and relatives had no privacy with the patients due to the lay out and logistics of the ward, as discussed previously. For example, patient 30’s wife was found sleeping on a chair next to her husband’s bed in full view of other patients (GO-36 20-22). Visitors could not communicate freely because of the closeness of other patients and their relatives (GO-44: 29-30). Emotions towards their relatives had to be displayed in public, particularly if a relative was very ill or dying. I recorded such an episode as follows:
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Patient 26 ... is semi-conscious and his wife and son are standing nearby. His wife is in a wheelchair and she is constantly shaking while trying to talk to her husband. The son looks rather distressed and is trying to talk to his father and is stroking him with his hand. Other patients are watching them (GO-37: 6-9).

This scenario is a typical example that was witnessed frequently. Patient 26’s relatives were obviously distressed. His wife, who was wheelchair-bound because of her disability, was attempting to communicate with her husband. However, every word that she uttered could be heard by everybody in that bay. The son, aged at least 50 probably wanted to do more for his father but was restrained owing to the presence of other patients and their relatives who were intensely observing his movements. When patient 160 was asked whether she had a degree of privacy with her husband during her visit to the ward, she replied:

_No. How can you? I would have liked to be involved in his care. But how can you do it on the ward. It is so open up here (UIP-104: 33-34)._ 

Patient 160’s wife would have liked to participate in the personal care of her husband but it appeared that she was restrained due to lack of privacy.

It became apparent in this category that the relatives or friends were not just visiting their loved ones or friends, but they were also seen as advocates of these patients. They were seen taking an active part in the protection of the privacy and dignity of the patients, while such personal care was either ignored or overlooked by staff. A typical incident was observed as follows. Patient 23 was being cared for in one of the side rooms. The door was wide open and the patient’s body could be seen from the corridor. His naked legs were hanging by the side of the bed. The television was on
loud and the room looked very bright (GO-28: 47-50). The room was in a chaotic state. Following a visit of his daughter the following notes were made:

When I next passed the side room, the patient looked peaceful. He was covered and the daughter is trying to give water and at the same time converse with him (GO-29: 7-11).

This illustration is typical and demonstrates that visitors and friends played a vital part in the protection of patients' interests. In a short span, patient 23's daughter brought a sense of calmness to the room. She had turned off the ceiling lights and the television and covered the patient's legs.

The bond between relatives and patients is so strong that patient 2 at one point refused to be bathed by nurses, preferring this to be done by his fiancée he thought was better placed to respect the privacy of his person. As patient 2 was being nursed in a side room, away from the gaze of other patients and their relatives, presumably he felt comfortable enough to seek such help for such an intimate care. He made the following observation:

My fiancée comes in and half of the time now I will let her give me a bed bath, because I feel that we are happier doing that. I am not saying that nurses don't do it properly or it's undignified. But I just have a little bit more care and attention from my fiancée and its just nice that we are in a private room (SIP-8: 40-46)

Although visitors and friends were seen as important to the well being of patients, their presence on the ward was the source of tension to other patients. In the already overcrowded ward, they were seen as invaders of other patients' privacy. Patient 32
thought that the presence of visitors could be very irritating, particularly when one was:

...Constantly surrounded by visitors who are always looking at you ... Visitors can be loud. They are constantly trying to make jokes, treating visiting time like a social event (UIP-42: 3-6).

Patient 32 typically exemplified the experience of other patients. She felt that visiting time and number of visitors should be curtailed. It was observed later that when patient 32’s mobility was improved she was seen holding conference with her visitors in the day room.

The observation data reinforced the view that certain visitors were apparently insensitive to the needs of other patients at times. The following notes were made during a period of observation:

*Patient 48 is ... trying to sleep while the visitors of patient 5 are having a loud discussion among themselves (GO-53: 32-33).*

Owing to the lack of facilities for visitors in the three wards and the closeness of the beds in the bays, visitors were often seen sitting on the neighbouring patients’ beds (GO-53: 41-43), standing around in large groups and observing the delivery of personal care to other patients (GO-136: 36-39). In another instance the following notes were made:

*Patient 342 has two visitors. They are very close to patient 343 ... who is reading a book (GO-137: 1-5).*
In the above example patient 343 had no visitors. He was attempting to concentrate on his book but it was apparent that the presence of the visitors was disturbing his concentration by the way he kept looking at them. According to patient 348:

Visitors can be very disturbing because of the overcrowding. They can be noisy (UIP-137: 30-32).

The above data suggest that although the presence of visitors can be a source of pleasure to many patients, their presence can also violate the privacy of other patients.

5.11 Category K: Regulatory and government standards

This section presents the data that demonstrate the extent to which professionals have knowledge-based awareness of, and attach importance to the many recently published documents that have stressed the importance of respecting patients' privacy.

Despite the fact that some importance has been given to protocols issued by the government and professional organisations, the data indicate that overall the practitioners' knowledge of these protocols was vague and in many instances non-existent. For example, when nurse 1 was asked whether she was aware of any government guidelines that placed importance on respecting the patients' privacy, she was very vague in her answer. She had heard of the National Health Service Plan (NHS Plan 2000) and the Patient's Charter (1995) but was not specific in her reply. With regard to the NHS Plan, she said:
I can't remember exactly everything in it. I've got it at home actually and I am pretty sure it said something in there about patients' privacy (SIN-47: 40-43).

When nurses 2, 3 and 6 were asked whether they had seen any ward protocols that guided nurses in the respecting of patients' privacy, they replied in the negative (SIN-57: 33-36, 62: 18). Nurse 3 imagined the existence of a ward protocol but, as a matter of fact, she had never seen one. However, nurse 6 admitted:

To be honest with you I don't know (SIN-79: 27).

Department of Health circulars have given many distinct guidelines in the area of respecting patients' privacy and dignity. When nurse 4 was questioned whether she had recently read any of the circulars that specifically direct the practitioners to respecting the patient's privacy, she replied:

I cannot think off the top of my head (SIN-69: 5).

It is apparent from these answers that all three nurses had no knowledge of any of the protocols. The replies of the three nurses that I received reflected the level of awareness of the majority of the nurses who were interviewed as part of this study. With regard to the Human Rights Act 1998, nurse 1 admitted that 'I could not tell you much about it' (SIN-47: 46). On the other hand, nurse 2 had not even heard of the 1998 Act (SIN-61: 3). Similarly, most of the doctors interviewed had no awareness of the Human Rights Act 1998 and Department of Health circulars. Doctor 2 was very honest in his reply when he said:
Although a majority of the doctors had no knowledge of any Department of Health protocols, certain members of the medical team had shown vague knowledge of the General Medical Council guidelines (1998). It was apparent that these doctors had a degree of awareness of their own code of conduct. According to doctor 5:

\[
\text{I know that the GMC also recently published a new handbook that they have distributed to us all, explaining confidentiality and advising us on how to go about managing patients (SID-33: 36-38).}
\]

In this statement doctor 5 hinted that he was aware of certain parts of his own code of conduct that stressed the importance of respecting the confidentiality of his patients. It is interesting to note that he equated 'confidentiality' with 'privacy' of the patient. However, he failed to stipulate that the General Medical Council has also stressed the importance of respecting the privacy of the patients.

When the deficit in the knowledge of the Department of Health circulars and the Human Rights Act 1998, among the members of the medical team, was raised with doctor 1, he replied:

\[
\text{This government at the moment, they make promises and they have no idea of how they are going to work out and then they institute things without any research because it looks good to the electorate, and we can see this time and time again (SID-2: 10-14).}
\]

Doctor 1 argued that the government have published all the circulars and protocols without systematic consultation with NHS staff. He felt that since the issues of shortage of staff and the adequacy of facilities in the hospitals have not been properly
addressed, it was very difficult to implement the principles of these protocols. He thought that 'the BMA and the government have been ill advised' (SID-3: 17-19) in the production of guidelines, the practical applications of which had not been thought through. In order to support his argument, he cited the recent protocol of informed consent as an example, that the medical practitioners had to implement by a certain date (SID-2: 20).

It was interesting to note that when fourth year student nurse 7 (final year of BSc Health Science Course) was interviewed about the Department of Health circulars, including 'Your Guide to the NHS' (DoH 2001) and 'Essence of Care' (DoH 2001) document, she demonstrated a good knowledge of their encompassing principles. She thought that 'Essence of Care' principles were being implemented in the ward by the health practitioners, particularly with regard to respecting the patients' personal privacy by shutting the bed curtains whenever possible (SIN-99: 27-32). She admitted that more could be done, particularly when administering medicine to patients (SIN-99: 33-35).

I was also interested to find out whether a philosophy of care determines the care in the ward. When the issue of the ward philosophy of care was raised with nurse 4, she added that the Trust mission statement had incorporated a statement that implied respecting the patients' privacy. Although the mission statement was recently devised, she thought that in due course the practitioners would start delivering care from common values and philosophy (SIN-68: 25-31). My records show that although the philosophy of care was raised many times with the nursing team, none was able to produce one or even locate its existence. According to nurse 14 such
protocols were normally kept in the sister’s office. When the question of whether generally nurses were aware of its location was raised, she replied:

\[\text{Some of them. I wouldn’t say all of them (SIN-145: 9).}\]

When nurse 14 was asked whether she had knowledge of the contents of the ward philosophy, she explained:

\[\text{Our philosophy is to get everybody independent and get them back to their own state of working and just to help them get their independence back and to do the best that we can (SIN-145: 17-19)}\]

It is interesting to note, according to the above statement of nurse 14, that the philosophy of care did not incorporate respecting the privacy and dignity of the patients.

5.12 Category M: Professional rationale for ‘overriding’ patients’ privacy

This category presents the data that describe the health professional’s explanations, particularly those of nurses and doctors, for their behaviour in relation to patients’ privacy. Many reasons were put forward by nurses and doctors in support of compromising their privacy. These are explored under the following headings: custom and practice, prioritisation of patients’ care, and ward structure.

All staff were interviewed following a long spell of observation. As explained previously, this strategy was deliberately taken to avoid, as far as possible any
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‘Hawthorne effect’ (Roethlisberger and Dickson 1939) on the daily ward activities of the health professionals.

5.12.1 Custom and practice within the wards

During the staff interviews observations already made previously were discussed with the individual staff and their explanations, if any, were sought. For example, when issues like the staff’s habit of sitting on patients’ bed without their permission was raised with doctor 5, he argued that he always asked the prior permission of his patients although the observation data showed otherwise (SID-37: 27-47). According to nurse 3, sitting on a patient’s bed was held as a ‘taboo’ once upon a time. However, these days, she remarked, patients felt more relaxed when conversation took place at eye level (SIN-63: 48-49, 64: 1-2). Other nurses thought that there are not enough facilities on the ward to discourse privately with patients. Nurse 15 argued that it was a custom and practice of the staff to sit on the patient’s bed when holding an intimate conversation (SIN-160: 1-2). With regard to other issues, like staff peeping through a fully drawn curtain, failure of staff to introduce themselves or not providing water for patients to wash their hands following the use of a commode or a urinal, various accounts were put forward. Doctor 1 thought that because staff were daily exposed to the personal and intimate care of their patients, certain staff had become so desensitised working on the wards that they had stopped questioning the impact of their actions (SID-10: 11-12). Nurse 1 concurred with this argument as she reflected as follows:
We have nearly lost somehow the inhibition because we see [it] day in day out, that we sometimes do tend to forget that it is something quite private for a person, toileting, and for us its quite normal (SIN-51: 42-44).

According to nurse 15, since patients are grouped together in a bay with similar conditions and they are of the same gender, many staff become ‘quite blasé’, as they often assumed that patients, particularly women, did not mind having their privacy violated by staff in front of each other (SIN-157: 6-14).

5.12.2 Prioritisation of care

Another common element in the staff account was that Wards A and B had a shortage of nursing staff. This was not found in Ward C. Nurse 1 from Ward A explained:

We are so understaffed and we are so busy doing everything else, get the patients washed, do this do and that, and in order to make sure that there are no complaints ... that we sometimes do tend to forget about privacy and dignity, quite frankly (SIN-55: 8-12).

According to nurse 1, the shortage of staff meant that the remaining staff were so busy that their main priority was to prevent patients’ complaints by providing essential care to the patients. Respecting the patient’s privacy and dignity was usually forgotten, since to many nurses these were not seen as a priority. According to doctor 4:

Life is more important than observing privacy. Privacy comes when ... the patient is unconscious or semiconscious. He probably may not know what is happening around him (SID-27: 21-23).
This doctor summarised the feelings of many staff that the issue of preserving life was more important than respecting the patients’ privacy. He also stressed that respecting privacy was important for those patients who could not care for themselves, like the unconscious and semi-conscious patients. This doctor also thought that the provision of basic care to a patient was more central than provision of privacy (SID-30: 33-36). He continued:

*Everybody observes privacy, and as far as I know, most of the doctors I know are very conscious about it (SID-27: 38-39).*

This doctor was adamant that most of his medical colleagues observed the privacy of their patients. He felt that many patients blamed doctors for nothing. He believed that the reason could be because:

*What they are observing may be different from what the doctors are observing most of the time (SID-27: 35-37).*

To many staff the presence of many different groups of patients made it difficult to respect their privacy. For example if a patient was elderly or partially deaf, nurse 3 explained:

*When the patient can’t hear ... you have to talk loudly (SIN-63: 33).*

Doctor 3 argued that the hospital was a busy place with very ill patients and the common topic for discussion among doctors was the physiological needs of patients rather than maintaining their privacy (SID-21: 17-18). He reflected as follows:
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It is a very busy hospital and there are very serious patients on the ward. So sometimes it is not always very possible to keep such a high degree of privacy for every single patient (SID-21: 15-17).

According to doctor 2, it was very difficult to practise holistic care in NHS wards when patients were being admitted with identified problems. He argued that owing to 'time pressure' the issue of patients' privacy was often overlooked. He admitted that the general practitioners in the community were more likely to practise the principle of holistic care than the doctors in hospitals (SID-14: 11-25). He explained that doctors were so busy in hospitals that they did not have time to reflect on the care of their patients and often tended to lose sight of what they were trying to achieve (SID-14: 19-20).

Nurse 6 agreed with the views of doctor 2 that the patients' care was still being driven by the medical model. She summarised her statement as follows:

*I think things are very much medical model driven still in the NHS. Things are still very much aimed at getting people better, looking at the medical side of things, looking at the tests and medicines (SIN-87: 45-47).*

Nurse 6 explained that since the whole aspect of patients' care was medically led, the patients' privacy, dignity and spiritual needs were given lesser priority compared to treating the actual conditions of the patient (SIN-87: 48-50).

5.12.3 Ward structure

Many staff and patients felt that the layout of the bays with six patients in Wards A and B and eight patients in two of the bays in Ward C made their presence very
difficult for the staff to respect the patients’ privacy. Patient 3 thought that the bays were continuously being disturbed by the fact that patients were undergoing operations, by new admissions and discharges (SIP-19: 34-36). Patient 17 concurred when he was asked whether privacy could be maintained in the bay:

*How can you with an open ward? But I don’t think you can achieve it under these circumstances anyway (SIP-92: 6-7).*

Patient 17 thought that it was impossible to ensure privacy (information privacy) in an open ward owing to the presence of so many patients in the bay. Doctor 1 also felt that it was difficult to maintain privacy of a patient owing to the closeness of the patients in the bay. He remarked as follows:

*The majority of people in hospital, however, are in multi bedded wards or in side rooms with doors left open which do invade their privacy ... As far as information privacy is concerned, you have got to look after the number of patients you’ve got ... You cannot physically leave the compact environment. We are in where everybody is overheard. There is no private area that I can go and talk to my staff (SID-1: 15-33).*

This was reinforced by nurse 14 who said that the layout of the bay and the overcrowding made it difficult to respect the privacy of the patients (SIN-52: 31-32, 147: 33).

5.13 Conclusion

This chapter described the data in detail, using each of the headings of the eleven categories as a basis for exploration of the key themes. These categories are: a) conceptions of privacy; b) territory and space; c) control and choice; d) personal care
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and de-personalisation of the patient; e) privacy of patients’ information; f) professional blind spot and habituation; g) ward lay out and logistics; h) patients’ coping mechanisms; j) visitors and relatives; k) regulatory and government standards and category m) professional rationale for ‘overriding’ the patients’ privacy. The description of the data was supported using actual statements of the participants or observation notes from each of the three data documents, ‘patients data’, ‘staff data’ and ‘observation data’. In the next chapter these categories are analysed in depth and various explanations are sought for the findings.
6. DISCUSSION OF THE DATA

6.1 Introduction

This chapter explains and discusses the data of each category as presented in the previous chapter, before drawing conclusions and recommendations for future practice (Parahoo 1997: 365). Every effort is made to compare the findings with previous studies and where these are different, possible explanations are offered. Emphasis is placed on doing more than just describing how patients and health professionals view privacy. As Werner and Schoepfle (1987) have suggested, 'We need to be able to explain how the natives could possibly view the world as they do' (p 60). I will therefore produce some in-depth explanations of my ethnographic experience. In order to substantiate these explanations further, guidance has been sought especially from the works of Goffman, *The Presentation of Self in Everyday Life* (1959), *Asylums* (1968a) and *Stigma* (1968b) as well as Benner (1984), Berger and Luckmann (1966) and amongst others as interpretive tools to make sense of the findings within each of the categories. In order that, as a researcher, I can contribute to the pool of knowledge about patients' privacy, I have devised a privacy model (see section 6.13), which is based on the notion that the selves of patients and staff are reshaped by various factors on the ward.
6.2 Category A: Conceptions of privacy

In chapter 5 the data within category A: Conceptions of privacy, was described under several subheadings: definition of privacy, meanings of privacy, having neighbours of choice, privacy of information, importance of privacy, and privacy within NHS wards. In this section these conceptions of privacy are discussed in their entirety.

The data show that the majority of patients had difficulty in articulating their expectation of privacy. The patients' perception of privacy depended to a large extent on whether patients were ill or recovering from illness or whether they had previous experience of being patients in the main bay or in a single-bedded room (UIP-48: 35-38). There were always many pauses and hesitations before giving an account. According to patient 207, privacy was of a very personal nature. Patient 157 thought that privacy could not be seriously considered in NHS wards because personal privacy ‘does not exist on the ward’ (UIP-102: 38-41). Such findings were in line with the Younger Committee’s report (1972), that the term privacy could not be defined clearly. According to this Committee, ‘Privacy is a concept which means widely different things to different people and changes significantly over a relatively short period of time’ (p 206). For example, when a patient was very ill, his or her first priority was to recover from illness at any price. The issue of privacy was never uppermost in such a patient’s mind. Such findings support the view of Bauer (1994) that when patients were ill their privacy threshold was low (SIP-16: 7-9).

Overall, the findings confirm the view that the perception of privacy was different from one individual patient to another within the wards (Younger Committee 1972).
Moreover, besides the influence of environment, individuals’ autonomy and self-determination, perception of privacy seemed to be a subjective experience (Bates 1964, Beauchamp and Childress 2001). For example, if patients were cared for in a single-bedded room, they thought, (assuming that they were mentally competent), that they had all the privacy they wanted with regard to both information privacy and privacy of the person. Such patients had their own toilet and shower facilities and could shut their doors to maintain some sort of privacy for themselves and their visitors. In the side room patients could receive intimate care, as related by patient 2. They had their own entertainment facilities and could even conduct their business in private from this side room as was initially undertaken by patient 160 (UIP-104: 14-21).

While in the side room, such patients thought that they were in control of their personal space and territory. They could withdraw and avoid of being with others, thus confirming Altman’s (1976) idea of privacy being governed by sociological factors. To these patients, as Bates (1964) had observed, privacy was seen as similar to the situation in one’s home. This notion was confirmed by patient 2 when he declared that in the single-bedded room he could have as many visitors as he wished and most importantly could receive intimate care from his fiancée (SIP-8: 33-36, 40-46). Section 2.8 noted Goffman’s (1959) belief that the state of an environment could greatly impact on the psychological well being and performance of an individual. Goffman explains that, for successful performances, individuals need two such regions: a ‘front region’ and a ‘back region’ (1959:114). My evidence suggests that by applying Goffman’s (1959) philosophy a side room could be interpreted as a ‘back room’. Goffman defines a ‘back room’ as a place in which individuals are not
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visible to the public and 'where the suppressed facts make an appearance' (p 114). In such a region patients are able to relax with their relatives in private without wearing any 'mask' and be able to rehearse their strategy of 'performance' for the moment when they face the professionals during their routine ward rounds. Equally, 'It is here that the capacity of a performance to express something beyond itself may be painstakingly fabricated; it is here that illusions and impressions are openly constructed' (Goffman 1959:114). For example, in the privacy of the side-room patients were perhaps able to make plans while discussing with their friends and relatives the type of questions that ought to be raised with members of the professional team, or might be able to share criticisms of staff whose delivery of care they are not happy about.

However, too much separation from other human beings was viewed as unacceptable by many patients. Although these patients valued the idea of being by oneself and avoidance of interaction with others (Chapin 1951, Altman 1976), and having freedom and personal independence (Bates 1964) in the side room, patient 2 thought that 'a lot of privacy during the day gets a bit much and you would like to be with people or seeing things move, watching the world go by' (SIP-12:37-38). He felt very lonely at times and craved the companionship of others. Since he was bed bound he could not achieve the desired levels of privacy by behavioural mechanisms (Altman 1976). This finding supports Westin's (1967) analysis of the components of privacy in that people tend to seek a balance between being with people and maintaining a reserved state. Such data also support the view that the need to privacy is an active process (Altman 1976) and it is both positively and negatively valued (Bates 1964).
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In the main bay, where patients were grouped together with five other patients in Wards A and B and seven patients in at least two bays in Ward C, the majority of the patients and staff thought that neither personal nor information privacy existed (SID-16: 37-49, UIP-42: 15-17). Applying Goffman’s (1959) principles of interaction and performance, these bays could be classified as the ‘front’ region for these patients where the daily drama took place in front of a set audience that comprised staff, other patients and their own relatives. These patients did not have a ‘back region’ in the bay. Most of these patients had to share toilets with groups of patients with whom, as patient 321 stated, they had been ‘lumped’ together (UIP-131: 49-50) without due regard of the state of their neighbours’ physical and mental conditions.

In the Department of Health document, ‘Your Guide to the NHS’ (2001:28), it states that patients are ‘expected to be involved in all decisions about their treatment’. Being ‘lumped’ together, without due regard to the patient’s choice was probably never envisaged by the government’s directive as part of a patient’s treatment. It is therefore assumed that the principle of patient participation in the decision making process relates only to aspects of physical treatment. If it were envisaged that the notion of collaborative care between patients and staff applied equally to the maintenance of an individual patient’s privacy, this was not evident in my data. Many patients suggested that, having to form long queues for the toilet was in itself demeaning to their dignity, as implied by patient 321 (UIP-131: 49-50). These findings perhaps confirm the data of Back and Wikblad (1998). They demonstrated that when a group of patients was being cared for in the main bay, such patients showed great concern about sharing toilet facilities with other patients. Most patients scored a highest preference value to having their own toilet facilities. Similarly,
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Bauer (1994) also found that many of her patients thought of ‘sharing toilets [with other patients] was awkward, mainly based on suspicion as to the adequacy of the hygiene and embarrassing’ (p 120). Her patients imagined that sharing the toilets with other patients was unhygienic because some assumed that certain patients did not normally clean the toilet pans adequately after their use.

It was obvious that the principles of the four states (chapter 2, section 2.3): solitude, intimacy, anonymity and reserve, stipulated by Westin (1967), regarding the main ingredients for ensuring privacy were not adhered to in these bays. There was no place in the bay where patients, if they really wanted to, could ensure an environment of ‘solitude’ for themselves. Although there was a day room in all the three wards, it was hardly ever occupied by patients. Perhaps a main reason for this was that the patients were not informed of this facility on their admission to the wards. Even if they knew of its existence, the room was so small that it could only comfortably accommodate three patients at a time. Even when the bed curtains were fully closed, while using a commode for example, patients were still conscious of sounds and smells pervading outside his space. It was also impossible to maintain a climate of ‘intimacy’ with one’s relatives because the neighbouring patients could overhear any conversation. There was no room for ‘anonymity’ on the ward because everybody else knew the profiles and diagnosis of each other. Even if patients wanted to keep their diagnosis a secret, this was impossible because of the physical closeness of other patients and the nature of the doctor’s ward rounds. Patient 109 reflected the feelings of the majority of other patients in the bay when she said that the ‘most intimate things are talked about and I can hear everything ... it can be very embarrassing sometimes’ (UIP-95: 39-41). Although patients could ensure a
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'reserve' state, Westin's (1967) fourth principle, by sitting next to their beds and creating a psychological barrier against unwanted intrusions, very often this state appeared to be denied by doctors, nurses and other paramedical staff. Patients were disturbed at frequent intervals by unsolicited ward rounds and neighbouring patients’ willingness to involve others in conversation in order to break their boredom. The patients in the bay were not in control of their time and space. In fact, it was quite obvious that the practitioners were in control of the ultimate privacy of their patients, as reinforced by patient 157 (UIP-102: 38-41).

Similarly, although most of the staff had accepted the importance of maintaining privacy for patients while they were being cared for in the wards, 92% (see figure 2) of the formally interviewed doctors and nurses appeared to confirm that patients had little privacy in the bays, compared to 77% of patients. According to nurse 3, when patients were admitted to the wards, ‘privacy that was enjoyed at home by such patients is thrown out of the window’ (SIN-66: 42-45). Doctor 6 thought that the privacy of patients could not be ‘guaranteed’ on the wards owing to the closeness of beds in the bays and the fact that neighbours could hear exactly what was being said to patients (SID-42: 43-47). When discussing privacy, this doctor was more concerned about information privacy rather than privacy of the person. The fact that the majority of staff thought that privacy did not exist in the bays was in many respects a surprising result. I had assumed that staff would maintain that privacy of their patients existed in the bays. Instead it was clear that most of the staff thought that their patients had little privacy in the bays of the wards. These findings were quite opposite to the results found by Back and Wikblad (1998). These authors showed that when nurses were asked to rate the existence of privacy in hospital, the
practitioners rated such existence more highly than the patients themselves did. It is not clear from the analysis of their research whether the rating of privacy by the nurses meant actual existence or ideal expectation of privacy. In the absence of such clarification, I have assumed that the rating process included the definition of actual privacy in the clinical setting. If this is the case and since their study was mainly based on the use of questionnaires, I wondered whether the use of this methodology could have led to a different result. In this study an observational ethnographic methodology was utilised prior to interviewing the staff. I would speculate that the staff knew that they were being observed in the ward environment and that I had a truer picture of the ward climate. Therefore when asked a direct question about the existence of privacy, they could not deviate from the truth.

