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Gender, Power and Practices in Tension:
Mixed-sex Rooming in Hospital

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Beverley Ann Burrell

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Abstract

Using a feminist poststructural framework this study analyses interview reports and the complex contextual elements existing in the uncommon event of sharing one's bedroom space with a stranger of the opposite sex whilst in hospital. Dilemmas of gender sensibility, patients' rights and privacy are evident for the eight women interviewed for this study who experienced mixed-sex rooming (MSR) in New Zealand hospitals. Sex differentiation and gender difference significantly influence the conditions upon which social relationships evolve. This research examines the significance of the category 'woman' and the impact of gender and patient norms, including the foundations on which any objection to MSR might rest. Deconstruction revealed tensions around spatial confines and the operation of institutional power and authority at macro and micro levels. Conflicts between, the rhetoric of health reform, and the practices affecting patients' right to choose, and privacy, are discussed in the wake of the New Zealand health services restructuring of the 1990s and the re-organisation of patient accommodation, marked by mixing the sexes, thereby raising the question of whether gender is rendered somehow irrelevant.

It is concluded that particular interests are served by MSR and that patient concerns risk being neglected where choice is withheld. The exertion of institutional power was found to override some patients' choice. Patient acceptance of the practice is conditional in respect to preservation of their privacy, especially in regard to toileting and washing. Assumptions about gender persist even though mixing the sexes would appear to relegate gender to a neutral state. Recourse to blanket policies is found to be inappropriate when it is individual patients' rights that health professionals are bound to respect.

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1 Introduction

1.1. Presentation of Content

Genders can be neither true nor false, neither real nor apparent, neither original nor derived. As credible bearers of those attributes, however, genders can also be rendered thoroughly and radically *incredible*.

Judith Butler (1990:141)

This thesis analyses anomalies regarding gendered being, practices and power relations for women generated by mixed-sex rooming (MSR) and utilises feminist theoretical debates to discuss the issues. How gender is conceptualised is critical to how people conduct themselves in the social world. Hospitals, as social institutions, bring together the professional and lay in a setting that cannot be divorced from cultural and political influence. Political influence in New Zealand hospitals has involved radical change in the administration of hospitals and the delivery of health care. Many delineations of culture have been characterised by gender difference. Now, in a climate of change, mixed-sex rooming presents a dilemma about the continuing differentiations of gender and how these affect patients and the delivery of patient care. This research addresses whether society's thinking about gender has shifted to the degree that this change in patient rooming appears to suggest.

In chapter two some key dilemmas presented by MSR are identified by recourse to the literature; in this case it is almost exclusively British nursing literature, as mixed-sex placement of patients in general wards is confined to the United Kingdom and New Zealand. There is a paucity of literature pertaining to New Zealand; there has been some public comment through newspaper articles, but an absence of material reporting patients' views. The medical and sociological literature have largely failed to address the topic.

My interest in this area of research grew over several years as I became aware of instances of patients' distress (particularly women) on being mixed-sex roomed in the local hospital.

Conversations with nursing colleagues and members of the public informed me that the practice, though not common, was occurring in other localities and it was rarely what patients expected or felt was comfortable. What interested me was the tension in administrators, on the one hand, maintaining the usual practice of single-sex placement for the majority of patients, yet, on the other hand, defending in the media the occasions they abandoned their usual procedures and placed patients in mixed-sex rooms. This provoked my thinking about how it can be justified that a policy, based in conventions about sex difference, is in place yet can be suspended or dispensed with at times, and how such a shift risks rendering sex difference irrelevant.

Each chapter of this thesis features an introduction outlining the content of the chapter and a summary tracing the key aspects discussed. Following this introduction is a section that overviews features of the New Zealand health system (1.2). This overview gives the context of political and structural upheaval over the last decade which has had marked impact on the health system and health care delivery. The fallout from reform has featured as a significant backdrop to issues illuminated here.

This study also investigates the social process of being MS roomed using theoretical exploration situated in feminist debates about social assumptions and gender differentiation with reference to the 'always-already' (Derrida 1976) sexed body. The applicability of certain theories is assessed in relation to minimising gender differentiation and the regulation of bodies in the public institutions of hospitals. The experiences of eight women illustrate the theoretical points raised by the study. The participants were recruited and interviewed retrospective to their admission in hospital. The participants were drawn from various geographical locations and cover a wide age range. In a qualitative study the deliberate selection of participants relied on several factors, hopefully providing material involving a wide scope of the issues despite a small group. Chapter three details my methodological approach and presents the participants' interview material.

Insights from feminist poststructural writing inform the analysis which is approached in two sections. In chapter four, feminist theoretical frameworks are applied to discussion of MSR

and the body as a site of contestation, and to questions about the centrality of gender to subjectivity and identity. My key theoretical informants are: Elizabeth Grosz (1994), Judith Butler (1993, 1997), Margrit Shildrick (1997), Lynne Alice (1994), Katie King (1994) and Laura Ring (1994).

The fifth chapter investigates the practice of MSR from a perspective of spatial and institutional environments and the uses to which space is put. Geographical theory and bioethics come together in a discussion of power and power relations that is heavily influenced by Michel Foucault's propositions about power and its operation. This thesis is concluded with a summary of the issues raised and an assessment of what it might be that informs and challenges the commitment of stakeholders to their positioning in this complex situation.

1.2. Overview of the New Zealand Health System

This brief discussion of the New Zealand health system is not comprehensive but sets out to provide an overview of significant changes, their philosophical motivation and how restructuring affected patient care. Public confidence in the health system has been in decline over the last decade; the system has been subject to sweeping structural changes and the political agendas of successive governments. Reform of the system has ushered in obvious structural change but confusion over accountability has plagued the rapid change process. John Martin (1997), a commentator who has tracked the reforms, notes that attention to values other than efficiency gains have been lacking. Progressive softening of the radical directions of earlier reform has featured in policy since the mid 1990s (Cumming 1998; Martin 1997). The incoming Labour government, of November 1999, has signalled further reform, committing to work with health professionals and consumers and to restore local governance (King 2000).

The New Zealand health system underwent radical and fundamental changes in the early 1990s. The system was restructured from a service-oriented model to a business-like commercial model. Restructuring was a common feature of reform shared with the public sector throughout New Zealand. Up until this period a model of state and welfare provision prevailed, based on principles of universal access, according to need, to a publicly funded

health service. A radical philosophical shift to the right occurred introducing fee-for-service and commercial principles to public sector activities. A broad political consensus evolved over the preceding decade as successive governments implemented policies aimed at deregulation, decentralisation and privatisation of the state sector (Salmond, Mooney, & Laugesen 1994). Social policy moves paralleled health reform as ideology favouring increased personal responsibility was the impetus for the devolution of social responsibility by centralised government. A growing belief that there was excessive spending and inefficiency in the health sector was a catalyst to implement managerial strategies which shifted degrees of responsibility for health care from the state to individuals by way of strategies such as introducing user-pay charges. Radical reformers proposed privatising the health service as the Health and Related Services Taskforce chaired by Alan Gibbs in 1988 revealed. Although the more radical aspects were not implemented, significant and fundamental change did occur.

In 1993, major reform of the health sector ushered in key changes. Significant features were: separation of the purchaser and provider roles; definition of core health services; establishing separate systems for public and personal health; and integration of funding. Separation of the purchaser and provider roles of the sector entailed hospitals (providers) relinquishing the dual role as purchasers. Purchasing was placed in the hands of four Regional Health Authorities (RHAs), (later amalgamated into one Health Funding Authority (HFA)). The government maintained its role as dominant funder while opening provisions to include the private sector. The philosophy was that competition would encourage efficiency (Malcolm and Barnett 1994). The defining of core health services set priorities which targeted individual entitlement to gain the most overall benefit for the population's health from health expenditure. Establishing separate systems for public and personal health sought to ration health assistance, separating services with individual benefit from those benefiting populations. Integration of funding placed responsibility for purchasing with the RHAs centralising contracting for service provision for geographical districts. The key aim being that competition between providers would improve efficiency (Ministry of Health 1991).

It was claimed several intentions would be realised by the new structure. Cost-benefit analysis strategies were applied to gain accountability for a system assessed as subject to constant failures and inefficiencies (Laugesen & Salmond 1994; Scott 1994). Containment of excessive spending was to be achieved through targeted assistance to low income groups and high users of services. The aim was to reduce the cost of both hospital care and primary care for the state. Application of population-based funding formulas entailed a reassessment of funding based on age-sex characteristics and factors contributing to health status (Scott 1994). The reforms facilitated an enlarged role for private providers across the sector, removing the monopoly status of public hospitals and services such as laboratories and diagnostic services. Escalating pharmaceutical costs were to be contained by the formation of a government purchasing agency (Pharmac) to oversee subsidizing and distribution of pharmaceuticals. Private health insurers featured in an expanding role as those who did not qualify for subsidised care sought to secure future access (Laugesen & Salmond 1994).

Cost containment has remained a major focus throughout the reforms, rationalising of the system has entailed: cost/benefit analysis of medicines and selective subsidising of generic drugs whilst restricting other products; creating, firstly, three tier and, later, two tier system for different levels of subsidy for income brackets, entitlements for the lowest earners and frequent users to protected access; the introduction of in-patient hospital services charges (abolished in 1993, after a public outcry politically damaged the government (Kelsey 1997; Scott 1994); and user part-charges (Scott 1994).

The population based funding scheme involved restructuring activities of the secondary care sector where hospitals were to run on a private sector business model competing with private providers for contested public funds. Hospitals, renamed Crown Health Enterprises (CHEs) signalled their character as business-like organisations. Measures included the introduction of a points systems for surgery to manage waiting lists and achieve equity of access; centralising of services, closure of smaller hospitals, reduction of overall hospital bed numbers and early discharge and the contracting out of services (diagnostic, laboratory, cleaning & laundry) to the private sector.

Generic managers, often with no experience in the health sector, were employed to manage the new structures replacing health professional managers. Health professionals were separated from administrative oversight and had an advisory role only. Collegiality was undermined by competition. One significant outcome of targeting assistance was the growth of the private health insurance industry as those who could afford cover took out private insurance. The Coalition for Public Health, comprising past senior health officials, health professionals, community organisations and unions, was a potent lobby group monitoring the progress on processes and efficiency claims (Easton 1997).

Although there was agreement about the need for reform, public confidence was quickly eroded by the ferocity of the changes. In evaluating the effects of change observers noted that not all the promises were realised. There was strong public objection to the commercial imperatives. A number of the newly appointed CEOs quickly identified the incompatibility of achieving health care delivery with a commercial mandate to make a profit.

Overwhelming public objection to patient co-payments and ongoing condemnation of the 'for profit' model led to the eventual removal of the requirement for CHEs to make a profit (Kelsey 1997). Communities throughout the country mobilised in opposition to the changes and closing of services. Despite the reforms there had been a failure to demonstrate productivity gains; CHEs recorded losses (Easton 1997; Cumming 1998). Failures of the system toward individual patients were exposed in the media. There was an exodus of skilled staff as a shrinking service caused losses and remaining staff were demoralised and stressed under the constraints of capped funding. Public confidence in and international

perceptions of, the system declined (Kelsey 1997). More recently concern has shifted to the disparity of health outcomes for the poor, and particularly Maori and Pacific Islander peoples (Ministry of Health 1999). In parts of the country with growing populations, overcrowding in hospitals has caused extra stress.

The public perception is that the system is under stress and that a competitive model has not served it well. Quality of service, effectiveness of care and accountability have become key foci in assessments of the system (Cumming 1998; King 2000). Quality of care is an aim expressed in current documents and includes 'the freedom from preventable harm to an individual's physical and non-physical well being as a consumer of hospital services.' (Ministry of Health 1998:101). Quality issues are an important feature with relevance to this study.

Statutory obligations about patient care in Aotearoa/New Zealand are outlined in the Privacy Act 1993 and the Code of Health and Disability Services Consumers' Rights, a regulation under the Health and Disability Commissioner Act, 1994. Under the Health and Disability Commissioner Act a Health and Disability Commissioner is appointed whose role is to resolve complaints about infringement of patient rights under the code. One provision relates to the establishment of a consumer advocacy service and, importantly, a further provision is the regulation concerning the Code of Health and Disability Services Consumers' Rights. Clause Two details the ten rights of consumers and the duties of providers.

- Right 1: the right to be treated with respect
- Right 2: the right to freedom from discrimination, coercion, harassment, and exploitation
- Right 3: the right to dignity and independence
- Right 4: the right to services of an appropriate standard
- Right 5: the right to effective communication
- Right 6: the right to be fully informed
- Right 7: the right to make an informed choice and give informed consent
- Right 8: the right to support

- Right 9: rights in respect of teaching or research
- Right 10: the right to complain

These rights, though broad and open to interpretation, set regulatory boundaries for professional practice and sit alongside the codes of practice of individual health professions and their respective registration and regulatory mechanisms.

Since the appointment, in 1995, of the Health and Disability Commissioner consumers have been increasingly made aware of their rights and of what is reasonable to expect of the health service. For the public and interest groups tension persists between perceived commercial goals of reform and consumers' rights to delivery of an adequate health system. Health commentator John Martin (1997:3) notes that the complexity of the system attenuates public confidence, stating, '(C)itizens find it difficult to locate responsibility among the various contractual parties (in the present structure)'. In particular, Martin points out the public need to identify where accountability resides among the abundance of monitoring bodies.

This study is undertaken at a time of intense political debate of contentious health policy including public scepticism of the legitimacy of ongoing changes. The incoming Labour government of November 1999 was elected on promises of further reform to address inefficiencies and inequities in the system. Analysed here, is one effect of radical change as it impacts directly on patient care, how resources are allocated and how hospitals are organised.

2 Literature Review

2.1. Historical Background

A considerable volume of literature has been published in the United Kingdom about the controversial practice of mixed-sex warding (MSW)¹. There are several major aspects to the debate stretching out over 20 years. The discussion comes full circle with the current British government's commitment to end mixed warding in the National Health Service (NHS) (Warner 1998; Snell 1997). It appears this aim will be achieved slowly as funding allows as philosophical commitment is far in advance of the fiscal reality. Patient advocate groups, health professionals and health administrators have contributed to a debate on whether mixed wards provide a therapeutic environ or are contrary to 'therapy'. This debate covers the development of mixed sex provision (MSP) that was intended to mimic society's mix of the sexes under the principle of 'normalisation' in the 1970s. MS provision appears to have proliferated to general settings from its commencement, initially in the specific settings of long stay and rehabilitation areas such as mental health and gerontology. Over time it became more of a customary practice as it suited managers as any available bed, whether in a female or male ward, could be filled. Running parallel in the same time period a second philosophy, or rationale, proposed that patients with similar needs be nursed together irrespective of sex, thus concentrating resources and services for particular groupings of patients, streamlining medical and practical servicing of patients in wards. Later in the 1980s and 90s, when economic considerations increased and pressure on beds swelled, the convention regarding single-sex provision was already relaxed and MSW spread easily to other settings. MSW itself, thus, gained conventional status, although the degree of sharing within facilities varied. MSR has its genesis in the mixing of wards and seems to have mutated as a measure undifferentiated from mixed-warding in much of the literature. The

¹ Mixed-sex warding (MSW) defines ward accommodation where men and women occupy single-sex bays or partitioned areas within an individual ward. This differs from mixed-sex rooming (MSR) where patients of both sexes are placed in adjacent beds without structural partitions. In this study mixed sex provision (MSP) is used to describe either pattern of mixed placement of patients.

A definitive definition of MS facilities is difficult to achieve; due to the variations in building design and layout in many hospitals, the setting of individual wards will alter the experience of people from ward to ward. In older buildings (some 200 years old), the placement of toilet and washing facilities may necessitate the sexes cross paths between sleeping and service areas in ostensibly single-bay facilities.

point needs to be made though, that MSW, has been across the decades, a controversial practice whose contestation is reinforced by contrasting philosophies of 'ideal' care. One question investigated in this study asks why the health bureaucracy has failed to preserve the equally compelling principle of sex segregation, a principle well entrenched in the UK and western societies and still firmly adhered to in private health services and many other areas of society. Economic reasons appear to best explain the increasing growth of mixed-sex warding while evidence persists in the literature of MS provision being anything but therapeutic.

2.1.1. Mixed Provision in Gerontology

Gerontological care is one area where the 'normalisation' principle influenced changes culminating in mixed provision. In this field the transition has been less controversial as residents (no longer called patients) live in facilities which are their home. Recreating a homelike facility is a particular focus of long stay rest homes or hospitals. Separate sleeping areas are maintained whereas day facilities are shared. These facilities usually have a stable staff and resident population, so staff coverage is consistent and does not therefore entail the stresses of acute care settings. This does not mean to say that gerontological care facilities are free from any problems due to mixing the sexes.

2.2. The Impact of the Principle of 'Normalisation'

The history of the introduction of MSW is documented by several authors. In the 1960s and 1970s growing dissatisfaction with outdated, draconian regimentation of the lives of patients, especially the mentally ill, an apparent 'common-sense' approach was taken toward mixing the sexes; that it was 'normal and natural' for men and women to live together (Loten 1975; Batcup 1997). 'Normalisation' describes a mode of patient care that superseded 'institutionalisation' which historically dominated in hospitals. The process of 'normalisation' is intended to replicate as closely as possible the usual environment of the person and to reflect the conditions of the community thereby contributing to de-institutionalisation. The ideology of 'normalisation', which in varying degrees incorporated MSW, gained ascendancy among providers and led to a normative practice, particularly in the delivery of care in mental health services. The convincing premise was that society is

made up of both sexes and that, that mix would also be the best social environment for patients. This idea was widely accepted as 'good practice' (Batcup 1997; Swan 1994; Thomas, Liness, Vearnals & Griffin 1992). Thomas et al note,

(T)he policy of integrating men and women in psychiatric wards has generally been accepted as good practice throughout the UK over the last 30 years....Psychiatrists and psychiatric nurses believed that the practice of separating men and women was outdated and undermined their rehabilitation (1992:58).

This idea gained sway as it was (and still is, in many cases) thought to reflect a 'progressive' approach to care (Batcup 1997).

2.2.1. Querying the Merits of Normalisation

Some dissenters existed to the wholesale application of mixed provision (Feinmann 1988; Nazer 1979). Firm (1995:56) asks what is 'normal' about sharing intimate facilities with strangers of the opposite sex? It seems from the literature of the last 20 years, an absolute measure of proof of harm is required to change the practice, where it is popular; a measure of proof, incidentally, that was never applied to the introduction of mixed provision in regard to its ability to be therapeutic. Although studies were conducted where patients appeared to support MSW, researchers were swayed by majority arguments, often ignoring a sizeable minority of objectors, resulting in staff capitulating to the trend. A further criticism of some studies is that patients were surveyed as current inpatients, a factor that can be seen to skew the findings as patients may well be reluctant to criticize the care they are receiving (Burgess 1994; Cole 1995). Booth (1994) asked elderly patients (admitted to an acute ward) about their being separated by a curtain only but he received no objections. Retrospectively he followed up patients by telephone to gain feedback about their time in hospital and found that MSR was considered by them to be the worst aspect of patients' stay.

2.3. Rethinking Mixed-sex Provision

Over the decades in the UK there have been many complaints at every level of the health service leading to a rethink of the practice (Altounyan 1993; Burgess 1994; Cohen 1992; Feinmann 1988; Nazer 1979; Snell 1997). The Patients' Association (UK) notes MSW features among the 10 most common complaints to their organization (Snell 1997). Burgess

(1994) details a shift in policy from the Royal College of Nurses (RCN) over time. In 1978, the RCN policy statement recommended admitting patients without regard to sex where limited resources restricted space. Later, in 1993, RCN issued guidelines on mixed sex wards highlighting patients' need for privacy and dignity, stopping short of outright opposition but recommending purpose built units or those adapted to retain privacy (Cole 1993).

Two interconnected elements persist in the literature in the mental health field. The first element, is that the presence of women in wards has a calming effect on the men and that men behave better due to the presence of women. Consequently mixed-sex warding has been favoured for this supposed benefit (Batcup 1997; Burgess 1994; Feinmann 1988; Firm 1995; Loten 1975; Nursing Standard 1994; Swan 1994; Thomas 1992). It can thus be interpreted that both the male patients who inhabit a more peaceful therapeutic environment and staff, who have introduced a further variable to the environment that aids the management of disturbed patients, appear to profit. This particular 'benefit' of MSW has had varying responses: continuation of the practice is promoted by some commentators for this 'benefit' and condemned by others for exploiting women, overriding their rights to a safe environment free from negative social effects gender integration produced. The second interconnected element, is that alarming incidences of sexual assaults and harassment have been reported in the literature, identifying MSP as occasioning the opportunity for these attacks (Altounyan 1993; Batcup 1997; Cohen 1992; Copperman 1992; Faugier 1992; Feinmann 1988; McMillan 1992; Thomas 1992). Concerns about sexual assaults arise predominately in the mental health field.

2.3.1. Normalisation Revisited

Critics of the normalisation argument note that, in society, people live intimately with relatives or others of their choosing, not strangers (Burgess 1994). The 'normalisation' argument proffered in defence of mixing the sexes has dubious relevance in medical and surgical areas where therapy does not entail a socialising mandate. The 'normalising' mandate, then, cannot be held to justify MSW in these settings. Stephen Firm (1995) considers the argument redundant in acute mental health wards as short stays preclude

'normalisation' aims, and long stay care is more often than not carried out in the community². As mentioned, reasons for the abandonment of the old single-sex wards in psychiatry was based in an adherence to the principle of deinstitutionalisation, not in itself an unworthy aim, but integration of the sexes within the remaining wards became integral to, and maybe an offshoot of, this process.

A humane relaxing of the rigid routines and controls over patients' freedom and choices within hospital care ought, arguably, to be achievable without putting some patients at risk. Dawn Batcup states that 'Britain is the only country in Europe where patients had no legal right to demand treatment on a 'single sex' ward' (1997:1019).

2.4. Patient Acceptance is Conditional

Concluding her research, Filkins (1987), states the proviso that patient acceptance of MSR provision is conditional. After a trial introduction of a mixed-sex urology ward, Filkins, concluded that MSR was popular with patients and worthwhile as facilities were used optimally. Filkins (1987) was careful, though, to note the conditions necessary for MSR to work. For example, patients received written information about MSR on admission and were asked if they had any objections during the admission interview, and 'channels for comment were well publicised'. She notes, it is 'essential' to have separate toilet and washing facilities. The male patients, who were the minority in this ward, were never left alone by staff and the staff vigilant in monitoring patient satisfaction (1987:43).

However a survey conducted on the new initiative was not unanimous. Approximately an eighth of the sample found mixed rooming inhibiting and over a quarter of the female patients and an eighth of the male patients would have preferred a single-sex ward. The limitations of a survey style questionnaire are revealed with this study. The reader is left not knowing what 'inhibitions' experienced by patients actually means. It might be any number of things, embarrassment or inability to ask questions freely of staff including full disclosure of one's condition or reactions to various treatments.

² Since radical restructuring of the New Zealand health service and the deinstitutionalisation of most long term mental health patients, most hospital care of the mentally ill is acute care.

Cleary and Warren (1998) conducted a study on mixed provision in a Sydney (Australia) acute mental health admitting unit housing twenty-two patients who shared day rooms. Sleeping and ward ablution amenities were separate. Data was collected from ten women in six focus group sessions over an eight-week period. It is unclear how many sessions consisted of the same attendees. The issues arising fell into three categories: environment; gender; and vulnerability. In relation to environment, plenty of space was provided for the numbers housed, quiet spaces and privacy were reported as sufficient. It was reported that patients with 'standout' personalities and behaviours dominated the ward atmosphere. In addressing the gender aspect, the level of integration in this ward was seen as beneficial participants labeled the ward as single-sex due to the separate facilities. Some participants compared the mixed character of the ward to co-educational schooling.

The submission of this comparison allows us the insight that this facility permitted a great deal of privacy for the more intimate areas of daily living. Some male patients were perceived as aggressive and this engendered more apprehension for the women than felt toward aggressive women patients. Patients reported staff responded readily and appropriately to their safety concerns. The open spaces of the ward aided adequate staff surveillance which meant that staff intervened as incidents occurred. Set procedures existed for staff to follow in the case of aggression or sexual assault. Despite the degree of vulnerability expressed in their results, the authors, in supporting MSW, appear to minimise or overlook the fact that the critical ingredient of the success of the ward they studied are, the provision of adequate privacy and a level of staff intervention that assures feelings of safety. Their study reconfirms Filkin's original assertions about privacy and staff support as fundamental to the safety of women in any mixed ward.

2.5. Concern over Safe Spaces

Designating 'women only' areas in integrated facilities is one method of adapting available space and achieving a principle of safe provision (Batcup 1997; MacMillan 1997; Warner and Ford 1998). Batcup mentions the unanimous support by women patients for a 'women only' area in one unit, where the women were vulnerable to harassment and stress in the mixed environment. Alleviating vulnerability was made a high priority in this mental health

unit. Several studies conclude that provision of 'women only' areas is successful and that more women patients than males support the policy. Women report regular use of separate areas where they can relax, feeling safer than in mixed areas, and fewer incidents of harassment and assault are noted (Joule 1995; McMillian 1997; Warner and Ford 1998). These findings override the view that mixed wards are more 'civilised'. Batcup condemns the use of women patients as a 'therapeutic' tool to moderate the behaviour of aggressive male patients.

Another measure suggested is to ensure that same sex staff members are available on every shift. As a practical policy this would be difficult to guarantee as staff quotas are always subject to alteration due to sickness, balancing patient cover and leave provisions (Warner and Ford 1998).

2.6. Contextual Issues Impacting on Mixed Provision

Lucy Burgess (1994) reviewed the literature indicating the major issues and trends in the British experience especially in relation to general hospitals. She documents the tension between the competing needs of hospitals to increase through-put and cut waiting lists (often up to 2 years) and patient complaints about MSW. The Royal College of Nurses (RCN) moved to clarify their position, first published in 1978, that was widely interpreted as being supportive of MSW. In 1993, the RCN published guidelines for nursing practice which sought to set parameters around mixed provision and encompassed both resource issues as well as patient concerns. Consumer groups had persistently ranged between outright condemnation and reluctant support with the proviso that separate toilet and washing facilities exist. The Patient's Charter 1992, a Department of Health (UK) document, while seeking to guarantee patients' right to speedier admission, had a flip side. The guarantees made MSW more common as patients on the waiting lists would be given the option of choosing early admission to a MS ward, if they were disinclined to take that option, then, admission would be deferred until a bed in a single sex ward was available at a later date, patients desperate for treatment are left with a dubious 'choice'.

Burgess 1994, Kettles 1997, McMillan 1997, and Thomas 1992 all state that, women, vulnerable because of their current illness, especially in mental health areas, and often, too, victims of previous abuse or abuse during their stay in hospital, report that being MS warded undermines their safety and recuperation. Warner (1994) makes the point that when mixed-sex warding was introduced in the 1970s greater numbers of staff were employed which enabled more consistent observation and closer security in wards than today's staff quotas permit.

Findings in a study by Pamela Morrison, of a surgical ward in Scotland, conclude that women are more concerned than men about mixed-sex warding and men are concerned they make women feel vulnerable (Wallis 1998). Recognition of the success of 'women only' areas and support for single-sex bay facilities (though sited in mixed wards) both reveal an acceptance that patients feel safer when such provisions exist (Batcup 1997; Burgess 1994; Burgess 1994a; Thomas 1992; Warner 1998). Patient toleration of mixed-sex wards has been largely qualified by the proviso that single-sex and private facilities exist for sleeping, toileting and washing (Editor, Nursing Standard 1994; Page 1995; Snell 1997).

Janet Snell (1997) quotes Stephanie Ellis, the UK Patient's Association secretary, as noting that people find mixing with the opposite sex undermines their dignity. The Patient's Charter states that patients have a right to be informed before arrival at hospital if their admission involves being mix-sex warded and, in any case, they have the right to use single-sex washing and toilet facilities.

