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Privacy and the hospitalization experience

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PRIVACY AND THE HOSPITALIZATION EXPERIENCE

by

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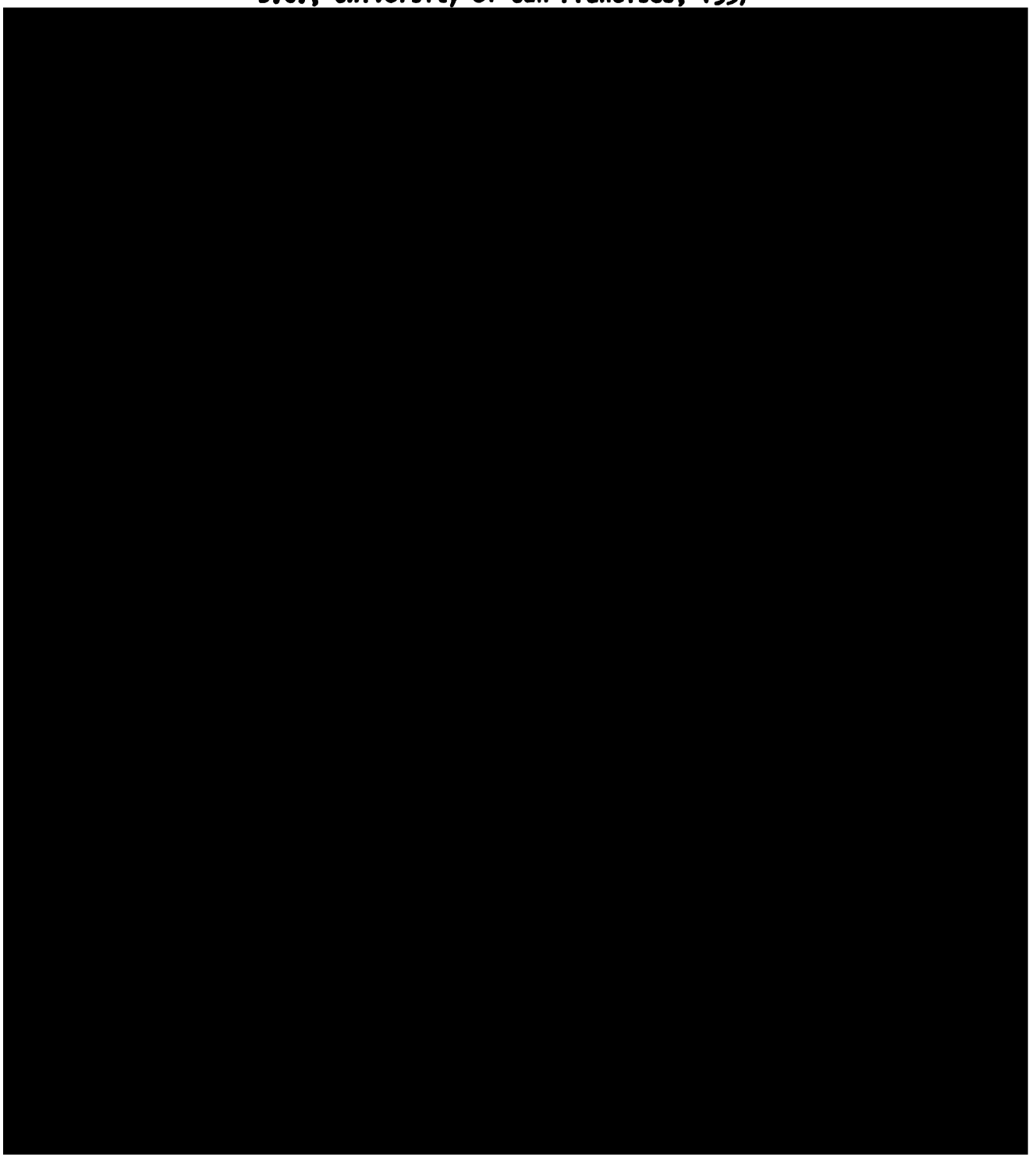

ABSTRACT

HEALTH SCIENCES, NURSING

Title: Privacy and the Hospitalization Experience

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This is an exploratory study of privacy as a social phenomenon. It is derived from a larger area of investigator interest in the ways the autonomy of the patient is affected during the course of his hospitalization. A phenomenological approach is used in an attempt to determine from the subjects themselves what "privacy" means to them and whay they do to attain and maintain it, particularly within the hospital setting. The constant comparative method of data analysis is employed.

A preliminary investigation of the concept of privacy as understood by individuals was conducted with a population of eighteen adults--ten nurses actively engaged in the care of adult patients in a general hospital, four hospitalized patients and four ex-patients. This investigation provided guidelines for selection of population and the refinement of an interview schedule for a more formalized study.

In the subsequent, formal study of privacy, a population of twenty-one adult men and women was selected from among the patients of two general hospitals, within five

weeks following discharge, each subject participated in one taped interview conducted by the investigator. The main purposes of the interview were to learn from each subject: 1) his definition of privacy; 2) what happened to his privacy during hospitalization; 3) the ways he involved himself in interpersonal distancing and information-flow while a patient.

Four problems for study were derived from the interview data: 1) developing a definition of "privacy" based on subject responses; 2) developing a conceptual model of interpersonal distancing within hospitalization; 3) identifying the processes whereby the patient balances his need for withdrawal and retreat with his need for disclosure and communication; 4) relating the theory of interpersonal distancing to privacy within the hospitalization experience.

Findings from data analysis disclosed three aspects of interpersonal distancing-- 1) privacy of personality; 2) privacy of event and, 3) privacy of life style. These three aspects are similar since each involves interpersonal distancing, personal boundary and a defensive response on the occasion of threat to boundary. They are dissimilar in the level of awareness of boundary, the ability to control the dimensions of boundary, the aspect of time-dimension and their relationship to a withdrawal/retreat and disclosure/communication continuum. While "privacy" in its broadest sense may be used to refer to the three aspects of interpersonal distancing, the cognitive meaning was consistently directed to "privacy of event" while the significant meaning was directed to "privacy

of personality." Within the population of this study, "problems" occurred only in the event of threat to privacy of personality.

From the model of interpersonal distancing, it was learned that all interpersonal distancing is similar in terms of purpose, functions, goals and operations. However, interpersonal distancing within hospitalization is affected by the four major variables of: 1) mobility; 2) level of consciousness and awareness; 3) the specific character of patient-to-patient relationships and; 4) role perception. Interpersonal distancing, specific to the population of this study, was evident in terms of perceived needs and the particular actions directed to these needs.

The study concludes that the referent "privacy," in its broadest sense, may be applied to any form of interpersonal distancing; that the subjective withdrawal and retreat proper to privacy of personality differs essentially from the withdrawal and retreat proper to privacy of events. Within the population of this study, the magnitude of concern over interpersonal distancing increased in relation to perceived threat to privacy of personality. Threats to privacy, especially to privacy of personality, were met with coping strategies of greater or lesser effectiveness.

Specific implications for patient care may be derived mainly from the nurse's awareness of the significant meaning of interpersonal distancing to the patient and her awareness

of the vulnerable point of juncture between the patient's desire to control his personal boundary and his ability to do so.

ACKNOWLEDGMENT

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A special debt is due to the individuals comprising the population of this study who willingly gave of their time and efforts to make the investigation possible. In the interests of confidentiality, they are not identified by name in the report.

I am most appreciative of the counsel and guidance of the committee members appointed to assist me: Betty L. Highley, Marlene Kramer, Fred Davis, Anne Davis and Richard Seiden. Their constant and supportive interest was invaluable to me throughout the two-year progression of this study. The final typing was done by Dictation West, but a special word of appreciation goes to Mr. O'Keefe of Dictation West for his assistance with the technical details and for overseeing the production of the final manuscript.

Eleanor A. Schuster

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CHAPTER I

INTRODUCTION

This study, broadly conceived, is concerned with deepening and refining an understanding of one aspect of everyday life as viewed from symbolic interactionist perspective. Symbolic interaction theory is one declaring all social actions to be meaningful actions which must be studied and explained in terms of their situations and their meanings to the actors themselves.[1] Social meanings are seen to be, in some way, the fundamental determinants of social actions.

The aspect of everyday life considered here is privacy, a concept in wide usage in the natural stance but lacking analysis from a theoretic point of view. "Natural stance" as described by phenomenologists, is the stance taken by the individual in everyday life. It does not raise serious and persistent questions concerning the nature of everyday experience but, instead, takes that experience as a fact. "Theoretical stance" is to stand back from, to reflect upon and to review the experience taken for granted in the natural stance. It is to treat the everyday world as a phenomenon.

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[1]Discussion of symbolic interaction by Jack D. Douglas, "Understanding Everyday Life," Understanding Everyday Life, Ch. 1 (London: Routledge and Kegan Paul, 1971), pp.3-44.

For discussion of natural stance and daily life: Douglas, op. cit., p. 15. Alfred Schutz, "The Problem of Social Reality," Collected Papers, Vol. 1 (The Hague, Martinus Nijhoff, 1962), preface p. viii.

Analysis from the theoretic stance begins with and is built upon an understanding of the everyday life of the members performing the actions. Therefore, the thrust of this study is to learn from the subjects,themselves what privacy means as they understand it and, specifically, what they do to attain and maintain it.

Purposes and Problems

This project evolved from investigator interest in the ways the autonomy of the patient is affected and influenced during the course of his hospitalization. It is exploratory research for the purpose of investigating and understanding the nature of privacy as a social phenomenon by the consideration of four problems:

1. Developing a definition and description of privacy derived from subject data;
2. Developing a conceptual model representing a theory of interpersonal distancing within hospitalization;
3. Identifying the processes whereby the individual balances his need for withdrawal and retreat with his need for disclosure and communication; and
4. Relating the theory of interpersonal distancing to privacy within the hospitalization experience.

The four problems evolved and were refined during the course of data analysis. This is consistent with the purpose of exploratory method in research--drawing from an area

of general interest to formulate problems for precise study.

The first problem, the synthesis of a definition and description of privacy based on subject data, seemed a necessary "first step" of this study. It was an important point of departure in the attempt to understand "privacy" from a theoretic stance. The definition of privacy is presented and discussed in Chapter IV, Section Two.

The formulation of a conceptual model of interpersonal distancing was consequent to two insights: 1) that the notion of personal privacy is inseparable from the individual's control of his personal boundary, and 2) that the effort to understand privacy would be furthered by close examination of the processes the individual uses in balancing his need for withdrawal and retreat with his need for disclosure and communication. Thus, the second and third problems are concerned with the processes and the general framework of interpersonal distancing within which the processes occur. This provides the principal subject matter for Chapter V, Section Three.

The fourth problem developed from two insights: 1) that privacy, in any of its aspects, involves interpersonal distancing, yet not all interpersonal distancing is called "privacy"; and 2) that the individual's ability to engage himself in matters of interpersonal distancing are affected by his

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[2]Discussion of exploratory studies by Claire Selltiz, Marie Jahoda, Morton Deutsch, Stuart Cook, "Research Design: Exploratory and Descriptive Studies," Research Methods in Social Relations, Ch. 3 (New York: Holt, Rinehart and Winston, 1959), pp. 51-65.

patient status within the hospitalization experience. Therefore, it was necessary to specify the ways privacy differs from, yet is similar to, other forms of interpersonal distancing (Chapter IV, Section Four), and to point out the specific influence of patient status on interpersonal distancing in general, and on privacy in particular (Chapter IV, Section Three and Four).

AN OVERVIEW OF PRIVACY FROM AN EXPERIENTIAL PERSPECTIVE

The idea of privacy is elusive and evasive of the attempt to "capture" and circumscribe it in a precise manner. An individual, when asked, can either define or operationalize what "privacy" means to him. Furthermore, he often does so with a notable degree of intensity and interest, thereby assigning a singular value to this aspect of human existence.

Some subjective consideration of the concept of privacy may conjure up instances of space containment as in "private property" or in "private" parts of the human body or, perhaps, information considered a "private" family affair. Further rumination may touch upon such concerns as the relationship of privacy to isolation, to solitude or to intimacy.

On the experiential level within our culture, it is a familiar phenomenon to seek a moment alone--for thought, for expression of grief or of anger. One knows, too, what it is to share something of one's private experience. At times, disclosure is desirable and actively sought as a part of existence as a social being. Also, we can recall instances of "what it was like" to be intruded on, perhaps by someone seeking to

be of help yet entering unbidden to our physical or psychological realm. In conjunction with this awareness, we know what it is to cross over into another's "territory"--who has not unthinkingly opened a door only to find that the person on the other side was seeking a moment of solitude; who has not asked an untimely question, thus trespassing, however indeliberately, into another's private affair. Such instances bring with them singular physiological and psychological responses, even on recall--the red face of having found out or having been found out; the stomach muscles contract, heart rate increases and the urge to run away becomes painfully evident. Expressions of speech in contemporary usage reflect these phenomena--"I could have died"; "I was so embarrassed I could have dropped through the floor"; "Was my face red"; or "It really gets me where I live." In these instances, a bounary has been breached in some way; someone or something has drawn closer than is acceptable; information is obtained or relinquished in an unanticipated and, often, undesired way.

In all this, further perusal brings to light variables influencing the situation, changing the tenor of things. For instance, when one bursts into the solitary presence of another and hears, "Oh, it's you. I was hoping you'd come," this could indicate that the <u>reason</u> another seeks to be alone influences his response to the person's entry. Also, <u>who</u> the persons are and their relationship to one another brings about a shift of circumstance introducing the notion of role. The role may be a formal one, by title, "That man is my doctor,"

or an informal, functional role, "She is the one who listens to what I say." Chronological age is an influence. A person may not think to offer an apology to a child when interrupting his privacy whereas the same person would do so in the instance of disturbing an adult. Probably the most influential variable in the perception and valuation of privacy is that of culture and cultural differences. This phenomenon has been studied in depth and discussed as "proxemics" by Hall.[3] His findings disclose that a sense of personal space is common to animals and to the human species but that the placement and valuation of the space are culturally derived.

Sex-role socialization is an important and obvious variable in many cultures. Witness the confusion of the woman who mistakenly enters the public washroom marked "men" rather than the one designated "women."[4] Social status is another consideration bringing with it certain prerogatives over the personal use of space.[5] The higher in the organizational hierarchy a person rises, the more privacy he is accorded and access to him

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[3]Discussion of man's use of space appear in two sources: Edward T. Hall, The Silent Language (New York: Fawcett Publications, 1968), and Edward T. Hall, The Hidden Dimension (New York: Anchor Books, Doubleday and Co., 1969). These works make it clear that the way individuals define interpersonal privacy is heavily affected by each culture's conceptions of sensory relations.

[4]This example was relevant at the time this study was being formulated. Women's liberation movement may have its impact on this situation.

[5]Correlation between social rank and privacy discussed by Arnold Simmel, "Privacy," International Encyclopedia of the Social Sciences, Ed. David L. Sills (New York: Macmillan and The Free Press, 1968), p. 483.

is decidedly more difficult. Added reflection indicates that when difficulties arise over the position or transgression of personal or territorial prerogatives, they can be due to a lack of agreement regarding placement of boundary and/or title to entry, e.g., "Who gave him the right to come in?"

GENERAL OBSERVATIONS ABOUT PRIVACY AND THE PATIENT ROLE

Speculatively, in what ways may the awarenesses mentioned in the preceding paragraphs be applicable to the person introduced to the patient role? For one thing, it is safe to assert that most persons receiving the designation "patient" already have considerable experience in day-to-day living. Life itself is largely an engagement in adjusting distance between self and other; in gaining and giving information. A large degree of autonomy has been consistently exercised by most adult patients prior to admittance for care in the general hospital. To some extent, the adult individual controls the degree of social distance he wishes to maintain as well as that information he chooses to acquire or relinquish about himself. Once consigned to care in an institutional setting, he must contend with himself in role-as-patient. How does one go about being a patient? What are the rules? Who establishes the rules and keeps score? This involves aspects of what the person expects of himself-as-patient and, obviously, what others expect of him; how these expectations are enacted within the context of hospitalization and the congruence of the converging

sets of expectations.[6] The expectations themselves are concerned with information and distances--casually, perhaps, as in a recreational setting or forcibly as in the Intensive Care Unit[7] (where the contraction of the name to "ICU" becomes, quite literally,"I see you!").