However, despite the fact that 77% of the patients indicated that there was little privacy in the bays, the majority of the patients never made any overt complaints about this situation. Most of the patients thought that staff were too busy to ensure such 'niceties of life' (UIP-79: 1-5). Other patients made it clear (as explored further in category C) that such a situation did not bother them. It is apparent from this data that when patients were admitted to hospital they did not expect to have much privacy in the bays (SIP-1: 49-50). They tended to 'let down their barriers', as confirmed by patient 44 (UIP-49: 49-50) and tended to adopt and assimilate the sick role. They learned to adopt this role either from previous experience as a patient in a hospital or by observing fellow patients or staff (Freidson 1970, Schuster 1976). What was uppermost in the mind of most of these patients was getting good and safe treatment. For example, when patients were asked to rate privacy on a scale of importance, nearly all the patients felt that receiving medical treatments were more
important than privacy. Patient 5 summarised the feelings of many of these patients when he stressed that 'medicines save life. Privacy cannot' (UIP-102: 34).

When doctors and nurses were questioned about the importance of giving medications, on a scale of 1 to 10, to a patient compared with ensuring privacy, evidence suggested that there was no difference in their perception from those of the patients. Privacy was rated lower than receiving treatments. Many nurses thought that since doctors did not prescribe privacy, it was not considered to have the same priority as giving medicine and treatment to a patient. It might be inferred that since patients' complaints were more likely about staff breaching their obligation with respect to clinical treatment as explained by nurse 1 (SIN-55: 8-12), it is no wonder that staff saw that carrying out treatments was more important than respecting the privacy of a patient. In the year 1999-2000 out of 86,536 complaints received from NHS patients, only 1,103 cases were directly related to violation of patients' privacy and dignity (DoH 1999-2000). It is not clear from the Commission's Report how these figures were obtained. It would have perhaps been useful to know what constitutes a 'complaint'; what forms of complaints became the final part of the statistics; to what extent did the breaches of the patient's privacy of the person form part of the final number of the figure? If privacy of the person did form part of the final figure, I would have liked to know their definition of the privacy of the person. Furthermore, was there a causal relationship between low privacy protection and high clinical complaint rate? Can it be argued that if a patient is dehumanised by the lack of privacy, he or she is more likely to complain about a clinical matter? It could therefore be assumed that since complaints from such patients about privacy were rarely made on the ward, patients themselves did not see the respect of their privacy
as a priority. Both Barron (1990) and the Younger Committee (1972) argued respectively that privacy is a basic need. It allows people to maintain their individuality and psychological well being. Although some patients felt embarrassed, it was not clear from the data to what extent their individuality was affected. Since most of these patients had already mentally accepted the fact that privacy did not exist in NHS hospital wards, the adoption of such a change in perception probably helped them to cope better in the light of what could otherwise be seen as prima facie breaches of their personal and information privacy. Such findings further confirm the view of Bates (1964) that privacy is more likely to be defined by ‘attitudinal and affective responses of the individual’ (p 429).

6.3 Category B: Territory and space

In chapter 5 the data of this category were presented under two distinct headings. The first part of the category related to the various mechanisms that staff and patients used to maintain the patients’ personal space and territory, and the second part explored the data that demonstrated the extent to which patients’ space and territory were perceived to be invaded or respected by the staff.

Altman (1976) defines personal space as ‘an invisible boundary surrounding one’s self’ (p 20) and says that this personal space of an individual is ‘attached’ to the self. The space of a person is not entirely fixed but is carried everywhere when the individual moves from one area to another. Hall (1966) explains that personal space can be subdivided into four distance zones in accordance with interpersonal contact. These are: 1) an intimate distance, ranging from body contact to about 12 inches.
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This is appropriate to close intimate relationships. 2) Personal distance is spanned to a distance of 1.5 to 4 feet, which allows considerable exchanges between the participants. 3) There is social distance of 4-12 feet that allows impersonal interaction, particularly in work situations or in casual relationships. 4) The last distance zone is known as the public zone, which is normally beyond the range of 12 feet. This type of zone is appropriate to meetings. According to Louis (1981), personal space is an area that is external to an individual, characterised by boundaries that are not clearly demarcated. She explains that each individual has a 'personal space boundary' (p 396) that is the outer limits of the invisible area. Her study supports the position that the personal space needs of an individual are not the same for all persons. The distances measured in her study ranged from less than one inch to more than three feet for the same stimulus situation at which point the individual starts to feel uncomfortable. She found that an individual personal boundary might be influenced by the role identity of the stimulus-individual. For example, an individual patient is more likely to allow a registered nurse to intrude in one's space without evoking an unpleasant response compared to a stimulus-individual devoid of a role identity.

On the other hand, the concept of an individual's territory is rather fixed. It is geographically immobile. It is the physical space of individuals that is their home, office or any place that they can call their own (Altman 1976). According to Edney (1976), human territoriality serves 'as an important organiser of behaviour on several levels' (p 31). For example, territories provide humans with a reliable piece of space in which to exercise everyday functions, 'such as sleeping, copulating, child rearing' (p 32). Edney reinforces that a person without a territory would be living a 'social...
existence with a huge Grand Central Station experience’ (p 34). This person would be constantly milling around at random, distractions and interruptions would be routine. ‘With no place to settle, people could not start and complete behaviours that required uninterrupted sequences, since moving around is by itself a powerful disrupter of behaviour’ (34). Since loss of one’s territory can unsettle an individual, Roosa (1982) explains that in nursing homes, residents demonstrate their ownership of a territory by filling their territorial space with their own possessions. ‘Personal photographs or articles placed on a dresser top or room divider tell others that this place is occupied’ (p 242).

6.3.1 Maintenance of patients’ territory and space

The data in this category supports Altman’s (1976), Edney’s (1976) and Roosa’s (1982) concepts that a person’s territory and space are important and lack of them can unsettle one’s behaviour. I found that while patients were in hospital the majority of them viewed their bed, locker and bed table as their own and the space around their bed as their own territory (UIP-102: 109). At most times, their territory boundary was marked with flowers and photographs of their loved ones, thus supporting Roosa’ (1982) findings. The patients had no problem with regard to the distant zones as specified by Hall (1966) in the single bedded side room because at most times they were by themselves unless they were involved in some sort of activities with staff, friends or relatives. They could enjoy some form of aloneness. They could read, watch television and receive visitors without interruptions. They were in control of their territory. They were able to invite friends according to the knowledge they had of them (Bates 1964).
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In the bays of Wards A and B, the patients' beds could be said to be located at a 'social distance', whereas in Ward C the distance zones between the patients were at a 'personal distant' level (Hall 1966). However, in all three wards, if patients were mobile and owing to the position of the chairs, the distant zones and therefore the personal space of the patients could change to an intimate level. In order to ensure some privacy by the bed, the patients in the main bays could close the bed curtains around their beds (SIP-8: 52-53). However, in most instances, the initiative for closing the bed curtains remained with the staff without seeking the permission of the patient (SIN-92: 29). The activity of closing bed curtains by staff was particularly observed when the medical staff were examining patients physically, nurses changing the bed linens of bedridden patients, and patients using commodes by their bedside.

According to Lawler (1991), nursing staff tend deliberately to utilise the techniques of closing the bed curtains for certain intimate activities with their patients in order to ensure that there was 'a lack of audience, no unnecessary exposure of the body and to minimise the possibility of [their own] embarrassment' (p 166). Since nurses are 'heavily involved in emotional labour' (p 126) and many types of 'dirty' nursing, Lawler noted that closing the bed curtains probably helped these professionals to cope with their own embarrassing positions. My observation supports Lawler's (1991) comments. It is argued that the main reason for drawing the curtains by staff was to ensure some sort of physical privacy of the person by preventing stares and glances from other patients and visitors. Yet if the staff knew that the bed space around the patient's bed was his, how was it that the staff hardly ever asked the patient's permission prior to closing the bed curtain? Was it mere thoughtlessness or
lack of awareness on the part of staff of the importance of territory and space to the health and well being of a patient as Edney (1976), Louis (1981) and Bauer (1994) have argued? Or were the staff simply performing the task of a caring professional in the presence of their patients in order to exercise ultimate control over their patients (Goffman 1959)? Since patients hardly ever made any adverse comments against the staff’s tendency of not seeking their permission prior to drawing their curtains, could this silence gave the staff ‘legitimacy of entry’ (Schuster 1976) within the personal space of their patients and therefore asking their permission in itself became unimportant? My data support Schuster’s (1976) and Louis’s (1981) values of caring, that the care and comfort of patients can be improved if such thoughtless acts on the part of staff are avoided and the personal space boundary of patients are recognised by staff. Staff attitudes and behaviour are important to patients’ privacy (DoH 2001). Staff members who seek the permission of patients prior to closing their bed curtains or consult with them before involving them in any activities are demonstrating that they respect the patients’ autonomy and their privacy (Beauchamp and Childress 2001).

Patients were seen closing their own bed curtains on the rare occasions when they were being discharged or to create some sort of physical barrier from their nearest neighbour, as was the case for patient 169 and patient 345 (GO-136:17-21). With regard to patient 345, it was not clear who drew the curtain. However, it could be argued that since this patient was a Moslem, her culture required her to have more privacy. This woman was eating different types of food (in most instances curry) and probably staff and the patient felt that other patients’ stares were intrusive of her
privacy. This data clearly support the view of Bates (1964) and Altman (1976) that a person's culture to a large extent determines a person's perception of privacy.

Despite the availability of a sitting room, and the patients' mobility in the bay, even the mobile patients hardly ever used it. These patients preferred to sit by their beds and observe the activities of the bay and converse with the neighbouring patients. This finding contradicts the research of Schuster (1976) who argued that a person's mobility and level of consciousness and awareness help in controlling one's boundary. My data show that the mobile patients on the three wards hardly ever moved from their own beds to the common sitting room or shut their bed curtains themselves to ensure some sort of privacy. Such behaviour can be explained by assuming that most of these patients had probably adopted the patients' role, either from experience or through conformity by observing the actions or inaction of other patients. The most probable explanation might be that most of these patients was not informed of the facilities of the day room (see category H) and whether it was under their control to shut their own curtains at will. Another reason could be that, being in the sitting room brought strangers within an intimate zone in which personal conversation was bound to start. It could be argued that those mobile patients who rejected the use of the day room could be consciously creating a personal distance from others and straining to maintain some sort of privacy within a crowded environment.
6.3.2 Invasion of patients' territory and space

Altman (1976), Barron (1990), Oxtoby (2003), Westin (1967) and the Younger Committee (1972) support the view that the need for privacy is a basic human need. According to Oxtoby (2003) 'privacy and dignity is built into holistic care' (p 19). However, while the patients were being cared for in the bay my evidence suggests that this ethos was not respected by the majority of the health practitioners. The data show that while patients were being intimately cared for within a closed curtain, doctors and nurses rarely forewarned patients prior to entering the patient’s territory (GO-21: 6-10, 40: 1-5). In both these cases a patient was being cared intimately by a nurse, yet in each case a doctor disturbed this relationship and their privacy. According to nurse 1 (SIN-51: 10-13), if a patient was located within a fully closed curtain and had rung the bell for assistance, the ringing of the bell had legitimised the nurse’s entering through the closed curtain. However, nurse 1 did not state at any time that when giving the warning signal to the patient that she awaited for a reply from her patients prior to entering the closed curtain.

Peeping through the closed bed curtains was a common occurrence by all grades of staff, particularly doctors and nurses, even when very intimate care was being carried out behind the closed curtain (GO-40:1-5, SIN-93: 27-30). In the latter case the nurse was conducting a very intimate dressing on a patient who was suffering from pilonidal sinus. According to this nurse, the patient was already in an embarrassed state and such invasion of one’s space and territory without any prior warning was unacceptable. In another case patient 24 was using a bedpan within a fully closed curtain, when sister, who was passing by, opened the curtain without any warning by
just stating 'are you OK there?' (GO-51: 5-7). Nurses and doctors showed, what appeared to me, a lack of tact and sensitivity by frequently walking in and out of fully closed curtains either to seek advice from the inside practitioner or just talking to the patient (GO-5: 22-25). Sometimes bed curtains were never closed or only partly closed even if an intimate care like the use of a urinal by a male patient, the commode by a female patient or the removal of a venflon from the arm of a patient (GO-13: 20-23, UIP-106: 14) was being carried out.

In many societies, people normally cover their bodies and it is unacceptable to expose one's body in the presence of strangers in certain places. However, in a hospital environment of the NHS this strict rule is relaxed as it becomes acceptable to expose one's body in the presence of health practitioners (Emerson 1970, Edelmann 1981, Lawler 1991). Despite this flexibility Lawler argues that 'strict taken-for-granted rules' should apply within a hospital setting. She explains that both patient and staff must negotiate the process of 'handing over' and 'taking over' (p 139) the body for its physical care. When this rule is breached, patients feel embarrassed. Edelmann (1981) has defined embarrassment as a 'common and often dramatic experience, consisting of a highly uncomfortable psychological state, which can have a severely disruptive effect on social interaction' (p 125). According to Lawler (1991) nurses tend to associate embarrassment with feelings of the 'patient's vulnerability, dependence and social discomfort and they regard embarrassment as a consequence of inadequate protection of patient's privacy' (p142). I believe that such peeping behaviour or any behaviour that could place the patient in an embarrassing situation should be avoided. It is a clear 'violation of patient expectation' that their dignity and privacy are respected within the confines of their territory and space.
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(Lawler 1991). Patients have a right to have their privacy and dignity respected (Oxtoby 2003).

My findings are also supported by Barron’s (1990) study who found that nurses frequently failed to ensure the patients’ privacy by not closing the curtains fully or by failing to forewarn them of their approach, especially when patients were either using a bed pan or washing in bed. Such a ‘slipshod practice’, as Barron (1990.) called it is unacceptable in the current climate. While Barron mainly focused her study on nurses and patients, this study shows that doctors also appeared to practice poorly in this regard. There are many explanations for such behaviour. It was apparent that nurses and doctors were busy people, having their own agenda for the day and in the pursuit of this agenda, patients’ need for privacy was probably pushed aside. These days practitioners are more likely to be involved in high-tech care, thus reducing the time that they could spend on the individual patient (Oxtoby 2003). However, not all practitioners were responsible for such ‘slipshod practices’. Certain members of the health team had demonstrated that patients’ privacy could be respected if a conscious effort was made. For example, it was noticed that a third year student nurse (GO-2: 40-41) and a health care assistant (GO-4: 8-12) did make an extra effort at alerting patients before entering the closed curtain. These findings could be explained that certain members of the ward team had not yet fully assimilated the institutional culture of the ward. On the other hand, it could be argued that my very presence might have made the students adopt an ‘idealised’ version of their ‘front’ (Goffman 1959:44) which is more consistent with Anglo/British cultural norms and social values when entering somebody’s space. Goffman (1959) defines ‘front’ as ‘the expressive equipment of a standard kind intentionally or unwittingly employed by
the individual during his performance' (p 32). He explains that a person's front is a
'set of abstract stereotyped expectations' that prepares others for the ensuing
performance (p 37). It could be further argued that while adopting such a front the
students and the health care assistant had no belief in their own performance or any
concerns with the beliefs of their patients. They could have consciously adopted such
a 'front' adding 'dramatic realisation' to their performance, which otherwise might
have remained undetected by their audience, including other patients and myself
(Goffman 1959: 40).

Sitting on the patients' beds without the patients' permission was a common
occurrence by doctors (GO-52: 14-15), nurses (GO-10: 6-9) and other paramedical
staff (GO-7: 36-39). In fact, this behaviour was so common that the patients thought
that it was the norm in the three wards. Both doctors and nurses considered that
sitting on the patients' beds was a good thing as such behaviour ensured a cordial and
unique relationship between staff and patients (SID-7: 5-45, SIN-58: 25-27, SID-43:
11-12). The traditional explanation that sitting on the patients' beds could be a causal
factor for the spread of cross infection like Methicillin Resistant Staphylococcus
Aureus (MRSA) was rejected outright by both nurse 4 (SIN-70: 18-21) and doctor 5
(SID-37: 27-47). It is argued that the health practitioners, in establishing a
paternalistic relationship with their patients, sometimes minimised their patients'
autonomy, as patient 16 confirmed (SIP-89: 23-25).

The movement of personal items from the patient's bed table or locker by cleaners
(GO-56: 48-49), nurses (GO-79: 38-41), and care assistants (GO-3: 46-49), without
seeking the permission of the owners of these items, could be perceived as an
invasion of their territory and privacy (UIP-91: 42-46, 98: 27-30). However, my findings suggest that many of these patients did not see such issues as sitting on patients' beds or movement of personal items on their bed table or locker as a high preference value, as Back and Wikblad (1998) had found in their study. Most of the patients in this study thought that such occurrences were so frequent that they had to accept such things as part of being a patient. In fact my evidence suggests that most of these patients did not realise that sitting on their beds could be seen as violation of their boundary. As they had already adopted the roles of patients they accepted the notion that it was 'legitimate' for nurses and doctors to sit on their beds without seeking their permission (Schuster 1976, Louis 1981). However, I did not find any of these 'so called' violations as deliberate or conscious acts on the part of the cleaners or nurses, as Bauer (1994) had argued in her study, but rather as thoughtlessness, as Bauer (1994) also confirmed later.

6.4 Category C: Control and choice

Analysis of the data of category C: Control and choice demonstrates that patients in the main bays of the wards generally had no control and choice over many of their own affairs. Patients were frequently moved at very short notice between bays and from a single-bedded side room to a bay without seeking their consent (SIP-50: 35, 32: 9-15). Although patients were informed of their movements, they were not given a choice to make an informed judgement of their bed's position. In most instances such movements meant that patients had to leave their established friends behind and learn to cope with the characteristics of their new neighbours. My evidence suggests that at no time were they given any choice of neighbours.
Lack of control and choice was also evident in many other areas of their daily care, such as sleep patterns, the time for getting up or how and when they received their meals. (UIP-24: 11-23, GO-77: 35-42, 77: 44-46, UIP-61: 21-23).

Lack of control and choice was also obvious in the areas of the patient's personal hygiene and toileting facilities. Nursing staff were more likely to provide a patient a commode by the bed rather than take the patient to the toilet. The choice of using the toilet rather than commode was hardly explored with the patient. Similarly, evidence suggests that patients were hardly provided with facilities to wash their hands after the use of a commode or urinal.

Since coming to power in 1997 New Labour has promoted a policy of creating a flexible climate within the NHS whereby the balance of power would be shifted to patients (DoH 2002). The principles of this philosophy are clearly documented within the NHS plan in the form of policy guidelines. For example the Department of Health booklet 'Your guide to the NHS' (DoH 2001) spells out clearly the standards of care that patients should expect when they are admitted to NHS hospitals. Page 28 of this booklet states that patients should 'expect to be involved in all decisions about your treatment'. Similarly, the establishment of Commission for Health Improvement (CHI) in 1999, by sections 19 to 24 of the Health Act 1999, has ensured that the principles of patient empowerment, patient-centeredness and transparency of health professionals' activities become part of core values within the NHS. This principle suggests that patients' participation in their own care, as long as they have capacity to make their own decisions, would be respected.
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My evidence suggests that the principles of patient empowerment and patient-centeredness are ideals that professionals would find difficult to implement. In the present NHS bureaucratic system, the organisation structure lends itself to a hierarchical control of practitioners' activities and patients' care. According to Jones (1994), bureaucratic organisations can take many forms. Weber (1979) explains that such an organisation includes a hierarchy of authority in which a clearly established system of supervision exists of the lower workers by higher officers. As I explained in section 4.7.1, a system of team nursing was in place in all the three wards. My data show that such team nursing resembles closely a two-tier system as advocated by Adams (1996). Under a two-tier system although the members of the nursing team were given certain power, the ultimate authority and accountability remained in the hands of the ward sister. The ethos of such a two-tier system was to ensure that the daily nursing tasks were completed by exercising control on the nursing taskforce and patients' activities. My data show that the majority of patients were unable to exercise their autonomy in such an environment.

According to Brown et al (1992) autonomy is defined as consisting of self-determination, which includes one's ability to understand one's situation, to make plans and choices and to pursue one's personal goals. For Thomasma (1984) autonomy includes the notion of 'freedom' and the freedom to act at will. Beauchamp and Childress (2001) believe that the word autonomy includes as diverse meanings as 'liberty rights, privacy, individual choice, [and] freedom of the will' (p 58). They argue that certain factors, such as freedom from interferences by others and meaningful choices are essential to personal autonomy and exercising control over one's affairs. They explain that autonomous persons are free to act in
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accordance with a ‘self-chosen plan’ (p 58). By contrast they argue that persons with diminished autonomy are in some respect controlled by others or incapable of acting ‘on the basis of [their] desires and plans’ (p 58). Overall the data of Category C (Control and Choice) present a picture that generally patients’ autonomy was restricted over many aspects of their care, despite the various Department of Health’s guidelines. Patients had little control and choice during their stay in the wards. They were not free to act on their own plans. If patients had any plans of their own, such as choice of bed position or less interference by staff, opportunities were not provided to discuss them. My evidence suggests that staff controlled the patients’ stay in hospitals. These autonomous patients were treated as if they were incapable of acting on their own plans.

It is suggested that patients face many obstacles in NHS wards in the exercise of their choice and control over their own care. According to Elander and Hermeren (1984), cited by Leino-Kilpi et al (2000: 66), organisational issues are important factors in preventing patients from expressing their choice and control over their own affairs during their stay in hospital. According to these authors such issues include ‘the atmosphere in the hospital, hospital organisation, and rules and routines of the hospital’ (p 66). It is argued that as staff in a hospital possessed superior skills and knowledge about the conditions of their patients, many patients tended to adopt a passive role and wholly relied on the expert knowledge of the professionals, as described by patient 191 (UIP-116: 21-22). Such a patient-professional relationship would undoubtedly lead to an environment in which patients were expected to assume a compliant role that further gave credence to the professionals to remove control and choice from their patients. There is no doubt that nurses tended to
manage the environment in which the patients were being cared for without much negotiation with the patients. Practitioners organised the ward routines and the medical and nursing care without much discussion with the patients.

Drawing on the works of Foucault (1982) and Burr (1994), Williams et al (1998) have stated that nurses use sophisticated techniques in order to exercise power and control over their patients. Besides having knowledge of the patients and managing the patients' environment, they also use 'productive power that [nurses] are able to exercise by building relationships with their patients' (p 123). In The presentation of Self in Everyday Life (1959), Asylums (1968a) and Stigma (1968b), Goffman has demonstrated how individuals and professionals can use knowledge and their positions to wield power over their patients that could lead to stripping of their identity. In Asylums Goffman (1968a) explains how the admission procedures were designed to mortify the self of the patients. For example, the way patients were undressed, bathed and disinfected. Although these are extreme examples, could the principles might still be applicable in to-days NHS hospitals? In the three wards the data suggest that nurses and doctors had overall control of the daily lives of their patients and most of the data support this principle. Foucault (1982) explains that the rituals of power lead to 'nonegalitarian and asymmetrical relations' (p 185) between two groups. To understand the impact of 'power in its materiality', Foucault suggests that it should be studied in 'its day to day operation and ... to the level of the micropractices' (p 185). Equally, Foucault (1982) saw power not as some sort of possession that certain individuals have and others do not, but as embedded in discourse. This was precisely what was observed in this study between patients and staff.
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The empirical study of McLeod (1994), on verbal and non-verbal interaction between nurses and patients, has shown that nurses have learned to sharpen their techniques of communication as they see discourse as a very important tool in controlling patients. Hewison (1995) also supports the view that nurses exert a lot of control over the patients during their interactions by the use of specialised linguistic devices. Hewison argues that the power base of the relationship between nurses and patients is unequal. He notes that there is an ‘expectation on the part of the nurse, and an acceptance on the part of the patient, that the nurse will be in control’ (p 79). Hewison (1995) and Palviainen et al (2003) support my findings that nurses and doctors tended to exert power through language to persuade and control the agenda of the patients.

Bauer (1994) also confirms the findings that patients tend to play expected roles. She found that patients’ personal choice and control were limited in a hospital. She demonstrated that hospitals did not offer any choice to their patients with regard to different meals. Food had to be accepted as it was served. In my study the choice of food was not a real issue because patients could make a personal choice from a selection of meals. What was of concern in this study was that patients had very little say on the timing of the arrival of their meals, particularly if a patient had diabetes. By the time the food arrived it was cold, to the great dissatisfaction of the patients. Bauer (1994) also found that patients had no control in the area of their personal hygiene. Half of her patients showed great concern about sharing toilets with other patients.
Although patients had very limited choices and control in many of their affairs within the bays, the question is, in the present climate of economic constraints, is it reasonable for patients to expect these rights? Drought and Koenig (2002) argued that such a choice model is fundamentally flawed. They suggested that the concept of choice in end-of-life care, for example, is meaningless with regard to resuscitation decisions, since the survival rate following resuscitation attempts is poor. Similarly, the majority of the patients would have liked the facility of the single bedded room with all its added facilities of privacy. However, many of these patients had accepted the notion that since money and other resources are not infinite, they could live with their choice limitation as long as such constraints did not affect their personal medical treatment.

6.5 Category D: Personal care and depersonalisation of the patient

There has been a great emphasis recently in a variety of UK Department of Health circulars, within nurses' (NMC 2002) and doctors' (GMC 1998) own codes of conduct and the Human Rights Act 1998, on the importance of maintaining the dignity and privacy of patients while they are being cared for in hospitals.

