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Private Goes Public - An Exploration of the Translation of Social Reality Within a Hospital Setting

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The first thing that hits you is the smell. Instantly recognisable, it is the smell of your first visit to the dentist; the time you had your broken arm set in that bright pink plaster cast; the time you reassured your pet through their dreaded yearly check up. Clinical disinfectant. It hangs in the air, clinging to your every move, to every step you take across the dazzling linoleum floor. Then comes the noise. Not yet desensitized, your ears are assaulted by the different television and radio stations blaring from every room; by the incessant buzzing of alarms and the crunch of plastic sheeting as it is stripped from a bed. Trolleys hurl past at breakneck speed, dividing the constant stream of nurses, doctors and visitors that file through the hallways. Although a place of healing, no hospital is a place of rest. It is a constant hub of activity, a transient space in which one rarely sees the same face twice.

I had not planned to carry out my ethnography in a hospital. However, as the time drew nearer, I became resigned to the fact that my research would be conducted in a rather depressing looking Highland hospital. It was not a change of plan I approached with enthusiasm. On my first day I entered the building with no notion of the direction I was to take. To my surprise, it was in the waiting room that my project found its first big break. In this room, I was struck by the contrast between the hospital as a social setting and the 'outside World'. I was not sure *what* was different, but it was through this that I decided my study would address the hospital's disregard of accepted social norms. With this in mind, I conducted my research. Throughout, it became clear that the lack of 'normal' privacy within hospitals was a major concern, one that I too experienced as a visitor. My study became one concerned with the impact of such a lack of privacy, and the means through which individuals overcame it through attempts to 'normalise' the situation. This lack of privacy was experienced by each of my informants, and as such, both their reactions and attempts to defy it will be explored throughout this essay.

Methodology

The majority of my ethnography was not based upon interviews, but upon participant observation facilitated by my role as a visitor. From this position, I spent my first day in an observational capacity, beginning in the waiting room. This room was filled with posters communicating their messages – ranging from innocuous ones advising the washing of hands, to more explicit ones offering advice to those suspecting they suffered from one of an assortment of sexually transmitted diseases. Despite this, the social space itself was not so open. Little direct eye contact was sustained and conversation was stunted, stemming from the awareness that conversations could be overheard. I then moved into the ward, still occupying the role of observer.

It was here that my ethnography found its focus. In this ward, there were four sleeping areas, each containing a patient and a visitor. Each pair were carrying out their own conversation, ignoring those around them. However, as this took place, an elderly woman attempted to leave her bed and promptly fell over. All heads turned. Conversations ceased immediately, and everyone in the room played a role in helping her to get up. However, as soon as order had been restored, those who had previously communicated as a group retreated back to their private conversations. It was through this that I realised that there was more to be said about privacy, specifically the way people seemed to pretend that the situation they were in was a 'normal' one. This led me to develop the way in which I conducted my fieldwork. I decided that I did not want to conduct interviews with patients but simply observe, as it seemed disrespectful to intrude. Similarly, although I had passing conversations with nurses, I did not want to interfere with their work, so did not interview them on an individual basis. The subjects of the interviews I did conduct comprised of both male and female adult visitors, ranging from 40 to 60 years of age. For the purposes of privacy, the names of all interviewees and the hospital itself have been changed. The interviews I conducted were semi-structured and began with four pre-prepared questions:

1) Who are you visiting?
2) Describe a typical visit.
3) Has anything ever happened that made you get involved with another patient or visitor?

4) In what way is your behaviour or speech different because you know you are in a hospital?

Although these questions were asked in the same order to allow continuity between interviews, I also allowed my informants to steer the conversation in their own direction. Interviews were carried out both in the hospital itself and in a local coffee shop, depending on the informant's choice. My informants were extremely responsive, and interested in what I was doing. Their responses were startlingly open, my interviews clearly providing much needed respite.

Having conducted my interviews, I collated my data, and found the issue of privacy to be common to each. Thus, I decided that in order to present a comprehensive study, it was essential to research the concept itself including any cross-cultural variation. Through this I hoped to understand in what way the hospital setting upsets the 'normal' ideas of privacy. Although common in modern ethnography, its relatively recent prominence is often attributed to the endeavours of Edward Hall. In his work, Hall dedicated much attention to the varied social and cultural practices of distancing. Although often over-generalising, Hall noted that whilst some cultures do not appear concerned with privacy, others value it highly. In his ethnography of Ghanyan, an Indian village, he describes how it was impossible to 'maintain any kind of bodily privacy' as even the 'house itself is permeable to the gaze of others' (cited by Hendry and Watson 2001: 122). Contrastingly, many Western cultures view privacy as a basic human right, with Germans tending to be 'extremely sensitive to special invasion' (cited by Altman and Chemers 1984:106) and the English often attempting to 'maintain a psychological distance from others by verbal and non verbal means.'(Altman and Chemers 1984: 107) This research provoked much interest, and by 1960 the study of cultural variations within attitudes to personal space had become commonplace. However, whilst it is generally acknowledged that the maintenance of privacy is a fundamental aspect of many Western societies, this is a desire unable to materialise within the hospital setting. In societies so concerned with the creation of personal boundaries, the hospital becomes what King describes as a unique way of life, 'a subculture of a sort within the total society' (cited by Zaman 2005:12). Within this 'subculture', not only is there a distinct lack of privacy but also, 'the customs, the relationships between people, the particular problems of everyday living are significantly different from those of other social organisations' (Zaman

2005: 12). Thus, the hospital must be approached as an entirely 'other' space in terms of its adherence to social norms. However, in cultures so defined by their valuing of personal space, what happens when this right to privacy is removed? After all, the NHS is a public service, not a private one.