Aside from providing the arena for interpersonal distancing and varieties of information flow, the hospital as a physical plant can maintain, enhance or compromise the individual's needed and/or desired state of privacy. For instance, in some hospitals, the communication system between the patient in his room and the nurse at the nurses' station insures that many persons, including visitors, learn that Mr. D. would like his pain medication now and that Mrs. S. has evacuated her bowels today. Thus, the institution itself can build in ways of violating what some persons would consider their rightful claim to privacy. Also, various senses of the body may be impinged upon, perhaps by having the lights in the room so arranged that one person reading at night will keep others

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[6]The degree to which qualities of the self--traits, values, beliefs--and requirements of the role exhibit fittingness or overlap. Discussed by Theodore R. Sarbin, "Role Theory," The Handbook of Social Psychology, Ed. Lindzey, Gardner, Aronson, Elliott (Reading, Mass., Addison-Wesley Co., 1968), pp. 488-568; also, in relation to nurse/patient relationships and their congruence, Laurel A. Copp, A Projective Cartoon Investigation of Nurse-Patient Psycho-dramatic Role Perception and Expectation (Proceedings from Seventh Nursing Research Conference, March 1971), pp. 251-269.

[7]One study documents the number of interruptions of rest postoperatively--up to 56 in an eight-hour period. This serves as one index of heightened surveillance in the Intensive Care Unit, Betty Boyd Walker, "The Post-surgery Heart Patient," Nursing Research, 21 (March-April, 1972), pp. 164-169.

awake. A melange of sounds, sights and scents assail a patient, bringing about a tremendous array of responses from pleasure to disgust. In all this, there are multiple ways in which the patient's autonomy may be affected, should he choose to alter his state of affairs, from the obvious one of being so ill that he cannot act on his own behalf to the subtle instance of what it may "cost" an individual to be assertive about his needs, especially when confronted by a new and strange environment.

What are some of the practical ramifications of breach of privacy in patient care? One recent publication warns that invasion of privacy may result in litigation in the form of a tort action. For instance, a Michigan woman recovered damages for her injured feelings and excessive anxiety after she learned that an unauthorized, non-professional man had witnessed the hospital delivery of her child; a young couple charged invasion of privacy because of an unauthorized publication of a picture of their infant. One woman, lying on a surgery stretcher in an operating room corridor, overheard a conversation between her physician and a nurse which so upset her that the operation had to be cancelled. Settlement of a suit in her favor was reached on the basis of the anxiety and mental suffering she claimed was due to the thoughtless statements of the doctor and nurse.[8]

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[8]A tort action is a legal wrong committed upon the person or property independent of a contract and may be filed against a person who seriously or unreasonably interferes with having another individual's affairs known or his image or likeness displayed publicly. Frances Ginsberg, Barbara Clark, "Patients Need Privacy - and May Sue if They Don't Get It," Modern Hospital (June, 1972), p. 110.

Hospitalization can contribute to the overall well-being of the patients inclusive of his need for privacy. Regarding standards for building, a hospital may be so conceived and executed that the ultimate result can be an enrichment for people who spend part of their lives within it. Contemporary environmentalists champion the philosophy that a building can be "an environmental culture medium that stimulates and enriches the creative responses of the community to its most creative life."[9] The point to be made here is that the total environment, which includes the physical and the human, is never neutral but either contributes to or detracts from human needs, one of which is privacy.

Within hospitalization, the continual presence of some person to administer caring acts is of singular importance. In most instances in our culture, this is the nurse whose consistent, long-term contact with the patient gives unsurpassed occasion to influence the physical and psychological milieu of her patients. This may be done as readily by acts of omission as those of commission.

The hospitalization event, then, serves to provide the point in time for the convergence of three main forces: the patient with his fears, hopes, and expectations; the caregivers with their discernment of role, convictions of "what should be done" to and for the patient based on their philosophy of care and modified by the various institutional

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[9]Kenneth Rexroth wrote in the Forward to: Serge Chermayeff, Christopher Alexander, Community and Privacy (New York: Anchor Books, 1965), p. 16.

policies; and the controlled environment comprised of many stimuli, each affecting the patient in a specific way.

CHAPTER II

EVOLUTION OF THE STUDY

THEORETICAL INTERESTS

It may be that the progression of forces influencing a researcher to identify and define a problem for systematic study is mainly one of personal interest. However, it is the enduring fascination of "something that needs looking into" that provides direction and impetus for the final emergence of a discrete study. The investigator contends that such germination process is an integral part of the research endeavor. The following paragraphs will summarize the specific interests and their convergence, leading to the study of privacy and the hospitalization experience.

Clinically, the various facets of health care having to do with human beginnings were attention-arresting: the issues of planned parenthood with their multiple ramifications; optimal health care for parents with beginning families; and most especially, genetic counseling with its bio-ethical impact, along with the tendency in some instances to cast the geneticist as a composite mystic, judge and jury. In all this, it seemed remarkably evident that the professional persons providing health care could be vigorously (if not intentionally) invasive of the privacy of the individual. They become, in fact, spectators and participants in the most intimate moments of the lives of their clients. Intrinsic to genetic

counseling, for instance, is karyotyping or the detailed microscopic study of the individual's chromosomes. How intrusive to the patient's "self" this might be, for what is more a part of the self than the generative microcosms making up and determining, to great extent, what the person is. A year-long affiliation with families seeking help through a genetic counseling clinic enabled the investigator to gain a sense of the ways in which the person's privacy and self-esteem could have been, and occasionally were, compromised.

Another provocative facet of the professional role of nursing, inclusive of peer as well as client relationships, was that of role enactment.[1] What does it mean to be a patient? What does it mean to be a nurse? Or, to put it another way, the patient is one who_____(endures, suffers, is cured); the nurse is one who_____(comforts, inflicts pain, cares...). Consequent to this, what happens when there is a lack of congruence on the part of the patient or nurse as to what he or she should do or should be like? What are the variations of role and, more important, what are the commonalities? Regarding commonalities, the study of role reveals that one constant component of role enactment is orientation to

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[1]Role enactment is what a person says and does in a particular setting. It may be modified by (a) number of roles, (b) pre-emptiveness of roles, and (3) organismic involvement. Sarbin, op. cit., p. 491.

authority or to "power."[2] By virtue of his perceived social role, one person always has ways, more or less transient, to influence others--an index of his power in their regard.

Power may be studied from many points of view,[3] beginning with earliest mythology through Machiavelli and on to instances of our own daily lives. A key notion to all power manifestations is that it affects that which a person values. That is, another person is powerless over me unless he can affect or influence what it is I value. Such influence admits of degrees of effectiveness, duration and refinement; for instance, from physical attack by an enraged two-year-old child (I value my shins!) to the subtle and sophisticated undermining of self-esteem (I value myself.).

Becoming less global in a consideration of power in its relationship to role, what is it that a patient in the hospital values? Who and what can exercise power over him, affecting what he values? From clinical knowledge and perusal of the literature, three different but closely related values of patients emerged. On reflection, it became evident that these

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[2]Bennis discusses the use of power and its distribution. Power can be thought of as "coming from on high" (Pyramidal distribution) and filtering down to influence the action of others. There can be a collaborative use of power--"flexible and adaptable structure, utilization of individual abilities, clear and agreed-upon goals, standards of openness, trust, cooperation, interdependence, high intrinsic rewards and transactional controls." Warren G. Bennis, "Post-Bureaucratic Leadership," Transaction, (July-August, 1969), p. 4.

[3]Berle analyzes the concept of "power" from historical, social, economic and psychological and philosophical perspectives, Adolph A. Berle, Power (New York: Harcourt, Brace and World, 1969).

are the values of persons by virtue of their personhood and not as specific to the patient role. However, in the hospital setting, certain facts of the values become more acutely evident and role-connected. The three values are: information, identity and privacy. Broadly speaking, "information" deals with the facts a patient has access to (e.g., diagnosis, chart, knowledge about his medications, etc.) and, conversely, what is known about him (e.g., history, physical, financial and social status, etc.). "Identity" is concerned with the patient's idea of himself in his relationships with others throughout the process of becoming and being a patient. "Privacy," as pointed out previously, is somewhat elusive. It can refer to the body, to information; in its broadest sense, it does involve information flow to and from the patient and, also, the dynamics of his distance setting.

Since the literature yielded little by way of systematic studies of privacy from a phenomenological stance, the questions were raised, "What do patients <u>say</u> privacy is?" "Do they perceive problems with privacy during the course of hospitalization?" "What do patients do to establish and maintain the aspects of privacy valuable to them?" These questions, in effect, were drawn from the aforementioned clinical and theory interests. In turn, they initiated and guided this study to a final formulation.

AN OVERVIEW OF THE NATURE OF PRIVACY DERIVED FROM THE LITERATURE

The "Privacy issue" evokes spirited response in our contemporary society with much being said and written about this complex notion. Consequent to governmental surveillance activities in the 1960's and the heated response of citizenry to these functions, literature on the subject has flowered in a dramatic way. This has evolved most markedly in the past twenty years. As an indication of the trend, the Reader's Guide to Periodic Literature lists five references to articles in its 1949-50 volume with a barely perceptible increase throughout that decade. Beginning in 1960 and continuing to our present time, at least fifty articles appear in the public media yearly, each dealing directly with aspects of privacy. This number does not take into account the closely related areas of "wire-tapping" or the issues of the use of computerized data. The materials written about privacy during the past ten years, including books, magazine and newspaper articles, were obtained and reviewed by the investigator. As the direction of the research endeavor took shape, preference was given to any reference source contributing to an increased understanding of the nature of privacy.

Needs for privacy, both individual and group, result in social norms and are present in virtually every society. Each society that has been systematically examined manifests four general aspects of privacy which apply to all men living

together.[4] First, man seeks privacy at one time and disclosure at another. Various forms of extending himself to others, then drawing apart from them in either a psychological or physical way, comprise his life. Secondly, man has specific ways of perceiving his situation when alone. This perception is open to multiple variations which are culturally derived and developmentally influenced. Although physically alone, he may see himself under the scrutiny of another, as a diety. Conversely, although in the presence of others, he may perceive isolation, alienation or anonymity.

A third universal aspect of privacy is the tendency for individuals to invade the privacy of others, and of society to engage in surveillance to guard against anti-social thought and action. Instances of intense curiosity have been recorded through the ages, as the story of Pandora and her box, Eve and the apple, Lot's wife and, of course, the inevitable neighborhood gossip. Westin,[5] in his analysis of this propensity, notes that it has developed in Western culture in two discernible directions. One of these two competing traditions is associated primarily with phenomena like the democratic city-state in ancient Greece, English Protestantism and common-law traditions, and American constitutionalism and property concepts. In these instances, there has been a trend to place limits on the surveillance powers of governmental, religious

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[4]Alan F. Westin, Privacy and Freedom (New York: Atheneum Press, 1970), pp. 13-18.

[5]Westin, Ibid., p. 22.

and economic authorities in the interest of privacy for individuals, families and social groups in each society. A competing tradition in Western history, associated with societies such as Sparta, the Roman Empire, the medieval Church and the continental nation-state, continued very broad powers of surveillance for governmental, economic and religious authorities. The fourth notion of privacy is that the movement from primitive to modern societies increases both the psychological and physical opportunities for privacy by individual and family units and converts these opportunities into choices of values in the socio-political realm. Brief reflection in this context calls to mind that, prior to this century, family size was larger, individual beds and private bedrooms unusual and the automobile was non-existent.

Survey of literature having to do with privacy reveals a remarkable dearth of formal definition. This fact reflects the vastness and complexity of the concept. Those definitions offered remain partial ones, usually set in the context of one particular aspect of privacy. One article presents privacy as a "highly institutionalized mode of withdrawal."[6] Another claims privacy as "the right to be let alone."[7] One professor of business law speaks of privacy as

> "that which lies at the heart of all human rights... this is the term by which we indicate our respect for the individual. This is the term which enables

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[6]Barry Schwartz, "The Social Psychology of Privacy," American Journal of Sociology (May, 1968), p. 741.

[7]Morris L. Ernst, Alan V. Schwartz, Privacy: The Right to Be Let Alone (New York: Macmillan Co., 1962).

> individuals to call some things their own. Privacy encompasses all matters considered private as distinguished from public. Public affairs are concerned only with collective endeavors and aspirations. However, even the collective endeavors of the public are aimed at the promotion and preservation of the individual well-being and advancement.[8]

Another author states:

> Privacy is a concept related to solitude, secrecy, and autonomy but it is not synonymous with these terms, for beyond the purely descriptive aspects of privacy as isolation from the company, the curiosity and the influence of others, privacy implies a normative element: the rights of exclusive control of access to private realms.[9]

One researcher claims privacy as a

> dimension for describing behavior that deals with control over interaction with others, the domain of privacy including, a) behavior that is oriented away from others, and b) presentation of barriers to the behavior of others oriented toward oneself.[10]

Various writers present eloquent commentary on privacy in ways that leave no doubt of its importance in the development of the individual's autonomy. They remind members of a free society that only grave societal needs can ever justify destruction of the privacy which guards the individual's ultimate autonomy. Leontine Young has noted, "without privacy

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[8]William Zelermeyer, Invasion of Privacy (New York: Syracuse University Press, 1959), preface, p. v.

[9]Arnold Simmel, op. cit., p. 480.

[10]Nancy Joan Chapman Marshall, "Orientation Toward Privacy: Environmental and Personality Components," (Unpublished Doctoral dissertation, Environmental Design Library, University of California, Berkeley, 1971), p. 1.

there is no individuality. There are only types. Who can know what he thinks and feels if he never has the opportunity to be alone with his thoughts and feelings."[11] Westin adds that this development of individuality is particularly important in democratic societies, "since qualities of independent thought, diversity of views and nonconformity are considered desirable traits for individuals."[12] The same author adds, "Such independence requires time for sheltered experimentation and testing of ideas, for preparation and practice in thought and conduct without fear of ridicule and penalty and for the opportunity to alter opinions before making them public."[13] The individual's sense that it is he who decides when to "go public" is a crucial part of his feeling of autonomy. Clinton Rossiter also stresses this feature of autonomy,

> Privacy is a special kind of independence which can be understood as an attempt to secure autonomy in at least a few personal and spiritual concerns...it seeks to erect an unbreachable wall of dignity and reserve against the entire world. The free man is the private man, the man who still keeps some of his thoughts and judgments entirely to himself, who feels no over-riding compulsion to share everything of value with others, not even those he loves and trusts.[14]

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[11]Leontine Young, Life Among the Giants (New York: McGraw-Hill, 1966).

[12]Westin, op. cit., p. 36.

[13]Ibid., p. 36.

[14]Clinton Rossiter, "The Pattern of Liberty," Aspects of Liberty (ed. M. R. Konwitz, Clinton Rossiter, Ithaca, New York, 1959), pp. 15-17.

Rexroth provides a summarization by stating,

> A large share of man's activities are social but they ultimately, however practical and outgoing, have their source in privacy. Man is not only a rational animal, he is a contemplative one.[15]

By far the most comprehensive and, for this study, the most valuable definition of privacy is Westin's. It combines clarity of thought with the notion of privacy as process,

> Privacy is the claim of individuals, groups or institutions to determine for themselves when, how and to what extent information about them is communicated to others. Viewed in terms of the relation of the individual to social participation, privacy is the voluntary and temporary withdrawal of the person from the general society through physical or psychological means, either in a state of solitude or small-group intimacy or, when among larger groups, in a condition of anonymity or reserve. The individual's desire for privacy is never absolute since participation in society is an equally powerful desire. Thus each individual is continually engaged in a personal adjustment process in which he balances the desire for privacy with the desire for disclosure and communication of himself to others, in light of the environmental conditions and social norms set by the society in which he lives.[16]

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[15]Rexroth, loc. cit.

[16]Westin, op. cit., p. 7.