The data obtained during this research demonstrate that the way the patients' dignity and privacy were compromised in the wards led to the depersonalisation of patients in many respects. Besides losing the overall control of their lives and their independence on admission to the wards the majority of the patients also felt that they had lost their individuality. For example, during the doctors' rounds the patients were hardly ever introduced to other doctors around their bed. It was implicit during
such ward rounds that the presence of other doctors would be accepted by the patients without question and in most instances this was what happened. The consultants or registrars had assumed that all other doctors around the patients' beds would not be viewed as strangers since junior doctors normally saw the patients at an individual level and that patients would remember their names (SID-4:16-22). This assumption is rejected because my observation data showed that during weekends particularly, the ward patients were looked after by a generic doctor. However, certain patients did not attach much importance to the issue of self-introduction (UIP-66: 20-21). This group of patients attached less value to self-introduction from doctors around their beds because, as exemplified by patient 68 and doctor 5, even if a doctor were to introduce himself or herself patients would not be able to recall their names anyway (SID-35: 22-35).

However, the majority of the patients thought that doctors should have introduced themselves before seeking any personal information from them. These patients argued that they had the right to know the name of the person with whom they were sharing their information. In fact, they did not mind having students around them. They were supportive of the notion that students had to gain experience as part of their training. The doctor's own code of conduct (GMC 1998) states, at section 12, that 'a successful relationship between doctors and patients depends on trust'. Although the issue of self-introduction is not included in the list of section 12, it is argued that the notion of self-introduction is a basic human requirement in our society to ensure a trusting relationship and as a first sign of showing respect to another person. This does not imply that doctors did not show respect to their patients in other ways. The importance of self-introduction was stressed by a
consultant doctor when he said, 'I find that a very interesting fact, and that's something I will instantly put in my ward round' (SID-4: 16-22). Many known researchers in the areas of 'privacy and dignity' have failed to raise the specific issue of self-introduction of doctors to their patients, including Bauer (1994), Back and Wikblad (1998) and Schuster (1976). It is probable that, as most of these researchers used questionnaires in their search for data, the issue of self-introduction did not emerge strongly and was therefore ignored. However, the study by Marini (1999), about institutionalised elderly persons' perceptions of nurse caring behaviours supports the principle that many patients believe that treating patients as individuals and with respect form part of the caring behaviours of a nurse. I feel that professionals should recognise the importance of introducing themselves to patients and show behaviours and attitudes that enable patients to feel that they matter at all times as individuals.

Exposure of one's body is only seen as appropriate and acceptable in intimate surroundings (Westin 1967, Bates 1964). According to the Crime and Disorder Act 1998, intentional exposure of certain parts of the body by any individual in public places is viewed as a criminal act, if such an anti-social act 'caused distress to one or more persons not of the same household as himself' (s. 1.1a). My data show that, when patients were admitted to the wards, wearing hospital gowns (theatre gown) beyond their usefulness was commonplace and routine. There is no doubt that there are many advantages in wearing of the gown in the operating theatre. However, the design of the gowns made it practically impossible for any patient, however adept from preventing the whole posterior part of the body being exposed to the gaze of other patients, visitors and practitioners. That lying in bed or sitting on a chair in the
hospital gown was no protection against undue exposure of the sensitive parts of the body. The majority of these patients thought that in the gowns they looked like fools (UIP-57: 5-9), felt dehumanised and dreadful (UIP-17:13-14, 35: 25-31). They felt a deep revulsion towards the gown as they were made very vulnerable in them (UIP-105: 36-37). Many of these patients were very embarrassed as they argued that by just wearing the gown, it made them lose their identity as a person and their dignity as a human being. The issue of embarrassment was previously raised in section 6.3.2, when impacts of peeping through the curtains on the well being of the patients were discussed. The principles raised by Emerson (1970), Edelmann (1981) and Lawler (1991) raised in that section are equally applicable here. Exposure of the body is likely to cause social and psychological discomfort to patients and staff should understand that caring of patients involve actively protecting the patient’s modesty.

Although most of the patients and staff had shown disgust towards the gown (SIN-67: 13-19, SID-6: 17-43), my evidence suggests that none had made any overt effort to speak out against it. Most probably, patients had accepted that such exposure was part and parcel of being patients and were prepared to ‘conform to the institution rules’ (UIP-80: 36-37). The question remains though, that if our nurse practitioners are the effective advocates of our patients, why have these very able practitioners allowed such poor practice or arguably malpractice to continue despite the Nursing and Midwifery Council’s guidelines (NMC 2002:8). Clause 8(2) of the Code of Professional Conduct states, ‘You should act quickly to protect patients and clients from risk’. This issue is analysed further in section 6.12 when category M (Professional rationale for ‘overriding’ patient’s privacy) is considered.
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The research by Parrott et al (1989) and the study by Lawler (1991) demonstrated that exposure of the body could be viewed as a violation of privacy by patients. Parrott et al (1989) also found that it was more likely that younger patients would regard such exposure as invasive of their privacy. In my study it was noted that all ages of patients were wearing hospital gowns beyond their reasonable uses, and it is suggested that these patients might have felt embarrassment.

The study by Walsh and Kowanko (2002) supports the well-accepted notion that the definition of dignity incorporates many characteristics. Both patients and nurses thought that the notion of patient dignity included such elements as respect, privacy and control. According to their patients, respect for patients was achieved when their personhood was acknowledged. The nurses stressed that patients’ dignity revolved around not exposing the body and protecting patients from the unnecessary gazes of other individuals. Their study cited a vivid example that matched my own data how wearing a hospital gown could lead to exposure of the body and compromise the dignity and privacy of the patients. One of their interviewee nurses had made the following comments:

When they’ve got a hospital gown on and they’ve not covered up at the back and often the patients are unaware, they are showing their whole rear view to anybody who happens to come up behind them (p 145).

Similarly, the study by Bauer (1994) also supports my findings that wearing hospital gowns by patients could be a very undignifying experience. Most of Bauer’s patients felt very uncomfortable knowing that their sense of privacy was violated as their backs and buttocks were exposed to the gazes of others. The ‘Essence of Care’ document (DoH 2001), explored in chapter 2, has emphasised the importance of
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respecting the privacy and dignity of patients. One of the key benchmarks of best
practice stipulates that ‘patients/clients care actively promotes their privacy and
dignity and protects their modesty’ (p182). Despite the hospital’s own pilot trial of
the principle of ‘privacy and dignity’ within the hospital of my research and the full
knowledge of the impact on privacy and dignity on the patients, my evidence
suggests that the modesty of the patients had continued to be allowed to be
compromised in the wards. Until this research, the practitioners had not thought of
taking any actions against the practice of allowing hospital gowns to be worn beyond
their clinical usefulness. The rationale for adopting such an attitude will be explained
further in section 6.12.

Another aspect of care that emerged strongly from the data was the way in which
patients were identified and addressed by nurses during their daily activities. Nursing
students and qualified nursing staff called most patients by their first names despite
the patients’ age and experience of life. Words like ‘darling’, ‘Jack’ or ‘John’ were
frequently used by nurses to call their patients. It was very interesting to find that
such endearing expressions were used more frequently by the nursing team rather
than by the medical staff. Doctors often used their surnames to address their patients.
They were often heard using words like ‘Sir’, ‘Mr so and so’. The nurses’ and
doctors’ own codes of conducts (NMC 2002:3 and GMC 1998:5) emphasise that
professionals should respect patients as individuals. The ‘Essence of Care’ document
(DoH 2001) emphasised that, as a benchmark of best practice, staff should ensure
that ‘communication between patients/clients takes place in a manner which respects
their [patients] individuality’ (p 182:4).
The study by Marini (1999) demonstrates that patients want to be treated as individuals and with respect. However, my data suggest that most patients did not mind being addressed by their first names or with endearing language. According to Duranti and Goodwin (1992), language is inextricably linked to culture and to the social environment. Since nurses give care in closer proximity to their patients, they adopt a language that reflects the culture and social environment of the wards. They assume that the use of first names maintains good relationships with their patients. I argue that there is a danger that addressing patients by their first names without their prior permission could compromise the individuality and dignity of their patients. It is possible that the patients were so overwhelmed by the culture of the wards that they were willing to sacrifice their individuality during their stay in hospital. According to Hewison (1995) the use of ‘terms of endearment reinforces a reality in which the patient is childlike and the nurse the parent figure’ (p 80). The adoption of such language, according to Hewison (1995), reinforces the assumption that nurses are generally in control of the affairs of the patients.

Another aspect of care that is thought to have led to the depersonalisation of the patients and their privacy and dignity was the way that the patients' urinals were disposed of following their use. Full urinals were left lying about on the patients’ bed tables and their lockers. Although the majority of nurses thought that this practice was unacceptable, it is surprising that nobody appeared to change the practice. The patients' habit of carrying the urine drainage bags in their hands was also found rather undignified. It is natural and an acceptable fact that in most cultures adult individuals wish to perform their elimination functions in private. However, as soon as a patient is admitted to hospital, such private and personal matters attract the
concerns and gaze of other people. One of the lead sisters of one of the wards explained to me that since such urine bags were heavy, a leg bag could not be used (SIN-111: 35-40). Bauer (1994) argued that such displays of one's elimination was a source of great embarrassment to her patients. It is argued that in both instances such practices were allowed to continue because of the habituation process of the staff. They did not see that there was anything wrong and undignifying for patients.

Goffman (1959) argues that an individual's self is the product of various things. In the way that individuals react to each other during routine interaction or the way practitioners may treat their patients, the self may become damaged, resulting in embarrassment. In such situations, according to Goffman in *The Presentation of Self in Everyday Life* (1959), 'the participants may find themselves without a course of action ... and come to feel awkward, flustered, and, literally, out of countenance' (p 235). In *Asylums* (1968a) Goffman explains that owing to a series of debasements, degradations and humiliations that the inmates received in the mental institution, their selves were 'systematically, if often unintentionally, mortified' (p 24). The patients were forced to humble themselves before superiors. The patients' selves were mortified to such an extent that the inmate required permission to perform even the most basic task of human functions and in certain cases their humiliation was increased by an absence of privacy. The question that I would have liked to pursue further was whether these dehumanising treatments that the patients appeared to have received in my research had in fact led to any signs of embarrassment or 'mortification' of their selves as Goffman had stipulated. However, in accordance to my data, even if the patients had suffered 'embarrassment' or 'mortification' of their selves, it was impossible to differentiate these features. I suggest the fact that the
patients did not make any complaints and sat by their beds starring at each other may denote the first stages of embarrassment and mortification.

In summary, the data show that patients can be depersonalised in many respects. On admission to the wards many patients lost their control and independence in the way that they had to change into their own pyjamas, night-gowns or theatre gowns. It is suggested that these patients appeared to lose their individuality by the way they were addressed by nurses. During ward rounds patients were not introduced to others around their beds as both doctors and nurses thought this was acceptable by patients. It is argued that making patients wear hospital gowns beyond their usefulness and carry their urine bags in their hands was degrading and dehumanising and these dehumanising behaviours may have affected the patients’ self and their identity as persons.

6.6 Category E: Privacy of patients’ information

This research was primarily concerned about finding out the extent to which the privacy of the person was being respected in NHS wards. However, during the data collection periods, category E: ‘Privacy of patients’ information’ emerged so strongly that it was impossible to ignore this data completely. To many patients and even staff, when the term privacy was mentioned, privacy of information was almost always uppermost in their minds, whereas privacy of the person was only thought of following the many prompts by me during the data collection phase.
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The data in section 5.6 appear to confirm the view that a patient's personal information as an element of ward discourse, was openly shared with other patients in the bays of the wards. This was particularly so during the doctors' and nurses' ward rounds. When patients were admitted to the ward they necessarily surrendered some of their personal information to staff with the expectation that such information would be kept secret from individuals who were not directly involved in their care. But what was disconcerting from the findings was the way that staff conducted their ward rounds, with other patients able to hear what was being said. Since these other patients were not 'close friends, relatives, or professionals associates' (Parent 1988: 216), it is argued that a patient's privacy was diminished exactly to the degree that other patients had that information about him without his consent (Parent 1988).

Beauchamp and Childress (2001) differentiate confidentiality and privacy of information by explaining that confidentiality is a 'branch or subset' (p 304) of information privacy in that it is infringed if the staff to whom the information was disclosed in confidence fail to protect that information without the patients' prior consent. By contrast information privacy is violated when an unauthorised person is able to gain access to another person's private information. My data appear to support the view that staff infringed both confidentiality and privacy of information of the patients.

Bauer's study (1994: 116) confirms my own findings to a large extent. With regard to breaches of information privacy in the bay, Bauer found that her respondents adopted four distinct approaches. She found that 75% of her patients thought that doctors should talk to patients in private and 90% of her patients had stated that personal matters should never be discussed in front of other patients. However, one
of her groups had also stated that they did not mind if their information was being shared with other patients. Similarly, in this study, the majority of the patients had accepted that during a ward round conversations between doctors and nurses and patients would be overheard in the bay. Patient 7 summarised the views of many patients when he said, 'you have got to accept that there will be limitations' (SIP-43: 21-23). Patient 6 represented the views of the majority of the patients in thinking that the only way in which privacy could be improved in a ward was by allocating each patient to a side room. He accepted, as did the majority of patients, that in the present economic climate it was impossible to provide such facilities for each patient (SIP-40: 17-18). Back and Wikblad (1998) confirmed the thoughts and feelings of patient 6. In their study, the majority of patients showed a high preference value for having a conference with their doctors in a private room rather than discussing their cases within earshot of other patients. My data show that despite the existence of a staff room, this facility was rarely used to interview patients and relatives in private.

There is no doubt that staff could deliberately lower their voices in the bays when dealing with patients, as was exemplified by one consultant when examining patient 169 (GO-111: 40-45). However, it was assumed that this event only occurred because I had already interviewed this consultant previously and raised the implications of interviewing patients in a loud voice. Most probably, my presence reminded him of the contents of our interview while he was interviewing patient 169. This is a typical example of the 'Hawthorne effect' explained by Roethlisberger and Dickson (1939). On the other hand, the consultant’s behaviour could be explained as wanting to impress his audience around him by displaying an 'idealised' version of
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the front (Goffman 1959) as being more consistent with the acceptable norms and values of caring patients.

My evidence suggests that generally patients did not have much information privacy while using their bedside telephone as any conversation could be overheard by all present (GO-21:1-4). Patient 42 confirmed this when he said that he would rather use a mobile phone than use the bedside telephone, but use of mobile phones in the wards was banned in that hospital (UIP-48: 46-49). However, the use of the trolley telephone in a quiet place was limited as on most occasions during the research period it was out of order. Even when in working order, it could only be connected in the dayroom, which was supposed to be a common room for all patients with mobility. Since there were many advantages of having an individual telephone by each patient's bed, to some patients the risks of having their personal matters become public was of lesser consequence, as confirmed by patient 125. He thought that since most of the patients were suffering from the same conditions, it was of no consequence to him if others could hear his conversation. Such data confirm the findings of Schuster (1976) that the majority of patients did not mind the status quo because they thought that their stay in hospital was either 'a singular situation' or 'one-time encounter' (p 247) with other patients.

However, it was apparent that most of these patients had no choice but to resort to using their bedside telephone. They had accepted that there was no privacy of information on the telephone. Many patients had adopted various mechanisms to ensure privacy. They had learned to lower their voices. In most instances they had to keep their conversation brief and to the point (GO-78: 19-22). Bauer's (1994)
patients had also shown great concern about using the public telephone in the ward. She found that the use of the phone posed a serious problem to many of her patients. As in this study, she found that when a patient was talking on the telephone, it was eagerly listened to. Following a particular telephone call, most of her patients felt pressured to give some details about the calls and certain intricacies of the conversation to their neighbours, because after the end of the call other patients expected to share individual conversation with others. Although such patterns were not noted in this study, it was quite apparent that any patients could tell the relationship of the caller to the patient simply by following the flow of the conversation.

The Caldicott Report (1997) stresses the importance of keeping identifiable information of patients confidential so that strangers would not be able to identify patients by exposure of the patients’ data. However, in the three wards it was noticed that any patients’ whereabouts in the ward was very easily identifiable by following the plan on the white board which was located by the sister’s office in the corridor of the ward (GO-9: 10-14). It was also disconcerting to find patients’ case notes lying about at the nurses’ station and in many instances opened instead of appropriately filed in the relevant cabinet. Although I did not find any strangers accessing these notes, serious risk existed that such notes could be mislaid and strangers and visitors to the wards could exploit the patients’ data. In such a situation the principles of the Data Protection Act 1998 and Freedom of Information Act 2000 would undoubtedly be breached. Both these statutes have stressed that if a third party, not being members of the caring team, accesses the personal data of a patient without consent, the victim could seek redress in the courts.
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The medical professionals’ own code of conduct (GMC 1998) stresses that doctors are required to ‘treat information about patients as confidential’ (p 3). Similarly, the Nursing and Midwifery Council (2002), in Clause 5 of its Code of Professional Conduct, reminds the nursing and midwifery professionals of the importance of protecting the patients’ information. Other Department of Health documents, for example ‘Essence of Care’ (2001:182) and ‘Your Guide to the NHS’ (2001:3) are equally committed to the provision of high quality service by respecting the confidentiality of individual patients. My evidence suggests that despite the professionals’ obligations of respecting the confidentiality and privacy of information of their patients, they did not adhere to these guidelines. The professionals gave many reasons for their non-adherence of the principles of confidentiality and these are analysed in a later section.

6.7 Category F: Professional ‘blind spot’ and habituation

In chapter 5 (5.7: category F), data were presented that suggested that certain behaviours of practitioners that impacted on the privacy and dignity of patients could be institution-driven.

It was noted that nurses’ and doctors’ daily activities were bound by certain routines. All patients were woken at 06.00 because certain routine tasks, such as completing the observations (temperature, pulse and blood pressure), treating the pressure areas (back rounds) and serving the morning teas, started at that time. The main ward lights were switched on simultaneously at 06.00. Switching on these lights gave
license to the staff to start all activities that had been only cautiously carried out until then.

Some of these activities had to be commenced earlier in order to keep pace with the workload and the staff's drive to complete certain tasks before the arrival of the morning shift at 07.30. Certain patients had to be made ready and sitting on the chairs by their beds, very often without dressing gowns, although the patients' breakfasts only arrived about 08.00 or later. It was apparent that the exercise of such routines meant that the patients' personal needs and, more importantly, their sleep patterns, were ignored. The medicine round also had to be completed before 08.00 when the night staff officially finished their work. Although the majority of the patients were unhappy about the thought of getting up that early in the morning, they appeared to accept such routines. Patient 13 summed up the views of the majority of the patients when he remarked that such routines are made for the staff. 'It is to let them [staff] get through their work' (SIP-72: 12-14).

A great effort has been made to implement the philosophy of the nursing process in most hospitals over recent years (McFarlane 1977, Alfaro-LeFevre 2002) thus 'promot[ing] a people rather than task-orientated approach' (Smith 1992:9). Yet I found that the principles of ward rituals and routines were still practised. In my view the patients' personal needs for sleep, privacy, choice and control of their own affairs were definitely compromised. According to Walsh and Ford (1989), ritual action 'implies carrying out a task without thinking it through in a problem-solving, logical way' (p ix). They suggest that staff generally do not think about the implications of their actions and tend to carry out certain activities because of past habits, and at
times in an autonomous way. They believe that 'many aspects of nursing care are ritualistic and demonstrably of no value, if not positively harmful to patients' (p 150). Equally, Martin (1998) suggests that the existence of ward rituals 'can only serve to bring about an uncaring approach' (p 190). He suggests that set routines and rituals enable nurses to maintain an appearance of care as their behaviour is structured to enable them some degree of distancing from patients. He believes that rituals associated with language have undermined the nurses' ability to advocate for their patients. This research demonstrates that although nurses were aware that certain of their routines affected the dignity and privacy of their patients, they were not prepared to speak out against practices that compromised this. The Nursing and Midwifery Council (NMC 2003) has recently expressed grave concern about the rituals of early waking of patients. The NMC argues that waking people early in the morning to lighten the workload of the day staff is not in a patient's best interests. It stresses that such practice 'does not recognise and respect the individual dignity of each patient as outlined in the Code of Professional Conduct' (p 16). The NMC views this practice so seriously that it is encouraging nurses to raise their concerns openly with their managers.

It is argued that despite the existence of research that has clearly shown that many routine practices are useless (Walsh and Ford 1989:150), the fundamental problems of translating research findings to nursing practice remains an issue (Lunkenbill-Brett 1987). Many reasons have been put forward by Claxton (1987) such as nurses having fixed assumptions about research, resistance to change and personal commitments. However, Menzies (1988) maintains that rituals and task centred care serve as defensive techniques to protect nurses from the anxieties of making difficult
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decisions. According to her, and reinforcing Martin’s (1998) view, such routines allowed the nurses to maintain a distance from the patients. Menzies (1988) remarked:

The nursing service attempts to protect her from the anxiety by splitting up her contact with patients ... The total workload of a ward or department is broken down into lists of tasks, each of which is allocated to a particular nurse (p 51).

Besides the existence of rituals and routines of the wards, another issue that emerged strongly in this category was the way in which many activities directly interfered with the personal needs of the patients. Ward rounds, particularly those by doctors, nurses, physiotherapists and others, were taking place throughout the day. During such rounds patients were interrupted, no matter what they happened to be doing at that time. It appeared that doctors and nurses had their own set agenda and these had to be achieved at the expense of patients’ needs. The case of patient 84 (GO-77: 35-42), illustrated in category C, is a good example. Patient 84 had a major operation in the early hours of the morning. He was in a deep sleep when he was interrupted by a doctor’s round at approximately 08.00 and again later by two physiotherapists (GO-77: 44-45). There is no doubt that sleep is vital to the wellbeing of a person. It is as necessary to maintaining life as are food or exercise. Research has shown that sleep deprivation can cause heart disease (Nebraska 2003). This interference episode led me to believe that during the doctor’s round, the importance of sleep was not fully appreciated. It is argued that such professionals failed to respect the privacy of their patients, in the pursuit of achieving their own agenda. It was probable that the consultant had planned to see all these patients prior to undertaking other activities. Such evidence suggests that many practitioners failed to incorporate the specific
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needs of patients when planning the treatments of their patients. Westin (1967) advocates that solitude and reserve (see chapter 2) are important elements of privacy. It is suggested that individuals should be given the opportunities to maintain these states. Not many years ago patients were given a certain time in the afternoon to rest without much interruption from visitors and staff. On my research wards there was a philosophy of open visiting time. It is accepted that in certain cases interruptions are necessary in monitoring the wellbeing of the patients. Although researchers in the area of privacy have not specifically looked at the rate of interruptions and its impact on the well being of patients, Baur (1994:125) has confirmed that control of one’s body is essential as a key element of ensuring one’s dignity and privacy.

My evidence suggests that there were other activities of care that were undertaken by professionals that failed to meet the individual needs of the patients. For example, it was observed that patients’ meals were often left at the end of the bed, which could not be reached by patients (GO-83: 36-38). Patients were advised by doctors to drink copious fluids, yet the water jug was left lying about beyond their reach. Following a ward round, it was a common occurrence to leave the bed curtains half-drawn and thereby partly barring the views of other patients. Although some of these data do not directly form part of respecting the privacy of patients, they are vivid examples of the professionals’ blind spots and habituation.

It is therefore argued that, in the process of achieving their own agenda, professionals tend to develop ‘blind spots’. They become so habituated by rituals and routines that they fail at times to realise the consequence of their actions on the wellbeing of their patients. Goffman (1968a) suggests that such rituals emphasise the control that staff
have over their patients which in turn convinces them that they are inferior beings. According to Berger and Luckmann (1966), habituation means: ‘any action that is repeated frequently become[ing] cast into a pattern, which can then be reproduced with an economy of effort’. They argue that habituation saves energy since the process ‘carries with it the important psychological gain that choices are narrowed’ (p 71). Individuals are thus freed from the burden of ‘all those decisions’ (p 71) and obtain psychological relief. They explain that such a state provides the individuals with a stable background in which human activities can be carried out with a minimum of decision making. This principle is supported by Menzies (1988) when she explained that making a decision requires of a nurse to make a choice between different possible courses of action. According to her, ‘to spare staff this anxiety, the nursing service attempts to minimise the number and variety of decisions that must be made’ (p 55). Although professionals had many blind spots in the exercise of their daily duties that had direct impact on the dignity and privacy of patients, there is no doubt that, in the light of Menzies’ (1988), and Berger and Luckmann’s (1966) arguments, such habituation processes saved many moments of anxiety. Practitioners did not have to interrupt their routines and since patients made hardly any complaints (NMC 2003), such habituation processes continued to form patterns and subsequently became part and parcel of their daily activities without them realising it.

6.8 Category G: Ward lay out and logistics

According to certain patients, the difference between their own home and the hospital ward was like being in two different worlds. At home people can have all
the privacy they want and they are surrounded by a variety of facilities of their choice. Their sensory organs are tuned to different types of noises and they are well adapted to a stable environment. People are able to invite visitors of their choice and at the time of their own choosing. In fact, people are masters of their 'castle' with full control of their life. In such a stable environment, people do not have to play a part and offer a 'performance and put on [a] show "for the benefit" of other people' (Goffman 1959:28). In such an environment people are on the 'back stage' (Goffman 1959) and are able to perform sincerely and do not have to be concerned with the beliefs and impressions of strangers on their actions.

On admission to a hospital ward, individual patients instantly found themselves in a strange environment with five other patients in Wards A and B and seven other patients in Ward C and their visitors whom they had never met previously. Patients had to interact and make a favourable impression (Goffman 1959) not only on their strange neighbours but also on different health professionals. In this strange surrounding, the space between the beds was so narrow that very often patients found themselves sitting inches away from their neighbour. According to patient 1, in Ward B, the beds in the bay 'are reasonably close together ... not to expect ... any privacy' (SIP-1: 50, 2: 1-2). During bed making, doctors ward rounds and visiting times the wards seemed very crowded with limited space around each patient (GO-94: 19-22, 127: 6-7). Bauer (1994) found similar state of affairs in her study. The patients also showed concerns about the closeness of the beds. One of the patients thought that 'other patients could be disgusting, therefore, he liked some space between beds' (p 76).
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At home people have normally ample space to store their personal belongings. In hospital bays they are given a waist high unlockable locker with very limited space for storing personal items in a dignified way. Personal clothing of patients was therefore lying about in crumpled states on chairs, lockers and in plastic bags under the bed (GO-63: 50, 64: 1-3), increasing the impression of crowding. However, although patient 352 was most concerned about the lack of facilities in the bay for hanging her personal towels, she did not think that there was a need for a lockable locker. Since she was more or less permanently sitting by her bed and had probably developed a trusting relationship with her neighbouring patients, she did not see the need for a private locker. However, Back and Wikblad’s study (1998) showed that their female patients gave a high preference value to having access to a locked box in the ward. This was an interesting finding as my research showed a general apathy towards the need for having a personal lockable locker in the bay. This could be explained by the trusting relationship that the patients had developed towards the staff.