'Why Is It Different in a Hospital?'

The most interesting point to come from my research was the way in which this lack of privacy was experienced differently by nurses, patients and visitors. In general, nurses and patients appeared oblivious to the lack of privacy. The nurses I encountered had all developed a larger-than-life persona, a coping mechanism of sorts. On my first visit, without even being able to see her, I heard one nurse shout cheerily down the corridor, asking 'all right old man, ready for your physio?' (unidentified nurse, hospital ward: 2012). This exchange was a reassuring gesture, but what struck me was the lack of concern that others could hear it. I didn't even know his name, but for some reason it didn't matter and I now knew this patient was receiving treatment for a broken hip. Similarly, patients seemed unaware of the distinction between private and public conversation, often talking loudly about their neighbours. One patient even described an elderly lady as 'the wee one in the corner' (unidentified patient, hospital ward: 2012) and excitedly recounted the story of how she had a 'right go' (patient, ward: 2012) at one of the nurses.[1] The lack of privacy when this conversation took place did not concern the speaker, and if anything appeared to cheer her up. Patients did not seem to register the difference between the private and the public sphere, simply as a result of their prolonged residence in a setting devoid of privacy. Each patient had a board above their bed listing their most private and intimate details - everything that once would have been private was now in public. At no point did any patient attempt to 'normalise' their situation – for them, the hospital had become 'normality', thus lack of privacy was not a concern.

However, whilst the lack of privacy bothered neither patients nor nurses, it was a subject of great distress amongst my visiting informants. My first interview was with Leslie, a middle aged ex-nurse visiting her mother in law. The issue of privacy became apparent when I asked her, 'In what way is your behaviour or speech different because you are in a

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[1] 'right go'- slang: To start a verbal confrontation.

hospital?' Although very open, at this point she became uncomfortable, and laughed nervously whilst weighing up whether to present me with the true or abridged answer. After deciding which to give, she told me that she is aware that she alters her behaviour, trying to be more respectful as there 'can be people who are actually dying.'(Leslie, coffee shop: 2012) Although she makes the conscious effort to modify her behaviour, it 'really bugs' (Leslie: 2012) her that patients make no attempt to do so. She even went on to tell me that she found the hospital's attempt to create privacy ridiculous. She reacted particularly strongly to the use of curtains around beds, criticising the way that nurses think they are 'magic curtains' (Leslie: 2012) and so talk of sensitive subjects as if in a separate room. She repeated that the lack of private space in hospitals 'bugs' (Leslie: 2012) her, and even asked me 'why is it different in a hospital?' (Leslie: 2012). Good question.

In my second interview with Hugh, a middle-aged executive visiting his mother, it took little time before he too launched into a complaint about the use of curtains in the hospital. He criticised the 'automatic assumption that they make it into a room' (Hugh, hospital ward: 2012), describing his anger when his mother's private medical problems were discussed loudly in a full ward. Similarly, in my third interview Henrietta, a retired social worker visiting her mother, she also reacted strongly to this issue. Although she stated that she did not modify her behaviour in any way, she told me that she found conversation with her mother difficult. As her mother is severely deaf, she had to speak very loudly, but as a result was aware that everything could be overheard. Thus, she tended to limit her interaction to questions about the weather or food to avoid uncomfortable situations. As a visitor, entering a hospital is almost like entering a different World. In this World, whilst it is *necessary* for all information to be in the open, this lack of privacy consistently surprises even the most weathered of visitors. As Henrietta pointed out, it was something 'you are always expecting, yet it still annoys the hell out of you' (Henrietta, ward: 2012).

Manufacturing Normality

Through these interviews, it became clear that the lack of privacy affected visitors greatly. Most visitors tended to make a great effort to overcome it, attempting to 'normalise' the situation. As Hugh pointed out, all visitors are aware that they are in an unusual social situation yet like to pretend that this is not the case in order to cope with the perceived lack of privacy. Visitors often attempt to create a private social sphere, one in

which a false sense of privacy and 'normality' is established. One way in which this is achieved is through their attempts to ignore others. Even when they enter the ward, visitors tend only to acknowledge the patients and visitors that are part of their immediate group. It is only on very rare occasions that this understood rule is broken. For instance, Hugh described how he and another visitor were forced to interact due to a mix up of clothing. The situation itself was slightly awkward, and so required a sense of humour to break the ice. Although the interaction ended once the problem had been sorted out, he now waves to her whenever he sees her even though they haven't had another conversation since. Although in reality it is not always possible to ignore those around you, it was clear that through ignoring others, visitors hoped to manufacture a sense of privacy. They wished to create a 'normal' and enclosed space in which they could converse with their loved ones as though they were in a living room and not a hospital ward – as though they were in a private space and not a public one. It was an unwritten rule - one that as a visitor I myself had to adhere to. The tendency to ignore others did not stem from poor manners, but instead from a desire for 'normality'.