2.7. Doubting Therapeutic Value

A complex set of issues surround sexual harassment as it is addressed in the literature in relation to MSW. Batcup (1997) challenges the idea of the actual 'therapeutic' effect of mixed-sex wards, an incongruity exists when, consistently, there have been reports of sexual harassment and sex attacks on women patients. Cleary and Warren (1997) make the point, along with Firm (1995) and Warner (1994), that in placing the principle of 'normalisation' above safety overlooks the fact that in the community (where the principle of mainstreaming

predominates) patients take their place in an integrated society with the freedoms we all share, including choosing where, and with whom, we live. In New Zealand, those under supervised care in the community join a facility only after meeting the other residents and, once a resident, participates in the scrutinizing of would be co-residents. They, thus, have a degree of control over with who they share their lives, unlike a hospital ward. This point is crucial as 'normalisation', as it has evolved in community care, has awarded choice and self determination to patients. This same right to choice and self determination (albeit human right) is removed from hospital patients who do not wish to be MSR. If this same principle of the rights/freedoms of citizenship operated in hospitals many patients would likely choose not to share with 'problematic' individuals.

In the mental health literature researchers have identified the problem of patients not being believed when they report sexual harassment and abuse (Altounyan 1993; Batcup 1997). Firstly, women with a diagnosis of mental illness are placed in a category of the 'mad'. Secondly, within mainstream society, the concept of 'sexual harassment' is not accepted by all as a universally identifiable, or verifiable, phenomena and, therefore, is not always accepted as a damaging, or scarring, event. For example, Altounyan (1993) quotes Professor Brice Pitt, Public Education Director of the Royal College of Psychiatrists who states that, in his 30 years of practice, he has never come across sexual harassment. Yet, he adds that it is 'extremely rare' admitting that it does occur but choosing to diminish occurrences and, thereby, any possible harm. Altounyan reports several instances where staff failed to respond to complaints about unwanted sexual advances covering the range of activity. If there is not recognition of a problem then there will be a failure to address the issue.

Warner and Ford (1998) report on the findings of the Mental Health Act Commission 1996 national visit. The commissioners visited 47% of the acute mental health units in England and Wales where 94% of the wards were mixed-sex (numbering 291). Over half the staff of the 291 mixed-sex wards surveyed in 1996 reported problems of harassment of women patients (Warner, 1998). One aspect of the report related to ward policies and procedures concerning the safety of women patients. Although nearly three quarters of the wards had

policies relating to women's safety only 36 had written policies. The state of affairs begs the question that a verbal policy must be at greater risk of individual interpretation than the written form and therefore agreement upon identification of what counts as an incident, and an appropriate course of action, could be in doubt. Copperman and Burrows (1992), Thomas et al (1992) and Altounyan (1993) conclude that staff training about sexuality and sexual harassment holds a key to making it safer for patients. Cleary and Warren's (1998) Australian study appears to bear this out. Women's complaints in this setting were taken seriously and staff responded to patients' requests for help.

2.7.1. Patients Rendered Silent

Patients report their ability to consult with doctors and nurses about their condition, was affected by being MSR (Benn 1995; Snell 1997). In refusing to acknowledge patients' concerns on MSR, professionals erode the status of the patient as an equal person; a status essential to patients in gaining informed consent, an enshrined right of patients. Informed consent is based on reciprocal sharing of information. If the patient does not feel free and able to ask questions or state their condition clearly, informed consent will not be achieved.

2.8. Discrepancy between Public and Private Health Provision in NZ

The practice of mixed sex rooming highlights a clear discrepancy in the delivery of care between the public and private systems in New Zealand. The long held adherence to single-sex (SS) rooming of patients is an unquestioned practice of patient placement in our private hospitals. Strict observance of this practice is seemingly 'natural' and obvious; patients are never offered the option to select mixed rooming as they might be offered other preferences, such as food preferences, or single rooming or sharing with other patients of the same sex. By its very omission it is being recognized that MSR is not part of running a suitable facility for paying clientele; it is not a mode of patient placement that is considered. Yet the principle of same-sex provision is overridden in the public sector by capitulation to economic considerations over patient needs.

2.8.1. A Comment on Citizenship

This state of affairs raises the question, in my view, of a discrepancy in the rights accorded various patients; all who are citizens (taxpayers) and recipients of publicly funded health. The taxpayer has what they believe to be a contract, that is, to pay taxes and receive a service, in this case, health care. The contract involves an understanding of the standard of that care as outlined in specific New Zealand legislation such as the Health and Disability Commissioner Act 1994, the Code of Health and Disability Services Consumers' Rights, 1996, and the Privacy Act 1993. Respect for individual dignity is enshrined in the Code of Rights in Right 3 and the right to services of an appropriate standard in Right 4. In the case of MSR the interpretation of these Rights varies on each hospitals' method of bed placement. As soon as rights are overridden, or abandoned in favour of some other aim, professionals and health care providers are on a "slippery slope" to breaching fundamental human rights, as the 1988 National Women's Hospital debacle over cervical cancer revealed in New Zealand.

The new economically rationalised approach to health provision has turned the patient into a customer yet disenfranchised patients in the same movement. Equal citizenship is somehow undermined where recipients of public health care suffer compared to recipients of care in private hospitals, and other public hospitals where single-sex provision remains the norm. While only some citizens have access to the private system, all pay taxes and thus meet their obligations as citizens.

2.8.2. Discretion in Management Practices

Sex-segregated provision in New Zealand is the dominant form of housing patients. This style of patient placement retains a 'conventional status'; that is, it is the norm. In the 1960s and 1970s a number of new hospitals were built throughout the country. They were purpose built to provide separate toilet and washing facilities and, although wards would contain both females and males, patients were accommodated in separate four or six bed units. This norm is now disregarded by some hospitals while, in others, sex-segregation as a principle motivates the placement of patients and is taken to be 'natural'; an unquestioned practice that is conventionally observed. At issue is the degree of discretion seized by some

managers in the public sector. While agreeing that single-sex provision is the ideal and preferred these managers still appear to lack the will necessary to prioritize the placing of patients in single-sex rooms. If they genuinely disagree with MSR, yet persist with the practice, then, a contradiction exists in their stated preference for provision and their actual practices.

2.9. Policy and Cultural Assumptions

A heteronormative³ assumption is repeated in the literature by several managers and staff when they state, blanket fashion, that, because some women put on make up and appear to 'take greater pride' in their appearance in the presence of men, all women ought to do the same (Cole 1993 & 1995; Loten and Evans 1975). This stance ignores women who, for whatever reason, are not enamoured of the company of strange men while they are ill. Additionally this may include particular groups, for example, lesbian women, women who may be victims of rape or violence from men and women whose cultural mores dictate sex segregation in care situations. An assumption is made that 'taking pride in oneself' translates into being 'therapeutic'; while it may be good for self esteem it may not be the most 'therapeutic' response when convalescing. A response centred on gaining knowledge about one's condition and rehabilitation is likely to produce an enhanced 'therapeutic' outcome.

One manager, Mark Docherty, Lincoln Hospitals Trust (UK), took the issue further suggesting that a consequence of stopping MSP on principle would necessarily lead to a rethink of the appropriateness of opposite sex visitors in wards (Cole 1995). Responding in this way overlooks the difference between visitor status and short visits compared to patients sharing all daily living activities and treatments in close proximity over long periods of time. The condition of MSR curtails in-patients' willingness to challenge or criticize the status

³ Heteronormativity is a phrase which identifies the collective social structures and forces that have privileged '... heterosexual culture's exclusive ability to interpret itself as society'. And in doing so heterosexual culture assigns (and maligns) others to the category of 'abnormal'. The term refers to more than sexuality alone representing '...a totalized view of the social.. (in which) ... Western political thought has taken the heterosexual couple to represent the principle of social union itself' (Warner 1993:xxi). Hence heteronormativity identifies that '(T)he social realm, in short, is a cultural form, interwoven with the political form of administrative state and with the normalizing methodologies of modern social knowledge' (Warner 1993:xxvii).

quo, as reported by Booth (1994) in a retrospective survey. The possibility of acknowledging that some women feel differently is essentially foreclosed. An alternative response is marginalised by the covert message relayed that 'real women' respond to an integrated ward endeavouring to appear pleasing to men. If such a presentation is not forthcoming are those withholding not 'real women'? Burgess (1994) and Cleary and Warren (1998) note that being vulnerable as an in-patient may prevent women freely expressing negative views of mixed-sex accommodation. Many patients are not able to be assertive, maintaining silence while bearing discomforts and/or do not wish to invite the possibility of compromising their care. The ultimate purpose of hospital is to be therapeutic. Patients have a right to expect the environs, as well as treatment regimes, to be therapeutic. It goes without saying that patient care is of a standard considered therapeutic.

2.10. Summary

The literature assessed in this review presents the range of rationale put forward by health providers who condone and condemn use of mixed rooming. Added to this multiplicity of positions are the views of patients and patient advocates and their attempts to establish and assert their rights in relation to the practice. Although, a range of positions, are covered by published literature, most publications are from the discipline of nursing. A near silence exists in the medical and health administration literature on the practice of mixed provision.

From the justifications proffered, one potent idea underpinning the practice was the belief in 'normalisation' which is linked to the 'progressive' movement of de-institutionalisation. As a sweeping approach to patient placement this position was found to neglect individual patient's needs when, for example, the safety of women patients was overlooked due to the civilizing effect on male patients their presence was said to produce (Batcup 1997; Firm 1995; Warner and Ford 1998). When adopted across the board, the structural and amenity variations in different hospitals lead to vast differences in patients' experience of what is considered mixing the sexes. Patients housed in modern purpose built mixed units do not 'mix' in the same way as those housed in partitioned old style wards. The degrees of contact and character of the contact differs depending on whether sleeping areas, day areas and/or

ablutions are shared (Cleary and Warren 1998). Structural disadvantages were overcome in some areas by the designation of 'women only' areas.

Qualification of patient acceptance of mixed provision rested upon provision of separate facilities. A strength of Cleary and Warren's study is that it echoes earlier studies stating this qualification, as well as noting the importance of access to private spaces. They reiterate that a close and effective nursing presence diminishes vulnerability.

A significant finding in literature from the United Kingdom, is that government policy has now moved to eliminate MS provision from National Health Service. Warner and Ford (1998) report findings of the Mental Health Act Commission 1996 National Visit. One purpose of the visit was to report on the care of women patients. Within this mandate they reported on how many facilities complied with the policy to eliminate mixed provision. Staff training and re-education is a focus of the policy shift. Ongoing lobbying from patient advocacy groups and persistent reports in the media of sexual assaults and harassment could no longer be ignored (Joule 1995; Snell 1997; Warner and Ford 1998).

A sweeping policy that disregards these individual discrepancies can be criticised for not focusing on patient need. Firm (1995) addressed a flaw in adopting such policies when he queried the normalcy of sharing a bedroom with strangers of the opposite sex. He also questioned the infiltration of an idea applied in mental health care and its inappropriate adoption in medical/surgical settings. Over the years, since the introduction of MS provision, conditions have changed sufficiently for reassessment: staff ratios have widened and the average duration of patient stays has reduced. Self-determination is a key concept underpinning both 'de-institutionalisation' and 'normalisation'; self determination for patients is thwarted when choice is not offered. Policy to pursue MS provision on a premise of 'normalisation' is therefore not tenable if choices do not exist for patients, and 'normalising' as an aim is inappropriate. The consistent conformity of the private sector to single sex provision revealed the commitment of sectors of society to the entrenched norm regarding appropriate separation of the sexes.

An instructive finding for my study is the criticism made of inpatient surveys and their inability to accurately gain patients' responses to mixed provision (Booth 1994; Burgess 1994; Cleary and Warren 1998). These authors reported that vulnerability and fears about their future care prevented some patients from disclosing their views.

A recurrent theme of the literature was the debate around MS provision and patient rights. Many instances of invasions of rights to privacy and dignity were repeatedly raised by patient advocates in the literature. Across the sector, interest groups such as professional organisations, policy makers, patient advocates, patients and staff were noted to express concerns about compromises to privacy (Cole 1993; Burgess 1994; Kettles 1997). Intrusion upon privacy contravenes patients' rights under codes of practice. Privacy is a universal right expressed in such codes and individual patient opinion cannot be ignored. From cases reported in the literature any argument to defend a practice which patients state erodes their privacy overrides and discounts patients' views and potentially their rights (Batcup 1997; Warner and Ford 1998).

3 Feminist Research Methodology

3.1. Introduction

Historically in academic disciplines, women's perspectives have been invisible in the construction of knowledge and have been invisible or overshadowed by male-centred perspectives. Feminist research is characterised by the adoption of female perspectives and seeks to illuminate those perspectives and foreground women's experiences equally and alongside men. For example, definitions of work in sociology ignored the contribution of women in the form of housework until researchers in the 1970s, such as Ann Oakley and Dorothy Smith, challenged distorted conceptions that hid women's experiences of work which were less likely than those of men to be in the formal economy (Oakley 1974; Smith 1979). In identifying what may constitute feminist research it is pertinent to avoid a formula or checklist approach. Some enduring factors which feminist researchers do share, form the objectives of, and foundations for, what counts as feminist research. This is apart from the various methods used. Feminist endeavours in theory and research have sought to open a space in which women's issues appear as a central focus of inquiry. Such scholarship has eroded the certainties of knowledge produced in an absence of women's viewpoints. Assumptions were produced which excluded women from the public sphere and, therefore, from cultural representation.

Several feminist authors consider that feminist research needs to be change-orientated as well as being pro-women (Boyce and Armstrong 1989; Mies 1983; Reinharz 1992). In this sense, feminist research becomes a necessarily political process with change to existing conditions an explicit or implicit aim. Politics influences the whole process, that is, from identifying a research question or topic, to the methods chosen in pursuit of findings and selection of the personnel involved. Values and opinions are overt and are central catalysts to the research direction, including making 'gender a fundamental category for our understanding of the social order' (Lather 1986:68).

A further crucial aspect of feminist research is an emphasis on bridging the subject/object divide. The scientific method is secured by an established dichotomy between researched

and researcher. Feminists question the objectivity and neutrality of the scientific method, especially in regard to research concerning women, choosing to acknowledge diverse conceptions of reality (Harding 1987; Flax 1990; Keller 1992). Feminist researchers seek to account for human diversity, to identify and reveal divergences to received theory. Feminist methods have sought to overcome the risk of exploitation of research participants (Finch 1984; Webb 1993).

3.2. Application of Feminist Principles in this Study

This study is feminist in approach, focusing on the distinctive experience of eight women and taking a critical look at existing gender arrangements and assumptions about sex differentiation that provides the conceptual basis of 'gender'. I analyse how current understandings impact on the social and ethical anomalies generated by MS rooming.

Below I explain my methodological approach in two sections. Firstly, feminist interviewing method is outlined detailing the qualitative research process and relationship aspects. The second part addresses the feminist poststructural analytical framework I have applied to the discussion and analysis of the findings.

3.3. Feminist Interviewing Method

The aim of feminist qualitative research, using interviewing, is to reveal the complexity of reality as it is experienced by individuals. Discussing feminist interview research, Reinharz (1992: 34) refers to the ethic of commitment by feminist researchers to their participants and the integrity of the research. The interview method entails a relationship built-up over time. The relationship is sustained through first contact between parties, collecting initial information which determines selection, setting up and conducting the interviews and releasing a summary of the findings to participants. The sustained relationship necessitates trust (Oakley 1981; Roberts 1981). I am accepting, as Middleton (1988: 130) does, that in interviewing adults about earlier events, adult memories and interpretations are 'valid', since my interviewees' perceptions and interpretation of this experience are crucial elements of the event to be displayed. It is what the event of being mixed-sex roomed meant to individual women which is important. Their recollection of the experience illuminated

significant parts, including ambiguity, but the importance attached to circumstances or events by the women is nevertheless revealed. Both the historical and interpersonal contexts affect the narrative produced (Personal Narrative Group 1989:11). The individual sets of information add to the picture gained of issues under scrutiny.

Once established, trust between parties (the researcher and researched) allows reciprocity to develop. The established rapport can have a negative side, for example, researchers need to be alert to the risks of disclosure by the participants who may divulge material they later regret (Graham 1984; Reinharz 1992:280). Webb (1993) discusses the inevitability of the relationship between researcher and researched being one-sided. The researcher has a different status is possibly more highly educated and shapes the final product. There are still paradoxes even when the researcher negotiates what will be included in transcripts; tension can exist in the relating/communicating that takes place (Wise in Webb 1993). If participants are already known to the researcher complex issues may arise or conversely be more readily overcome. Authors vary on this point (Reinharz 1992:26). There can be moral dilemmas raised by the type of relationship, influenced by empathy that may evolve and the type of questioning used (Finch 1984). Examination of the issues mentioned here requires researchers to consider 'whose interests are being served' by the processes and the project (Hall and Stevens 1991).

3.3.1. Qualitative Research Framework

Throughout the research process careful attention needs to be given to detail, especially the circumstances and dynamics of the process (Acker, Barry and Esseveld 1983; Hall and Stevens 1991). Self-reflexivity is the process of revealing the 'decision trails' that have been taken, being aware as researcher to one's own assumptions and values that may shape the finished product (Hall and Stevens 1991). For example, I personally expect it would be a negative experience to be mixed-roomed, so my own values may bring the women's view into sharper focus because of an inherent empathy or, conversely, obscure vital differences, requiring me to be alert to my own position and pre-conceived ideas about the participants' experiences (Cook and Fonow 1986:6). Anne Opie (1989) states the analyzing of text requires detailed assessing of the participant's world, the researcher is involved in a fluid

process, taking into account, her own location within the literature and the personal and political implications of the process. She proposes "disempowerment is linked to textual and ideological appropriation" which is diminished by qualitative methods that, by giving voice, allow silenced groups a public space to be heard (1). In a later publication Opie (1990) mentions the "major reason (participants) took part in (her) research was to make their experience public and therefore a vehicle by which ...their private experiences are open to a more public gaze" (49). Some of my participants expect that an outcome of participation in this study will be that their views will be reported for health officials' information.

3.4. Feminist Poststructural Analytical Framework

In this section, I turn to the feminist literature, to examine which theories might shed light on the social and personal dynamics originating in and from gender that arise in the circumstances of MSR. MSR is a situation where the relevance of being female is minimised in an established social institution of hospitals rendering gender differentiation inconsequential. The categories 'woman' and 'man' are binary classifications that Western culture has thoroughly entrenched and therefore normalised, that is, they are conceptualisations that define our thinking and which we therefore take for granted. In Western thinking, countless inferences ensue from the word 'woman' beyond simple identification of a biological entity. This study examines the utility of some postmodern feminists' theories and their scrutiny of the category 'woman' in search of an efficacious position from which to understand the dilemma of MSR. Given the complex issues found in the literature it is important to clarify the theoretical grounds upon which discussion of the event can proceed. Central to this project is ascertaining whether particular theories clarify the foundations on which women's objections or acquiescence to this practice may rest. To achieve this I have applied theories on subjectivity put forward by Grosz (1994) and Butler (1993). I evaluate their poststructural accounts of a multi-centred and fluid subjectivity and the efficacy of the subject thus interpreted for unpacking and resolving the dilemma. Ascertained then, is, whether their theories are capable of grounding a notion of subjectivity that enables resistance in situations where the implications of an 'always already' sexed body is ignored, that is, in mixed-sex rooming. Their understandings of gender recognise

the asymmetry of power relations underpinning sexual difference as a pivotal concept in both understanding the feelings and responses arising from MSR for women and in resolving the dilemma posed by continuation of the practice of mixed rooming. On the one hand, it can be assumed that biological sex is important, while, on the other, it is necessary to abandon traditional assumptions attached to women's biology. Assumptions where reproductive capacity has determined social status and resulted in inequity, restricted social freedoms for women and having been the basis on which privilege has been bestowed on men. In some instances, for the safety of women, feminist theorists, such as Brownmiller (1976) and Daly (1978), support special recognition of the category 'women' and, in doing so, need to be clear about what it is that is invoked.

Necessary to this project is an examination of the feminist engagement of Michel Foucault's theories of the operation of power, resistance and self-discipline. Foucault's theories on power inform sections in the analysis on governmentality, that is, the working of power in authoritative institutions and in discourses of gender and the status of patients who order their bodily experiences in accordance with such normative structures. For Foucault (1977), power is expressed and exemplified in discourses that govern the bounds of one's position in the social order and especially in regard to subjectivity and gender. To Foucault, though, normative discursive boundaries are not fixed, there is always a provisional and permeable capacity for resistance to the normalising processes. I utilise Foucault's notion of power in analysing the dynamics of the practice of MSR.

An analysis of discourse is central to a poststructural understanding of knowledge. 'Discourse' relates to the dynamic of political ideologies, cultural imperatives and social constructs that appear imbued with the ability to sway individuals, setting parameters of subjectivity itself. Joan Scott (1988:35) defines a discourse as a '...specific structure of statements, terms, categories and beliefs.' Foucault and other poststructuralists, Flax (1990), Butler (1994) and Grosz (1994), articulate that universal underlying 'truths' do not exist. Rather it is via discursive constructs imbued with, and expressive of, power that knowledge is anchored. I propose that discourse is understood as an expression of social relationships, that is, that 'power' and 'text' interplay creating 'discourses'. I therefore have applied

feminist poststructural writings, which maintain that meanings accruing to the material body are always discursively produced and therefore fluid and changeable (Butler 1993; Cain 1993; Grosz 1994; and Flax 1993).

As Chris Weedon (1987) explains, discourses configure various subject positions individuals can 'take up'. The subjectivity of self is always in process, constituting and reformulating according to available discourses. These are multiple and contradictory as varying interpretations of the world are presented. In this study, post structural analysis provides insight into the positioning of the research participants; as patients, as women and as recipients of the health care system. My participants are located in given institutions and subject to cultural, political and philosophical milieu generated by particular dominant discourses. I am interested in the intersecting discourses related to the positioning of my participants as women, in the context of the New Zealand hospitals, which are themselves social entities.

Here I present, briefly, Laura Ring's (1994) examination of social phenomena which illustrates theoretical applications of discourse analysis that clarify my usage of a feminist poststructural analytical framework in the theoretical chapters.

Laura Ring (1994) sets out a feminist analysis of discourses relating to sexual harassment, two aspects of which are pertinent to this study. The first key concept she terms the 'call to gender'. Social encounters can be responded to in keeping with dominant norms, expressed within society day to day or, conversely, an individual's responses can subvert norms. Ring (1994) argues that:

A useful way to interpret the social moment of sexual harassment is as a solicitation of subjects (women) to take on gendered identities. It is a call to gender, a role call of sorts (137).

A call for women to 'fall in line' with the dominant cultural imperative, that is; being an accepting/passive feminine recipient of male advances. Whether or not they are welcome. In Ring's study, she determines her participants (nine women interviewees who had

experienced sexual harassment) responded to harassment across a range of possibilities from fulfilling feminine norms to strongly resisting traditional feminine responses/norms.

Participants who resisted prevailing norms accessed subjugated or resistant discourses, determining Ring's second key concept; the enacting of resistant positions. Participants in Ring's Foucauldian analysis then, 'took up' various subject positions, often multiple and contradictory as Weedon (1987) above, states.

Ring's exposition is a further example of discourse being understood as encapsulating the dynamic of relationships that extends beyond language/text which is but one aspect of meaning-making. 'Discourse' in this thesis is used in the fuller sense to refer to the whole constellation of interplay, deployment and operativeness of meaning-creation and continuous transmission of meaning.

Judith Butler's writing makes a crucial contribution to understanding how 'meaning making' can be understood in relation to the subject. I draw from three of Butler's books; 'Gender Trouble' (1990), 'Bodies That Matter' (1993) and 'Excitable Speech' (1997) in applying her theses to understand the implications of an 'always already' sexed body in the conundrum that is MSR. Butler investigates sex differentiation, positing that femininity is subject to contingencies (culturally prescribed roles and behaviours) which circumscribe our understandings and meanings constituting the category 'women'. Bodies and sex differentiation are discursively produced and act as dominant discursive imperatives. Language is used to assign and mediate understandings of matter by nominating, selecting and devising categories through which matter is then defined.

'Sex/gender' becomes a focus in Butler's project in order to show how we might understand that bodies and gender are socially prescribed and how assumptions about ostensibly recognisable social and gendered roles work to elicit compliance to norms from individuals. The significance which sex difference is awarded in culture, is unequivocally due to the nominating, categorising selectivity of language rather than the essential materiality of bodies. The materiality of a body is never revealed in a 'raw' state; discourse 'prefigures and constrains any use of terms regarding bodies' (Butler 1993:29). Thus the women in the

study have society's mandate(s) for femininity ingrained in their conceptions about womanhood.

The trajectory of cultural thinking which has shaped concepts of sexed bodies over time, has pre-figured the meanings and conceptualisations available to specific bodies. The understanding of the terms 'female/male' and the material body are indissoluble and resolutely bound up with each other. Any attempt to isolate the 'raw' biological aspects from cultural understandings is a lost cause. The 'raw' is 'sedimented' and inlaid with discourses. However, Butler (1993) is not arguing that all matter is cultural fiction. She stresses the concept of materiality but attempts to neither presume nor negate its physicality. The 'sedimenting' of gender on bodies should, in her view and mine, neither limit our understanding of the social construction of biology, nor force us to rely on the viability of cultural assumptions or mores about certain kinds of bodies. This exploration leads to an investigation of identity as crucial to gender. Here, my work is informed by the writing of Diana Fuss (1989) and Lynne Alice (1994).

A further pivotal theoretical aspect to my thesis, considered in chapter five, is an exploration of concepts I am terming the 'corporeality of space'. Here, I am looking at when we, as cultural beings, delineate privileged access, that is, the conditions on which entry by others is accepted into our personal space. Considered are the 'rules' determining access to our space and the 'rules' which govern 'contravention' of that space. That is, when shared social markers in relation to the proximity of others, especially the opposite sex, are recognised and observation of those markers is maintained. Cleary and Warren's (1998) study revealed that the spaciousness of the ward permitted a vista that gave an assurance to the women of their safety as the likelihood of staff intervention was increased by spaces that were open to view. The feeling of safety also depended upon the provision of private single-sex areas. To assist in examining space in relation to corporeality, I draw upon Foucault's metaphor of the panopticon as applied to the plagues and specifically, his usage that relates to the docile and self-disciplining subject. Self-surveillance achieves compliance to dominant social and political discourses. In tandem with Foucault is Benno Werlen's 'action theory' which relates to the human effect on space and the '...corporeality of the actor, in the context of

specific socio-cultural, subjective and material conditions' (1993:3). Taking a lead from Foucault, his action theory posits that power only exists when put into action by a human agent. Space cannot hold any power, save the sense of power that infuses geographical space due to the corporeality of the actor and the material effect of actions and behaviours.

A central theme in this study is privacy and patients' rights to privacy. Privacy and the preservation of privacy is unequivocally bound up with spaciality. Margrit Shildrick's (1997) work offers insights focusing on gender in this section. Pertinent here is that privacy, treasured by the women, relates to immediate physical surroundings and human action within a confined locality. Privacy here relates to bodies in space, the type of bodies, the proximity of bodies and the distinctions of a gendered environment that corporealise space.

The public/private divide is inserted into this debate as MSR (as does hospitalisation in many circumstances) transgresses the usual separation of public/private, where what is usually understood as private and personal is thrust into a public setting.

3.5. The Processes Utilised in this Study

Firstly it needs to be stated that this study is an exploratory study largely for the purpose of an academic qualification and as such is limited in scope by this purpose as well as the limitations of a time frame, these limitations necessitated a manageable project and therefore influenced the number of participants recruited and the method.