If patients were happens to be admitted into a single-bedded room, besides other facilities, they also had the entertainment facilities with a television. In a bay, patients did not have such facilities. Although a bedside radio was provided to each patient, it was found that frequently the radio set’s ear pieces were missing. Even if a patient could work out the existence of the radio, certain elderly patients could not figure out the mechanics of the system (UIP-58: 42). My data suggest that patients were poorly informed of the existence of other ward facilities, such as television in the day room. The majority of the patients thought that they ought to have the facility of the television in each of the bays. Although many of the patients showed surprise
at first in finding the facility of the day room, very few of them used the day room subsequently. The explanation could be that the room was also used as a waiting room for a specific clinic. In Ward C there was a larger day room which was located at the very end of the ward. However, since that room was also utilised by visitors, few patients used it.

It is also argued that the state of the individual bed curtains and the rails exacerbated the exposure of patients when personal intimate care was afforded, supposedly in private and within a closed curtain. The various gaps (GO-50: 33-35) in a closed curtain enabled other patients and visitors to observe very intimate care being provided. This meant that, although staff were trying to ensure the privacy of the person of their patients, other factors such as chairs and patients sitting next to each other proved to be physical barriers for curtains to close appropriately. Bauer (1994) also noted similar problems. She wrote ‘curtains ... do not close properly, are too short or embrace a much too narrow space which impedes free movement or does not leave room for a wheelchair’ (p 120).

On admission to hospital individual patients were exposed to a variety of unusual noises. Besides noises emanating from other patients, visitors and staff, patients were affected by the incessant noises of drips and ripple-bed machines. These noises were found particularly annoying by many patients at night as they impacted on their sleep patterns (UIP73: 31). The squeaky wheels of the ‘back round’ trolleys, and the noise of the dripping tap of the inappropriately placed sinks in the bay combined to affect the privacy of patients in one way or another. Normally an individual can get used to a variety of noise levels over a period of time, but in the research wards the patients’
stay was usually only of two to six days. In the News section (p 17) of the Sunday Mail (April 12, 2000), it was reported that a group of researchers led by Mackenzie (2000) from Heriot-Watt University, Edinburgh, were studying into the effects of noise levels for hospital patients with particular regard to patients’ recovery times and increasing nurses’ stress levels. The researchers hoped to demonstrate the impact of installing special sound-absorbing ceilings on the noise levels of the wards. There is no doubt that hospital wards are noisy and further studies are required to demonstrate the impact of noise on the well being of patients, their dignity and privacy.

The architectural structure and lay out of the bays support the notion that the wards were specifically made for the staff rather than for the patients (SIP-71: 1-4). Patient 107 reinforced this statement when he said, ‘there is no privacy at all in this bay. The place is made for nurses so that they can see all the patients’ (UIP-37-41). The presence of large transparent glass windows that separate the bays from the corridor undoubtedly afforded easy observation for the staff of all the activities of the patients from a distance. Any patients at risk were easily detected and actions could be initiated immediately. The presence of such large and transparent glass windows unfortunately also allowed strangers, visitors and other patients walking in the corridor, to view the state of the patients openly within the bay. Undoubtedly such behaviours of strangers and staff also infringed the privacy and dignity of the patients. Patients lying in or sitting by their beds in a variety of situations and positions could not help but become subjects of public scrutiny without the individual’s knowledge.
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It is argued therefore that owing to the structural features and logistics of the bays of the wards, patients' sensory organs could become overloaded by the various stimuli in the wards with resulting effects on their individuality and privacy. According to Milgram (1970) cited by Stokols (1976: 51), 'overload' is defined as a situation 'in which the amount and rate of environmental inputs impinging on an organism exceeds its capacity to cope with them'. Milgram (1970) implies that for individuals to operate effectively in an overload environment, they must adopt specific behavioural strategies in order to survive. Simmel (1950), as cited by Stokols (1976), has further argued that an overload system that persists can lead to impatience, aloofness and social isolation in individuals. Although I did not specifically study the impact of noise and 'overload' on the body system, the data appear to confirm the argument that the variety of noise levels could have eroded patients' privacy. This is further explored in the next section, where the various adaptive strategies that the patients adopted are analysed in detail.

6.9 Category H: Patients' coping mechanisms

The data in this study suggest that patients' privacy and dignity were compromised in many respects while they were being cared for in the bays of the ward. Yet, despite the existence of this data, a minority of patients denied the fact that their privacy and dignity were ever compromised. They continued to maintain this posture of denial despite clear evidence that it appeared that their privacy had in fact been compromised. These patients frequently said that it did not 'worry' or 'bother' them (UIP-123: 43-44, SIP- 19: 22-23). This might be regarded as psychological denial. According to Cohen (2001), such denial is classified as 'literal, factual or blatant
denial' (p 21). He defined this type of denial as an ‘assertion that something did not happen, ... the fact or knowledge of the fact is denied’. For example, when patient 163 was asked whether his privacy was respected in the bay, he blatantly replied ‘I have no problem with my privacy’ (UIP-110: 14-17). Cohen (2001) believes that an individual denies actual events as a mode of ‘defence which consists in the subject’s refusing to recognise the reality of a traumatic perception’ (p 25). Although the issue of his possibly traumatic perception was not explored in detail with patient 163, it was obvious that he refused to recognise the state of affairs, most probably as a mode of defence. Similarly, patient 6 was very convincing when he said, ‘it is a lot nicer than the press gives out and I felt any privacy you want will be respected’ (SIP-38: 13-14). He explained that whenever he wanted any privacy the nurses would close the bed curtains to prevent him being embarrassed (SIP-38: 14-15). Patient 8 was convinced that he had every privacy in the bay. He said, ‘in a way I am saying, you have all the privacy that you want. If you go to the loo, and when you are in bed, you have invariably still got your dressing gown on. As far as I can see you’ve got all the privacy you require or need’ (SIP-49: 25-29).

Although these patients denied the fact that there was any lack of privacy in the bay, they were adamant that closing the bed curtains and wearing their own dressing gown would maintain their privacy. It is obvious that the concluding statements of this minority group of patients appear to be inconsistent. Such an attitude on the part of these patients was explained by Festinger (1957) as ‘Cognitive Dissonance’. Cognitive dissonance theory assumes that there is a drive on the part of individuals toward cognitive consistency. When two cognitions are inconsistent with one another, they will produce discomfort for the individual and will motivate the person
to remove inconsistency and bring the cognitions into harmony. Although it was apparent that there was little privacy in the bay, these patients had come to believe that there was complete privacy for them as long as they wore their dressing gowns and their bed curtain was closed. Atkinson et al (1990) have argued that 'Cognitive Dissonance Theory' can be said to be a provocative theory 'in predicting that engaging in behaviour that is counter to one's attitude creates dissonance pressure to change the attitudes so that they are consistent with the behaviour' (p 708).

However, the evidence suggests that the majority of the patients had accepted the principle that their privacy and dignity had been compromised during their stay in hospital. Yet, these patients were very reluctant to criticise this violation. This issue will be explored in this section. How did these patients cope during their stay in hospital? What made them accept the status quo of such a state of affairs, and what could be the explanations for this?

The data in section 5.9 demonstrated that the patients had utilised various mechanisms to cope in the ward. From the moment of admission, most patients had accepted that privacy did not exist in the bays as they had been used to in their own homes (SIP-33: 28-31). It was apparent that they were mainly interested in receiving safe medical care and treatment. In order to achieve this objective, they felt that certain aspects of care had to be compromised and that maintaining their dignity and privacy was not as important as receiving good medical treatment (SIP-33: 41-42). Certain patients thought that NHS hospitals were like a factory and patients were part of the production line (SIP-70: 28-38). However, the majority of the patients had accepted that, generally, staff were very busy people (SIP-78: 27) and had to balance
their time and skills between meeting the basic needs of all their patients and respecting their privacy (SIP-70: 28-38).

Goffman’s (1959) sociology of personal behaviour in a strange setting perhaps sheds light on the rationalisation process that most patients had adopted. Under the heading of ‘Dramatic Realisation’, Goffman explained that in the presence of others [patients], an individual [professional staff] ‘typically infuses his activity with signs which dramatically highlight and portray confirmatory facts that might otherwise remain unapparent or obscure’ (p 40). According to Goffman (1959), individuals are able to act in a way that expresses what they hope to convey. He gave an example from his own study of a surgical ward and a medical ward to support this argument. In a surgical ward staff were able to be involved in nursing activities that appear to be important to patients. In such an environment, they were able to demonstrate their nursing skills overtly. By changing the bandages of a patient following an aseptic technique or caring for patients with intravenous infusions in the open bay, nurses were more likely to convince new patients with such ‘purposeful activities’ that they were very busy people. He also noticed that nursing in a medical ward was equally ‘highly skilled work’, the pace of work was slower than in the surgical ward. As nurses were commonly involved in spending higher proportions of their time in taking observation and talking to their patients, this gave the impression that ‘nurses are wasting time unless they are darting about doing some visible things such as hypodermics’ (p 41).

My research arena was comprised mainly of three surgical wards, but with a mixture of medical patients in Ward B. Staff were generally involved in many recognisable
and purposeful activities in front of other patients. Therefore, the analysis of Goffman’s (1959) principles of ‘Dramatic realisation’ during social interactions in the bays can be used to support the argument that the majority of patients in this research viewed health practitioners as busy people.

My evidence suggests that in many instances patients had no choice and control over their own lives because of the layout, routines and logistics of the ward and most felt that they had no choice but to conform with the institutional rules and act as patients (UIP-80: 30-32). They had ‘to put up with it’, as patient 160 explained who represented the views of many. They did not want to interfere with ward routines and interrupt the agenda of the staff (UIP-32: 34-35).

My data suggest that the majority of the patients trusted the competence of the nurses and doctors and placed complete faith in them (SIP-66: 38-45). They thought that most of the doctors and nurses were faultless and did an ‘excellent’ job (UIP-88: 28-29). They had accepted their care at face value and without any question whatever (UIP-116: 21-23). Patient 12 thought that if a patient questioned staff at every point of their care ‘it would lead to anarchy’ (SIP-68: 44-50). Other patients argued that since their hospital stay was short, they were prepared to accept anything, as long as their behaviour did not upset the staff. They did not wish to be labelled as disruptive and thereby become unpopular in the eyes of the health practitioners. Stockwell (1972) had documented the dangers of such labelling and it was not surprising that many of the patients in my study would prefer to adopt the qualities of a compliant patient. Patient 111 affirmed this notion when she said ‘you can’t tell bad things
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about this place’ as it was likely that she was going to be readmitted in the future and had to face the same consultant and nursing staff (UIP-88: 28-29).

Many other patients had apparently learned to create a mental barrier around them. The study of Holloway et al’s (1998) study reinforces my findings that patients enjoyed having some sort of structure to a day. They liked the daily routines, such as the doctor’s rounds, meal times, medicine rounds and, most importantly, the time when their friends and relatives could visit. Holloway et al (1998) explain that in order to cope with the anxiety, depression and loneliness of their hospital stay, patients pass their time by ‘reading books and magazines, watching television and talking to and helping others’ (p 462).

Many patients were seen spending their time talking with their neighbours, sometimes quite loudly and without due regard for the needs of other patients (GO-69: 12-130). These patients were quite willing to divulge their personal diagnosis and treatments and share their personal affairs with other patients. Some of these patients were normally inquisitive and apparently made every effort to know the affairs of others (UIP-67: 9-10). My evidence suggests that to many of these patients, privacy of personal issues was of no importance. Most probably, involvement in such interactions helped them to reduce their own anxiety state and helped them to cope with being in a strange environment with strange people. According to Holloway et al (1998), involvement with other patients helped these patients to manage their time better in hospital.
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According to Schuster (1976) there are broadly two types of patients in a hospital. One group attempts retreat and withdrawal, and the other attempts disclosure and communication with other patients. Schuster explains that patients tend to adopt such behaviours according to their individual need and situation. Although I did not systematically quantify these two groups of patients, my research supports Schuster's (1976) findings.

Altman (1976) has argued that the ability to exclude or include others in one's fold and the ability to regulate and control the desired level of contact with others are necessary in the maintenance of one's self esteem. This mechanism of an individual breaks down when choice and control of the environment are taken over by others, as I found in my research. In such instances, when individuals lose the ability to control, any breaches of privacy fail to trigger any responses. On the other hand, knowledge of perceived breaches of privacy that could not be avoided can lead to stress and disturbance in the individual concerned. However, according to Altman (1976), an individual is quite willing to accept any breach of privacy if it is a means of getting better or achieving something. This was also my finding. Most of the patients were prepared to give away some of their privacy and dignity as long as they received the medical treatment of their choice.

My data appear to support the arguments that most of the patients were quite happy to be compliant and were in fact very reluctant to make any complaints against any practice in the ward that a neutral observer might think unacceptable (NMC 2003). It was apparent that patients were not prepared to fight for their rights for individual
privacy in the ward and seemed to be at ease with themselves in accepting the status quo.

As explained in section 6.3.2, Goffman (1959) argued that individuals tend to adopt a 'front' in the presence of observers. They have the capacity to play different roles according to the setting in which they are. Under the sub-heading of 'Idealization', Goffman explained that 'when the individual presents himself before others, his performance will tend to incorporate and exemplify the officially accredited values of the society' (p 45). This is a good dramatisation of what was found during this research. Professional individuals and others were willing to play the compliant roles of patients. Immediately on admission they were prepared to wear pyjamas even during the daytime, or hospital gowns and trust the expertise of professionals without questioning. They were prepared to eat their meals surrounded by full urinals and be exposed to the views of other patients, their visitors and staff. In order to play such a role successfully, many of these patients had learned to exercise systematic modesty by underplaying the 'ideal values which accord to the performer [patient] a lower position than he covertly accepts for himself' (Goffman 1959:47). Thus, it is argued, that most of these individuals by placing themselves in the hands of professionals and playing down their intelligence and skills, were prepared to play the weaker roles in the presence of the superior skills of the health practitioners. These patients had learned to 'reorient their frame of reference and devote their efforts to the creation of desired impressions' (p 243) of good and compliant patients.

By adopting such postures of compliance, it was obvious that patients themselves had apparently contributed greatly to the continuance of breaches of their personal
and information privacy. During ward rounds, when information privacy of neighbouring patients appeared to be openly violated by staff, most of the other patients adopted ‘a tact of protective practices’ (Goffman 1959). They sat in or by their beds showing signs of complete inattention about what was happening around them. At no time did any of these patients remind the staff of the importance of respecting the privacy of individual patients. According to Goffman (1959), this is a natural cultural reaction of western citizens to such a situation. He explains that ‘tactful outsiders in a physical position to overhear an interaction may offer a show of inattention’ (p 227). These patients were not willing to interrupt the flow of the ward rounds or demand a code of acceptable etiquette from the staff. They did not want to create a ‘faux pas, the desire, above all else, to avoid a scene’ (p 224) and thus be labelled ‘unpopular’ (Stockwell 1972). In short, they had learned ‘the arts of impression management’ (Goffman 1959) of a fully compliant patient (Argyle 1983) to maintain the status quo of the situation in order to receive good medical treatment and care.

There may be another reason why the majority of patients played such a compliant role. The patients’ performance could be viewed ‘as some kind of image, usually creditable, which the individual [patient] on stage [hospital wards] and in character effectively attempts to induce others to hold in good regard to him’ (Goffman 1959: 244). Goffman explains that a person’s self is not ‘derived from its possessor’ but ‘from the whole scene of his actions, being generated by that attribute of local events which renders them interpretable by the witnesses’ (p 244). According to Goffman an individual self ‘is a product of a scene’ (p 245). In other words, patients on the wards had adopted the behaviours of compliance because of the way in which they
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were treated as individuals by the practitioners. It was explained in section 6.5 how the treatment of inmates in a total institution of a mental hospital could cause their selves to be systematically, if not unintentionally, mortified (Goffman 1968a). There is no suggestion that my research wards could be classified as a total institution as described in Asylum by Goffman (1968a). However, certain comparisons can still be made. Just like Goffman's inmates, I found that on admission to hospital all patients changed into pyjamas, night gowns or even hospital gowns. All patients had to wear an identification badge at all times. It could be argued that by this very action their individual identity was 'stripped'. The hospital routines and the existence of inequality of roles between patients and professionals all contributed to the fact that patients would relinquish personal control and power over their own affairs to the professionals.

6.10 Category J: Visitors and relatives

When patients were admitted for the first time to the hospital they immediately found themselves in a strange environment with strange people. They had to eat, sleep and resort to elimination activities with the full knowledge of other patients in the bay. At home they could share their grief and joys with their relatives. As patients they were suddenly cut off from what is normally taken for granted at home. The presence of visitors and friends was therefore very welcoming. They were a source of contact with the outside world (GO-54: 11-12). Since time became an important element in the life of patients, visitors and relatives helped to pass their time. According to Holloway et al (1998), visitors made the time in hospital precious to patients; 'so precious that patients were very careful not to ruin it' (p 462). Patients tended to look
forward to meeting their friends and relatives since they saw such meetings as 'of high social worth' (p 462).

However, the bays appeared to be a public place during visiting time. Patients had to share very personal information with friends and relatives within earshot of other patients and their relatives by their bedside. Relatives had no choice but to engage in any activities under the full gaze of other patients. In many instances relatives would have liked to give personal care to their loved ones in the ward, like maintaining dignity, giving intimate care and controlling their environment. Certain relatives found this very frustrating as confirmed by patient 160 (UIP-104: 33-34). As staff had not explained the roles expected of relatives, many of them were unsure of what they could do or could not do in the main bays. My evidence suggests that close relatives and friends found great difficulty in expressing their emotions and maintaining an intimate communication line in a bay in the presence of other patients and their relatives (GO-37: 6-9). If nurses are to give constructive personal care to patients, then the roles of relatives must be recognised by professionals in the provision of privacy for their relatives or any intrusion of the privacy of other patients by them. The study by Åstedt-Kurki et al (1997), who explored the experiences of family members in a situation where a next of kin had been hospitalised, confirmed my findings that mostly professionals are not interested 'in the family's well being' (p 2).

However, in the privacy of the single bedded room, the evidence suggests that a patient could receive intimate care from his relatives such as bed bathing and assistance with toileting, and closing the door to ensure that intimate information
could be shared in private (SIP-8: 40-46). In a single bedded room therefore a patient could have a certain level of privacy and relatives were able to display emotion with their loved ones in private, which was not possible in the bays.

There is no doubt that the presence of relatives in such close quarters often contributed to the crowding effect in the bays (UIP-137: 31-32). Patients who did not have visitors found their presence a source of irritation and frustration (UIP-42-3-6). Many patients detested the idea of visitors being noisy and treating visiting time like a social event. Patients who liked solitude away from the gaze of others had no other choice but to stay on or by their beds. Their sleep and other daily patterns were undoubtedly disturbed (GO-53: 32-33). Since one of the functions of privacy is 'emotional release' in solitude (Westin 1967, Roosa 1982), such patients did not find visiting time 'calming and comforting and secure' (Roosa:242) occasions. My evidence suggests that staff did not realise the extent of the concerns of these patients during visiting time. In fact, they exacerbated the problem by allowing more than two visitors by each bed. At times there were more than five visitors by a bed, creating an atmosphere of a market place owing to its crowded effect (GO-136: 36-39).

My findings also confirmed Bauer's (1994) study. The majority of her patients complained of a lack of privacy with their visitors. During visiting time patients employed 'a number of methods to secure at least some form of acoustic isolation' (p 117). However, the evidence demonstrates that owing to the lay out and logistics of the wards, patients had no 'back room' (Goffman 1959) where they could withdraw with their relatives and 'enjoy some form of aloneness with them' (Roosa: 243).
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Bauer’s (1994) view is shared that in most instances visitors did not want to share secrets with their relative patients, but they did want an environment in which they could talk freely without others hearing them. Other patients’ visitors were also found to be a nuisance, particularly when they were numerous and noisy. Interestingly, Bauer (1994) found that patients who were cared for in a two-bedded room were more likely to show intolerance about the visitors of the other patient, whereas patients in four-bedded bays were more tolerant. In my study, perhaps the presence of six or eight patients together with their relatives led to a state in which the patients’ systems were so overloaded by stimuli that certain patients were unable to cope with them and showed more signs of intolerance.

However, Milgram’s (1970) study has confirmed that if an individual is overloaded with certain stimuli, in due course a process of adaptation is followed, which in turn allows a pattern of decreased involvement to develop by avoiding excessive stimulation under conditions of high density. However, in the bays the patients had no other places to go to. They had to stay by their beds. Accordingly, most of them had no choice but to be left exposed to the excessive noises created by certain visitors during visiting time.

6.11 Category K: Discussion of privacy in the light of regulatory and government standards

The importance of many recently published documents that stressed respect for patients’ privacy and dignity has been addressed in chapter 2. In particular, Human Rights Act 1998 incorporates legal rights for the protection of their privacy. Of course, these are open to interpretation and test. Article 8 of the European
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Convention of Human Rights created qualified rights to privacy, by stating that 'Every one has the right to respect for his private life' (see section 2.5).

The term 'privacy' is not defined within Article 8 of Human Rights Act 1998. Although the Department of Health document, 'Your Guide to the NHS' (2001), categorically raised an expected and ethical right of privacy for patients (p 29), this too has failed to explain the components of privacy. In accordance with the Younger Committee (1972), 'privacy' means freedom from intrusion upon oneself, one's home, family relationships and privacy of information. This definition of privacy, 'freedom from intrusion' has been incorporated by the Department of Health in the 'Essence of Care' document (2001: 182). 'Freedom from intrusion' should also be understood in the light of Niemetz v Germany's [1993] decision. In that case the court held that individuals could not exclude entirely other individuals from their life. Concerning Article 8, the Judge explained that respect for 'private life':

Must also comprise to a certain degree the right to establish and develop relationships with human beings (para. 29).

The professionals' own organisations, the Nursing and Midwifery Council (2002) and the General Medical Council (1998) have published specific guidelines to their respective practitioners with regard to the importance of respecting the patients' privacy and dignity. Although the Nursing and Midwifery Council has not specifically mentioned the word 'privacy' in clause 5 in the Code of Professional Conduct (2002), respect of patients' privacy is subsumed within the word 'dignity' at
clause 2.2. Walsh and Kowanko (2002) confirm that nurses tend to associate the word ‘dignity’ with respect, privacy, control, advocacy and time.

In this research I had to decide by which criteria I would judge whether or not a health professional had intruded on the privacy of patients. Article 8 (2) of the Human Rights Act 1998 cites the circumstances where health professionals can safely intrude on the privacy of the person without the risk of legal action from the victim of the breach (patient). The derogation allows professionals a solid defence if, for example a patient’s privacy is breached in an emergency situation, in the interests of national security, public safety, the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of other patients. My evidence suggests that when professionals appeared to have compromised the privacy of patients, the above derogation hardly ever applied.

The ‘Essence of Care’ document, in line with the NHS Plan (DoH 2000), have produced a set of benchmarks against which the intrusion of privacy can be judged. In section 15.7 of the NHS Plan (DoH 2000), the Department of Health has set a target that when meeting the needs of elderly patients; practitioners should ‘demonstrate proper respect for the autonomy, dignity and privacy of older people’ (p 124).

My evidence suggests that most practitioners had very little or no awareness of the importance of the Human Rights Act 1998 or any of the documents that stress the importance of respecting the privacy of the patients (SIN-47: 46, SIN-61: 3, SID-14:
31). Some of the practitioners' knowledge in this area was so poor that at times I gave up pursuing the subject in detail (SID-14: 27-31, SIN-61: 3). Even if the professionals showed little or no knowledge of the above documents, I assumed initially that they might have forgotten the names of these documents, but would at least show respect for the patients' privacy in their daily activities while caring for them.

I decided to test this assumption by utilising the seven distinct factors within the area of privacy and dignity of the 'Essence of Care' (DoH 2001) document (see chapter 2, section 2.6, figure 1) in order to determine whether or not the professionals had in fact intruded on the privacy of patients. This stance was taken because the principles of 'Essence of care' (DoH 2001) are part and parcel of Clinical Governance (DoH 1997) to improve the quality of health care. Clinical Governance has been defined as:

A system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish (DoH 2002)

The seven factors of 'Essence of Care' document are now discussed by revisiting the findings in each of the categories discussed previously.

Factor 1: Attitudes and behaviours of the professionals: The evidence suggests that the patients did not 'feel that they matter all of the time'. It was demonstrated in category F that certain behaviours of professionals were institutionally driven. Patients were routinely woken well before 06.00 and their sleep patterns were disturbed at the will of professionals. Many activities like the completion of the patient's vital signs, administration of morning medications, and making certain
groups of patients sit by their beds for their breakfast had to be completed before the arrival of the morning shifts. Throughout the day the care of patients was driven by the agenda of professionals. During the day patients were constantly interrupted by professionals no matter what they happened to be doing at the time. By such actions of the professionals, the patients' states of reserve and solitude were not being respected (Westin 1967). Although ward routines have certain benefits for the professionals, it was argued by analysis of the works of (Menzies 1988, Berger and Luckmann 1966) that the majority of the professionals had developed 'blind spots' through their habituation process that often made them perform their daily activities without due reflection (see section 6.7).

