RESEARCH ARTICLES

Patient privacy: a qualitative study on the views and experiences of nurses and patients

AUTHORS

SERPIL AKGUL YILMAZ MSc, RN[1]
SEVILAY SENOL CELIK PhD, RN[2]

1. Ankara Training and Research Hospital, University of Health Sciences, Ankara, Turkey
2. School of Nursing, Koc University, İstanbul, Turkey

CORRESPONDING AUTHOR

SEVILAY SENOL CELIK School of Nursing, Koc University, Istanbul, Turkey. Email: sevilaycelik@ku.edu.tr

ABSTRACT

Objective: The aim of the study was to determine views and experiences of intensive care unit nurses and patients on the issue of protecting patient privacy.

Background: Intensive care should be delivered to protect the privacy of intensive care patients because these patients experience a loss of personal identity and significant limitations in physical activity and emotional expression. Intensive care patients may not be able to dress themselves; they may not communicate effectively without glasses and hearing aids; they cannot control the environment; they may not govern their actions, and they may not advocate for themselves. For these reasons, nurses should assume a primary role to protect patient privacy because they spend many hours with them and witness patients' loneliness, pain, and death as their primary caregivers.

Study design and methods: This is a qualitative study using a phenomenological method with data gathered through interview. The study was conducted with nurses (n = 14) and patients (n = 14) in the intensive care units of a state hospital in a metropolitan city in Turkey between 12 March 2018 – 4 October 2019. Data were collected from nurses and patients using semi-structured interview forms. Content analysis revealed categories, themes, and sub-themes. We have followed the Consolidated criteria for reporting qualitative research (COREQ).

Results: The categories explored in the study for both nurses and patients were the concepts of privacy, privacy protection and privacy violation. Some of the sub-themes were physical privacy, not sharing personal information, using screens or curtains, using aprons or sheets, insufficient number of nurses or excessive number of patients, and a lack of inspection and equipment.

Conclusion: This study shows that the acquired information and the awareness of privacy, protection of privacy, and violations of privacy were adequate among both nurses and patients. Some of the nurses in the study stated that institution-related violations occurred because of the inadequate numbers of nurses to provide care to an exceedingly large number of patients.

The implications for research, policy, and practice: Increasing awareness of nurses and patients on patients' rights and protection of privacy and violations of privacy and taking adequate measures to protect patient privacy increase both patient satisfaction and service quality in health.

What is already known about the topic?
- Privacy is a fundamental human right.
- Protection of patient privacy is the responsibility of healthcare professionals.

What this paper adds:

- The awareness of patient rights for privacy and privacy protection has been well established among patients and nurses, and both participating patients and nurses were knowledgeable of respective privacy violations.
- Institution-related factors such as the insufficient numbers of nurses, exceedingly large numbers of patients, problems with the main door access control systems in intensive care units, and the provision of care in smaller units than optimum ones are significant factors involved in the privacy violations of patients.
- Patients were reluctant to report privacy violations because they believed this could negatively affect their treatment and care.

Keywords: privacy, intensive care unit, patient, nurse, qualitative research

INTRODUCTION

Intensive care unit (ICU) patients are dependent on nurses for the provision of care 24/7 for their physical, mental, and social needs resulting from invasive interventions, family deprivation, limitations of movements, pain, mechanical ventilation, and memory disorders. Moreover, the protection of the patient's privacy may not be easy in ICUs because of the presence of many patients in the same environment witnessing the treatment and care of other patients and the incapacity of patients to communicate and make decisions to protect their privacy.[1,2,3] In this context, several principles and regulations have been developed by international and national organisations for the protection of patient privacy. Such principles and regulations may include ensuring the integrity of electronic or paper-based health report data, forbidding the disclosure of personal and confidential information, and the discipline of showing respect to patients' choices, empowering patients in decision making, and delivering appropriate and culture-related care. The implementation of such regulations and principles leads to the assumption of new responsibilities and ethical obligations by nurses to ensure the privacy and confidentiality of patients.[4,5,6,7,8]