Additionally, over the course of my research I identified another way in which visitors attempted to 'normalise' the situation and create a private space for those they were visiting. It is universally acknowledged that when one visits a patient it is polite to present them with a gift. For instance, in Tongan society, a mother will remain in hospital after the birth of her child and the father of the child and their close relatives will visit bringing food and other gifts to the mother (Morton 1996: 50). This gathering is referred to as the 'po tama' (Morton 1996:50), an event that symbolically welcomes the child to the family. Whilst gifts such as these function as a means of social confirmation, personal gifts also serve as a way of creating private space. Through observing, I realised that many visitors were bringing items that they knew the patient would have appreciated if they were at home. For instance, Ann, a retired receptionist, visited her friend every second day. Each time she entered the ward she would hold up a tatty Marks and Spencer's bag, and cheerfully shout 'here's your chocolate bars, all the ones you like' (Ann, hospital ward: 2012). Another visitor brought DVDs of her mother's 'favourite shows' (unidentified visitor, hospital ward: 2012) because she didn't know how to work her television in the hospital. Others brought favourite items of clothing, and even framed photographs. In many cases, these gifts had not been requested by the patient, but were presented by the visitor

regardless. It was through these personal gifts that visitors attempted to recreate the private World the patient had left at home. Through gifts such as these, each bed area became a personal microcosm of the outside World – a representation of the World visitors seemed unwilling to leave behind at the door.

Another way in which visitors attempt to combat the lack of privacy within the hospital setting is through the establishment of habit. Upon entering the building, visitors unconsciously act out a routine. When asked to describe a typical visit, Hugh described how he always does exactly the same things: he checks what staff are at reception; washes his hands with that 'fancy gel' (Hugh, hospital ward: 2012); looks at the fish in the day room and looks into the ward from the corridor. Other visitors I interviewed described their behaviour in a similar way. Whilst visitors seem to have personal habits that govern their actions, they also structure their interactions with patients in such a way. When describing a typical visit, Leslie told me that she always does the same things each time. She always asks the patient how she is, if she has eaten or drunk anything yet and if she has been given any medication. Once these questions have been asked she looks at the chart at the bottom of the bed. She then settles into conversations about assorted family members before finally collecting any washing that needs removed. This represents the end of the visit, her collecting of the washing 'usually signalling that I am about to leave' (Leslie, coffee shop: 2012). To her, the acting out of this routine is about 'reality orientation' (Leslie: 2012), about creating a structure that lends a sense of normality to the situation. These habitual interactions also lend a sense of privacy in that they are unique. They are not public interactions, but private ones, ones that are unique to those who carry them out. The establishment of habit clearly put visitors, and patients, at ease. It allowed them to establish their own World within a setting devoid of both 'normality' and privacy. It allows them to reconstruct the boundaries removed by the hospital setting and thus to regain social control over the situation.

Limitations

Whilst my ethnography presents a fairly accurate picture of social reality within a hospital setting, this is not to argue it is devoid of fault. Although I attempted to remain unbiased, as both an anthropologist and visitor it was often difficult to ignore my own experiences. Though the data presented is based purely upon interviews, it would be naïve to claim that I in no way influenced the responses I received from my informants. As a

visitor myself, my informants could identify with me and thus were willing to speak freely. Thus, whilst this position had its difficulties, I found that being a fellow visitor was much more a strength than a weakness. It allowed my informants to feel at ease, to feel as if they weren't talking to simply another anonymous individual with a clipboard. Similarly, in an ethnographic study of a hospital, it would have been advisable to gather information from patients, medical professionals and visitors. However, given the nature of the hospital I visited, this was impossible. The majority of patients in this hospital were either advanced in years or terminally ill. Thus, it would not have been respectful to intrude. Similarly, the hospital was understaffed, thus no nurse would have had the time to speak with me. Whilst all ethnography requires a balance between ethics and desire for information, this setting required more emphasis upon ethics. The hospital is first and foremost a place of healing, and consequently must always be approached as such.

Conclusion

This essay has attempted to construct a realistic presentation of social reality within a hospital setting. My analysis of the data gathered through both observation and interviews, has explored the reaction to lack of privacy as well as the numerous methods through which this social abnormality is counteracted. Although visitors seemed especially determined in some way to construct 'normality', their endeavours surely beg the question – were they successful? As both a fellow visitor and anthropologist, I would have to say no. No attempt to 'normalise' the hospital could ever alter its reality. The hospital is not an extension of our private and conventional outside World, it will always be first and foremost a service - a *public* service.

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