Factor 2: Personal world/personal identity: The data show that the patients might not have 'experienced care in the NHS environment that actively encompasses individual values, beliefs and relationships'. On admission to the ward nearly all the patients had to wear pyjamas, night dresses or even theatre gowns, thereby losing their own identity as individuals. In category C (see section 5.4) it was shown that patients did not have much control and choice over their fixed territory or any aspects of their life as patients. Their bed position was changed at the will of the staff and placed near strangers without any introduction. For those who were dependent on the care of staff, their choice and control over their own needs was even more limited. For example, it was found frequently that patients appeared to be given little choice of toileting facilities. They were rarely given the opportunity to wash their hands following the use of urinals or commode. Patients did not seem to have a set sleeping pattern owing to the pre-determined agenda, task centred care and routines of the staff and the constant interruptions.
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Factor 3: Personal boundaries and space: My evidence suggests that staff generally failed to 'promote actively the personal space and territory for their patients'. In category B (see section 5.3) it was demonstrated that most of the patients had assumed that the bed spaces around their beds were their territory and their bed tables, locker and beds were theirs while they were in hospital. By using the definition of territory and space of Altman (1976, Edney (1976), Hall (1966), Louis (1981) and Roosa (1982), it was explained (see section 6.3) that patients' territory and space were mainly defined by the staff. I argued from the observation data that patients' territory and space were frequently compromised by the medical and nursing staff by failing to close the bed curtains fully and peeping through these curtains even when intimate care was being carried out, thus leading to embarrassing situations for patients (Barron 1990, Lawler 1991). Sitting on the patients' bed was an equally common occurrence by both doctors and nurses without the consent of the patients. Accessing the patients' personal belongings located either in or on their lockers was equally common by staff without seeking the prior permission of the patients.

Factor 4: Communicating with patients/clients: The evidence suggests that generally nurses failed to 'communicate with patients in a manner that indicated any assumption that patient's individuality was 'respected' at all times. It was demonstrated in category D (see section 6.5) that patients' individuality, dignity and their personal identity appeared to be compromised by the way the majority of nurses addressed their patients by their first names and in an endearing manner, using words such as, 'love' and 'darling'. However, I also showed that the majority of the medical staff addressed patients with great respect, usually calling the patients by
their surnames, or 'sir' or 'Mrs'. By citing the works of Goffman (1959), Marini (1999), and Hewison (1995), it was explained that addressing patients in a familiar way without their prior permission, constituted a compromise of their dignity and individuality. It was also observed that patients were very rarely introduced to other members of the team around their beds even when these patients had full capacity.

**Factor 5: Privacy of patient-confidentiality of client information:** In category E it was demonstrated that patients who were being cared for in the bays did not have much privacy of their personal information. Their 'information was shared', but without their consent. During ward rounds and examinations or other interactions between staff and patients, the personal information of patients became public knowledge to any one else in the bay. My findings were also confirmed by Bauer (1994) during her study that patients tend to adopt different approaches to the invasion of their information privacy (see section 6.6). It was argued that the principles of the Caldicott Report (1997) were compromised by the way patients' personal data were seen recorded on a white board which was openly accessible by any strangers in the ward. Patients' notes lying around on the desk by the nurses' station was argued as unacceptable. The majority of the patients thought that they had no privacy during their use of their bedside telephones. Many patients attempted to use the facilities of the telephone trolley to seek some sort of privacy but without much success. Despite this awareness, most of the patients thought that the advantages of having the bedside telephone outweighed the disadvantages of the risk of being heard by other patients and their visitors.
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Factor 6: Privacy, dignity and modesty: On the whole, I did not find that the staff ‘actively promoted the dignity and privacy of their patients and protected their modesty’. It was demonstrated through the analysis of category D (see section 6.5) that the majority of patients felt very undignified in their hospital gowns when they had to wear them beyond their usefulness. Since the gowns were particularly designed for use in the operating theatre, my evidence suggests that when patients were wearing these gowns in the bays as a routine, their whole back and buttocks were often left exposed to the gazes and glances of other patients, visitors and strangers. The majority of the patients thought that they appeared like ‘fools’ and felt ‘dehumanised’ in them. The findings were also supported by the studies of Walsh and Kowanko (2002) and Bauer (1994). Patients were at times seen surrounded by full urinals while they were eating their meals or when their visitors were present. It was argued during the analysis of category D that such findings affected the patients’ dignity and privacy and depersonalised them as individuals.

Factor 7: Availability of an area for complete privacy: My evidence suggests that the patients in the bays were not ‘provided with an area that safely provide privacy’. Although there was a private sitting room for staff, I hardly observed patients being interviewed in this place or any other place where complete privacy could be ensured. Most of the discussion and interviews with patients and their relatives took place in the bays of the wards where other patients and their relatives could follow the gist of any conversation.

In short, the data suggest that the factors illustrated under the heading ‘Privacy and dignity, in the ‘Essence of Care’ document (DoH 2001), appeared not to have been
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met by the health professionals. I realise that this is a strong statement but I did not find enough data to support the contrary. The fieldwork of this research was undertaken in the early months of 2002. Most of the Department of Health documents were published in the early part of 2001 following the enactment of Human Rights Act 1998. I had assumed that since an intensive awareness exercise about Human Rights was taking place at that time, and the principles of the ‘Essence of Care’ (2001) document were being piloted in the Trusts of my research, the ward philosophy would at least reflect the importance of respecting the privacy of the patients. However, when I questioned my interviewee nurse practitioners about the ward philosophy of care, most of them did not know of its existence or where it was kept. Although nurse 14 had a fairly good knowledge of the ward philosophy, according to her (SIN-145: 9) respecting the privacy and dignity of their patients did not form part of the philosophy.

The Department of Health has tried very hard to publicise the importance of patients’ rights with particular regard to respecting their privacy. It is not clear whether the Trusts or the practitioners had equally accepted the seriousness of respecting the privacy of their patients. It is possible that they did, but that they had no time or resources to implement the principles as part of their risk management strategy. It is argued that since the patients’ care was still spearheaded by the so-called ‘medical model’, the priority of care remained treating the patients’ biological conditions. Respecting the patients’ privacy was played down to an unsatisfactory extent. The ‘little things’ highlighted by Smith (1992) were often forgotten. I suggest that the advent of political change imposed by the government may not be implemented at ward level if the feelings and motivation of the staff are ignored. According to Hunt
(1985), the understanding of Gramsci’s (1973) philosophy of power may help to implement an effective change in the National Health Service. Hunt (2003) explains that ‘Gramsci’s theory provides a solution and has wide repercussions for our understanding of the relationship between, power, inequality, and exploitation on the one hand, and culture, education, and social institutions’ on the other (p1). Hunt (2003) suggests that in order for a shift in power to be brought about in any society in this case from professionals to patients elements of coercion will have to be avoided. Instead, the consent of the relevant population, and political and cultural leadership, are necessary; such a system is known as ‘hegemony’. According to Gramsci (1973), it is leadership and not domination that is important in bringing about a fruitful change in the power relation of health care.

It is apparent that not only did the majority of the qualified practitioners demonstrate little knowledge of most of the Department of Health circulars that stress the importance of respecting the privacy and dignity of their patients, my evidence suggests that they also failed to achieve the seven factors of the ‘Essence of Care document’ (DoH 2001) that determine benchmarks of good practice in the area of respecting the privacy of the patients. However, the student nurses still in training demonstrated greater awareness of certain of the Department of Health circulars. This suggests that many qualified nurses failed to keep themselves professionally updated and demonstrated this by their behaviours. The fact that they had only a vague idea of the existence of these circulars does not mean that these nurses and doctors did not understand or value the notion of privacy of the person. That both the doctors and nurses might have a ‘theoretical’ knowledge of the key elements that constituted privacy and dignity of their patients is not disputed. What was clear to me
was that if they had this knowledge, they did not demonstrate it during the delivery of their care in the clinical setting.

6.12 Category M: Professional rationale for ‘overriding’ patients’ privacy

It is apparent from the emerging data that many nursing staff felt that the custom and practice of the wards have been transformed in recent years. The staff argued that the ward atmosphere was now more relaxed and there was a culture of openness between staff and patients. It was therefore generally assumed among staff that the majority of patients did not mind if they (staff) sat on patients’ beds or called them by their first names. It was explained to me that such approaches on the part of the staff brought a closer relationship with patients (SID-37: 27-47). This was not true for all the patients. A minority of the patients resented the idea of anybody sitting on their beds and calling them by their first names without their prior consent (UIP-82: 47-48). Instead of showing ‘detachment and denial of personal feelings’ as Menzies (1988) had stipulated as a way of coping with personal anxiety, the findings show that the majority of the staff were in some ways less likely ‘to control their personal feelings, refrain from excessive involvement and avoid disturbing identifications’ (p 53) with their patients who were mobile and well on the way to recovery. The staff argued that maintenance of such a friendly atmosphere in the ward made their relationship with their patients less tense. I can only conclude that the balance of caring has tilted heavily towards showing a closer attachment with patients as a way of coping with the stress of daily burdensome activities.
According to Goffman (1959), in the 'front region', an effort is made by the players to give an appearance 'that his activity in the region maintains and embodies certain standards' (p 110). He uses the term 'decorum' to explain that the players (staff) in the front region ought to have certain 'moral standards' when interacting with their audiences (patients). With regard to moral standards, he explains that the moral requirements ought to cover rules of politeness, respect, non-molestation and non-interference by others. In social establishments players normally 'take many of these standards for granted, not realising they have done so until an accident, or crisis, or peculiar circumstances occurs' (p 111). In the 'back region', where the audience is not allowed, what the players suppressed during their interaction in the front region became apparent. In this back region, the players are able to relax and tend to drop their front of moral standards when interacting among themselves. Although in a bay the patients did not have the ultimate facility a back region, the staff, particularly the nursing staff, had a private rest room in each of the three wards, which could safely be described as a back region. I suggest that the majority of the nurses had problems maintaining the moral standards expected of them in the front region when dealing with their patients. Since most of the patients had not made any complaints about the way they were addressed, I accept Goffman's (1959) analysis of the situation that most of these nurses had taken for granted that lowering their front and with it their moral standards, would be acceptable to most patients. However, it was interesting to find that nearly all the doctors had maintained their front when interacting with their patients. Could this be explained that these professionals were more able to cope with personal anxiety by showing signs of certain detachment from their patients (Menzies 1988)?
Many staff were convinced that the common reason for compromising the dignity and privacy of the individual patients in their day to day care was the fact that certain staff had lost their own inhibition due to the habituation process. Nursing was no longer viewed as a vocation but was commonly seen as part of a job. Individual patients were seen as just patients. As a result ‘the little things’ (Smith 1992) that form part of genuine caring were probably forgotten. This was reinforced by nurse 1 when she stated that ‘we sometimes do tend to forget that there is something quite private for a person’ (SIN-51: 41-44).

However, the majority of doctors and nurses reasoned rather forcefully that staff were generally very busy because of staff shortage and poor skill mix in the wards. (The wards were unusually staffed by high level of care assistants, the majority being qualified Philippino nurses who were awaiting registration). This meant that during the prioritisation of a patient’s care, privacy and dignity of the patients were often forgotten as they were seen as less important than receiving medical treatment (SIN-55: 8-16). Doctor 3 confirmed that my research arena ‘was a very busy hospital … and the fact that there are very serious patients on the ward’ made it difficult ‘to keep such a high degree of privacy for every single patient’ (SID-21: 15-17). According to doctor 4, who summarised the feelings of the majority of the medical staff ‘life is more important than observing privacy’ (SID-27: 21-23). There was certainly a shortage of nursing staff in both Wards A and B. For example in Ward B the funded establishment of the ward (see section 4.7.1, table1) as whole time equivalents was for 15 qualified nursing staff. During the research period this ward was functioning at 10.1, a shortage of 4.9 qualified staff. To compensate for this shortage the ward was manned by agency nurses and recently recruited qualified Philippino nurses who
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were yet to assimilate the mores of society. It was argued by certain staff that this resulted in the continuity of patients' care being dislocated. Some of the agency nurses were from different hospitals and with different levels of experience. As none of these agency nurses had any comprehensive induction, this could have contributed to a system where different moral standards of care were being applied without any inbuilt checks and balances. Walsh and Kowanko (2002:150) found that nurses tended to blame the shortage of staff and the busyness of the ward as valid reasons for overlooking the privacy and dignity of patients. Benner et al (1982) also describe a similar state of affairs in their study. They found that a hospital with acute staff shortages, 'reduces the nursing role almost exclusively to administering medications and intervening in patient crises' (p 32). They noted that the amount of time that nurses could spend with their patients 'was minimal and not of very high quality because they were preoccupied with the multiple problems and tasks confronting them' (p 32). Such state of affairs left very little time for staff to reflect and review their clinical judgement (Benner et al 1982). They argued that a programme in clinical knowledge in such an environment would fail unless the issue of work overload 'was resolved through increased nurse-patient ratios and definitive role structuring' (p 32).

During the observation period it was noticed that, although each of the wards had distinct cultures, some of these cultures were shared by all the wards. For example, the evidence suggests that the type of care that the patients received reflected very much the philosophy of the ward sister who was on duty at the time. This was more apparent on Ward B where there were two ward sisters whose approaches to nursing care were very different. When sister X was on duty the ward looked more
organised. There were signs of firm leadership and an atmosphere of calmness prevailed on the ward. All the members of the nursing team appeared to be functioning together. Attempts were made to close the bed curtains when patients were being examined. Consultants were encouraged to involve their patients in their care. Some sorts of teaching sessions were always taking place with the student nurses either in the bay or in the sister’s office. On the other hand, the presence of sister Y led at times to an appearance of disorganisation on the ward. The ward appeared to lack firm leadership (GO-60: 6-9) and overall co-ordination between members of staff seemed to be lacking. There was no doubt that sister X was admired by both staff and doctors. There was a general lack of leadership in both Wards A and C and in Ward B when sister Y was present. According to Smith (1992), an ‘ideal nurse, frequently modelled on a much admired ward sister represents the high expectations that nurses have for themselves and each other, which are passed on from one generation to the next’ (p 74). It is argued that overall a good modelling effect was lacking in all the wards and a philosophy of conformity was followed to match the expectation of the lead person in charge of the ward at the time.

There was no doubt that the layout of the bays definitely contributed to a climate of overcrowding. Both the medical and nursing staff argued that such an environment was not conducive to respecting the dignity and privacy of patients and their relatives (SID-15-33, UIN-52: 31-32). Although team care was practised in all the wards, it was apparent that this care was practised only in name. There was not a clear philosophy of care applied in any of the wards. It could be argued that because of the shortage of staff, task centred care was more apparent than the delivery of
individualised care. Most of the staff agreed that the medical model did not help in respecting the patient's privacy. According to doctor 2, 'the hospital medicine is much more difficult because the patient comes here with a specific problem and it is very easy just to look at that specific problem' and forget the holistic needs of patients (SID-14:3-4).

The data in this category also point out that generally there was a lack of freely flowing communication between the members of the medical and nursing teams. The segregation of the two roles was quite apparent at times, particularly among the junior members of the medical and nursing teams. Such members of the medical staff were often seen sitting together by the nurses' station talking among themselves and they always went as a group to the dining room. During one of my observation periods the following notes were made:

Most of the time doctors and nurses do not mix. It is a different world for each group. The only time when there is an interaction between these two groups is when a doctor wants to talk to a nurse about a patient. Doctors do not answer the telephone even if it rings for 5-10 minutes (GO-51: 48-49, 52: 1-2).

This entry in my notebook was typical of many such situations. There was poor interaction between the two groups. On one occasion I noticed that the day nurses and the sister were receiving the morning reports from the night staff. At this time three doctors walked in to the ward for their morning round. However, not a word was passed between the nurses and the doctors, but the doctors were quite happy to exchange greetings with a fourth doctor who was waiting by the white board (GO-63: 31-36). The physical separation between the two professions no doubt reinforced the hierarchical nature of the social relations between them (Smith 1992) and
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exacerbated the already poor communication lines and delivery of holistic care to individual patients.

Many patients saw doctors as the 'power house' behind their care. They were viewed with awe and with great admiration (GO-67:32, SIP-66: 38-45). In the wards the medical team remained the guiding force behind all treatments. The planning of individualised care of the patients followed closely the principles of the medical model. The nursing staff appeared to have discarded the principles of nursing process and the philosophy of individualised care and in some instances followed blindly the medical model. Certain nurses rationalised that, since privacy and the dignity of the patients were never prescribed by doctors, respecting them were not as important as the administration of medication. My evidence suggests that overall, nurses still did not have sufficient power to bring about changes in the treatment of their patients independent of the medical team. Policies and procedures were clearly dictated by doctors and were executed by the nursing team without questioning at times. I claim that until a change of philosophy is brought about and nurses, who are the most numerous, hands-on providers of care, accept the rein of constructive leadership, the 'little things' (Smith 1992), like respecting the privacy and dignity of patients, will remain in the background.

As a researcher the main question that I wanted to ask, was why these group of practitioners behaved in the way I saw towards their patients. Why did these professionals allow the privacy and dignity of their patients to be compromised and did not raise any questions or complaints against the violators? Such violations can be viewed as poor practice or even malpractice in the care of the patients. Yet despite
the guarantee of protection for any complainants by the Public Interest Disclosure Act 1998, staff generally failed to speak out against such compromising practices.

The writings of Goffman (1959) help me here also to explain some of the actions of the staff. I observed that despite the clear presence of a hierarchical structure between nurses and doctors, all the practitioners worked as a team when caring for their patients. Since the ultimate responsibility for patients' treatment remained in the hands of the lead consultants, the nurses, care assistants, all other health workers and the respective junior and senior doctors followed the guiding principles of their consultants. Because of the hierarchical structure the team concept remained very strong in all the three wards. There was good co-operation and solidarity between nurses and doctors in maintaining the patients' treatments and achieving the ultimate goals of the lead consultants. All team members were definitely bound 'by bonds of reciprocal dependence and reciprocal familiarity' (Goffman 1959: 88), linking the team members to one another with ultimate 'loyalty to one's team and one's team mates to provide support for the team line' (p 91). According to Goffman (1959) when such a state exists, public disagreements among members of the team become very rare. All the members of the team tend to adopt a unanimous position and maintain a show of self-respect before one another 'in staging a definition of the situation' (p 93), as here in the carrying out of the ultimate goals of the consultants. Hence, when the privacy and dignity of patients were compromised by members of the team, despite the personal beliefs of any members of the team that such a compromising situation was wrong, the members failed to speak out against poor practices. It appeared that staff were colluding against their patients for the sole
reason of maintaining the party line. Doctor 6 confirmed the complexities of a team concept well when he said:

*I think relationships in hospital between staff and among staff at different levels ... is a very complex inter-relationship ... So everybody will have a certain idea of how to be nice or how to behave decently when you realise that an other person does not do that to your taste, then It can indeed very easily can lead to a conflict ... You should be careful with plain criticism. I don't think that is the right thing to do (SID-45:35-46).*

Similarly when I asked doctor 5 whether he would be prepared to advocate on behalf of his patient against the poor practices of his consultant, he gave a guarded reply

*Hm, it is very difficult. It depends on your relationship with the consultant ... Well it's not something that I would rush to. No. No (SID-39: 8-15).*

These statements confirm the key points raised that staff would be reluctant to breach the bonds of a team and criticise a member of a team either in the presence of patients or even in the background even if that means compromising the privacy and dignity of their patients.

6.13 Towards a formal model of privacy

In this section I have built a privacy model (see figure 3) that is based on the emergent themes following the description and interpretation phases of my data. According to Morse (1994), in qualitative research the theory is developed from ‘comprehending and synthesizing data’ (p 32). Although theory building is nothing more than a ‘best guess’ (Morse and Field 1996), qualitative results without a theory, ‘would be without a structure, without application, and would be disconnected from
the greater body of knowledge’ (p 105). Although this model relates to privacy of an individual patient within the context of NHS clinical wards, it should be equally applicable to other clinical settings.

The model has the following four parts:

1. The staff’s self and its impact on their behaviour
2. The patients’ self and its impact on their behaviour
3. A privacy interface and reconfiguration of the privacy boundary
4. A feedback loop from privacy interface to the individual’s self

Each participant within this research - doctor, nurse or patient - was seen as a unique person with a distinctive self. According to Mead (1934), a person’s self is only created following social interaction with others. ‘It [self] is not initially there, at birth, but arises in the process of social experience and activity’ (p 132). Goffman (1959, 1968a and 1968b) also believes that the self is formed during an interactive process with others. In explaining the impact of self on one’s performance, Goffman (1959) divides an individual by implication into two basic parts. He views an individual as a performer and as a character. He equates the character of an individual as his or her self, which ‘is usually seen as something housed within the body of its possessor’ (p 244). Since an individual’s self is shaped through the interaction process with others, the factors that could influence the self of the participants within NHS wards became important ingredients in the formulation of this privacy model.
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PRIVACY MODEL

Ward culture/climate

Expectation

Ward structure

Role model

Knowledge

Personal agenda

Staff Self

Routine  Habituation  Blind spot  Prioritisation  Acquiescent

PRIVACY INTERFACE

BOUNDARY CHANGES

Adopting patient role  Trusting relationship  Compliance  Acceptance  Prioritisation

Expectation

Previous experience

Control and Choice

Ward culture

Staff's behaviour

Ward structure

Figure 3: showing the impact of self on the behaviours of individuals

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6.13.1 The staff's self and its impact on their behaviour

When individual staff members, be they a doctor, a nurse or a health care assistant, start work as a practitioner for the first time in a clinical setting, their personal self is continuously bombarded by various factors on the ward (figure 3), leading to reshaping of their character (Goffman 1959). Some of the issues that would impinge on the self of the practitioner are: the role models of the lead nurses or doctors, current ward culture and philosophy, personal expectation and goals of the staff, the constraint of the ward structure, and any previous experience or knowledge of a similar situation. The re-shaped self is in turn projected in various performances of individuals that become the established standards in their caring activities for their patients. These performances can be displayed by individual practitioners on the wards as undertaking activities in an routine way. Set patterns of practice are thus formulated and lead to habituation process (Berger and Luckmann 1966) and formation of blind spots that can lead to thoughtlessness. Individuals tend to conform to principles of team concepts to ensure solidarity and respect within the team (Goffman 1959) and prioritise the notion of medical treatments at the expense of respecting the privacy of the patients.

6.13.2 The patients' self and its impact on their behaviour

Similarly when individuals are admitted to a hospital for a specific treatment, various features within the ward setting impact upon their previously formed self. This self (figure 3) is reformulated by the strange environment of the ward setting, with its own culture, language and hierarchy within practitioner ranks. The performances of
staff and the drill of wearing pyjamas and theatre gowns, loss of independence and control, and previous experiences as a patient all add up to changed expectations. This reformulated self of individual persons is similarly projected in various performances as a patient on the wards, which lead to prioritisation of medical needs for receiving safe medical treatment over privacy. For patients to achieve their own agenda, their behaviour is changed to adopt patients' role (Friedson 1970) and develop trusting relationships (Goffman 1959) with the staff. They learn to accept and adopt an ingratiating attitude (Goffman 1959, 1968a, Argyle 1983) and comply with the performance of the staff for fear of being labelled as awkward patients (Stockwell 1972).

6.13.3 A privacy interface and reconfiguration of privacy boundary

Because of the respective performances of staff and patients, the privacy interface is realigned. The boundary becomes pliable and is changed. The staff are able to press against the boundary of privacy until a threshold is reached that can become intolerable for competent patients. The staff are able to change the boundary of privacy because the patients have accepted such changes without any complaints. In this research such compliance was specifically recorded in the area of exposure of personal identity, physical exposure and invasion of territory and space.

6.13.4 A feedback loop from privacy interface to the individual's self

As the boundary interface of privacy changes because of the performance of both patients and staff, this in turn creates a feed back loop to the reformulated selves of
staff and patients (figure 3). This causes further ongoing changes to the selves, and further adjustment of performances of staff and patients until an ultimate threshold is reached beyond which it would be intolerable for both parties within society's expected norms and codes of behaviour.

6.14 Conclusion

In this chapter I have discussed my data in detail to inform this research in the area of privacy with particular regard to the questions raised in chapter 1. I have taken each of the eleven categories of my emergent data in turn and produced in-depth explanations for my findings. In order to substantiate the discussions of my data, I have utilised the classic works of Goffman (1959, 1968a and 1968b) as a framework for the discussion, and the writings of Berger and Luckmann (1966), Benner (1984) and others as interpretive tools to make sense of my data. In the last section I have formulated a model of privacy that is based on the concept that the patients' and staff's performances are affected by their reshaped selves, derived from various factors in the clinical setting.
7 CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

In this final chapter I summarise the findings of this research in the light of the research questions and analysis of data. Since I do not wish to repeat all the findings, I have selected certain key points to demonstrate the answers to the research questions. To give greater insight the strengths and weaknesses of the research methodology are briefly explored. I make recommendations that I feel will have relevance not only to nursing and medicine generally in the context of practice, but to policy makers of the National Health Service Trusts and the Department of Health.

7.2 The research questions

To remind ourselves, the aim of the research was to seek answers to the following questions:

1. What issues of privacy of the person arise in NHS hospital ward settings?

2. What behaviours and perceptions on the part of patients, doctors and nurses are relevant to issues of privacy of the person?

3. To what extent are there currently intrusions into the patients' privacy of the person, by the standards set out in regulatory and legislative instruments?
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7.3 Summary of the findings in relation to the research questions

Research question 1: What issues of privacy of the person arise in NHS hospital ward setting?

The key issues of privacy that arose in this research were:

- Territory and space in the bays of the ward.
- Control and choice for patients with regard to their bed position, toileting facilities, sleeping patterns, hygiene needs, meal times etc.
- Patients' individuality, dignity and identity.
- Availability of an area for complete privacy for patients and their visitors.
- Rituals and routines of staff.
- Professional blind spot and habituation of staff.
- Staff's knowledge of regulatory and government standards that mainly focus on patients' privacy.
- Ward layout and logistics, such as overcrowding in the bays, variety of noise levels, state of bed curtains etc.
- Storage of patients' belongings.

Research question 2: What behaviours and perceptions on the part of patients, doctors and nurses are relevant to issues of privacy of the person?