RESEARCH EFFORTS DEALING DIRECTLY WITH INTERPERSONAL PRIVACY

Within the past six years, two research projects have been designed and executed providing enlightenment about privacy as it is perceived by the individual. One study[17] called for the response of aged domiciliary residents (veterans) to questions assessing their perception of physical space. This was done as part of a larger effort to understand the process of aging. Interviewing the one-hundred-and-twenty-nine elderly men, the investigator learned that each subject could outline on a chart the physical areas he considered "his own" territory within the sleeping quarters. Each could describe what he considered an acceptable degree of privacy. To each subject, the importance of his cumulative written records was highly evident; concern was expressed over the possibility of lessened confidentiality through repeated interviews, investigations, and examinations. In this study, the question of the use of coping mechanisms was raised. It became evident through interview that some men did not know the name of the person in the adjacent bed. The investigator pointed out that such an individual was often labeled "unsocial" and suggested a plausible reason--that when one's use of physical space is severely constricted, possibly the only choice left in the area of privacy is the primitive one

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[17]Arthur N. Schwartz, Hans C. Proppe, "Perception of Privacy Among Institutionalized Aged," (reprinted from the Proceedings, 77th Annual Convention, APA, 1969).

of "won't talk" or "will talk" to a neighbor.

The most significant observations of the study are applicable to privacy and the hospitalization experience--that each subject had an idea of what "privacy" meant to him; there was evidence of a two-fold aspect of privacy (information flow and interpersonal distancing); each man had assigned a value to his privacy, although differing in extent and intensity.

Another study[18] considers orientations to privacy and analyzes their relationships to personality and elements of physical and social environment. Through use of a Privacy Preference Scale, the investigator was able to construct a "privacy profile" for her young adult subjects and their parents. The six-fold orientation to privacy consisted of these factors:

a. neighboring
b. seclusion
c. solitude
d. anonymity
e. self-disclosure and,
f. intimacy

The four hypotheses of the study had to do with the interrelationships between personality and privacy variables. Those noteworthy in terms of the present study (contributing to population criteria) concerned age and sex differences in preferred degree of self-disclosure and privacy; the relationship of introversion/extroversion to privacy; the relationship

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[18]Marshall, op. cit.

of past environment to present privacy preferences. Most importantly, both studies indicate that the individual has an orientation to privacy influencing his current strivings to establish or protect it.

In conclusion, the literature about interpersonal privacy considered in aggregate presents four discernible characteristics: 1. Definitions of privacy are contingent upon an implicit definition of man--who he is and what is his by right. Thus, if man is not seen as having certain inalienable rights by virtue of his human status, his claim to privacy is likely to be non-existent. In this instance, whatever privacy exists may do so because it is bestowed by the state, as in a totalitarian regime. The claim of man to privacy as his intrinsic right runs a spectacular gamut from non-existent to that of being specifically and stringently protected by law.

2. A "boundary" is always implicit in the notion of privacy whatever definition or description is utilized. The uninvited advance of the other ("other" meaning person or object) beyond such boundary is viewed by the one approached as an invasion of privacy. The boundary may be a visible one such as a wall or door; it may be less tangible as in a forbidding posture or tone of voice. The dimensions of the boundary may be rigid or elastic, whether material or not. They are assigned by individuals. They are modified by culture, age, status, the given circumstances and the individuals' perceptions of what the circumstances are.

3. A third characteristic derived from the literature is a type of "permeability" of the boundary. (Here, "permeability" connotes the ease of passage whereby one may draw toward or withdraw from another; may allow the advance or retreat of another.) This can be assigned or brought about by the individual(s) and seems to be intimately connected to role and to the legitimacy of entry as defined by the participants.

4. Implicit in definition and discussion of privacy and closely related to the notion of boundary is a type of autonomy or control. This is the fourth characteristic which seems to be manifested through the degree of effectiveness a person exhibits in his assignation of boundary and in his attempts to maintain or modify it.

In the judgment of the investigator, these characteristics encompass, in effect, four constituents of interpersonal privacy.

CHAPTER III

THE RESEARCH DESIGN AND METHOD

The exploratory design of this investigation was elected as the best means to gain familiarity with the phenomenon of privacy and to achieve new insights into it. Exploratory method, by its nature, encourages the refinement of questions and the delineation of more precise research problems. Its strength, as perceived by this investigator, is the promotion of freedom of inquiry, as many facets of situations or entities may be minutely examined and explored. Major weaknesses may be found in the use of the method rather than as characteristics of the methodology itself. Frequently this is investigator vulnerability to the impact of vast amounts of data resulting either in premature finalization and constriction of the project or in failure to establish a viable means to draw order from the data. The primary task is to preserve integrity of data in a realistic and credible way while investing a proportionate use of time, energy and financing.

PHASE ONE: A PRELIMINARY INVESTIGATION

The investigation of privacy had its inception one year prior to the initiation of the formal study reported here. During July and August of 1970, the investigator engaged in an informal inquiry focused on privacy. Although, in retrospect, the endeavor contributed greatly to the research design

as eventually formulated, this was not the intent at the time. It was a step toward learning the ways in which persons view and deal with privacy in hospitals.

The population of eighteen subjects chosen for the preliminary investigation was comprised of ten nurses currently engaged in caring for adult patients in the general hospital, four hospitalized patients and four ex-patients. The only criteria for selection were the willingness of the persons to participate in a taped interview session with the investigator and the ability of each to do so. These interviews lasted from twenty to seventy minutes; the ages of the interviewees ranged from twenty to eighty-three years. There were two men and sixteen women.

The query involving this small population was, "What would happen when nurses, patients and ex-patients were asked an open-ended question regarding privacy?" For the nurse-interviewees, the specific question was, "In what ways do you deal with the privacy of your patients as you care for them?" For the currently hospitalized patients, the question was, "What happens to your privacy here in the hospital?" The ex-patients were asked, "What happened to your privacy while you were a patient in the hospital?" Also, each person was asked to give his definition of "privacy."

The major advantage of this task was that it offered the investigator enough data to identify some commonalities and diversities as well as themes contributing to the constitution of privacy. Most often, the responses were

descriptive or anecdotal; however, many of the respondents were able to give a formalized definition of privacy. The data revealed the host of variables intrinsic to this type investigation--overwhelming in one way yet fascinating in another. The project, in toto, strongly contributed to the eventual selection of population for a more formalized study; also it presented specific parameters for the development of an interview schedule.

Three overall impressions were the strongest--first, there was a positive response on the part of the interviewees to participate and recount their experiences, although the four currently hospitalized patients were more reserved in their responses. There was considerable reinforcement from the interviewees that privacy was important to talk about. (As an informal index of concern about privacy, the Director of Nursing allowed each of the ten nurses on-duty time for the entire interview.) Secondly, each respondent centered on an aspect or theme of what "privacy" meant to him--to some it involved bodily aspects as in adequate draping during physical examination; to others it was principally a matter of confidentiality of information as in accessibility of patient records. Two of the nurses equated "privacy" with "dignity" and proceeded to specify, "A patient needs to be alone at times with his grief and it is my job to see that he gets this privacy." And, "He needs to be protected from the nosiness of visitors or other patients on the unit." A third finding had to do with an aspect of information flow. At the time of

inquiry, the investigator thought of "information" principally in terms of history-giving, financial status, etc., which can be termed "information egress." These are instances when information goes from the patient to another person. The data indicated that the patients were acutely aware of the ingressive mode of information-flow during their time in the hospital. Specific instances reflected their discomfiture in overhearing a ward partner, "I couldn't help hearing them (patient and husband) because I wasn't able to get out of bed and leave the ward." And, "the woman next to me was retching and vomiting--I could hardly stand that though I felt so sorry for her. I felt so helpless with that and my own problems as well."

Careful consideration of the eighteen interviews highlighted two components of privacy: 1) information flow, both egress and ingress; 2) the desire and/or ability to set distance between self and others. A litany of variables emerged from this small sample. Some seemed self-evident while others were more inferential. For instance, the level of debility of a patient wanting to do something for himself but being unable to (bathe himself, go to the bathroom) was unequivocal. There were more subtle influences in effect such as the person's apparent orientation to authority or to role performance, "I just do what they tell me; that's what a patient is supposed to do if he wants to get well."

Other variables included relationships--those which helped the person feel more at ease in his role-as-patient--such as confidence in the fact that his doctor would "level with him"

or the ability to "get along well" with the nurses and other patients. Preparedness for the hospitalization event was clearly an influence, those having a first-time experience as compared to persons with a vast hospitalization "career." The nature of the physical condition necessitating the hospital stay figured largely in the privacy issue. Differences in self-image, brought about by a disfiguring procedure (e.g. mastectomy), resulted in various forms of reserve and concealment. Gender appeared to play a role--the responses of men patients, as recipients of nursing care, differed from those of women. Here it was noted that the nurse was aware that physical nursing tasks might be identical in her care of men and women patients but the way in which she went about them differed. The length of time anticipated for the hospital stay was mentioned and was important to the patient, "As long as I knew I'd be out in a few days, I stayed in the ward rather than push for a private room." During the actual time of interview, there was evidence that physical pain and medication influenced the subject's ability to attend and respond to questioning. This finding emphasized that, in itself, the interview procedure was potentially invasive of the patient's privacy.

The listing of variables with citing of instances is not exhaustive. It does serve to illustrate one stage of the evolution of the research project. It was particularly useful in allowing the investigator to gain insight into what and when

to ask, when to listen, when to question further. It offered needed experience in negotiation for the privilege of conducting an interview.

PHASE TWO: A FORMAL STUDY OF PRIVACY AND THE HOSPITALIZATION EXPERIENCE

The initial investigation of privacy, as perceived by eighteen individuals in the particular social setting of hospitalization served as inducement to the investigator to enlarge and refine the inquiry. A research design was formulated and a population specified a short time following the conclusion of the informal project. Activities proper to a formal study began in Fall, 1970; data collection was concluded in June, 1972.[1]

Population

The population for this study was chosen from the adult patients in two general hospitals of the San Francisco Bay Area. Two hospitals were utilized to increase the likelihood of consistent access to patients meeting the established criteria.

Criteria for selection of subjects included Caucasian, American-born men and women between the ages of twenty and sixty-five. The hospitalization was to be not less than

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[1]Subsequent to the completion of the Preliminary Investigation, the investigator had the opportunity to confer with Professor Alan F. Westin, Department of Political Science, Columbia University (New York, March 22, 1971). Professor Westin, a noted authority on the topic of "privacy," provided cordial interest, support and specific suggestions about the proposed study of privacy and the hospitalized patient.

three days and two nights nor more than three weeks in duration. There was a mix of private, semi-private and ward accommodations. Each patient was under the care of a private physician. In addition, the occasion for admission to the hospital was anticipated, in contrast to emergency admission.[2] The diagnoses included both medical and surgical problems and excluded patients with known psychiatric manifestations and women hospitalized for childbirth. Subjects selected were those having conditions of varying degrees of intrusiveness.[3] Only those persons who felt physically able to participate in an interview were included. These criteria were established for the purpose of minimizing the effect of the most obvious variables. The main variables influencing subject perception of hospitalization had been identified in the preliminary investigation as cultural origins, early socialization, age and level of debility.

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[2]As the study progressed, it became evident that two subjects had been admitted from the doctor's office. These were termed "unplanned" admissions. Two patients did experience emergency admission occasioned by accidental injury. Due to investigator oversight, these four subjects were interviewed.

[3]This was a general designation--"intrusive procedures" meaning any that brought about disfigurement or discrediting. Also, procedures involving the genitalia were termed "intrusive." Non-intrusive procedures were of a more neutral valuation. Since this criterion was applied to each prospective subject prior to interview, it could not take into account what the diagnosis or condition <u>really</u> meant to the patient.

Population Profile

The Population Profile is divided into two parts: male subjects (Table 1) and female subjects (Table 2). It presents two categories of characteristics and includes the time of the post-dismissal interview. The first category is comprised of the three personal characteristics: age, marital status, employment status. The second category is comprised of the seven items directly related to the illness and hospitalization experience: number of previous hospitalizations, length of recent hospital stay, type of accommodations, diagnosis designated as intrusive/non-intrusive, acute/chronic, medical/surgical, circumstance of admission.

Male Subjects

Ten men were interviewed. Nine of the interviews took place between the second and third week post-dismissal; one interview was conducted during the fifth week. The eldest subject was sixty-one years of age and the youngest was twenty (median age: 45.5). Of these men, six had previous hospital admissions and four had never been patients before. The majority (6) had been hospitalized between two and six times. Six subjects were patients for a duration of six to eight days; the longest stay was three weeks and the shortest five days. Two of the male patients were admitted to the hospital for medical reasons and seven had surgical procedures performed. In the intrusive/non-intrusive category, seven subjects were involved in intrusive procedures and six were not. Seven men were in ward (three to five beds) accommodations;

MEN

POPULATION PROFILE - MALE SUBJECTS TABLE 1

	Week of Interview	Age	Number of Previous Hosp.	Duration of Stay-Days	M= Medical S= Surgical	I= Intrusive N= Nonintrusive	W=Ward S=Semi-Private P= Private	P= Planned U= Unplanned E= Emergency	A-Acute C=Chronic	M= Married D= Divorced S= Single	E=Employed U=Unemployed P=Professional N=Non-professional
1	1	43	4	10	M	N	W	P	C	D	E/NP
2	1	61	0	8	S	I	P	P	A	M	E/NP
3	1	37	0	5	S	I	W	P	C	M	E/NP
4	1	41	0	14	S	N	W	P	C	M	U/NP
5	1	58	6	12	S	N	SP	P	A	S	U/NP
6	1	44	12	21	S	N	W	E	A	D	E/P
7	2	20	0	5	S	I	W	P	A	S	E/NP
8	1	47	2	5	S	I	W	P	A	D	U/P
9	1	54	1	5	S	I	W	P	A	M	E/P
10	1	58	1	6	M	N	SP	U	A	M	E/NP

POPULATION PROFILE - FEMALE SUBJECTS TABLE 2

WOMEN

	Week of Interview	Age	Number of Previous Hosp.	Duration of Stay-days	M=Medical S=Surgical	I=Intrusive N=Nonintrusive	W=Ward S=Semi-private P=Private	P=Planned U=Unplanned E=Emergency	A=Acute C=Chronic	M=Married D=Divorced S=Single	E=Employed U=Unemployed P=Professional N=Nonprofessional
1	1	35	4	7	S	I	SP	P	A	M	U/NP
2	1	59	0	7	S	I	SP	P	A	S	U/NP
3	1	63	6	14	S	I	P	P	C	M	U/NP
4	2	50	4	7	S	I	P	P	A	M	E/NP
5	1	25	3	4	M	N	W	P	C	M	U/NP
6	1	20	1	6	S	N	W	P	A	M	U/NP
7	1	46	4	6	M	N	P	E	A	M	E/NP
8	1	60	1	14	S	N	SP	U	A	M	U/NP
9	1	29	2	7	S	I	SP	P	A	M	E/NP
10	1	54	30	8	M	N	SP	P	C	M	U/NP
11	1	28	1	4	M	N	SP	P	C	M	E/NP

two elected semi-private rooms; one chose a private room. Regarding the circumstances of admission, eight were planned admissions. There was one unplanned and one emergency admission. Seven men were designated as "acute" and three were admitted for chronic conditions.

Personal data included the facts that six men were married, two were single and two divorced. (In this population there were no widowers or widows). Of the ten men, seven were employed, three unemployed; four were professional and six non-professional workers.

Female Subjects

Eleven women were interviewed. Ten interviews took place within three weeks post-dismissal; one was conducted during the fourth week. The eldest subject was sixty-three years of age; the youngest was twenty. (Median age: 46) Of these subjects, one had not been hospitalized before while ten had experienced previous hospitalization. A majority of six had been patients two to six times. Seven women remained in the hospital six to eight days. The longest stay was two weeks and the shortest was four days. Four of the patients had been admitted to the hospital for medical reasons and seven had surgical procedures performed. In the intrusive/non-intrusive category, seven subjects were involved in intrusive procedures and four were not. Two women were in wards (three to five beds); six were in semi-private and two in private accommodations. Regarding circumstances of admission, nine were planned admissions, one unplanned and one emergency.

Seven women were designated as "acute" and four were admitted for chronic conditions.

Personal data included the facts that ten women were married and one was single. Of the eleven women, four were employed, seven unemployed. There were no professional women among the subjects.

