PATIENT PRIVACY IN A SHARED HOSPITAL ROOM: RIGHT OR LUXURY?

Helen Malcolm, RGON, MN
Lecturer, School of Nursing, Faculty of Medical and Health Sciences,
University of Auckland

Abstract

The expectation of personal privacy is reasonable, provided for by the law, and is a view supported by current literature. Yet in the hospital setting where patients are required to share a room with strangers it is questionable whether privacy is adequately protected. In this article the author discusses the New Zealand legislation aimed at protecting the individual's right to privacy and concludes that practice may place healthcare consumers' rights at risk. While patient privacy should be of concern to all health professionals, the focus here is on the nurse's role in relation to recently formulated competencies published by the Nursing Council of New Zealand, which includes the recommendation that care be seen to exhibit an awareness of healthcare consumers' rights to privacy alongside the expectation that nurses question practices that compromise patient privacy.

Key Words: Patient privacy, health legislation, codes of conduct, nursing competencies

Introduction

Nurses are in a privileged position, with the intimate nature of many nursing procedures often resulting in confidential revelations from the patient about their feelings, thoughts, past experiences and even matters concerning family members (Williams, 2001). Patient vulnerability and dependence on nurses and nursing care can bring about a special connection that does not exist in any other social setting (Lawler, 1991). A key component to any relationship, but particularly the nurse-patient one, is trust. Explicitly the patient places their trust and belief in the nurse, that she or he will provide suitable care and protection (Pask, 1995) which includes security of confidential information. Hoey (1998) regards privacy as a basic tenet of dignity and respect that patients can expect in their relationship with healthcare professionals. This view reflects that of MacNeill (1992) who, in reference to the patient-physician relationship, describes the moral view of confidentiality as "rooted in respect for individual's autonomy over information about themselves as well as respect for the integrity and importance of the confidential relationship in which such information is shared" (p.169). While MacNeill is exploring the association between doctor and patient, this statement could equally apply to the

Malcolm, H. (2004). Patient privacy in a shared hospital room: Right or luxury? *Nursing Praxis in New Zealand, 20*(1), 28-35.

patients' relationships with nurses. International health-sector journals detail similar issues regarding privacy (Curtin, 1993; Erlen, 1998; Hoey, 1998) including use of health information for epidemiological studies (Vandenbourcke, 1998). Flegel and Lant's (1998) study of health professionals' conversations in a Canadian hospital elevator found that a large proportion of the comments overheard represented infringements of patient confidentiality. Although such discussions between health professionals are generally conducted to further the treatment of an individual it may disturb many people to know that their personal details are heard by others who have no right to such information.

Why the interest in patient privacy?

Recent clinical experience in a public hospital caused me to reflect on the implications of New Zealand legislation designed to protect vulnerable people, in particular privacy rights. The situation described below was one where the patient's privacy was disregarded and where her personal circumstances were exposed within the hearing of strangers. This event caused distress to both the patient concerned and the other women who shared the room. Mrs B, an eighty-two year old woman, widowed and fiercely independent had made good progress in recovering from the illness that caused her admission to hospital but because of her physical frailty her personal circumstances may need to change. She shared the hospital room with three other women who, like her, were fairly immobile. As she rested on her bed the 'team' of two consultants, registrar, house surgeon, trainee intern, nursing co-ordinator, physiotherapist, occupational therapist and social worker entered and took up the space around her bed. The senior consultant introduced himself then invited the house surgeon to 'present' Mrs B to the group. The latter process involved providing a description of the woman's past and current physical problems, details of her deteriorating personal coping mechanisms and proposed plan for future treatment. The house surgeon's voice carried, the number present meant the curtains were not drawn and Mrs B was never offered the opportunity to be taken to a more private setting.

Initially I listened in disbelief. I saw the look of embarrassment sweep over Mrs B's face when her living conditions were described. The other patients' faces registered anger, indignation and discomfort. When the team had retreated to the corridor I addressed the two consultants on the issue of patient privacy. The senior consultant took control and seemed to be trying to make me feel foolish for questioning this situation. I suggested other ways of presenting this information without sacrificing the patient's privacy, but my ideas were not acceptable to him. He insisted that such ward rounds were normal in the public hospital. The outcome of all this was that Mrs B remained distressed about this event but did not want to "rock the boat" by complaining. The other women in the room showed sympathy for Mrs B. I

felt upset by the whole situation: for Mrs B whose rights were violated, my futile efforts to advocate for the patient's rights, and for the sense of powerlessness that often accompanies nursing in an environment dominated by the medical model.

Healthcare professionals are required to practise, cognisant of such legal provisions as the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Regulations (1996) and the Privacy Commissioner's rules contained in the Health Information Privacy Code 1994 (Office of the Privacy Commissioner, 1994) and subsequent amendments (Office of the Privacy Commissioner 2000, 2003). The example cited here is evidence that the application of such codes and rules can be overlooked during interactions between members of the public and these health providers. However, the Nursing Council of New Zealand (NCNZ) has formulated competencies for nursing practice and these guidelines prompt nurses to take a more assertive stance in protecting patients, including their right to privacy (NCNZ, 1999).