In the analysis of the categories it was demonstrated overwhelmingly in section 6.2 that patients, their relatives, and both doctors and nurses believed that patients had little privacy of their person or information privacy within the bays of the three wards. On admission to the ward the majority of patients indicated that they did not expect much privacy in the bays. Patients and staff gave wide variations of the definition of the privacy, reinforcing the findings of the Younger Committee (1972),
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Bates (1964), Altman (1976) and Barron (1990). My evidence suggests, as discussed in section 6.3, that the patients' space and territory were frequently violated by both doctors and nurses by their habit of peeping through the closed curtain even if intimate care was being carried out. Sitting on the patient's beds without the patients' consent was also a common occurrence by both nurses and doctors. During bed making it was commonly observed that the nurses accessed the patients' locker without first asking their permission.

My evidence suggests that by the behaviours and attitudes of staff, the patients' autonomy was frequently eroded, thus leading to loss of their individual control and choice in the wards (Goffman 1959, 1968a, Beauchamp and Childress 2001). For example, it was observed that the patient's bed position was frequently changed without much notice to the patient. In section 6.5 it was demonstrated that the patients' routines were often interrupted by both doctors and nurses, thus affecting their sleep patterns, personal telephone conversation with their relatives and enjoyment of their meals. Rituals and routines were found to be governed the activities of both doctors and nurses. It was found that the staff were frequently driven by their own personal agenda rather than the individual needs of the patients. Patients were found eating their meals surrounded by full urinals. A choice of toileting facilities was hardly provided. There was a general preference for patients to use the commode by the bed-side. It was also observed that dependent patients were rarely provided with water to wash their hands.

It was noticed frequently that the nursing staff did not respect patients' identity and individuality by the way they addressed the patients in an endearing manner (see
section 6.5). By citing the works of Goffman (1959), Marini (1999), and Hewison (1995), it was explained that addressing the patients in such a way without their prior permission constituted compromising their dignity and individuality. On the other hand, it was observed that the medical staff showed different types of behaviour when addressing their patients. Members of the medical team made an effort to show respect to their patients by calling them by their surnames. I also demonstrated in this section that the consultant or his registrar rarely introduced other members of the medical team during a ward round even when patients had full capacity.

It was argued in section 6.5 that the majority of patients felt very undignified in their hospital gowns (theatre gowns) when they had to wear them beyond their usefulness. Since the gowns were designed for use in the operating theatre, I showed through my data that when patients were wearing these gowns in the bays, their backs and buttocks were often left exposed to the gaze of other patients, visitors and strangers. The majority of patients thought that they appeared like 'fools' and felt 'dehumanised' in them (Walsh and Kowanko 2002, Bauer 1994). It was demonstrated in section 6.7 that certain behaviours by professionals were institutionally driven. By using tact and gentle approaches - often with a cup of tea - that could however be described as indirect pressure, patients were woken at inappropriate times in the morning to enable the nursing staff to complete their task-centred care (NMC 2003). Patients' rest periods and meal times were interrupted during the day by both medical and nursing staff to meet their routine needs.

Despite the fact that their privacy appeared to have been compromised by staff behaviour, the majority of patients did not perceive this as a problem. Since they had
already accepted the fact that there was no privacy, they did not mind if the staff, particularly the members of the medical team, did not introduce themselves. They accepted that the ward routines were made for the staff and were quite prepared to have their sleep patterns interrupted by the routines and rituals of staff. They had learned to act as patients by adopting a front of compliance (Goffman 1959, Friedson 1970, Argyle 1983) and did not want to be seen as 'unpopular patients' (Stockwell 1972). Most of the patients thought that patients in a side room had more privacy with facilities for their own toilet, shower room and individual entertainment. They could receive intimate care from relatives and visitors. However, they also believed that too much privacy could lead to loneliness and boredom, thus confirming the notion that human beings are primarily sociable animals (Chapin 1951, Bates 1964, Westin 1967, Altman 1976). Most of the patients equally argued that the constraint of cost within the NHS would make it impossible for each patient to be cared for in an individual room.

In order that people could cope as patients in the hospital, many of them appeared to have prioritised their needs (see section 6.9). By accepting that there was little privacy in the bays, the majority of patients thought that receiving medical care was more important than privacy within the bay. They were found mostly sitting by their beds and reading books. At other times they were seen either starring at each other or talking to each other, thus confirming Bate's (1964) concept of privacy, as being like one's house, into which one could invite only those one chose. Other patients appeared to have created a mental barrier around them. I showed that many patients were not informed of the entertainment facilities within the bays and the location of the day room. I explained that even if the patients were told of these facilities mostly
due to the smallness of the dayroom and the non-functional state of the bedside radio, the patients could not exploit them to their own advantage.

In section 6.12, my evidence suggests that when staff were interviewed about their perception of privacy, the majority of doctors and nurses accepted the fact that there was little privacy in the bays. They admitted that staff did not always draw the bed curtains fully during intimate examination of the patients; that peeping through a fully drawn curtain was a frequent occurrence by all grades of staff, and by making the patients wear hospital gowns was a 'dehumanising' action affecting the patients' individuality. They equally thought that the conduct of ward rounds by nurses and doctors was wrong when it entailed discussing the patients' profiles in front of other patients, and abhorred the thoughts of patients eating their meals surrounded by full urinals. Most of them agreed that patients should be given choice and control over their treatment.

Research question 3: To what extent are there currently intrusions into the patients' privacy of the person, by the standards set out in regulatory and legislative instruments?

In chapter 2 and section 6.11, it was explained that with the publications of the Human Rights Act 1998 (Article 8) and various Department of Health documents, 'Your Guide to the NHS’ (2001, 'Essence of Care' (2001), and the NHS Plan (2000: s 15.7), the importance of respecting the privacy of patients has been raised. I also showed that the professionals’ own organisations, the Nursing and Midwifery Council and the General Medical Council have made an active effort to raise the
professionals' awareness in regard to respecting the patient's privacy and dignity while delivering care to their patients through their codes of practice.

It was quite apparent, therefore, that by the time I started my research, the standards by which professionals were expected to respect the privacy of their individual patients were already set by these documents. It was assumed that most professionals would have had a sound knowledge or awareness of these documents. Staff in their daily care of their patients would show respect of privacy and dignity for their patients by reflecting the principles of the Human Rights Act 1998 and particularly those of the 'Essence of Care' (2001). However, the research findings showed evidence to the contrary, as discussed in 6.11. Most of the staff had accepted that their awareness and knowledge of the various documents, outlined above, which stressed the importance of respecting the privacy of their patients, were limited. Certain nurses thought that their ward philosophy reflected the principle of the 'Essence of Care' document (2001) but on request they failed to produce one.

I reasoned in section 6.11 that even if professionals had forgotten the names of these documents, they would at least show respect for the privacy of their patients and their relatives or visitors in their daily activities when delivering care for their patients. This assumption was tested by using the seven factors in the area of privacy and dignity, indicated in the 'Essence of Care' (2001) (see chapter 2, section 2.6: figure 1) document as benchmarks for best practice (discussed in section 6.11). The analysis in section 6.11 shows that practitioners had in fact failed to meet almost all the standards set within it and the NHS Plan (2000: 15.7) in respecting the privacy and dignity of their patients. It was also argued that in the light of my findings
patients could make a case that their human rights to privacy were infringed as in most instances the exemptions listed in Article 8(2) (see section 6.11) were held to be inapplicable.

7.4 Summary of my data interpretation

In section 6.9 explanations were sought for my findings by raising many questions. For example, how did these patients cope as individuals in the wards, in the light of their rights for privacy being compromised? What made them walk about in the corridor of the bays dressed only in hospital gowns, with their backs and buttocks exposed? How could these patients eat their meals surrounded by full urinals on their bed tables? What made them accept the status quo?

I sought guidance from Cohen’s (2001), Goffman’s (1959, 1968a and 1968b) and Berger and Luckmann’s (1966) writings to supply a framework to help me to interpret these findings. It was apparent that most of the patients did not care about their own privacy. They knew that on admission to the hospital they had lost their control and choice. They had accepted therefore that by adopting a front of compliance and an ingratiating and submissive attitude (Goffman 1959, Argyle 1983), being the characteristics of a model patient (Friedson 1970), they would not upset the staff. They did not want to be labelled as unpopular patients (Stockwell 1972) and thereby affect their medical treatments. Certain patients had denied that their individual privacy was ever compromised (Cohen 2001). Other patients rationalised that staff were too busy for the ‘niceties’ explained by Goffman (1959) under the heading of ‘dramatic realisation’. It was further argued that these patients
tended to conceal and underplay their feelings even when their backs and buttocks were seen exposed and they were carrying urine bags like ‘hand bags’ along the corridor of the wards. I explained that the majority of the patients had learned to adopt ‘a tack of protective practices’ (Goffman 1959) in the bays either by reading books, avoiding direct gazes or just by a process of inattention as a coping strategy in the light of breaches of the privacy and dignity of their neighbours by the staff. I concluded this category by stating that patients had learned the art of ‘impression management’ (Goffman 1959) of a compliant patient in order to cope with the reality of the ward situation.

Throughout the research periods I also asked myself what made these nurses and doctors behave in the way that I was observing. How could these professionals allow their patients’ privacy to be compromised? In section 6.12, I supported the arguments of Benner (1982) that the shortage of staff could have contributed to task centred and ritualistic care (Walsh and Ford 1989) and could thereby have affected the overall quality of care. However, it was concluded that one of the main reasons for such ‘slipshod practice’ (Barron 1990) was because of the ‘blind spots’ that certain staff had developed by their habituation process (Berger and Luckmann 1966). It was further argued that since the ultimate power of managing the care of patients had remained in the hands of the medical team, the practice of the ‘medical model’ rather than holistic care was a common occurrence in the three wards. Many nurses argued (see section 6.12) that, since doctors did not prescribe privacy of the patients, it was not seen as a priority. It was apparent that the majority of the nurses were carrying out the agenda of the medical team, not demonstrating a questioning attitude. I showed in section 6.12, reflecting Goffman’s (1959) writings that despite the
presence of the hierarchical structure within the ward setting there was a very strong
bond, loyalty and solidarity between members of the ward team headed by the lead
consultant in each of the three wards. All the doctors, nurses and other grades of staff
showed great allegiance to their respective consultants. My evidence suggested that
because of the existence of such a strong team loyalty, members would be reluctant
to speak out against the poor practices of a senior member despite the recent
publication of the Public Interest Disclosure Act 1998. Accordingly, and despite any
member's individual feelings about respecting the dignity and privacy of patients,
for the sake of maintaining the unanimity within the team, the privacy and dignity of
patients in all the three wards continued to be compromised.

It was further explained that doctors continued to be viewed as the ultimate body
who held the reins of power. Foucault’s (1982) theory that knowledge is power
could be seen in practice. According to the majority of the medical team, the
publication of the Human Rights Act 1998 and the Department of Health guidelines
had created more problems in the ward. They thought that proper consultation had
not taken place with the medical profession before publication of the various
Department of Health documents. Since they had to meet their various deadlines
such as reducing the waiting lists of patients, the issue of privacy had been ignored. It
was argued that this was a good example that the understanding of Gramsci’s (Hunt
2003) model of 'hegemony' is crucial in bringing about an effective change in an
organisation through the process of proper consultation and discussion.

In all the three wards it was found that a good role model was lacking. The
consultants and sisters in charge of the wards or their deputies could themselves at
times be questioned about compromising the privacy of the patients. The presence of many agency nurses and newly recruited staff from abroad did not help the situation. I found them to be passive individuals. Since this group of individuals was from different cultural background it was more likely that they would accept the authority of the medical team without questioning. It generally appeared that the 'little things' (Smith 1992) that are crucial to the care of patients, such as respecting their privacy and dignity, were ignored by all grades of staff under the pressing needs of meeting the set agenda of the 'medical model'.

In section 6.13 I devised a model of privacy (figure 3) to explain how the various factors just described had affected the selves of the staff and the patients, which in turn contributed to the behaviours that I witnessed. Because of the reconfigured selves, staff were able to change the privacy interface and patients were able to accept such a boundary change without question.

7.5 Recommendations

Nurses and doctors need to realise that patients and their relatives have various rights as patients and visitors in NHS hospitals. Since October 2000 when the Human Rights Act 1998 came into force in the United Kingdom, patients have the right to seek legal redress if their privacy is compromised within the National Health Service. It is the professional obligation of practitioners to keep their knowledge and skills up to date throughout their working lives (GMC 1998:5, NMC 2002:6). It is therefore recommended that staff must keep themselves updated in current developments and research.
Nurses and doctors need to develop the culture of a caring attitude towards their patients. This includes working together as a team with their patients in order to meet the holistic needs of individual patients (McFarland 1977, Smith 1992). Patients' treatment should no longer be seen as the sole prerogative of the medical team. The care of patients should be planned jointly by the medical and nursing teams. At present the treatment of patients is directed mainly by the medical team and the nursing teams tend to follow the directives in order to meet the agenda of the medical team. The nursing profession must be conversant with their own Code of Professional Conduct, particularly clause 1.3 (NMC 2002), which states that nurses and midwives are 'answerable for [their] actions and omissions, regardless of advice or directions from another professional'.

The present format of ward rounds by both doctors and nurses must be abolished. They are the main vehicles of breaching the information privacy of patients. If possible, all mobile patients must be seen in a designated quiet place.

When planning the care of patients, their privacy and dignity should be given priority and be seen to be as important as giving medications. Aspects of privacy of the person and information privacy, highlighted in this research, should become part and parcel of caring. It is therefore suggested that professionals visiting the bedside should introduce themselves; endearing expressions towards patients should be avoided and an effort should be made, particularly by nursing staff, to address patients appropriately.
It is recommended that when a patient is being cared for within a closed curtain, some sort of system should be devised to warn other members of the team that peeping through closed curtains is not acceptable. Positioning of some sort of coloured tags or pegs on the closed curtains would undoubtedly place greater constraint on such behaviour. Bed curtains ought to be regularly checked to ensure their proper closure. If staff have to go within a fully closed curtain, an acceptable verbal code or warning signal should be devised and used in order to pre-warn patients.

Nearly all practitioners, patients and their relatives, showed great concern about the present design of hospital gowns (theatre gowns). All agreed that making patients wear such gowns devalued them as persons and degraded their selves as individuals (Goffman 1959, 1968a and 1968b). It is unacceptable that patients should be allowed to walk about in gowns that expose their backs and buttocks to the glares of staff, visitors, and other patients. Patients should be given the choice of wearing their own pyjamas and nightgowns during the day. For the group of patients who would not be able to arrange their own laundering, the hospitals should provide this facility. Wearing of hospital gowns ought to be restricted to theatre only. Many doctors and nurses agreed that the present design of hospital gowns is unacceptable. Hospitals should show a lead in the design of a hospital gown that could be opened in the front and fastened easily without the aid of strings.

A special effort should be made to create a climate whereby patients' autonomy, as long as they have capacity, is respected. They ought to be allowed to be involved in all aspects of decision making of their care instead of just 'treatment' as mentioned
in the Department of Health booklet ‘Your Guide to the NHS’ (200:28). The word ‘treatment’ should be broadened to include respecting the patient’s privacy and dignity. At present it is assumed by both medical and nursing members that the word ‘treatment’ only includes medical treatment, thus reinforcing the ethos of the ‘medical model’. Such a broadening of the definition will enable patients to have more control and choice of their own care, including the routine of the ward and the periods of the day when the patients could be interrupted less frequently, thereby maintaining their states of reserve and solitude (Westin 1967).

It is considered unacceptable that patients should be allowed to eat their meals surrounded by full urinals. Similarly, the practice of allowing patients to walk about the corridor, carrying their full urine bags like ‘hand bags’ ought to be avoided. These bags should be frequently and routinely emptied, thereby enabling patients to wear bags attached to their legs. If patients prefer to carry their bags, a protective material could be used to hide the contents of the bag.

Through the analysis of category E, I showed that the use of whiteboards as a device for managing the care of patients, and the way patients’ personal records were being left about by the nurses station, could lead to the risks of patients’ identifiable records becoming public knowledge. In order for the principles of the Caldicott Report (1997) to be respected, the use of white boards should be abolished and personal records of patients be filed appropriately. I have no doubt that the removal of the whiteboard from the corridor of the wards would create certain disquiet among practitioners. However, the fact that Ward C has recently decided to do away with the white board is proof enough that it is dispensable.
Patients expect to be cared for by competent staff. Competency does not only mean having medical knowledge and being able to treat patients. Patients anticipate that members of the caring team are effective advocates on their behalf if they are placed at risk by certain practitioners (GMC 1998:23, NMC:8). Each Trust has a policy in place reflecting the principles of the Public Interest Disclosure Act 1998. This means that if patients’ privacy is compromised, staff must be prepared to speak out against such poor practice. In order that staff are able to carry out these duties effectively, lead doctors and nurses should actively make an effort to create a conducive climate.

For the privacy of patients to become a central aspect of care, the leaders of wards, particularly consultants and ward sisters, should act as good role models to other members of their teams (Fretwell 1982, Smith 1992). My data showed that very often such lead members were themselves poor examples to their juniors. An active effort should be made on the part of these personnel to show good leadership in meeting the privacy needs of their patients and relatives.

Managers have a clear responsibility to inform their staff in areas of important developments and research. They should organise study days at frequent intervals to update their staff in the fields of human rights and current research in the area of patient privacy. Using the ‘Essence of Care’ (2001) document as a framework, staff should be made aware of the key elements of privacy. Doctors and nurses should attend such study days together. In such a climate they would be able to discuss, analyse and reflect on the management of patient privacy and devise strategies to protect it. It is important to note that for such strategies to work effectively in the clinical settings, the users’ perspectives are taken into account.
Chapter 7: Conclusion and recommendations

Any management of change will not work unless the issue of staff shortages are addressed at clinical level (Benner et al 1982). When appointing any new clinical leaders, the issue of patients’ privacy should be addressed in the selection process. If agency nurses, any newly recruited staff or health care assistants are to be employed in order to meet the staffing needs, any such practitioners should be required to attend the study days discussed above as a prerequisite condition.

Educationalists should show a lead in devising educational programmes for their medical or nursing students that provide an opportunity to understand the practicalities of respecting the privacy of patients. Students are frequently taught principles of care in large classes rather than given insights into practical issues. The teaching and disseminating of good practice to student nurses is left to nurse practitioners at ward level who are presently responsible for assessing 50 per cent of the course components through the students’ practice portfolios. It is essential that a collective vision of practice (Benner 1984), reflecting the principles of ‘Fitness for Practice’ (UKCC 1999), is consolidated between ward managers, practitioners and educationalists, through ongoing and effective joint collaboration in implementing the strategies for maintaining the patients’ privacy.

It is advocated that further research is undertaken on the impact of ward noise levels and the extent of staff interruptions on patients within NHS wards. It is hoped that the findings would further increase the understanding of their influence on the privacy and well being of patients.
Chapter 7: Conclusion and recommendations

The privacy model devised in this study requires further testing within a NHS setting. It is recommended that researchers should select two or three behaviours of the parties and test their impact on their selves and ultimate effect on the privacy interface.

This research study has focussed on the behaviour and values of health care professionals. But, finally, to maintain a sense of balance, the various patients' bodies (and indeed individual patients) need to re-consider their own perceptions, expectations, and demands within the limitations of any healthcare system. Official directives on protecting privacy may, if insufficient attention is given to the human everyday realities of healthcare provision, engender expectations that cannot be met.

Because of the inevitable financial constraints and the necessary procedures of any large-scale healthcare delivery system (for example ward-round) it will be impossible to meet the personal privacy preferences of all patients at all times. We have seen that for the most part patients understand this. Whereas, as I have observed, professionals may infringe privacy or show insensitivity to it, it is also possible and even probable that some patients will go beyond what are reasonable demands for the protection of the privacy of their person. In such cases it is the patients who may be described as insensitive, and could even be said to be indirectly undermining the possibility of privacy for the other patients. In my study I do not specifically investigate the issue of unreasonable privacy demands by patients, since I have focussed on professional behaviour, especially in the light of the relevant legislation, regulation and policy guidance. I recommend that the findings of this research study be given fair consideration by patients and the public as indicating where the reasonable limits to the protection of personal privacy may lie.
7.6 Strengths and limitations of the study

As I explained in chapter 3, owing to the nature of the ethnographic approach, the findings may not be generalised. However, I hope the results of this research will provide some illuminating insights into the practice of all health care staff. If practitioners discover a replica of my findings in their own area of practice, it is hoped that my recommendations will provide some sort of benchmark for maintaining the privacy of their patients and their relatives. I envisage that this research will generate discussion and debate among doctors and nurses (and the public) and thereby bring further reflection and understanding on the subject of privacy of the person. I believe that this research will make a significant contribution to nursing and medical practice. I expect that practitioners will be moved to question their own practice and thereby improve the privacy and dignity of their patients and clients.

Any study has limitations. I recognise that some of limitations of this study are as follows:

During the interview processes I could have sought more demographic data from the patients, such as age, education level and social class. These data might have enabled me to differentiate the perceptions of privacy of these patients in a more refined way.

Ethnography has a great weakness because it relies mainly on the subjectivity of the researcher (De Vaus 1991) and is not open to orthodox scientific analysis. I am a nurse and a lawyer and these combined experiences may have affected my
objectivity. However, having a legal background, enabled me to focus on issues of privacy that may otherwise have been ignored, particularly in the area of evidence gathering.

I interviewed all the patients either formally or informally on the wards. This could be described as the 'front region' (Goffman 1959) where individuals make a deliberate attempt to enact their performance. I could have interviewed patients in their own home environment or their 'back region' (Goffman 1959). The patient would have been in a state of 'emotional release' (Westin 1967) from his adopted social role as a patient. Perhaps the 'masks' that they were wearing in a hospital environment might have come down in their own home environment.

Initially I had planned to seek confirmation of the accuracy of the transcripts with all the informants whom I had formally interviewed, by returning to the field of study. However, by the time the transcripts were ready, all the patients were discharged home and I had great difficulty in tracking them. Similarly, a majority of the staff had left the ward. I was able only to involve two nursing staff in rechecking of their transcripts to affirm the findings. It was obvious that they had forgotten what they had said at the interview. I had to play the audiotape simultaneously as they were reading the transcripts. I was satisfied in both instances of the accuracy of the transcription and that major errors in interpretation of facts had not occurred.
Chapter 7: Conclusion and recommendations

7.7 Closing reflection

My study establishes that educationalists, doctors, nurses and other practitioners must make a genuine effort to promote the importance of the management of patients' privacy within an NHS environment. Unwarranted rationalisations for why such a caring attitude is not evidenced are unacceptable. Every citizen may one day become a patient within the NHS system and deserves to have his or her rights to privacy respected. In the strange environment of a hospital it is the professionals’ duty to ensure that the patients’ privacy is valued. This study undoubtedly contributes to the pool of knowledge of the patients’ right for privacy, which must be integrated into undergraduate and postgraduate health care curricula to ensure that all professionals behave accountably in practice, thus reflecting the principles of clinical governance (DoH 2002).


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X v Y [1988] 2 All ER 648


APPENDICES:

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Our Ref: EC30/01
20 June 2001

Mr Jay Woogara

Dear Mr Woogara

An ethnographic study of patients’ and professionals’ perception of privacy in National Health Service care settings with special reference to Human Rights

Thank you for your letter dated 17 May in response to the Committee’s comments on the above study.

Having taken full account of the additional and amended documents enclosed with your letter I am pleased to inform you that the Chairman of the Ethics Committee have approved the study. The Chairman’s decision is subject to ratification by the Committee when it next meets on 24 July 2001. I will be in touch with you again shortly after that date.

When we met briefly on 6 June we discussed your response to the Committee’s comments and you amended the Consent Form at appendix 3.1 of your submission. The Chairman’s approval is based on the amended document and I enclose a copy of that to enable you to produce a clean version of it.

Yours sincerely
APPENDIX 5

PATIENT INTERVIEW SCHEDULE

1. What is it like being a patient on this ward?

2. What is your general understanding and expectation of your personal privacy while in hospital?

3. Compared to your own home environment, how are you able to maintain your personal privacy and self-respect while in hospital?

4. What aspects of personal care delivered by the health professionals are you most concerned about and most impressed about?

5. How are you coping with the set routines of the ward?

6. How is your personal identity and self respect cared for on the ward?

7. In what ways does the present layout or arrangement of the ward affect your individual care?

8. How do you feel about your personal privacy when doctors, nurses and other staff are in discussion with you about your condition?

9. When you had visitors on the ward, what did you feel about your privacy?

10. Can you think in any ways in which your protection of privacy, while in hospital, might be improved?
APPENDIX 6

STAFF INTERVIEW SCHEDULE

1. What is your general understanding and expectation of patients' personal privacy while they are in hospital?

2. In your day to day care of your patients, how are you able to maintain the personal privacy of your patients?

3. Can you name any recent government initiatives that have given guidance to health professionals with regard to respecting patients' privacy?

4. Can you very briefly explain the impact of Human Rights Act 1998 on the delivery of health care to your patients?

5. Are there any protocols on the ward that give you guidance in the respecting of patient's privacy?

6. In what ways does a set ward-routine affect the privacy of your patients?

7. In what ways does the present layout of the ward affect the individualised care of your patients?

8. What strategies do you use to protect your patients' personal data during a ward round and/or hand over of patients' reports?

9. Can you think of ways in which the protection of patients' privacy may be improved in the hospital?

10. How do you ensure your patients' privacy with their visitors?
APPENDIX 7

INTERVIEW PROFILE SHEET

Participant code

Interview date  Starting time  Ending time

Description of environment

Pre-interview goals for interview:

Location of interview

Location of Participant on the ward/grade

Non-verbal behaviour

Content of interview

Researcher’s impressions

Analysis

Technological problems
APPENDIX 8

RESEARCH STUDY IN THE CLINICAL SETTING

INFORMATION SHEET FOR PATIENTS AND HEALTH PROFESSIONALS

My name is Jay Woogara and I am currently reading for my PhD degree at the University of Surrey. I am a registered nurse and also a lecturer in health law at the European Institute of Health & Medical Sciences at the said University.

As part of my project, I propose to undertake an in depth examination of patients’ and health professional's perception of care provision in the National Health Service with special reference to Human Rights and privacy.