The study utilises a feminist interviewing approach involving eight women participants. The aim was to purposefully choose participants in terms of locale, ethnicity, age and representing various categories of health/illhealth conditions. A further criterion was that participants were MSR in hospital for at least an overnight stay. Length of stay in this study ranged from two nights to one month. This type of targeted recruiting, or 'maximum variety sampling' as Morse (1994) terms it, attempts a coverage of the variables which may make the experience different for different women, enhancing the expectation that what is of shared significance for women in this group may also be of significance for similarly identified/positioned women. No attempt is made to generalise findings. A heterogeneous

group is deliberately selected to observe commonalities in participants' views of abstract concepts such as 'discomfort' or 'distress'. This technique also yields high-quality case descriptions (Patton 1990). Yet, as the numbers are very small no attempt can be made to generalise findings in this type of study (Morse 1994, Patton 1990). Patton (1990) states that the intention in maximum variety sampling is to gain 'information-rich' cases for in depth study, cases are selected for the diversity they offer on the central purpose of inquiry. To Patton, two outcomes can be expected from this approach,

- (1). high quality, detailed description of each case which are useful for documenting uniqueness, and
- (2) important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity (1990:172).

Twenty three responses were received to my advertisements. Of these, eight met the criteria for inclusion as women who covered a variety of characteristics, that is, were dissimilar from one another, in accordance with 'maximum variety sampling'. The criteria had three aims, firstly, to achieve a variety sample in that age, ethnicity, urban and rural and medical conditions were different (maximising variety) and, secondly, to ensure the experience of MSR had been of sufficient duration to offer 'information-rich' material and thirdly, to avoid the possibility that hospital admission per se as opposed to MS rooming would account for responses. It was decided to exclude any respondents from my city of residence to avoid the possibility of recognition of cases locally. The criteria adopted are listed below:

- A range of ages
- A variety of medical conditions
- A range of mobility states: bedrest and mobile
- A range of ethnic identities represented
- Women admitted to as wide a geographic selection of hospitals as possible
- MS roomed admission in the last five years that included at least one night's stay
- A previous or subsequent admission with single-sex rooming

From the initial respondents a group of eight women was selected who collectively met most of these criteria. Some responses were from hospital staff members interested in the outcome of the study and thus eliminated as participants. The other respondents did not fit

the criteria or represented an age group already selected. Initially it was intended to have five participants, the decision to include eight was based on gaining a heterogeneous group. All the respondents were pakeha which meant that the criteria for ethnic representation could not be met, while the other criteria were sufficiently met. The ages of the eight women ranged from thirty three to seventy eight years. The MS roomed admissions involved a spread of New Zealand hospitals, large city teaching hospitals and smaller city hospitals, no small town rural units were represented and the admissions were for more than one night's duration. No women from my city of work and residence were included. The intention to gain a variety of medical conditions in the group was successful as the admissions concerned three orthopaedic procedures, spinal injury, breast surgery, investigation of abdomino-gynaecological pain and two cardiac investigations. And the group covered the mobility range, from bedrest to fully mobile. Most had had either previous or subsequent single sex rooming admissions for one of the women the only single sex admission had been previously as a maternity rather than general admission.

Although no attempt is made to generalise from a maximum variety sampling strategy 'information is sought that elucidates (situation) variation and significant common patterns' (Patton 1990:172). Elements in common resulting from similar social experiences are revealed and a certain substantiation of the common elements is gained by the informants being a heterogeneous group.

Retrospective interviewing was the method of choice so any fear of compromise to the women's care is avoided. The design of this study also drew participants seeking recognition of their experiences and this group was more likely to be those who remained dissatisfied with their hospital admission. Participants volunteered, having become aware of the study, as ex-patients, via newspaper advertisements. This method of recruitment served two purposes. Firstly, the participant is clearly a willing volunteer, no coercion can be construed and secondly, exploitation of their status as patient and, as such, a "captive" in the hospital setting is avoided. Recruiting from more than one locality was deliberately chosen to ensure anonymity, masking identities of both the women and the hospitals concerned.

My own positioning is important as researcher and the author of the text which forms this report. I am positioned as feminist, as Pakeha, a nurse in my forties and poststructuralist⁴ in my approach to theory. The design of the study is feminist in character because my commitment to feminism is integral to my approach and choice of topic. I work as a nursing lecturer. I am therefore in the position of being privy to 'insider' information. I have been aware of the usual pattern of sex segregation, in some New Zealand hospitals, being eroded over recent years by my own observation and hearsay from within the ranks of nursing. Due to my association with the local hospital I decided not to include any admissions to that hospital in the study group. This exclusion avoids the possibility of identifying participants by possible connection to myself or my students. The concept of 'insider' is pertinent to the material in this study as my own positioning as a nurse may have determined some of the information offered and/or sought and consequently gained. It would be reasonable to assume I had degrees of knowledge, generally, about their condition. My status as a nurse influenced my selection of the topic, as 'inside' information alerted me to the fact that mixed-sex rooming was of concern and the depth of that concern to some patients.

3.5.1. Collection of Material

Audio-taped interviews from 40 minutes to 1 hour were conducted. Open-ended, unstructured, starter/lead-in type questions allowed the participant to tell their own story in their own words. Any further questions followed-up themes that emerged. The unstructured design prevents the researcher imposing a 'shape' or line of questioning which could presuppose the issues involved (Webb 1993: 421). The women in this study told their stories with eloquence and in detail. Very little prompting was required. Questioning mostly involved clarification about the structural aspects of the setting, checking details such as, where toilet and washing facilities were placed or description of the proximity of beds, entrances or windows.

⁴ Post structural describes the philosophy underpinning analysis in this study as explained earlier. The post structural discourses are 'deconstructive in that they seek to distance us from and make us skeptical about beliefs concerning truth, knowledge, power, the self, and language that are often taken for granted within and serve as legitimation for contemporary Western culture' (Flax 1990:41).

3.5.2. Ethical Framework of Project

Special care was required in planning for the ethical concerns relevant to this project. Three aspects of the project detailed below require explanation in regard to the ethics of the project.

Sample size and recruitment, informed consent

Sensitive Topic

Interviewing

A small group necessitates extra care in ensuring participants' identity is protected. Considering the smallness of New Zealand I recruited from distant localities, avoiding my province of residence. This measure was taken to ensure anonymity and avoid any connection between participants and myself, the researcher and a nurse educator in a centre with a teaching hospital. A second measure, involved participants responding to newspaper advertisements retrospective to their hospital admission, thus avoiding the easy connection of any participant with a particular hospital admission. Possible compromise to anonymity is avoided as concurrent inpatient status may expose participants to recognition. With a group of only eight participants, the likelihood of identification by staff would be greatly increased if recruiting had been from the woman's status as a current patient. The retrospective nature of the interviews and the women's voluntary response to an advertisement separated their involvement with the study from any relationships involved with their care as patients. Any possibility of obligation and/or obstruction, by health personnel is thus avoided. Burgess (1994) Cleary and Warren (1998) note, vulnerability as an in-patient may prevent women freely expressing negative views of MS accommodation.

Participants were offered a choice of location for the interviews, a private space negotiated with an educational institution, public library or their own homes. The majority elected their own homes while two nominated a private space in their own work places. This meant that there was minimum disruption for them as I was the one who travelled and they had control over the setting and the timing.

My participants were informed in an information sheet, before giving consent, of the nature of the study as a masters project and, additionally, of the limitations of a smaller study and of the possibility that publications in refereed journals and/or conference presentations may ensue from the research. The political implications that could follow from this sensitive topic were discussed and participants informed of their right to withdraw from the study at any time.

Participants' right to privacy was assured by the following measures: a private and uninterrupted place to interview was guaranteed; participants were informed that only myself, my supervisor and a transcriber who signs a statement of confidentiality would have access to audio tapes; and the tapes would be returned to them if they wished or otherwise destroyed on completion of the research.

Participants' names would not be used and some characteristics of their story would be omitted or altered to protect their identity, such as actual age, hospital and residential locality.

- Participants' personal and contact details would be stored securely on disk with password-only access. Participants' contact details and transcripts would not be downloaded or saved on the system and the disks securely stored when not in use. All disks would be wiped, and hardcopy versions of the transcripts and audio-tapes would be destroyed at the completion of the thesis, unless participants identified they would like the audio-tape of their interview returned to them.
- All audio-tapes and transcripts would be stored in a locked filing cabinet in my office at home, accessed by myself only, the transcriber having agreed to ensure the confidentiality of all material in their possession and having returned all material related to the project to me.

I am bound by, and accept the limitations of, several Acts in respect of the participants. The Privacy Act (1993) and its requirements informed the procedures taken regarding confidentiality and anonymity. The possibility that health information might be shared, although not directly sought, was considered in planning this study. The Code of Health and Disability Services Consumers' Rights (1996) under the Health and Disability

Commissioner's Act (1994) require health practitioners to respect patients' rights, I provided for matters arising under this code by, firstly, informing participants of the channels for complaints under the Code and secondly, making available the local contact address and phone numbers for the Patient Advocacy Service. I am committed to maintaining confidentiality and ensuring full and informed consent was freely given. This project gained ethical approval from the Massey University Human Ethics Committee.

The possibility of harm arising from the sharing of distressing experiences was considered and as researcher/practitioner committed to advise as appropriate or recommend referral. Any possibility of raising false hope about the impact of this research was minimised by truthful disclosure that any findings, although disseminated via publishing, still depended upon health authorities to consider. Finch (1984) relates that it behoves the researcher to be fully aware and have regard for the sensitive and personal nature of information shared by participants and that a responsibility to advocate for them is associated with this privileged knowledge.

3.6. Participant Profiles

The eight profiles are set out to a format with information that shows the context of each woman's hospitalisation and some demographic data. Each woman indicated whether, or not, they had any prior knowledge about being mix sexed (MS) roomed or if they had ever been single sex roomed in hospital. Six of the profiles are similar in length while two are shorter. Pseudonyms have been used to protect anonymity. Short phrases of actual quotes from the interviews have been used in these accounts, and are indicated by parentheses. In the demographic data of the profiles the women ages are given by decades, spanning the 70-80 year old bracket to 30-40 bracket. 'Relationship status' has been given as some of the women shared information related to their immediate family circumstances. A brief description of the room and fellow patients is provided. The woman's medical condition is summarised briefly, including whether or not the women were mobile or their movement restricted. 'Hospital stay' refers to two matters: firstly, the period of time between the date of the admission and my research interview and secondly, the duration of the MS room admission.

The profile for the woman I have called Karen is an exception compared to the others in that Karen was roomed with another woman patient not a male patient. Karen has been included in the study group as the other woman patient had her husband in attendance 24 hours a day. Both women were on complete bed rest, so Karen was in the constant company of the husband too which, to Karen, constituted being MS roomed.

3.6.1. Eleanor

Age: 70/80 decade.

Relationship Status: Widow.

Hospital Stay: 2 years prior to interview, 3 days duration.

Room: 6 bed unit, shared with 2 men & 2 women.

Condition: Cardiac monitoring, acute admission, total bed rest.

Prior information to MSR: Informed immediately prior to entering room.

Single sex admission: 1x 10years previously & 10days later in same year.

Eleanor was apprehensive about the prospect of being in a mixed room and remains indignant about the experience. As she was told on nearly entering the room she felt no real choice was offered about MSR. She regrets not complaining at the time and recalls feeling 'quite stressed'. She was placed in an overflow ward adjacent to the cardiac ward. Her son saw the advertisement for this study and brought it to her attention, recalling her distress both while she was in hospital and following the admission.

Initially there was one man beside her and another opposite. The man beside her requested to shift closer to the door and then both men were opposite Eleanor. She was relieved to be beside the wall on her right as the beds were 'very close'. She suffered extreme embarrassment at using the bedpan, behind only flimsy curtains. The curtains were too far away for Eleanor herself to pull to 'gain' any privacy. Eleanor did not want to be 'a nuisance' by indicating dissatisfaction. Eleanor recalled that on the last day the room had only women as another woman had requested to shift to a single-sex room and the women discussed how negatively they all felt about MSR. The new woman said she had avoided the doctors' questions about 'the change of life and her periods' in the presence of men. The

women agreed that rooming with men could be a barrier to sharing health information with one another as well as with staff. Eleanor did not want to bother busy staff so chose to put up with it. She holds a very strong conviction that she would refuse to be MSR in the future.

3.6.2. Raewyn

Age: 60/70 decade.

Relationship status: Widow.

Hospital Stay: 3 years prior to interview, 3 days duration.

Room: 4 bed unit, shared with 2 men & 1 woman, ensuite toilet & bathroom.

Condition: Cardiac monitoring, acute admission, bed rest; up to toilet only.

Prior information to MSR: No preparation before entering room.

Single sex admission: 3 months later for 6 days.

Raewyn was admitted after experiencing chest pain and placed in a specialist cardiac ward. She had no warning about being MSR, but understood, on reflection, that only some rooms had the facilities for monitoring. She was 'staggered' to find she had to undress for bedrest with men in the room, the curtains did not meet and were not 'sound proof' and she was extremely self conscious. The men, similar in age to herself, were friendly and 'they put each other at ease', she felt. She was conscious of needing to pass the men to go to the toilet. She remembers it as 'fairly traumatic and very unpleasant'. Several events stand out for her. On the first night a very drunk man was admitted to the bed beside her. He was especially noisy snoring all day and then had a series of visitors. She felt the men monopolised the room by long conversations which excluded her. She had no sleep for three nights. For a short period one other woman was in the room. She had had cardiac surgery. One of the men commented that he could see her chest scar and talked about his wife having had similar surgery. This embarrassed both the woman and Raewyn who considered the comment an intrusion especially as the scar began at her cleavage. Raewyn felt the nurses were 'matter of fact' and did not comment about MSR. Raewyn felt that no choice existed in the situation. She complained 'bitterly' to her daughter about it later feeling it was unreasonable to expect patients with a heart condition to have added stress.

Raewyn had already experienced similar pain which led to emergency treatment. Raewyn is emphatic that she will not accept MSR again.

3.6.3. Jocelyn

Age: 50/60 decade.

Relationship Status: Widow.

Hospital Stay: 3 years prior to interview, 4 weeks duration.

Room: 6 bed unit, shared with men & women, ensuite toilet & bathroom.

Condition: Planned spinal surgery, total bed rest.

Prior information to MSR: Staff asked to place males as beds became available.

Single-sex admission: 4 week stay, later same year.

Jocelyn was initially admitted to a single-sex room for arranged surgery after a six-year wait on the waiting list. She suffered extreme pain related to the surgery. Jocelyn said staff asked the three women currently roomed together 'did we (the women) mind if they brought male patients in?' Jocelyn and one other woman were able to consent. Jocelyn felt that the third woman, who was elderly, 'would not have noticed' indicating the woman's confused state and possible cognitive impairment. The male patients were, in turn, asked if they 'minded'. One male patient (David, who identified as gay) and Jocelyn shared for almost all of her hospital stay while the other patients, both women and men, changed. In all, she shared with about ten other patients over the weeks. All the patients were orthopaedic cases. Jocelyn took a pragmatic approach, stating that her priority was in terms of need and getting expert medical and nursing care. She felt that for economic reasons all wards could be mixed-sex wards with the qualification that those individuals who were not comfortable could have a choice. The degree of camaraderie experienced by Jocelyn (and, she felt, shared by her room-mates) 'lifted you out of yourself.'

Jocelyn compared being MS roomed to brother/sister sharing. She considered that everyone was 'in the same boat', having the same surgeons (as it happened), physiotherapy and similar process of recovery, involving bed rest and bed pans. Jocelyn and her room-mates

overcame any self-consciousness and were empathetic to one another. She reported 'it felt normal', whereas separating the sexes, she felt, was 'shutting people away'. A feeling of support and encouragement developed between this group of longer term patients. They helped each other out. Jocelyn admired the assistance and respect she observed the younger men offered a frail elderly woman patient. For Jocelyn, more than one lasting friendship with other patients and their families evolved from room sharing. Jocelyn remembered the feeling of isolation from her single-sex schooling days and the perception that separation was an artificial situation. Jocelyn perceived mixed rooming as an innovation as she noted some staff, particularly agency nurses, did not seem to be familiar with it or at times approving. Jocelyn noted the attitude of nurses made a significant difference to the atmosphere of the room. Single sex rooming would be a low priority for Jocelyn on any future admission. She said 'I don't think male, female. I think: need'.

3.6.4. Julia

Age: 50/60 decade.

Relationship status: Married.

Hospital Stay: Same year as interview, 5 days MSR out of 9.

Room: 6 bed unit, shared with, 3 men & 2 women window on one side.

Condition: Broken ankle, acute admission, bed rest.

Prior information to MSR: No preparation before entering room, knew of practice.

Single sex admission: 12 months earlier.

Although Julia had had a relative in a MSR two years earlier and thus, was aware of the practice, she did not expect it to happen to her; she was surprised by it. The nurse attending her simply wheeled her into the mixed room and introduced her fellow room-mates. She had no inkling before entering the room. It was treated as a matter of course by staff (with the exception of one nurse who later told Julia she was 'appalled' by it). She felt the philosophy of the hospital was to 'fill beds no matter the sex'. Julia's elderly female relative had been 'freaked out' by mixed rooming and had grown very angry over her two week stay, requesting to be discharged. Julia was nursed on bed rest, her bed was beside the window.

A man in his forties was beside her, a young man in his twenties opposite her and, the others were an older man and two elderly women.

The first morning Julia woke up and she and the man beside her were facing one another, heads on pillows, over what was a short distance. This made Julia feel quite uncomfortable, even intimidated. She did not like the fact of being in her nightie and a man beside her. Julia decided to draw the curtains to attempt to gain some privacy. She did ask if the man minded as she was aware his view of the window would be obscured. He was not bothered so she kept them drawn the whole time. Julia and this patient had a polite rapport; she described him as 'a nice man'. The curtain at the foot of the bed was too far away for her to reach. Julia was frightened by the young man opposite her, he was on methadone and had an orthopaedic condition. This patient had a fixed gaze and appeared to stare in Julia's direction all the time. She said he was 'creepy in the extreme'. He sneakily smoked in the room despite offers by staff to escort him to a smoking area. His demeanor made Julia anxious and frightened.

Julia had to wear a hospital gown which was open down the back. As she sat up most of the time the shoulders of the gown would constantly fall down, making her very self-conscious. Julia expressed it like this: 'I mean, I'm not a prude but I really didn't like that extra sensation that here on either side of me were these two men, and I realised that visitors were surprised that there were men in the room.'

Julia experienced a degree of neglect in the ward. She was not given full bed sponges. On more than one occasion nurses did not help her to complete washing the parts of her body she couldn't reach. She did not clean her teeth for three days as no one offered her a tooth brush. No washes were given after she used a bed pan unless she asked. She said she felt powerless when left by nurses who said they were returning promptly but failed to do so. Her fear of infections was heightened by these oversights. Julia said she had to balance her need 'to have things right' yet avoid 'being difficult'.

One of the men in the room was an elderly Polynesian man with whom Julia empathised as he was obviously very uncomfortable in the mixed room, averting his eyes and replying in whispers to the nurses' inquiries about his passing of urine.

She found it intimidating to go on a bedpan with male patients in the room. Julia talked about a lack of 'visual' and 'sound' privacy. Having to deal with MSR on top of the degree of severe pain she was experiencing was 'added misery' and made the hospital stay 'daunting'. Julia would refuse to be MSR another time. It was quite distressing and 'an unpleasantness that she could have done without.' Julia felt quite unsafe in the ward with the combination of stresses she experienced.

3.6.5. Carol

Age: 40/50 decade.

Relationship status: Married, 3 children.

Hospital Stay: 2 years prior to interview, 4 days duration.

Room: 6 bed unit, shared with 5 men, ensuite toilet and bathroom.

Condition: Spinal injury, acute admission, mobile.

Prior information to MSR: No preparation before entering room, knew of practice anecdotally.

Single sex admission: Maternity only.

None of the staff indicated to Carol that she was to be placed in a MS room. She was placed in a six-bed unit with one woman and four males. Carol had previously heard of MS rooming. When the other woman was discharged Carol was with five male patients for three nights. Her admission was acute, her back pain was extreme and staff commenced a morphine drip. Carol was relieved to be placed beside a window as she could get out of bed on the window side and avoid climbing out on the side facing the man in the bed beside her. To Carol, this was especially crucial as she had to wear the open backed style hospital gown due to the intravenous line in one arm. The gown was too short for her five foot, eleven inch frame. Carol felt particularly vulnerable getting up to the toilet in this semi-dressed state,

wheeling the drip stand, suffering increased pain on movement and trying to hold her clothing about her to maintain any semblance of modesty.

Carol was disgusted by the dirty state of the toilet in her room. At first, she attempted to clean it despite her back but, as it was consistently left in a dirty state, she would walk long distances, in great pain, to other toilets. Carol had a unique reason for being disgusted at the state of the toilets; a family member has an immune deficiency disorder, so Carol was especially conscious to avoid being a vector of disease, and felt at risk from the dirty conditions.

Carol did ask the nurses why the room was mixed-sex. The explanation referred to limited hospital funds and resources as the reason for having mixed rooms. Carol found this strange as most of the rooms she passed were mixed-sex which led her to wonder why some could not have been single sex to give patients an option. She did not complain due to a perception that staff were 'so stressed anyway'. She was acutely aware of the lack of choice and said that was 'pretty defiling'.

Carol kept the curtains drawn all the time, and harboured a feeling of 'meanness' for doing so, aware that the curtains blocked the view for her neighbour. This feeling was outweighed, though, by her need for seclusion as she was very embarrassed, in her state of partial dress, performing her daily living activities and climbing on and off the bed. The curtains provided a degree of privacy for her in a state she described as vulnerable. One aspect which added to her feeling awkward was an inability to maintain her usual state of personal grooming, for example, not being able to wash her hair daily, a state she found 'degrading'.

One of the male patients was covered in tattoos. Carol perceived him as ferocious and felt quite scared. Carol struggled with herself, feeling angry that she was 'sharing' her bedroom and nights, in a room with someone with whom she would never choose to share, on top of being in a lot of pain and suffering nausea from the morphine. This left her feeling further traumatised.

Carol believed that such 'sharing' cut across a norm in our society. To explain, she compared room allocation at business conferences, stating that although conference delegates may twin share with same sex peers, women and men, unknown to one another, would never be asked by hotel proprietors to consider sharing together. Carol elected early discharge. Carol stated it was difficult to be assertive and advocate for oneself while in a vulnerable state due to being in the throes of a crisis, thrust into hospital, and in extreme pain.

3.6.6. Louise

Age: 50/60 decade.

Relationship status: Single (previously married).

Hospital Stay: Same year as interview, 4 days duration.

Room: 6 bed unit, shared with, 3 men & 2 women, ensuite toilets only.

Condition: Breast reconstruction, planned admission, mobile.

Prior information to MSR: No preparation before entering room, refused second occasion.

Single-sex admission: Several days, before and after in same year.

Louise had no prior knowledge about MS rooming. Initially in the six-bed unit, the men were placed all down one side and the women along the opposite wall looking across at each other. For the last two nights Louise was the only woman in the room with the three men opposite. Louise underwent painful surgery for breast reconstruction on the second day. When she needed to go to the toilet the first time after surgery, she was reluctant to get up due to pain, but two nurses insisted they help her walk to the toilet. Louise experienced excruciating pain and could not walk the distance. Her distress was obvious to other patients and their visitors, one visitor quickly placed a chair for her to sit and a nurse then went for a wheel chair as the toilet was down the corridor. Adding to Louise's embarrassment at not managing to walk was a greater embarrassment about her state of partial dress, clothed as she was in only the open-backed style gown, with no pants on. A nurse tried to assist her walking, while, at the same time, attempted to hold the gown closed at the back. Louise was acutely aware that her naked body was visible especially as she was lifted from chair to wheelchair.

Later, the men expressed sympathy and were embarrassed about her plight and inquired later about her condition. At first Louise replied that she had had plastic surgery on her breasts then, as she was aware that may imply she had surgery for cosmetic reasons only clarified that she had had cancer and 'lost both her breasts'. The men showed further embarrassment. Louise's reaction was to feel like crying.

The next day her doctor's consultation took place at her bed side with the curtains drawn. She was acutely conscious that every word could be heard through the curtains. The doctor commented on the reconstruction and attempts to create a defined cleavage and the shape and size of her new breasts. These discussions, which focused on Louise's body and involved her body image and sexuality, made Louise feel as though she was on display. The men were polite and friendly, but Louise had an overwhelming feeling of injustice at these involuntary disclosures which left her very vulnerable and exposed. Louise told of one of the other women patients (admitted to the MS room on the day Louise went home) being asked by a nurse whether or not she was menstruating; this caused the woman obvious discomfort.

After this admission, Louise complained to her surgeon about MS rooming and consultations, and the repeated admissions without proper investigation of her symptoms which also meant she was not believed. He acknowledged the extreme embarrassment she suffered. He accepted she had a valid complaint about the distress that MS rooming had caused and complained to management on her behalf.

As a result of swollen and painful breast implants Louise had numerous readmissions to the same ward in the period between the two occasions she was MS roomed. On these interim occasions she was single-sex roomed. Over this period of time her pain, swelling and high temperatures persisted but doctors failed to identify the cause of her symptoms. After numerous investigations and courses of antibiotics it was eventually acknowledged that the implants were leaking and causing her continued problems. On one occasion she was to be discharged without any satisfactory treatment or relief of her pain and a male friend advocated on her behalf, refusing to take her home until her pain had been addressed.

Seven months after the first episode of MS rooming, Louise was readmitted for further breast surgery, and shown to a MS room again without any prior warning. This room had one other woman, four men (one in his mid teens), and herself. Louise immediately objected and stated she would not stay in that room and that she did not wish to be placed there after her surgery either. At this, Louise said the nurse 'got cross and shrugged' as she left. Louise sat in the day room and refused to go to the MS room for the doctor's examination. The manager arrived and immediately found her a bed with other women.

Louise felt she had been labelled a 'troublesome patient' by some staff. She had discussed matters regarding her treatment and MS rooming with the surgeon who had written a letter of complaint to the hospital on her behalf. Louise felt breast treatment was very personal and she did not want men knowing about it and then feeling she had to socialise with these same male patients. The experience overwhelmed her, it added considerably to her distress, enough for her to make a complaint to her surgeon after discharge and discuss it with the medical social worker. Louise expressed that she felt safe and free from the tensions experienced on MSR while roomed with other women.

3.6.7. Karen

Age: 30/40 decade.

Relationship status: Married, 3 children.

Hospital Stay: 3yrs prior to interview, 13 days duration.

Room: 2 bed unit, shared with 1 woman with her husband rooming-in.

Condition: Neck injury, emergency admission, total bed rest.

Prior information to MSR: No preparation before entering room.

Single-sex admission: 2 previous occasions.

Karen was admitted, after severe trauma from a car accident, and placed in a two-bed room in a spinal unit with a woman who was also on complete bed rest. Karen was hospitalised in a city approximately two hours from her home town. Her husband commuted to visit, after work, as often as he could and at the weekends. She did get visitors but was fairly isolated.

The other woman's husband spent all day and nights in the room. He had a mattress on the floor between the two beds. Karen described the couple as Asian; the woman did not speak English while her husband did. The woman had been an inpatient for several weeks and was near recovery. The husband attended his wife 24 hours a day only leaving the room to buy extra food. There was just one wash basin in the room and this was adjacent to Karen's bed. He frequently washed food utensils in this basin.

Karen found it difficult to achieve any privacy in the room. She insisted on the curtains being used for her intimate cares but was 'told off' by staff for wanting the curtains pulled at other times when she felt like 'some space of her own'. Being on complete bed rest, flat on her back in traction, Karen had to rely on others to pull the curtains; she could not do so herself. Karen was in considerable pain, on pain medication and suffered nausea and vomiting.

The other patient's husband did most of his wife's cares, including toileting and washing. The couple did not pull the curtains for any of the wife's intimate cares or when they shared affectionate moments, kissing and cuddling. The staff pulled the curtains to perform intimate cares for each woman. Karen was an unwilling party to overhearing the other patient's private concerns, (the couple were counselled at the bedside about a possible termination of pregnancy) and Karen was upset on their behalf for this breach of privacy as she heard every word.

