Stigma of Infertility And Privacy Invasion in Medical Spaces

Ching-pei Wu
Institute of Sociology
Academia Sinica, Taiwan

Chyi-in Wu
Institute of Sociology
Academia Sinica, Taiwan

Institute of Sociology R2313, Academia Sinica, No.128, Sec. 2, Academia Rd., Nankang District,
Taipei City 115, Taiwan
cpwu@gate.sinica.edu.tw

ABSTRACT

Although the birth rate is decreasing worldwide, it’s still an important responsibility for women to bear babies in the Taiwan context. The prevalence of infertility is a trend in Taiwan recently; nevertheless, it is a “stigma” of no kids to carry on the family name.

The stigma theory as Goffman mentioned, not like a cripple with a cane gives quite visible evidence, infertility is a particular stigma that we could not immediately know whom she or he is a infertile one. Infertile person’s diffrentness is a discretable one, not discredited. Besides managing information about her failing, an infertile woman should be active going to hospital to try to have children to rid of the stigma of infertility.

My focus in this article is on the infertile women whom derive from three clinics in Taiwan about their attitude to involuntary childlessness, their responses to infertile stigma, and their reaction to privacy invasion in medical space. There are 165 valid samples in quantitative data and 12 valid samples in qualitative data (from 165 quantitative samples).

Findings:

First of all, is infertility still a stigma to these interviewers? “Meet acquaintance or not” is the key factor to them to feel “lose face or not.” If there are all strangers in the hospital, they felt nothing about lose face or not. Secondly, information management is a part of secret concealment, but the hospitals in Taiwan don’t pay much attention to patients’ privacy and invade their privacy at clinics. Owing to having a child, the infertile women still keep on going to consult doctors about reproduction and receive treatments voluntarily. And because of the different attributes which clinics have, they react such a non-private situation differently as follows: exit, voice, and loyalty. For the same reason--the different attributes of clinics--supported them easier destigmatize themselves.

Conclusion:

The interviewers in this study hope that hospitals could pay more attention to their privacy and take notice of spatial hardware in hospital. It may let them feel ease and comfortable in each phase of treatment.

Key Words: Infertility, stigma, medical space, privacy invasion.

INTRODUCTION

Erving Goffman has mentioned how bodily signs that depart from the "ordinary and natural" are deeply discrediting. His insights have been extended to a variety of others, not always visible, conditions such as metal illness and homosexuality. People who possess visible stigma is discredited, others who possess invisible stigma is discretable. Infertility belongs to the latter. We cannot know him or her is infertile when we see him or her; we just can guess why he or she is childless.

Although it's a prevalence of childless families recently, and more and more place accept these exists. However, not every society, country or culture would accept this phenomenon. Cultural norms, values, and policies (Miall, 1986) may affect infertility as stigma. For example, Bulgaria women have been conceptualized a role of mother (Todorova & Kotzeva, 2003). Greil (1991) articulated that infertility is a social stigma. The infertile, like the chronically ill and disabled, see their condition as stigmatized by society at large. When cultural norms and values encourage reproduction and celebrate parenthood, and then childlessness becomes a potentially stigmatizing status that can adversely affect the identities and interpersonal relationships of married persons.

Unlike paraplegic or the blind, the infertile possess a secret stigma; they display no obvious stigmatizing features, and it is relatively easy for them to pass as normal. However, in early traditional Taiwan society, voluntary childlessness is virtually unknown. There was no secret to the stigma of infertility in that time. If a woman did not have children, people assumed she was infertile. Those who are targets of stigma label would take an active role, either by resisting or accepting the label. No matter what action they take, they really do actions.

Since the feeling of infertile stigma, I assume that infertile women may pay much attention to their privacy of infertility. When they visit hospital for pregnancy, they may not hope others know this private personal information. Hospitals in Taiwan nowadays always invade patients' privacy in medical spaces. Meanings and experiences of infertility have been studied in a variety of cultural settings (Greil, 1991; Todorova & Kotzeva, 2003; Riessman, 2000). There is less invasion of privacy in medical spaces to infertile women. I would like to add to this literature a perspective from Taiwan and particularly the voices of the Taiwan women I have heard. Do they feel infertility is still a stigma to them? What strategies do they use to reply when they are invaded in medical spaces? In this study, I'll present how they felt about visit hospital for pregnancy and how they reply to invasion of privacy in medical spaces. This research contributes to comparative studies of invasion privacy in medical spaces, and by inviting women's voices into infertility discourse, there are insights for doctor-patient relation and the arrangement in

medical spaces studies as well. My analysis also raises questions about stigma theory as it has developed in the West.

