INFORMATIONAL PRIVACY IN THE RECOVERY ROOM – PATIENTS' PERSPECTIVE

Authors:

Hannele Koivula-Tynnilä

RN, MNSc, Department of Nursing Science, University of Turku, Finland

Nurse Manager, Ambulatory Surgery Unit for Ear, Nose and Throat Diseases, Helsinki University Hospital, Finland

Anna Axelin

RN, PhD, Docent, University Research Fellow, Department of Nursing Science,

University of Turku, Finland

Helena Leino-Kilpi

RN, PhD, FEANS, Professor and Chair, Department Nursing Science, University of

Turku

Nurse Director, Turku University Hospital, Turku, Finland

Corresponding author:

Hannele Koivula-Tynnilä

e-mail: hannele.koivula-tynnila@hus.fi

Land mail: Haukkakallio 2 D 8, 02620 Espoo, Finland

Phone: +358 41 522 0025

Disclaimers: The views expressed in the article are the authors own and not an official position of the institutions they represent.

Word count: abstract 146, article 4603 (excluding abstract, figures, table, references and corrected words - sentences)

Number of figures: 2

Number of tables: 1

Conflict of interest: None.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for profit sectors.

INFORMATIONAL PRIVACY IN THE RECOVERY ROOM – PATIENTS' PERSPECTIVE

Keywords: informational privacy; patient health information; recovery room; acute care

Purpose: To describe patients' perceptions of informational privacy and factors promoting it in the recovery room.

Design and Methods: A descriptive semi-structured interview study was conducted in 2013, and the data were analyzed with inductive content analysis. Adult surgical recovery room patients (n=17) were recruited with purposive sampling at one department of Ear, Nose and Throat (ENT) diseases in a university hospital in Finland.

Findings: Informational privacy was described as control of patients' health information maintained by the healthcare professionals and the patients. Informational privacy was especially important in relation to other patients. Healthcare professionals and patients' attitudes, behaviors and knowledge of informational privacy, barriers of hearing and seeing, societal rules and the electronic patient data system promoted informational privacy.

Conclusion: Informational privacy in relation to other patients could be improved in the recovery room, for example, by developing patient health information transmission and architectural solutions.

Introduction

Informational privacy is an important principle in healthcare. It supports patients' dignity, self-determination,[1, 2, 3]and patient safety.[4] However, the protection of patients' health information is found to be the weakest part of good patient care in surgical wards.[5] Informational privacy is not always respected [6, 7] and there is limited confidentiality of patient health information in the hospital wards.[7-11]

Informational privacy concerns information related to patient's health, how it should be protected, and who has the right to access it.[12, 13] Informational privacy is defined as patients' right to decide how, when, and how much information they are willing to share with another person[14] or in the healthcare organization.[1] The main content of informational privacy is considered to be the confidentiality of the patient's health information.[12, 15]

Informational privacy has an ethical and legal dimension in healthcare. In this study, the ethical dimension is investigated from the patients' perspective in the context of the recovery room. Informational privacy is protected by the ethical codes of nurses and physicians.[16, 17] National legal acts regarding the handling of patient health information are connected by the International human rights.[18, 19]

Patients are increasingly aware of their rights for privacy and they expect these rights to be ensured in healthcare organizations.[20] Patients may share with healthcare professional issues that they do not always share even with their significant others. The increasing capability to store and distribute patients' health information with the help of information technology highlights the importance of the protection of informational privacy.[12] Patient safety can also be at risk if patients feel unsafe sharing their private information with healthcare professionals.[4, 8] This is especially true in the recovery room where the patient is in a vulnerable position under sedative medication, possibly with many patients in the same room at the same time.

The context of this study is a hospital, more precisely, the recovery room. In the hospital setting, patients' perspective of informational privacy has been studied mostly in medical and surgical wards. Patients in long-term care had previously expressed higher expectations of informational privacy than patients in acute care[6] However, recent studies in acute care settings such as emergency departments [10, 11, 21, 22] indicate that patients in acute care may have become more critical towards the lack of informational privacy than in the earlier studies.