Negotiations for Securing the Population

Negotiations for access to a patient population were initiated by the investigator in April, 1971. Written permissions to conduct recruitment of subjects were obtained from the administrator of each institution after a lengthy series of meetings with administrative personnel, medical and surgical doctors on active staff and members of the nursing teams. Their response to the project was one of interest, curiosity and general support but critical of the ways it might prove intrusive to the patient and threatening or inconvenient to personnel.

Questions were raised, too, about the role of the investigator--namely, was she to make observations about the quality of patient care and report them, and, if so, to whom? Dialogue on these and other points allayed the concerns, both at that time and during the course of data collection.

Concurrently during the negotiation period, the investigator participated in the orientation programs established for new personnel. Although these were conducted differently in each hospital, the desired results were the same--to gain acquaintance with the personnel and with the local geography;

to share on-going and sufficient knowledge of the project so that those responsible for care would be adequately informed. This not only introduced them to aspects of research relevant to patient care but made entry into the institutional setting easier and more cordial. Staff member participation was invaluable in the "mechanics" of subject selection.

The majority of the attending staff of both hospitals requested that they be contacted prior to the investigator's meeting with the patient. This proved an advantage rather than an impediment and was worth the expenditure of considerable time and effort. The advantages were several--to reacquaint the doctor with the project; to learn from him if there were deterrent factors present, such as medication influencing subject response; to request that he not mention the project to the patient since compliance might result simply because the doctor introduced the idea of participation to his patient. Of the several hundred doctors on active staff, three requested that their patients not be contacted at all. Forty to fifty doctors were personally approached by the investigator and, of these, four denied access to specific patients on grounds either of debility or the degree of emotional lability.

Method

The method used for data collection was a semi-structured, single interview conducted by the investigator and transcribed on tape. Previous use of field methodology in the form of personal interview indicated that this approach was adequate to allow the subject to "tell his story" of hospitalization.

It was anticipated that data would yield increased understanding of what this experience was to each person--what it was like and what it meant.[4]

Prospective subjects were approached one or two days prior to their hospital discharge for the purpose of meeting them and enlisting their participation in the study. The investigator identified herself as a researcher and a graduate student in nursing who was interested in learning what the experience of hospitalization meant to individuals. These patients were told that participation in the study would involve one taped interview in the home (or elsewhere, should they choose) within six weeks of the discharge date. The patients were not expected to give an answer on the occasion of the first meeting. Instead, a time was specified for the investigator to call by telephone. The call provided an opportunity to clarify the purpose of the study, to gain a commitment of a termination and to establish a mutually agreeable time and place for the interview. The interest and response of the persons contacted was positive. No one contacted within the hospital refused to allow a telephone call. One of the subjects agreeing to the interview cancelled his appointment, claiming to be too involved with prior commitments.

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[4]"Meaning is not a quality inherent in certain experiences emerging within the stream of consciousness but the result of an interpretation of a past experience looked at from the present now with a reflective attitude." Schutz, op. cit., p. 210. This is a strong advantage of an interview which allows a retrospective survey of a past experience.

On several occasions, individuals voiced concern about "not being of any real help" in the study. They seemed adequately reassured when told that whatever they had to say was of value since it reflected the very singular experience of what hospitalization was like and what it meant to them.

The Interview Schedule

The tool (Appendix A) used to collect the data was a semi-structured interview schedule developed for the project. It had its beginnings in the preliminary investigation, with two subsequent refinements. It is based on categories derived from original subject responses (the preliminary investigation) combined with theoretical notions of privacy obtained from the literature.

The final tool for the project was the product of a third refinement. It is comprised of three major parts: 1) The first portion explores the subject's involvement in information-flow and distance-setting activities; 2) the second seeks to learn what parts of the hospitalization were judged by the subject as negative or positive experiences; 3) the third part deals directly with privacy-- a) privacy as it was experienced in the recent hospitalization and, b) privacy as defined by the subject.

The result was a tool enabling the investigator to gain access to a remarkably clear picture of the recent hospitalization and its meaning to the interviewee. Also, it provided specific instances of the ways the patient had involved himself in the flow of day-to-day activity.

The Interview Sessions

Each session was introduced by reviewing with the subject the reason for the interview.[5] He was asked to read and sign the form which had been developed to assure his informed participation in the project.[6] (Appendix B) Each subject was encouraged to speak candidly but was told, should he judge a question intrusive, a response would not be expected. (Throughout the data-collection phase, no subject gave indication of considering the questions intrusive.) The interviewee was reminded to request clarification of restatement should he not understand the questions. Also, he was assured that an interruption of the interview was acceptable should he think it necessary.[7]

The length of time for the sessions varied. The most brief was twenty-five minutes in length and the longest was seventy minutes. Generally, they were fifty minutes to one hour in duration. All but one interview took place in the respondent's home; the one exception was conducted in a bar and grill, the subject's place of business.

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[5]Generally, the subject was not clear about the purpose of the investigator role even though this had been specified on the occasion of the first meeting. Often the investigator was seen as an agent of the hospital. Great care was taken in correcting any misconceptions because of the influence they would have on subject's freedom of response.

[6]This was a convenient and workable way to focus the subject's attention on the task at hand. The form had been developed to meet the criteria of California, San Francisco Medical Center's Ad Hoc Committee on Human Experimentation. Aside from being a requirement for the study, it promoted the idea of research as a shared event with the subject.

[7]On several occasions, the nature of the subject's physical ailment did not allow immobility for the length of time of interview.

The investigator did not specify whether other persons could be present during the interviews. On two occasions, a spouse was in the same room but did not participate verbally. Since many of the subjects were homemakers, young children were often in and around the immediate area.[8]

The feeling tone was relaxed in most instances; the subjects were highly responsive in discussing their perceptions and experiences. One exception to the general cordiality was occasioned when a wife judged her husband as too ill and tired to become involved in the project whereas he overruled this in favor of his interest in "talking about what it was like for him."[9]

Pertinent information was compiled for each subject on a Subject Information Sheet. (Appendix C) This was begun at the first meeting in the hospital and completed after the transcribed interview.

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[8]It was not unusual for the investigator to enter into some of the child-care activities in a minor way--tying shoelaces, holding a baby, etc. Rather than deter from the flow of the interview, it enabled the subject as well as the investigator to be more at ease.

[9]This subject had terminal cancer and was more caught up by his present circumstances (of undergoing extensive radiation therapy) than desirous of discussing the prior hospitalization. The degree of chronicity or the presence of an incurable condition was not considered at the time of establishing criteria for selection of subjects. Undoubtedly these are highly influential variables.

CHAPTER IV

ANALYSIS OF DATA AND RESULTS

Chapter IV is divided into four major sections: The first section discusses the process of data analysis. Section Two is devoted to the definition and description of "privacy" as derived from patient data. The third section presents and discusses a Model of Interpersonal Distancing Within Hospitalization. A grid depicting the relationships between privacy and the features or interpersonal distancing within hospitalization is the focus of discussion in Section Four.

Section One: The Analytical Process

The analysis of data[1] evolved and progressed throughout the course of the study. Initially, the questions being asked were virtually boundless in scope, assuming that within the data provided by recently hospitalized adults, "something" could be learned about privacy--what it is, what it means to individuals and how it is attained. Consistent with

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[1]The investigator did not embark on this study with generation of theory as an explicitly defined goal. During the process of data analysis, however, it became evident that the development of a working theory of inter-personal distancing was integral to understanding the nature of privacy. Therefore, data analysis was based on the constant comparative method of generating theory as described by Glaser and Strauss. Barney G. Glaser, Anselm L. Strauss, "The Constant Comparative Method of Qualitative Analysis," The Discovery of Grounded Theory, Ch. V, (Chicago: Aldine Publishing Co., 1967) pp. 101-117.

the course of exploratory research, the four problems were refined and finalized only after considerable time had been spent in the study of data.[2]

Progression of analysis can be divided, roughly, into three major steps or phases. In the first phase, hunches and insights were gathered regarding the nature of privacy as it was understood by the subjects, beginning, with the fact that they considered privacy an important thing to talk about. One approach to analysis was operative at the time whereby theoretical notions, as derived from the literature, were measured against the data. At that point, it seemed enticing to draw upon theory for major categories then distribute data items into the appropriate categorical "baskets." An early example of this was the investigator's view that privacy was primarily confined to the individual's ability to influence information-flow and distance-setting. There was a degree of peril in this, namely the temptation to tailor the data to fit the theory. Adherence to such a choice would result in not "hearing" much of what the subject was saying, thus negating a phenomenological approach to research.

The second phase began with as free a perusal of the

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[2]Analysis of data is described in a fairly detailed way. This was done in a deliberate attempt to portray process as well as findings. Explicit reference to the need for documentation of the process of the study of sociological phenomena has been made by at least three authors: Douglas, op. cit., pp. 29-32; Glaser and Strauss, op. cit., p. 8; Abraham Kaplan, The Conduct of Inquiry: Methodology for Behavioral Science (San Francisco: Chandler Publishing Co., 1964), p. 269.

data as possible. This phase progressed concurrently with the collection of data and paralleled the editing of interview transcriptions. Notations were made concerning insights and the recurrence of various themes, not necessarily those themes having to do with prior understanding of privacy. All data were treated as a composite rather than considering the interview questions and their subsequent discussion on an individual basis. An example of a consistently emerging theme or category was that of mobility--subjects spoke of the ability to "move about" in a multitude of ways: bedrest, bathroom privileges; restrictions of mobility due to pain, tractions, casts, intravenous feeding, doctor's orders; treatment to improve the ability to move; reasons why they could or couldn't move and so on.

During Phase Two, memos were made. For instance, the fact was noted that certain situations within the period of hospitalization were important to the patient because they gave rise to worry, puzzlement or some other form of concern. In this context, the theme of "not knowing" became evident. When patients felt the need of information, of being "clued in" about what was happening or about to happen, a type of discomfiture resulted. This was compounded when an adequate (to them) and timely explanation was not forthcoming. Conversely, there were situations which brought about an extraordinarily pleasurable response. One subject reported that, while a patient, he could "always get a cup of coffee, no matter what hour of the day or night." For him, this was a

source of special gratification. Further exploration of this item disclosed--not only did he like coffee but it meant that someone was available to him at all times; also, "They were so nice about it." These occasions, of singular importance to the subject, were reported quite regularly. They were evident to the investigator through heightened affect in speaking of them, in being volunteered spontaneously either in or out of context with interview format, or by a return to the incident to re-tell or to elaborate on it.

Phase two terminated with the identification of four major categories and their properties[3] -- 1) role perception, 2) control of environment, 3) personal boundary, and 4) entry. These were rich categories and served, in fact, to explicate socialization within the hospitalization context. At this juncture, the investigator realized that the data could be used to discover and discuss the problem of how persons become patients. This is, in itself, a timely and enticing venture, but not specific to the overall purpose of this study.

Phase three was introduced by the uncomfortable and unrelenting question, "What do these categories have to do with privacy?" It was time to pause, take stock and state a way to deal with privacy, utilizing theory while continuing to

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[3]The identifications of these categories was an important milestone in the chronological sequence of analysis. This occurred at a given point in time. Concepts proper to the categories were to be used later in the construction of the Model of Interpersonal Distancing. (This exemplifies one difficulty the investigator experienced--accounting for chronological sequence of development while attempting to present thoughts in logical order. They are not synonymous.)

preserve the integrity of subject data. It was at this time that the first two research problems were formulated; the development of problems three and four occurred consequentially (Chapter I, p. 2).

The first problem was opened to analysis by asking, "In the dimensions of privacy as represented by the definitions and examples of the subjects, what are the common features and what are the variations?" To gain access to the "dimensions of privacy" data were approached in a more particular manner than occurred in either phase one or phase two. Specific items were transferred from the transcriptions to individual, color-coded cards. These included: 1) all references to privacy, whether elicited or spontaneous, 2) the contexts in which privacy was mentioned, 3) instances involving information-flow, 4) instances involving distance-setting, 5) sources of comfort, 6) sources of discomfort, 7) what the subject would want different should he be hospitalized again, 8) any instance of importance to the subject, using as criteria, a) heightened affect, b) spontaneous introduction of the instance, c) a re-telling or elaboration of the instance.

Through study of the items referring explicitly to privacy in its various contexts, it was possible to identify common components. A definition of privacy was developed through a synthesis of these common elements. One example of a commonality was the fact that the individual <u>determines</u> to a great extent when and under what circumstances privacy is necessary for him, that is, privacy is within his <u>control</u>.

Variation occurred in the statement of mode and of circumstance. ("Mode" refers to whether the instance concerned distancing and/or information. "Circumstance" includes the dimensions of when, where, how and why privacy was attained as well as who was involved.)

The second major task, that of constructing a model, began by asking many questions of the data (Appendix D) but returned to the statement of the problem itself to ask the most important questions: 1) "Of what significance to the individual is his ability to balance retreat and disclosure?" 2) "What does he do to effect a desired state?" 3) "What actions does he take to bring about a desired level of withdrawal/retreat or disclosure/communication?" 5) "What interferes with his ability to attain or to maintain a desired condition of retreat or disclosure?" and 6) "In what ways do his actions affect others?" Providing answers to these six questions served to sketch in the major features of the model and, also, incorporated the third problem.

The development of the fourth research problem was a matter of comparing and contrasting the aspects of privacy, as the subjects described it, to features proper to interpersonal distancing in general and to forms of withdrawal and retreat in particular. This task was expedited through the use of a grid demonstrating the relationship of privacy to the features of interpersonal distancing.

The approaches to analysis via definition and model-

building, yielded concepts derived from actual situations but can be thought of as independent of them. In concert, they bring about increased understanding of privacy.

Section Two: A Definition and Description of Privacy Derived from Patient Data

Definitions and descriptions of privacy are manifold within the literature, showing sign of intense and occasionally painful effort to attain clarity. The term "privacy," as an abstract noun, can and does convey a vast conglomerate of meaning.

A good definition is "that which both conveys and clarifies with greatest economy of language the meaning of the term defined. It should be precise in the central characteristics and should be commensurate with what it defines."[4] A definition may be thought of as psychologically effective when it includes example, breadth, precision and conciseness. Brevity of definition may diminish credibility by its abstractness.

In the context of this study, privacy is restricted to that concept understood by persons involved in meeting their day-to-day needs as members of society. This does not minimize nor detract from the importance of larger societal issues, as in governmental surveillance. However, privacy beyond the interpersonal level is not opened to discussion here.

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[4]Harold A. Larrabee, Reliable Knowledge (Boston: Houghton-Mifflin Co., 1964), pp. 190-191.

The investigator attempted to represent the meanings of privacy within the dimensions provided by subject data, providing excerpts from interviews when illuminative. Portions of this task have been relatively simple. That is, the objective elements of privacy such as space, distance, and information are readily accessible within the data. The subjective components, whether cognitive or affective, are more elusive. To be made external and reportable, the investigator must make inferences about content based upon his own commonsense understanding of meanings. This is one characteristic of field research--that it is impossible to do any more than partially reproduce the total wealth of contextual meaning of any observations. As an example, the notion of "comfort" is a major point at issue within the definition of privacy as it has been synthesized from the data. Only two items within the transcriptions referred, explicitly, to comfort. Yet, the investigator proposes that the condition of privacy entails harmony of circumstance to the point where a certain equilibrium, called "comfort," prevails. It is this type qualification, in contradistinction to quantification, that is particularly exacting--to avoid it would be to stultify richness of meaning, to incorporate it entails the risk of over-extending meaning through imposition of one's own predilections. The definition of privacy, as presented in this chapter, leans heavily on the understanding that words belong to those who use them, and not to any academy of "authorities."

Definition and Description of Privacy, as Derived from Data

"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 control of the one seeking privacy. It is a personal and internal state to the extent that privacy cannot be imposed from without while the states of isolation and separation may be brought about through external sources. Privacy often makes use of but is not dependent upon factors outside the individual.

Privacy may be spoken of in an informational mode whereby the individual is free to disclose only that information about himself consistent with his circumstances and desires. Also, it is removed from the necessity of taking in unwanted information from outside sources.