The husband used a gas camp stove to cook meals in the room. Every night he cooked at 10 pm and, at about midnight, washed up the utensils in the sink beside Karen. After three nights when she had remained nauseous, in pain and lacked sleep Karen spoke to staff about this ritual. The late night cooking stopped but other daytime meals were still cooked in the room. Karen viewed the cooking as dangerous as well as upsetting her by adding to her nausea; she was not tolerating food well and lost a significant amount of weight over the 12 days of her hospital stay.

Karen's attempts to speak up for herself were met by disdain from the staff assigned to her care. On the night she complained about the cooking, she felt the nurse was 'vindictive', refusing to give her her nightly pain relief and saying that she could not understand Karen's problem with the couple's routines. Karen was extremely upset by this response.

Karen felt like a 'nuisance' to the staff. She was made to feel an 'un-nice person' by staff for attempting to change her situation. She felt belittled by their attitude. Her care required two staff members for turning or toileting/washing. She would often be left for half an hour after requesting help. The worst occasion was when she had her period and needed a pad change. A male nurse attending her suggested a female nurse might be better to attend her on this occasion. Karen was left for two hours before someone came and, by then, needed a full wash and bed change.

The other woman's husband could come and go from the room, he did not attempt a rapport with Karen. Feeling trapped in a room where other people lived out their lives, she compared it to being in someone's living room. Staff never asked the other woman's husband to leave the room for Karen's privacy or cares.

Karen was desperately unhappy and opted for a halo brace to be fitted. This would allow her early discharge compared to staying in the traction for a protracted period. Karen stated that, after getting home, she was incredibly angry about the events of her stay. She would refuse to be roomed in similar circumstances again and would not go back to that hospital. She considered making a formal complaint but has not done so. She has been left with a deep feeling of injustice about her treatment, strong enough to prompt her to participate in this study.

3.6.8 Nicola

Age: 30/40 decade.

Relationship Status: Married, 2 small children.

Hospital Stay: Same year, 3 days.

Room: 6 bed unit, ensuite toilet only, shared with 1 woman & 4 men.

Condition: Pelvic/abdomino pain, acute admission, mobile.

Prior information to MSR: No preparation before entering room.

Single-sex admission: several days, 3 years earlier, general admission

Nicola had heard of mixed sex rooming from social conversations. On admission no staff member informed her that she was allocated a MS room. Nicola was admitted for abdominal investigations in a state of acute pain that was so intense she was crying and 'rolling about in agony'. No staff mentioned the mixed-room or asked if she minded. Nicola was interviewed about her history in the room, behind curtains. The doctor asked permission for students to be present. Nicola tried to speak quietly hoping that everyone in the room would not hear. She felt it was 'incredibly insensitive' to ask about her gynaecological history in the hearing of male patients. She was also asked questions about her urinary tract and bowel routines. The doctor discussed one investigation they could do which would involve an ultra sound and vaginal probe to assist diagnosis. Nicola did not ask for all the information she wanted to know about this test due to the explicit nature of the description and her subsequent consciousness and embarrassment at male patients, on the other side of the curtain, hearing every word.

If comfortable Nicola could get up, she was instructed to drink large amounts and therefore needed to go to the toilet frequently. She discovered the toilet off the room had no lock on the door after she accidentally walked in on an elderly man who was using the toilet. This was very embarrassing for them both. After that incident Nicola walked, pushing her intravenous drip stand, along two long corridors to another toilet. A second reason she avoided the toilet in the room was because it was dirty. Nicola said she pretended to staff that she preferred to walk rather than complain about either MS rooming or about the dirty toilet.

Nicola stated she could not overlook her personal discomfort to be sociable toward the male patients whom she was acutely aware had heard the intimate details of her condition discussed with staff. The man beside her was similar in age to herself and personable, but Nicola was constrained in conversation by her embarrassment. Another barrier to being

sociable was Nicola's consciousness of being in nightclothes, causing a feeling of further exposure. The other woman in the room was not at all sociable and kept to herself. Nicola's husband commented on his shock at her rooming situation and thought it 'terrible'. Nicola was aware of being 'on show' as a young woman and feeling her life was on view, too, as her family visited.

Nicola perceived the staff as defensive. She believed her care could be compromised and she might be labelled as 'difficult' if she stated her problems to staff. MS rooming made Nicola feel constantly uncomfortable. Though she suffered pain walking the long distances to find other toilets she preferred to do so rather than use the ensuite toilet. Nicola would refuse to be MS roomed another time. Although Nicola views herself as an assertive person she regretted not complaining to staff as being MS roomed 'was not conducive to recovery'.

3.6.9. Summary of Profiles

The retrospective study was chosen because of criticisms arising in the literature of deficiencies in inpatient surveys. The benefit of collecting data retrospective to admission, mentioned by Booth (1994), was borne out in the responses gained in this study. The period of time between admission and interview ranged from one month to three years earlier; three of the women had been admitted and MS roomed the year of the interview. Julia, Carol, Karen and Nicola shared a concern that their care might be affected if they disclosed dissatisfaction about their hospital stay to staff. Julia and Carol both asked staff about MS rooming, though stopping short of complaining, but the queries did represent their hesitation about being placed with men. The literature refers to similar concerns expressed by many patients (Booth 1994; Cohen 1992; Warner and Ford 1998). With the exception of Jocelyn, the group said had they been offered the opportunity to be single sex roomed they would have taken up the offer. For the women who favoured single sex rooming, their preference was based around feeling more comfortable sharing with women who shared common bodily experiences as women and being free from dealing with the social expectations of forming a rapport with the male patients when they felt ill and compromised. These women indicated that compromise involved the exposure of parts of their lives not usually disclosed to males they do not know and had not chosen to include in a circle of intimates. MSR

placed one in a social relationship of an intimate nature, beyond the level of acquaintance. Carol and Julia were each roomed with at least one man whose appearance they found intimidating. Firm (1995), Cohen (1992) and Warner and Ford (1998) all condemn the rooming of patients where women (or any patient) does not feel safe or where safety is compromised.

Jocelyn's position differed from the others. She was presented with the choice to MS room and agreed. She appreciated the companionship and the support of room-mates. She subsequently experienced single sex rooming and, for her, this was a negative experience. She was placed with mainly very elderly patients, she considered it being 'shut away'. Jocelyn's experience of her introduction to MS rooming differed from the rest of the study group. Jocelyn was offered the option while none of the other women were. Eleanor and Raewyn both knew that beds for patients needing cardiac monitoring were limited and qualified their partial acceptance in stating that these special facilities were a restricted resource. An initial conclusion can be drawn from the experiences of the group that offering options regarding room placement to patients would seem to meet the various needs of both patients and stakeholders in the rooming of patients.

Lack of privacy was a recurring theme in the women's accounts. Some of these concerns could be common to being a patient per se (for example, receiving bed rest cares and toileting in the company of other patients), while some were specific to being roomed with men. Both Nicola and Louise had ailments that specifically involved their female anatomy and the information overheard and treatments they received drew attention to their female sexuality and bodies in a way that is not usually shared in social settings with men one does not know. The disclosure of health histories, by staff in the presence of male patients, was profoundly embarrassing for both women and they felt a serious breach of their rights to privacy. Carol, Julia, Louise and Nicola all had intravenous therapy and had little choice about their attire; they attributed some distress to being partially clothed in the presence of male patients.

These women all made specific attempts to alter the environs to gain some privacy, either absenting themselves from the room for long periods or drawing curtains to contain the gaze of others. Karen would have liked the movement and freedom to utilise the curtains to achieve some seclusion. Raewyn and Eleanor found being on bedrest cares in the presence of males excruciatingly embarrassing compared to experiencing less embarrassment, though still some awkwardness, whilst single sex roomed. Concern about patient rights and privacy have been persistently emphasised in the literature addressing MS provision and several authors state the integrity of principles of rights are undermined by compromises to privacy (Batcup 1997; Kettles 1997; Thomas 1992; Warner and Ford 1998). Patient advocate groups have constantly petitioned for change to MS provision on the basis of rights to privacy (Cole 1993; Kettles 1997; Royal College of Nurses 1993; Snell 1997).

Julia, Eleanor, Karen, Carol and Nicola shared the common concern about being perceived a 'nuisance' if they stated problems to staff. Linked to this concern is a perception that the hospitals and staff are very busy and that resources are stretched. Karen believed that dismissive and uncaring attitudes by staff toward her were directly due to her assertiveness about expressing concerns and standing up for herself. Snell (1997), Burgess (1994) and Booth (1994) concur that patients' election to remain silent on the issue during their admission, does not indicate how they really respond to MS provision.

Several women commented upon poor toilet facilities. Carol and Nicola commented on dirty facilities in the room and Nicola noted the toilet door did not lock. They both elected to use toilets away from the room to avoid the other patients 'knowing' their elimination needs as well as to access cleaner facilities. Filkin (1987), Page (1995) and Cleary & Warren (1997) conclude from their respective studies that provision of separate toilet and washing facilities are imperative for patients. This criteria could not be met for Eleanor, Raewyn, Julia or Karen who were all on bedrest. As all the rooms, with the exception of Louise's, had ensuite facilities the provision of separate facilities for the sexes was lacking. None of the group reported facilities designated for separate use. The practice in this New Zealand study reveals a difference from the United Kingdom where concerted effort is

applied to achieve separate facilities in line with government policy to end MS warding (Kettles 1997; Warner and Ford 1998).

Most of the women commented that MS rooming was not helpful to healing, whilst Jocelyn did not consider it a hindrance. Carol, Julia, Karen and Nicola reported feeling very angry about being MS roomed, and have complained to family and friends and, in Louise's case, her surgeon, about their distress. Much of their indignation rested on lack of choice.

Stephen Firm (1995) writes that single sex provision is about choice not segregation. The participants in this study support this position. All of the women, including Jocelyn who tolerated MS rooming, agreed that a choice must be offered and no one should be denied the right to choose.

4 Feminist Poststructural Analysis

4.1. Introduction

In this chapter I address the timeless yet pressing issues of gender and sex difference. The sexed body is ever-present and crucially important to one's identity and being in the world. In MS rooming the risk is ever-present that the importance of gendered, or sex differentiated, experiences are manipulated, minimised or disregarded. Although women and men, as patients in hospital, share a certain 'sameness' they differ fundamentally in their experience of the social world as gendered subjects. The practice of MS rooming raises a set of concerns involving relationships, power and gendered being. The idea of being 'room-mates' hides the important sex/gender differences and sidelines those female or male differences compared to the shared elements common as patients. Room sharing implies equality, a 'level playing field' of sorts but the experience of most informants in this study reveals that male and female patients were not necessarily inclined to become 'matey', that is, become friends. The influence (whether implicit or explicit) of 'always already' sexed bodies (those of the women and the men) negatively affected the majority of the informants hospital stay.

To be MS roomed can be likened to being placed in a fishbowl⁵ where the intimacies of life (hitherto performed in the privacy of home or the health professional's clinic) are performed, not only under the monitoring 'eyes' of staff but in the presence of unwitting 'observers' of the opposite sex. The women are subject to certain tensions and expectations due to the influence of institutional-officialdom, as well as their status as 'patient' and their status as 'women'. Being 'fishbowed' foregrounds the women's female identity: it begs a 'moment' of decision about how they will (re)present themselves as women, or perform their gendered being. The 'moment' calls for a reaction that may depend, heavily, on recourse to some repertoire of responses or may demand a creative deployment of responses. Responses may be invested in a familiar discourse of sociality or femininity.

⁵ Being roomed with others of the same sex may well have this quality too, but without the added dimension of gender difference.

In resolving the problematics arising in MS rooming, the pertinence of gender to both subjectivity and agency is scrutinized with reference to theorising by the feminist authors noted earlier in chapter 1, that is, Elizabeth Grosz (1994), Judith Butler (1993, 1997), Susan Bordo (1993), Margrit Shildrick (1997), Lynne Alice (1994), Katie King (1994) and Laura Ring (1994). These theorists draw upon poststructural insights into the operativeness of power, and analyse gendered notions of power and agency discussing how constraints and enablements might be understood. Feminist post structuralism yields an efficacious theory to mount a challenge to the normative constructions of 'women' and 'patient' that have impinged upon, and eroded, individuality in the scenario of MS rooming.

As noted earlier, Laura Ring's discursive mechanism, a 'call to gender', is a helpful tool in theorizing how difference and identity interact within normalizing discursive constructs. The themes of sameness and difference help to elucidate the instances where informants have been made poignantly aware of their own sex difference. Traditionally in Western philosophy, differential assessments of capacity (intellectual, moral, and physical) have been drawn between the sexes⁶. Requisite to unpacking the sameness/difference dilemma is the need to examine the category 'woman'. Its usefulness, as a tool in theorizing a position from which women can speak as acknowledged subjects, is assessed.

'Heteronormativity' refers to the ways in which heterosexuality repeatedly marginalizes the homosexual possibility, and 'heteronormativity' identifies that the normalizing ability of the heterosexual paradigm, to fix and structure Western thinking and social interaction, always asserting heterosexuality as the superior mode of being⁷. Hence its value and utility, as a term, in isolating the automatic multi-focal dominance of the heterosexual mode, including its imperative to participate and sanctioning of those who refuse, identified by Adrienne Rich (1980)⁸.

⁶ See Shildrick Margrit. 1997. *Leaky bodies and boundaries: Feminism, postmodernism and (Bio)ethics*. London: Routledge for an assessment of traditional ethical and moral philosophy and gender. Also Lloyd Genevieve. 1984 *The man of reason: "Male" and "Female" in western philosophy*. London: Methuen.

⁷ For an earlier reference of heteronormativity see note 3, page 20.

⁸ Rich (1980) purported heterosexuality to be 'compulsory' as other sexualities are rendered invisible by the persistent validation of heterosexuality, eclipsing the possibility of any other expression of sexuality.

As I have argued earlier, normalization of MS rooming, and an expectation that mixing the sexes is 'what happens here', was signaled to the women when they were placed in mixed rooms without any prior warning or comment. MS rooming, as has been shown, is a localized practice, happening in a limited number of wards in some hospitals. A much more dominant and persuasive cultural imperative is that referred to by Laura Ring as a 'call to gender' in which discourses of femininity are heteronormative and normatively reproduced. Once entering the MS room, it could be argued that the women were compelled to be conscious of their difference, while their difference was simultaneously ignored and discounted. To the instances of consciousness regarding their difference, affecting how they would relate or respond in the presence of men, I am applying Laura Ring's (1994) theory to the outworking of gender in specific social interaction. Ring claims, in her study on sexual harassment, that the social moment of encounter with men, can be represented as a call to take up gendered identities. The distinction between Ring's work on sexual harassment and this study is that in Ring's research the concept of a 'call to gender' is based in the acts of solicitation in public spaces, whereas in this study the 'call to gender' is located in the encounters with men in enclosed 'bedroom-type' spaces. Responses to any 'call to gender' depend on heteronormative discourses of femininity which have their basis in the category of 'woman' delineated within western philosophy. Some, but not all, theorists⁹ postulate special recognition of the category 'woman' as essential in asserting a response where the implications of an 'always already' sexed-body is ignored.

4.2. Challenging Normative Theories of the Female Body

Feminist discussions of the lived experience of femaleness see the body as irreducible, biologically assigned, ahistorical matter which is significantly differentiated by sex¹⁰. What actually constitutes that differentiation is a matter of dispute between, for example, radical

⁹ For example, for a theorist who reinforces conventional and stereotypical views of femininity see Carol Gilligan. 1982. *In a different voice: Psychological theory and women's development*. Cambridge Mass.: Harvard University Press, while in contrast postmodern author Diana Fuss challenges essentialism outlining the essence/construct divide in; Fuss D. 1989. *Essentially speaking: Feminism, nature and difference*. New York: Routledge.

¹⁰ See Susan Brownmiller. 1976. *Against our will: Men, women and rape*. New York: Bantam, Susan Griffin 1980. *Woman and nature: The roaring inside her*. New York: Harper Colophon and Mary Daly 1978. *Gyn/Ecology: The metaethics of radical feminism*. Boston: Beacon Press for feminist accounts which view biology as the basis of oppression.

feminists and postmodern feminists. The epistemological dispute arises from what, if anything at all, of the social/emotional being follows from the biological core. The debate lies in what it is one may know and how it is that one may know about things corporeal and of things that lie outside of matter. If sex-specific qualities are considered not to be significant beyond their function then sex-differentiation (that is, the process gendering) is a socially acquired attribute. According to Grosz (1994) and Butler (1993) a pre-discursive, or foundational, reality about 'bodies' cannot be known. Instead bodies become understood as the entities discourse creates the 'body' to be. While a pre-discursive materiality exists that is "irrefutable" but indefinable (Butler 1993:xi) our understanding and, hence, experience of our body are a production of dominant, or socially sanctioned, discourses, that is, meanings accruing to the material body are discursively produced and, therefore, fluid and changeable as the historicity of what is 'normal' demonstrates.

Post structural feminists tend to concur that it is in the recognition of a fluid, multi-faceted and participatory notion of subjectivity that an enabling feminism can be based (Shildrick (1997), Fuss (1994), Alice (1994), Cain (1993) and Flax (1993). Fuss notes that the existence of categories ('women', 'men', and 'class') is already a product of coalition politics formed on exclusions. Fuss believes the formation of new coalitions that avoid dependence on such categories is the way ahead for an effective feminism. In similar vein, Cain (1993) refers to relational standpointism; essentially consensus politics, where consensus arises from shared positions/sites and not from biological givens (93). A cohesive position is the motivation for a political stance.

Subjectivity is chameleon-like, not fixed in biology, rather, complex, fluid and changing. Flax (1993) reiterates this position in her work, identifying negotiation as the imperative building block of effective feminist politics. It is necessary to move from the naïve position of looking for universal truths, or 'once-and-for-all' explanations, which are 'out there' and pre-existing. Assuming subjective responsibility, thus, not hiding behind biology as a universal, as though it excuses or causes our commitments. Freedom from normative assumptions about biology as the basis of sexed experiences enables negotiation of coalitions of more equitable standpoints.

According to these feminist authors the fragmentation of subjectivity enabled by post structural origins is to be welcomed for the possibilities of re-inscribing the feminine. Identity politics must be addressed as feminism utilizes its political agency. Fuss (1989:36) notes that politics is 'precisely the self-evident category in feminist discourse - that which is most irreducible and most indispensable'. Making politics, that is, affinities and allegiances, areas of common concern (such as an objection to MSR) are the only grounds from which to lobby as feminists rather than on the basis of a universal notion of woman. Jocelyn, for example, is no less a 'woman' for her tolerance, even enjoyment, of MSR. Strong affinity does exist for the other informants in their indignation about MSR that cannot be said to be sited in identity but rather in accord being reached on this particular issue. The naïve position would be to believe it possible to achieve a universal statement about MS rooming and all women. Whereas shared biology does not offer or determine a position that all women share.

An important element, to examining the sexed subject, which cannot be ignored, is the body. To theorise the behaviours and feelings of those MS roomed and placed in close proximity, it is necessary to address the issue of the 'body' itself and the cultural meanings that are shared, or assumed, about female and male 'bodies'. The mixed placing of bodies appears to dismiss or minimise the actual and social/cultural difference of the bodies. To achieve this I have turned to Elizabeth Grosz' theory of the 'body', analysing how the female body might be recuperated from subordination as a gendered entity. The 'body' cannot be overlooked in a discussion of MSR as the body is not left at the door on entering the mixed-sex room. The patient/subject is embodied. The intimacies of bodily assessment, hygiene and treatment are performed on particular bodies, layered and infiltrated as they are, with multiple meanings and significations. It is in these bodies, laden with social meaning, that the women occupy a position in a mixed-sex hospital room.

4.3. Re-inscribing the Feminine

In her 1994 book 'Volatile Bodies', Elizabeth Grosz offers an exposition of the work of notable western philosophers¹¹ who have constructed and deconstructed the culture/nature binary in relation to the body. She argues that meaning, framed within social differentiation of the sexes, that is, dependent upon the construction of a divide between the feminine and the masculine, has acted as a reason to attribute an undervalued agency to women. Grosz attempts to devise a theory which will recuperate women's bodies from the inevitable subordination of gendered inscriptions of culture and assumptions about what is deemed natural. Her aim is to disrupt normative theories of the body and to explore how the female body might be rethought to overcome the subordination of the female sex. Central to her discussion is that bodies are not simply biological (natural) objects, inscribed by social and cultural modes. There is a materiality which has been socially and culturally represented, producing certain types of bodies with specific culturally-delineated attributes within assumptions about biology. Grosz challenges the ways in which the male body has been construed as 'the norm' of western philosophy¹². A significant concept in Grosz' work is her exposition of 'inscription' and the part it plays in producing 'volatile' bodies. Bodies and power are integrally linked through,

modes of corporeal inscription....bodies are made amenable to the prevailing exigencies of power (1994:142).

Grosz posits that, lived bodies defy being relegated to a fixed natural status because bodies are constantly imprinted by culture, re-imprinted and transformed in, and by, the social discourses which exert influence upon them. To Grosz, modernist, prescriptive 'grand theories' endeavour to contain, and limit, bodies to a binary opposition that privileges the male norm. In her view, bodies escape and defy such encapsulations usurping any bounded

¹¹ Grosz discusses work by philosophers; Gilles Deleuze., Jacques Derrida, Michel Foucault, Sigmund Freud, Luce Irigaray, Julia Kristeva, Jacques Lacan, Alphonso Lingis, Maurice Merleau-Ponty and Friedrich Nietzsche.

¹² For example: explored by Grosz is the Cartesian mind/body split. In this configuration of thought about the person, the mind is elevated to superiority whilst the body takes second place, a move that renders the body perpetually abject. The imbalance between concepts removes any symmetry of the elements of the dyad. One element, the mind, is privileged and valued over the other, the body. This asymmetry was transmuted onto the male/female binary of the sexes: relegating women to a less valued sphere as women's bodies were scripted as lacking in comparison to men's, sidelining women to the realm of the mundane (Grosz 1994:60).

norms, a property (of possibility) that Grosz nominates as 'volatility'. Grosz' disavowal of the existence of a presocial, ahistorical subject with a body cemented in a clearly defined materiality, situates her work as poststructuralist.

For Grosz, western discourse has created an 'ideal' body, a prototype of the white, male body; a creation which favours the male while marginalizing all other bodies (female, coloured or black). As a powerful norm in representation, the 'ideal' relegates all others to a status of lack and inadequacy in comparison. The existence of an 'ideal' sets otherness apart in an unequal division.

Grosz (1994:157) contests the notion of the 'neutered' body proposed by the modern European philosopher, Lingis. For Lingis (1984) it is the social sphere which transforms the body from a state devoid of eroticism or sexually specific responses. Before social imprinting, the body is a pure, undifferentiated set of processes and functions. In Grosz analysis, Lingis' presumption that bodies are 'bisexual', or indeterminate, lead him to proceed with a flawed equation of clitoridectomy with circumcision. The 'annihilation' of women's organ of pleasure is overlooked by Lingis whilst circumcision does not deprive the male of sexual pleasure; it may even enhance pleasure. Lingis fails to perceive the very differentiation his slippage creates. Grosz succeeds in revealing that Lingis fails to render the sex differentiation as irrelevant, showing that such a comparison of terms is flawed. To Grosz, the accurate comparison would be castration and clitoridectomy where discussion would centre on the organs of pleasure. Arguably, Grosz' distinction between the two practices is only valid if one assumes that pleasure is a primary component of sex and being as the capacity to reproduce remains intact despite clitoridectomy as does the reproductive capacity for males remain despite circumcision.

In furthering Grosz' point, though, I argue this example provides evidence of how discourses become invested with power, leading to asymmetrical concepts and biases in knowledge and understanding which, in turn, lead to social inequities. Circumcision and clitoridectomy are represented in many contexts as rites of a similar nature (correlative to the respective sex), that is, as passage into reproductive exchange. As such, they are

conceptualized as similar while denying the fundamental difference between the two acts: one act which preserves the sex/pleasure organ whilst the other act excises the sex/pleasure organ. The discursive formation presenting the concepts as equivalent, hides the *difference*, thereby neutralizing the mutilation of women's bodies. Once rendered neutral, silence cloaks the loss. In effect, the patriarchal discourse, presenting the terms as equivalent, is invested with power/knowledge and privileges its own interpretation over any contrary position. In other words, the definition is created via an asymmetrical binary, a binary in which men have been equated with the mind as privileged while women have been equated with the body as abject.

The asymmetry can, for example, also be identified in Sigmund Freud's early work in psychoanalysis. Grosz points out that in Freud's theorem of the Oedipus complex, the resolution depends upon constituting women's bodies as lacking. The 'lack' for women is always in the shadow of the 'have' attributed to males. Patriarchy is blind to its own saturations and conclusions that are always invested in the masculine. Grosz posits that,

The condition under which patriarchy is psychically produced is the constitution of women's bodies as lacking (1994:60).

Likewise Shildrick (1997) notes Freud's conflation of babies and penises as objects of women's desire revealing a male interpretation of women's sexuality being focused entirely on reproduction. Totally ignored is the part women's erotica performs and that female desire exists beyond maternity. Women's bodies are disfigured by lack, presenting as castrated males (the phallus is absent) and concealed is simply a hole (43).

Firstly, for Grosz, the body is not determining in itself. Sex differences are cultural imposition infusing bodies with fixed possibilities and limitations around sex, colour or class, shaping nature (or materiality) along a culturally created trajectory. Secondly, Grosz claims that, since the body is constantly and culturally produced, it is therefore malleable and pliable and not restricted or contained by culturally assigned difference(s) hence the fixedness of sex difference is dissolved opening new possibilities of reconceptualising the body. Grosz argues that,

[t]here must be some kinds of biological limit or constraint (on bodies), these constraints are perpetually capable of being superseded, overcome, through the human body's capacity to open itself up to prosthetic synthesis, to transform or rewrite its environment, to continually augment its powers and capacities through the incorporation into the body's own spaces and modalities of objects... that supplement and surpass the organic body (1994:187).

In the quote above, we see that Grosz views the physicality of the body as the bottom line, as some sort of constraining influence, although she says the constraint may not necessarily take a pre-set form and is open to varied and multiple transformations. 'Volatility' (a fluidity and stretchability and 'a set of tendencies') describes the openness to change which Grosz claims resists fixedness and constancy (1994:191).

The 'volatile' body is not a neutral surface on which text is inscribed. It matters to Grosz that the body is 'always already' (Derrida 1976) sexed; it matters that materially, the female and male bodies are different and it matters which type of surface is inscribed. It is Grosz' definition of 'volatile' that permits the reader to speculate that tacit to 'volatility' is a form of 'resistance' a point explored further in the section on resistant subject positions. Grosz' work then offers a conceptualisation of the female subject that departs from past assumptions linking the feminine with passivity in an absolute set of differences. Bodies are never self-evident to Grosz, 'volatile' corporeality (embodiment) carries alterity that is 'the very possibility and process of embodiment' which can account for differences, even extreme difference, in how individual women react to phenomena such as MS rooming (1994:209).

4.4. Producing Gender: Discourses of Femininity

Significant in the women's stories is their awareness of gender identity as women. It is important to look at how the asymmetry of the sexes permeates gender production and the prescription of gendered discourses. Gender as a system of discursive formations reproduces, and is a product of, normative categories of cultural representation. Judith Butler's analyses give an important insight into the processes by which this link between the construction of the category 'woman' and normative discourses of femininity can be displayed (1990, 1993). Bodies, to Butler, are constituted through a process of social signification, in line with clearly articulated and recognizable markers. Discourses of

femininity produce markers inserting cultural imperatives that insidiously promote standards to which women are repeatedly compared, and compare themselves.

Judith Butler's (1990, 1993 & 1997) theory of 'performativity' offers insight into how discourses inscribe the subject and proliferate from, and beyond, the speaker.

'Performativity is the living-out and being in process of the subject, a subjectivity amenable to differences, 'not fully determined in advance' yet conditioned upon constraints (1993:94-5). Butler (1990:25) states that gender, for example, is not a noun as such. There is no arrival or completion in being gendered, rather there is a process 'constituting the identity it is purported to be.' In clarification, Butler (1993:107) posits that 'performativity' acts as its own referent 'producing that which it names'. Butler clarifies her use of the term 'performativity' by suggesting that it,

cannot be understood outside of a process of iterability, a regularised and constrained repetition of norms. And this repetition is not performed by a subject; this repetition is what enables a subject and constitutes the temporal condition of the subject. This iterability implies that 'performance' is not a singular 'act' or event, but a ritualised production, a ritual reiterated under and through constraint' (1993:95).

Discourses of femininity extend beyond the subject as meaning disperses beyond any single signification reproducing and reiterating discursive constructs. In the (re)establishing of culturally sanctioned discourses as identifiable patternings, norms are reiterated and repeatedly supported as we as subjects are 'performative'. A restraining and binding effect results for the performer and those interpellated as the impact of participation in a discourse reconfirms the discursive formation. By ritual reiteration subjects become discursive entities, bounded, limited and conforming to dominant modes of thought and behaviour. Female stereotypes are simplified as negative examples yet can show the potency of identifiable discursive formations. The reiteration of norms is productive in the sense that norms are self-fulfilling prophecies and productive in their ability to elicit complicity in self and from others¹³.

¹³ Butler's theory differs markedly from a social deterministic position (biology is destiny). The 'performative' in Butler's post structural writing is anti-essentialist, challenging the essential unity of self, it is that gender and identity are provisional and contested. Gender identity is a discursive and regulatory mechanism (not an attribute of the modernist self) that aids and maintains the norm of heterosexuality. Her claim of provisionality signals an ever present state of change a conditional epistemologically incompatible

Using the example of marriage, Butler notes that the 'pronouncement' of speaking into being the husband and wife unit holds expectations and assumptions already inculcated into the thought processes of the couples and their family and friends. The state of marriage is a well articulated form, individuals have preconceived ideas with which to proceed into it, marriage is 'practised' and, so, patterned in a culture and onlookers hold conceptualisations and expectations of marriage. Those expectations may exceed individual choice, for example, the expectation of children, owning one's own home, monogamy, kinship privileges and responsibilities, all proceed from marriage as a normative institution. It is constraining both legally and conventionally. Legal rights and obligations of kinship awarded (by the state and families) follow from marriage but are denied others who form 'informal' partnerships (de facto or same-sex couplings) even though the parties may have binding legal and financial agreements. The taking and imposing of the husband's name is an act uniquely sited in language, calling into being and creating, linguistically, an identified family unit. On one's commencement in marriage the weight of the discursive formation (the institution of marriage) elicits the conformity it also regulates.

Butler substantiates the operation of the performative as signification, a process by which norms are instituted and at the same time signified. In the citing of a norm, a referent is indicated, an imperative which contains a shared and compelling, regularized understanding, for example, as heterosexuality as the taken-for-granted norm of sexual expression. The shared understandings signalled are/may be loaded with assumptions and, possibly, expectations. Butler (1993) explains,

...(d)iscursive productions..... continue to signify in spite of their authors, and sometimes against their author's most precious intentions (241).

Performativity explains how one might be, in Laura Ring's (1994) words, 'called to gender'. The call is an injunction (a call to fulfill a culturally intelligible identity) that, as it elicits responses to gendered configurations (such as to be a mother), acts as a cultivation of that particular understanding of genderedness. In agreeing with Butler, Ring argues that the

with social determinism's association with essentialism. For further explanation see Butler J., 1990. *Gender trouble: Feminism and the subversion of identity*. New York: Routledge, pp145-146.

construction of gender is both product and process of the subject's positioning in available discourses of gender.

In a potent example of the assumptions around gender in this study about MSR, Karen recounted the interaction when she had her period and a male nurse was looking after her.

I just had to have a pad, no tampons were offered..... those horrible hospital ones they just wedge between your legs, you know, you were lying in muck. One morning with the male nurse on, he said 'Oh, this pad needs a change, it's nicer if a woman does that, isn't it? I'll just slip something under you and get someone.' Well, it was about 2 hours before anybody did (come) and that was just such a mess. I knew I was.... I just needed a complete wash. I despised him for doing that, that wasn't kind to do that to a woman because he was a man, it was better for him to deal with it than say well...(leave me).'

Sensibilities about gender were demonstrated by the nurse in his comment that it was 'nicer if a woman does that' instead of himself. His feelings about the task and his position (as in his ability to opt out and delegate) took precedence over her comfort. He mistakenly assigned to Karen his own sensibilities around gender without offering her choice or ascertaining her actual concerns or physical discomfort. The above exchange took place in the hearing of Karen's female room-mate and the room-mate's husband. Karen experienced an overwhelming feeling of exposure when her womanly processes were dealt with in the presence of the woman's husband only with flimsy curtains offering a charade of privacy. In the light of an analysis of MS rooming, it is ironic that a male nurse, trained professionally to care, should abdicate this task whilst inciting a discourse of gender to do so. In a further irony; a female patient and male relative 'roomed' together are obliged to ignore potent discourses of gender. Yet the nurse's preference to give this sensitive task to a female staff member is consistent with nursing literature that examines roles and gender (Edwards 1998:814). Nursing literature bears out that discourses of femininity and masculinity constrain roles and practice.

Susan Bordo (1993) further elaborates the regulating effect of discourses of femininity, especially the idealization of the female body. Bordo points out that normalised femininity is countered and disrupted in our culture by various modes of being feminine that co-exist and present choices of sorts. Despite apparent 'choices', there is coercion to conform to

acceptable modes of being feminine. So, although a resisting position may be proffered, the conventions of femininity persist. Individuals constantly, but not always self-consciously, participate in self-surveillance, that is, self-check and constantly alter behaviour to achieve normalisation. We are normalised by complicity within hegemonic patterns (Bordo 1993:191) or, as Butler (1990) would say, 'socially imaginable domains of gender'. Foucault credits this effect to the dispersed operation of power. Power does not radiate from a lofty single locus but through multiple insidious filtrations, disparate in origin, and within which subjects are positioned differentially. Individuals' own self-correction and voluntary complicity means material constraints are unnecessary. For example, both Nicola and Carol felt the pull of a style of femininity, characterized by modesty, that encompassed a need to contain their bodies (specifically their breasts) signalled by the feeling that they ought to wear a bra despite being in bedclothes. They felt compelled to be discreet and not permit their specifically female bodies to be displayed in any way incompatible with their usual clothing of the body in the public arena, despite being no obvious hospital requirements that they do so.

As we have seen, in theorising the meaning of the material body and its constituting effect, Butler disputes the conventional view that the material body is referenced as if it were entirely foundational; that matter is attributed with an 'itness' that is somehow unquestionable. For Butler, understanding of the 'itness' of bodies is always acquired via language, since it is the vehicle by which attributions, corporeality and function can be 'known'. Thus, language assigns and mediates understandings of matter, by nominating, selecting and devising categories through which matter is then defined.

4.5. Sexing the Subject: Identity

MS rooming creates a circumstance that challenges norms and assumptions about the place of gender and how we might dissolve, respect or adhere to social demarcations based in sexed categories and the accompanying practices regarding the treatment of women and men. Central to addressing this challenge is analyzing the status of the sexed subject and the meanings of 'being sexed'. In the following section I detail Judith Butler's concepts which set out her theory of persons as sexed subject commencing with her analysis of the

acquisition of knowledge in the production of the subject. This discussion depends upon the post structural concept that sexing the subject is open ended and constant. Integral to the above are Butler's notions of coherency and deviations from apparent coherency within sexual identity. Lastly, the crucial notion of agency is elaborated in relation to the issue of MS rooming.

Butler's (1993, 1997) work invokes the Foucauldian (1980) twin concepts of power/knowledge as she discusses the interplay of 'constitution and constraint', 'constitutive' being similar to 'knowledge' and 'constraint' (regulation) being similar to the operation of 'power'. Central to a Foucauldian concept of power relations, is the inextricable role of power in the production of knowledge. To Foucault (1980), a circular interdependency functions, between any claim to a 'truth' and then the self-same 'truth' as the foundation upon which exercise of power (or the establishment of a power-hold) rests. In this way, privileged forms of knowledge gain ascendancy; maintaining and asserting a position of power through the conditions of rationalization/justification of a 'truth', a self-promulgating cycle of power/knowledge (McHoul and Grace 1993). Historically, the power bases shift on the justifications and persuasions of many knowledges, as shifts across time and the circular interdependency of power/knowledge is mediated. Foucault cites the nineteenth century as a time characterised by the replacement of diminishing religious authority over western European peoples with the hegemonic rise of science and medicine as persuasive systems of thought that filtered knowledge and became universal lenses on the world. For Butler, as for Bordo (1993) and Grosz (1994) the subject is always in process and never completely constituted. The subject is propositioned by established configurations of discursive formulations (such as modes of femininity). In sexual identity formation, one is constituted by claiming one's sexed place within language. The recognition of an identity signals boundedness, patterns prefigure and configure the subject, that is, the legacy of an identity foreshadows and delimits the very possibilities of identity. An intelligible entity is articulated and reiterated; signifying and signified. Intelligible, as it signifies a recognizable referent, resignifying and reiterating its own institution. Intelligibility depends upon constraint to exclude shades of difference which would taint the subject's readability, so the subject is produced/constituted but in that very constitution lies constraint and prohibitions

in which power works to exclude other possibilities (Butler 1992; 1993). Butler credits language with the power of pre/proscribing 'types' or 'norms' which are directive and constraining, while all the time a fluidity co-exists with constraint. Performativity is the living-out and being in process of the subject, 'not... determining it fully in advance' Butler (1993:95). With the institution of a norm, the exclusions created become the abject and unsanctioned elements/possibilities.

The work of Butler and Grosz connects on this conception of the subject. As MS rooming appears habitual (and thus, normalized) in some settings, the position of the objector becomes the unsanctioned (abject) position relative to those who comply with (including the staff who carry out) MS rooming. MS rooming is a contested practice, not always consistently applied, as such it can be seen as a tentative norm, though as mentioned earlier where the practice is habitual and common-place it is, then, a localized norm/practice. I explore below how Butler's work delves into contestation, boundary formation, and the tension between conformity and dissonance in relation to practices and subjectivity. Her theory sheds light on the tension of competing discourses the women had to negotiate in dealing with MS rooming.

Characteristic of 'performativity' is that it acts as its own referent. Butler notes that,

Discursive performativity appears to produce that which it names, to enact its own referent, to name and to do, to name and to make (1993:107).

In clarification of this concept Butler uses the example of the dominance of the heterosexual norm. She notes that sex is instituted as a binary, spoken (coded) into being and the binary is then enacted in how sex is understood (decoded). As a set of normative assumptions, heterosexuality is entrenched and coded as a bifurcated configuration that precludes any other way of understanding 'normal' sex. Lesbian, gay, intersexed and bisexual persons are thereby relegated to the abject as unsanctioned identities, regarded as deviant by the power and exclusiveness of heterosexually-privileged discourses. Constraint is, thus, the boundedness and regulatory capacity of a norm. For Butler, 'performativity' is contingent upon constraint in the sense that performativity constantly exposes regulatory processes,

reiterating and deconstructing their seeming demand for conformity (94). Constraint operates as a mechanism of a sanctioned discourse, regulating subjects and subjugating the inadmissible possibilities. In complying with constraints of a dominant discourse, subjects are 'normalized'. When operating in dominant discourses, subjects are constituted and reiterated 'pre-figuring and constraining' their agency (Butler 1993:29). On being MS roomed the women faced the competing constraints of dominant discourses; discourses regarding modesty and female embodiment and common justifications for separation of the sexes were at odds with traditional compulsions on patients to be compliant within a large and economically embattled hospital environment.

Significant in Butler's work is her constant interrogation of categories. MS rooming provides an instance where the ground is shifting under rigid boundaries of sex segregation, confronting long held norms and necessitating the renegotiation of gender identity. Although Butler habitually states a category she never overlooks the outcast elements created by the very act of imposing a category. In counting certain characteristics/elements as belonging to a category, other characteristics do not belong and create an 'outside', characteristics which are redundant to the category, but exist as a site of difference or contest. Nealon (1994:1) states that Butler applies this 'relentless dual focus' to effect, permitting the reader insight into the always becoming of the subject and it is in this fissure between normalized constructions and their 'outside' that agency acts to produce the ever formulating and reformulating subject. To Butler, the decision point between 'repetition' of norms and action rendering the category' ...redundant...is the space of agency' (1997:129). The boundaries around a category, then, are penetrable and leaky so it is in this 'space of agency' that the subjects of MS rooming negotiate their sexed subjectivity.

Butler addresses the question of coherence within sexual identity to reveal the instability of categories. Heterosexual identity is a hyperbole (Butler's word) for what stands for 'real men' and 'real women'. The identification, and exclusion, of the 'unreal' delineates the category of the 'real'. Butler explains that sets of binding descriptors mark out gender

coherency¹⁴. The body, once named, is to become what is named and known by that name. In possessing coherency, identity and subject coherence are bound to their recognised framing, to the exclusion of unstabilising elements that would render the concept doubtful or fluid. Yet the category can be broad, admitting variation and flexibility. Coherent identities speak exclusion into being by the establishment and maintenance of norms and categorization. Coherent concepts, to Butler, are constraining in themselves; coherency indicates an ideal, a concept that restrains ambiguity having transparent markers permitting a shared knowing (Butler 1993). Boundaries are imposed by the acknowledgement of coherent discourses, demarcating range and scope, and distinguishing particularity and constituent elements, thus, presenting a readable discursive construct.

An intermeshing of female identity and mothering is reinforced in multiple ways to women. The mother figure is an identifiable conceptual frame possessing a certain coherency of its own. Nicola and Jocelyn spoke of falling into a support role for others in their respective rooms. In the instances they recounted it appeared the roles they took expressed mothering. For Jocelyn, as a long-term patient, other patients' relatives enquired of her about their relative's progress. It became a pattern for her to take mental note of doctors' visits and report the events concerning their relative. Nicola told of the wife of one male patient who would refer to her about their relationship and the stresses of illness. Nicola reluctantly filled this role of pseudo counselor, feeling it an intrusion but responding to the expectation she would be supportive. So, although, they were strangers to the other room-mates their very womanliness could be said to have contributed to their being viewed as potentially supportive. These examples show that a conceptual reciprocity about expectations surrounding 'roles' is necessary for the rapport, inculcated with meanings of mothering, to occur.

¹⁴ For example, the concept of 'girl' is weighted with expectations and contains a recognized coherence. A gender imperative exists for girls and boys that we are forced to negotiate. The naming 'reads less as an assignment than as a command and, as such, produces its own insubordinations, (Butler 1993:237). Expected are certain behaviours and positioning which are prompted and promoted while others are condemned. 'Girl' encapsulates its own stereotype, the spoken word constitutes 'the identity it is purporting to be' Butler (1990:25).

Important, within Butler's analysis, is her point that compulsion to conform generates its own divergences and violations creating tension and contention in the maintenance of gender norms. A certain compulsion existed for Nicola bound up with social expectations surrounding femaleness. Butler refers specifically to sexual identities. Heterosexual identity is always pressured by the existence of (in)coherent identities, lesbian, gay and drag; the marginalized 'other(s)' which elucidate the problematic of sustaining coherency. So, agency levers that fissure/aperture/site of possibility to admit difference where the coherent and the (in)coherent coexist. The contesting and constant reiteration and resignification of boundaries signals the ever-present instability of gender and identity.

It is in the fragility and ambiguities of constructions of identity, the space between the disparate positions ('the non-space of cultural collisions') which are being repeatedly offered, that spaces are opened for new possibilities that can be selected or, alternatively, be refused or partially fulfilled (Butler 1993:124). Butler's 'double movement' approach allows her to insert the possibility of the subject as active agent (222). Butler links constitution and constraint together as concepts which constantly interact and affect one another so that the subject is fluid and never determined fully in advance; the subject is generative. Constitution of subjectivity depends on the volition of the individual, for example, whether or not one adheres to discourses or commits to coherency of identity. Though she never implies these as stable, gender identity is provisional and constantly contested. Butler (1997:129) refers to an 'ambiguity of agency' in a linguistic sense, that is, a speaker must author a text or subject position arising from a set of options already familiar and understood. Yet a site of possibilities is opened by the unpredictability of the subject and her ability to choose, thus implicating power in the mechanism of agency. A tension existed for some of the participants between their identity as women and the neuter-type patient role assigned to them, particularly; where, in the act of mix-sex rooming, no account was taken of their sex. This created a paradox for them, on the one hand they experienced a focus on their corporeality by the bodily exposures/manipulations entailed in being a patient, and on the other hand, that very body was desexed, and relegated 'neutral'. The resolution of this ambiguity is a matter of process and contestation for the women.

4.6. A Reconsideration of Agency

Alice's work opens a door on how a resolution might proceed. Alice expands on the above concepts outlining that identity is always plural and the subject is a multi-formed entity with shades of 'identities' resident together, refusing isolation as discreet entities in any projected 'pure' form. In dispensing with reliance on essential notions of subjectivity, identity then is 'irreducibly multiple' (1998:20). The concept of agency is a matter of discussion amongst feminist theorists including King (1994), Shildrick (1997) and Alice (1994). The discussion articulates the mechanics of the processes by which subjects reveal their fluidity, exert influence and formativeness, usually termed 'agency'. Alice posits the idea that agency is always negotiated and, thereby, constituted differently by participants within the relations of domination and subjection. For Alice, it is through the 'dialogic of margin and centre' that the subject is formed, the tensions of the constructed against the less clearly articulated shades of difference leave a creative space in (re)forming possibilities for the configuration of an identity. The bi-surfaced conceptualization of sex difference cannot account for the multiple influences of overlapping and inter-twining connections of past and present, of cultural roots, histories and individual volition which shape the subject. Katie King identifies agency as transforming, 'not yet decidable', she sees it hinging in the dichotomy

"subject/subject" (noun/verb) -an analytic tool that precisely balances on the undecidability of agency' (1994:163).

Agency eludes attempts to fix it thus revealing it to be embedded with power. Shildrick (1997:155) in reference to moral agency, notes that the ethical moment is in the 'movement of *différance*', that is, in recognising the plurality of possibilities permitting 'intervention from places that have hitherto been fixed and marginalised'.

It is important here, to examine the complementariness of Ring's (1994) concept of a 'call do gender' and Butler's (1993) articulation of coherent identities. A 'call to gender' is a citation that depends upon coherency; it is a discursive reiteration of a recognizable (coherent) discourse of femininity. The receiver is propositioned by the citing of brand, or 'hallmark', frames of femininity, called to assume a coherent identity. Shared meanings distinguish the emblematic 'female-type' enlisted in the act of the propositioning. As Ring's

study shows, some of her participants also utilized 'hallmark' discourses in responding, such as, the castigating parental figure or the caring maternal figure, while others resisted the boundedness of such discourses. Utilising apparent coherent identities denied the women their multi-formed and fluid subjectivity. Neither the women in Ring's study nor the women in this study of MS rooming, can be reduced to emblematic female subjects. For my informants, though, certain discourses of femininity had constraining effects¹⁵ yet the multiplicity of their identities permitted them choices about how they would play out their objections/reactions to MS rooming.

Briefly introduced earlier was Alice's (1994:20) idea of a 'dialogic of margins and centre', a discursive conduit of oscillating discourses which, Alice proffers, holds ineluctable formative ability in the constitution of subjects. In the naming of the feminine, black and less privileged classes as 'other', a devaluation and universalization occurs that necessarily maintains an asymmetry in which white, male and heterosexual are elevated. Alice's position differs from Grosz' who appeared to conceptualise difference in a binary, omitting the formative notions of race, sexuality and class. Alice (1994) posits the notion of 'interactive inscription' which entails recognition of the body's participation in the evolving process of inscription.

Inscribed by multiple discourses the body may be imagined as 'holographic' in the sense that its negotiations as both subject and object, signify, re-inscribe and proliferate other corporeal possibilities (115).

It is Alice's view that all the multiform ways that one may signify as a participating subject and also be signified (objectified) are, together, the formative elements of subjectivity. Put another way, it is in the selecting (negotiating) of uplifting dominant discursive positions, (that is, the common ground) and assuming the markers of difference (signaling the marginalized positions) that the subject is inscribed and re-inscribed as those markers (and margins) alter and shift.

¹⁵ See page 68 above, for an example regarding the compulsion to retain modesty experienced by Carol and Nicola.

I address identity below, as the concept is integral to an analysis of subjectivity and cannot be ignored in deconstructing the effects of MS rooming. In any attempt to maintain or bolster coherent, fixed identities (for example universalizing women), dissent is silenced and marginalized. Conceptualising identity as a unitary entity relies upon distinctiveness from (an)other or other entities (Fuss 1989). Entry to particular and defined identity is delimited and bounded and fluidity is denied. Identities become hedged-about, perpetuating exclusions. On naming others as different or inauthentic, individuals participate in acts of othering which marginalize those who do not fit the mould. In acts of othering the seed of discrimination is always present. Contained within a binary of identity and non-identity are also the polarities of contestations over authentic and inauthentic subjectivities.

Fuss refuses this position on identity, positing, instead, that identities are multiple, contingent upon differing contexts (experiences) and, therefore, provisional. Due to the shifting nature of the authentic (as it is redefined with new understandings and the passage of time), identities can only ever be evolving and continuously 'reinvented'. Therefore, identity cannot be a reason to exclude yet often functions as just that. Difference appears to mock the ideal of unity in an effort to maintain hedged identities, instead of attempting to subsume difference. Differences should be viewed as sites of possibility and potential (Alice 1994). Identity, then, is never reached but is 'in process', elusive and paradoxical.

Alice's conception of identity formation gives explanation to the multi-focal, and even conflicting positions with which the informants found themselves struggling in their responses to MS rooming. Maybe the key to shades of difference and identity is, as Fuss puts it, that it is possible to see all identities as coherent, yet incoherent, at the same time. So, there is not a single approach to analyzing MS rooming; the women's positions are only partially related to one another, as points of connection exist but so do points of departure. Hospital managers, set on defending mixed provision based on observations that some women 'took more pride in their appearance in the presence of male patients',¹⁶ attempt to universalise women, thus subsuming the equally valid position expressed in the contrary reactions of those women who objected to being MS roomed.

¹⁶ See page 20 for earlier reference in the literature.

This position can be read as a compulsion for all women to fulfill a style of femininity which is idealised and which some women expressed. It could be interpreted that the women who 'took pride' were, in this case, viewed as 'real' women, insidiously inferring those who objected were less than 'real women'. Here, the feminine is universalized, difference is marginalized and women subjected to punitive measures. Upholding this position neglects a duty of care towards the patients who are distressed by MS provision. Policy, in this case, is based on a false premise that a universal ideal exists. If no female universal exists, objection or approval of MS rooming cannot rest on a unified, universal and identifiable female identity, any woman's response must germinate from their complex, elusive and ever forming identity. Every individual woman, thus divested of universal assumptions around gender, has a right to the provision of hospital care that is safe, dignified and therapeutic. Providers are bound by a duty of care to every individual patient.

'Consumer' (recipient) of healthcare delivery and 'patient' are compelling frames of reference clearly articulated in our society. In the medical encounter the patient is repeatedly constructed as 'patient'. Turner (1992:214 & 215) suggests that,

being sick involves a special type of linguistic membership through socialization in a sick role.....becoming a member of a social community.

The patient learns their appropriate role, to offer up one's body for inspection, measurement and tabling, providing a history of illness in progressive steps. Through the systemisation of the doctor/patient encounter medicine produces a disciplined body. Rosalind Diprose (1998:36) refers to this process in her work on sexuality in the clinical encounter,

(A)s the clinician has the authority to issue a prescription, the knowledge for reassurance and access to technical procedures, then patients must subject themselves to the questions and interpretations if they are to secure the help they need.

The numerous incidences of my informants (patients) being constituted as passive patients were evidenced in the encounters with doctors when their conditions and/or treatments were discussed in the hearing of other room-mates. The women viewed themselves as capable, confident people who, in these circumstances, were rendered silent and disempowered, in

contrast to their usual assertiveness. Nicola, for example, acquiesced to the system, despite her embarrassment at doctors' discussions involving a proposed vaginal examination in the hearing of male room-mates. She re-examined her lack of assertiveness as she felt it was out of character for herself, as a teacher, to be compliant despite her disquiet. Re-visiting her feelings prompted her response to my advertisement.

A Foucauldian interpretation of a subject's reflection of 'coherency' is suggestive of the 'docile' subject (1977). 'Docile' subjects are produced through various forms and techniques of discipline, in particular, self-surveillance, in which individuals continually measure, judge and correct their own behaviours to comply with norms. The women experienced the subordinating power-effects of codified and authoritative medical knowledges and public discourses that suggest health care is imperilled and subject to the governance of economic reason. Subordination resulted in silencing of questions or objections. They felt constrained to avoid 'making waves' or appearing demanding or 'stropy' instead maintaining behaviours that walked the thin line between getting some needs met while remaining a compliant patient. In these circumstances, the discourses of corporatisation qualifying patients as customers (who unmistakably command service) were eclipsed by the potency and immediacy of discourses of normalization regarding patients. The intersection of political discourses, related to economic constraint on health institutions, the shift in authority from health professionals to non health professionals in hospital management and changing emphasis in discourses of gender (relaxed from the strongly delineated and narrow forms of the past) all contribute to a maze of power relations at local sites where a more structural notion of domination is not an accurate way to conceive of the interstices of power and its effects. Foucault's (1977, 1980) envisaging of power as issuing from various and changing sites, is descriptive of the operation of power in the milieu of decisions and their effects in health care as shown by the dilemmas surrounding MS rooming.

4.7. Power: Compliance and Resistance

The concept of resistance is integral to power relations; bodies are constructed in the tension between disciplinary power and the potential to resist. Firstly, the post structural project

contests that sexual difference is a stable binary where there is no possibility of evading the inherent limitations of fixed categories (as shown by Grosz) and secondly, admitting the multiplicity of difference overcomes such limitations where resistance (or possibility for change) becomes pivotal to contestation and provisionality. The possibility of resistance lies in the provisional nature of subjectivity & identity.

According to Foucault, power in its productiveness generates the possibility of resistance; the relentlessness of relations of power incites the points of divergence that permit subjects alternative and resistant positions. Foucault (1980:13) states individuals (as subjects free from force) are not 'trapped' by power, thus claiming modification of the hold of power is possible, and an opportunity for resistance is always present. Free subjects occupy positions where choice is possible even though their actions might be structured by dominant discursive formulations (Sawicki 1991). For the women in this study, their status as 'patient' is read from their bodies as they lack street clothes and are positioned as 'patient'. Their context is structured, yet they are choosing subjects. Carol and Nicola deployed resistance as they elected to absent themselves from their rooms to avoid the discomforts of mixed-sex space. They refused inscription as 'patient' as they remained mobile and transient, exceeding normative positioning and codes of behaviour. The resistant position is not exclusive to women in this study. In response to my advertisement for participants, two women replied who had immediately refused to be MS roomed on becoming aware that a MS room had been allocated. They refused to comply with the planned room placement.

Subjugated knowledges are basic to Foucault's concept of resistance. Criticism of accepted systems of knowledge arises from subjugated forms of knowledge, as they are,

opposed not to the contents, methods or concepts of a science, but to the effects of centralizing powers which are linked to the institutionalization and functioning of an organized scientific discourse (Foucault 1980:84).

Foucault (1980:80) utilizes the case of anti-psychiatric discourse and its effectiveness, over time, in eroding the solid functionality and coherence of totalizing theories. He purports that, at a local level, criticisms and insurrections erode the synchronicity of established

regimes of thought. While unstable, discontinuous and free from reliance on established knowledge, subjugated discourses offer criticisms, intermittently but consistently, undermining the universal hold of established realms of disciplinary power. These historical components engender a local criticism producing an informal counter-theory (subjugated knowledge) to the transcendent hierarchy of knowledge (81). Foucault differentiates two aspects regarding subjugated knowledges. Firstly, noting that particular elements are sidelined and neglected as formal systemization is asserted. The ideas relegated to an abyss reveal the fraught process of the masking of their presence in any drive for uniform and coherent systems of thought. Secondly, subjugated knowledge refers to:

a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity (Foucault 1980:82).

Here, Foucault counts the knowledge, at an individual level, of the psychiatric patient (the ill person), the nurse and the doctor among those low ranking, popular knowledges compared to the paradigmatic medico-scientific knowledge. They are disparate knowledges, marginalized by their lack of systematic detail and elaborated methodology. Foucault uses the term 'genealogy' to describe the operative sequence emancipating relegated knowledge to achieve a tactical challenge to formalized and ubiquitous discourses. Foucault is careful to point out that things 'genealogical' are not based in empirically researched, paradigmatic forms, they are the 'local', 'discontinuous' and non-theoretical challenges which run contrary to politically sanctioned official discourses whose powerful embodiment constitutes system and institution (1980:83,84).

Patient advocacy has a history of agitation and lobbying against medico-scientifism as institution and system. Advocacy arises out of local contexts and existing conditions, addressing diverse and disparate concerns. Deficient circumstances and practices spark advocacy; it is an irritant to a uniform science a loose set of principles, only partially articulated, sporadically authorized and lacking explicit parameters. It operates as an insurrection of subjugated knowledges, bringing to the surface those elements (such as patient and relatives rights) which may be relegated and marginalized by the practices of

authoritative science. In New Zealand, for example Maori have strongly challenged the practice at autopsy of removing body parts without permission from relatives. Maori spiritual beliefs are based in genealogy and the body is sacred, it is a travesty of the spiritual meaning to dismember the body. The consequences of autopsy are not merely scientifically pragmatic but effect spiritual and cultural wellbeing.¹⁷

Genealogically speaking, it is the persistent and impassioned responses of patients, their families, individual health workers and action groups that call attention to flaws and misdeeds of service providers¹⁸. As noted in the literature reviewed earlier, changes in health policy in Britain, resulted from assiduous calls by groups, such as the UK Patients' Association's consistent comments on patient dissatisfaction with MS provision, comment supported by research findings (Joule 1995; Snell 1997; Warner and Ford 1998). Research initiatives were prompted by patient complaints and staff disquiet. In line with a Foucauldian analysis, patient self-advocacy can be equated to resistance in action.

On two separate occasions, Louise, experienced MS rooming in the same ward with numerous admissions in the interim (a seven-month period). Both admissions related to her reconstructive breast surgery after earlier bi-lateral mastectomy. Louise perceived that staff had 'typed' her as an 'hysterical woman'. Louise was vulnerable both as a cancer patient facing an uncertain future and body-altering procedures as well as a woman recently separated after a twenty-five year marriage. She had had counseling in the process of deciding whether or not she would have implants post surgery. Louise suffered undiagnosed pain after the bi-lateral breast implants. This pain was extreme and accompanied by high temperatures and was the cause of her frequent admissions over the seven-month period. It was eventually recognized that the right implant had ruptured and leaking fluid and a further three operations were necessary. In the meantime, though, Louise found herself enmeshed in the downward spiralling effect of being a patient with ongoing complaints of pain that eluded diagnosis, and being labeled a 'troublesome' patient.

¹⁷ New Zealand legislation has recently formalised the right to respect of Maori (as indigenous peoples)cultural values and beliefs in health care in Regulation 2, Right 1, (3) of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

Louise was being constructed as a 'disordered female', despite her efforts to position herself as a credible and responsible patient by reporting the facts of her disease state (recording symptoms, duration and elevated temperature) and presenting at the hospital when her illness was not manageable at home. She felt the tendency of staff was to treat her as 'disordered' and a 'problem'. Two things are drawn into focus in Louise's scenario; first, she was subjected to relegation as an hysterical woman within the parameters of medical discourse and second, her own subjugated discourse of discontent with her treatment added to the multiple, local discursivities thereby presenting challenges to the established wisdom of medical science.

Freud is historically credited with sexualizing hysteria and thus characterising women in particular. Freud's lack of an adequate elaboration of women's sexuality results in generalizations being applied to women that the label 'hysterical' compounds (Irigaray 1985). Hysteria is coded feminine, a neurotic state where the patient somatizes psychological stressors. Grosz (1994) queries the origin of the tendency of psychoanalysts to label women as hysterical, noting the tendency is girded by a discriminating gendered transference of the mind/body split; discrimination that has historically permeated not only psychoanalysis but the knowledge of science and medicine. Shildrick (1997) concludes that the scientific project of the Enlightenment contains an inherent hostility to women, revealed in habitual identification of women with nature (wild and unpredictable) compared to identification of men with rationality and control. I recall, here, the references made earlier to Freud's inferences about women as 'lacking'¹⁹. In order to clarify, the origins of the discriminating tendency to diagnose women with hysteria it is pertinent to include Freud's second narcissism attributed to women. In Freud's view, women necessarily carry a flawed self concept; women are incomplete, they lack the phallus, and psychological distress arises in the inevitable mourning and lamenting of such a lack.

¹⁸ Overlap of the informal and formal systems of advocacy does occur, a filtering across of ideas flows from one to another.

¹⁹ See page 63.

I have traced the historical influences attempting to show the 'archeology'²⁰ of the discourse of relegation to which Louise was subject. Central to a discourse of hysteria, is a resolute perception that women lack of self-control. Shildrick (1997:26) elaborates,

In scientific and medical discourse, in particular, (losing control) ..is quintessentially a feminine rather than masculine trait, predictable and tolerated in women, but sufficient to disqualify us from the mental self-governance necessary to (rational) agency.

Louise's persistent symptoms were not sufficiently investigated to isolate the physiological origins of her pain. In the absence of infection, looking for a cause beyond infection was not rigorously pursued. Louise was ambivalent about having implants and took time to decide, undergoing counseling in the decision process. Louise was labeled as 'not coping' and a 'troublesome female' in similar vein to the women in Victoria Grace's (1997) study of chronic pelvic pain where women's persistent reporting of symptoms were trivialised by doctors. It was as though staff considered that cognitively and emotionally, Louise was unsuccessful in adapting to her altered body, transformed from sexually complete female (with breasts) to sexually incomplete (without breasts) presumably resulting in body image disturbance. Grosz identifies that the concept of body image, and the dilemmas thought to arise out of arrested body image development, now mediate the mind/body split in the disciplines of neurology, psychology, and psychoanalysis. Grosz concludes there is,

...radical inseparability of biological from psychical elements, the mutual dependence of the psychical and the biological, and thus the intimate connection between the question of sexual specificity (biological sexual difference) and psychical identity (1994:85).

Despite Louise's awareness of her relegation to the ranks of the mentally fragile she became her own self-advocate and resisted the practices of the system. Significant points of resistance for Louise were her refusal to be MS roomed a second time, complaining about her treatment and writing letters of complaint to hospital management. On one occasion, after several readmissions, a friend intervened and refused to take her home because she was still unwell and Louise attempted to deter her friend from speaking on her behalf as she did not want 'a fuss' made, recounting that she was 'still trying to be good about it'.

²⁰ Here this term is used in its Foucauldian sense, See Michel Foucault (1972) *The Archeology of Knowledge & The Discourse on Language*. New York: Tavistock, pp138-139.

Louise destabilized the notion of herself as 'mentally fragile' and a 'passive patient' by countering the imposition of those norms in specific behaviours; making complaints, verbally and in writing, rearticulating facts about her symptoms which were consistently dismissed by staff and eventually, refusing to enter the mixed-sex room allocated to her, instead sitting in the patients' lounge, reiterating the reasons for her refusal to several staff members until she was given another room.

Louise wavered between docility and resistance. Foucault is adamant that power always holds the potential for resistance. Louise occupied a deviant, resistant position as someone distressed by MS rooming, and converted that distress into active resistance.

The discourses regarding gender norms, patient norms and the normative practice of MS rooming, as the informants encountered them, acted as 'systems of power' constraining the women, yet, that very constraint opened the way to potential resistance (Shildrick 1997). The theories explored here reveal the basis on which a coalition around an objection to MS rooming might form to lobby about objections to MS rooming stressing the risk that gender might be minimized or disregarded.

Some of the women expressed to me their reasons for participation in the study were twofold: one, to inform (and warn) others of the possible risk to one's personal integrity that MS rooming posed for them; and second, to inform, by proxy, those in authority, of the distress this policy engenders for many patients (but not all as Jocelyn's interview shows). Interestingly, most of the women proffered their opinion of the men's reactions, some felt they discerned discontentment from the men too. Julia, for example, observed the discomfort of the elderly Polynesian man in her room, who showed obvious embarrassment (which she attributed to the presence of females) at the nurses' requests for urine samples. The nurses spoke rather loudly and the man replied in whispers revealing his need for privacy (Julia).

4.8. Summary

This chapter has utilized feminist frameworks to examine the pertinence of the body to subjectivity with an aim to unraveling the dilemmas MS rooming poses for some women. I have suggested that MS rooming not only renders the effects of gender irrelevant it also constitutes dismissal of the social meanings encompassing bodies, the reality of differently sexed bodies and the implications for subjectivity and personal agency. The post structural approach helps elucidate the problem inherent in assuming a 'sameness' between women, and the flaw in applying a majority politics (because some women tolerate MS rooming all women ought to) in a situation where individual treatment is always the purpose of patient care. The strength of a poststructural interpretation takes us beyond the binary of fixed identities, into the unstable territory of shifting identities which explains differences between and within subjects. Elizabeth Grosz' work challenges normative constructions of female embodiment. She has shown there are distinct differences but they are not essential in character, or dependent upon a given physicality. Her rethinking of subjectivity as 'volatile' rather than given, unseats long held assumptions about the inferiority of the female body, permitting an objection to MS rooming to be grounded in an individual woman's volition rather than on a discourse of a universalized state of womanliness. In seeking to uncover the foundations of normative constructions and the mechanism of heteronormalisation, Grosz' analysis of sex differentiation and the materiality of bodies was useful.

Laura Ring's writing illuminated the effects of normative discourses of femininity. Encoded with shared conceptual frames about 'real' women, these discourses operate to obligate women to behave in preordered ways. A similar understanding was shown in Brian Turner's discussion in relation to the status of patients who, in the system of medical/health care, are also significantly constrained by the weight of systems.

Judith Butler's theory is central to understanding the process of gendering the subject. Butler clarifies that a fluid and provisional subjectivity is always only partially constituted. Butler's discussion of how the subject is constrained yet, at the same time, the presence of fluidity inserting alternatives possibilities, assists in showing the unstable character of individual responds to MS rooming. A body politics is revealed in the tension between

discursive constructions and the possibility of eluding construction. Her theory of iteration of norms and the compulsion to 'fit' dominant modes of being as repeatedly impressed upon the subject, shows that ritualized signification reveals the power of discursive formations. MS rooming raises such a decision point for the women; weighing up the compounding choices; to be the compliant woman/patient and acquiescing or, alternatively, choosing the outcast position by objecting to a practice invested with authority (even, though, the practice runs contrary to the usual norm of catering for the sexes separately).

Both Butler and Alice propose that the interplay between opposing, or alternative, categories/possibilities lays open a site of productive possibility, a necessary ingredient or source of identity and agency and change and difference. The site of possibility suggested here, along with a Foucauldian conception of power and resistance, has provided an insight into the different reactions and motivations expressed by the participants.

Karen's story of her encounter with the male nurse illustrated how it is not men that are problematic per se. The crux of the matter is whether the woman, at any given point, assents, consents or objects with a decision regarding her care. The point, made by post structural theorists, is that it is not sex or gender but rather the subject's right to take up subject positions chosen by themselves, irrespective of any discourse, or norm, such 'taking up' may fulfill or refute.

5 Space, Power and Corporeality

5.1. Introduction

The mixed-sex hospital room is a geographic space. It is an enclosed space where the activities of disclosing both medical and personal history take place, as well as the treatments performed upon the body which necessitate partial clothing and nakedness. The room, though, does not belong to the occupants; they inhabit a space that is situated within a public service institution. The institution is invested with, and constituted, in part, by significant power over physical bodies. It is represented by medical and nursing personnel who enter and exit patients' rooms at will. In the bounded and intimate space of the patients' shared room, occupants no longer possess privacy; each patient's activities are performed with varying degrees of exposure to their 'room-mates'. The configuration of space, the perceptions of power and individual need for privacy are juxtaposed in the shared hospital room.

My intention in this chapter is to demonstrate the important relationships between space, privacy, corporeality and power as they bear on the women's experiences of mixed-sex rooming in the study. Through this study I have come to see a deconstruction of space and corporeality has two foci: one on the macro level where political and social nuances of techno-medical discourses, health care administration and the politics of sex difference intersect all relationships and hierarchies. Secondly, at the micro level, these influential discourses are concentrated on a local site where sexed-bodies, 'captive' (as patients) in close proximity to each other, are subject to institutional practices, assumptions around sex difference and power effects. Thus, the women participants of the study are enmeshed in a double set of cogent forces. The first section of this chapter addresses the macro level of discursive space and its multiple power effects, while the second section, deals with the micro level of spatiality, corporeality and privacy in the locality of the hospital room. My discussion is structured around these two broad conceptual levels for clarity, the levels are not always totally discreet from one another, but interrelated, as analysis of the issues reveals cross over between the macro and the micro.

In deconstructing the events, and searching for resolution, of the dilemmas faced by participants no one model sufficed to deal with the myriad tensions, dilemmas and relationships provoked in this study. I draw on several analytical models that address separate components of the data. A salient analysis emerges from applying Michel Foucault's (1977, 1980) theorising of the operation of power, Benno Werlen's (1993) theory of spatiality and an assessment of the issues of privacy, which relies on the bioethical literature, including Margrit Shildrick's (1997) recent critiques.

Foucault's analysis of the operation of power as multifaceted permits a detailed scrutiny of the matrix of elements that interplay on the macro level of this study. 'Power', in this discussion involves looking at both macro and micro institutional relations. Foucault's concepts of 'governmentality', 'population surveillance' and 'discipline' can be seen to relate to authoritative power in hospitals. Discussion is then focused on technologies of power and the corporeal effects upon those mixed-sex roomed.

Certain insights regarding subjectivity have been gained by applying Benno Werlen's (1993) action-oriented geography of spatiality in this study. The motivations and activity of the women as they defined, and redefined, space in the configurations of their assigned accommodation are examined. In particular, Margrit Shildrick's (1997) theory of a feminist post structural ethics informs how privacy may be understood at the micro level of the experience of the patients in MS rooms.

To begin, I examine Shildrick's position, that knowledge(s) or paradigms of thought are discursive constructs and, therefore, bioethics is a series of discursive formations which are built upon negotiated alliances and political coalitions, rather than being any objective foundation of morality. Ethical principles (such as autonomy and rights to privacy) are negotiated, and agreed upon principles, which operate as discursive constructs invested with the authority of the discipline of ethics. Margrit Shildrick (1997:-212) explains:

(D)estruction concerns itself with how all foundational and universal claims are simply an effect of discourse, held in place by the naming and violent exclusions of difference. The yearning for the certainty of absolutes has resulted historically not in justice or equality or

liberty, but in the denial of moral personhood to all those categories of living beings who cannot be identified in terms of the ideal standard.

Jane Flax (1993) also refuses the notion that universal truths exist to be uncovered and instead proposes that a political endeavour (feminist or otherwise) is grounded in negotiation and emerging alliances, not 'truths'.

Traditional ethics has produced a complex set of conflicting rights and duties for practitioners (service providers) and patients. For Shildrick, Foucault's power/knowledge nexus offers a way to understand competing rights, and the resolution of dilemmas, that recognises power differentials rather than obscuring them. Shildrick claims that, at times, patient self-determination is overridden by 'discursive exclusion of rationality' (83). Under discussion in this study, is the participants' desire for privacy, their beliefs in a right to privacy, and how the physical (as well as discursive) spaces made available to them, as patients, bear upon both access to, and breaches, of privacy.

5.1.1. Defining Terminology

In addressing the ethics around privacy I utilize concepts from traditional ethics since our health system is subject to these particular principles, forming the guidelines and legislative boundaries for practice which in turn, inform and constrain, practitioners. Local hospital documents, legislation and practices are referred to in this context. I will also propose post-structural alternatives to explore how a rethinking of ethics (Shildrick style), might appear. This approach raises an epistemological dilemma between the post structuralist claim about a provisional and decentered subject, and the humanist notions of a stable and unified subject prevalent in the bioethical literature, where the issues of privacy have been widely explored. The post structural position utilizes a provisional, and always-in -process 'self', or subjectivity, whilst the liberal humanists refer to the 'self' as a stable entity. The synthesis between the two positions, though, is the recognition of a thinking, acting subject. Albeit configured from entirely different premises.

Institutions are structured around particular belief systems, subject to economies of scale and funding. For example, hospitals are both physical (geographical) spaces, as well as,

repositories of medical knowledge, bioethical and administrative discourses, and subject to the wider discourses of gender, politics, and individual and collective entitlements that Western societies are built upon. The hospital room is therefore infused with cultural and gendered conventions that each individual brings with them. In this study on MS rooming, mixing the sexes in close proximity opened the women up to the conventions of heteronormativity where the majority experienced an unwelcome awareness of their normalised, gendered (possibly stereotyped) corporeality.

At the outset it needs to be said that privacy issues arise in single-sex settings as well, but, in the majority of the women's accounts, in this study, the extra dimension of the gendered environs added to their feelings of being affronted by personal exposure (in word or physically) in the presence of male patients. As previously mentioned, most of these women have also been hospitalised in single-sex settings and felt their grievances were tied up with mixed-sex rooming in particular.

Some 'frames of reference'²¹ relate to authority and the investment by society in specific individuals and power structures. These may operate as formal and informal systems of power proceeding from established conventions. The fulfillment of these conventions is in the form of disciplines of which, medico-science, is a discipline pertinent to this discussion. In regard to privacy, conventions and requirements are substantiated/cemented in the Privacy Act 1993 and the Code of Health and Disability Services Consumers' Rights, a regulation under the Health and Disability Commissioner Act, 1996, in Aotearoa/New Zealand.

5.2. Discursive Power in Spaces and Localities: The Macro Level

Foucault's theory presents a way of looking at how 'conventions' become dominant and even directive of human behaviour. Foucault (1972) coins the term *discourse or discursive formations* in which he captures the idea that ideological positions are articulated, spread

²¹ Frames of reference are ideological belief systems that propel and drive our social and political interactions and which structure responses.

and gain agreement in words and behaviours²². In other words, a convention or norm, becomes a legitimised position holding sets of practices. A discursive formation, in the form of a convention, is so utterly entrenched that its origins are unquestioned, revealing what Foucault terms 'diffuse power'. I believe two dominant discursive formations of the late twentieth century that affect hospital care delivery, in New Zealand, are medicine and economic-fiscal policies of the new right (Kelsey 1997). Historically, and today, the regimes of medicine not only direct life habits for the ill but also instruct the well. Medical prescriptors direct thought, and conduct, to produce healthiness and assign unhealthiness, medicalising all aspects of life, resulting in, it will be shown, a 'disciplined' society (Turner 1992, 1997). In the later part of the twentieth century a fiscal discourse has changed hospital services to commodities with measures of productivity applied to health where no 'product' exists. 'Patients' have been renamed 'consumers', and 'surpluses' renamed 'profit'. The health service has been fragmented and competition between providers has been created²³. These ideological discourses have particular, and immediate, effects upon the corporeality of patients in hospitals. The next section proposes, how in a Foucauldian analysis these persuasive discourses may be understood.

5. 2.1. Fiscal and Medical Governmentality in Hospitals

Here, Foucault's historical analyses shed light on discourses and how particular disciplines gain ascendancy over other world views. 'Structures' evolve and gain ascendancy, over historical time periods, where certain conceptualizations are invested with power and constraint. Our hospitals, over the last decade, have been subject to the discourses of new right economical theory, a professional discourse (in Foucauldian terms) to rival the earlier discourses of medicine and science. Maureen Cain (1993) explains Foucault's use of genealogy as a 'descent' of ideas through history, a descent which is not teleological. She

²² To Foucault (1972:120) a discursive formation '...appears as an asset-finite, limited, desirable, useful-that has its own rules of appearance, but also its own conditions of appropriation and operation: an asset that consequently, from the moment of its existence (and not only in its 'practical applications'), poses the question of power; an asset that is, by nature, the object of a struggle, a political struggle.' In this sense discursive formations are productive, even of themselves. 'All manifest discourse is secretly based on an 'already said', and that 'already said' is not merely a phrase that has already been spoken, or text that has already been written, but a 'never said', an incorporeal discourse....a writing that is merely the hollow of its own mark' (Foucault 1972:25).

²³ See overview, presented earlier, of reform of the New Zealand Health System, Chapter 1 in section 1.2. See Laugesen and Salmond (1994) and Cumming (1998) for detailed analyses of the reforms.

notes that via 'genealogy' professional discourses could just as easily be devoid of their eminence, and equally, any other discourse could assume potency. Discourses gain potency in a field of political relations and generating tensions, knowledge production galvanized through relationships, connections, dependencies and co-dependencies (Foucault 1991).

Bryan Turner (1992, 1997) calls Foucault's notion of governmentality a form of 'normative coercion' existing in institutions, such as, medicine and modern forms of management. In these significant social institutions lies coercive ability to shape what individuals come to see as their choices or possibility. For example, Turner (1997) notes the recent emphasis by the medical profession on health promotion and self care as a shift from population strategies for the provision of health care to individual responsibility. Similarly, Shildrick (1997) mentions the shift from assessment by agencies for living allowances moving to the clients needing to 'prove' they qualify for allowances. Thus, moving responsibility onto the person with a disability and away from state agencies. And likewise, monetarist programmes have swung away from welfare-state provision to the commodification of health care provision with new managerial approaches where fiscal concerns overshadow moral and humanitarian considerations, such as privacy (Kelsey 1997, Warner and Ford 1998). Foucault, talking of the eighteenth century, viewed medicine and religion as exercising governance over the body. The coerciveness of a discourse is that, in creating the effects of truth, it is repressive in the sense that other views are rendered illegitimate and the discourse is inculcated with power. Foucault refers to the state apparatus as being the more recent site, historically, attributed with a tangible power base. Rather than viewing power as negative- 'repressive', and/or 'censoring', Foucault views it as productive: 'power produces; it produces reality; it produces domains of objects and rituals of truth' (Foucault 1977: 194). The new right economics being a 'ritual of truth'.

Translating Foucault's claim to the irony of MSR, I am claiming that patients are subject to the 'normative coercions' exerted both by medicine, with its surveillance mechanisms, and, the coercive influence of a discourse of fiscal expediency, marked by measures regarding cost containment and corporatisation of institutions. Foucault explains that the shift from sovereign power, in the past seen to be invested in specific state apparatus like hospitals and

prisons, to power being divested from some overarching source is instead diffuse: not invested in one 'speaker' but 'emanating from a number of possible sites' (Butler 1997: 78). Foucault directs us to avoid thinking of persons holding power and ultimately exercising power and instead, look to the extremities of where power acts, that is, the 'point of intention..... its real and effective practices', (Foucault 1980: 97). At times, Foucault, referred to this effect of power as sited at the 'capillary level' (1977:198).

For example, in the 'material instances' of MS rooming power appears to operate in precisely the diffuse forms claimed by Foucault. No single individual is held responsible for the acts of power involved in the physical placement of patients in designated beds/rooms, yet the material event of mixed-sex placement is a continuing practice in some settings. The policy of one New Zealand hospital on mixed-sex rooming is outlined in their Patients' Handbook (given to every patient before a planned admission or otherwise on admission). The policy is headed 'Room Sharing' and states in kafka-esque style;

When you are admitted to hospital, every effort will be made to place you in a room with members of your own sex - this is(our)..... policy. From time to time there are circumstances when we are forced to place men and women in the same room. If this happens to you we will move you to a room with a member of your own sex as soon as possible. In special care or intensive care units, mixing of men and women is necessary for intensive monitoring. Please talk to your nurse if you have any concerns (Healthcare Otago undated).

Although the administration views MS rooming as contrary to an ideal of single sex provision, they permit it, even facilitate it, by claiming they are 'forced' to do it. They absolve themselves of responsibility for the occurrences and, yet, in practice, they alone hold the power to decide the use of space. The managers, or such people in authority, might argue that the admission booklet invites patients to 'talk to your nurse if you have any concerns'. If this is taken to imply that something can be done about it, then the claim that they are 'forced' to mix room is false.

Two things can be said: 1) if things can be done about it by way of a complaint, then their admission booklet is patently misleading by implying they are 'forced' to MS room. 2) even if things can be done about it and patients are invited to object, failure to object does

not imply consent even with an invitation to complain because the patient never willingly agreed that they would complain. The ambiguity of the admission booklet's statement is just such an example of Foucault's diffused power in operation. Judith Butler (1997) adds clarity to Foucault's description by stating that the operation of power seems to be,

(d)iffused throughout disparate and competing domains of the state apparatus' and through civil society in diffuse forms as well, power cannot be easily or definitively traced to a single subject who is its 'speaker', to a sovereign representative of the state (78).

It can be seen that Judith Butler (1997: 78), takes up Foucault's argument, that the historical dissipation of the 'sovereign' organisation of power in the contemporary configuration is multi-sited and diffuse, and seems to 'occasion the fantasy of its (the sovereign's) return'. Here, she means that the return operates in language and that discourses are presented as though they have some 'sovereign' reinforcement, ensuring the security of hegemonic practices. In the hospital setting, the terms 'efficiency' and 'economy', are used to justify interpretations of reasonable patient care, despite also being used oppositionally, to cut costs. It is this 'sovereign' aspect to institutional practices of hospitals that I believe operates as a constraining cordon, silencing those who feel distressed with MS rooming. In my view, a Foucauldian analysis of power, offers the most adequate description of the operability of power, shaping the complex and juxtaposed effects in the events of MS rooming, which is a deviation from the norm of single-sex allocation of space in hospitals.

5.2.2. The Operation of Power

One way in which discipline is outworked in Foucault's writing, relates to, how space is associated with, and constituted by, the operation of power relations. One comes to 'know one's place' by one's position in the order of things, that is, in the distribution/allocation of space within given institutions (McHoul & Grace 1993). An antecedent to the allocation of space in any institution is an asymmetry of power. As Nicola and Carol's experiences show an asymmetry of power existed between hospital staff, who placed beds, and patients, who passively filled beds. Persons operating in a dominant discursive position are authorised to control how space is used; this might be in a chain of command that no particular person takes direct responsibility for. Decisions reflect the discursive construct those in

power/authority are committed to. The pivotal 'discursive construct' of 'new right economic theory', as a paradigm, has turned patients into customers. New Zealand experienced a period where this philosophy toward healthcare 'consumers' resulted in the user-pays strategy, noted earlier, in public hospitals (Mooney, Gavin and Salmond 1994). Duncan (1996) reminds us that no place is politically neutral. As consumers, our very corporeality in the material world, locates us in social and political spheres whose domains, governance and boundaries are also constantly being contested. Policy makers in New Zealand, for example, rationalized the introduction of user-pays by reference to excessive costs in health care, so patients became consumers, at a time that coincided with budget constraints (Kelsey 1997). But ironically, as 'consumers' were newly created, the services these consumers could access, were reduced. Patients were moved from being 'citizens' with automatic rights and access, to 'consumers' who pay twice; once as citizen/tax payers and again as customers. As users who pay, the 'consumer' is disenfranchised as a 'citizen'.

Some patients, it seems, are expected (and feel compelled) to comply with a practice that is itself running counter to the more common practice of single-sex rooming. Using the above explanation of power relations we can see how the hospital administration, as quoted earlier, divests itself of responsibility for the compromises in the physical rooming of patients. In the era of health service restructuring and the devolution of state directed administration, political, economic, and managerial discourses intersect with and oppose each other, and create points of pressure that affect policy formulation.

Under the banner of ensuring increased accountability, economic expediency is pursued energetically. Appointees at all levels of the health system are urged to cut costs. The consequences of practices adopted with this goal in mind have not yet been realised in their entirety. Economic efficiency is one prevalent discourse often called upon in support of changes to practices arising at all levels of the health service. With the 1996 New Zealand election, political will had swung and the profit goal for CHEs was abandoned but the business like imperative remained (Kelsey 1997). With this historical backdrop, patients are well aware of budget constraints being applied within hospitals. Resistance to policies has

produced tensions, and sites of contestation, where ideas previously disavowed have gained some ground, attesting to Foucault's claim that power is unstable and diffuse.

In the face of authority invested in hospital institutions, individuals are silenced, and their gagging is reinforced by the constraining of physical space. Eleanor, for example, reported feeling acute apprehension at the prospect of being MS roomed. For Louise, Nicola, and Raewyn being placed sharing with men, without any forewarning, was really uncomfortable and a source of added stress during their stay. The women's apparent silence (as they did not complain to staff) regarding their situation, cannot be interpreted as acceptance. Failure by the women to object does not imply acceptance and cannot justifiably be taken as such. They did not give their assent, they complied with the ordering of space as staff organized it but they held strong reservations about the practice and felt powerless to change it. The women made no direct complaint to staff, although they did discuss it with their relatives, friends and other women patients. Carol and Julia did ask staff about the policy attempting to get some clarification. A report in the Otago Daily Times Newspaper (Topham-Kindley 1992) quotes a manager implying that patient acceptance of the practice is assumed if people do not complain. The manager's presumption, that silence implies consent, assumes that all subject positions are equal, in that each person, whether well or ill and, therefore, possibly distressed, makes a rational decision and would be free to express contrary opinions. If such opinions go unexpressed the manager assumes the contrary position is void. Consent is one thing, silence is another, and it may be a big jump, from one to the other, for some women, a jump that cannot be presumed. A failure to emphasize consent overtly (itself an active process), cannot be conflated with agreement and this is protected in New Zealand law where lack of verbal consent in itself or lack of resistance may not be interpreted as consent 'freely given'²⁴. In the popular imagination, however, to consent one must *do* something: that is, choose between options or consider a possibility, its consequences and outcomes, then, voluntarily, give consent *and* be understood by others to have done so. A further problem with this manager's response is the apparent assumption

²⁴ Patients' rights to information and informed consent in New Zealand are set out in Regulation 2, Rights 6 & 7 of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Also see New Zealand criminal legislation relating to consent in sexual crime: Crimes Act 1961 043 VII: Crimes Against Religion, Morality, and Public Welfare, Sexual Crimes, 128 (1) (a-d).

that all parties possess equal subject positions. The manager admitted that MS rooming 'was the exception rather than the rule', implying the preferred practice is single-sex accommodation, clearly the interests of the hospital are preeminent to the patients' interests and this is not equal, (between all rooming categories of patients or to staff). Responsibility for the material effects of power/authority are, here, being denied by administrators, and responsibility for the placement of patients, is being thrown onto patients themselves, hiding where power actually lies²⁵. Patients, then, are subject to potent discourses of rationality, and economic expediency, which ironically, stress individual choice and responsibility, but in practice, curtail the range of options available to individuals (who as taxpayers assist both the governance and the structure of public management, at least in theory). Susan Bordo (1993: 191) sheds light on a relevant aspect of Foucault's interpretation of power,

(Foucault's)... 'impersonal' conception of power does *not* entail that there are no dominant positions....power is held by no-one; but people or groups *are* positioned differently within it...not all players on the field are equal
(Bordo's emphasis).

Some hospital staff deny the power they have and actually exercise to structure the environment patients must inhabit. Julia and Carol noticed that all the rooms in the wards they were in, were mixed sex rooms, given that, it would seem possible for some single sex rooms to be established. Julia recounted discussions with a nursing friend, who informed her, that where she worked in a medical ward (in the same hospital as Julie was treated), the staff exercise discretion and "make an effort" to keep men and women separate.

In the health care setting, the patient is the ostensive client and, supposedly, able to withdraw their 'custom' at anytime, yet they (and especially women when MS roomed) may be immobilised or silenced by the subordinating power-effects of codified medical knowledges, figures of authority and public discourses, that suggest health care is under threat and we must be governed by the ideals of economic reason despite any disquiet and compromise to other social and ethical considerations.

²⁵ The dilemma outlined here, parallels the ethical issues discussed earlier in regard to the ambiguity of the wording contained a hospital's admission booklet, see page 93.

Management of the fallout from budget constraints, beyond key policies, though, is a matter left to the discretion of local hospital personnel. The practice of MS rooming is not universal, taking New Zealand hospitals across the board, only a small proportion of all patients encounter the practice (Cannon 1998 Healthcare Otago undated and Topham-Kindley1992). It is clear, then, that a degree of discretion exists in the allocation of beds by local managers, as Julia's story attests. Proponents of certain vested interests vie for the discretionary possibilities, as interests shape negotiations of power relationships and the material outcomes.

Foucault's theory as outlined, explains the ascendancy of both medical-science and new right economics. The vested interest of medicine in the allocation of beds is clearly demonstrated through the organization of patients according to their medical diagnosis, in fact, whole hospitals, were structured for the ease of medical personnels' access to patients. Wards are designated for example; medical, orthopaedic, surgical or gynecological according to specialties (Turner 1992). And in teaching hospitals, specialist departments are located in close proximity to their designated ward(s).

5.2.3. Technologies of Power

Foucault proposes that certain technologies of power exist, they constitute the modes and processes by which particular groups and philosophies maintain hegemony. Foucault has described the panoptican effect to illustrate how power /knowledge works to produce docility. Foucault uses two models of the panoptican effect, one about prisons and another of the quarantined city, an ancient method of plague control. In the first example, he describes the prison where the warder is in a central position, positioned as an 'all-seeing' eye, able to view each prisoner from his vantage point. Each prisoner is under the constant 'gaze' of the warder who is simultaneously in full view of the prisoners. The gaze elicits the compliance of prisoners, even in the absence of a specific observer at a given time, each prisoner knows they are always on view, this knowledge in itself realises (produces) compliance to the rules of the institution and thus docile bodies are produced. As, at the same time, the authoritative role of the warder is determined by the gaze of the subjected (that is, prisoners) and their resulting and inevitable self-surveillance (Foucault 1977).

The application of the panopticon model to the plagues, allows us to look at an alternative interpretation. The quarantined mediaeval city is closed to outsiders, entrances are heavily guarded, curfews imposed, and all movement is prohibited, unless, by authorised persons. In this example, inhabitants present themselves at the windows of their houses in order that they can be counted among the living, by those who are required to observe, and tidy away, the progress of the plague. The city is divided into sections with appointed officials who are reported to by section overseers, and themselves, report to city authorities. Records are continually written and updated so the location and condition of every citizen is known. Citizens also monitor their overseers, reporting any misdemeanors in procedures. When houses are fumigated, the workers are searched to be sure no citizens' belongings are stolen. The representation of the panoptic 'all seeing' gaze, above, differs in two aspects from the prison version.

Firstly, surveillance of the city depends upon citizens presenting themselves for view at their windows, thus participating in their own monitoring, a type of self-discipline, it could be said. Additionally, the citizens, likewise, monitor the patrollers as they report any misuse of power by the appointed overseers and officials. It is in these two aspects, that the analogy of the quarantined city best reflects Foucault's view of 'bottom-up' power in practice; the populace is self-disciplined (Foucault 1977).

The illustrations offer an idealized form of Foucault's concept of the operation of power, both systems are functional and both avoid dependence upon an individual person who exercises power. A weakness, I believe, in Foucault's examples is the threat of coercion that exists in both illustrations of the panopticon; coercion in the sense that as prisoners are captive the use of force is always a possibility and, alternatively, once quarantined it is under penalty of death that a citizen would move about the city without permission. Essential to an appreciation of the panopticon is that compliance is elicited simply because people know they are being endlessly watched and surveyed. Foucault uses these examples to show that the behaviour of populations is constitutive of regimes of power; people participate in their own surveillance. It needs to be noted that integral to Foucault's perspective on power is a set of technologies that he collectively identifies as *the gaze*. Having made the above

critique, I concede, utility exists in both versions of the panopticon for understanding the tensions in MS rooming, as a site for observing both the physical and discursive power relations of spaciality.

Patients are under authority while in hospital, both medical authority and civic authority in the form of the hospital administration. On hospitalization, as ones 'under authority', patients, whilst always subject to *the gaze*; become 'inmates' of sorts. They are allocated their ward, their room, their regime of food, fluids, treatments, and observations. Like the prisoner, patients are removed from their own people and homes and placed among others, not of their choosing, and closely monitored. But unlike the prisoner, and reminiscent of the quarantined civilians, there is a measure of volunarity to their submission to discursive practices, as the patient presents for treatment just as the citizens of the quarantined city presented themselves at their windows. The patient is captured in the medical gaze, through the institutional configurations of hospitals and systems of monitoring, as well as, in face-to-face consultation and maintenance of documented progress, which is an acute concentration of the gaze. It can be contended that, the staff are, likewise, under the gaze of superiors.

Surveillance by health administrators is proliferating with technological developments such as the ability to share health information in networks of registers and recall systems (Staples 1997). The Health Funding Authority (HFA), in New Zealand, obligates hospitals to operate points systems for elective surgery to rank all prospective patients according to urgency and achieve preference for the most needy on waiting lists. The New Zealand Health Information Service (NZHIS) operates the national health register centralizing health information. Patients are assigned a unique identifier on the National Health Index, a population-based register. These aspects of the system facilitate population surveillance and reveal that the patient is indeed enmeshed in a system of surveillance on entering hospital.

Foucault sees power operating in a fragmented fashion rather than emanating from central sources. The very knowledge of one's visibility is enough to constrain actions and affect self-discipline, patients fall into line with dominant discursive formations. Discipline is integral to the operations of power in the panopticon model. Foucault shows how systems,

such as the medico-scientific paradigm, are invested with power that enjoys the complicity of persons/populations in their own surveillance. Force is not necessary to gain the co-operation of patients.

5.2.4. Rendering the Patient Docile

The following section details how technologies of power, outlined above, might be applied to a hospitalised population. Foucault's articulation of 'normalisation'²⁶ offers insight into the processes which produce subjects as passive in the context of medical authority.

Normalisation, refers to the mechanisms by which individuals acquiesce to the norms of society. Foucault is referring to how we 'read', observe, comply, reproduce and practise the dominant social norms. He states the division of 'normal' from 'abnormal', is crucial to the understanding of power's work in normalisation. The body is trained to align itself with practices which indicate it as 'normal'. Discipline: '...actively seeks to cultivate a certain type of body on the basis of knowledge considered 'true', (McHoul and Grace 1993: 69). In her feminist application Bordo (1993) describes it as,

...all those modes of acculturation which work by setting up standards or 'norms' against which individuals continually measure, judge, 'discipline' and 'correct' their behaviour and presentation of self' (199).

Standards (norms) within culture are unstable rather than stable, also volatile admitting resistance and change. Bordo (1993) points out that normalised femininity is countered and disrupted in our culture by constant propositions that choices exist; invisible under the guise of choice is the coercion to conform. So, although, a resisting position may be proffered, the convention of femininity has a recognisable frame and demands enactment. Individuals utilise the mechanism of self-surveillance, that is, the self-checking and constant alterations of behaviour, in normalising. We are normalised by complicity with hegemonic patterns (Bordo 1993:191). Three of the participants, discussed their mode of dress, expressing a desire for modesty to avoid drawing attention to their feminine frames. An awareness that night clothes exposed her shoulders, made Julia feel very self-conscious, constantly, adjusting her sitting position and pulling up her hospital gown. Both Nicola and Carol wore

their own night gowns. Nicola found it very hot in the hospital in summer, and she was running a temperature, she said,

for the sake of modesty I didn't feel that I could put on one of the sort of big heavy hospital gowns, but I did feel really uncomfortable, I just sort of felt that every time I was getting into bed I was trying to arrange myself so that things weren't jiggling around.

As Carol went in as an emergency admission, at first, she wore a hospital gown which was open down the back, she remembered being very conscious of how short the gown was, and that, as she was bent over in extreme pain at times, she had difficulty maintaining her modesty when climbing on and off the bed and getting up. On the first night, her husband brought in two nighties he had purchased that day, they were white, and she felt it necessary to always wear her bra underneath, and put on a dressing gown everytime she got up. Carol felt some slight relief in the fact that she was beside the window, and could get out of bed on that side avoiding the side next to the male patient. Carol and Nicola stated that they made specific adjustments and alterations to their behaviour because of the presence of men.

The combined affects of the concepts outlined above produce 'docile' or conforming bodies. One is rendered compliant, passive, and falls in line with standards prescribed, for one, by social codes of conduct. 'Docile' bodies do not have to be ruled by force from above as punishment entails. Individuals are produced as docile bodies through various forms and techniques of discipline, including those they exert over themselves (Ramazang̃lu & Holland 1993: 261). As noted earlier, Foucault's panopticism illustrates technologies of power as populations are self-disciplined in line with hegemonic discourses.

Medical discourse produces the 'patient'. The medical construction of the 'patient' is universalized as anatomical features, physiological processes and genetic blueprints. On entering the institution of the hospital, every aspect of the person is open to scrutiny, their medical history, their social connections and their occupation. Patients are monitored twenty-four hours a day; findings are recorded and enter a systemic collection of

²⁶ Foucault's usage of 'normalisation' differs from the social science term applied to mental health care in chapter 2.

information. Every part of the person becomes medicine's business, no part of ones' life is exempt from enquiry (Turner 1992).

5.2.5. Power/knowledge Dyad as Productive

Foucault awards a particular status to knowledges. Knowledge is linked to power in an inevitable dyad, where the two are intergenerative, one of the other. Relations of power for Foucault depend on the efficacy and functionality of discourses. This section discusses how Foucault's concept of power/knowledge aids understanding of the operation of discursive constructions of patient care. Individuals capitulate to a discourse which speaks the anatomo-clinical subject into being. A state that entails being examined, observed, scrutinized and regulated by regimes of drug and therapy modalities. These modalities depend upon scientific knowledge. Doctors are critically placed in fields of power relations, where the scope their specialist knowledge is far reaching, affecting a position of dominance. Shildrick (1997), contends that the patient/practitioner relationship is formulated along gender lines and can be deconstructed, to reveal, that doctors are cast as 'male' and patients as 'female'; the 'well' are differentiated from 'other(s)' who are cast as feminine, in an asymmetry of power relations.

The patient is an open book, a continuous record is scripted of the various episodes of consultation and treatment. The patient is not under duress, but submits to observation and is rendered transparent to an expert gaze. The resulting knowledge belongs to medicine. A version is filtered, divested of its scientific framing and distilled, to make it palatable to the patient who is more often than not, infantilised (read feminised) in this process. The concept of docility is important in analysing why/how people conform to practices, and in this case, the practice of mixed-sex rooming.

Foucault details the medical gaze in *The Birth of the Clinic* (1973). An ever evolving constellation of techniques form the medical specialist gaze, as science extends the boundaries of knowledge. The classificatory gaze is looking for patterns, sets of identifiers that indicate the presence of particular disease, sifting through signs and symptoms for known archetypes. The patient is only relevant, in that, what they reveal in history, symptoms and measurements, permits identification of disease. Foucault notes a relentless

reciprocity between doctor and patient in the reading and re-reading of the signs in the patient. In the very circularity of assessing, there is recognition of disease and healing. The medical gaze, then, is the process of discovery, of recording and mapping, of the archetype and its variations, an abstracted searching and evaluating.

Discursive constructs are not static but are subject to transformations, both, sympathetic and contrary. In the process of being hegemonic, discursive constructs, also, are presented as neutral, that is, the concepts are based in an accepted knowledge/wisdom and consequently hold particular power. Importantly, Bailey's (1993) description of hegemonic discourses posits that,

...the interests involved in the truths and knowledges circulating in western post industrial societies have been erased, allowing them to be presented as neutral' (120).

A disciplined populace is produced in being subject to a dominant discourse. I am suggesting that the 'truths and knowledges' of new right economics, which circulate in the restructuring of New Zealand's public sector, are being presented as neutral and viewed by proponents as 'interest' free. Rationale for permitting MS rooming, depend upon the hegemony of such a discourse, and it being carried over into the uses which space/architecture is deployed.

5.2.6 Resistance: The Redefinition of Space

An important theme in the interviews describes the efforts the women made to redefine the space, to survive in their rooms. For 24hrs a day, Julie closed the curtains as best she could, with her limited mobility. She reflected, that, she constantly tried to balance her need for privacy against feeling that she may be cast as 'being a difficult patient'. She was 'determined to have things as right for myself, as I could'. She had to ask nurses to draw the curtains at the foot of her bed to eliminate the fixed and constant stare of the 'druggie' opposite. Carol, although mobile, also pulled the curtains 'most of the time'. They were both very conscious that their actions affected their room-mates. Carol said she felt 'mean and snobby' for keeping the curtains drawn. But despite this social awareness, her need for privacy was overriding.

I am contending that these efforts represent resistance to being made a spectacle, an unwilling object, under the gaze of multiple observers. The position of onlooker is constituted in several versions: the male gaze, the medical gaze and the institutional gaze, in the form of the hospital. Hospital power is exercised in the above situations at the capillary level, that is, in the 'smallest details of everyday life' (Foucault 1977: 198). The women are enmeshed, in interlocking regulatory discourses, one of medicine which exerts its form of disciplinary surveillance, and a second discourse of modern health administration, and its governance and management of patients, and lastly, the discourse of heteronormativity, in which, female gender and sexuality are defined.

Staff actively dissuaded Karen from having the curtains drawn, she was even chastised by nurses for wanting to pull them during the day. As she couldn't pull them herself, she was left in the 'open'. Karen conveys her feeling of being in the 'open', as similar to being in the middle of the living room of a student flat, with everybody else's lives, comings and goings, happening around you. Julie, carefully differentiated between visual and auditory privacy, curtains only provided a semblance of privacy as they were flimsy and every sound, conversation and smell could still be sensed. Therefore, curtaining provided only a façade of privacy. The women's efforts to reap privacy from their shared space, can be interpreted as resistance, enacted to gain some control. Resistance though, was tempered with well learned social graces. Carol and Julia, acknowledged the effect of pulling the curtains for their neighbour, especially the fact that the windows would be largely obscured, and asked their room-mates, if they minded the curtains pulled. In each case, the men were happy for the curtain to be drawn.

As mentioned in the previous chapter, an example of the exercise of resistance, occurred as Carol and Nicola decided to spend as much time as they could out of their rooms. Both women took this action knowing they really needed more rest than they allowed themselves, yet, they preferred to be free of the closeted and watchful space of their rooms. A certain compromise of their medical condition, though, ensued from their decisions. Nicola was drinking large amounts of fluids to combat fever and pushed herself to walk the long

distances to find toilets out of the ward. Carol was in extreme pain, walking with difficulty, yet, she choose to look for clean toilets in public areas of the hospital and avoided time spent in her room.

A further strategy the women deployed, to escape the discomforts of the situation was to insist on early discharge. Karen went to great lengths to achieve her 'escape' by submitting to the traumatic process of being fitted with a halo brace²⁷. She learnt to raise herself off the bed to sitting, and then, learning to walk after over a week flat on her back, an accomplishment on which early discharge depended.

In some institutions where it is practiced, MS rooming is constructed as 'normal' and 'normalcy' is confirmed and reproduced on the multiple occasions it is repeated without recourse to explanations or excuses. Topham-Kindley (1992) reports Mr Jim Magee, the Dunedin Hospital Manager as claiming 'most people seemed to find it (MSR) quite acceptable.' Compliance, by patients is expected in these settings, and any objection is at risk of being categorized as deviant. Inquiring, or complaining, female patients exceed not only normative femininity, by speaking out and questioning, the appropriateness of a common practice of the institution, but, also challenge normative views about patients as docile and regulated individuals.

Subjugated discourses are those that are blocked by a system of power, they contain suppressed knowledge; knowledge that is discounted for its lack of formality or unsupported by dominant regimes. Suppressing, and policing, an alternative discourse has the effect of neutralising and depoliticizing dominant discourses and rendering other positions as deviant (Cain 1993). The need for privacy, and expression of embarrassment, by individuals often reflects suppressed knowledge. Schoeman (1984: 315), explains the role privacy plays in the freedom of the individual, '(P)rivacy removes classes of social restraint and permits one to exercise autonomy.'

²⁷ A halo brace is a steel device that stabilizes the upper spine in a fixed position with the head facing directly forward and immobilized by a frame which is screwed into the skull, halo like, and extensions ensure the neck is immovable. Usually fitted for several weeks while the vertebrae heal.

Edelmann (1981), comments that,

the crucial condition necessary for embarrassment to occur is that an individual behaves in a manner inconsistent with the way in which he or she would have wished to behave.... social expectation which governs and defines desirable behaviour has been violated.

I am positing that dominant discourses of gender constitute 'classes of social restraint' which prescribe social relations. Subjugated knowledges can operate in contexts free of an active system of power. Privacy can permit a space where systems of power are less influential. The likelihood exists, that, privacy is severely compromised when one is mixed-sex roomed. 'Classes of social restraint', and the operation of discourses, to 'police' and 'silence' are interlinking facets integral to discerning discomfort and distress expressed by those who have experienced mixed-sex rooming. It is important, here, to recall from the previous chapter, Foucault's explanation, that it is in the relations of power, that points of divergence permit alternative and resistant positions. Therefore, privacy can be seen to negate some material and structural effects of dominant discourses, while privacy permits social and personal freedoms/expressions that, otherwise, might be constrained in varying degrees.

The above theoretical positions usefully set out a framework to apply to the women's interview material of this study. They show how hegemonic discourses of femininity circulate and how competing and resistant discourses exist, and come through to influence social relations and demarcations based in sex. Below the discussion addresses, space and corporeality, at the micro level of intimate proximity, under discussion are the influences of constraining social norms upon individuals.

5.3. A Geography of Intimate Space: The Micro Level

Benno Werlen's (1993) work explores theories of spatiality. Werlen is concerned that discussions within traditional geography, regarding space, mistakenly attribute causality, volition and qualities of power to space, supposing space an entity. A theoretical position based on the attribution of empirical and, therefore, substantive qualities to space, that has been pursued by geographers such as Bartles (1970) and Bunge (1973), and, the

anthropologist Hall (1966), who claimed that space 'speaks'. Werlen denies that space, in itself, can have causal effects, arguing, that it is human actions that are responsible for the presence or lack of influences in social relationships, not spatial dimensions in themselves. Werlen maintains that traditional spatial models of geographic philosophy are reductionist, in so far as, they adhere to the premises of cognitive behaviourism. Werlen proposes that an action-oriented social geography offers an effectual model for investigating the social world and discerning the apparent dynamics of space. In Werlen's view, 'dynamism' or causation, can only be due to human action, it is the volition of the subject, and the subjects' action, which determine the effects of power often attributed to space and location.

In other words space does not have the ability to cause, or influence, anything because it is human action which firstly determines the effect of space. The facilitation of movement, or constraint on actions, due to spatial arrangements depends on the symbolic coding and cultural meanings people attach to given physical settings. Giddens summarises a key point in Werlen's (1993) book noting that,

(L)ocation is only socially relevant... when filtered through the frames of reference that orient individuals' conduct' (xv).

Privacy and beliefs about a right to privacy, are vital 'frames of reference' in examining the social relations essential to the care of the patient in the spatial configurations of the hospital.

Werlen's discussion is pertinent in regard to conventions regarding privacy. Through Werlen, we can see that the characteristics of space, such as how it is used, assessed, bounded, and defined, impact upon how privacy is maintained or compromised. Persons, or actors, operate in spatial localities that are orientated by conceptual frameworks. The nature of a locality, its physical dimensions, construction and the proximity of objects, contribute to structuring possibilities of self-expression and relationships.

The literature, revealed that the characteristics of the space, or localities, where women patients are housed makes a distinct difference to the women's perceptions about their own

safety²⁸. Single-sex bay wards received endorsement, as opposed to, fully mixed facilities, and provision of separate toilet and washing rooms were repeatedly noted as preferable (Page 1995; Kettles 1997; Cleary and Warren 1997; Warner and Ford 1998). The levels of staff monitoring, and chaperoning, altered the stress and comfort levels of patients. These structural measures, both physical and organizational, offered degrees of privacy vital to patient security.

5.3.1. Privacy at Issue

In bioethics, an extended philosophical exploration on privacy has resulted from Warren and Brandeis' (1890) early paper titled 'The Right to privacy'. Schoeman's (1984) anthology brings together contemporary philosophers' discussions that attempt to define the meaning and significance of privacy. A significant body of work discusses privacy, as related to our integrity as persons, involving respect for persons as a tenant, and, as an element necessary to the formation of the self²⁹. Fried (1984) states that essential elements of trust, love and friendship contributing to our success as social beings, depend upon privacy. Trust is relational, it is 'reciprocal forbearance' offered between individuals and, as such, is functional. Privacy is the necessary condition for the development of trusting relationships and one's ability to maintain relationships. Revelations regarding personal matters have the propensity to be rewarding, or detrimental, depending on the relationship between parties. Personal information revealed in a context, where the relationship is not compatible with disclosure, is most likely to be detrimental. The one disclosing is opened to the vagaries of strangers, who have no investment in a relationship, and when personal information is disclosed in 'an improper setting a sense of violation is occasioned', particularly, when such disclosure is occasioned by a third party (Schoeman 1984:408). While disclosure, by the patient, is fundamental to the practitioner/patient relationship, disclosure of a patient's intimate details and physical body to 'room-mates' is incongruent to the casual meeting/relationship, of one patient with another in hospital, where meeting is merely opportunistic and not 'chosen'.

²⁸ See page 14 & 15 in reference to single-sex bays and 'women only' provisions.

²⁹ A second interpretation of privacy within traditional ethics proposes that privacy is a right that is derived from other essential rights, such as property rights, personal rights (for example the right to freedom from

Women in this study and cases in the literature remarked that they curtailed their contribution to doctor's consultations due to the lack of privacy. The patient/practitioner relationship is effective only if trust exists, and informed consent, ultimately depends on trust. In 1995, a Dunedin newspaper reported, a gynaecology patient who was angry about being interviewed by doctors in a room with male patients present. She is quoted as saying 'I had a lot of questions written down but it wasn't private enough so I was scared to ask them all' (Benn 1995). Responding to a United Kingdom Community Health Council's survey and echoing this same sentiment, an English woman said,

Talking to medical staff is sometimes embarrassing and even worse when someone of the opposite sex might be listening. It makes it hard to give all the facts that may help with your recovery (Snell 1997:29).

Nicola and Louise had difficulty offering some information to their doctors, and did not pursue lines of questioning about their condition and treatment because of embarrassment at being overheard by male patients. Nicola was embarrassed and did not pursue questions about the merits, or disadvantages, when doctors (accompanied by students), discussed the possibility of investigations involving vaginal examination behind curtains with men in the room. Louise relayed her feeling of being silenced, and experiencing extreme distress, when her doctor commented on the shape of her breasts after reconstructive surgery and that she had a 'good cleavage now'. Thus, lack of privacy, limited the flow of information with the result that consent could no longer be held to be truly *informed* consent. The possibility that misinformation is produced, in these circumstances, must mean that optimal decision-making is foreclosed.

For the women above, a safe space was essential to freely share necessary health information. A feeling of powerlessness, in relation to the presence of men, existed as an adjunct to the differential in power between patient and doctors who steer and conduct consultations. The location in which the consultations took place was a constraint upon the women's choices and, thus, compromised or prevented the giving of informed consent. The

harm). Though acknowledging these other viewpoints I need to state that for my purposes in this discussion of privacy it is more useful to view privacy as an essential right rather than as derivative from other rights.

social significance of the positions of bodies in the given locality bore upon the women's actions. Werlen (1993:202) maintains that,

(I)n particular situational conditions, there are human actions which produce intended and unintended objective consequences in spatial arrangements.

To Werlen, space does not 'cause' events, it is a complex constraint on them and primacy must be given to the subjective agency of the players in any encounter. Snell (1997:28), recounts a nurse saying to a female patient "For goodness sake cover your legs up" implying the elderly woman was being immodest in the presence of male patients. This patient was in a single-sex side of the ward, but male patients 'milled about', and wandered 'up and down' the women's side. Their activity placed this woman 'in view', yet the woman was admonished for her apparent immodesty (at least to the nurse, and the implication was clear to the woman). Although the elderly woman had limited mobility and pain due to an injury from a bad fall, her perspective was discounted, the male sensitivities (whether actual or imagined) were accorded precedence in the eyes of the nurse. The act of defining space, along any number of social conventions, is played out by individuals as active agents. Here, it can be seen, that the male perspective was legitimized due to a convention or expectation that it is women who are constrained to maintain modesty. The presence of males heteronormalised this 'women only' space. Men move in public spaces with '...more legitimacy and physical safety than women' (Duncan 1996:129). Despite the years of women's liberation, men's presence and activities have legitimacy, in both the public and private spheres, that exceeds that which is accorded women (Duncan 1996).

It can also be concluded, that, the men contravened an equally compelling convention which entails recognizing, and maintaining, the demarcation between space deemed public (the walkway area) and the private space of someone's allocated bedroom area. Demarcation of space, and sexual difference, in this setting is dependent upon each individual's compliance with and willingness to follow social 'rules'. Demarcation is not achieved by fixed structural objects, but is expected to be achieved via the choice of each individual using the building and walkway areas and maintained by the authority invested in staff. Demarcation happens moment by moment in countless episodes of human activity, and at any time, there

is a risk of violation, breach or abandonment of conventions. Werlen's (1993:7) action-orientated social geography offers a theoretical insight into the meanings of bodies in space; it is not space itself that emanates power, or sexualized spaces, but persons of action and agency who enter, exit, and occupy any given space.

Self-determination is eroded when another's actions place one in circumstances that are exceptional, even contrary, to a societal norm. Carol described this feeling of injustice as she reacted to being placed with male patients. She explained, how in her view, to be asked to share sleeping quarters with strange men is not the norm. In her professional life, she often attends business conferences, in hotel complexes. From her experience, as part of large contingents of conference guests, hotel staff would never suggest that a woman share a room with a male guest. Two women attending the same conference may be asked if they are happy to share, and likewise, male conference goers may be asked if they are happy to share, but it is unthinkable for women and men, as strangers, to be asked to consider being accommodated together. It is long established convention and norms that dictate the bounds of acceptable possibilities, and, here, gender norms are the counterforce to consideration of mixed hotel accommodation. Let me further illustrate this point, by comparing, the public and private hospitals' use of bed space. In private hospitals cost will dictate whether a patient has single or shared accommodation, but the same convention regarding gender and segregating the sexes, sanctions mixed-sex provision, as in the case of hotel accommodation.

Returning to Fried's (1984) notion of trust as 'reciprocal forbearance', to achieve reciprocity it must be assumed both parties are equal. In Shildrick's words, the parties are 'co-active' as 'potentially self-actualising agents' (1997:80). Shildrick (1997:81) reveals that equality does not exist when female subjectivity is relegated by 'the exclusion of women from the attribute of full rationality' within philosophical discourse. Rationality, being the attribute central to moral agency. Here, Shildrick concurs with Grosz (1994) on the liberal humanist conception of female subjectivity. For 'reciprocal forbearance' to yield patients' informed consent, conditions must be such that no coercion, intimidation, or external pressure be bought to bear. As the women did not feel free to question, or disclose, all the relevant information, the ideal conditions for freely given and informed consent were

lacking. Informed, or rational, decision making involves having all the information from which to selectively choose³⁰. Shildrick shows that the usual outcome of practitioner/patient interaction is patient compliance, a process that reiterates docility rather than promoting agency.

Doctors' enquiries into 'personal' (sexual and bodily) areas about the women, in the presence of males, precluded the exploration of important questions the women intended to address. In investigating the set of relationships between the 'actors' in the encounter of doctor/patient/overhearing-other-patient (gendered male), the boundedness of the hospital room admits a potential voyeurism; the women feel 'on view', objectified under a relentless gaze. It needs to be noted that male patients are objectified too, as according to the women's reports they, too, were interviewed in the company of other patients. In the mixed-sex room two objectifications are at work, firstly, patients are objectified by medicine as objects to examined, measured, assessed and monitored. And secondly, the women are subject to scrutiny, not only by medicine, but by male patients, relegating them as female and 'other', as detailed in the previous chapter.

5.3.2. Trust in Tension

Considering trust, and its relationship to personal disclosure, may give insight into why some people do not find shared rooming distressing, if, as Jocelyn experienced trusting social relationships are formed with fellow patients, then embarrassment, may not occur in uncomfortable degrees. Jocelyn commented that she and fellow patients were 'all in the same boat' a reflection that may indicate they shared recognition of this feeling in conversation or gestures which led to a degree of rapport, and trust, being established between room-mates. Reciprocity was a feature of the relationships in this hospital room, showing that each patient was a willing party to the forming of relationships. Consenting to sharing was a factor shared by this particular grouping of patients, in this, they all started on the same footing; sharing voluntarily.

³⁰ In the New Zealand legislation Regulation 2, Rights 6, Nos 1-4 of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 set out patients' rights to full

Benn (1984) notes, that privacy is integrally linked to respect for persons. The norms of society demarcate the parameters of what is deemed private, and infer a duty to maintain the inadmissible from public scrutiny. Thus, the elements deemed private are regulated by disciplinary regimes which restrict wholesale access, viewing and reporting. For example, the norm that requires us to regard the genitals as 'private parts', obliging us to cover those parts of the body, and requiring a duty to ensure the parts remain private, avoids giving offense. Benn proposes that the principle of privacy rests upon a more general principle of respect for persons. He defines the person as an active subject capable of exercising choices, a chooser pursuing projects, and, one who monitors her/his own actions and progress relevant to the fulfillment of goals. Benn terms this collection of activities one's 'enterprise'. Benn (1984:229) states that,

To *respect* someone as a person is to concede that one ought to take account of the way in which his/her enterprise might be affected by one's own decisions. By the principle of respect for persons, then, I mean the principle that every human being, is entitled to this minimal degree of consideration.

As expressed by the women, their key 'enterprise' was to get better, and this goal is linked to preservation of dignity and integrity. When physical surroundings were such that this goal was compromised, the women suffered distress and their very person was undermined. To Shildrick, the free person is characterized by self-determination and as such has 'interests', should one's interests be ignored self determination is overridden (1997:81).

Privacy is a necessary condition for personal autonomy to be realized. First, it is necessary to clarify the post structural position regarding 'autonomy'. In Shildrick's view, 'autonomy' is a restricted form of self-determination and a contributing factor to moral agency (81). Shildrick notes, that within bioethics, the autonomy of the practitioner is assumed, the focus on the principles of non-maleficence and beneficence which center on the agency of the professional, bear this out. It is only recently, that subjectivity and agency, have been co-extended to the recipients of health care, attested to by the work of the writers used here on privacy. A post structural assessment proposes that, freedom to determine privacy must involve power shifts, between domination and resistance. Regimes of power, whether

information regarding their treatment in the health service.

discursive exclusions based in logic and rationality, or policies, or normalized practices, work to constrain one's freedom and such constraints limit 'autonomy'.

In explaining the relationship of privacy to autonomy, Bloustein (1984), claims the fundamental issue at the heart of privacy is that individuals have the right to their liberty and free will, so long as exercising that right, does not impinge on others. Liberty and free will are necessarily inclusive of the preservation of one's dignity and individuality. An intrusion on one's dignity breaches the right to privacy. Bloustein (1984:188) notes,

Our law of privacy attempts to preserve individuality by placing sanctions upon outrageous or unreasonable violations of the conditions of its sustenance.

In similar vein, Reiman (1984), proffers that the condition of privacy is essential to the formation of the self. Privacy is fundamental to an individual's ability to decide between options before embarking on any course of action, and is fundamental to the formation of opinions, whether political, religious, relational or whatever. Decisions about the degree to which persons reveal their innermost assertions, even ambivalent positions, must be made firstly in the realm of individual privacy. Privacy is absolutely necessary to a person's formation of self-concept and the condition upon which one's conceptualization of self is developed and maintained. Reiman (1984:314) phrases it as follows,

(P)ersonal and property rights presuppose an individual with title to her/his existence- and privacy is the social ritual by which that title is conferred. The right to privacy protects the individual's interest in becoming, being and remaining a person.

Reiman's concept is that privacy is a material condition which supports the formation of individuality. Recalling Alice's (1994:115) exposition (in the previous chapter), of subject formation as being produced via the 'negotiations as both subject and object, signify...and proliferate other corporeal possibilities'. It is then, in the confines of privacy that the marginalized subject is asserted. Marginalisation is integrally linked to objectification which cannot wholly exist in 'private'. The condition of privacy temporarily removes certain types of objectifications (such as, viewing females as objects).

Underlying the demonstration of respect, is the fact that one concedes/upholds another's right to make choices, unaffected by others actions/opinions which might limit their freedom or alter the significance of options before one. Social norms, for example, involving socially acceptable practices about toileting and nakedness, dictate actions appropriate to solitude, intimate relations, and those that are deemed admissible, publicly. Defaecation is relegated to the sphere of individual solitude, persons observed while toileting experience extreme embarrassment (Benn 1984).

Raewyn and Eleanor, who were both on bedrest care for cardiac monitoring, found using the bedpan an excruciatingly embarrassing experience. Karen needed assistance with elimination and when she menstruated. She said she resented having no privacy for that personal aspect and felt her rights to privacy were subsumed by staffs' acceptance of the other woman's husband's constant presence. He was never asked to leave the room by staff for her benefit or privacy. Karen also faced the daily dilemma of being positioned as voyeur herself in relation to the other woman's care. The husband, who did most of the intimate cares for his wife, never pulled the curtains, Karen related,

Even putting her on the bedpan, you know, I had to watch all that too, wiping her bum, and they (the couple) didn't care, and there was no way I could get away from it.... So it was good motivation, I was given the choice of lying there for 7/8 weeks or going and having one of those halo braces put on. There just wasn't any choice.

The cumulative effect of persistent humiliations, led to Karen's decision to accept a treatment option (having the halo brace fitted) that would enable early discharge and her regaining her freedom of person.

Personal integrity and dignity are key terms relevant to this discussion. In a post structural account the terms articulate discursive constructs about the human condition. Jean Elshtain (1997), states that privacy is 'constitutively necessary' in the preservation of human dignity. Elshtain discusses, how self-disclosure and public revelation, of 'things private' expose one to exploitation, a breaking of trust that indicates the crossing of a boundary between the public and the private, a vital element to 'safeguarding the freedom of the body' (177). Human dignity is maintained in the separation of private space and public space. During

patients' hospitalization, restrictions on freedom of movement limit their ability to secure the conditions of privacy, usually accessible to them in their own homes and lifestyle. Furthermore privacy is asymmetrical between the sexes. Women's lives are more privatised than men's lives, due to traditional sanctity of the family and male sovereignty of the home, coupled with, non-interference by civil society in the affairs of the family. The public arena advantages men, who enjoy a currency in public spheres, that is, less readily available to women (Duncan 1996).

Nicola and Carol and others were placed in MS rooms without the courtesy of prior knowledge, staff who admitted them did not tell them that the room was mixed. Once placed in the room any query or objection would have to be voiced in the hearing of 'room-mates'. Their disquiet was silenced by the presence of others. The women expected that, in all probability, they would be sharing a room, as long established practices of placing only seriously ill in single rooms pave the way to that expectation. It is 'common knowledge' that patients of the same sex share. But, they held no expectation that they would be roomed with men. The affront (to use Carol's word) to their dignity, signals the denial of a fundamental right, that is, loss of control over their person.

5.4 Summary

Examining the relationships between space, power and corporeality has revealed several salient factors in regard to the operant discourses surrounding MS rooming. It can be seen now that Werner's subject-in-action operating in space and Reiman, and Bloustein's views of privacy cohere (as a condition necessary to personhood and thus inherent to the subject). The intersection involves their conceptions of the subject. I am not claiming that they are unanimous in their view of the subject, but that they agree that, to Werner, it is subjectivity that imputes agency in given spatial contexts, and to Reiman and Bloustein, it is privacy (which is space dependent) which is integral to the formation of the subject. Concomitantly, it is one's subjectivity which is acted upon in breaches (or conversely maintenance) of privacy, due to outworking or restrictions, on agency within a micro level space. The majority of women in this study expressed that MS rooming was an affront to their dignity and breached their privacy, especially as they were not given any option or choice about it.

The breaches, and intrusions, involved many of the myriad attributes that collectively contribute to the formulation of the subject, attributes such as status as women, patients, professionals or workers, partners, sexuality, ethnicity, daughters, wives and mothers.

The presence of men heteronormalised the hospital room, inadvertently the cultural/sexual complexities of society accrue, due, to the presence of both sexes in close spatial proximity. Something of the attributes of the public sphere penetrates the space that is held to be private, as indeed, one's bedroom space is normally presumed to be. The social understandings of marco levels about what it is to be men and women enter into the space. As social beings we relate to one another inculcated with a kaleidoscope of trappings represented in our cultures.

To Benno Werlen, the subject-in action, exerts affects on the environment; space takes on particular character due to the actions of persons. Werlen's work compliments Foucault's insights on the operativeness of power. Power is operative through peoples' actions, whether those actions affect close adherence, or resistance, to discursive constructs. Werlen and Foucault attribute power to individual subjects. For example, the exercise of discretion by hospital staff, to accommodate or not to accommodate, patients in mixed settings is power in operation. A particular decision is given precedence by somebody over alternative possibilities. Patients asserting power, by resisting, display themselves to be subjects-in-action.

For most of the women in this study, the micro level spatial arrangements, diminished and undermined the therapeutic aims of hospitalization. The positioning of patients was detrimental to 'getting well'. The mixed sex spatial arrangements ushered in constraints, which prevented some participants from gaining and giving information relevant to their therapy, and their giving informed consent. Constraints on information, potentially, have fiscal, as well as, treatment consequences. As optimal therapeutic value might be obstructed by lack of accurate information, then, poor decisions result in a state of affairs which is counter productive to fiscal goals of efficiency and improving the overall health of patients. Managers abdicated responsibility for the material effects on patients of MS rooming.

Instead, women were assigned responsibility for negative effects, it was implied some flaw existed in them if they were uncomfortable with the arrangements. Arguments to justify MS rooming based on universal concepts of womanhood run contrary to principles in the Code of Rights, which directs health professionals and health service providers to address individual need and respect individual patients. As Shildrick shows, the individual is neglected if universals are assumed, and applied, and women categorized by their willingness or failure to 'fit in' to prescribed categories. The macro and micro levels of interplay of techno-medical discourses, economo-managerial discourses and heteronormalising discourses, contribute to the institutional processes and corporeal effects on patients in hospitals.

In Foucauldian terms, the local effects of power, were seen in operation in the ambiguous character of accounts offered by hospital personnel of their actions. The literature, newspaper reports and the women's accounts of conversations with staff, revealed instances of staff (managers) stating MS rooming was less than desirable. Yet, at the same time staff deployed arguments to justify the continuation of the practice. I have shown that, assuming forceful compulsion is upon managers, to MS room, is a misrepresentation of processes of relating to managing hospitals, no manager it appears is under great duress, but could (and did in Louise's case) achieve single sex rooming, in the face of a complaint. They are not forced, but feel constrained to implement the arrangement (while consciously attempting to limit it in some instances) revealing they themselves believe it is not an ideal practice. Significantly, the issue is that, no solid grounds exist on which to justify a practice already nominated as unsatisfactory. It is my view, influenced from a Foucauldian perspective, that it is the exercise of diffuse power relations that sustains the unpopular practice.

6 Conclusion

My approach in this research has involved recourse to the literature that assisted in identifying the major implications of mixed-sex rooming for patients and the historical development of the practice. Analysing gender and gender politics became a core focus of the study as the women's responses to mixed-sex rooming revealed perceptions around gender difference and comfort levels and an assessment that the practice appears to attempt to render the differences between genders irrelevant. A further focus was a consideration of power within institutional structures and its influence on privacy and space. This permitted scrutiny of the actions of key players in placing patients, and the possible motivations or causes behind placement within the constraints of hospital spatial arrangements.

The literature searched for this project, has influenced the study in several ways. Firstly, it revealed that mixed sex rooming is on the whole limited, in western capitalist countries, to the United Kingdom and New Zealand. It is not the accommodation of choice for patients from countries that share similarities in many aspects of their health services, for example, the United States of America, Canada and Europe. One Australian study noted the practice in the mental health service. I was recently informed, by word of mouth, that The Royal Melbourne Hospital houses patients in mixed sex facilities, although I have not found evidence of this in the literature. Recent British articles noted their government's commitment to end mixed-sex provision by the year 2000. I am therefore concluding, from the sources accessed, that it is a minority practice and not favoured as an ideal.

A second influence from the literature affected method. My decision to undertake interviews with women retrospectively, after discharge from hospital arose from insights gleaned from previous studies in which the authors found inpatient surveys were not the best tool to gain accurate patient responses. A maximum variety sample was chosen as a style of selecting participants that would generate material across a spread of ages, relationship status, ill health conditions and localities, hereby, giving as broad a picture as possible within the scope of a small study of eight participants. This proved fruitful as participants

stated that they had avoided complaining to hospital staff about dissatisfaction yet felt sufficiently strongly to volunteer to be part of this study.

Thirdly, apparent acceptance of the practice by patients is definitely conditional rather than conclusive. My study supports the need to qualify patients' apparent acceptance of conditions centering around assurances of privacy and single sex ablutions.

Fourthly, the literature revealed the complexity of ethical, managerial and gendered discourses that are influential in discussion about mixed-sex provision. The New Zealand setting is no less complex. Health care takes place in politically-charged environs. Events such as ongoing structural changes and high profile medical misadventure cases, followed by legal proceedings, have drawn public attention and critique of the system (Easton 1997; Kelsey 1997; Martin 1997).

This study uncovers a serious tension between health professionals and health service providers obligations (legally and professionally) to honour and observe patients' rights and patient's entitlement to certain ethical rights. I have concluded that a practice cannot be defended by recourse to majority opinion or other rationale, when the substance of the issue in question involves the individual patient's right to dignity. I believe there is consistent evidence, from this study and from the literature, that mixed-sex provision does impinge on particular rights for some patients (rights to privacy, dignity and information) and it is untenable to pursue justification of the practice on practical or monetary grounds while the practice impinges upon any patient's rights protected under the Code of Rights in the Health and Disability Commissioner's Regulations 1996. Therefore a moral dilemma is exposed in the event of patient wishes being ignored and placement policies pursued. It is my belief that further research is required in New Zealand to assess the effects of MSR on patients.

In examining a politics of the body as it arose in this study, subjectivity is discussed with reference to feminist poststructural authors. A critical idea from this section is the identification of subjectivity as fluid and provisional. This insight challenges the existence of a universal and stable subject as put forward in grand theories. The 'site of possibility'

(referred to in Chapter 4), opened by fluid subjectivity, and including agency, has assisted me in accounting for the differences in the women's living out of their femaleness and their different responses to MSR. This understanding further informs me that it is inappropriate, given the above, to seek a universal policy in the expectation that all women conform in some way under the presumed umbrella status as 'women'. Any, and all, grounds upon which women (and men) may object to MSR are valid given that patients' individual dignity is to be respected (Benn 1984; Fried 1984; Shildrick 1997). This brings me to the point that it is, then, someone other than patients' interests that are being served by MSR when patients do not wish it. Louise and Karen's stories in particular, show that their interests were relegated as secondary to the practice of the institution(s) when in Karen's case her objections to the presence of the other patient's husband were ignored and in Louise's case that it was only after vigorous and persistent refusal to enter the mixed-sex room that she was allocated a single sex room. Gender can never be rendered neutral as dismissals of its centrality to being appear to signify (Butler 1993; Fuss 1989; Grosz 1994; King 1994). Those who are responsible for patient placement deny their own power and 'interests' (invested with the authority of an institution) when they neglect to offer any choice in the matter (Turner 1992). The 'interests' of the women participants who were distressed by MSR were overlooked and therefore trivialised.

A discussion of the environment and locale specificity of the practice of MSR looked at space, corporeality and privacy. Application of the Foucauldian concept of power/knowledge proved an effective tool to unravel the complex and juxtaposed elements that influence the practice of MSR on two planes, the macro and micro levels of space. The women's concerns centered on the personal level of their care and dignity while the ordering of space, could not be separated from the political influences upon health care delivery. The management strategies of some health providers, by focusing on cost containment, have allowed the erosion of therapeutic aspects of care (Benn 1995; Snell 1997; Warner and Ford 1998). A significant finding was that predominantly this group of women perceived that they lacked voice within the system, felt silenced and unable/unwilling to object to the practice. Their silence indicated the operation of power and its effects (Foucault 1980;

Turner 1997; Werlen 1993). The women were disenfranchised in a system that, in most of their cases, failed to offer choice.

It is my conclusion that the harm caused by failing to offer choice, is extremely significant, when what is at stake, potentially, is the avoidance of breaches of patients' rights. Any compromise to policy or the effort required of staff to reorganise patient placements and meet the single sex rooming needs of those patients who desire it, needs to be weighed against this potential for harm. It would seem in the best interests of patients and staff alike, to MSR only patients who give their free assent to this accommodation arrangement.

Health care reformers' rhetoric about increased accountability is at odds with those patients' experience of the practicalities of the hospital environment in cases where staff have not offered choice. The women's perceptions of the health system being under stress and staff being busy was a contributing factor to them feeling powerless to complain. Further change is envisaged in New Zealand's health sector and issues of quality are increasingly emphasised with an expectation of the assumption of collective responsibility (Cumming 1998; King 2000; Martin 1997). The first change to be enacted, following the passage of The New Zealand Public Health and Disability Bill on 7th of December 2000; seeks to ensure accountability of providers. This study may provide some insight about an aspect of quality care that, up until now, has not captured the attention of policy makers in a way that has been open to wide public scrutiny or comment. The topic has been cloaked in near silence with only occasional New Zealand media references over a decade of change (Benn 1995; Cannan 1998; Munroe 1999; Topham-Kindley 1992). The level of response to five recruitment advertisements for this study, run over two days in daily newspapers, is sufficiently high (twenty three people from localities across the country) to speculate that MSR is a matter of serious concern to consumers of the health service. It may be further speculated that, in volunteering to share concerns as part of research (where anonymity is assured) participants may have been encouraged to make comment that would not otherwise have become known to service providers. A near immutable unwillingness of consumers of the health system to criticise it remains of concern to me. I have shown that, where staff do not take responsibility to ensure patient satisfaction about rooming, it is patients who must

initiate steps to complain. In the very act of taking this step the patient/health professional relationship is changed. The patient is no longer, simply, the recipient of care, the political realm is entered as one resists the system and becomes one's self advocate (Shildrick 1997). This position necessitates the interplay of the individual situated at the margins of a system invested with power, and the central positioning of those who constitute the system. As Foucault has shown, the margins are difficult positions to occupy, and patients, compromised as they are by the life crises of ill health, deserve a health care service where patients' needs are preeminent over the needs of systems.

Subjecting patients to MS rooming despite their dissatisfaction, ignores difference and, in effect, disembodies patients, separating the centrality of the sexed body to being; the all-important body is relegated to a neutral state, a state that does not exist and is a denial of actual and agentic bodies. The process in which sex and gender are constituted with lived bodily experience cannot be so lightly dismissed.

7 Appendices

15 November 1999

Ms Beverley A BURRELL
PG Student
Sociology & Women's Studies
TURITEA

Dear Beverley

Re: Human Ethics Application – MUHEC 99/138
“Does Gender Matter? Untangling the significance of the Sexed Body”

Thank you for your letter of 5 November 1999 enclosing an amended protocol, Information Sheet, Consent Form, Confidentiality Agreement and Interview Schedule.

The amendments you have made now meet the requirements of the Massey University Human Ethics Committee and the ethics of your application are approved.

Yours sincerely



Professor Philip J Dewe
Chairperson
Massey University Human Ethics Committee - Palmerston North

cc Dr Lynne Alice
Sociology & Women's Studies
TURITEA

Mixed-sex Rooming in Hospital

An Invitation to Women to Take Part in a Research Project

Have you been a patient in hospital in the last 5 years and found yourself in a room where men and women are adjacent to each other?

If so, you are invited to take part in a research study aimed at finding out the issues and consequences of being mixed-sex roomed. Volunteering would mean being available for an interview to tell of your experience.

This project is conducted as part of post-graduate study at Massey University, approved by Massey University's Human Ethics Committee.

To take part or find out more information please contact:

Beverley Burrell
C/- Nursing and Midwifery Dept
Otago Polytechnic
PO Box 1910
Dunedin



OR

Dr Lynne Alice
Women's Studies Department,
Massey University,
Private Bag 11-222
Palmerston North
phone 06 350 5799 ext 2618

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For further information : The Secretary, Women's Studies, Massey University, Private Bag 11-222 Palmerston North, New Zealand. Tel. (06) 350.350 5799 extension 2618 Fax (06) 350.5627. Email L.C.Alice@massey.ac.nz

Research Topic:
Does Gender Matter? Untangling the Significance of the Sexed Body
Information Sheet

This information sheet is provided to participants to inform you about the research, who is conducting it and what your participation may involve.

This project is conducted by:

Beverley Burrell, RGON, BA(Otago), Dip. Tertiary Teaching.

I am currently a masters student at Massey University in the Women's Studies Programme. This study is research toward my thesis. I work as a lecturer in nursing and midwifery and have an interest in the care of women in hospitals.

The supervisor appointed to my topic is: Dr Lynne Alice, Women's Studies Programme, School of Sociology and Women's Studies, Massey University, phone 06 350 4938.

The purpose of the research is to find out the issues and consequences for women who have been mixed-sex roomed while in hospital during the last five years. My approach is to interview several women on their experiences of mixed-sex rooming after discharge from hospital.

If this has been your experience you are invited to volunteer to take part in this study.

Taking part would involve being available for an interview of approximately one to two hours, if one session does not allow sufficient time, a second interview can be arranged. An interpreter can be made available if desired. The interview will be audio taped with your permission. The interview can be arranged at a neutral venue and times that are comfortable to you. Following writing up of the interview you will be asked to check that the report represents your experience. You may decline to enter the study without effecting your future health care.

You are invited to ask questions about the research at any time during the study. You may refuse to answer any particular questions or request the tape is turned off at any time. You may withdraw from the project at any stage.

Information you provide will be used only for this research and publications arising from this project. The results may be edited and submitted to refereed journals and/or presented as a conference presentation so that other health professionals and consumers can benefit from the information you provide. A summary of the findings will be made available to you. You will be able to access the final report at the Massey University Library and the Bill Robertson Library (Dunedin).

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For further information : The Secretary, Women's Studies, Massey University, Private Bag 11-222 Palmerston North, New Zealand. Tel. (06) 350.350 5799 extension 2618 Fax (06) 350.5627. Email L.C.Alice@massey.ac.nz

**Research Topic:
Does Gender Matter? Untangling the Significance of the Sexed Body**

Consent Form

I have read the Information Sheet and have had details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.

I agree that my information be used only for this research and publications arising from this research project.

I agree/do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

I have had time to consider whether to take part in this study.

I know who to contact if I have concerns about the study.

Option (strike out where not applicable)

- I am happy/not happy for quotes to be used in the final report and publications providing these in no way identify me.

Signed:

Name:

Date:

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