To our knowledge, there is only one study pertaining to informational privacy in the recovery room. As early as 1968, Minckley[23] observed that the patients controlled their privacy in the recovery room by ignoring the fellow patients' presence, hiding behind

the cover or turning their faces towards the wall. Both patients and nurses lowered their voices when communicating since there were no visual or auditory barriers in use.[23]

Recovery rooms have challenges in promoting patients' privacy. To ensure patient safety, nurses need to exchange patient information[24] and observe the patients continuously. [25] There are also multiple staff members participating in patient care.[26] In addition, the increased number of ambulatory surgery procedures puts pressure to share more information with the patient immediately after surgery in the recovery room. At the same time, many operations are performed under regional anesthesia and with short-acting sedative medication so that patients can be discharged quickly; therefore, they are more aware of the events around them. All this puts new challenges to adequate protection of patients' informational privacy. The aim of this interview study was to describe, with an inductive approach, patients' perceptions of informational privacy and factors promoting it in the recovery room.

Methods

The study was conducted as a descriptive qualitative interview study. This design is used when there is scarce information about the phenomenon under investigation[27] and it allowed the researchers to get a comprehensive understanding of the patients' perceptions of informational privacy in the recovery room.[28]

Settings and sample

The data collection took place in July–September 2013 in the department of ear, nose and throat (ENT) diseases in one out of five university hospitals in Finland. This department was chosen because of the high number of operations and the expectations of having several patients in the recovery room at the same time.

The ENT department recovery room was located next to the operating rooms. Approximately 20 patients per day, representing both genders and aged from 6 months up, were taken care of in the same recovery room.[29] Some of the patients had problems with hearing and in communication due to hearing loss or laryngo-tracheal operations.

The patients were observed and cared postoperatively by the recovery room nurses. Information about the patients was exchanged verbally among staff at the patients' bedside after the operation and when they were transferred to the post-operative ward. Patient folders were kept on a table next to the bed.

There were screens between the patients which could be drawn out if needed. (Figure 1.) Each patient had one nurse with main responsibility for their care in the recovery room. Family members were not allowed to visit adult patients in the recovery room.

In this department, the recovery room stay lasted a median of 1–2 hours, range from 15 minutes up to 24 hours. Two to six nurses worked at the same time in the recovery

room. Anesthesiologists, surgeons, nurses from other wards and assistant non-medical staff increased the number of personnel from time to time.