Privacy frequently incorporates a connotation of propriety. It is a term applicable to man for only he, as distinguished from infra-human species, is capable of operations proper to the valuation, establishment and maintenance of privacy."

The definition of privacy contains the four objective dimensions of space, time, matter and fact. It includes subjective elements of value, meaning, purpose, control, judgment and perception of comfort. Privacy entails a particular and simultaneous interrelationship of these parts. The following discussion explains and enlarges upon the principle

components of the definition.

Comfort

The adjective of "comfortable" and the noun "comfort" meaning a state of being at ease, of being undisturbed. It applies to "conditions that make for content, security, well-being and the like."[5] From the consideration of patient data, this word is judged an appropriate and accurate descriptive when applied to privacy. Allusions to comfort in the context of privacy include these instances, "At times I like to relax and read or listen to music. Talking at a time like this would disrupt my thoughts," (interview #4, p. 12) and, "In the hospital they gave me pajamas (instead of a gown) and I didn't have to worry about the back of the gown opening up and so forth. Most of the time I could just freely and comfortably lay on top of the bed." (interview #6, p. 31)

"Comfortable" indicates an absence of concern--that one is free from being watched or overheard. It includes, as well, the assurance that activities carried on in private are not disturbing to others. Thus, the tone or mood is one of being in balance, of enjoying a pleasing and desirable equilibrium.

Judgment or Need for Privacy

The judgment of the need for privacy emanates from the individual who, in response, knowingly seeks to establish the internal and external conditions conducive to this state. Within subject data is consistent reference to deliberate action, "When I want privacy, I...close the door, go upstairs,

go to the garden." This is in contradistinction to an undesired state. For instance, if the dimensions proper to privacy are present except for the fact that the individual desires it, there would not be "privacy." It could be exclusiveness, solitude, isolation, separation and so on. If the state is not in accord with the person's desires, "privacy" does not apply. Data indicate, when privacy is a referent, there is a reason, a goal, "...because I needed to think things through"; "because we had personal matters to discuss." Thus, privacy is purposeful as well as deliberative.

Value of Privacy

Additional insight is gained into the nature of privacy through the fact that breach of the state is deemed an invasion or disruption, "...they intruded on my privacy"; "privacy went down the drain"; "they broke up my privacy." This characterizes interference as violation of something valued and positively meaningful to the person.

Withdrawal

"Withdrawal" may be understood as a physical distancing and/or a psychological "turning in" to the internal state of reflection, concentration, reverie. As indicated by Westin,[6] such withdrawal need not be solitary but can include small group intimacy or anonymity within a larger group. Within this context, one subject described his perception of privacy.

> Privacy is a mental state. You can have privacy if you want it by turning yourself inward and enjoy all the privacy in the world. It doesn't

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[6]Westin, op. cit., p. 7.

> matter if there are a million people around you. And then, if you don't want privacy, you turn yourself on and start communicating with people around you. If I want privacy, I'd turn in and put a book in front of my face and start reading or maybe close my eyes and try to doze off... (interview #14, p. 29)

Dimensions of Privacy

"Dimensions" refers to the mental and physical conditions comprising privacy to this individual. It was depicted by subjects in a wide range of situational variety--"Normally when you speak of privacy, you speak of your own individual body, yourself as an individual." (interview #3, p. 17) "Well, being ear oriented, to me it means being not just beyond sight of but also the sound of other people, so that I can play my trombone without offending them and vice-versa." (interview #16, p. 26) "If you just want to be quiet, OK; it's hard to explain--just that people are different and those who want to be alone all the time or at a particular time, if they're not allowed to be, that's just an invasion." (interview #17, p. 24)

Propriety

"Propriety" means that the individual's act or condition of retreat is seen by him as appropriate and fitting for the particular time and occasion. This may be understood in various contexts. It can refer to the decorum proper to manners and customs of a given society. One woman stated,

> I am probably of the age group that privacy is a bit more important to me than it is to my grown children. For example, I don't run around without

> a robe on and I do wear night clothes and this type of thing even though we just have daughters in the house. I don't do this and I am one of a vanishing breed because the younger people are worried far less than I..." (Interview #12, p. 34)

Expression of grief or anger are released, often, in a place and at a time removed from the presence of others. One woman refers to crying and retreating to the privacy of her hospital room,

> The next discomfort was the morning when I'd been in the hospital a long time, into the second week, and the blues hit. And I don't like to let go and I don't like to cry but I cried. And that was annoying to me. After you once start, you can't stop from crying...I washed my face finally and made myself take a walk. But then, hear the end of the walk, it started again, so back to the room I went. (Interview #4, p. 4)

"Propriety" is a noun somewhat difficult to use since it can suggest a puritanical rigidity or, at least, being a little better than the "common man." The term may include, but is by no means confined to, these nuances. It is, rather, an internal appreciation of what is fitting or appropriate to a given occasion. In this sense, it is related to the notion of comfort--a person is normally ill-at-ease in performing actions he judges out of keeping with a situation.

Informational mode

"Informational mode", as introduced earlier, includes the need and ability to communicate knowledge about self to others. It involved, as well, the taking-in of information from external sources. Within data, the informational aspect assumed these forms representing both egress and ingress,

> If they want to know questions, it's for a purpose and I'm really willing to let them know everything. If it's to help me then great, they can go on from there. I'll let them know everything they want to know. I have nothing to hide. There was nothing invasive of my privacy. (Interview #10, p. 21)

Another patient was not favorably impressed by the conversational efforts of a ward-partner on the afternoon of his hospital admission,

> I thought, "I'm going to get out of here if he stays here." He was more like a do-gooder and wanted to talk and I wanted to read. (Interview #17, p. 23)

Duration

"Duration" refers to the period of time involved as well as to the act of initiation and termination of privacy. These are within control or, at least, the strong influence of the person. Once control--"I want it so"--is lost or interfered with, privacy is no longer in effect. The notion of duration appeared in three specific forms.[7] One was more transient and could be called "privacy of event," meaning that for a specific activity, privacy is necessary. For instance,

> Privacy to me would be where the door is closed while you're doing your showering and different things, where you are absolutely by yourself. That is what I would say privacy is, with your door closed and nobody else around. (Interview #2, p. 20)

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[7]The three aspects of privacy will be discussed and compared in Section Four. They first became evident to the investigator at the time of trying to develop the definition and description of privacy so they are dealt with here, in the context of time-duration.

The second aspect of duration is less transient and can be termed "privacy of life style."

> Well, I like the fact that people don't infringe on your privacy. You can be as friendly or as aloof as you want. Living here in this apartment, we were told when we first moved into an apartment, "You won't like it because your neighbors will be running in and out all the time." Well, that's not true. We say "hello" to our neighbors and that's about the size of it. I'm not an over-friendly person, Oh, if anyone needed help or we have a neighbor that's in trouble, sure we'd go to their assistance, but I don't like women running in and out of my place in the morning for coffee and that sort of thing. I like to tend to my knitting and if we're going to visit, then let's do it by appointment. (Interview #7, p. 22)

The notion of time duration has served to introduce the terms "privacy of event" and "privacy of life style." However important, these perspectives appear to be means rather than ends in themselves for they serve to protect and maintain a more fundamental aspect of privacy, "privacy of personality." This designation, "privacy of personality," is not transient in duration; it is difficult to objectify, thus less easy to apprehend. Privacy of personality entails that which is the innermost part of self and the <u>domain</u> of autonomous activity.[8] Within data, one subject may have captured the heart of the matter in speaking of dignity,

> They (hospital personnel) do everything they can to preserve your dignity. Dignity is a part of privacy. (Interview #3, p. 16)

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[8]There are frontiers not artificially drawn, within which men should be inviolable, these frontiers being defined in terms of rules so long and widely accepted that their observance has entered into the very conception of what it is to be a normal human being." Isiah Berlin, <u>Two Concepts of Liberty</u>, (Oxford: Clarendon, 1958), p. 51.

Data disclose instances when individuals perceived a threat--in some way pernicious to this inmost being. Such instances entailed for them a feeling of dismay, disquiet, and a degree of indignation. One subject, an obese young woman admitted for treatment of asthma, represented her discomfiture in this way,

> The only thing that bothered me was some of the conversations with the nurses, which I don't think they meant to get me depressed or hurt my feelings, but it seemed like every single nurse that came in would say something like, "You should be on this diet" or "Did you ever try that diet?" or something pertaining to a diet, or how much better I would feel if I were thinner and everything. Like when I went to the hospital I have this thing about my weight anyway, where I was very depressed. When they came at me with this, it was really too heavy on me. And I went home and ended up going to see a psychiatrist the day after I got home. I was so worked up about it. Because I felt they should just leave a person alone if they're heavy. A heavy person knows she should be on a diet and they know they'd feel 100% better if they were thin and everything but it seems like nobody ever stops to think what the person is feeling inside, what their feelings are about these things. They think because they're fat and they smile about it and everything that it's a happy-go-lucky thing for them. But it's not. It really hurts a person, I feel that they shouldn't keep coming in and telling me "You should be on this or that diet." And I never said anything but I got so fed up that I wanted to say, "Would you please shut up and leave the room!" I was really so fed up with it. (Interview #21, p. 14)

Interestingly, subjects would experience the same indignant concern when, in their opinion, another's rights were being transgressed. One woman reported of her partner,

> I thought it (level of privacy) was not too bad for me. I saw what happened to one of my roommates, though, and I objected to her privacy

> invasion...She had plastic surgery of the vagina and it seemed like every new nurse and everybody on duty wanted to see. And it would have bothered me no end. It seemed like just a case of out-and-out curiosity with a lot of people who came in...she was feeling very sensitive about it because it was a deformity from birth and she's not really wanting to advertise the fact. And now, everybody in the world is going to look...they shouldn't have done anything more than was absolutely necessary for real medical reasons to make sure she was all right. I felt a little bad for her. (Interview #18, p. 31)

Within the three aspects of privacy described here, effectiveness of boundary maintenance is the common and crucial issue. The boundary may differ in terms of composition and placement but ability to protect it is of the essence.

Privacy Proper to Man

The act of judging, assignation of value, meaning and purpose are intellectual operations. Control emanates from intellectual activity but utilizes a physical force to influence something external to self. Perception of comfort combines intellectual with sensient abilities. Privacy, then may be understood as properly applied to man for he alone, as distinguished from infra-human species, is capable of the constellation of factors comprising privacy.

This section offers definition and description of privacy, specifying its various components. The most valuable insight gained through this task is, in the judgment of the investigator, the differentiation of the three aspects of privacy--privacy of personality, privacy of event and privacy of life-style. It is evident that the definition is particular

to privacy of event. This fact and its significance will be discussed further (in Section Four).

Throughout this chapter, the words "state," "status," "conditions" and "situation" have been used repeatedly. While the use of these terms is not totally inaccurate, it does distort by incompleteness. It suggests mainly a static view of privacy when it is, in actuality, a dynamic equilibration or balancing of various factors. The presentation, so far, has concentrated on a physiognomy of privacy. The section to follow attempts to enliven the concept by focusing on action. To accomplish this, a conceptual model is presented and explained for the purpose of depicting a theory of interpersonal distancing and specifying processes involved in the individual's balancing of his need for disclosure and communication with his need for withdrawal and retreat.

Section Three: A Model of Interpersonal Distancing Within Hospitalization

Within research endeavors the meaning of and uses for "model" are varied. For this study, the model is used to depict, visually and verbally, the interrelationship of concepts. These concepts, drawn from data, comprise a theory of interpersonal distancing within a specific sociological setting--that of hospitalization. The model is a means to allow the scientist to make clear to others what he has in mind.[9]

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[9]For a detailed discussion of the various types of models and their uses (and abuses) see, Kaplan, "Models," Ch. VIII, op. cit., pp. 258-291.

During the course of this study, it became increasingly evident that "privacy" is directly involved with interpersonal distancing; however, all concerns about interpersonal distancing were not called "privacy" by respondents. Because of this, it seemed necessary and useful to portray a schemata of interpersonal distancing and, from this orientation, proceed to delineate the way(s) in which privacy is related to the larger structure. It will be noted throughout the study that the term "privacy" and "interpersonal distancing" are used interchangeably. This occurred in an almost spontaneous way as a means to portray the activity proper to privacy establishment and maintenance rather than the more static connotation of the noun, "privacy."

This section presents, first, the model and its explanation. As in the preceding discussion, excerpts from interviews are included as illustrations of the points being made. The section concludes by naming and describing the four variables as the factors differentiating the hospital experience from other forms of social interchange.

Model of Interpersonal Distancing

The model is a dynamic one, despite the limitations of one-dimensional representation (figure 2). It depicts the processes whereby the individual balances his need for withdrawal and retreat with his need for disclosure and communication.

Each person, throughout his existence, is engaged in drawing toward or away from other persons or thing. The

activity is one of constant and mutual adjustment of physical and/or psychological proximity. Part of this distancing involved the disclosure or the witholding of information about self. As a social phenomenon, all individuals are similarly participating in and are influenced by distancing activities. This results either in congruence or conflict of agreement of personal preference regarding distance.

Description of Model

The horizontal bar of the model represents the two major human needs--withdrawal and retreat, disclosure and communication--as goals. The overall purpose of the continual election of withdrawal and retreat or disclosure and communication is specified as comfort. The ability to determine one's current orientation in the continuum from withdrawal and retreat to disclosure and communication depends upon two functions: 1) effectiveness in establishing boundary and 2) the ability to influence another's entry within the boundary. These abilities are manifested by way of operations and actions directed to perceived needs. As described so far, the model is transsituational. Within the hospitalization experience, however, four major variables affect the ability to establish boundary and influence entry. There are the two variables specific to the person: 1) mobility and 2) levels and awareness of consciousness; and the two interpersonal variables of: 3) the specific character of patient/patient relationships and 4) role perception.

The model remains relatively sterile without expansion and discussion. The following section is directed to

FIGURE 1: MODEL OF INTERPERSONAL DISTANCING WITHIN HOSPITALIZATION

GOAL: Withdrawal and retreat ← PURPOSE: COMFORT →

PERCEIVED NEEDS	OPERATIONS	ACTIONS	FUNCTIONS
1. being out of sight 2. resting 3. thinking 4. bathing 5. dressing 6. elimination 7. grieving 8. shutting out external stimuli 9. excluding sources of threat	1. screening out (exclusion) 2. increasing physical and/or psychological distance	1. closing door 2. drawing curtain 3. leaving the room 4. erecting a physical barrier (e.g. book in front of face) 5. adjusting facial expression or posture 6. inattention 7. changing the subject of conversation 8. not answering 9. not inquiring	1. effectiveness in establishing a boundary 2. ability to influence another's entry within boundary VARIABLES 1. mobility 2. level of consciousness 3. specific character of patient/patient relationships 4. role perception

→ GOAL: Disclosure and Communication

ACTIONS	OPERATIONS	PERCEIVED NEEDS
1. asking	1. screening-in (inclusion)	1. sharing concerns
2. telling	2. decreasing physical and/or psychological distance	2. gaining or giving information
3. listening		3. allaying fear (within self or another)
4. watching		4. gaining or giving assistance
5. monitoring		5. gaining or giving reassurance
6. adjusting posture or facial expression		6. protecting self or another
7. touching		

enlargement of the model through definition of terms, within the context of this study, and the specification of their relationship within the structure.

Definition of Terms

Comfort: The concept of comfort was introduced in the previous section. It will be re-emphasized here as the point of convergence (purpose) for all distancing activities. The term is meant to convey the subjective awareness of well-being achieved through approximating a preferred distance from others. A frequent concommitent to the notion of comfort is the achievement of the preferred quality of information-flow (information to or information from the individual). Comfort is not to be construed as a rigid determinant of distancing activities, for personal comfort can be, and often is, set aside in favor of someone else's well-being or, perhaps, one's own eventual goals.

Goals: That specific interpersonal distance and/or quality of information-flow yielding a desired (or acceptable) level of comfort. This may be anywhere along the continuum from withdrawal and retreat to disclosure and communication.

Withdrawal and Retreat: Refers to movements, physical and/or psychological, by which an individual effects a barrier or enlarges the distance between himself and another(person or object).

Disclosure and Communication: Refers to movements, physical and/or psychological, by which an individual removes barriers or diminishes distance between himself and another (person or object).