METHOD AND PARTICIPANTS

I approached the study of experience of infertility in Taiwan in a way that assured voluntary participation. The data here derive from observation of 165 clinic sessions in three hospitals in north Taiwan—Taipei. Each hospitals of three has its reproductive center. These 165 women participated in the quantitative study, of them 12 participated deep interview too. I would show some simple frequency tables and present more qualitative data in this paper. The interviews used a semi-structured format. Informed consent and the interviews were taped and later transcribed verbatim. Only pseudonyms are used to identify the participants. The 165 women were diverse in terms of age, education, and profession. The participants ranged in age from 22 to 55, and they had a variety of professions, including junior high school and college teachers, insurance agent, car sales, comptroller, and director of enterprise.

RESULT AND ANALYSIS

The following **TABLE 1** is the characteristics of participants in this research. Most of them had jobs, while 60 percent were more than 34 years old; nearly 45 percent lived with their parents (or parents in law). More than 80 percent attended collage and nearly 80% married for three years.

TABLE 1. Characteristics of Sample (in percentage)

Years of Education	
Less than 12 years	18.0
15-16 years	68.5
More than 18 years	13.5
Age	
≤ 26	1.9
27 - 33	38.0
≥ 34	60.1
Average ＝34.39 S.D. ＝4.08	
Years of Married	
1 - 2	21.8
3 - 4	47.3
5 or more	30.9
Average ＝3.59 S.D. ＝3.69	
Occupation	
Have	78.6
None	21.4
Live with parents (or parents in low)	
Yes	44.4
No	55.6

FEEL LOSING FACE OR NOT

The attitude of birth in culture shapes the view of infertility. In a society that encourages birth, you may be blamed if you don't have babies and you may be stigmatized if you cannot product babies. Individuals feel stigmatized because of the cultural value has deeply embedded in their minds. If they do efforts but can't reach the "normal" standards, they may easily perceive the feeling of failure (Greil, 1991).

The **TABLE 2** presents the traditional birth values. Here we could see nearly eighty percent (77.5%) agree with the statement "it's important having babies let parents happy", about seventy percent (67.7%) agree with "having babies can continue a family", and more than half (55.3%) agree with "it's a filial piety to have a son." To these interviewers, the traditional birth values of continuing a family and have a son to carry on the family name are very important.

TABLE 2. The traditional birth values

	1. It's a filial piety to have a son.		2. Having babies can continue a family.		3. It's important having babies let parents happy.	
	N	%	N	%	N	%
Agree	90	54.3	127	67.7	127	77.5
Not Agree	73	44.7	37	32.3	37	22.5
Total	N=163	100.0	N=164	100.0	N=164	100.0

Since the traditional birth values embed deeply in women's mind, infertility becomes a stigma. Try their best to get pregnancy is the basic solution to remove the label on them. Is visiting hospitals for pregnancy a shame event to them? Most of them would answered "no, it's irrelevant to feel losing face or not." (See **TABLE 3**) There are more than ninety percent interviewers do not agree the statement "it's a lose-face thing visiting hospital for pregnancy." I'm so surprised that such a very low percent women agree the same statement and I want to examine deeply.

TABLE 3. Feel Losing face or not to visit hospital for pregnancy

Do you think it's a lose-face thing visiting hospital for pregnancy?		
	N	%
Agree very much	2	1.2
Agree	12	7.3
Not agree	86	52.1
Not agree very much	65	39.4
Total	N=165	100.0

There are some statements they talked about. Let us see the following presentation:

Find out the problem, it's no relevant to losing face. It's fortunate that we have doctors to visit, and then doctors will find out what's wrong in your body (Ms B).

I think you have to consult doctor when there is something wrong with you. And I have been married and I'm in a birth age so that I think it's normal for me visiting for pregnant (Ms A).

It's a normal thing consulting a gynecologist-obstetrician, just like visit other departments. The goal is the same---solve problems. So I think it's normal to see a doctor for infertility (Ms D).

Nevertheless, do they really feel no losing face? For this question, we will focus on "who will know your condition" in following paragraphs.

Our interviewers gave us a key factor to answer the question "do you feel losing face when visiting hospital for pregnancy?" Whom you meet in hospital is acquaintance or not is the most important factor that may make a sense of stigma.