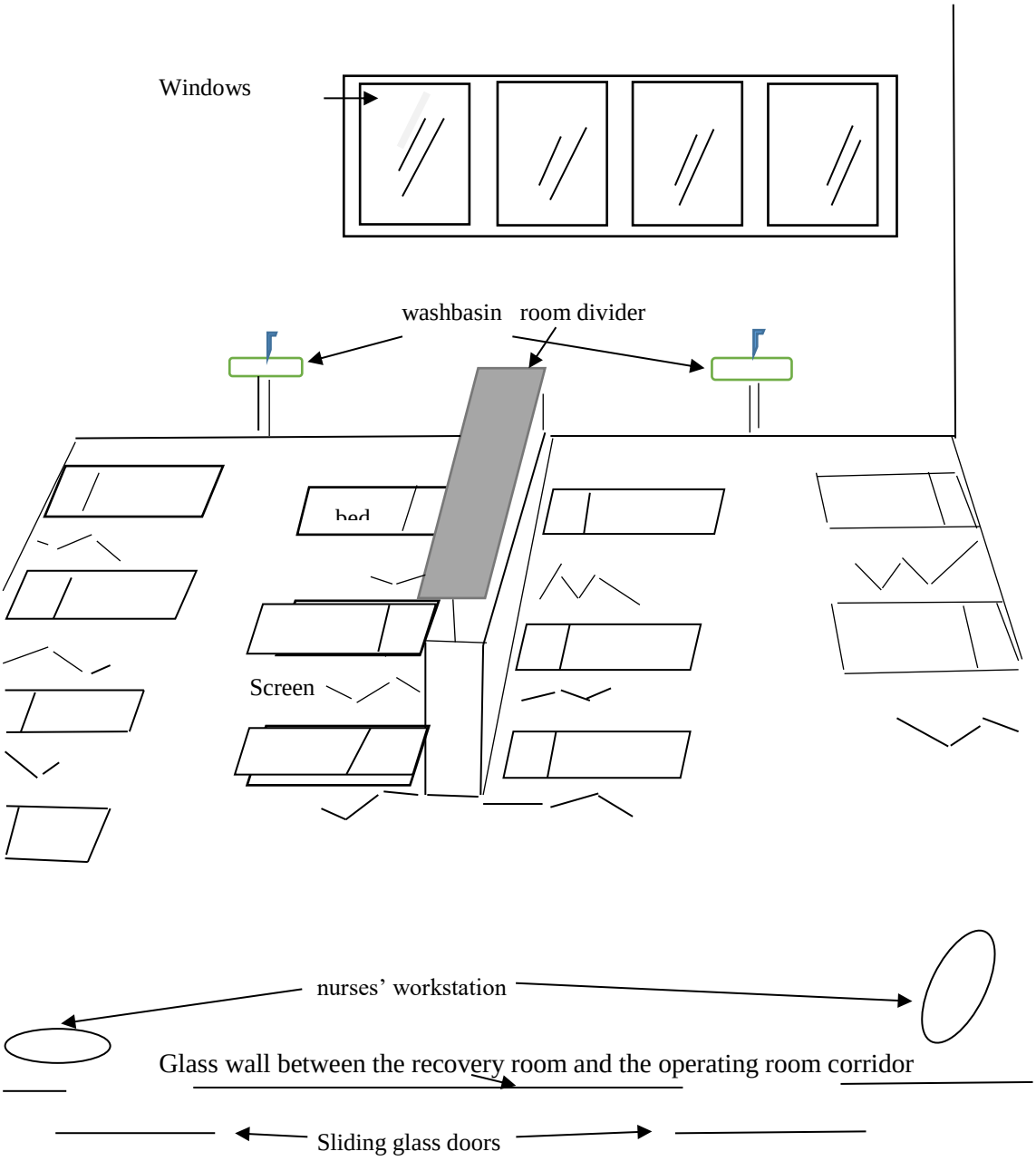

Figure 1. Layout of the recovery room

The patients were recruited with purposive sampling.[30] The recruitment was performed at two surgical wards of the ENT department. In these wards, nurses asked the patients' willingness to participate in the study on the day of the operation.

The inclusion criteria were: patients had to be over 18 years of age, Finnish speaking, able to hear and speak normally. Among the patients willing to participate, the ones whose stay in the recovery lasted longer than 30 minutes and who had had other patients in the recovery room at the same time with them were recruited. The data were collected and analyzed simultaneously in order to follow the data saturation. The patients were recruited until data saturation was reached.

Interviews

The recorded interviews conducted by the researcher (H K-T) took place one or two hours after the patient had been discharged from the recovery room, in a single room in the postoperative ward. The patients were not transferred to the post-operative ward before they were fully conscious, their respiration and cardiovascular function had returned to preoperative level, and their bleeding, pain and nausea were appropriately controlled. [31] In addition, the researcher made sure the patient was ready for interview by confirming the patient did not suffer any pain or nausea and that the patient generally felt in good enough condition for the interview. The interview was carried out only if the patient felt strong enough for the interview. None of the interviews were ceased due

to the patients' unstable condition or for any other reason. The interviews lasted approximately 24 minutes (range 14 to 43 minutes). A semi-structured interview guide with the following main themes was used: 1) how did the patient perceive informational privacy, 2) how did the patient perceive the realization of informational privacy in the recovery room, and 3) what were the factors promoting informational privacy in the recovery room? To describe the participants, the following background information was collected: participant's age, gender, education, the type of anesthesia (general or local) and operation, the number of previous hospitalizations, the length of stay in the recovery room, patient satisfaction (scale 0 the worst–10 the best grade) with a) nursing care, b) pain management and opinion of his well-being in the recovery room.

Data analysis

The verbatim data were analyzed with inductive content analysis.[27] The data was searched for meaningful descriptions of informational privacy. Key sentences and phrases were coded using in vivo codes.[30]

The in vivo codes were categorized and named under the indigenous concepts. The indigenous concepts were then summarized into patterns and major themes describing patients' experiences of informational privacy. The major themes were named so that they described the content of the indigenious concepts. In vivo codes, indigenous concepts, patterns and major themes were organized into a matrix (Table 1.). The use of

indigenous concepts and careful reviewing of the formed major themes ensured that the findings were described from the perspective of patients.[30]

Table 1. Example of the formation of in vivo codes into a major theme.