Perceived Needs: Are the immediate reasons why the person may choose to adjust his distance from another, or seek to influence information-flow. These needs have been drawn from data and specified within the model under the withdrawal and retreat heading as: 1) being out-of-sight, 2) resting, 3) thinking, 4) bathing, 5) dressing, 6) elimination, 7) grieving, 8) shutting out external stimuli (light, noise, odor) and 9) excluding sources of threat. Perceived needs under the disclosure and communication heading include: 1) sharing concerns, 2) gaining and giving information, 3) allaying fear (self and other), 4) gaining and giving physical assistance, 5) gaining and giving reassurance, 6) protecting self or other.

Action: Is that specific human act through which the distancing or influence of information-flow is effected. The actions proper to withdrawal and retreat as drawn from data, are: 1) closing the door, 2) drawing the curtain, 3) leaving the room, 4) erecting a physical barrier (e.g. placing a book in front of face), 5) adjusting facial expression or posture, 6) inattention, 7) changing of subject, 8) not answering, 9) not inquiring. Actions, as drawn from data, specific to disclosure and communication, are: 1) asking, 2) telling, 3)listening, 4) watching, 5) monitoring, 6) adjusting posture and facial expression, 7) touching.

Boundary: A barrier, whether physical and/or psychological to one's thoughts, feelings, person or possessions.

Entry: The movement, whether physical and/or psychological, of entering beyond the boundary established by another person.

The concepts of "boundary" and "entry" are interrelated since each has to do with the proximity of persons or things to a given individual. When a person circumscribes a boundary for himself, the potential presence of someone or something else is emphasized. A boundary is provided against the eventuality of attempted entry. In "entry," the actual presence of someone or something else is extant. The difference between the terms is essentially one of timing--"boundary" more closely aligned to the eventuality of entry; "entry" is concerned with the immediate presence of the other. In social relationships at least two persons are involved--one who can allow entry and the other who attempts entry.

Operations: Refers to the general category of combined internal and external movement resulting in an adjustment of distance or influence of information-flow. Beneath the heading of withdrawal and retreat, the operations have been specified as: 1) screening-out (excluding) and 2) increasing physical and/or psychological distance. Beneath disclosure and communication heading, the operations are identified as: 1) screening-in (inclusion) and 2) diminishing of physical and/or psychological distance.

The operation of physical distancing is more impracticable within the hospital setting than it would be in other circumstances. The patient is geographically confined to greater or lesser degree. Evidence of physical distancing did appear in subject data--going to hallway, going to solarium, having location of bed changed. However, screening

operations served, in many instances, to gain physical and/or psychological distance from other persons or things.

Screening operations emerged as a constant and common theme throughout the subjects' reports of hospitalization. The actions comprising screening were peculiar to either enclosing or keeping at a distance other persons or objects. The use of the curtain (enclosing the bed) was mentioned repeatedly. Its value and importance seemed intertwined with the fact that the patient could control, to some extent, whether or not he was to be visually apart from others. While there was mention that the curtain was of little value in some instances--"those curtains don't prevent you from hearing what's going on"--it was named by many subjects as a consistent means to enhance privacy. The door to the ward or the door to the room was used for screening purposes part of the time but it was not as effective. Except for the persons in private rooms, the door was not seen by the patient as within his jurisdiction of control. It was kept open most of the time by staff members and only a few subjects reported feeling free to close it. The door was always referred to as <u>the</u> door while the curtain was <u>my</u> curtain, over which there was a degree of personal control. The majority of respondents preferred the curtain or door open except when taking care of bathing or elimination needs--"I like to see the activity." "It helps me pass the time to watch what's going on out there."

Exceptions to a desire for mutual visibility from room to hallway were instance when an unwelcome draft was created,

when the occupant was feeling too ill or too tired to enjoy the outside activity. Also, one subject kept the door to her private room closed "because of the nature of my operation." She had undergone bilateral mastectomy and was sensitive to "looking different," thinking of the procedure as disfigurement. An elderly gentleman, hospitalized for the first time, preferred his door to be closed because "I feel like an intruder, looking right in at that man across the hall."

The screening was visible in various forms. One man reported, "Oh, when I am tired and don't want to talk any more, I just close my eyes and they (visitors) go away." A young woman put a pillow over her head to protect herself from the light and sound of the television. One subject said she knew when her room partner was through chatting, "She would just turn her head and I knew she was through chatting."

The use of physical screening was more common among the women than among the men patients. The men seemed to regard the ward dimensions as sufficient for most of their activities. This derived, in part, from their differences in socialization,

> ...the person who has spent ten years in military service thrown together in large clumps with bunches of other people, any shyness about personal privacy was worn off me many years ago...it doesn't bother me in the least but I can see how it would bother some people (Interview #16, p. 1)

In this context, it was noteworthy that eight of the male respondents preferred to be in room accommodations with more than one other person, while ten of the women specified a preference for semi-private rooms.

As a conclusion of this portion of the discussion, it should be noted that, in screening and/or distancing operations, the individual can either be going to something or from something. Later in the study (Section Four) it will be seen that this is an important clue to the nature of privacy.

Variables

Within data, four major variables had decided impact on the ability of the subject to delineate boundary and to influence entry. In this section, the variable will be named and defined. Pertinent excerpts from interviews will be incorporated to clarify contextual meaning and, also, to illustrate instances of the patient's "problems" relative to the variable.

The First Variable: Mobility

Mobility: Mobility is a general term used in this context to depict the ease with which the patient can move about physically, performing tasks for himself. It incorporates the notion of navagability, moving from bed to other parts of the room, bathroom, solarium, etc. It includes the ability to move and use body parts while confined to bed--sitting, reaching, lifting, pulling, etc.

Decreased mobility may derive from external sources rather than from the individual himself--as in bedrest ordered by the physician or in partial immobilization afforded by pelvic traction. Internal impediments to mobility include weakness, the nature of the illness or surgical procedure, medication, infirmity due to aging.

Impaired mobility inhibits one means--motion/locomotion--

of influencing personal boundary and entry within the boundary. This limitation gives rise to three directions of recourse for the patient: 1) he may make his needs known and depend on others to supply what he cannot do for himself; 2) he may devise an alternate action that is within his range of capability; 3) he may endure the situation. The data disclosed samples of each of these options and their sequelae. In the first two alternatives, the individual overtly "reaches out" in some way, thus modifying his personal boundary and influencing the entry of another. In the third alternative, the individual assumes a more passive stance which may be a covert way of "reaching out" (helplessness engendering concern/within another) or it may be a way of entrenching one's self more firmly within a boundary.

When problems or occasions of discomfiture arose in terms of mobility, they occurred in these ways: There was the discomfort of preceiving one's own helplessness in performance of simple tasks. The feeling was compounded in some instances by other factors such as not wanting to "bother" busy personnel members through requesting their services; by not wanting to be considered a "demanding" patient. Some patients did not want to be a source of disturbance to their ward companions so delayed in asking for help. The feeling of helplessness was heightened on occasion by the manner in which assistance was proffered. That is, the patient perceived the helper as impatient, hurried, disinterested, inexpert or as expecting more of the patient than seemed feasible to him.

A second problem arose from lack of adequate understanding of the decreased impaired mobility. One young woman reports,

> I thought I wasn't going to be able to walk right, having a nerve removed (surgery of foot). I though I was going to continue to flop over on my foot. He (doctor) said that was something I shouldn't worry about at all. He said if he'd known that it had been upsetting me for so long, he wished I had asked. But I didn't know how to ask him because I hadn't known him for too long. (Interview #11, p. 24)

Another pointed example of lack of information is the instance of the man who did not know that spinal anesthesia would result in temporary immobilization and loss of sensation in his lower extremities,

> It might have been wise on the part of the doctor to forewarn that you'll undergo a period upon recovery when you can't move your legs and it may be a little discomforting and so forth. I don't remember any such pre-conditioning. It's a funny thing to describe. It was a sensation of boundness, as though you were physically bound by straps; numbness like when a limb goes to sleep. But when it's asleep you can kind of move the limb and that tells you it's alive. Numbness accompanied by inability to move is something--I wouldn't say it was frightening but it was distressing somewhat. (Interview #16, pp. 19-20)

A third problem was the fact that decreased mobility renders the person vulnerable to intrusion, such as certain visitors,

> There were times when I didn't feel like talking about the ramifications of a hysterectomy. And there are people who consider you a captive audience there in bed and they can tell you all about their troubles and all about, "I remember my hysterectomy and, oh, the pain and oh, gee," and you wish you could turn them off. (Interview #18, p. 24)

The ability to compensate for decreased mobility assumed various forms of greater or lesser effectiveness. These were operations of screening-out and distancing. Ordinary, physical measures were to draw the curtain, turn away or raise a book before the face. A more subtle but quite effective means was to effect a role-shift. Role-shift is when an individual assumes a role rendering him less accessible to the other person. An example of this was when a clergyman visited a woman at her bedside for the purpose of encouraging her to receive the sacraments, thereby to gain comfort and solace during her illness. He perceived this as a priest/penitent relationship. The subject gained distance by refusing the "penitent" role and assuming the role of the adult whose prerogative it was to initiate this kind of assistance when <u>she</u> felt the need,

> I wasn't expecting to see anyone from the clergy and I wasn't in the mood to see anyone from the clergy at all. I just couldn't talk while he was there although his presence seemed to require me to say something to him. Finally, I just said, "It's something I would rather not talk about." And he accepted it and said, "Fine, I won't intrude upon you." (Interview #1, p. 24)

Other means of compensating for lack of mobility included <u>reporting</u>--One woman cried in frustration to her doctor about her inability to reach her meal tray and (to her) the insensitivity of the nurse upon her request for more assistance. Some patients <u>endure</u>, knowing that sooner or later they will be able to help themselves. For example, one woman did not comb her hair, nor request to have it combed ("just didn't

feel up to it") until she was able to have her own beautician come to the hospital. One man devised an effective alternative action to achieve the purpose he had in mind,

> Look, I weigh 335 pounds and there is no way my body is going to fit on that bedpan. You know, if you just don't look for about three minutes each day, I'll get up and go defecate. Then, the doctor will be happy and I'll be happy and you can write it on the chart. Otherwise, I can't go on the bedpan and you'll have to give me an enema. It will go all over the bed and you will be an hour and a half cleaning it up, so let's be reasonable..." We reached this understanding and, even though I wasn't supposed to be up, late at night I'd jump up and run to the bathroom. (Interview #3, p. 10)

It is obvious that the means for compensating vary widely in effectiveness.

Second Variable: Levels of Conscious and Awareness

The subjective level of consciousness influences ability to adjust boundary and allow entry. It refers to any alteration of the person's awareness, thus differentiating it, in essence, from "mobility." It may range throughout the vast spectrum of total to brief impairment of consciousness. Level of consciousness may be initiated through sources outside the person, such as medication, anesthesia and injury; it may come about through internal sources of the aging process, debility of illness, fear and pain.

Within the population of this study, there were definite but limited references to this variable. One obvious reason for limited reporting is the fact that a diminished level of consciousness decreases likelihood of reflective awareness. The concerns mentioned by subjects included loss of control,

the effect of own state of awareness upon family members, the effects of seeing others with impaired awareness, the narrowing of awareness occasioned by physical discomfort and the importance of having someone in attendance in the instance of impaired awareness.

One young woman had a reaction from her anesthesia in combination with drugs she had been taking prior to surgery. She recounted the incident several times during interview which seemed to point up several things--her feelings that staff members were "wary" of her because she had been labeled a "user," regret that she had not been candid with her doctor about drug intake, a sense of aloneness which surfaced throughout the interview as a case of "me" against "them,"

> If I hadn't done that (take drugs) things wouldn't have gone so bad because my last operation I had no problem at all in the recovery room. This time, I remember screaming and wanting my pain pills. I was foggy and asked the nurse if she could help me into my nightgown and take the things out of my suitcase. She walked off so I got up and got them myself. I didn't have crutches and I wasn't supposed to be up but I got my things myself and put my stuff back. (Interview #11, p. 3)

One woman's source of concern was the impact of her post-surgery state on members of her family, especially her husband,

> I thought, "Now, I have to make him feel better because I really don't feel as bad as I look." He came in and I was groggy and the bedrails were up and he said, "How do you feel?" and I said, "Oh, I feel OK." And he said, "Oh, my God, it's stuffy in here; look, I'll see you later, OK?" And away he went. (Interview #1, p. 27)

Within the hospitalization experience, especially the ward situation, patients were at once fascinated and repelled

by the sights, sounds (and odors) of the "surgery event." Several subjects described what such observations were like to them,

> I had kind of a strange feeling when they'd come in (into the ward) to get a person for an operation and it would be just like sending somebody to the death chamber. This kind of feeling--they roll this thing and put him on it and out he goes. And you know in a ward that is going to happen quite a few times. And I thought that when they brought some of them back they could have done a better job of taking them from the cart and putting them on the bed. (Interview #17, p. 22)

The men, in particular, had a way of using "black humor" to palliate the impact of the goings and comings of surgery,

> To hear someone say to a guy on his way to surgery, "Well, it looks like you're going to die, buddy," you know that sort of thing cheers one up! (Interview #16, p. 2)

One man claimed as his main source of discomfort during a two-week hospitalization, the fact that he knew he wasn't supposed to bend his leg. He explained that much of the time, his awareness was directed to the leg rather than to other things going on in the ward.

> The only thing that bothered me the whole time I was there was that I couldn't bend that leg. And you know, when you can't do something--that was the only thing that bothered me, just to know that I couldn't bend my leg. (Interview #8, p. 33)

Within data, were frequent allusions to the timely presence of helping persons during the period of impaired awareness,

> I was crying one night because I was having a lot of pain. I didn't say anything while my parents and husband were there. They gave me a shot and a pill and I asked her (the nurse) to stay with me. It calmed me down because I knew there was somebody there during the time I needed somebody. (Interview #11, p. 9)

> The day of surgery I don't even remember. All I know is someone kept feeding me ice. The second day someone was bringing ginger ale. I remember something about jello, but my memory isn't too strong on that. The nurses were taking very good care of me. They really watched over me well and I hadn't asked for anyone that I know of. As a matter of fact, I didn't even know where the signal button was. But they started bringing me ice when I was just parched. It was perfect. Someone came in periodically and gave me ice without my asking for it. (Interview #18, p. 10)

As in the variable of mobility, when problems arose regarding level of awareness they were concerned with the perceived manner of the helping person. This manner, as described by the patient, delivered the message that the need or request was unnecessary and untimely. In some instances, this served to reinforce subjective feeling of helplessness and of not "measuring up" to expectations.

The occasion of altered consciousness and awareness is a singular situation in which the boundaries of the individual are impaired or totally relinquished. The relinquishment may be specific and voluntary, as in the case of a surgical permit, or it may be imposed through accident or other incapacitation. Simultaneously, the ability to influence entry is grossly affected. At this time, the individual is highly vulnerable to and dependent upon others for his well-being. Of necessity, he must rely on another to act on his behalf. What these actions are and whether or not they contribute to the patient's "best interest" comprise a large measure of what health care is about.

The Third Variable: The Specific Character of Patient-To-Patient Relationships

Hospitalization provides a singular situation, unlike any other event shared by adult individuals. With the data of both men and women subjects, the nature of the relationships between them assumed particular significance.[10] One aspect of this unique situation can best be described in the sense, "we're all in this thing together," a notable camaraderie serving, among other things, to mitigate the restrictions of ordinary day-to-day socialization. The sharing of patient status brought about a certain leveling effect, a de-emphasis of what, in ordinary life, might be called the bounds of propriety. One man who was a patient in a ward, expressed himself in this way,

> You lose a good deal of your privacy but it's all false anyway. I gave it very little thought. Like I say, your privacy is reduced but not enough to make much difference. You lose this kind of false modesty--I would call it false. You are more down to basics and you're really not thinking of that. I was scurrying around there with just the top (hospital gown) open in the back. I was all around and never did stop to think what kind of sight I would be making. It didn't bother me a bit. It's amazing, too--I think the thing is, you're in a hospital. You are around people who are used to everything--all parts of the human body --so you really don't attach importance to it. Naturally, there is a little modesty but it's still not that important where it's bothering you too much. (Interview #19, p. 19)

Within patient-to-patient relationships, there was evidence

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[10]For a detailed discussion of the character of patient interrelationships, see Renee C. Fox, Experiment Perilous (Glencoe: The Free Press, 1959), pp. 139-190.

of notable concern for and interest in one another's condition. This extended to the sharing of intimate details and questioning about physical status and its meaning to the individual. The subjects reported, as one primary source of comfort, the interest and care evinced by others, especially fellow-patients.