We all don't know each other! Even though she knows I'm infertile, it's all right that I don't know her. Right? (Ms. C)

I don't care how others stare at me, but I fear to meet acquaintances. Yes, stranger is no influence to me because it's impossible for us to get other again. That's why I don't think I should be shy or hide myself in the hospital. However, I…I fear to meet acquaintances (Ms A).

From above, the interviewers emphasized that people whom they met in hospital didn't know each other; they don't care if these strangers know their coming for pregnancy. And Ms A mentioned that she feared to meet acquaintances while they may ask you "How are you? Why do you visit hospital?" Moreover, they may get together in many occasions in the future. It's hard to avoid that they acquaintances wouldn't ask you the same subject. If they met acquaintances in hospital, what should they do? Ms B gave us a vivid discourse:

"I don't mind how others stare at me. Because.., ,yes, I know what you mean. For example, sometimes I may think that others may guess my coming for pregnancy but I just think that you don't know me and I don't know you, right? It's nothing about we see each other. Oh, last time I met my colleague in T1 hospital. I have not let anyone know my condition that time so I dodged quickly.

Yup, I think it may be embarrassing when we met each other. Maybe I could not tell her the truth; maybe I would say something else (Ms B).

Ms B thought that she would not mind others see her in hospital in the beginning talk, she also point out the “know” and “acquaintances” statement. If you were not acquaintance, and then I don’t want to worry about I would be known visiting for pregnancy in hospital. The experience “dodged the colleague quickly” was because Ms B didn’t want her colleague know her visiting hospital was for becoming pregnant. If visiting hospital for pregnancy is not a losing face thing, why didn’t she let her colleague know?

“Losing face or not” must be in a context that others around were acquaintances or not. Most people in hospital are strangers to us including doctors, nurses, cleaning worker, front desk server, other patients and these patients’ relations. All these people don’t know each other and there are not any overlaps in each daily life. Even though they are in the same space-time, when the moment passes by, they won’t overlap next minute. That’s the reason why they don’t think it’s a lose-face thing visiting hospital for pregnancy when others around were not acquaintances.

THE RESPONDENTS TO INVASION OF THE PRIVACY IN MEDICAL SPACES

Space could deliver messages. The stuff in the space and their arrangement would bring diverse feelings to people and impact them. It's a long-term treatment to infertility. Women who receive infertile treatment have to accept subsequent consultations again and again. In such a suffering mood, everything changed in the clinic space may possible influence their mood. Such as the increasing or decreasing of persons at clinic is a change in space: How many persons there? And what kind of people are they? All of these may affect the outpatient's emotion at clinic. Hospital is a place where let patients receive the remedy and get restored. Could hospital nowadays take care of patients' privacy and let them feel at ease?

Most women in this research were invaded of their privacy. See the **TABEL 4** the top three invasion in medical space in this study are 87.73% in "more than one patient stand by in the same consulting room," 63.41% in "the space was not private enough when you received private parts examination (e.g. vagina examination)," and 59.51% in "the voice of medical personnel explained patients' condition is too loud that people nearby all heard." And it's almost 60% outpatients experienced "interns were present on your private parts examination not getting your agreement (59.51%)" and "non-medical personnel always intruded when you were consulting a doctor at clinic (57.06%)." The data shows that hospitals seriously ignore patients' privacy and do not sense such a general condition.

TABEL 4. The Experiences of Privacy Invasion In Medical Spaces

	1. More than one patient standby in the same consulting room when you're consulting		2. Interns were present on your private parts examination not getting your agreement		3. The space was not private enough when you received private parts examination		4. The voice of medical personnel explained patients' condition is too loud that people nearby all heard		5. The clinic's door opened all the time that people outdoor could watch into the consultation		6. Non-medical personnel always intruded when you were consulting a doctor at clinic	
	N	%	N	%	N	%	N	%	N	%	N	%
Have experience or not												
Always	49	30.06	19	11.59	24	14.63	9	5.52	3	1.84	7	4.29
Often	51	31.29	26	15.85	19	11.59	23	14.11	9	5.52	18	11.04
Sometimes	43	26.38	52	31.71	61	37.20	65	39.88	42	25.77	68	41.72
Almost not	20	12.27	67	40.85	60	36.59	66	40.49	109	66.87	70	42.94
Total	N=163		N=164		N=164		N=163		N=163		N=163	
The experience made you uncomfortable?												
Yes	101	70.14	79	81.44	93	90.29	66	68.75	30	56.60	54	59.34
No	43	29.86	18	18.56	10	9.71	30	31.25	23	43.40	37	40.66
Total	N=144		N=97		N=103		N=96		N=53		N=91	
The experience may lower your willing to this hospital?												
Yes	61	42.36	57	59.38	69	66.99	44	45.83	21	40.38	33	35.87
No	83	57.64	39	40.63	34	33.01	52	54.17	31	59.62	59	64.13
Total	N=144		N=96		N=103		N=96		N=52		N=92	