In vivo codes	Indigenous concepts	Pattern	Major theme
Does the patient information remain confidential between the nurse and the patient?	Confidentiality in communication	Informational privacy controlled by professionals	Twofold control of patient information
Privacy of personal health information, so that the nurses do not disclose my background or information about the operation to outsiders in the recovery room			
Private information is available only to the professionals taking care of the patient	Confidential access to patient information		
Patient information belongs only to the team taking care of the patient			
I want to control what information I share and with whom.	Limited information sharing	Informational privacy controlled by patients	

If the information is unnecessary for the doctor, for example former psychological problems, I do not think he should get to know it			
The patient should have a right to hear his own health information in the recovery room	Access to own patient information		
I should have a right to see and get the health information about me			

Ethical considerations

The study protocol received ethical approval from the Ethical Committee of the University of Turku (14/2013) and the permission to conduct the study by the authorities of the university hospital.

The patients received written and verbal information about the study on the day of the operation at the hospital. They had three to seven hours to consider participation in the study. The patients informed the nurse on the ward about their willingness to participate, after which the researcher met the patient. Written informed consent was obtained from each participant. The research findings are reported anonymously.

Findings

The participants' (n=17) mean age was 49 years (range 20–83). Both genders were represented (8 females, 9 males). Their educational background was mainly 12 -years of basic education plus 3.5 -year upper secondary level education (n=11), those with 12 -years of basic education plus academic education (n=5) and six years of schooling (n=1) being in the minority.[32]

The participants were operated under general anesthesia (n=15) or local anesthesia (n=2). The operations done to the participants were: tonsillectomy (n=6), parotidectomy (n=4), nose (n=4), and throat or thyroid gland operation (n=3). Most of the patients (n=16) had been previously hospitalized on average three times (range 0–10). Their recovery room stay lasted a median of 50 minutes (range 30 minutes–5 hours 30 minutes). There were 2 to 9 patients in the recovery room at the same time with the participants. The participants rated their satisfaction with a mean of 8.9 on nursing care, 9.7 on pain management, and 8.7 on patient general wellbeing in the recovery room.

Informational privacy from the patients' perspective

The patients described informational privacy as twofold control of their health information: a) control by professionals and b) control by the patient. (Figure 2.) Healthcare professionals were expected to control the confidentiality in communication

and in access to patient health information. The patients controlled their health information by limiting the sharing of verbal or written information with the health care professionals and having access to their own information. This access meant availability of the patients' written and verbal health information.

"The first thought in a hospital is that not everybody should hear about my matters" **1:24 (number of the code in ATLAS.ti 6.1 program)**

"The informational privacy concerns how I'm able to control the information about me that is spread around the hospital" **16:95**

The expectations on confidential communication in the recovery room varied between the patients. Some of the patients representing the other end of the continuum considered informational privacy as an unconditional principal which should not be violated under any circumstances. They found confidential communication especially important in relation to hospital roommates, their acquaintances and with patients representing the opposite sex. However, the patients were ready to balance informational privacy in relation to patient safety. The acuity of care entitled healthcare professionals to compromise confidential communication. The patients perceived that healthcare professionals had to exchange information about the patient to ensure safe patient care, for example during a life-threatening situation, even though other patients could hear the discussion.

"Obviously, confidentiality of patient information doesn't matter if I'm dying. The situation makes a difference. If you are really fighting for your life, then it does not matter." **7:126**

Confidential communication was not a priority for all the patients in the recovery room. This neutral attitude was ascribed to the fact that the patients did not consider their ENT diseases to be very sensitive or serious. If they had had more sensitive or serious issues, such as an incurable illness, they would have liked to receive the information privately, not in the recovery room.