> We got very intimate. We would ask each other very intimate questions because it was the main thought of the day. There were things in the area of what I would call my "plumbing problems." We would joke and laugh about it and that would take away the seriousness. As far as emotional comfort, I would say it was the other women rather than the nurses or anyone. (Interview #1, p. 26)

During the hospital stay, the patients assumed the role of monitor for one another. By necessity as well as mutual interest, the activities going on in relation to each patient were observable or could be overheard. Responses to these activities advanced beyond mere watching. "Monitoring" means observation but enlarges it to include a judgment about what's happening and a response by acting,

> I'd like to go back to one thing in the ward. It's good like this. We had a tendency to watch over one another. "Remember what the doctor said," because you can't help but overhearing. "You shouldn't have this and you should have that," and we'd tell the nurse and she'd check and find out. Because the way we were looking out for one another; it was good that way. (Interview #17, p. 20)

Some problems were evident in the patient-to-patient relationships. One occurred as a patient cast her ward partner in the role of "care-giver" to the extent that it was an imposition--the younger woman enjoyed performing small helping tasks but, when this became excessive, she wanted to revert

to her own patient-role. She resolved the problem to some extent by assisting only when she was out of bed but, in doing so, claimed to feel a little guilty because her neighbor "was so much sicker than I was."

Considerable anxiety was engendered when other patients were in evident distress, especially when they cried out. As in previous examples from interviews, this problem was exacerbated when an adequate explanation was not available,

> All you could hear was, "Get a doctor quick and a tongue depressor!" And her daughter was there and was crying. I was concerned about her and I asked but couldn't get any information. All they would tell me was that she was no longer on the floor. Well, you get these eerie thoughts, "Did she die?" And I couldn't get anyone to tell me what she was doing. I guess this is the usual thing to do. (Interview #1, p. 17)

Judgments were made relative to the quality of care given one another. This was especially evident when the person being observed was lacking in ability to respond for himself. Many of these judgments were positive.

> They (nursing staff) were friendly and outgoing. They answered you honestly and seemed to want to help. My roommate needed more help than I did. He was always doing something causing them quite a bit of trouble. You know, not on purpose. And they'd change his bed and give him a bath two or three times a day. You'd think they would get very irked but not a trace of it. It's amazing. (Interview #19, p. 16)

Other judgments were not positive,

> He (the other patient) could not control his bowel movements. He had cancer and they were giving him drugs and x-ray. Well, this nurse's aide treated him and his wife so badly...you know, you don't have to give him sympathy but it was obvious that he couldn't help himself. Instead of giving him

> understanding...every time something like that happened, he would try to call out but they didn't come. (Interview #3, p. 7)

Occasionally, direct confrontation would occur in the matter of the quality of care for a fellow patient. One elderly and confused gentleman was asked to sign a permit for some neurological testing. He did not understand and said, "I'm not going to sign that." The subject took up his cause and told the nurse who was attempting to secure the signature,

> You know, this is a crude way of doing things. Personally, I think that the doctor should have come up and explained to him and allayed his fears. But here a stranger comes up with a bunch of tests and wants him to sign this thing. (Interview #17, p. 16)[11]

There was evidence of some distancing between patients and staff members by means of a "we-they" stance. This occurred when patients were wary or distrustful of the care being given. When personnel were trusted, there was inclusion of them in the everyday small talk, the teasing and informal pleasantries.

Within the patient-to-patient relationships, there was a decrease of interpersonal distance through intimate sharing of information and events while, simultaneously, a degree of reserve was maintained through the anonymity of a one-time encounter. As valued as the hospital relationships were, they were limited by the period of hospitalization--a frequently intense but transient source of mutual strengthening,

> It's a fleeting thing. I will never see him again in all my life because it is a one-time situation.

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[11]As a matter of human interest, the elderly patient didn't sign the permit and didn't have the tests!

> We both shared the same room, both had the same problems and that was it. When it's over, it's over. Although I certainly wouldn't mind seeing him again. (Interview #19, p. 3)

The Fourth Variable: Perception of Role

Perception of role refers, in part, to the view the individual has of himself "as patient." This includes, as well, his interrelationship with others in their respective roles. Perception of role is formed in great degree from previous personal experience and orientation to illness. For some subjects, coping with impaired health had become a way of life throughout years of chronicity--to the point where the individual knew more about his physical condition, his medical and dietary regime than staff members. For others, illness was a transient event, marking a period of temporary inconveniences. Several subjects had severe illnesses presaging a radically different way of life for them. Perception of one's own illness is a highly personal event. Seeing oneself as less-than-normal is often exceedingly distasteful, even to the point of being dissembled or denied. This impression of self is either heightened or diminished by the response of others to the person-as-ill.

Being a patient or becoming a patient introduces the individual to a complex realm of implicit and explicit rules governing boundary and entry. In a manner of speaking, personal boundary had already been violated for some subjects by means of infection or injury. For them, entry had been forcibly attained via foreign organism or object.

When problems arose relative to role perception within the population of this study, they occurred in three major ways: in learning the "rules of the game" (of being a patient); in terms of "legitimacy" of entry; in the lack of congruence of role perception between individuals.

Frequent mention was made by subjects about what to expect of their hospital experience and, also, what would be expected of them. A few subjects approached hospitalization with an apparent equanimity. One woman, very familiar with the hospital and staff members, said that it was almost "like going home." One man explained his attitude in this way:

> One arriving at a hospital I have the feeling that I have no control over my own fate whatsoever, so I just plop and what happens happens. Literally put yourself in the hands of the organization and expect the organization to do its work, which it did in fine fettle. (Interview #16, p. 17)

Other patients wanted to know more of what was expected of them,

> There are other things I would have liked to know. As far as going to surgery itself, I would've liked to have known how long you just have to lay there on that table before anything starts to take place. Somebody comes over and they strap this arm down and this arm and somebody else is down on your leg strapping that and you...I was just laying there shaking because I didn't know what was taking place next. I realize that the doctor doesn't have time, especially the doc I have, to explain point after point. But just a general, broad breakdown, that would've been nice. (Interview #8, p. 9)

Knowing the"rules of the game" manifested itself in the matter of being "in" or "out-of-bounds" geographically. For

instance, one ambulatory patient from a surgical ward was happily entertaining the new mothers on the maternity section by playing the piano for them. This continued until a staff member informed him of the "transgression" and asked him to stay within his own unit.

The notion of "legitimacy of entry" refers to the fact that, upon hospitalization, the patient is confronted with multiple occasions for highly personal contact with other individuals. For instance, samples of secretions are obtained, personal information is elicited and recorded; often there are intrusive procedures in the form of surgical preparation, injections, infusions, examinations and treatments. From data, it was learned that one main factor palliating the necessary unpleasantness was the fact that the individual performing the tasks had <u>legitimate</u> access to the patient by virtue of his role. Comments such as "it's their job," "that's what they are prepared to do" and "they know what they are doing" were liberally distributed throughout the interviews,

> I had a laxative and the doctor said I had to report the results. I felt funny about that but I felt, well, that's what they are here for and that's what I have to do and make the best of it. It was only once and I figured it was over with. (Interview #6, p. 31)

Some subjects reported an attitude of watchfulness enabling them to ascertain the legitimacy of the presence of other persons in their ward or room,

> The first couple of days, I found myself thinking that I had to be alert. Who was it and what were they doing here? It took me at least

> two days to figure out what was happening. Just sit there and see who you really had to pay attention to. (Interview #1, p. 4)

Lack of congruence of role expectations occurs when two or more persons conceive of their own and/or another's role in different ways. One's idea of what "should be" does not coincide with that of the other person.

The lack of congruence was evident in subtle but important ways. In one instance it appeared, from the concern evinced during interview, that a nurse had "gone out of bounds" of her role (possibly as one who "should" provide comfort or enhance ease of mind),

> We (nurse and patient) were having a conversation about normal life and we were talking calmly and everything. Then she asked me what my husband did for a living and I said, "Well, right now, he's not working. We're living on welfare." And she said, "You mean, we're floating you." And that just didn't hit me right at the time. It just made me feel like two cents when she said that. And she came back later to ask if I needed anything and I just said, "No, I don't need anything," and I turned my back just to avoid talking to her. And she probably didn't mean what she said. It just didn't hit me right; I felt bad about being on welfare right now and to have somebody come up with, "Well, we're paying...supporting you." Well, it made me feel worse. (Interview #21, p. 16)

On another occasion, a patient was bathing at a wash basin in the open ward because she thought the bathroom unbearably warm. This did not coincide with the nurse's idea of what "should be,"

> If I took a bath inside I would get so sticky from the heat in that room I would end up feeling like I hadn't washed at all. But we had a basin in the room and I would wash there. And there was one nurse who disapproved and said,

"Oops, taking a sponge bath outside?"
(Interview #18, p. 18)

On the surface such interchange seems minor and inconsequential yet the sense of being "put down" perceived by the patient was a source of discomfort to her.

This section depicts a model of interpersonal distancing. Considered in its main dimensions--purpose, goals, functions and operations--it is broad enough to be applicable to any human interchange. It becomes specific to the hospitalized patient through the incorporation of the four variables. By addition and specification of perceived needs and actions, the model becomes applicable only to the twenty-one subjects of this study.

The goal-directed processes whereby the individual balances his need for withdrawal and retreat with his need for disclosure and communication are: perceiving needs, performing operations and executing actions. They represent the "why," "how," and "what" within the model of interpersonal distancing. Implicit within this triad are the individual's own abilities in assessing situations and in making judgments for action.

The two preceding sections have been directed to "privacy" (Problem #1) and to the processes involved in interpersonal distancing within hospitalization (Problems #2 and #3). In the concluding section of this chapter, an examination is made of the interrelationships of the three aspects of privacy. By this means further insights are gained into the nature of interpersonal distancing and its relationship to privacy within

the hospitalization experience (Problem #4).

Section Four: Discussion of Interpersonal Distancing and Privacy Within Hospitalization

There are three distinct but interrelated forms of interpersonal distancing: privacy of personality, privacy of event and privacy of life style. These forms of interpersonal distancing were introduced earlier in this chapter. They became evident within the subjects' definitions of privacy, particularly in terms of a time-duration category. It is useful now to point out additional categories for the purpose of specifying and summarizing further relationships. Figure 3 is a grid encapsulating the salient features of distancing (vertical listing) as they are manifested within the three aspects of privacy (horizontal listing). There are nine features of interpersonal distancing: 1) subjective awareness of boundary, 2) control of boundary placement, 3) properties of boundary, 4) distance involvement, 5) time-dimension, 6) referent, 7) subjective response to threat (of entry), 8) relationship to the withdrawal/retreat and disclosure/communication continuum, 9) distancing "problems" within hospitalization.

The grid helps point out that the referent "privacy" properly applies to any one of the three aspects of privacy. However, within the population, the cognitive meaning of privacy(when subjects gave a definition or description) was most frequently "privacy of event," e.g. "when I have something to think over, I like to have some privacy." The significant meaning of privacy (the subjective level of importance to the

Figure 2:

The Relationship of Privacy to Nine Features of Interpersonal Distancing

		PRIVACY OF PERSONALITY	PRIVACY OF EVENT	PRIVACY OF LIFE-STYLE
(1)	Subjective awareness of boundary	Usually not within conscious awareness unless threatened or brought into conscious awareness for some other reason	Within conscious awareness	Culturally derived; usually not within conscious awareness until time of threat or decision-making
(2)	Control of boundary placement	Not within individual control	Within individual control	Within individual control to some degree; strongly influenced by cultural bonds
(3)	Properties of boundary	Psychological	Physical and/or psychological	Physical and/or psychological
(4)	Distance involvement	Principally involves psychological distancing from others - may have physical manifestations	Involves physical and/or psychological distancing	Involves physical and/or psychological distancing
(5)	Time-dimension	Indivisible from personal life-span	Determined by nature of event and its participants	Strongly influenced by individual preferences and ability to act on preferences
(6)	Referent	"dignity" "freedom" "self" "privacy"	"privacy"	"reserve" "solitude" "privacy"
(7)	Subjective responses to threat of entry	Highly involved; organismic; coping mechanisms employed	Can vary from minor annoyance to deep involvement	Can vary from minor annoyance to deep involvement

(8)	Relationship to withdrawal/retreat and disclosure/communication continuum	Remains constant throughout all parts of the continuum	Refers principally to being apart from others alone or intimate group; definitely tends toward withdrawal/retreat end of continuum	Propensity toward preferred placement on continuum culturally derived; refers principally to dwelling, geographic location, family constellation
(9)	Distancing "problems" within hospitalization	Most evident here in form of coping (confrontation or avoidance of confrontation)	Little evidence within the population of this study	No evidence (population culturally homogenous with those giving care)

individual) was usually in terms of privacy of personality. This was most evident during occasions when the "self" was threatened in some way,[12] within data, these were the specific events: 1) when the individual could not meet his own or another's expectations, 2) when he could not "make sense" of what was happening to him or around him, 3) when input of information was lacking, untimely or not understood, 4) when there was role-confusion, either within himself or between himself and others, 5) when he perceived self as unacceptable to others, 6) when there was persistent unexplained or unwelcome presence of others, 7) when there was evidence of lack of concern about self from those who "should care." (Conversely, a sense of self-worth and well-being was enhanced: 1) when able to "make sense" of what was happening to him or around him, 2) when he was able to elicit information, 3) when information was voluntarily supplied in an understandable and timely way, 4) when there was a close proximity of others at time of need, 5) when there was encouragement and other evidence of caring from others, 6) when there was evidence of professional capability of those giving care, 7) when his ability to give help to others was commensurate with his desire to do so.)

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[12]Efforts to explore and to understand what is meant by the "self" have been espoused by social psychologists since the early nineteenth century. "Self-concept" has been defined as "that organization of qualities that the individual attributes to himself (qualities referring to attributes as well as to roles). The individual's conception of himself emerges from a more primordial self-awareness. It develops through social interaction which, in turn, guides or influences the behavior of that individual." John W. Kinch, "A Formalized Theory of the Self Concept," Symbolic Interaction: A Reader in Social Psychology (Ed. Bernard Meltzer and Jerome Manis, Boston: Allyn and Bacon, 1967), p. 233.

The referent to privacy of personality was rarely "privacy" but, rather, "dignity," "person" or "self." Most evident to the investigator, however, were voice inflections, affect and other non-verbal clues conveying a sense of being invaded, violated or threatened in some way. (See interview excerpts pp. 59, 60, 86, 87). Thus, it can be concluded that the distancing problems within the hospitalization experience for this population were those directly related to privacy of personality rather than to privacy of event or privacy of life style.

From subject data concerned with interpersonal distancing, there is evidence that the characteristic of withdrawal and retreat specific to privacy of event differ from the characteristics of the withdrawal and retreat specific to privacy of personality. The evidence for this assertion is derived from what the subjects said, the way in which they said it and, also, the retrospective observations each subject made concerning the specific instances of interpersonal distancing. Ten characteristics have been identified:

Withdrawal and retreat proper to privacy of event	Withdrawal and retreat proper to privacy of personality
1. Emphasis is on going to something or someone; seeking out an occasion of being apart from others.	1. Emphasis is on drawing away from something or someone; flight; escape.
2. Often includes an element of calmness and equanimity; internal and external.	2. Often includes an element of confusion, interior and/or turmoil.
3. Usually an absence of fear; subjective comfort.	3. Often an element of subjective fear; discomfort.
4. A sense of interior and exterior equilibrium.	4. A sense of interior and/or exterior disequilibrium.
5. Often an occasion to enhance self.	5. An occasion to protect self.
6. "Tool"	6. "Weapon"
7. Absence of threat.	7. Presence of threat.
8. Elected.	8. Forced.
9. Initiation.	9. Reaction.
10. Compatible with, "blend with" the on-going flow of daily life.	10. A disruptive event in the flow of daily life.