Women experienced invasion of privacy in this study almost felt uncomfortable. From **TABEL 4** we can see that there are 90.29% women felt bad to “the space was not private enough when you received private parts examination,” 81.44% felt awful to “interns were present on your private parts examination not getting your agreement,” and 70.14% felt terrible to in “more than one patient standby in the same consulting room.” These data tell us that these outpatients are not used to this non-private circumstance and they all show express their ill feeling. As the higher degree of invasion of privacy, the more uncomfortable feeling will emerge out. And we can say that most interviewers in this study may have the needs of keeping privacy.

TABEL 5. Privacy Invasion in medical space

Which one may make you uncomfortable?	N	%
1 Interns were present on your private parts examination not getting your agreement	68	44.16
2 The space was not private enough when you received private parts examination	25	16.23
3 More than one patient standby in the same consulting room when you’re consulting	22	14.29
4 The voice of medical personnel explained patients' condition is too loud that people nearby all heard	8	5.19
5 The clinic’s door opened all the time that people outdoor could watch into the consultation	5	3.25
6 Non-medical personnel always intruded when you were consulting a doctor at clinic	1	0.65
7 None of above	25	16.23
Total	N=154	100.0

Surprisingly, although most of these interviewers felt uncomfortable to such an awful non-private medical space, many of them would still come back to consult doctors in the same hospital. About 60% interviewers experienced “the space was not private enough when you received private parts examination (eg. per vaginal examination)“ and “interns were present on your private parts examination not getting your agreement.” And these experiences will lower their willingness to the same hospital.

TABEL 5 is the ranking about six situation of invasion in medical space. The most uncomfortable condition is “interns are present on your private parts examination and do not getting your agreement (44.16%).” The second one is “the space was not private enough when you received private parts examination (16.23%).” And the third is “more than one patient standby in the same consulting room (14.29%).” Then, there are 5.19% in “the voice of medical personnel explained patients' condition is too loud that people near by all heard,” 3.25% in

“the clinic’s door opened all the time that people outdoor could watch into the consultation”, and 0.65% in “non-medical personnel always intruded when you were consulting a doctor at clinic”. Besides, there are 25 interviewers (about 16.23%) don’t think these six situation are uncomfortable to them.

I’m interested to these 25 persons why don’t they feel uncomfortable about these six non-private situations. Let’s see their backgrounds: 14 of them are over 34 years old, 13 live with their parents-in-law, 24 were asked to produce children by their parents. The clinical data indicated that the best birth ages are from age 20 to age 30, and the probability of pregnant will descend year by year from age 34. Besides, three clinics in this research are famous for their high successful rates in reproduction department and their excellent obstetrician-gynecologists. Maybe that’s the reason why these women try all their possible to consult doctors again and again in the same hospital. Of course, there may not enough situations listed on our questionnaire so that interviewers have no more opportunity to express their feeling in invasion of privacy. So, the inference as above is just “inference.” Following qualitative research may give us more explanation.

In 2002, Wu and Huang’s survey about “Analysis of Patient’s Action” have mentioned four reactions to uncomfortable feeing in the process of medical treatment: loyalty, stow away, voice, and exit. It means that patients may “exit” when they were discontented with the bad situation; patients who stay may give “voice” out; “stow-away “ are who do not give voice out may do some silent protest, and others do nothing but just stayed are “loyalty.” In this study I will cite three reactions--loyalty, voice, and exit--from Wu and Huang’s research (2002) plus the special attributes that clinics have in Taiwan to present discourses and experiences of women who took part in my study.

1. Loyalty (1): ***“ The most important thing is becoming pregnant!”***

The interviewers in this research were all “patients” having reproductive problem. To reach the goal “get pregnancy”, they were willing to bear all invasion of privacy in medical space. Ms. E[1] came from far place to Taipei to consult the doctor in T1-hospital expressed her aspiration:

> *I don’t care the circumstance because the most important thing to me is becoming pregnant. Other women may concern more things because they aren’t like me coming so far and spend much time to here. That’s why I don’t mind these invasions and I really hope I could get pregnancy as soon as possible, and then I will not come here again.*

[1] Ms E came from Lo-Tung. The buses connect Taipei and Lo-Tung are not frequently so that she had to ride bus at 5:00 AM to Taipei and transfer many buses to T1-hospital.