What is privacy?

The Health Information Privacy Code, 1994 (Office of the Privacy Commissioner, 1994) rules set out to guide health professionals' practice when managing the personal information relating to people receiving healthcare. First it is important to understand the meaning of privacy. As a very individual concept, privacy varies within racial groups, cultures and families. Alongside other western nations, New Zealand society espouses a moral philosophy based on the concepts of virtue, justice, obligations, rights and wrong (Neill, 2001; Regan, 1995). These values define many of our laws, and attitudes towards others in society. The freedom to retain or prevent physical exposure or information disclosure by an individual aligns with the qualities of confidentiality and privacy (Neill, 2001). When considering the word 'privacy' it is necessary to define the term, determine the moral values for defending privacy rights and how these 'rights' are supported by legislation (MacNeill, 1992). Privacy can be considered a normative value, the meaning of which differs from one individual to another but is universally understood. Curtin (1993) describes it as being freedom from unwanted intrusions including dispersal of private facts.

Regard for privacy is particularly important in the hospital environment. There are three aspects to be considered. The first is *personal information privacy*, whereby patients' personal details are contained in a filing system in the ward office, only accessible to health professionals associated with the patient. Second is *visual privacy*, in which health professionals generally make a conscious effort to preserve patients' privacy behind drawn curtains or closed doors when carrying out procedures that may reveal certain parts of the body. Thirdly there is *auditory privacy* which involves sounds or speech audible to others and is frequently overlooked in the architectural structure of a hospital

that determines the sharing of rooms. It is this last component that I am concerned with in relation to the scenario described previously.

The moral grounds on which to defend the right to privacy are allied, in my view, to the foundation for the democratic society in which we live (Neill, 2001). Confidentiality is tied to the view that each individual has the freedom to divulge personal information in the expectation that this knowledge will be treated with discretion and used to further their welfare (MacNeill, 1992). Receiving information in confidence is intrinsic to the relationship between professionals and individuals, regardless of occupation (Williams, 2001). nternationally, limited research has been undertaken on the issues around privacy in the health sector. A recent study on patients' perspectives of their rights, conducted in two London hospitals, highlighted concerns regarding privacy and loss of dignity (Britten & Shaw, 1994). In contrast, a patient satisfaction survey, carried out in six hospitals in Greece, suggested respondents had limited knowledge of established patient rights, including the right to privacy (Merakou, Dalla-Vorgia, Garanis-Papadatos & Kourea-Kremastinou, 2001).

Legislation, codes of conduct and practice competencies

To further understand the application of the above principles in the healthcare context it is important to examine the relevant legislation needs. The laws that govern and protect society are broad and complex. New Zealand, as with other Western countries, has developed legislation to protect the individual from any incident that presents some form of endangerment; physical, psychological or cultural. The New Zealand legislation, designed to protect individual privacy, has been in place since the enactment of the Privacy Act, 1993. This Act resulted in the Office of the Privacy Commissioner (1994) developing the Health Information Privacy Code, designed to govern privacy provisions for individuals, including the collection, storage and disclosure limitations of patients' personal information. The Commissioner for Health and Disability also included reference to privacy when drafting a code of rights for recipients and providers of healthcare (Health and Disability Commissioner, 1996). While open to interpretation, these policies along with individual professional codes and registration systems, form guidelines for healthcare providers practice (Burrell, 2000). Successive governments have acknowledged the special relationship between health professionals and patients by enacting legislation that provides a framework for practice that is aimed at protecting the privacy of people requiring healthcare services. The New Zealand Nurses Organisation's (1995) code of ethics also includes reference to the privileged nature of the nurse-patient relationship, urging nurses to safeguard patients and their personal information from unwarranted breaches of confidentiality. The NCNZ (1995) has defined a code of conduct for nursing practice and suggests inappropriate disclosure of patients'

information and failure to adhere to legal and ethical doctrine equates to unacceptable behaviour. Moreover, the recently formulated competencies demand a more progressive stance for nursing practice and reflect international trends in the development of professional competence (NCNZ, 1999).

On the web sites of both the Health and Disability Commissioner and the Commissioner of Privacy an apparent absence of significant case reports regarding privacy issues for healthcare consumers is open to several interpretations. It may be that the enacted privacy provisions are not well known; there is a reluctance to challenge these legal rights; or people are content with the practical application of the provisions.

Is healthcare consumers' privacy at risk?

My own observations and anecdotal evidence from colleagues would suggest inappropriate disclosure of patients' personal information does occur in public hospitals. Such revelations often arise when discretion is not exercised in the context of the necessary discussions betweens staff members planning a patient's ongoing treatment. At other times patient details are revealed during collegial talk in public places such as the hospital cafeteria.

Violation of privacy has the potential to undermine the respect and trust inherent in the unique relationship between patient and health professional (Margalit, 2001; Williams, 2001). The implication of unwanted disclosure of information is the possibility that patients may withhold information pertinent to their medical, social or psychological situation for fear that these details may be subject to unwarranted exposure (Wainwright, 1994). Informed consent relies on freely sharing information between health professional and patient, therefore such inhibition of information flow could impact on the quality of the process (Burrell, 2000).