In order to complete the research, I propose to spend certain periods of my time for at least four days a week on your ward observing the interaction between staff and patients. I would also like to spend my time talking to patients and staff (nurses and doctors) informally as and when appropriate.

At a certain stage of the research I propose to invite patients and staff on a voluntary basis at a prearranged time to take part in a formal interview that may last up to 30 - 40 minutes. All interviews will be tape recorded and later transcribed. The interview tapes will be kept in a locked box and will be destroyed after their use. During the interview you will be asked your name, address and your telephone number in case I have to contact you again. All responses will remain anonymous and confidential. All participants will be asked to sign a consent form prior to the interview.

You are under no obligation to participate in the formal interview. But since anonymity and confidentiality will be fully respected, it is hoped that those participants who are selected may volunteer to take part in the research. If you choose to participate, you have the right to withdraw from the study at any time, without any medical care or legal rights affected.

If you would like further information about the study, please do not hesitate to contact my Supervisor, Professor G. Hunt, on 01483 259779 or Dr C Murphy, Head of Postgraduate Programmes, EIHMS, Duke of Kent Building, University of Surrey, Guildford, Surrey, GU2 5TE, Tel: 01483 879726. Fax: 01483 879749.

I thank you for taking the time to read this information letter. Your support would be greatly appreciated.

Jay Woogara
Researcher, EIHMS – Tel: 01483 300 800 Ext; 4649
APPENDIX 9

CONSENT FORM TO PARTICIPATE IN THE STUDY

A study to examine patients’ and health professionals’ perception of care provision in the National Health Service with special reference to Human Rights and privacy

This is to certify that I .................................. (print name) give my full consent to participate in the above-mentioned research.

I have read and understood the information sheet provided, which has explained the nature of the research to me.

I am assured that anonymity and confidentiality will be maintained at all times according to the Data Protection Act 1998 and that it will not be possible to trace back any information I provide.

I understand that my participation is voluntary and I can withdraw from the study at any stage without necessarily giving a reason for doing so. I have been assured that my decision will be respected and it will not affect my medical care or legal rights.

Signature of Participant .................................. Date..................

Signature of Witness .................................. Date..................

Signature of Researcher .................................. Date ..................
RECORDED INTERVIEW CONSENT FORM

A study to examine patients’ and health professionals’ perception of care provision in the National Health Service with special reference to Human Rights and privacy

This is to certify that I ...........................................(print name) give my full consent to participate in the above-mentioned research.

I have read and understood the information sheet provided, which has explained the nature of the research to me. I understand that the interview will be recorded and later transcribed. Interview tapes will be kept in a locked box and destroyed in the future after their use. I understand that I will be contacted to arrange a mutually agreeable time to conduct the interview.

I am assured that anonymity and confidentiality will be maintained at all times according to the Data Protection Act 1998 and that it will not be possible to trace back any information I provide.

I understand that I can withdraw from the study at any stage without necessarily giving a reason for doing so. I have been assured that my decision will be respected and it will not adversely affect me in any way.

Signature of Participant ........................................ Date....................
Signature of Witness ........................................ Date....................
Signature of researcher........................................ Date....................
APPENDIX 11

AN EXAMPLE OF A FORMAL INTERVIEW OF A PATIENT

(Excerpt from patients' data, pages 1-7)
PATIENT 1  A lady patient

Jay: How long have you been here?

Pt: Since Monday evening, nearly getting on for 24 hours.

No, no, getting on for 48 hours.

Jay: That's right yes. Have you got any observations to make about the care you have received so far?

Pt: All the nursing care is excellent, there's always plenty of people around, they are very attentive and they are willing to do anything for anybody on the ward.

Jay: That's what I noticed this morning, yes.

Pt: Mm. Mm

Jay: What is it like being in hospital compared to being at home?

Pt: Well it's totally different. You are with people you don't know. That's the big difference. You are living at very close quarters with people that you don't know.

Jay: I noticed this morning, I came about quarter to six this morning and em do you feel em what time do you normally get up at home?

Pt: 7ish.

Jay: And what did you think being in hospital and getting up early in the morning?

Pt: Well it's always early being in hospital its always 6 oclockish [or] thereabouts for me at any rate, there's no real hurry I slept on until about half past seven I think. I think different patients have got different requirements and it starts going pretty early for those who have requirements first thing in the morning.

Jay: Yes. I notice nurses were looking after all the patients -did you feel - does noise affect you, your sleep in any way?

Pt: Well yes, a but its in a public ward in a public hospital you expect it, I mean the wards are reasonably small, only six people but yes you don't expect to get a good nights sleep in a hospital do you.

Jay: If that's the case do you expect that nurses and doctors should address patients' rights in general?

Pt: Yes, Yes.

Jay: Once you have been in a hospital – here the last 48 hours have you got any observations to make about your own privacy?

Pt: Well I think you can't really expect to have very much privacy on a public ward in a public hospital, even with only six patients, you know, the beds are reasonably close
together. I don’t think anybody can really expect there going to be an enormous amount of privacy.

Jay: In the NHS guide DoH said that nurses and doctors should respect patients privacy.

Pt: Mm mm.

Jay: And you are saying you don’t expect privacy.

Pt: I don’t expect there to be much privacy no. I don’t fault the doctors or the domestic staff or the nurses at all for anything to do with privacy, I just think its unreasonable to expect that you will get much privacy.

Jay: No so you came with that premise. When you come to a hospital you don’t expect privacy?

Pt: No I don’t expect.

Jay: If that’s the case I’ve noticed that you have been walking up and down the corridor and when doctors visit you, how do you cope with all this?

Pt: Well I cope because I’m only going to here for a couple of days.

Jay: Yes.

Pt: But I think for people who are in hospital for longer than a couple of days, I think it may be better for them to be on a busy ward rather than be tucked in a room away by themselves. I know when I been in hospital having babies those of us who have been in a small private ward have always felt lonely. I never have been, but friends who have been, have always felt lonely after a few days but I think it can help just being with other people and seeing what goes on. I don’t like the idea of necessarily being cut off.  

Jay: You have a point, you can be left on your own too much.

Pt: Yes mm.

Jay: As you said in a side room or you can be as part of the other patients, so you are quite happy being part of the other patients?

Pt: Yes, yes

Jay: When you receive personal care, hygiene and all these things, have you any observation to make when you receive personal care?

Pt: No ehm everybody is very vigilant very careful very conscientious but no real observations no.
Jay: How do you feel sitting up there and facing your colleague who is opposite to you?

Pt: Oh well I'm usually reading a book.

Jay: I notice that you keep your eyes down.

Pt: Yes, yes. I've got to.

Jay: Does it bother you, you know using bed pans commode?

Pt: It does not really bother me because I know that's what going to happen and there's no real alternative, its ehm, it would be better if it didn't happen but I can't see that there's an alternative.

Jay: Do you think about it instead of giving bed pan by the bed the nurse could take the patient to the toilet, a lot of facilities there?

Pt: Yes that's a possibility if that works perhaps that would be better.

Jay: It didn't happen to you?

Pt: No, no. I've been mobile all the time.

Jay: You have been mobile all the time?

Pt: Yes, yes.

Jay: You are very impressed by the care given?

Pt: Yes, yes.

Jay: Is there any aspects of the care that you are concerned about that the nurses can improve upon it?

Pt: No nothing that's occurred to me at all.

Jay: That you are concerned about?

Pt: No, No.

Jay: We talked about the morning routines and the set routines upon the ward while you have been here and how have you coped with that the set routines on the ward?

Pt: Yes that's been fine, I am a creature of habit anyway, I like to know that its 7 o'clock here comes breakfast. That's fine, routines are fine.

Jay: Right – I notice that you are a very tidy person.
Pt: Yes.

Jay: I notice that you are a very tidy person, the bed table you know. While you are by your bed do you create some sort of boundary around you?

Pt: Yes I think so yes.

Jay: How do you do that?

Pt: Well I wasn’t really aware that I had but anywhere where I am, whether I am on the beach or having a picnic in the park or up the lido in … wherever I am I’ve got my towel there, I’ve got my bag there, its my patch huh huh so probably I do it in hospital as well.

Jay: Well I notice that I noticed that. You are a very tidy person and your boundaries are very nicely around. I’m thinking about other patients too. Did you feel in any way disturbed when somebody impinged on your boundary?

Pt: No, no. I don’t think they do. No people come round to visit or to chat or to do blood pressure and things, no.

Jay: You are quite happy for people to come in on your boundary to sit on your bed? You’re quite happy with that? Do you know I notice I am sure you have noticed as well that when doctors come round, like this morning and they talk openly how are you Mrs so and so in the earshot of all the patients.

Pt: Yes, yes.

Jay: And all the patients will know exactly what its all about, I notice also that while the doctors came this morning talking to those other patients you were reading a book and your eyes were down.

Pt: Yes, yes.

Jay: If a doctor will come you know 5 or 6 of them and talking to you at the earshot of other patients. Do you have any observations to make about it?

Pt: Yes I think ehm having been in hospital before on other occasions.

Jay: That’s what I am saying.

Pt: Yes. I mean doctors turn up with a whole gang of people and just bawl in a very loud voice and say “Hello, how are we today?”

Jay: That’s what happened this morning?

Pt: Yes, and you know without saying, ‘Good morning Mrs Bloggs, I am Dr so and so this is my student this is a nurse blah, blah, we have just come to see how you are blah blah, blah,’ very bold about it.
Jay: How do you think that such things could be improved?

Pt: Yes.

Jay: What do you think the doctors should do?

Pt: I think the doctors could be polite, to turn up and introduce himself, herself and who are all these people and say you know if you going to see somebody some particular person you find out their name first.

Jay: Do you feel - lets take that issue first - compared to nurses and doctors do you feel what we have just said, do you feel that doctors are not polite generally?

Pt: No, I wouldn’t say generally the doctor who comes, I think that each patient’s individual doctor is usually fine and turns up and says, ‘Hello Mrs …, how are you today?’ and ‘Hello Mr …, oh you are looking better today whatever,’ that’s usually fine but they maybe it’s the higher up doctors who pitch up you know and the patient doesn’t really know who they are and why they are there but the individual doctors for each patient who turn up daily, they are fine I think.

Jay: Right, thank you very much
Did you have any visitors while you have been here?

Pt: Yes my husband has been in twice, yes.

Jay: Right, did you feel when he visited you and ehm there was time, time for you, you know together you could discuss privately between yourself and your husband, without others hearing?

Pt: Yes, well no, everybody hears really, its not ideal but its what you expect really because it’s a public hospital, a public ward but -

Jay: Do you think that is good enough?

Pt: Well I think if we wanted to be more private we could have had curtains round or we could have asked to go off somewhere but you know I’m only here for a couple of days. That’s Ok, that’s Ok, perhaps for longer it makes a difference, like the lady in the end bed, she’s always out walking, walking up and down here and there she doesn’t have to be in the ward the whole time and the nursing staff are very relaxed about it. About her coming and going and with the chaps who have been with her for the last day or so, you know they are very relaxed about it.

Jay: Do you know what’s wrong with the other patients who’s going up and down?

Pt: No.

Jay: Do you know your neighbours, what’s wrong with them?
Pt: P... the lady on the end who's next to you yes I know a little bit about her, ehm.
Jay: How did you know about her?
Pt: Oh we struck up a conversation shortly after I got in.
Jay: Yes.
Pt: Yes.
Jay: Do you know exactly what's wrong with her?
Pt: Yes. She's she fell down and broke her hip in two places, I think and now she waiting for an operation but poor lady keeps getting put back because I think she's got a chesty cough and the Anaesthetist doesn't want to do anything with her until she's better poor thing, she's getting very frustrated about it.
Jay: Right. We discussed if there was any way we could protect people's privacy
Pt: Hm Hum
Jay: That's the whole thing because I hoping you know, that talking to someone like yourself in future or subsequently, we can help to protect patients privacy. That's what we hope the whole point of this. From your observations is there anything we can do to protect patients privacy?
Pt: I think that that's necessarily a good thing.
Jay: How about, you know the last thing, going on somebody's locker Like asking permission like if I open the locker I ask permission is it alright to open somebody's locker without permission?
Pt: Yes
Jay: Do you feel that your personal belongings is private?
Pt: Yes, that's OK you offered to get the dressing gown that's fine – you are always told not to bring anything valuable in, ehm its another yes that's a point, actually it would be nice if there was maybe a little lockable thing but then everybody would be losing keys but I mean I bought my CD player in. I wouldn't like that to go missing but on the other hand I'm willing to risk it so I can have it in hospital but I haven't brought in loads of cash but you know something like that
Jay: Yes.
Pt: Ehm to having to.
Jay: To improve your privacy yes and you don't think anything else?
Pt: Pardon.
Jay: You don’t think anything else at this stage?
Pt: No. I don’t think, you know I don’t think so.
Jay: The questions that I am asking you – do you think they were the right questions?
Pt: Ehmm as far as privacy on a ward is concerned yes, I should think so yes, ehmm it’s a contradiction in terms I think privacy on a hospital ward.
Jay: What do you mean?
Pt: I don’t think you can have privacy on a hospital ward. I mean you know a little bit of privacy with the curtains drawn but ehmm yes but certainly the questions you have been asking are all to do with privacy.
Jay: From our discussion what do we mean by privacy? What is your understanding of the meaning of privacy?
Pt: Ehmm, my idea of privacy is really having my own little space and I suppose inviting people into it but I put that aside when I come into hospital.
Jay: And yet this one is saying (pointing to Your Guide to the NHS).
Pt: Maybe they think, maybe privacy is something else. That’s my idea of privacy.
Jay: What about your personal data kept by the bed?
Pt: Kept by what say?
Jay: By the bed.
Pt: Oh sorry no.
Jay: I’m really very grateful, thank you very much.
Pt: Oh you are welcome, very welcome.
Jay: Thank you – so shall we stop it now?
Pt: Yes, OK.
AN EXAMPLE OF A FORMAL INTERVIEW OF A DOCTOR

(Excerpt from staff data, pages 42-46)
Jay: I have been on the ward observing for nearly six months now and now I think it's time to start interviewing staff. My area of research is about patients' privacy and I have observed you and your team on the ward. Please, are you aware of any recently published documents that say very clearly patients' privacy and dignity should be respected?

Dr: Yes I think the GMC has published a guideline.

Jay: Yes they certainly have, particularly doctor's code of conduct and on page 12 of the document says about patients privacy should be respected. From your understanding what do you think privacy is?

Dr: Privacy is personal space and intimacy.

Jay: If that's the case do you think our doctor colleagues or nursing colleagues respect those aspects of patients' privacy?

Dr: In our ward or hospital, yes we do.

Jay: I have been observing doctors' and nurses' round. When you go and make the round, do our doctor colleagues introduce themselves to the patient?

Dr: Not consistently, not always, they often do, I try to do that, the first patient contact but there are inconsistencies.

Jay: Do you think our patients expect to be introduced?

Dr: Oh yes, of course.

Jay: What could be the explanation of this inconsistency, then?

Dr: Its ehm, personal awareness of the individual doctor mm and then probably the assumption that when you know a patient that he knows you as well. Ehm, Ehm so I think one is easily carried away with a daily routine and so that is only one view, our patients certainly have a different view on things.

Jay: When you are examining patient, how do you ensure the patients' privacy?

Dr: We unfortunately only have the curtain and that is insufficient. I mean you cannot guarantee privacy and intimacy when the neighbour can hear exactly what you have told the patient. You can at least try to do the curtain business although the curtains as you well know are very insufficient because they don't close properly and they don't allow sufficient privacy really.

Jay: Yes, if that's the case ehm how do you meet the requirements of the GMC. Your code of conduct in practice.
Dr I only can work within the given circumstances and I think everybody tries to
do their best within these limitations.

Jay When you go around and doing visits have you ever sat on patients' beds?

Dr Yes.

Jay Do you feel you are invading the patients space by sitting on a patients bed?

Dr No. I don't feel that I do that. I usually sit towards the end of the patient's bed
and rather feel that I establish a doctor patient relationship when I do so.

Jay It is said that research has shown that one of the medium by which infection
can be spread is probably by sitting on patients' bed. Do you think there is
justification in such a research?

Dr Oh well I take it of course, I don't do that when a patient is MRSA positive.
When a patient is MRSA positive, then as far as I am aware, then our policy is
that we provide this patient with a single room where you then barrier nurse
and respond with all the necessary precautions including not sitting on the bed.

Jay So by sitting on the patients bed, does it ever occur to you that you may be
invading the patients' space?

Dr No. There are two different issues here. One infection control and the other is
the doctor patient relationship. I think that we can assume that the patient who
is not an MRSA risk or not known to have MRSA is not an MRSA patient or
carrier.

Jay I've noticed you know which is quite unusual when you go and visit the
patients, you shake hands, which is, and I've not noticed that often but have
seen it in your case, is that routine when you go and visit the patients that you
should shake their hands? Why do you do that?

Dr It is personal, it's friendly, it shows respect. I would it.

Jay Yes I would like it too, I would like it too yes.
You must have noticed our patients wearing hospital gown. Have you got any
observations to make about that?

Dr Yes, they are quite below standard of good taste. They indeed expose patients'
backs. It's very difficult to remain decent for a patient when mobile and when
they get up and to expose themselves, so it's a bit old fashioned.

Jay Yes. So as a very senior colleague in this place what have you done about it?

Dr Nothing. I have never thought it that I could do something about it that I could
actually take action and air my dislike of patients' gowns.
Jay One of your duties of care is advocacy of the patients, so if you see when
gowns is below par don't you think you should speak out?

Dr It never came to my awareness that this is an issue which needs direct action
on my part.

Jay I have interviewed many patients. They say to me that it destroys their dignity
when they wear their gown. I was just wondering that you as a senior
personnel, you would have done something about that?

Dr Oh, I mean I have no problem that patients wear their own gowns or pyjamas.
You have clearly a certain group of patients who are very old very old, indeed
and who need very intensive nursing care or might be even intensive care, this
is a different group of patients but when I look at the average patient of ours. I
mean there's really no reason whatsoever why they shouldn't be at least
allowed if they wish to use their own gowns. Some patients do. I mean I
haven't really assessed it numerically but some patients certainly do. So I'm
not sure whether they have to wear our hospital pyjamas or gowns or whether
they optionally do.

Jay With regard to prescribing, you do prescribe medicine?

Dr Rarely these days.

Jay If you think of a scale like 1 is most important and 10 is the least important,
where would you put medicines in relation to respecting their dignity and
privacy of a patient

Dr I'm not quite sure what this question actually aims at ehm what has medication
part of therapy to do with patients' dignity and I don't get your connection.

Jay What I am trying to say is how do you go about ensuring that patients' privacy
on the ward is an important issue?

Dr Oh right.

Jay What I'm trying to say is if 1 is most important and 10 is least important in
your mind where would you put medicine, drugs on that scale?

Dr Elm, no. It's really difficult for some patients there 1 for the bulk of the
patients they are probably 3 – 4 and then for a substantial proportion of
patients in probably more High Dependency Units they are very important and
would 2, 3 if not 1. Now the privacy and dignity is something they would
which doesn't change. Every patient you know however sick needs the same
amount, so probably it accounts for higher scores in every patient group so
that is probably you know at least 5 or 6 indeed.

Jay So you are saying is despite the patient being how ill he is or how well he is
the issue of privacy remains constant?
Dr  Well, yes. I would have thought so, yep I would expect that for me to.

Jay  That's alright, that's alright. In your medicine career so far have you ever prescribed privacy and dignity for a patient?

Dr  Sorry?

Jay  Have you ever prescribed privacy?

Dr  No, that's too esoteric for England huhuh.

Jay  That's alright. I shall record as esoteric. Do you think doctors should prescribe that patients' privacy should be respected?

Dr  No. I think that is too esoteric, I think as far as I am concerned I have a wish to treat human, I don't just want to apply medicine to patients but to human beings so therefore I dare say that I have a certain aim at least to keep patients' privacy, to respect them, to like them to maintain a standard within that relationship, so I don't need to prescribe that really.

Jay  You are saying that you treat patients as human beings. so do you feel it is your duty of care at least to give guidance to your nurses and your doctor colleagues in the area of respecting the patients' privacy?

Dr  Yes.

Jay  Have you ever done that?

Dr  Yes.

Jay  Would you be able to cite an example?

Dr  No. No it's difficult ehm. I am despite your impression not senior. I'm still junior, and I think relationships in hospital between staff and then amongst staff at different levels or different professional areas and then professions towards the patient it's a very complex inter relationship, very, very, very complex and I think the majority of people who choose to work in such a social area have a certain idea that they actually want to be there because they enjoy contact with people. So everybody will have a certain idea of how to be nice or how to behave decently and when you realise that other person doesn't do that to your taste, then it is indeed very easily a conflict, because you try to impose your personality, your approach to another person. You have to be very, very careful and makes it very difficult at times. So often you don't, and I probably think you don’t have the right necessarily anyway. You should be careful with plain criticism, I don’t think that is the right thing to do. Probably the right thing to do, is just to do in your way where you think in your way that you are doing the right thing and do it in a nice way so that other people who are a bit more ignorant as regards to respecting you and somebody who does it and seeing you a good example and they will follow you hopefully.
Jay: This is the last question. Do you think the fact that I am doing this research in the area of privacy it is worthwhile from your point of view?

Dr: Yes because I think there is not a lot of awareness in this area.

Jay: Why do you think this is a worthwhile research?

Dr: It is one of the core issues of our profession.

Jay: Thank you very much. Very kind of you.
AN EXAMPLE OF A FORMAL INTERVIEW OF A NURSE

(Excerpt from staff data, pages 47-56)
Nurse 1

Jay: If you would just introduce yourself. I would be extremely grateful my name is Jay and I am going to ask you certain questions in the area of patient’s privacy.

Nurse: I am E Grade Staff Nurse on ....

Jay: Ward .... Yes.

Nurse: I am on this side at the moment because I am changing over to the other side of the ward. I have been here three months at the moment.

Jay: Yes

Nurse: I used to be an ... grade.

Jay: And how long have you been here?

Nurse: I have been now exactly 2 years. I did the 'Back to Nursing course'.

Jay: Oh right.

Nurse: Yes, I started in February and it lasted 4 months until May and then I started in August, two years ago.

Jay: Yes. Can you think of any latest policy procedures that makes quite clear that patients privacy should be respected?

Nurse: Just policies from the hospital.

Jay: Do you know of any DoH guidelines that states that patients’ privacy should be respected?

Nurse: DoH’s guidance ehm. I think there have been new ones, anyway there’s a new National Health Plan which patients are aware. Before there was the Patients’ Charter and we had everything in there, that’s supposed to be replaced.

Jay: Have you seen this National Health Service Plan?

Nurse: I have seen it – I can’t remember exactly everything in it. I’ve got it at home actually and I am pretty sure it said something in there about patients’ privacy, confidentiality and privacy that it mentioned in there.

Jay: Have you heard of Human Rights Act 1998?

Nurse: Yes – I couldn’t tell you much about it. I think that’s an International thing isn’t it, yes that’s right.

Jay: Could you be able to tell me, if you are able to, how the principles of Human Rights Act 1998 can influence the care of the patient?
Nurse: Well I suppose I don't know exactly what the Human Rights Act says but I would assume that every person in their own right has got a right to privacy, anything which they are doing which is confidential, they have got the right to certain dignity and that would actually spill into the Health Service. Anything that we do with the patients is confidential, that every patient has got a right to keep any information private, even if you are in a room, like for example with other people, that other people should not be aware with what's going on with that particular patient.

Jay: Yes, yes.

Nurse: Its just like basic human rights that human being have got.

Jay: Yes, yes. Would you be able to set a scene or a situation where you have come across recently when the issue of privacy with a patient was important?

Nurse: I think quite a good example is that lady in room 1 - ehm and actually I had some other ones which were more important.

Jay: Which lady in room 1?

Nurse: With psychiatric problems and I have had other patients with psychiatric problems recently where you have to make, I have personally and we have to make sure that other patients in the same room are not actually aware why these patients are in, like suicide attempts, psychiatric problems, because I am pretty sure that these patients or clients would not want everybody else to know why they are in there, like anybody else maybe as well but if you got for example, a fracture like a femur its more likely somebody else will find out in the room why you are there but with something like schizophrenia and you have had a suicide attempt and that's why you came to us I feel that is something quite private, that the patients really don't want other people around him to know and.

Jay: If that's the case, what is your view, your perception of a group of health care professionals going around, like I saw this morning, with other doctors with a group of three or four doctors and openly discussing with a patient about her profile. Have you got any views on that?

Nurse: Yes I personally think that's wrong because I would try not to do that because there would always be people who listen in, we know that I know from experience as far as other patients have said to me oh say this and that you know

Jay: They do. Do they?

Nurse: Pardon?

Jay: They do?

Nurse: Oh yes, oh yes, they pick up, you will be surprised even elderly people they do that. They will listen in, yes they will listen in and they get quite concerned and sometimes it is just pure curiosity you know, to know. Its always nice to know that
somebody might be worse off than you in the next bed or something like that. I think it so ingrained that doctors probably and even as us nurses will go around with doctors and not even think about it, that we are actually doing something wrong, because it is wrong doing it like that with all the curtains open and quite openly discussing in front of other people, about somebody's condition.

Jay: Is it a routine on this ward?

Nurse: It is a routine.

Jay: All the doctors, all the consultants do that?

Nurse: There are one, two, three consultants who do that, first they have like a meeting with the visitor first and the nurses and the SHO's and whatever and then they go around and talk to the patients.

Jay: Right.

Nurse: Three doctors definitely do that actually I think all of them do it.

Jay: All of them do it?

Nurse: All of them do it. They might draw, maybe sometimes, the curtains around the patient but people still be able to hear them talk.

Jay: You as a practitioner and a Staff Nurse E Grade, how do you, in your day to day care, ensure the privacy of your patient?

Nurse: Well it's rather difficult in a room, like a high dependency room, like we have got where a lot of patients can be quite hard of hearing, where you literally have to scream at them.

Jay: I noticed.

Nurse: Ah huh, some of them are very hard of hearing. Its very difficult. We do try, I mean privacy certainly like for bodily functions or anything like that. You always draw the curtains em you can not avoid talking to the patient behind the curtains and sometimes talking about quite personal things like opening your bowels about vomiting even about your pain or anything like that, you will never ever in a room like that. It would be very difficult totally to be able to get privacy for the patient, its going to be very, very difficult.