Ms. E showed her loyalty to tolerant invasion of privacy of medical space because she was eager for having a baby. She gave us a strong motive, "becoming pregnant," the reason why she could ignore uncomfortable condition she experienced. She emphasized that she spend much time from Lo-Tung to T1-hospital and others didn't. It may made she felt others were so lucky living in Taipei and doubt their too many concern about invasion of privacy. Such a strong motive for getting pregnant let Ms E consult doctor again and again.

2. Teaching Clinic / Loyalty (2): ***" That's my choice!"***

It seems doesn't matter that the name (or title) of the clinic and the attribute of a clinic, but it impacts on women who are childless with ill feeing in the medical space. For example, the "infertility department" is so clear that we all know it's established for people who cannot bear children. The attributes of clinic in this research just discuss three ones: (1) the obstetrics and gynecology department; (2) the reproduction department; (3) the teaching (or practical training) department. Any department may be teaching department too. Teaching hospitals usually have teaching department, and senior professor attending doctors would lead interns to complete their internship.

Hospital is a place that doctors could get training and teaching department is established for them. Easy to say, there are VS (visiting staff) and interns in the teaching department. If a patient consults a doctor at teaching clinic, he or she may face more than one doctor but many interns around. It may affect the interaction of doctor and patient. Therefore, more eyes may watch what you performed and more ears may hear what you said.

Though some people may tolerate privacy invasion with the strong motive—have a baby, others may not bear this for the same reason. Since the different attributes of clinics, they respond differently. To use the teaching department as an example, some people may strengthen their mind to face such a non-private condition. Because they know interns are around at clinic, the interns will watch and hear your consultation, etc. before going into hospital. It's their choice. Ms A told us below discourse:

When I decided to visit this teaching hospital, I made a preparation in mind. It means that…the preparation is that…I know I will face what condition. There are not just one doctor, nurses, and I. There are interns nearby certainly. So it's my choice. If I reject such a non-private condition, I could choose another hospital without teaching department. Then it's no problem about this (Ms A).

Make a preparation in mind to face the non-private teaching clinic may be helpful to patients, but why should they do this? If they really don't mind consult a

doctor at teaching clinic, why should they make a preparation in mind? In this case, we find the "resistance" from patients. Patients have no choice but to accept the situation. "That's my choice" just because you have no choice. It's a forced loyalty, not a sincere loyalty. If patients have right to choose, they hope they could choose non-teaching hospital:

> *If this doctor has…I mean "if"…If the doctor has two clinics, one is teaching clinic and another is not, and then I will choose the latter. But this is a teaching clinic and I know that the teaching clinic is established for interns whom need to learn and accept training, and then I could not reject it. It's because I know the attribute of this clinic that interns will be around. Therefore, I don't mind interns talk with the doctor or observe the consultation (Ms D).*

From the above we could find that patients do not really "don't mind the invasion of the privacy." If they have choices to choose, they would rather choose the non-teaching clinic to keep their privacy. Maybe it's because of reputation for doctor's medical skill or high rate of success that could raise the probability of being pregnant. Nevertheless, "pregnancy" is not the only one reason to accept the teaching clinic and we get the other reason ---the attribute of clinic (…*that the teaching clinic is established for interns whom need to learn and accept training*).

3. Teaching Clinic / Voice: ***"I will ask him to go out."***

Teaching clinic also involves the invasion of body. Some people will take it for granted that interns nearby in consultation but others won't. An interviewer told us that she has the rights to permit interns to observe in consultation. She mentioned the resistance in her mind:

> *Maybe we should give a chance letting interns to learn and to get training if I have allowed …But now I…alright, it's ok…just let it go. They deserve this training and then they could (cure patients)… you know that (Ms G).*

Ms G is an open-minded and enthusiastic woman helping me to finish the questionnaire and interview. Such a warm-hearted woman pointed out "the rights for allowing interns' training around at clinic" showed her resistance to interns around. Since the hospital was near her house and she had to help her husband's business at home, she went to the same hospital again and again.

Another interviewer mentioned the gender of interns:

> *One time I got a per vaginal (PV) examination, there was a female intern around and the doctor discussed with her all the time, like "it's a little …" or "that's like the …" or "why did this …" Because of the intern was female that the*

degree of my resistance was not too strong. If this intern was male then I may not accept it and then I will ask him to go out (Ms C).

PV is a treatment that would invade patient's body. It's not only patients' body will be observed but invaded. Ms C felt uncomfortable that there was an intern around at clinic; she finally accepted it just because the intern is female. It's the question of "gender" so that Ms C was willing to bear the interns around (*Because of the intern was female that the degree of my resistance was not too strong)*. That means she still had resistance of interns around at clinic, she will resist too even if the intern is female but the degree of resistance is not too strong. If the intern is male, she will ask him to go out the clinic. Although Ms C had no chance yet to make a request asking interns go out, but she knew that she would do this if it happened.

(4) Teaching Clinic/ Exit: ***" The rate of subsequent visit is very low!"***

Patients should have to accept interns around when consulting a doctor? It's no rule to request patients accepting this. Hospitals ignore their autonomy and scarify their privacy. Could patients just yield to the condition but no other choices? Ms D mentioned one of her coworker's experience:

I can't help it that this is a teaching clinic. There are so many interns at clinic. She (my colleague) felt uncomfortable when doctor ask her questions, the interns hearing all the time. This doctor has a personal clinic outside and then she turned to the personal clinic not to here again. She said she just couldn't to accept the interns are all around her.

The colleague of Ms D couldn't stand for the interns around on her consultation with a doctor, besides there was not only "one" intern, there were many interns at clinic. That's reason why she turned to the same doctor's personal clinic outside to avoid the condition that interns nearby happen again.

How high is the rate of patients "exit" from the hospital? One day I had a conversation with a doctor in W hospital, we talked about privacy invasion in the teaching department. The doctor told me "I have a teaching department too. It's opened in the morning, but there are few people to visit. Even if they have come the first time, they won't come again next time. The rate of subsequent visit is very low!" In such a "personal" time, patients' right of autonomy is increasing higher and higher. They can choose hospitals, doctors, and any department of hospital. The teaching department makes me uncomfortable, and then I can change another one to visit.

(5) The respondent of hospital to patients' exit.

Many teaching hospitals use lots strategies to respond to patients' exit. Some hospitals employ famous and reputable doctors to attract patients; some hospital appeal patients with new promotions. To the former, patients are always looking for the best doctor to cure them so that they will visit teaching department without any reason but success. Therefore, patients' protests were not too much and they thought it was worth spending time waiting for the famous doctor. That's why this teaching department is always crowded and over 100 outpatients every time[2]. Besides, patients hope this famous doctor's medical skill will be handed down.

We hope the future doctor is as excellent as this doctor so that interns here are learning (Ms D).

So, most patients tacitly agree that interns around at clinic. To the latter, hospitals propagate a slogan "elaborate teaching & dual doctors department, let you acquire double care" to attract patients visit. This department emphasizes that there are less than 30 patients every outpatient service and it guarantee that each patient will have more time to consult with the doctor, especially when first visiting will proceed in this new pattern "more time, more patience, and more care." The difference between both is that the former is a "compelled pattern" letting patients accept interns around at clinic, sometimes may let patients uncomfortable; the latter respect patients' autonomy letting them visit of their own free will.

Here we see it's an effective exit that hospital carried out such a promotion to attract patients visiting teaching department. Hospitals use the means "exchange fine medical quality for patients' needs—privacy" to avoid "customers (patients)" exit in such a competing market. It's not only keep patients stay but also find volunteer to let interns finish their training.

(6) The obstetrics and gynecology department VS the reproductive department/ Loyalty: ***"The rate of subsequent visit is very low!"***

The obstetrics and gynecology department diagnose many items such as irregularity of menses, menopause, childbirth, etc (including infertility). Some infertile women are afraid of others know their infertility so they don't like visiting the obstetrics and gynecology department. But the reproductive department is directed at infertile patients so there are all infertile patients at clinic. It makes infertile women feel more ease and comfortable. An interviewer told us the difference and feeling between her visiting in both departments:

---

[2] The National Health Insurance System in Taiwan, doctors have evaluated by a merit system that the more patients are at your clinic the more merits you have. "More patients" is better!

I feel it's better to come here (hospital T1), because there are so many people and most of them are infertile or childless. It makes me not look like too strange. In Lo-Tung, there are few people (who were infertile). If this is a general obstetrics and gynecology department and then I'll feel not comfortable. Because…because I don't want to let others know that "oh, she comes here for infertility!" Yet in this department, everyone is infertile that makes no difference. The feeling is different (Ms. E).