'To respect the dignity, worth, equality, diversity, and privacy of all persons' is listed in the ethical codes of the World Health Organization.[4] Florence Nightingale's pledge has set various rules forth as an important guide for nurses and it is accepted as the first ethical code of nursing.[5] Privacy is emphasised in the original pledge as follows: 'I…will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my calling'. The current privacy statement in the pledge has been reformulated as: 'I will keep all the information given to me about the individual confidential'.[6] The Code of Ethics for Nurses of the International Council of Nurses (ICNs) also states that nurses are responsible for respecting human rights.[7] The principles of autonomy, privacy and secrecy are stated in 'Ethical Principles and Responsibilities for Nurses' published by the Turkish Nurses Association (TNA). The respect for human dignity, informing the patient and obtaining his/her consent are mentioned under the principle of autonomy. The protection of all aspects of privacy and ensuring the privacy of personal information are also included under the principles of privacy and confidentiality.[8] The protection of patients' privacy increases patients' trust, satisfaction, and quality of healthcare services.

International studies have also indicated that patient privacy may not be adequately protected or even violated.[9,10,11,13] Roos et al. report that patients were satisfied when they had more social interaction and were cared for in multiple-bed rooms, but noted a lack of privacy.[9] Another study has shown that nurses may sometimes not feel like respecting patients' privacy adequately and that they may feel like invading the patient's intimacy.[12] The same study reported that patients' privacy was not protected appropriately in a way that the patient would wish. A study showed that 48% of the nurses expressed concern over the security of electronic health records due to security vulnerability associated with administrative issues, inadequate training, access by unauthorised users, inadequate auditing, poor communication with technology vendors, and the lack of adequate time for appropriate documentation.[13]

Some of studies on patient's privacy in Turkey concluded that nurses and healthcare professionals did not pay enough attention to patient privacy or it was violated,[14,15] while some studies showed that nurses had usually positive opinion about patient privacy.[14,16-18] Although patient privacy is important in all units of hospitals and in all healthcare facilities at all levels, it might have critical importance in ICUs because of the unique medical characteristics of the admitted patients and services provided. However, studies conducted with nurses on the 'protection of patient privacy' in ICUs in Turkey are very few.[19,20,21] The use of protective screens or curtains may not be attentively used for patients in ICUs. Patients and their relatives may not be provided with adequate information about the interventions and treatments, and not enough attention was paid to patient privacy while transferring the patients from one unit to the other. Lastly, healthcare professionals may not be observant regarding the presence of third parties in the environment while they are providing information to relatives about

patients.[18,19,21] A study by Özata et al. discussed the issues of patient privacy in ICUs and reported that unconscious patients received great care but patients were separated with curtains only.[19] Based on these discussions, it is not difficult to anticipate that physical conditions and care needs put intensive care patients in a vulnerable position concerning their privacy.

METHOD

STUDY DESIGN AND ETHICS

The aim of this study was to determine the experiences and views of the nurses and the patients in the ICUs on patient privacy.

This study used the phenomenology design, a qualitative research method. Based on the interpretive phenomenology model developed by Van-Manen, semi-structured interviews were conducted.[22] In the interpretive phenomenology model, the experiences of individuals regarding a phenomenon are transformed into a structure, where experiences are described in the words of the patients. This phenomenon relates to experiences of some personal significance, such as the development of an important relationship or a major life event. The researcher makes a description that defines the essence of people's experiences based on his/her own experiences and literature.[22]

The study was approved by the Non-Interventional Clinical Research Ethics Board of a state university (06.02.2018; GO 18/138-06). Written consent was obtained from the patients and the nurses. Written permission to conduct the study was obtained from the hospital administration.

PARTICIPANTS

The study was conducted between 12 March 2018 – 4 October 2019 with the nurses working in the cardiovascular surgery, anaesthesia reanimation, and neurosurgery ICUs of a state hospital, and with the patients who were transferred to the surgical clinics after receiving health care from these ICUs.

The sample of the study was obtained using the purposive sampling method, which reveals the facts and events. In this methodology, data saturation is reached to stop research when the concepts and processes that may be the answer to the research question start to repeat, and when repetitive answers are given to the questions.[23,24] Polkinghorne reports that researchers should conduct their interviews with five to 25 people who have experienced the phenomenon created by them.[25] Accordingly, semi-structured individual interviews were conducted with 14 nurses working in the ICUs and 14 patients receiving healthcare service from these units. The inclusion criteria for patients were (1) aged 18 or older, (2) no mental health conditions, and (3) no communication problems. Further, (1) work experience for more than one year, and (2) working in ICUs were the inclusion criteria for nurses.

DATA COLLECTION

The views and experiences of nurses and patients were obtained by using semi-structured interview forms developed for nurses and patients (Table 1). A pilot study was conducted with two hospitalised patients and two nurses in order to evaluate the data collection tools and the applicability of the study. No change was made in the questionnaire forms after the pilot study, and the data obtained from the nurses and patients who participated in the pre-application were included in the study.

TABLE 1: SEMI-STRUCTURED INDIVIDUAL INTERVIEW QUESTIONS

Questions for nurse
Could you please explain the definition of privacy and its place and importance in nursing practices?
Could you please give examples of your practices that cover patient privacy when you think about your working day in an intensive care unit?
Could you please give some examples of practices on patient privacy of one of your colleagues at your workplace who is a role model for you?
Could you please state if you have ever encountered situations where patient privacy was violated? If so, what procedures are to be followed in case of violations?
Questions for patient
What do you think has been done to protect your privacy during your stay in the intensive care unit?
Is there ever a situation that would prevent the protection of your privacy while you receive care in the intensive care unit? Or have you witnessed such a situation?
Do you think that there have been interventions performed on you even though you did not want them done?
What do you think should be done in cases where privacy is not protected in the intensive care unit?

The researcher (SA) informed the nurses about the study, and conducted face-to-face interviews with them in the nursing rooms of the ICUs where the nurses worked. The interviews started when the nurses felt ready. The interviews were recorded on a tape recorder using the semi-structured interview form. The researcher (SA) informed the patients about the study and conducted face-to-face interviews with them in their rooms when they were alone. Those patients sharing their rooms with other patients were interviewed in the nursing room of the clinics to ensure confidentiality. When the patient felt ready the interview was begun, recorded on a tape recorder, and followed the semi-structured interview form. Each interview with nurses and patients lasted for about 20 minutes.

DATA ANALYSIS

Frequency and percentage were used to analyse descriptive characteristics of nurses and patients. Data analysis steps were followed for converging patterns for qualitative data.[26] Qualitative data collected independently from each participant was analysed independently.[27] The recorded

semi-structured face to face individual interviews were transcribed by the researchers. After the transcripts were created, the recordings were re-listened to, to prevent errors. The data were analysed by using content analysis as recommended by Strauss and Corbin.[28] Content analysis is based on the inductive analysis of similar data and the combination and interpretation of the data within the framework of certain categories and themes. The researchers read the transcripts separately and developed themes. They read the transcripts again and exchanged ideas and opinions through open discussion meeting. Data collected from nurses and patients were analysed independently, and results were interpreted in line with research purposes. Then, the opinions of five experts on ethics, privacy, psychiatry and/or intensive care nursing were obtained to make sure that the categories, themes and sub-themes were created appropriately. The interviews were numbered to conceal the identities of the participants. For instance, (P1, 20A, F) means participant 1, female and aged 20 years old. Male participants were also coded with the letter 'M'.

VALIDITY AND RELIABILITY/RIGOUR

We have rigorously followed the consolidated criteria for reporting qualitative research (COREQ). The researchers in this study are experienced and trained in relation to qualitative research methods. A strict process of transcription, categorisation and analysis of results was carried out according to the usual methodology.

RESULTS

Table 2 shows the demographic characteristics of the participants. The mean age of the nurses was 29.1±5.2. The total working experience of the nurses was 6.2±4.5 years on average, and the working experience in the ICU was 4.2±2.9 years on average. The mean age of patients was 51.3±16.6 and their mean length of stay in the ICU was 4.5±3.7 days.

QUALITATIVE FINDINGS

The findings of qualitative data of nurses and patients were grouped into three categories: concept of privacy, protection of privacy and violation of privacy (Table 3, Table 4).

CATEGORY, THEMES AND SUB-THEMES INDICATING NURSES' VIEWS AND EXPERIENCES ON PATIENT PRIVACY

Category 1: the concept of privacy

Theme 1: perception of privacy

The nurses mentioned the physical dimension of privacy related to the body and stated that personal information should not be shared. They also mentioned the social dimension of privacy by indicating that privacy is a private concept.

TABLE 2. DESCRIPTIVE CHARACTERISTICS OF NURSES (N=14) AND PATIENTS (N=14)

Descriptive characteristics	n	%
Nurse		
Age (year): x̄ ±SD= 29.1±5.2; min=25 and max=41		
Total working time in nursing (year): x̄ ±SD= 6.21±4.5; min=2 and max =20		
Working time in the intensive care unit (year): x̄ ±SD= 4.28±2.9; min=1 and max =11		
Gender		
Female	11	78.6
Male	3	21.4
Educational level		
Vocational high school	3	21.4
Undergraduate	11	78.6
Received education on patient rights		
Yes	14	100
No	0	0
Time of education on patient rights		
Within the last year	10	71.3
During undergraduate education	4	28.7
Received education on privacy		
Yes	11	78.6
No	3	21.4
Time of education on privacy		
Within the last year	7	63.6
During undergraduate education	4	36.4
Patient		
Age (year): x̄ ±SD= 51,35±16,6; min=20 and max=74		
Length of stay in the intensive care unit (day): x̄ ±SD= 4.5±3.7; min=1 and max=15		
Gender		
Female	6	42.9
Male	8	57.1
Educational status		
Literate/illiterate	2	14.2
Primary school	5	35.8
High school	6	42.9
University	1	7.1

'Sometimes, questions can be specific to patients. For example, when suicidal patients come in, our Turkish society is likely to dig in why they are suicidal and what they have experienced. This is the privacy of the patient, it's up to him to tell or not. But we often dig into the issue, and of course this can be overwhelming for the patient. This is the privacy of the patient after all.' (P11, 26A, F)

TABLE 3. CATEGORIES, THEMES, AND SUB-THEMES INDICATING NURSES' VIEWS AND EXPERIENCES ON PATIENT PRIVACY

Category	Theme	Sub-Theme
Concept of privacy	Perception of privacy	Physical privacy (n:10) Non-share of personal information (n:7) Social privacy (n:3)
Protection of privacy	Physical interventions	Use of screen/curtain/ apron/bed cover (n:11) Preventing the presence of third parties (n:9)
	Respect for personal preferences	Receiving care from a same gender nurse (n:6) Religious preferences (n:5)
	Cognitive protection	Protection of personal information (n:8)
	Adopting model behaviours (n:9)	
Violation of privacy	Physical violation	Non-use of apron/curtain (n:12)
	Cognitive violation	Sharing personal information (n:5)
	Job-related violation (n:5)	
	Violation due to unprofessional conduct	Considering insignificant (n:5) Lack of education (n:3) Conscious-unconscious patient distinction (n:10)
	Institution-related violation	Insufficient number of nurses and high number of patients (n:2) Long working hours and working for many years (n:4) Lack of control (n:7) Lack of equipment (n:4)
	Consequences of violation	Verbal warning (n:8) Remaining silent (n:6)

TABLE 4. CATEGORIES, THEMES AND SUB-THEMES INDICATING PATIENTS' VIEWS AND EXPERIENCES ON PATIENT PRIVACY

Categories	Theme	Sub-Theme
Concept of privacy	Perception of privacy	Physical privacy (n:10) Non-share of personal information (n:4)
Protection of privacy	Physical interventions	Use of curtain/covering the body (n:12)
	Respect for personal preferences	Receiving care from a same gender nurse (n:3)
Violation of privacy	Physical violation	Non-use of curtain (n:5) Presence of third parties in the environment (n:2)
	Cognitive violation	Sharing personal information (n:3)
	Disrespect for patient integrity	Being scolded (n:3)
	Violation due to unprofessional conduct	Considering insignificant (n:4) Conscious-unconscious patient distinction (n:1)
	Institution-related violation	Insufficient number of nurses/high number of patients (n: 1) Lack of equipment (n: 4)
	Consequences of violation	Complaining/verbal warning (n:3) Compulsory acceptance of interventions (n:6) Feeling helpless (n: 2)

Category 2: privacy protection

Theme 1: physical interventions

The nurses indicated that they used a screen/curtain and apron/bed cover to protect patients' privacy. They ensured that the patient occupied a single room, if available in the unit, and they attempted to prevent third persons from entering the intensive care unit. Furthermore, nurses only allowed the necessary personnel required to provide patients' bodily care.

> 'While relatives of patients visit their patients, there is a cardiac arrest in the other bed. Or an urgent care needs to be taken. We take patients' relatives out right away.' (P9, 25A, M)

Theme 2: respect for personal preferences

With regard to the protection of privacy, the nurses reported that they paid attention to ensure that the patients would receive care from same-gender nurses, and they reported that they respected their religious preferences.

> 'Female patients especially do not want male personnel to enter. She does not want to be touched while her body is wiped. Or, while inserting a catheter, they ask whether there is a male nurse or a female nurse even during the procedures." (P11, 26A, F)

Theme 3: cognitive protection

Concerning the protection of privacy, the nurses stated that they protected the personal information of the patient.

> 'We try to keep other information private. We try to avoid showing the whole file of the patient to the relatives of the patient as much as we can. . .." (P2, 31A, F)

Theme 4: adopting model behaviours

The nurses indicated that they had colleagues who served as role models for them regarding interventions to protect patients' privacy, and they appreciated these nurses' example.

> 'I have friends who check the curtains of the patients' beds and check the patients before the relatives of the other patient visit, especially during the visiting hours, and I try to pay attention to them as much as I can." (P5, 39A, M)

Category 3: violation of privacy

Theme 1: physical violation

The nurses stated that the violations against the patient occurred in the form of not using curtains or an apron.

> 'For example, there are times when many of our patients have fever, so the privacy we show to those patients is unfortunately not enough. In other words, we act with the focus on the treatment we do, not the privacy of the patient.' (P13, 27A, F)

Theme 2: cognitive violation

The nurses reported that the violation of privacy occurred in the form of sharing the personal information of the patient with others.

> 'At the moment we learn the patients' diagnosis, we might ask: methanol intoxication... what happened?'. Without talking about patients' any other medical knowledge, we have guessed information about private lives of patients." (P14, 41A, F)

Theme 3: job-related violation

The nurses indicated that privacy violations occurred during emergency situations.

> 'If there is a life-threatening risk, you cannot think of much privacy, for example, when they bring patients hurriedly from the emergency. The woman patient is uncovered bottom to the top. You know, since you give priority to intervention, privacy is a bit in the background.' (P12, 25A, F)

Theme 4: Violation Due to Unprofessional Conduct

The nurses reported that education and training concerning the issue of privacy was inadequate, and that their approaches to the privacy of the unconscious patient were different. In addition, either they considered privacy insignificant or they forgot about it.

> 'Healthcare staff approach privacy with the same mindset. For example, consulting doctors come from many different units of the hospital to the intensive care unit for patient consultation. They do not pay attention to privacy. It is wrong. Education and training are essential in meeting privacy needs of patients." (P7, 25A, F)

Theme 5: institution-related violation

The nurses indicated that the violations of patient privacy were caused by institution-related deficiencies such as a shortage of nurses, too many patients, long working hours in the ICU, lack of equipment, and the failure of hospital administration to control the entrance and exits of the ICU.

> 'There is a little fatigue, a little weariness. This also affects the patient. The nurse is dealing with something at that moment. When the patient asks the nurse to take measures to protect her/his privacy, the nurse can yell at the patient directly.' (P11, 26A, F)

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Theme 6: consequences of violation

The nurses reported that in cases where privacy was violated, the health professional who committed the violation was warned verbally. Some of the staff ignored the violation, and no sanction was given by the administration. Furthermore, they stated that it was impossible to intervene in the situation if the person who committed the violation was an administrator or a doctor.

> 'We say this, but people do not want to say this in order to not offend each other. Or when you say this, you hurt them and you become the bad person." (P8, 29A, F)

CATEGORIES, THEMES AND SUB-THEMES INDICATING PATIENTS' VIEWS AND EXPERIENCES ON PATIENT PRIVACY

Category 1: concept of privacy

Theme 1: perception of privacy

The patients mentioned the physical dimension of privacy related to the body and the privacy of personal information.

> 'The person's own private information remains private, not shared with others, that is, not shared other than with necessary persons. It could be a doctor, a healthcare professional, for example, a medical intervention person. It may be a caregiver, or a family relative, or lesser third parties." (P9, 20A, F)

Category 2: protection of privacy

Theme 1: physical interventions

The patients stated that the nurses working in ICUs sometimes did not close the curtains and cover the patients' bodies while they were putting aprons on the patients and providing special procedures.

> 'The curtain was not pulled. So, everyone was on their own of course, I think they draw the curtains of those who want to change their clothes." (P11, 56A, M)

Theme 2: respect for personal preferences

The patients reported that nurses paid attention to ensure that the patients would receive care from their same-gender nurse in the interventions for the protection of privacy.

> '….they were all females. If he was a man, of course I would refuse.' (P6, 27A, F)

Category 3: violation of privacy

Theme 1: physical violation

The patients reported that the violation of privacy occurred since nurses did not use the curtains separating the patient beds, the entrance to the ICU was always busy with people coming in and going out, and there were third parties.

> 'Sometimes they closed the curtain and sometimes they didn't, but even if they closed the curtain, it was the same. The patients feel embarrassed when care is being given….' (P6, 27A, F)

Theme 2: cognitive violation

The patients stated that it was a violation of privacy when information about themselves or other patients could be heard by others.

> 'I mean, everybody hears each other, and we find out their private information….' (P9, 20A, F)

Theme 3: disrespect for patient integrity

The patients reported that they were scolded by the nurses and that the nurses spoke in unfriendly or disapproving language to them.

> 'You are warning them why they aren't careful. For example, when you say 'why didn't you close the curtain?', they say 'I closed the curtain, I am doing my duty, please do not interfere, do not make my job difficult, I got some other things to do' and they shut the patient down admonishingly." (P4, 51A, F)

Theme 4: violation due to unprofessional conduct

The patients stated that violations occurred since nurses considered privacy insignificant and treated unconscious patients differently.

> 'What, uncovered genital organs? Me lying there naked? Personnel feelings are insensitive. They don't even care whether I am embarrassed or not, they are not doing anything to help me." (P4, 51A, F)

Theme 5: institution-related violations

The patients indicated that the protection of privacy was hindered by too few nurses, too many patients and the lack of equipment such as curtains, sheets, or other coverings to protect patients' privacy in the unit.

> 'So, it is already a very crowded environment. Everyone sees each other. I guess they are trying to protect the privacy of patients, but they cannot prevent privacy violations involuntarily. There were some deficiencies as well of course. The curtains are not enough.' (P9, 20A, F)

Theme 6: consequences of violation

Despite the violations of their privacy, patients stated that they felt obligated to accept the interventions of the healthcare workers because they were concerned about being mistreated. They understood that a complaint or warning should be expressed in case of violation. But they felt quite helpless.

> 'He/she said I had a fever, and I didn't believe it. I begged, 'how come I have a fever while I'm freezing here? I am begging you please, I'm freezing. The healthcare person refused to cover me. They saw each part of my body but in the end, life comes first" (P8, 74A, F)

DISCUSSION

Patient privacy should be emphasised as a main concern for nurses providing care to ICU patients due to the fact that ICUs have special architectural structures such as more beds and patients in the same environment, an open and/or cramped space; there might be sudden changes in the health conditions of patients; vital care interventions are first priority; third parties might witness the treatment and care of the patient; and ICU patients usually have lack of ability to communicate. Nevertheless, the care provided to patients in ICUs should always adhere to the principles of privacy.[2,9,12,29] The WHO's 2000 report emphasises the importance of patient privacy. According to this report, one of the goals of the health system should be the maintenance of responsiveness to people's expectations in regard to non-health matters, reflecting the importance of respecting the dignity and autonomy of individuals along with the confidentiality of information while delivering prompt attention and amenities of good quality to the patient and empowering the patient for access to social support networks and for the choice of a provider. In this context, responsiveness may refer to reducing an insult to one's dignity and autonomy and to alleviating the fear and shame that would potentially be brought about by sickness.[30] Ensuring the security and the protection of patient privacy are critical responsibilities to be assumed by both institutions and all healthcare personnel including nurses.

In our study, under the main theme of the perception of privacy, most of the nurses and all the patients mentioned the physical dimension of privacy. When defining the concept of privacy, they mainly relate it with 'the body being naked or covered'. Furthermore, the participants indicated that keeping their personal information confidential was also related to privacy. In a study conducted with nurses and midwives, 68.1% of the participants defined privacy as the privacy of both body and information.[31] Many individuals may prefer to keep information about themselves private. Their reasons may be related to 'being condemned, stigmatised' or 'non-interest to others'.[32] Therefore, patient privacy is an important issue that is the responsibility of health professionals and should be protected in accordance with ethical principles.[3] According to a study conducted by Mohajjel-Aghdam et al. in Iran, 97.4% of nurses had awareness of the confidentiality of patient information and patient privacy.[33]

Patient-centred care might be a solution to solve witnessed privacy issues since it considers the patient's cultural traditions and habits in the planning and providing process of medical interventions to patients' privacy as well as the quality of healthcare services.[34-36] In our study, the nurses indicated that privacy was a personal issue that is specific to each patient and is dependent on the patient's culture and religion. These views are compatible with the information in the literature and the national/international principles on patient rights and privacy protection.[7,8,29,34-36] The nurses in our study reported that using a curtain or a screen for the protection of privacy before bodily care and interventional procedures or mobilisation were important. In one study 95.4% of patients reported that all staff took care of their personal privacy (such as closing the door while being examined, pulling the curtain or screen).[37] Although patients' right to privacy is ensured and protected by legislation, and the values for privacy such as 'safety and security' are included in Maslow's pyramid of needs,[38] the study participants stated that their health was prioritised during their treatment period, and therefore, the importance they attached to privacy was minimised.

Making regulations or scheduling female and male nurses to provide care to the same gender patients might be an appropriate way to protect patients' privacy. In our study, both nurses and patient indicated that the nurses fulfilled the requests of their patients to receive care from a nurse of their own gender. In one study, it is stated that patients might be more comfortable if they receive the needed care and share their personal information with the nurses who are the same gender by quoting the saying: 'I would be more comfortable in terms of privacy and communication since I am the same gender'.[39] As reported in the literature, the patients in our study reported feeling embarrassed when they received care from nurses of the opposite gender. They preferred to receive care from nurses of the same gender, and they also expected nurses to be more careful about privacy, to communicate well with patients, and to be sensitive to the needs of unconscious patients.

The nurses reported that they shared the diagnosis of the patients, the reason for admission to the ICU, and the patients' private information with colleagues or others not related to the patients' care. Furthermore, patients in this study reported that information about themselves or other patients was mentioned in the ICU and heard by others. The study by Entzeridou et al. reported that the majority of participants agreed that they would be concerned about the likelihood of non-authorised third party access to their personal health information (48.8%) and that they would

worry about potential future discrimination, which may arise from disclosure of their health information (48.8%).[40] Reports from the literature indicate that nurses rank first among the primary care personnel in hospitals in terms of sharing information inappropriately with others. Reasons given are that nurses have different educational levels, stressors, and uncertainty about their roles and responsibilities.[41] However, the principles of 'Autonomy, Privacy and Secrecy' are among the ethical codes by which nurses must abide. Within the context of these principles, nurses are expected to evaluate the patient's information in accordance with the principles of 'do no harm' and 'usefulness'.[8]

The nurses in our study stated that the violations against the patient occurred in the form of not using curtains or an apron. Similar to the reasons indicated by the nurses, the patients stated that their privacy was violated because the curtains separating the patient beds were not closed and third parties were present in the environment due to high back-and-forth activity into the ICU. Indeed, some studies have reported that visiting practices could tire the patient, consume time and energy of staff, interfere with care and medical treatment by causing confusion, violate the privacy of other patients, increase the patients' physiological stress, and lead to security problems.[42-44] In the study on privacy, conducted by Ross et al. a patient stated: 'There are things you really shouldn't hear. There was a fellow patient that was told he only had a few weeks left. The curtains are not exactly soundproof.'[9] The nurses in this study reported that they considered the protection of patient privacy to be unimportant among employees. Or if there were only healthcare professionals in the unit, patient privacy was not a priority. Nurses also stated they did not take precautions to protect the privacy of unconscious patients. Patients stated that violations occurred since privacy was considered unimportant by nurses and unconscious patients were treated differently. It should be noted that when a person is hospitalised, this is often a very sudden change in their life. Fear and anxiety and changes in the patient's physical environment in the ICU may contribute to their lack of preparedness to protect their own privacy. Areas affected could be in communication and decision-making.[45] Therefore, nurses working in ICUs should make efforts to notice the intimate, sensitive and vulnerable aspects of the patients and should act to plan all patient care with a holistic approach, including when caring for unconscious patients.

In our study, some nurses could not take adequate measures to protect patient privacy because of the insufficient numbers of nurses, an exceedingly large number of patients, inadequate control of the main door access to ICU, and the availability of only relatively small units rather than optimum-sized ones for the provision of care. In a study conducted with healthcare professionals, 59.2% stated that 'the patients' right to privacy was not as important as the treatment of their disease.' and 83.2% stated that 'adequate care could not be given to the patient due to the high number of patients per nurse'.[46] Although the consequences of demanding and irregular working conditions lead to a decrease in work efficiency and a negative effect on nursing care, patients were reluctant to report privacy violations because they believed this could negatively impact their treatment and care. The study of Valizadeh and Ghasemi[47] showed that reported consequences of privacy violations for patients were nervousness (34.2%), annoyance (32.6%), discouragement (7.1%), disappointment (8.5%), insecurity (3.5%), sense of uncontrollability (2.7%), feeling of disability and futility (2.4%), and feeling guilty (3.6%). Another study reported that the patients remained silent due to 'fear of getting an angry response from health professionals' (55.7%), and 'worrying that the service they received would be negatively affected' (20%), respectively.[48]

CONCLUSION

Results of this study have revealed that patients and nurses had information and awareness about privacy, the protection of privacy, and the violations of privacy, and participants believed that the protection and the violation of privacy was a unique condition for the patient but a condition experienced more than once for nursing professionals. However, despite challenges in protecting the patient's privacy, nurses spend their best efforts to take stringent precautions for the protection of patient privacy, originating from their concern and empathy for patients. Considering such challenges, it can be suggested that patient privacy should be addressed further in nursing education and training. Furthermore, financial investments would be needed, and structural improvements should be implemented in critical patient units along with the recruitment of a nurse workforce of appropriate size. Given that privacy is a patient right and an ethical commitment of the professional, Kim et al. reported that nurses' awareness of privacy and confidential information exceeds the size of actual behaviors performed.[49]

We believe that the results of this study will advance the implementation of interventions to protect patient privacy in ICUs and will increase sensitivity in this regard. Based on the results of this study, we suggest that service trainings on the topic of patient privacy should be held on a regular basis and hospital administrations should put policies in place to ensure the protection of patient privacy in ICUs.

Limitations of the Study: The study has some limitations. The results are not generalisable because the study was conducted with a small sample in one centre using only a qualitative method. Patients may not have expressed their thoughts adequately because of the concerns that their care and treatment processes might be affected unfavorably. Conducting the patient interviews in the clinic before they were discharged from the hospital may have resulted in

such concerns. Because the patients were transferred from a complex and critical care unit to the clinic, they may have had some cognitive and emotional incapacity interfering with their willingness to express themselves appropriately. Participants might have felt some pressure to complete the interviews quickly so as not to interfere with the regular schedules and tasks in the hospital environment. Nurses may have had difficulties in expressing their feelings freely about patient privacy to avoid blaming the personnel.

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