Jay: Are you quite happy to carry on with this interview?

Nurse: Yes I am.

Jay: You feel OK

Nurse; Yes I'm feeling fine.
Jay: From your perception, from your understanding what do you think privacy is?

Nurse: Its ehm, for me that would be I don't want people to know certain things about me like, that its as I was saying earlier for example if I had say perhaps psychiatric problems in the past, I don't want anybody to know that.

Jay: Yes.

Nurse: Ehm certain things which maybe go on with my family I don't know relationships in my family. I would not want anything of that to get out to other people. I would like to keep that sort of thing private. Ehm I'm quite more than certain about privacy than I can actually visit the bathroom or do. What I need to do, you know in private, that is something I would consider quite important for myself actually, ehm that's about it I would say.

Jay: Things like being in the bathroom and toilet?

Nurse: Yes things like that. That would be quite important to me I think.

Jay: Ehm, for example if a patient of yours wants to go to the toilet, how do you ensure that patient's privacy?

Nurse: Depending obviously if they can walk to the toilet I will walk them to the toilet if that can be done. Otherwise we are talking of course by the bedside or in the bed all I can do is draw the curtains around.

Jay: Yes.

Nurse: Ehm, help them onto to the commode or bedpan whatever it is give them the bell, if I normally do leave the patients on their own.

Jay: From your observations, from your observations do you consider it is a normal occurrence if your patients wants to go to the toilet, staff will take that patient to the toilet rather than give them bedpan or a commode by the bedside?

Nurse: Yes, yes.

Jay: They do that?

Nurse: I would certainly do that yes because there's nothing worse and I speak from my own experience, having to sit on a bedpan or on the commode I don't think there's anything private about that whatsoever.

Jay: Even if a curtain is drawn?

Nurse: Its not enough privacy.

Jay: Not enough privacy?
Nurse: There is no privacy. You can still hear. I’m going to have to be frank about this. There are still noises, there’s still the smell and there’s still you can hear the patient because it is uncomfortable taking them off the bedpan or off the commode or the pain people can hear it and its just not private I’m sorry.

Jay: If that’s the case is there any point warning the patient like ‘I’m coming in Mrs Smith’ when the curtain is drawn? Is there any point warning the patient before opening the curtain? Do some of the nurses do that?

Nurse: No, because you see, if a patient rings you, I normally approach the curtains and say, ‘I’m coming Mrs so and so or Mr so and so,’ and then they know I am on my way and then I open the curtains. Very few will actually stand in front of the curtain and say ‘it’s me, the nurse, I’m coming in now Mrs so and so’.

Jay: Which I never saw today.

Nurse: Yes. Very few will do that very few will do that. Because we expect and I think the patient actually expects that that when they ring the bell we know they have finished and we just go in.

Jay: What would happen if they don’t ring the bell?

Nurse: We do ask, we do ask, ‘have you finished or do you need any help?’

Jay: Outside the curtain?

Nurse: Yes.

Jay: Before going in?

Nurse: Yes.

I would expect that to be done normally outside the curtain.

Jay: And you feel other professionals do the same thing?

Nurse: No.

Jay: And who would be the other professional who won’t do that?

Nurse: No, most nurses won’t do that. Most nurses won’t do that. I think also its got something to do with, we have nearly lost somehow the inhibition because we see day in day out, that we sometimes do tend to forget that that it is something quite private for a person, toileting, and for us its quite normal and we don’t even think about that.

Jay: Yes. Let’s talk about patients personal space and property. I noticed this morning many things happening at the same time, like cleaners cleaning the locker when patients are toileting and patient eating at the same time.

Nurse: Huh Huh.
Jay: Have you got any observation to make about that?

Nurse: Yes, I think its appalling huh huh. I have always said its appalling. I don’t like it. I have made a complaint about the cleaning staff you know, that they shouldn't observe at times coming into the ward. It doesn’t go very far because they’ve got problems, they’ve got problems with things like that and all the problem I’ve got is this, that patients toilet and some people are having breakfast for example I don’t know what the way around is.

Jay: you too have noticed?

Nurse: I have noticed it and another thing which I have seriously noticed and I have put my foot down is putting urinary bottles, men urinary bottles on the trolley (bed table) where they afterwards eat their meals.

Jay: Yes ,we saw that this morning didn’t we?

Nurse: That is appalling. That is actually that shouldn’t happen. That really shouldn’t happen.

Jay: Do you think nurses should respect patients’ space or do patients have any space where they can say, ‘this is my space, this is my bed and this is my locker’.

Nurse: I think we should respect it but I don’t think they have got any space, they have got. Yes they have got a little bit of space, let’s put it I would consider their bed probably their space and a locker there is not a locker round there. I would for example, I would try not to get into a locker without telling the patient what I am doing in the locker I will ask them, ‘What have you got in here? Have you got a napkin? Where is your soap? Where is all your stuff?’ before I try and go actually myself because I think their stuff is private. It’s in there and if they don’t want me to see it, that’s fair enough but apart from that I do not think they have got a lot of private space. It’s very crowded in there.

Jay: Do you have any views about doctors or nurses sitting on the patients’ bed?

Nurse: Yes, I do. It is as well I’ve noticed. I do it as well and I know its very unprofessional and it shouldn’t be done. Apart from cross contamination in the first place em that’s an infection control problem but it is invading their space actually because the bed is the patients private sphere and it shouldn’t be done, it shouldn’t be done.

Jay: The use of telephone by the bed. Have patients ever made any suggestions that they do not want to use the telephone, like this morning this lady who was on telephone, I could hear everything what she was saying.

Nurse: That is a problem, yes you are absolutely right.

Jay: Yes but has any patients made any suggestions that they have no privacy?
Nurse: Nobody has ever said anything about that apart there was an incident last week. It was last week yes, where somebody on the phone made a racist remark about me. Huh huh huh well, I'm a foreigner you know so that happens but it was overheard because it was extremely loud, it was made to be heard by the other nurses, and that particular nurse came to me and told me about it and I complained to the manager and I also told the patient that I made an official complaint about it because she was overheard and she then complained that we were listening into her telephone conversation. We could actually at the time prove that we didn't because all the other patients heard her as well but it could present a problem. Yes it could present a problem because they're all there and they all talk and you can actually listen in but nobody has actually ever said anything because I don't think normally people listen in to the private conversations. I've never come across it actually not even I when I and even if the phone rings and they are busy with the doctors or the nurses, they will say, 'can you ring me back' the nurses are with me or whatever and they will have to ring them back.

Jay: Right one or two more questions we are coming to the end now
When you are writing the cardex do nurses ever mention from your experience that privacy of this patient is an issue, have you ever seen documenting in that order?

Nurse: Never seen that.

Jay: But you write about injections antibiotics etc.

Nurse: Not necessarily we write, I would start off a cardex like say, did the patient need health and hygiene needs, personal hygiene needs, how did the patient feel in general during the morning or whatever I am writing about, most of the other information you will find actually by the bedside I don't know if you've noticed.

Jay: Yes I have noticed.

Nurse: We have got a lot more paperwork now, if for example I have to be by the bedside where it should be commented on every day because bed be checked. Whatever you need a wound chart by the bedside, you've got your search care plan by the bedside, you've got your manual handling, manual handling how this patient is supposed to be helped out of bed, sat up whatever, by the bedside. You got your drug chart by the bedside, you've got practically everything by the bedside. If its an integrated care pathway and then it is all in the integrated care pathway.

Jay: Yes.

Nurse: In the cardex you really do write down anything that is out of the ordinary, like permission to take a temperature for example, the patient has been sick you know or the blood pressure has been very low. You have done this in case we have contacted the doctors if there has been any incidents or anything like that, that all goes into the cardex anything else should really go by the bedside.

Jay: So in order of prioritisation on a scale of 1-10, if number 1 is most important where would you place giving medication on such a scale?
Nurse: Well if number 1 is important one.

Jay: Where would you place it with regard to giving patients’ medication?

Nurse: Well I would have to tell you 1.

Jay: 1?

Nurse: Yes, yes because it’s a priority. I have to follow, you know, doctors’ orders and also in order for patients safety they might need the medication sort of thing

Jay: Of course.

Nurse: So that would be 1. Having said that not necessarily because I personally think looking after the patient for his hygiene needs or making him comfortable or you know even just mobilising making sure he is properly mobilised might come before the medication – you have to see it in context.

Jay: Of course, if the patient is ill.

Nurse: If the patient is ill I would probably put it into 2.

Jay: Where would you put privacy? Or would you think of putting privacy anywhere?

Nurse: I have never thought of it as privacy.

Jay: Or respecting their dignity?

Nurse: Yes dignity for me personally.

Jay: No in your honest opinion or do you?

Nurse: I would prioritise that.

Jay: How would you prioritise that?

Nurse: I would put it probably 4 or 5.

Jay: Right. Is any ward policies or any protocol report that specifies as to how a nurse should respect a patient’s privacy, is there a ward protocol?

Nurse: I am sure there is a ward protocol.

Jay: As to how you respect a patients’ privacy?

Nurse: Yes I am pretty sure there is.
Jay: Another question. In your honest opinion do you think there is room to improve patients' privacy?

Nurse: Yes I think there is.

Jay: But why don't we do it?

Nurse: I think it is because we are so understaffed, it is the usual problem. We are so understaffed and we are so busy doing everything else, get the patients washed, do this, do that, and in order to make sure that there are no complaints from the patients because we always seem to be so worried about complaints, that we sometimes do tend to forget about privacy and dignity quite frankly. I still see very very often I have to say that particular patients are dying that's the one time that we actually give them privacy and when we actually give them dignity em but when the patients are doing alright, I think that tends to go on. Its not considered a high priority but when you are dying it becomes a priority.

Jay: What about their visitors, patients and visitors?

Nurse: In what way?

Jay: They have come to see their loved ones and do staff ensure some sort of privacy?

Nurse: I cant say that.

Jay: No. You have been great.

Nurse: Oh good huh huh.

Jay: Thank you very much.

Nurse: You are more than welcome

Jay: as I have said before I will respect the confidentiality. No body would be able to detect your name.

Nurse: That's good

Jay: Thank you.

Nurse: I believe you are doing a good job.

Jay: Thank you

Nurse: Huh Huh.

Jay: About undertaking this research?

Nurse: Absolutely.
Jay: Its very kind of you indeed.

Nurse: You are more than welcome. I hope its useful anyway, its very interesting actually because we don't think about enough, about the whole thing which is going around the way it works in England, the National Health Service. There's practically no place like something, like privacy on the ward in the National Health Service yet you've got protection and that sort of thing and human rights and whatever but when you actually do come on the ward there's no such thing as privacy, is there? And as I was saying earlier I know it's only a little point but there's nothing worse than having to toilet yourself with all these people around you and we nurses tend to forget that it is not normal doing it in surroundings like that. It just isn't because of smell because of anything until you have been in the situation yourself and actually realise this is horrible I don't want to do that, how do I put my patients through that you know? It tends to be forgotten because we feel there are so many other things which are important you see and we are pressurised from every other side, and its rather sad.

Jay: Did you feel tense when I was asking you these questions. You seem quite confident at the end.

Nurse: Yes.

Jay: Very interesting interview
You talked well.

Nurse: Thank you.

Jay: I hope you will enjoy your holidays.
AN EXAMPLE OF OBSERVATION DATA

(Excerpt from observation data, pages 36-42)
Observation data: Tuesday 12.15 – 18.00.

Yellow team: 3 trained staff and 1 care assistant

Green team: 3 trained staff and 1 care assistant

12.15

I am in room 10.

Patient 28 is sitting by his bed. He has his hospital gown on. Two urinals are on his bed table, that is just in front of him. His legs are exposed to his thighs. He is reading the daily newspaper. His name, as with all patients, is clearly showing above his bed.

Patient 29 is sitting on his bed. A urinal is on his locker. He can walk about. So the presence of the urinal puzzled me. Two visitors have just visited him despite it being mealtime.

Patient 30 looks asleep and he is lying on top of his bed. He is dressed in a hospital gown with a dressing gown on top of it. He is a new admission last night. His wife is sitting next to his chair and she too, seems to be fast asleep.

Patient 31 is sitting by his bed, dressed in his outdoor clothes. He has just arrived and will be going to the operating theatre this afternoon for certain investigation. A doctor is explaining to him what is going to happen to him. The doctor is sitting on the bed. The discussion is rather loud. The patient is asking certain very personal questions and the doctor has replied without lowering her voice. At no time was the curtain drawn.

12.50 lunch time

Patient 28 received his lunch on a tray. The urinals are still lying where they were. A nurse serves the meals, but the urinals are not removed.

Patient 29’s visitors are still around despite the fact that the meals are being served. After nearly 10 minutes, at the instigation of one of the visitors, patient 29 started eating, making jokes about the state of the food. As the lady visitor was sitting on the patient’s bed I volunteered to give up my chair for her to sit on.

Patient 31 is lying still. He is dressed in his theatre gown (also known as hospital gown). He is going to theatre this afternoon. His curtain is wide open and he is observing what is going on around him. The nurse brought a tray of food for patient 31 but he quickly reminded the nurse that he is on ‘nil by mouth’.

12.55

I am in room 9.
Patient 19 is sitting on his drainage bag, the bag is sticking out from underneath him. He has his hospital gown and his dressing gown on and is slowly finishing his dinner.

Bed 2 is empty

Patient 26 is lying in a sitting up position in his bed. He is semiconscious and his wife and son standing nearby. His wife is constantly shaking whilst trying to talk to her husband. The son looks rather distressed and is trying to talk to his father, stroking him with his hand. Other patients are watching them.

Patient 21 is sitting by his bed in his dressing gown and is reading a book. He is going to theatre this afternoon.

Patient 27 is sitting by his bed. He has a hospital gown on. He has no slippers and no dressing gown. He is not covered with a blanket. There is a drip running. He is asking for a urinal rather loudly. The visitors are looking at me wondering about my reaction, although I have already explained to them about my functions in the ward. No nurses are around and it is clear they are still receiving the report - that is the hand over is not completed yet.

'It is too late now.' Patient 27 said to himself. He has wet the floor. He has made a puddle in front of him. After 10 minutes a nurse appeared and he shouted at the nurse.

'Please, help. I have wet the floor.'
The nurse said, 'Don’t worry.' He left the room and brought a large pad and placed the pad on the floor in front of patient 27 so soak up the urine. The pad was left until 17.00 when a care assistant cleaned the floor and removed it.

Patient 22 is crying. He is in pain. His urinal catheter is in situ and the urinal drainage bag is on the stand in front of him. The bag is empty. He has a hospital gown on, no slippers and no dressing gown. When he is sitting down he is totally exposed and on and off his genitals can be seen.

'It is painful,' he said and he is making grimaces and making a shrieking noise. His dinner tray is lying in front of him. He has not touched anything yet. He tries to get up several times but the drip and his catheter are restricting his movements. He is asking for painkillers. At last a nurse arrived and saw his distressed state.

'In a minute,' the nurse said. After a while the nurse brought an anti spasmodic drug. 'That will relieve the spasm.' And he left the patient. It was very distressing for me.

His food tray remains untouched. Nobody has tried to feed him. I have not seen him drinking any sips of water since I have been there. I am thinking that the nurse surely must have seen his state. Yet he remains exposed.

I am sitting by patient 26. He said, 'I am waiting to go to theatre.'
I asked. 'Is everything all right with you?'
'No,' he said. This a dirty hospital.' 'Have you seen the state of the toilet?' 'I am not happy about it.'

A porter has just walked in. He wants to take patient 26 to theatre.

Patient 26 said, 'I am not ready.'
The porter went outside and fetched a hospital gown and gave it to the patient. The
patient started getting undressed without drawing the curtain. All the other patients are
watching the scene. Once he was dressed the porter helped him inside the bed and
covered him with a blanket. All this time I did not see a single nurse.

13.30

I am sitting by the nurses’ station.

Nurses are still having the hand over from 13.00. Patients’ notes are scattered
everywhere and the station looks rather untidy. Visitors are constantly passing by.

I am observing room 1 and sitting by patient 12.

Patient 12 has his own pyjamas on. He is walking round and round his bed. He has no
dressing gown on.

Patient 24 is sitting in bed. He has a hospital gown on. Two urinals are lying on the
bed table.

Patient 3 is lying on his bed and talking to somebody on the telephone. Every word
can be heard. He has his own dressing gown on.

Patient 2 is sleeping or trying to sleep, as I notice his eyes keep opening on and off.

Bed 5 is empty. Patient has gone to the x-ray department.

Patient 23 is transferred from room 7 to replace the previous patient who died
yesterday.

13.50. I am in room 6

Patient 32 is just transferred from one of the side rooms. Her urinary bag is full. She is
walking about with the urine bag in her hand. She is surrounded by nurses. Hand over
is in progress. Nurses are moving from patient to patient. They are discussing the care
of each patient. Although they are trying to speak quietly, I can hear from where I am
sitting. Both red and yellow teams are doing their rounds at the same time. So the bay is
crowded with nurses.

Patient 16 is sitting by her bed. Her mouth is wide open. She is trying to sleep. A
urinal is on her bed table. I wondered why. Her husband has just arrived and he is
trying to find a chair to sit on. I managed to find one for him and brought it by patient
16.

Patient 17 is in her bed. I can see her case notes and X-rays are lying at the bottom of
her bed.

Patient 6 looks alert. ‘I have had no trouble sleeping at first,’ she said, ‘once I
received my sleeping tablets I was all right. She is wearing a theatre gown.
Bed 5 is empty. This patient has gone to theatre.

Patient 18 is in bed. She is clad in a hospital gown. The front part is rather loose and she is exposed. Her legs are sticking out of the bed and her thighs can be seen.

Back in room 9

Patient 33’s curtain is drawn. A nurse is walking in and out of the curtain without prior warning. I heard twice, ‘Are you going to stand up ...(first name).’ I can see between the gaping curtain he is being changed. The nurse came out with a bowl of water, emptied it into the sink, went to the patient’s locker, opened it and placed it inside. She opened the curtain but left it half drawn. He is now sitting by his bed in his hospital gown with no dressing gown and both legs fully exposed.

Patient 19 is resting on top of his bed. His left slipper is still on and the right slipper on the floor.

Bed 2 is empty and it is being made by two nurses.

Patient 26 is being helped by two physiotherapists. The curtain is fully open. They are asking the patient to do deep chest exercises and asking him to cough.

Bed 4 is empty.

Patient 22 is sitting by his bed. He has his hospital gown on. He looks drowsy. He has no blankets on top of him. His genitals could be seen. His urine bag is on a stand, on the right side of the bed. This is partly full and a brownish colour. There is a dinner tray lying on the bed table. He has not touched his dinner at all because all the meals on the tray are intact.

14.30

I am sitting by the Nurses’ Station. A man walked in with his stethoscope around his neck. I have never seen him before. He went straight to the patients’ notes holder and stated looking at patients’ notes. No body stopped him. I asked a staff nurse about the person’s identity. She did not know and still she never questioned him.

14.40.

Room 1

Patient 12 looks relaxed. His wife is sitting next to him. Tea is being served. She is helping him with his tea. After tea, she combed his hair. (This is the first time I have noticed a patient hair, either personally or by a third party being combed).

Patient 24 is using a bedpan. The curtain is partly drawn. His visitors are sitting around the curtain. A nurse is moving in and out the curtain. After the patient has used his pan, the curtain is removed. No water is given to wash his hands. He is placed on a wheel chair and is being taken out by his wife and his daughter. Later it emerged they never went out, as the hospital lift was out of order.
Patient 4’s curtain is drawn. His dressing is being done. A doctor arrived and she started peeping through the curtain without prior warning. She went in and immediately came out, walked to the nurses’ station and asked another doctor for his opinion. They both then walked to patient 4’s bed, walked in through the curtain and together completed the procedure of taking blood. After a while the curtain is now opened. The patient is in his hospital gown but for the first time I noticed that a blanket covers him. (Was it because I was sitting there. I wondered). He asked to see his visitors and said they are waiting in the day room. Two ladies came over and immediately they started giving him water to drink, tidying his bed table and placing his tissue box nearby him and covering his shoulder with another blanket. This again I have never seen before. I can hear every word that they are saying. Once his visitors have left I noticed that the patient started crying and looking very upset. No nurses are around. On their way, one of the visitors approached me and said to me that they are his neighbours.

’We cannot look after him any more. I have told him that he must go to the nursing home. My husband is now disabled and I have told him that I have to look after him. Therefore I cannot do any of his shopping etc.’

I decided to approach him after a while (five minutes).
’Sorry,’ he said.
’I do not want to talk to any body at this moment of time.’ I respected his wishes and backed away from him.
(As his neighbour had told me some pertinent information about him I was left in a real dilemma. The issue was should I tell the ward sister. In this instance I decided to tell her so that she is fully informed).

Patient 24 has just arrived in his wheelchair, accompanied by his wife and daughter. In the meantime patient 12 is walking about with his pants down. His pants are wet. The wife of patient 24 who was sitting next to her husband’s bed said to patient 12:
’You lift your pants up.’ The patient did not pay any attention to her.
Patient 24 who was sitting on his wheel chair said he is very tired. But the bed is not made. He can’t go to bed by himself because of his bilateral amputation. He is waiting for 20 minutes now until a nurse came to make his bed and with the aid of a care assistant put him back to bed.

Patient 23 is lying flat in bed. His front is exposed. Nobody has helped him with water from the moment I have been on this ward. Tea has been served already and I noticed nobody gave him any tea. A nurse came to change his sheets. Patient is responding to conversation and talking. The curtain is half closed and I can see all the activities.
’I am going to make you comfortable.’
’Ok,’ he said. After a while the curtain is opened. The patient looks comfortable. But he continues to stare the ceiling and the shiny bright light.

Patient 4 - a nurse approached him and said ‘I’ll do your dressing in a minute Jack. Is that OK.’
’All right dear when you are ready.’ He said.
I am in room 6

All patients are resting and sleeping except patient 3.

Patient's 16's husband is still sitting nearby.

Patient 7 is completely exposed. Her nighty is covering only the top part of her body. She looks very ill. All sheets are thrown away from her. Her legs are apart and the upper part of the catheter is clearly visible. (I was rather embarrassed. I decided to withdraw to another position in the room.)

16.30

I am sitting by the nurses' station. A group of doctors x 4 walked into the ward and went straight to the notes trolley. They took out a note and walked to room 10 and saw patient 28. They stood over him for a while and explained the progress he is making. At no point was the curtain drawn. They were quite loud and I could follow every word they were telling the patient.

16.40 Room 10

Patient 34 had his operation this morning. He still has a hospital gown on. I asked, 'What do you think of this hospital gown?' His daughter is sitting nearby and she quickly replied. 'He is looking like a woman. Isn't he?'
The patient said he is rather cold. The daughter suggested that he should put his dressing gown on which precisely what he did.

Patient 35 said, 'my operation was cancelled at 16.15 when I have been waiting all day'. His wife who is sitting next to him said that a nurse just said so. The patient carried on and remarked, 'but this nil by mouth sign has not been removed yet. I am fed up. I have had nothing to eat all day.'

I am in room 9

Patient 22 is lying on his bed. He is drowsy. He has his dressing gown on.

Patient 36 is sitting by his bed surrounded by two visitors, one of the visitors is helping him with water. This is the first time I have observed that this patient is actually drinking.

Patient 26 is sitting upright. He is looking ill.

Back in room 6

I am sitting by patient 32 who has just been transferred from a side room to the main ward. I asked.
Jay: what difference have you found between being in the side room and being in the ward with 5 other ladies?

Patient: I can adapt up here. Previously I was in the main ward. I can put up with the irritation of not talking privately on the telephone, constantly surrounded by visitors who are always looking at you. If you are poorly it does not matter. You have to maintain your sanity somehow. Some visitors can be very loud. They are constantly trying to make jokes, treating visiting time like a social event. They forget that there are ill people up here. Visiting hours should not be that long. Another thing, staff have to be careful in the bay. They are always banging my bed when wheeling trolleys, moving the hoist machine and particularly when they are cleaning the floor. I have had my kidney removed and every time they bump to my bed I feel pain in the grove of my kidney.

Jay: How do you ensure your privacy up here?

Patient: There is no privacy up here. You can hear each other’s conversation. When I want to talk to my relative I have to whisper, same thing on the telephone you cannot talk about other things apart from being just short.

Jay: How do you cope, then?

Patient: I just try to read. I keep my head down. I keep some kind of barrier around me. It is difficult. Isn’t it?

Jay: Would you like to make certain observation when a group of doctors or nurses surround you during the report time or during the ward round of the doctors?

Patient: It is very daunting when so many people surround you. What I don’t like is when they don’t talk to you but talk about you. I do not trust doctors. I always question them closely with everything. If you ask too many questions you appear to be too critical. You can be labelled. So you have to be careful.

Jay: What time did you get up this morning?

Patient: At 05.30. They don’t care for patients up here. This bed is broken and they have done nothing about it.

Jay: How do you think your privacy can be improved up here?

Patient: More side rooms I suppose. There must be a large sitting room and doctors should see patients in a private room.

Jay: Thank you.

Left the ward at 18.00 hours.
APPENDIX 15

Glossary of terms

GO  General observation data: this was the type of data that was acquired through observation of the research field.

Practitioner  Refers to doctors, nurses, students, health care assistants and all paramedical staff.

Patients  All male and female individuals who were receiving certain medical treatments on the wards at the time of the research.

SID  Semi-structured interview data of doctors: data that was obtained through formal interview of doctors using a flexible staff interview schedule.

SIN  Semi-structured interview data of nurses: Data that was gained through formal interview of nurses using a flexible staff interview schedule.

SIP  Semi-structured interview data of patients: data that was gained through formal interview of patients using a flexible patient interview schedule.

Theatre gown  This gown was also known as ‘hospital gown’.

UIP  Unstructured interview data of patients: data that was obtained through informal conversation with patients during the observation phase.

UIS  Unstructured interview data of staff: data that was obtained through informal conversation with nurses, doctors, students and care assistants during the observation phase.