Ms E lived in Lo-Tung and has visited hospital there and all gynecologic disease (including infertility) could be diagnosed and treated in the obstetrics and gynecology department. It made Ms E felt she was "freak (special)". In hospital T1, the reproductive department was aimed at infertility and peoples were much, but the degree of "homogeneity" is high (everyone here was for one goal: get pregnant) that Ms E finally relieved.

Hence, even if many people stand by in the same department, even the next number and the next-next number know you came here for infertility, it war no difference. "We all" here were for one goal: get pregnant.

Yup, I thought that you have registered Dr. T and then our problem (infertility) is the same. It's no shame anymore… you could appear in front of me, then why not I appear in front of you (Ms A).

More than one patient standby in the same consulting room would invade patient's privacy. But the high degree of homogeneity made their feeling of privacy invasion lowered comparatively. Moreover, we find an interesting thing. Reproduction department was established for infertile person and even if more than one person standby in the same consulting room, many interviewers thought it was helpful to them:

I will listen…listen to what they are consulting about. Because I may not experience everything that it may remind me to notice…(Ms E)

Because I could acquire other problem that others experienced (Ms J).

Since not everyone may experience all kinds of symptoms, they thought they could listen what others questioned and what doctors answered. It's a good chance to acquire more information about infertility:

Of course, you may hear some patients' steps of treatments and their questions; it may extend some questions you want to ask. I think it's a bit of helpful to me (Ms A)

Last time the treatment I accepted, before I ask questions to doctor the other patient had ask the same question that let me know the answer early. It's just let me understand why and then I could focus on what she asked to extend my question (Ms J).

As above discourse we could know that it's not just a privacy invasion that many patients standby in the same consulting room but a profit to get more information to extend what they want to consult doctors.

(7) The Needs of Personal Information

Patients' names and their condition are parts of personal information. We could know patient's needs of personal information according to the information could be opened or not. **TABLE 6** is a condition that assumed nurses call your name loudly or explain your condition loudly in the waiting area that others nearby all heard. From **TABLE 6** we know that over half interviewers (54.9%) need loud calling reminding them go into the consulting room, but 85.4% thought medical personnel don't explain their condition loudly. These express that patients don't mind people nearby knows their name but they feel embarrassed when others heard their condition.

TABLE 6. The willingness of personal information be opened or not

Q: If your are not impaired hearing or seeing, do you think it's necessary nurse should do follow things in waiting are?				
	1.Call your name loudly reminding you come into the consulting room.		2. Explain your condition loudly.	
Needs*	N	%	N	%
3	12	7.3	5	3.0
2	78	47.6	19	11.6
1	64	39.0	104	63.4
0	10	6.1	36	22.0
Total	N=164	100.0	N=164	100.0

* The more the value is, the higher the willingness is.

It does not indicate that they really don't mind their names were be called loudly in public, but their condition is the key factor. If you don't know my condition and then it's meaningless for you to know my name. But if you know my condition and whatever you know my name or not, I mind it very much.

From **TABLE 7** we could see it obviously that interviewers' feeling of degree of privacy invasion when their name or condition was opened in public (waiting area). 53.7 % interviewers felt it won't invade privacy when their names were called loudly and be heard. And 91% interviewers thought it would invade privacy when their condition is heard.

TABLE 7. The Needs of Personal Information Privacy

	1. Does it **affect** your privacy that others heard your name in medical space?		2. Does it **affect** your privacy that others heard your condition in medical space?	
	N	%	N	%
Very much	1	0.6	31	18.9
Very	13	7.9	55	33.5
A little	62	37.8	62	37.8
None	88	53.7	16	9.8
Total	N=164	100.0	N=164	100.0

Most interviewers hope they could have the privacy of spaces and the privacy of personal information, especially involved the body invasion, they expressed their strong needs about this part. Besides, some interviewers thought the "register sheet[3]" on the consulting room's door might invade their personal privacy.

Sometimes I ran there to see…who is it on the sheet? I think there is no one who hopes herself will be known coming here for infertility problem. Right? I know it's not good to do it. …(Q: If it's a ill feeling, why do you come here again?*) The ill feeling? But you can't do anything about it! It's …it's because you have problem so that you have to see the doctor. Therefore, you have to overcome it. If you're uncomfortable, it's your thing. Isn't it? Yes, you may feel (uncomfortable)…but it's possible saying that "would you please don't show our names on it?" It's weird. Since the hospital is an authoritative place that I believe most people may let it be. Furthermore, we are not famous ones. You know what I mean? If I'm a famous person, I may care about everything, but I'm not. (*Q: You mean that just famous persons have privacy rights but others not?*) No, I think it just the problem of procedure, the medical procedure. We can't…and we don't want to change that. Just feel it is weird that my name shows on it, yes, weird, especially when it's a special department. But we always give way to this. If not so, what should we do? See, someone is watching the register sheet now but you can't do anything about that, right? (Ms B)*

Since the department "infertility" is a stigma that Ms B thought it was not appropriate to show patients' names on this register sheet ("*I think there is no one who hopes herself will be known coming here for infertility problem*"). Because you don't know others will see your name or not. However, after complaining such a great inequality, Ms B chose to be quiet and yield to this condition ("*The ill feeling? But you can't do anything about it,*" "*you have to overcome it. If you're uncomfortable, it's your thing*"). And she mentioned that she was not a famous

[3] This register sheet is a kind of name list that shows that who will come to consult the doctor today.

person and the medical procedure to rationalize her behavior and to express her helplessness.

Besides, another interviewer suggested that the “title” of department:

If the word “infertility” is so bothersome, we should find another word substitute it, for example, “reproductive department!” Because infertility is a symptom too, we use a word form the dimension of this symptom, and the problem is be solved. Maybe it’s not too unacceptable to elders (whom hope you can get pregnancy early). (Ms K)

The title of department also may disclose outpatients’ condition to others. “Infertility department” shows that you have infertile problem that you visit in. Ms K gave a suggestion “replace the title” to solve this problem. Just like Goffman (1963) mentioned to use a softer social label for the category.

CONCLUSION

Is infertility still a burden on infertile women? From this research we find that the stigma effect still exists. For the culture embed deeply and internalized in people’s mind, our participant also influenced by these effects. They really cared how others look at them and how others think them. Therefore, they don’t want acquaintances know their visiting hospital for pregnancy. However, they still do their best to get pregnancy to correct their conditions no matter how their privacy was invaded in medical spaces.

Except the fixed furnishings in the space, people flowing in-and-out is also a crucial factor changing the spatial structure. In Taiwan, hospitals do not pay much attention to patients’ privacy in medical spaces. For example, more than one people standby in the same consulting room is a common phenomenon. How many people and what are their backgrounds all bring influence to patients who visit in the same consulting room. The participants in this research are all infertile women who want to get pregnancy, for this reason, they sacrificed their privacy voluntarily and were willing to visit the same hospital again and again. Furthermore, understand the different attributes that clinics have also let them reply and adapt differently.

Drawing on fieldwork and interviews from three hospitals in North Taiwan, we find out those hospitals often sacrifice patients’ privacy in order to facilitate

medical procedures easy and smooth. Such as call patients' names loudly into the consulting room, or explain patients' condition loudly that others nearby all heard.

How did these interviewers reply to privacy invasion in medical spaces? In the consulting room, they would make a preparation in mind before visit the teaching department; they would endure lots patients in the same space because it was infertility department and all of them were infertile ones. In the public waiting area, especially personal information, they paid much attention on their condition concealed, but less on their names opened.

Even though the primary goal of visiting hospital is a pregnancy, hospital cannot ignore their privacy in medical spaces. Hospitals may show consideration for patients privacy and do some actions, such as one-by one consulting replace more-than-one pattern, use register number replace patient's name, low voice replace loud voice, etc. Thus, the medical quality would be raised and patients' exit would be decreased.

REFERENCES

Charlene E. Miall, 1986, "The Stigma of Involuntary Childlessness." **SOCIAL PROBLEMS**, Vol. 33. No. 4, April.

Eriving Goffman, 1963, ***Stigma: Notes on the Management of spoiled Identity.*** Englewood Cliffs, N.J. : Prentice-Hall.

Geestz, C., 1973, ***The interpretation of culture***. New York: Basic Books.

Greil A. L., 1991, ***Not Yet Pregnant: Infertility Couples in Contemporary America.*** Rutgers University Press, New Brunswick and London.

Riessman, 2000, "Stigma and Everyday Resistance Practices: Childless Women in south India." ***GENDER & SOCIETY***, Vol. 14, No. 1, 111-135.

Todorova & Kotzeva, 2003, "Social discourses, women's resistive voices: Facing Involuntary Childlessness in Bulgaria." ***Women's Studies International Forum***, Vol. 26, No. 2, pp. 139-151.

Wu & Huang，2002，〈順從、偷渡、發生與出走〉。《台灣社會學》3：73-117。