One difficulty many of my nursing colleagues describe is attempting to advocate for patients in an environment that favours the paternalistic supremacy of the medical profession. A power structure where medicine is the dominant ideology of healthcare leaves little room for other health professionals to exercise autonomy and also promotes oppression of less powerful nurse/patient groups (Freire, 1972; Street, 1992). Florence Nightingale's decree that nursing procedures required medical authority may have had legitimacy in its day, but unfortunately shades of the powerful position which it gave doctors in relation to nurses are still evident today. The resulting docile demeanour of many nurses inhibits them from advocating successfully for the patient (Walker, 1997).

What should the nurse's role be regarding patient privacy?

Advocacy is one aspect of the nursing role where the nurse, by knowing the person, acts as spokesperson on behalf of the patient (McGrath & Walker, 1999). Related to privacy this

would mean having an understanding of the legal provisions, knowing or anticipating the individual's desire for privacy, then having the courage to avert such interactions described in the previous exemplar. However, in practice, advocating for another person takes experience and courage. While nurses are expected to advocate for patients they are often restricted by the 'invisible' structures, which dominate their practice (Street, 1972). Many nurses will have experienced the tension of speaking out on behalf of their patient, in some cases fearful of the consequences for themselves. Obvious issues, such as the desire for further clarification before informed consent is given cause little apprehension. Conversely, if the area of concern is less clear cut, such as respect for individual privacy the nurse may be more hesitant in seeking to redress the patient's anxieties. However the NCNZ when it demands ethical accountability of registered nurses (NCNZ, 1999) has an expectation that nurses will address such issues as patient privacy. The authors of that document clearly have a vision of how nurses should act as patient advocates. Not only must nurses ensure that the right to privacy of patients' is met [7.8] but they must challenge "health care practice which could compromise client safety, privacy or dignity" [7.9] (p.18). No longer will nurses be allowed to hide behind a subservient position when patient rights are at stake. Furthermore, those nurses seeking nurse practitioner status will have to exhibit the ability to critically analyse their own and others' practice and challenge or change clinical standards (NCNZ, 2001). For recent nursing graduates, whose educational philosophy is underpinned by a doctrine that differs from the patriarchal structure, advocacy may be easier.

Can nurses foster an environment that meets patients privacy needs?

In order to facilitate and promote the best possible outcome for patients requiring healthcare services, nurses must first know the individual, their diagnosed condition, possible range of treatments, and choices this person has made. In the same way consideration for the more subtle qualities of human interaction should be intrinsic to nursing practice, such as the manifestation of respect, including the provision of an environment which ensures all aspects of privacy are met.

The 'Code of Rights' (The Health and Disability Commissioner, 1996) seeks to provide a guide for both consumers and providers of healthcare, and in its abbreviated form is often posted in public areas of healthcare facilities. Although the code lacks specificity regarding privacy, the Privacy Commissioner's rules are more detailed in such considerations. Likewise nurses will need to become familiar with the NCNZ (1999) competencies which both guide and govern their practice. Alongside other professionals, nurses need to be very aware of their role in providing a setting that fosters individual privacy, and be prepared to intercede when it is apparent that any aspect of these enactments, including those related to privacy, may be infringed.

In practice it may be necessary for medical presentations to take place in settings where privacy can be ensured, rather that at the patient's bedside, and for nurses to encourage this practice. The patient could be moved to an alternative room for the purpose of discussing their condition and treatment. Bedside discussions between patients and healthcare professionals, including nurses, might then be limited to details of immediate care or planned interventions. Similarly verbal interactions should be modified to ensure that any conversation, both at the bedside and elsewhere, strives to maintain confidentiality of the individual. Consideration must also be given to nurses' behaviour so that physical interventions or procedures are not revealed inappropriately to people not associated with the patient. For example, is it necessary for other patients (and their visitors) to know that the person in the next bed is experiencing urinary incontinence or another across the room is learning how to manage a newly formed colostomy? Recognition that patients may choose to discuss their health problems with other people in hospital does not excuse divulging of information, intentionally or otherwise, by healthcare personnel.

Conclusion

The literature reveals there is concern regarding patient privacy in public hospital environments and that healthcare professionals are often responsible for privacy breaches (Britten & Shaw, 1994; Margalit, 2001; Williams, 2001). The New Zealand parliament has approved legislation intended to provide limitations and guidelines in terms of unwarranted exposure of individuals' personal privacy. Nursing governance has reflected these enactments by including the determinant of privacy in the competencies for nursing practice (NCNZ, 1999).

Reflecting on the exemplar, I acknowledge my limited acquaintance with the law at that time prevented me being an effective patient advocate. To protect an individual's personal information may require the nurse to intervene to prevent the breaching of this confidence or to advocate for a private setting for the discussion of particular issues. It is up to the individual nurse to ensure their practice meets the obligations determined by the regulations for ethical and professional behaviour in the healthcare setting.

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