From subject interviews, it was learned that a threat to privacy (privacy of personality usually; privacy of event occasionally) resulted in a defense of boundary. This is compatible with Lazarus'[13] analysis of coping as response to threat. The coping actions identified from data were of two kinds: 1) Confrontation (disclosure and communication) and 2) avoidance of

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[13]Richard S. Lazarus, "Coping and the Process of Secondary Appraisal; Degree of Threat and Factors in the Stimulus Configuration," Psychological Stress and the Coping Process, Ch. 5 (New York: McGraw-Hill, 1966), pp. 151-208.

confrontation (withdrawal and retreat). Confrontation occurred in two forms: A) direct, such as accusation, seeking information from another and seeking definitive help; B) indirect confrontation, such as role-shift, the exclusion of others through physical or psychological means (screening-out), reporting. Avoidance of confrontation occurred in these ways: making excuses for own actions or the actions of others, seeking options, compensating for the actions of others and enduring the situation. It was noted in Chapter IV, p. that these coping acts varied widely as far as level of effectiveness (attaining desired end) was concerned.

In the judgment of the investigator, the deepest concerns over interpersonal distancing occurred in proportion to perceived threat to privacy of personality. Privacy of event did not present a notable difficulty to the twenty-one subjects during their hospitalization. There were definite anecdotal references to privacy of event, such as visitors "being in the way" during the time the patient wanted to get to the bathroom. However, these had the impact of an inconvenience or annoyance rather than the more pervasive and total personal involvement occasioned by threat to privacy of personality.

In conclusion, it may be stated (and noted on the grid) that the three aspects of privacy are similar since each involves interpersonal distance, boundary and a defensive response on the occasion of threat to boundary. There are essential differences, however, in level of awareness of boundary, degree of

control of boundary, time-dimension and relationship to the withdrawal/retreat and disclosure/communication continuum.

Chapter Summary

This lengthy chapter began with a description of the analytical method and emphasized that the research problems were developed and refined through study of the interview data. The second section was devoted to the definition and description of "privacy." Three interrelated but separate aspects of privacy were identified. In section three, the processes involved in interpersonal distancing were specified and discussed through the construction of a model of interpersonal distancing. In this section there was explicit and implicit evidence that all matters of privacy involve interpersonal distancing acts yet, not all subjective concerns about interpersonal distancing were termed "privacy" by respondents. Section four compared and contrasted the three aspects of privacy to the features of interpersonal distancing and related them to the hospital experience as reported by the subjects.

CHAPTER V

SUMMARY

This study evolved from a general interest in the nature of "privacy" as a concept and the way(s) it is understood and dealt with by specific individuals during the period of their hospitalization. It was an investigation undertaken from a theoretical stance which treats the everyday world as a phenomenon, reflecting upon and reviewing experiences taken for granted in the natural stance.

Four problems were developed through the constant comparative method of data analysis. The first problem was directed to the synthesis of a definition of privacy derived from the subjects' discussion of the term and its meaning to them. The act of defining gave rise to a three-fold differentiation of the meaning of the term "privacy": privacy of personality, privacy of event and privacy of life style. "Privacy" was identified as a form of interpersonal distancing. The second problem involved naming and describing the components of interpersonal distancing and demonstrated them through a Conceptual Model of Interpersonal Distancing and the use of illustrative quotations from subject interviews. The model designated comfort as the general purpose for all distancing activity and specified two functions proper to interpersonal distancing: 1) effectiveness in establishing boundary and 2) the ability

to influence another's entry within the boundary. Within the hospitalization experience, four major variables influenced the patients' mode of functioning: 1) mobility; 2) level of consciousness and awareness; 3) the specific character of patient-to-patient relationships; and 4) role perception. The third problem identified the processes whereby the subjects balanced their need for disclosure and communication with their need for withdrawal and retreat. These processes were named and described beneath the headings of: 1) perceived needs; 2) operations; and 3) actions. The fourth problem dealt with the relationship between interpersonal distancing and privacy within the hospitalization experience. Emphasis was directed to the interrelationship of the three aspects of privacy (privacy of personality, privacy of event and privacy of life style) with the nine features of interpersonal distancing (subjective awareness of boundary, control of boundary placement, properties of boundary, distance involvement, time-dimension, referent, subjective response to threat of entry, relationship to the withdrawal/retreat and disclosure/communication continuum, and distancing "problems" within hospitalization).

Findings

The findings of the study contribute to a deeper understanding of the nature of privacy and the relationship of privacy to the hospitalization event. They are summarized in the seven following statements:

1. There are three distinct but interrelated forms of interpersonal distancing: A) privacy of personality, B) privacy of event and C) privacy of life style.

2. "Privacy," in its broadest sense, may be properly used in reference to any instance of interpersonal distancing.

3. Within the population of this study, the cognitive meaning of privacy was directed to "privacy of event."

4. Within the population of this study, the significant meaning of privacy (level of importance to the individual) was directed to "privacy of personality."

5. The subjective "withdrawal and retreat" specific to privacy of event differs essentially from the "withdrawal and retreat" specific to privacy of personality.

6. Within the population of this study, the magnitude of concern in matters of interpersonal distancing increased in proportion to perceived threat to privacy of personality.

7. Threat to privacy, especially to privacy of personality, was met with coping strategies of greater or lesser effectiveness.

The study of privacy from the theoretical stance is one approach to an old problem in terms of the world of meaning--semantic abstraction versus practical experience. Socrates regarded this phenomenon as the "incessant dialectical effort to re-examine ideas in light of their meanings in practice."[1]

In the judgment of the investigator, three principal strengths of this study are: 1) the specification of the three aspects of "privacy in practice," 2) the identification of the four major variables influencing interpersonal distancing within

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[1]Larabee, op. cit., p. 341.

hospitalization, and 3) the emphasis on the significant (practical) meaning of interpersonal distancing. These strengths have their ramifications in terms of nursing care of patients.

Implications for Patient Care

It is unlikely that the health needs of individuals will be free from the intrusive nature of some acts of care. This means that personal boundaries will always be assailed to some degree. However, the quantity and quality of these acts may always be mitigated by the practitioner to present a minimum of threat to the individual patient. Akin to this is the fact that coping strategies, the defense of boundary, may be developed and strengthened. It is within the role of the practitioner to assist the patient to increase his coping skills.

Furthermore, it is possible for the nurse to ascertain, to some degree, the significant meaning[2] of "illness," "hospitalization," "nursing care acts," etc. to the patient. In conjunction with this insight, nursing care plans may be devised incorporating the understanding of significant meanings. This is not a minor task for it entails a practical understanding

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[2]Anthropology contributes to increasing knowledge of a designated cultural group thereby gaining an understanding of how they perceive their universe. Nurses as well as anthropologists are concerned with behavior during health and disease, but can fall into the human propensity to make judgments about others formulated on their own cultural and professional cognitions. Madeleine Leninger, "Ethnoscience: A Promising Research Approach to Improving Nursing Practice," Image, Vol. 3, Nov. 1969, pp. 2-8. Also discussed by Oliver H. Osborn, "Anthropology and Nursing: Some Common Interests", Nursing Research, Vol. 18 (May 1969), pp. 251-255.

of intersubjectivity[3] and a refinement of empathic skills. Often, this can be a painful and exacting role.[4]

Data disclosed, in the form of the four variables, an area of particular vulnerability for the patient. This was the point of juncture between his desire to control personal boundary and his ability to do so. Therefore, attention in the form of nursing care acts, can provide a "bridge" whereby the need is supplied. This may be in the form of doing for the patient, assisting him to help himself or providing opportunity for alternative choices.

The strategic placement of the nurse in clinical as well as non-clinical settings calls for her most refined sensitivity to what, in fact, comprises the privacy of another. This refers to colleagues and associates as well as to the patient. The ways she chooses to use her insights regarding need for privacy will influence in an essential way her acts of care. The nurse, too, is a private person having the need to be allowed (and to allow herself) to step back from her professional role. No one can be "on stage" all the time--the person who can "be himself," enjoying at times the anonymity (privacy) indispensable to human life, can bring an integrated self to public witness in the professional realm.

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[3]For a comprehensive and lucid analysis of the concept of empathy, see Loretta T. Zderad, "A Concept of Empathy," (unpublished Doctoral dissertation, Georgetown University, 1968).

[4]It is an unvalidated thought of the investigator that empathic skills, while available as an integral part of human nature, are not always utilized because of the "cost" in terms of personal discomfort to the empathizer.

Directions for Future Research

There are many ways in which this study might be expanded and/or directed to related areas of research. A few of these possibilities will be cited here. As one example, the notion of "comfort" might be explored in depth. What is it? What are its variations? What does it mean to individuals? How is it attained? How is it lost or diminished? For what reasons is it willingly relinquished? What, if anything, can compensate for the loss of comfort? Frequently, such concepts as "comfort," "care," etc. are employed in discussion with little actual knowledge of what they mean, particularly from a theoretical stance.

Four variables affecting interpersonal distancing within hospitalization were identified during the course of this study. Any one of these might be developed into a discrete research project. "Mobility," for example, could be examined; perhaps a comparative study between a population of persons who have always experienced impaired motor skills with individuals who have recently suffered impairment to some degree.

It was noted in the criteria for subject selection that the population for this study was relatively "homogenous." Future research regarding privacy could be based on aspects of the major variables. One possibility is a project to determine when, how and why the infant or child seeks to be apart from others and how this is dealt with in the social context (e.g. what is the response of parents and other adults to this need within the child?)

The study of privacy in this project emphasized the aspect of "being apart from others" as particular to privacy of event. The converse of this could be a study directed to "being with others resulting in an exploration of the nature of intimacy, the use and meaning of touch or the impact and significance of tone of voice.

Attention might be given to the "problem" areas identified in the study of privacy and the hospitalization experience. One of these problems, in the perception of the patient, was the lack of timely and understandable information. What happens to bring this about? How can it be mitigated or avoided? What is the relationship between what the patient wants to know and what he "ought" to know? These questions introduce a further notion--the realm of the patient's right to know (diagnosis, laboratory reports, etc.) and the attendant psychological and legal impact for patient, family members and personnel.

The foregoing are a few examples of the ideas generated by means of exploratory research. While the methodology has its limitations, particularly those of time and financial investment, it has the undeniable and irreplaceable advantage of remaining close to data and, thus, close to the concerns of those persons (the subjects in particular) sharing the research experience with the investigator.

APPENDIX A

INTERVIEW SCHEDULE

INTRODUCTION:

1. Your stay in the hospital <u>this</u> time.
2. No "right" or "wrong"--your impressions.
3. Answer as candidly as possible; if area you prefer not to discuss, OK.
4. If my questions not clear, ask.

DISTANCE:

1. What was your room arrangement like? Describe. Room accommodations as requested? What would you have liked different? What do?
2. Who has access to your room? For what purpose? Whatwould you have like different about this? What do?
3. Was your door open or shut? Who controlled?
4. When did you need help for things that you would ordinarily do yourself?

eat		ambulate
toilet	(incl.)	treatment/examinations
bathe		phone
dress		grooming

5. What sounds aware of? What do?
6. What odors aware of? What do?
7. What touch/textures?
8. What about heat/light; cold?
9. What did you see that bothered you?

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INFORMATION:

1. When were you asked to talk about yourself? Who? Why? What did you think about this?

   Were there times you <u>wanted</u> to talk about yourself? probe

Were there times you didn't want to talk about yourself? probe

2. What were the times you wanted someone, something, wanted to know about something?

medications
visitors
call light

****

1. What was your main source of discomfort when in hospital?

2. What was your main source of comfort when in hospital?

What would you have wanted different?

3. If you were going to suggest changes about the hospital (about your hospitalization) to someone who could do something about it, what would you say?

4. If you were to be hospitalized again, what would you want different about the experience?

****

PRIVACY:

1. What happened to your privacy when you were in the hospital? probe

2. What improvements could be made to safeguard your privacy in hospital?

3. In what way do you describe "privacy?" Have you a definition? (operationalize--home, hospital)

****

1. Is there anything else you think important about your experience that you can share with me?

APPENDIX B

Eleanor A. Schuster
157 - 3rd Avenue, S.F. 94118
U.C. School of Nursing
A.N.F. Research Project 2-71-029

CONSENT FORM

I, _____, am aware that --

1. The information I give in my interview with Eleanor A. Schuster may be used for a published study.
2. That my name, the names of my doctor and hospital will not be made known in the study.
3. That Eleanor A. Schuster does not represent the hospital but is a graduate student, University of California, and is conducting an independent research project. As such, she is not authorized to report to hospital personnel or to the doctor specific information concerning me or my experiences in the hospital.
4. That this interview is being recorded on magnetic tape.

Date:_____ Signed:_____
Interviewee

_____
Interviewer

APPENDIX C

APPENDIX D

ANALYSIS SCHEDULES

Questions in which the subjects were asked directly about privacy.

1. What happened to your privacy while you were in the hospital?

2. What is your definition of privacy?

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1. Feeling tone or note of concern in response?

2. Sense that privacy was adequate? Why so? Why not?

3. Variations in response to questions
a) privacy needed for what purposes? b) refer to space? c) refer to body? d) refer to information e) refer to confidentiality? f(other?

4. What interfered with privacy? e.g. intrusion

5. What enhanced privacy?

6. What action consequent to perceived breach of privacy?

7. What could be done to further protect privacy (in hosp. situation)

8. In what way was discomfort involved?

9. In what way was information involved?

10. In what way was distance involved?

11. What were the commonalities in the responses?

12. What reference was there to boundary? a) designation b) control c) consequences

13. What reference to entry? a) legitimacy b) intrusion

14. What indications that patient designated "his" space? His equipment, etc.?

15. What means of coping with intrusion or threat of it?

16. What variables influence perception of situation?

17. In what ways do privacy preferences effect others in the given situation?

ANALYSIS SCHEDULES CONT.

Instances in which the subjects speak of information-flow and distance setting.

1. In what context?

2. In what way boundary involved?

3. In what way entry involved? a) other to self b) self to other

4. What activities of the subject regulated distance-setting and information-flow?

5. In what ways related to privacy?

ANALYSIS SCHEDULES CONT.

Instances in which the subjects asked to speak of

1. Main source of comfort in the hospitalization.
2. Main source of discomfort in hospitalization.
3. What they would want different about subsequent hospitalization.
4. What they would suggest to administration to enhance the well-being of patients.
5. What seemed, in the judgment of the interviewer, to rate as "important" to the subject. (level of affect, a volunteered anecdote, repeated reference to the same instance)

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1. What were these instances?
2. What commonalities?
3. In what way related to distance-setting, information-flow?
4. In what way related to privacy?
5. What actions did patient take?
6. What were the outcomes of the action?

SUBJECT INFORMATION SHEET

INTERVIEW #_____

Eleanor A. Schuster
158 - 3rd Ave.
U.C. School of Nursing
Subject Information Sheet
A.N.F. Research Project
2-71-029 5/24/71

(1)_____ Subject Name (2)_____ M F (3)_____ Hospital (4)_____ Unit (5)_____ Room

(6)_____ Hospital Number (7)_____ Doctor (8)_____ Date first Contacted (9)_____ Interview Date (10)_____ Place of Interview

(11)_____ Date Permit signed (12)_____ Min. Length of Interview _____ Footage (13)_____ Number of Tape

(14)_____ Transcriber (15)_____ Date to (16)_____ Date From (17)_____ Subject's Address

(18)_____ Subject's Phone (19)_____ Time to contact (20)_____ Admission Diagnosis

(21)_____ Discharge Diagnosis (22)_____ to _____ Dates hospitalized (23)_____ Number of days

(24) _____ Number of Previous Admissions

(25) _____ Type Room Requested

(26) _____ Type Room Received

(27) _____ If accommodations changed, why?

(28) a) more intrusive: _____ b) less intrusive: _____ c) medical: _____ d) surgical: _____

(29) _____ Patient discharged home or other where _____ phone _____

(30) _____ Insurance Plan

(31) _____ Religion

(32) _____ Marital Status

(33) _____ Number of Children

(34) _____ Who at home

(35) _____ Age

(36) Comments: