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Miscarriage and Curtains: A phenomenological autoethnography of curtains, privacy, and loss in an Early Pregnancy Unit in the UK

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ABSTRACT

Curtains are an understudied everyday object which have considerable power. Research on their use within hospitals has primarily focused on their role in infection control, rather than as an agent for ensuring privacy and dignity. This paper presents an autoethnography of an Early Pregnancy Unit by a medical ethnographer experiencing an ectopic pregnancy, with a phenomenological focus on curtains. Within the treatment room, curtains facilitated bodily privacy and emotional support for those preparing for invasive scans. On the ward, staff attempted to use curtains to provide privacy, but the curtains were inadequate. This reduced the dignity of patients by allowing private moments, including visibly miscarrying a foetus, to be observed. It also allowed discussions around disposing of foetal remains to be overheard by others, reducing privacy. Hospital curtains are important agents of privacy and dignity, particularly around bereavement and loss.

1. Introduction

This article considers curtains' role as an agent that can facilitate privacy and dignity within hospital wards through an autoethnographic exploration of a UK Early Pregnancy Unit conducted by an experienced medical ethnographer. The paper draws on Sara Ahmed's *Queer Phenomenology* (2006) to centre the orientation towards the object – hospital privacy curtains – under study. To position the autoethnography, first, I discuss the role of curtains in society generally. Second, I consider the context of medical power in hospitals, with a particular focus on how hospital privacy curtains facilitate surveillance and infection control. Finally, I provide contextual information on pregnancy loss and its management in a UK context alongside existing literature from the geography of pregnancy loss and maternity.

The sudden move between discussing the mundane use of curtains in hospital and the life threatening – pregnancy loss – is intended to be somewhat jarring. Orientation is central to phenomenology (Ahmed, 2006), and having one's orientation entirely shifted by unexpected, urgent and life changing events is common with pregnancy loss. Despite this, pregnancy loss and those who experience it are often hidden; as a society, we orientate away from talking about the phenomenon. This includes delegitimising many pregnancy losses through not providing death certificates for early losses, which are those before 24 weeks in the UK (McNiven, 2016). My hope is that this feeling of being jarred and disoriented may enable me to bring readers along on this embodied phenomenological exploration.

1.1. Curtains

Curtains are everyday objects, found in homes, offices, and other buildings since the fifteenth century. Made of various materials, they are often part of the background to life and may be considered mundane. However, they have significant power in that they shape spaces architecturally by forming boundaries and influence the behaviour of those within and outside these spaces. Furthermore, they can prevent those outside curtained areas from seeing in, which may be desirable for people engaging in private or intimate activities. The drawing of curtains is also observed in some cultures as a symbol of respectful mourning following bereavement. Sociologically, curtains have not been considered in detail, although they have been used metaphorically in the discussion of often concealed activities such as developing reading lists for educational programmes (Little and Eichstedt, 1999); and yo-yo dieting behaviour (Ahmed Qazi and Keval, 2013). As well as being physical objects and metaphors for hidden activity, curtains have also been used to represent depression and loss in literature (Cadesky, 2017).

Whilst curtains may not be highly valued items, the feeling of potential observation in housing or institutional spaces without curtains is uncomfortable (Betton and Burrowes, 2009). In the UK, prisons are supposed to provide "privacy screens" to obscure those using toilets and showers, but curtains over internal doors or external windows are not

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considered essential items (HM Prisons and Probation Service, 2020: 8). This has led to the use of make-shift curtains in prisons using bedding to provide privacy, known colloquially as a *prison curtain*. Interestingly, in one study of a South African women's prison, it was noted that, despite breaking rules, these 'curtains' were allowed to stay in place during the day, despite a lack of curtains or doors in toilets and showers that transgressed usual standards of privacy (Dirsuweit, 1999).

2. Literature review

2.1. Visibility and curtains in hospitals

Power relations in health care settings between patients and staff are, in general, heavily balanced in favour of staff with opportunities for surveillance afforded to staff being a key marker in maintaining unequal power relations (Foucault, 1963). This is exacerbated in contexts where resources are scarce, such as the UK National Health Service, meaning that staff have considerable discretion (Hoyle, 2014). Healthcare can require intimate forms of "body work" where the bodies of (often low-paid migrant) staff come into close physical proximity to patients or their bodily fluids, (Dyer et al., 2008). Body work may be undertaken in ways that facilitate - or fail to facilitate – dignity for both patients and staff, depending on the culture of the health systems under study. Furthermore, surveillance in the form of patient visibility to staff has long been identified within medical settings and can be used to identify signs of clinical deterioration (Davies and Rees, 2010), as well as 'good' and 'bad' patient behaviour (Armstrong, 1995). There is, however, evidence that patients do not uniformly accept the authority of medical staff, including through familial surveillance of staff (Zhou and Grady, 2016). Furthermore, patients and families may also play important roles in undertaking surveillance and providing care, particularly within paediatric settings (Naylor et al., 2020; Allen et al., 2022).

As well as staff behaviour, the physical environment impacts on the emotional experience of patients and staff (Wood et al., 2015). Within traditional *Nightingale wards* (large rooms designed to host multiple patients without walls between them), the use of 'privacy curtains' remains common. To date, most research on curtains in clinical spaces has focused on their role in the spread of infections. For example, closed curtains have been theorised as potentially reducing patient-to-patient exposure of infectious diseases (Ching et al., 2008). More prominently, attention has been focused on curtains as agents capable of *transmitting* infection; cultures taken from the edge of curtains have shown the presence of bacteria known to be harmful such as methicillin-resistant Staphylococcus aureus (MRSA) (Brown et al., 2020). It has also been theorised that curtains restrict air flow and circulation around hospital wards, which can further contribute to the transmission of infections (Noh et al., 2018). As a response to this danger, interventions have involved impregnating hospital curtains with antimicrobial agents, but to date this has not been effective (Wilson et al., 2020). Arguably, curtains can also be a "very serious potential hazard" as they may be used in hospitals to facilitate suicide attempts, resulting in recommendations that they should be removed where present (Hunt, 2014: 38).

Research on the role of curtains in fostering surveillance, privacy and ward culture has been more limited. Their role in obscuring conversations to external parties has been assessed with patients reporting greater experiences of overhearing others' conversations, feelings of being overheard and lower privacy in curtained areas compared to those with solid walls (Barlas et al., 2001). 'Enhanced privacy curtains' have been developed to absorb higher percentages of sound, reaching a maximum of 30% in one assessment (Pope and Miller-Klein, 2016), and contributing to an increased ability for patients to rest in another (Locke and Pope, 2017). Within one ethnographic study, closed curtains on maternity wards were viewed as a way of patients attempting to secure privacy, whilst partially open curtains were a signal that patients were seeking information or support (Burden 1998).

2.2. Geographies of pregnancy loss

Around one fifth of pregnancies result in miscarriage or ectopic pregnancy (Alijotas-Reig and Garrido-Gimenez, 2013). This leads to long-lasting grief for many women affected (Fernandez et al., 2011), which may result in significant anxiety during subsequent pregnancies, for both the mother and her partner (Wheeler, 2000). Throughout the UK, specialist Early Pregnancy Units have been established to provide care to those experiencing complications in the first trimester of pregnancy. Activities conducted within these Units include scans, – both transvaginal and transabdominal - blood tests to assess pregnancy viability and, for non-viable pregnancies, 'watchful waiting', and medical or surgical removal of foetal remains (NICE, 2019). UK clinical guidance stresses that those experiencing complications in early pregnancy should be treated 'with dignity and respect' (NICE, 2019: 1.1.1). Similar guidance exists in the USA (ACOG, 2018).

Geographers have focused on pregnancy and early parenting experiences through a relatively large body of work, but so far have paid limited attention to pregnancy loss. In research with those who had experienced early pregnancy loss, McNiven (2016) notes that diagnostic scans could be "highly traumatic and distressing" (238). This was because the scans can quickly cause the reclassification of the pregnancy, from alive to dead, and the woman themselves, from mother to non-mother. This was particularly painful and shocking when participants were expecting a positive scan experience, as per the cultural norm, and had not had any symptoms associated with pregnancy complications. Furthermore, sonographers may not routinely turn the monitor away from patients, confronting them with a visual image showing the loss which may be unwanted, and was haunting for one participant. However, being denied a scan following a referral from a health professional could be equally distressing leading to days of anxiety. The wider context of Early Pregnancy Units has also been noted as problematic, with families receiving both good and bad news mingling in the same waiting room. In addition, the rooms themselves have the potential to "compound distress" as they may appear to be uncared for through their decoration (McNiven, 2016: 240).

Similarly, considering abortion – which shares many elements of medical and surgical treatment provided to those undergoing pregnancy loss - Calkin et al. (2022) have argued that greater attention is needed to consider space, power and citizenship. This is because abortion: affects large numbers of women; is a stigmatised behaviour which is compounded by its hidden nature; is politically contested and sometimes criminalised; and because of these factors it plays an important role in displaying the relationship between state and society. An additional body of relevant work is Colls and Fannin's (2013) research on the geographies of placentas; a pregnancy-related temporary organ, which moves from being inside the body to outside after birth, and may be consumed and returned to the maternal body. In doing so, potential for surveillance and regulation occur, where the placenta is handled and processed in particular ways. Consequently, placental material is handled differently and assigned a superior status to post-pregnancy bleeding. Like "blood loss" as part of pregnancy loss, post-pregnancy bleeding can be viewed as matter out of place through a lens of disgust, as has been identified in relation to breastmilk (Dowling and Pontin, 2017).

3. Data and methods

3.1. Theoretical approach: phenomenology and embodiment

Phenomenology is the intentional study of experience, from the researchers' point of view, which is often anchored to a particular concept or object. This article specifically draws on the work of Sara Ahmed's *Queer Phenomenology* (2006) to consider the interaction between physical space, objects (in particular, curtains), gender and the body. In doing so, it acknowledges that the bodies and objects which make up

spaces are moving and changeable; thus, the orientation of the researcher towards particular objects is ever shifting. Furthermore, objects that are central to our lived experience can blur into the background, as something more important is placed on top of or in front of them. In Ahmed (2006), a book on a table was described; within this study, I am considering curtains which are a backdrop to the hustle and bustle of activity on a busy Nightingale hospital ward. Alongside Ahmed's work which is focused on the importance of the central object, the curtain, the research draws on Leigh and Brown's (2021) embodied inquiry, in relation to the visceral embodied reality of the experience which contrasts the stability of the object under study.

3.2. Data production and analysis

In August and September 2020, I attended five emergency consultations at an Early Pregnancy Unit before being admitted on to the ward hosted at the Early Pregnancy Unit for emergency surgery. At the beginning of data production, I was around 7 weeks pregnant. Initially, I wrote long messages to my partner who was not allowed into the ward (due to COVID-19 restrictions –see RCOG, 2020), but this became detailed fieldnotes written on my smartphone as a form of distraction from pain and worry. My field notes were low inference in style, that is recording the environment, what was physically done and an outline of conversations (including short direct quotes when possible), rather than a general overview of events or my feelings.

Data were produced in continuous cycles. Prior to consultations with health professionals, I wrote questions or symptoms I wanted to discuss in the notes section of my smartphone. Then during or as soon as possible after an experience, I recorded notes on my smartphone without appearing to attract the attention of other patients or staff, as has been found in urban ethnography (Grant, 2021). Sometimes these were woven around my pre-written questions or notes, and other times they were unstructured to record as much of my recollections as quickly as possible to minimise potential data loss. Following this, the notes were expanded on, often within the waiting room on the ward when I attended as an emergency out patient, or at my bed when I had been admitted. There were sometimes gaps in fieldnote production, including due to my recovery from surgery. At the commencement of data collection, I was not explicitly aiming to undertake research on the role of curtains. However, upon reflecting on and expanding my field notes during my inpatient hospital stay, I recognised their importance and increased my focus on these objects. The fieldnotes were further expanded on after treatment had finished including the addition of emotional reflections and early analytical notes in a different font to the original notes. Furthermore, a timeline of events and the clinicians involved was created from my fieldnotes to help demarcate events and retain clarity.

Data analysis involved the reading and re-reading of field notes, which were then divided into units focused on events; some longer, others shorter, but with a clear beginning and end point, often demarcated by a change in physical location or the entry and exit of a person. To ensure that the analysis was a phenomenological "turn toward objects" (Ahmed, 2006: 25) and how they impacted events, each unit was reflected on in relation to the orientation of curtains and how this impacted events. Where similarities occurred between units, these were clustered into the groups which are reported on together in the results to create meaning.

Within the UK National Health Service, all studies are considered for ethical review by the Health Research Authority (HRA). The HRA (2022) require researchers to answer three questions, relating to: (i) if participants are randomised; (ii) if patient care is changed from standard practice as part of the study; and (iii) if researchers are aiming to provide generalisable findings. If the answer to all three questions is no, ethical review is not required as the study is not considered to be "research". However, to minimise any potential harm arising from my autoethnography, I considered the British Sociological Association's statement of ethical practice (2017). In particular, I did not record personal details of patients or staff, and I do not name the hospital.

3.3. Researcher positionality

I am a white British gender-ambivalent Disabled and Autistic woman from a working-class background. Each time I presented to the ward, my husband (a white Welsh man) came to the ward door with me, sometimes wearing a suit and tie. Furthermore, he was recorded as my next of kin (someone who I had nominated who could make medical decisions for me, if I were not able to make them myself). However, we do not share a last name and, due to hand pain, I often do not wear a wedding ring. On one occasion, I was questioned with disbelief about "actually" being married by one member of nursing staff. When asked about my occupational role, I reported that I was a researcher, with 'public health researcher' or 'infant feeding research' given as my topic if requested.

In terms of my physicality within the spaces, I was fat (obese in terms of BMI) and used a bright purple electric wheelchair to move more than a few metres. The spaces were narrow and challenging to navigate in my wheelchair. My hair was turquoise at the time of the first five appointments and purple at the final two appointments. I have large, colourful neo-traditional tattoos on one arm. Clothing is an important marker of status and can be used by ethnographers as a way of establishing common ground with potential participants (Delamont, 2016); when conducting ethnographic work in clinical spaces (see for example: Allen et al., 2022), I usually dress similarly to the doctors. In pregnancy, identity and clothing become entwined and clothing influences pregnant subjectivities (Longhurst, 2005). Whilst in the field, I was in so much pain that I wore the same pair of lightweight stretch black maternity dungarees (also known as 'overalls') every time I attended, including wearing them throughout my two nights as an inpatient. I did not wear socks or footwear - due to difficulty bending my abdomen - when visiting the toilet (also known as a restroom), shower, or treatment room during my 35 h as an inpatient. This was commented on in a seemingly judgemental manner by one nurse ("Really? You're not going to wear shoes?!"). My only other outfit whilst on the ward was a "patient gown" (a loose garment closed on the front but open along the whole back of the body) and net underwear that I wore immediately prior to being taken to the surgical theatre. In addition to my bodily presentation, on arrival at the hospital I provided a 'cheat sheet' of my diagnoses, doctors' names and telephone numbers, and allergies and medications, as I am medically complex. It was 1.5 sides of A4 and was introduced into my patient notes on my first attendance.

4. Results

Findings are presented in relation to a description of the two settings (the treatment room and the ward), alongside my experiences of consultations at the bedside, changing clothes behind curtains and the impact of partially closed curtains around other patients' hospital beds. Data are purposely used to provide a strong affectual impact centred around the physical space and its impacts, as related to curtains.

4.1. Setting 1: The treatment room and curtains

There was one treatment room on the ward (see Fig. 1), which consisted of two distinct areas: a small desk for consultations that involved interviewing to create clinical histories, taking blood, inserting cannulas, and very brief abdominal examinations. These brief examinations, which involved palpating the abdomen to identify large areas of internal bleeding, might have occurred at the desk for me because I am a wheelchair user (to save time or to reduce my need to expend energy getting onto the examination table) or might have been standard practice.

The second area, which could be divided from the first area using a blue disposable privacy curtain, contained a gynaecology examination

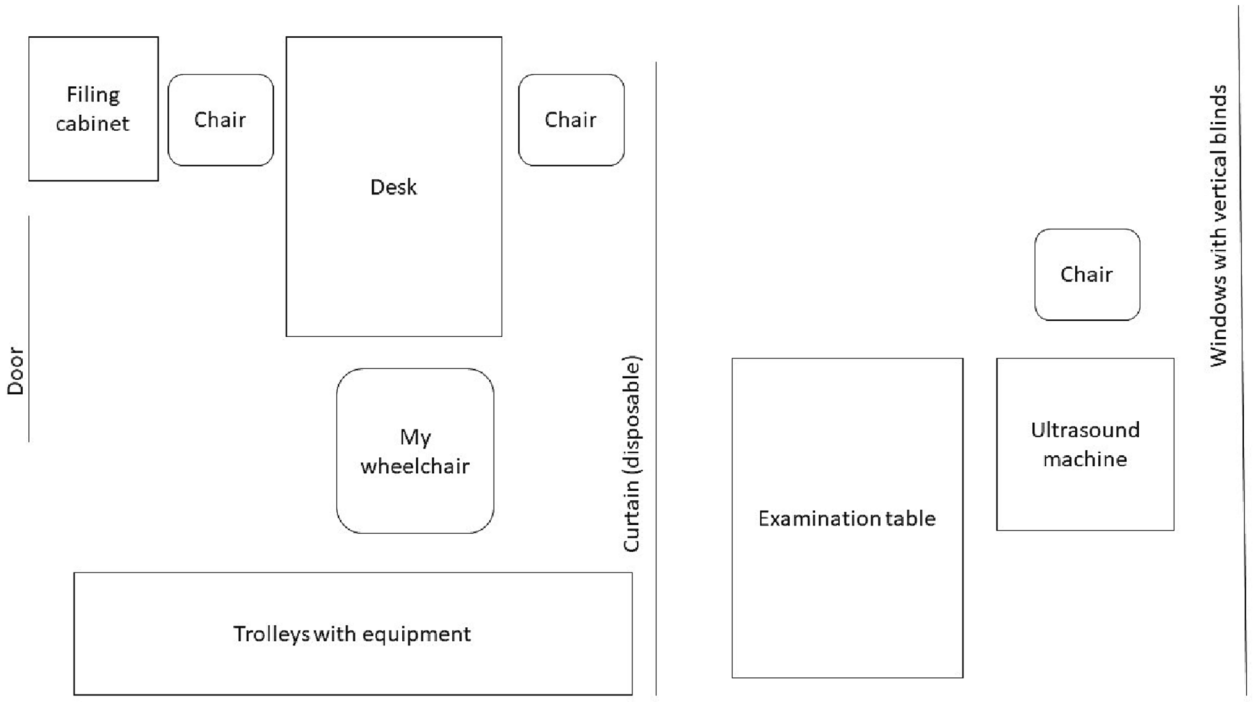

Fig. 1. A map of the treatment room.

couch covered in blue tissue paper, an ultrasound scanner and stool for the health professional undertaking the examination, and a plastic trolley (a storage cart with wheels to enable movement) with clear drawers containing a variety of items including blood test tubes, swabs, speculums of various sizes, and sanitary pads. I had two transvaginal scans and one examination of my cervix in this area. Each time, I was given instructions to 'strip off below the waist' and use the 'sheet' to cover myself, before the nurse and doctor had moved to the other side of the room and pulled across the dark blue paper curtain to allow privacy whilst getting ready. On two of the three occasions, the nurse chatted to me about light-hearted and unrelated topics from the other side of the curtain, trying to put me at ease. When I had arranged myself on the couch, I announced to them 'OK, I'm ready'.

On the third and final occasion, the consultant stated that they would wait outside of the room. I got ready and waited for several minutes before they re-entered the room. I felt much more awkward than on the previous occasions:

> Do they know I'm ready? Should I put my trousers back on and go outside to say 'I'm ready' (but of course I wouldn't be ready anymore). Should I shout out to them? I really don't want to waste their time. In the end, I did nothing(…) After a few minutes, the male consultant knocked on the door immediately opening it, announcing 'is it OK if we come in?' as he did so.

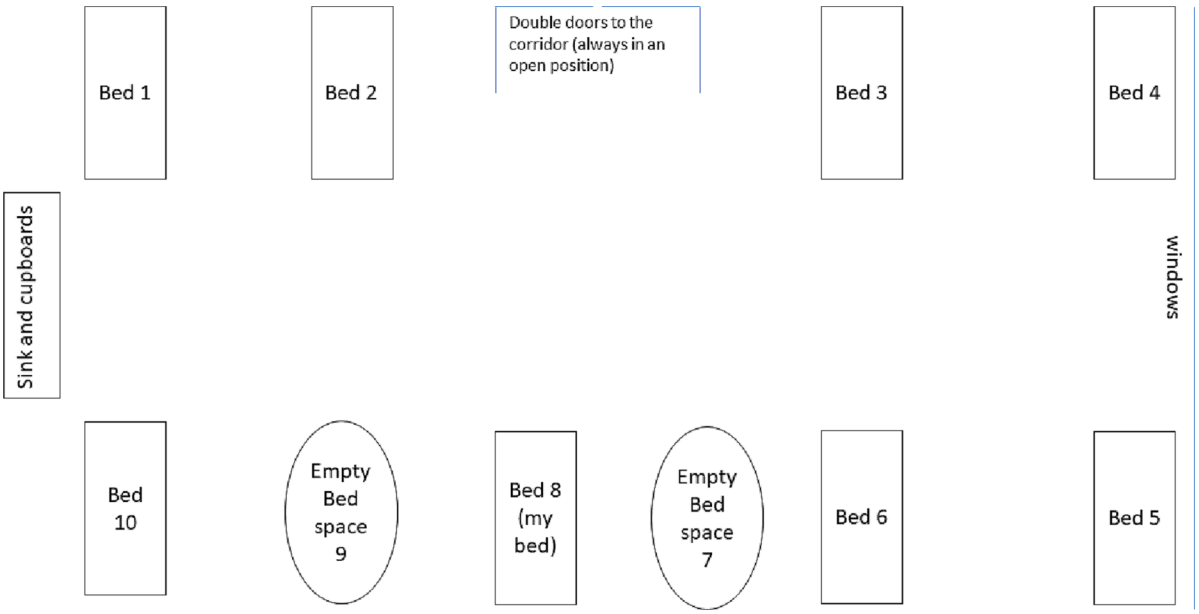

Fig. 2. A map of the ward, showing bed positions and spaces with no beds.

4.2. Setting 2: The ward and curtains

Hospital wards in a UK setting most often comprise of one or more rooms with multiple patient beds. When there is more than one multiple-patient room on a ward, they are often referred to as 'bays'. In the hospital in which I was treated, the staff referred to the room I stayed in as "the ward", although there was another smaller bay which appeared to be part of the same ward. The ward was a rectangular room containing space (and curtains) for ten beds, with two beds either side of the double doors and six beds on the opposite wall (see Fig. 2). Two bed spaces (spaces 7 and 9) did not have beds in them, possibly as an attempt to reduce COVID-19 spreading within the hospital.

My bed, bed 8, was directly opposite the double doors into the bay. Nurses sometimes place unstable patients where they are easiest to monitor (Allen 2015), and I may have been placed there for increased visibility. Alternatively, I may have been placed in this position as I arrived late at night when the lights had already been turned off, and several of the patients appeared to be trying to sleep:

> Having been assessed by the registrar, I did not arrive on the ward until gone 11 pm. The lights were dimmed, and the curtains around patients' cubicles were in various states. The curtains were made of an old, worn, soft fabric with a faded print and slightly shabby appearance. The patient in bed 5 (to my right) had her curtains pulled a little, allowing for facial privacy, whilst her body could still be seen. The woman in bed 3 (diagonally opposite me to the right) had her curtains entirely open. The patient in bed 1 (diagonally to the left) had her curtains pulled along the length of her bed, but open at the end; however there was a gap along the side, and I could see her face. The patient in bed 10 (to my left) had her curtains entirely closed around the space.
>
> My curtains were left open, with a nurse coming to ask questions to complete a nursing booklet and an HCA (Health Care Assistant) coming to take my 'obs' [clinical observations, including blood pressure, oxygen saturations and heart rate] every hour for three hours, and then every other hour. I wasn't asked if I wanted the curtains open or shut. With the curtains open, the light in the corridor was sufficiently bright that the staff did not need to use a source of light to be able to read and complete paperwork.

The feeling that I needed permission to control the curtains was reinforced when I partially closed the curtains during the following day, to try to dim the light and facilitate sleep. I later woke to find the curtains had been fully opened whilst I was asleep: "which was jarring and unexpected". In addition to these bedside curtains, in the two largest toilet/shower rooms, a curtain rail and disposable paper shower curtain was in place. On the edge of these curtains at the top was a sign stating that staff should not enter to allow the patient privacy. These privacy signs were not present on the curtains on the ward.

4.3. Consultations at the bedside

Until the morning after I was admitted, all my consultations had occurred within the treatment room or the doctors' office. The morning after my admission a consultant visits me at the bedside on three occasions. The first two times, the curtains are used haphazardly, but the third time, they are closed fully and remain closed afterwards to allow me privacy:

> Theatrically he pulls the curtains around with a flourish, like a magician's cape but there are three curtains making up my bedside curtains and one side stays open. I can see other people (in Beds 1 and 2). They can see me.
>
> (The second time he comes to my bed) he asks me what I understand is happening to me and then invites me to the treatment room for a scan. I do not know why this conversation couldn't have taken place there, where there are solid walls.

After the scan in the treatment room, the consultant returned to my bedside, a large A3 carbon-copied pad in his hand, to 'consent' me. Again, there is the gap on the left-hand side of my area where he doesn't fully close the curtains. Afterwards I note:

> He leaves and fully opens the curtains. I want to cry, but the two women to my right are having a nice chat about something banal and it feels awkward, so I hobble my way to the toilet to cry in privacy.
>
> (Shortly after) The doctor is back, a single A4 sheet of printed white paper is in his hand. This time he makes more effort with the curtains; they're fully closed, maybe because he pulls them more slowly, or it may just be luck. He also lowers his voice.
>
> Consultant: 'You might think this is a bit unusual, but we have to ask.'
>
> Me: 'OK.'
>
> Consultant: 'Would you like the remains returned to you? Or, the hospital can sensitively dispose of them?'
>
> I think he also says something about individually disposing of 'them'.
>
> I don't speak for a bit.
>
> Me: 'Could you please organise…' (trying not to cry, not able to finish my sentence)
>
> Consultant: 'Of course, you'd like the hospital to sensitively dispose of them?'
>
> I nod.
>
> Consultant: 'I'm sorry we have to ask.'
>
> Me: 'It's OK.' (crying)
>
> Consultant: 'I just need to (something) –'
>
> He starts writing on the form. I think I might have had to sign and date it but can't remember.
>
> When he leaves, he asks: 'Would you like the curtains opened or closed?'.
>
> Me: 'Closed please.'.

This is the only time I am asked about my preference for the curtains throughout my treatment.

Other members of staff were more cautious about ensuring closed curtains during our bedside consultations. For example, an anaesthetist came to the bedside, pulling the curtains around and standing on my right-hand side. She introduces herself and then:

> She notices the gap in the curtains on the left. She pulls the curtain open behind her, and goes around the outside of the cubicle to pull the curtain fully closed. Then she asks me questions about my previous anaesthesia experiences, allergies, loose teeth, piercings, metalwork and documents it all carefully in her notes.

4.4. Getting changed behind curtains

Around 9 pm, I am awakened by a patient, I'm not sure which one, probably the lady in bed 3, as the lady in Bed 5 is now obscured from view by the closed curtains of the new patient in Bed 6.

> 'Aimee, Aimee, wake up they're coming for you!'
>
> Nurse: 'OK, Aimee, let's get your gown on.'
>
> Me: 'Can I go to the toilet first please?'
>
> Nurse: 'Yes, go on then.'
>
> I take the gown and a clean postpartum cloth pad to put in my knickers [underwear] in the toilets.
>
> When I return, a male porter in a red polo shirt is hanging around by my bed space. He's quite young. I feel weird that he is getting to see the naked back of my body and my knickers.
>
> The nurse returns and draws the curtains.
>
> Me: 'Have I done this (gown) up right?'
>
> Nurse: 'Right enough. Although, you don't want to wear your own knickers, you might not come back with them.'
>
> Me: 'Do I go without knickers? I'm bleeding.'.
>
> Nurse: 'I'll get you some paper ones.'.

> The nurse returns with paper bikini briefs. The porter is immediately outside of my curtain, a bit like a bouncer, presumably to make sure I don't cause a hold up in the surgical schedule. The nurse pulls my curtain as she leaves, but they are not completely closed in two places – to the left and the front. I can see the back of the porter's body, the downy hair on his neck, and the face of the woman diagonally across from me (in Bed 3) – if I can see her, she can see a bit of me if she tries; fortunately, she isn't awake.

4.5. Partially closed curtains around other beds

In addition to my own experiences of curtains being left partially open, on three occasions when I lay awake in my bed, the curtains of my neighbours were not closed properly, and I was able to see very private moments.

The patient to my left in Bed 10 had physical disabilities and needed assistance to move her body on several occasions. On the first occasion, I saw movement out of the corner of my eye and saw that the patient was naked or close to naked and receiving a bed bath; they were not covering her body with towels as I had been taught as a Health Care Assistant more than a decade earlier. I felt embarrassed for her that I could see this, and quickly averted my gaze. I estimated that around 50 cm of curtain had been left open, as I was able to see a large section of her torso and thigh obscured only in part by a nurses' body.

On the second occasion, the same patient had rung her buzzer. Two Health Care Assistants came to her bedside and helped to reposition her body in the bed. Again, a gap was left in the curtains which enabled me to see inside the area, which I looked away from to reduce my intrusion into her care. Regardless of this, I could clearly hear one of the healthcare assistants asking the patient: 'Is that okay? Are you a bit comfier on that side?' and other questions to determine the best position to leave her. However, I felt that there was an important difference between overhearing a conversation about supporting somebody to move their body, which was conducted in a way I felt intended to maximise dignity, and viewing the inelegant physical manhandling of an adult body that I knew to be going on behind the curtain from my own nursing experience.

The third occasion occurred on the second day that I was in hospital as an inpatient; a new patient was admitted into the bed space to my right (Bed 6):

> I come back from the toilet and there is a woman in the cubicle next to me (on my right), with the curtains inadequately drawn around her bedside. The woman is quietly, but consistently crying. There is a gap in the curtain; I can completely see inside, but I try not to look. Out of the corner of my eye, I see her take off her trousers which are bloody at the crotch. Next come the knickers, which are presumably saturated with blood, she doesn't look like she's sure where to put these clothes. She is presumably losing her baby.
>
> I feel so awkward being able to see her distress, and the evidence of her miscarriage. To avoid looking, I turn over onto my other side – I'd been avoiding doing this because the nurses often left a gap in the curtains around the disabled woman's bed (bed 10) and I didn't want to infringe on her dignity, but this feels worse. I put in my headphones (so I can't hear her cry) to give her as much privacy as possible. I debate leaning over to close my curtain (between us there is an empty space for a bed), but I feel it would draw attention to me being able to see her and make me seem uncaring, or worse still judgemental about her crying.

I write in my notes: "I really want to offer her a hug, or even just to say 'are you OK? Can I get you anything?' but I don't (offer her a hug, or speak to her at all), because I can't move well." Afterwards I reflect that my hesitancy was more likely about me not breaking the unspoken code that the partially open curtain gives full privacy to noise and vision in case she would be embarrassed or not want to have to try to 'put a brave face on' her distress for me.

4.6. Curtains and infection control

My time on the ward was during the COVID-19 pandemic. At the time, I was part of the UK government "shielding" scheme for Disabled people likely to be significantly affected by COVID-19. "Shielding" meant that I was protected from COVID-19 exposure through policies such as free food shopping deliveries, my regular medication being delivered to my home and a formal letter I could show to my employer saying that they should allow me to work from home if at all possible. Due to the "shielding" policy and being on Disability leave from work, I had been well isolated from COVID-19.

However, during my treatment, shielding me from potential exposure to COVID-19 did not seem to be an obvious priority. For example, whilst I always wore a reusable N95 mask in the EPU waiting room, most patients didn't or couldn't wear masks:

> "(the woman opposite me in the waiting room) sometimes holds the tail of her headscarf over her mouth to cough into…(the woman with hyperemesis gravidarum) comes back from the treatment room with disposable cardboard bowls (to be sick in) and a bottle of water that she gingerly sips from. Nobody seems to care that people aren't wearing masks, and I feel a bit awkward wearing mine all of the time."

Furthermore, when I was admitted to the ward, I was shocked that only staff were wearing masks, and that they were basic surgical masks rather than N95 masks. During my time on the ward, I did not see another patient wear a mask:

> "It feels strange and unsafe to be around so many people with the windows barely open. I'm just going to keep my mask on, and will argue against it if I'm told to remove it…I keep on waking up not able to breathe properly; these masks aren't designed for sleeping in, with half of the surface pressed into a pillow… At some point I wake up and I've taken my mask off whilst half asleep. I put it back on and hope I've not been infected.
>
> When I am consented to have surgery, the consultant tells me that death rates following surgery using a general anaesthetic are now at around 25% due to COVID cases. He can't tell me what that means for me as someone with a BMI over 30, but logically it will be higher. I don't understand why they're not trying to protect us (from COVID-19) more.

At the time, I was very aware that home-made fabric masks, made from cotton material that was similar to the fabric of the curtains on the ward, were strongly recommended by Trish Greenhalgh as a way of preventing transmission (Greenhalgh et al., 2020). Having been part of the "army of volunteers" who sewed masks and scrubs for the NHS in the early days of the pandemic:

> I'm wondering why the curtains aren't being used to reduce the potential of infection, surely they'd be better than nothing?

5. Discussion

This paper has reported on the ways in which curtains were used within a UK Early Pregnancy Unit during the COVID-19 pandemic. Curtains were first considered as a tool to facilitate privacy whilst providing reassurance in a treatment room with solid walls where ultrasound scans were undertaken. Second, I considered the use of curtains within an inpatient Nightingale Ward comprising of space for 10 beds, with eight beds present. Curtains were routinely left open and were often left partially closed when patients were in undignified positions, such as being washed, getting changed prior to surgery, and whilst changing blood saturated clothing. Consultations and consent, including to dispose of foetal remains, occurred at the bedside surrounded by

flimsy curtains which did little to prevent sound travelling.

5.1. Phenomenological embodiment and spaces of loss

As Ahmed (2006) notes, the curtains, staff and to a lesser extent patients on the ward were continually moving and thus changed the flow and feeling of the space throughout this autoethnography. These shifting boundaries impacted on the "human understanding" and development of knowledge that occurred throughout this study (Leigh and Brown, 2021). My own response to other patients' dignity being breached by inadequate curtains included physically moving my body to provide the privacy the curtains failed to deliver. Within Ahmed's queer phenomenology, the orientation away from an object is as relevant as what is orientated toward, allowing me to look ""behind" phenomenology" (2006: p29) and to hear the phenomenon of care work without seeing it. Furthermore, it may have been part of a mental model in which I hoped *all* patients would provide this "civil inattention" (Goffman, 2005) so that my own privacy and dignity would be better respected. This behaviour was different to how I would have reacted if I were on the ward as an ethnographer, where I would have felt that I had more authority to observe patients, as they would have already consented to my presence, negating the need to abide by societal norms of civil inattention. However, as an ethnographer my role has generally been to shadow medical staff and thus I would have been much less focused on the issues caused by privacy curtains as, like staff, I would have been constantly moving. My position as a relatively stationary observer and participant allowed for a literal different angle to be observed, due to sitting or lying in a bed.

My behaviour, which attempted to provide greater privacy to other patients, may have also been related to the embodied experience of pregnancy loss as something that is often hidden, despite its frequency (Alijotas-Reig and Garrido-Gimenez, 2013; McNiven, 2016), implying that to lose a baby is shameful or even the mother's fault (Boynton, 2018). Like McNiven's (2016) participants, I shared spaces – both the waiting room and the ward - with patients who were not undergoing a pregnancy loss, which was awkward leading to a feeling of needing to hide my grief within the ward's toilets. Furthermore, the spaces and some curtains were shabby, and appeared uncared for (McNiven, 2016). These spatial issues may have been related to de-prioritisation of "women's healthcare needs" (Calkin et al., 2022). Within my fieldnotes, my focus on collecting low-inference accounts of the interactions with health professionals and later my detailed consideration of curtains and the physical environment impacted on how I, as a patient, inhabited the space. In doing so, I oriented my body away from my physically and emotionally painful experience (Leigh and Brown, 2021), replacing this role with that of an observer. By choosing to focus on curtains, I purposely orientated towards a group of objects within the physical environment, consigning other patients and medical equipment to the "background".

5.2. Curtains, visibility, and surveillance

Visibility within medical settings can be justified by the important role of visually 'eyeballing' patients (Davies and Rees, 2010), and it certainly felt that the nursing staff did not have time to do more than 'eyeball' me. Leaving curtains open can also be viewed as a way of facilitating peer-support among patients or signalling the desire for information by patients. Conversations occurred between myself and two other patients on the ward, facilitated by our beds being positioned roughly in a triangle shape and our curtains mostly being open (Burden, 1998), although I was the only one of this group to be undergoing pregnancy loss and I did not speak to these patients about my pregnancy loss, as it would have felt impolite to do so (McNiven, 2016). Open curtains can be viewed through a lens of allowing patients a choice over whether to make further displays to show that they are interactionally open (Goffman, 2005). Two of the patients who were on the ward when I arrived had their curtains open entirely most of the time; by contrast two patients, one of whom would have been unable to control her own curtains physically, had their curtains closed most of the time, but with gaps providing visibility. Control over whether to have my curtains closed did not appear to reside with me routinely, and this was possibly due to my status as a patient in need of emergency surgery (Allen, 2015), illustrated by the fact that the only time I closed my curtains they were open when I awoke. By contrast, I was offered the opportunity to have closed curtains by one doctor following an upsetting discussion about disposing of foetal remains at the bedside, where arguably the status of the loss as a "death" was at its highest compared to other experiences as it was the only time that paperwork needed to be completed (McNiven, 2016).

It is particularly important on the Early Pregnancy Unit to facilitate dignity (NICE 2019), especially on a mixed ward where some patients are losing babies and others are in hospital due to pregnancy related illness or gynaecological surgery, and gaps in curtains undermine this aim. Poorly closed curtains regularly allowed private moments to be observed leading to a loss of dignity. Furthermore, not all staff closed the curtains when treating patients, which seemed related to whether there was potentially something embarrassing to see, rather than to hear. Standard hospital privacy curtains eliminate only around 20% of noise (Pope and Miller-Klein, 2016); in my experience it was easy to overhear conversations nursing staff had with patients from behind closed curtains, although I did not observe any doctors' consultations at the bedside other than my own. Overall, conversations at the bedside with and without closed curtains led to a feeling that there was no privacy (Barlas et al., 2001), and I found myself talking to staff in hushed tones to attempt to enhance my privacy. As medical professionals internationally are held to strict confidentiality standards, the failures of privacy curtains feel like a potential breach. However, under the HIPAA privacy rule (Department of Human and Health Services, 2023), whilst clinicians are not able to disclose information without the patients' knowledge or consent, being present during a consultation could be viewed as consenting.

5.3. Curtains and COVID-19

Infection control has previously been identified as an important role for hospital privacy curtains, both as objects that can enable (Brown et al., 2020) and prevent (Ching et al., 2008) the spread of infection. This study took place within a global pandemic of an air-borne disease (SARS-cov-2; COVID-19). It is noteworthy that curtains were not used to reduce the spread of infection on the ward, perhaps by being pulled partially around each bed as standard practice. It may have been that the potential negative effects of reduced air flow (Noh et al., 2018) or the reduced opportunities for 'eyeballing' patients (Davies and Rees, 2010) were seen as more important or that spacing beds out with a gap between them where possible was viewed as sufficiently protective. Regardless, this lack of use of curtains to prevent infection control alongside not offering to provide masks for patients meant that the burden on attempting to minimise exposure to COVID-19 in the air fell to patients themselves.

5.4. Strengths and limitations

This research took place in one UK Early Pregnancy Unit over the course of five outpatient visits and 35 hours as an inpatient by one researcher/patient. This limits opportunities for generalisability. Furthermore, this inpatient stay included a period where the researcher/patient attended surgery and recovered from a general anaesthetic, meaning that there are times where field notes were very brief or missing and had to be written a few hours after events occurred. Accordingly, they may not have fully or accurately captured my thoughts about events at the time they occurred. During the fieldwork, the COVID-19 pandemic was impacting on the care provided in UK

hospitals, including reductions in staff, inadequate personal and protective equipment, and reductions in staff morale (Wood et al., 2021). Further changes occurred in the ecology of the ward due to the removal of partners and family who routinely play a role in identifying and reporting patient deterioration (Allen et al., 2022). This includes attendees within the Early Pregnancy Unit not being allowed partners or visitors to attend at all (RCOG, 2020) which may have resulted in a greater need for staff to be able to observe patients. Despite these limitations, the researcher is an experienced medical ethnographer, with experience of working ethnographically on hospital wards and as a Health Care Assistant within the NHS. During the data production phase, she was able to unobtrusively write field notes on her phone, allowing for many field notes to be recorded during or immediately after events.

6. Conclusion

Curtains are believed to perform important roles for dignity and privacy on hospital wards, particularly when bereavement is expected to occur. However, it is widely known that they are inadequate at preventing conversations being overheard, and the privacy curtains in the hospital under study were comprised of a series of three curtains, allowing for two gaps per curtain which resulted in private moments being observed as well as heard. Their utility for promoting dignity can be further undermined and escalated, particularly in the context of COVID-19, by busy health professionals needing to "eyeball" patients or not having the time to ensure the curtains were fully closed. Additional research should be undertaken to understand how dignity can be promoted on multi-patient wards.

Reproductive geography is a well-established discipline, but so far limited attention has been paid to the topic of pregnancy loss. This is despite its impacts on the lives of many women, which can have long-term impacts on mental health. Accordingly, additional study in this area would be valuable including observational research in health care settings and qualitative studies with those who have experienced pregnancy loss and staff providing care to them. Moving beyond curtains' roles, this study adds evidence to McNiven's assertion that the spaces in which treatment is provided for pregnancy loss can impact on experiences potentially compounding grief. Attention to the design of these spaces, potentially including the use of multiple waiting rooms, and separate spaces on ward for those experiencing pregnancy loss could allow for greater peer-to-peer support during pregnancy loss.

7. Data availability statement

Data are highly personal autoethnographic field notes, and are therefore not available for secondary analysis.

8. Funding statement

No funding was received for this research.

9. Ethics approval statement

I completed the Health Research Authority ("NHS ethics") tool (https://www.hra-decisiontools.org.uk/research/question1.html) "is my study research?" It decided that my study would not be considered research by the NHS and therefore was not eligible to be subjected to ethical review.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

The data that has been used is confidential.

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