If you'd have some sensitive illness, maybe you'd take it differently. Maybe an incurable illness would influence it, if you are really seriously ill. Then you'd need more privacy. **11:60**

Access to written patient information was expected to be limited only to the healthcare professionals taking care for the patients. The patients held healthcare professionals responsible for obtaining the necessary information concerning patients' care in order to secure patient safety. The patients allowed access to their health information also to the healthcare professionals who were not directly involved in their care if it benefited their care. They described it as a chance to get a second opinion. However, the patients did not consider it acceptable for any of the healthcare professionals to search for irrelevant, possibly stigmatizing information, such as psychological or gynecological problems, in regard to their current care.

” if there were for example psychological problems in the patient’s history, it would be unpleasant if these were dragged out and would affect the care you get later. They should not prejudice or stigmatize you” **16:1**

Selective sharing of patients’ own health information helped them to create a positive image of themselves in relation to the other patients. This positive image on its part supported the patients’ integrity and dignity in the recovery room. On the other hand, sharing of own feelings and experiences with other patients was seen as part of the hospital care.

The other patients are not allowed to hear my patient information. I create an image of myself and let the others hear what I want them to hear. **5:82**

“In my case, there is no such information (secret), you hear it in the patient room anyway. I think it belongs to the hospital that you discuss with the other patients about your disease history.” **11:58**

The patients described the access to own health information as a prerequisite for the control of patients’ informational privacy. Even though many of the patients were especially interested in what the doctor had written in their medical records they did not want to explore this information in the recovery room. They did not feel capable of reading or receiving detailed information immediately after the operation.

The patients’ perception of the realization of informational privacy in the recovery room

Realization of informational privacy controlled by healthcare professionals. Based on the patients' experiences, the realization of confidential communication varied. The discussions with the patient were often done anonymously, and the content mostly concerned postoperative pain and the patient's overall wellbeing after the operation. Some of the patients had not heard any sensitive patient information in the recovery room while others had been able to hear about the other patients' operations and medical history, and at times, to identify the patient. Hearing of other patients' health information was perceived as embarrassing. Opinions were divided concerning disclosure of patient's name or identification number. Some of the patients thought that addressing them by name was natural and that identifying the right patient was more important than protecting identity. Others worried about the disclosure and possible misuse of their name and identification number.

Confidential access to patient health information was perceived to be properly realized in the recovery room. The patients perceived that only the nurses and the physicians taking care of them had read their health information in the recovery room.

Realization of informational privacy controlled by the patient. The patients limited the sharing of their health information verbally in the recovery room. They refrained from asking questions about their current condition in order to limit disclosure of their health information to the other patients.

Access to own health information in the recovery room was ensured by receiving verbal information from the healthcare professionals. The patients were interested in whether the operation had been successful and if everything had gone well. Several patients were also interested in physiological measures like blood pressure, heart rate or their blood sugar level. The patients perceived they had received enough verbal information about their health in the recovery room.

The factors promoting informational privacy in the recovery room

The factors promoting informational privacy were divided into three sub-categories: factors related a) to healthcare professionals, b) to patients and c) to environment. (Figure 2.)

Promoting factors related to healthcare professionals consisted of positive attitude and knowledge of informational privacy and personal interaction with the patient. Healthcare professionals' positive attitude and knowledge of informational privacy was perceived to be the foundation of its realization. The patients trusted that healthcare professionals obey the laws, organizational regulations and their ethical guidelines concerning informational privacy. They assumed that healthcare professionals gained knowledge of informational privacy from their training and updated it regularly.

”It is not about some big structural changes or maneuvers. It is merely the attitude of the healthcare professionals. It has a major role in this matter” **7:131**

Personal interaction between nurses and patients promoted informational privacy in the recovery room. The nurses working in the recovery room came to the patient’s bed and used an appropriate voice to discuss with them.

I have noticed that the nurses here are very special, or they have learned to use their voices so that you feel they talk to you very personally **1:90**

Promoting factors related to the patients consisted of patients focusing on themselves, controlling the discussion of their health information and knowledge about informational privacy protection. The patients focused on themselves and did not pay attention to the other patients in the recovery room. Some of the patients had difficulties hearing or seeing as they did not have their hearing aid or eyeglasses with them. This shut out the presence of the other patients even more. They also described that good manners prevented them from listening to the other patients’ information. The same kind of solidarity behavior was expected from the other patients.

“after the operation, everybody is so focused on oneself, you aren’t interested in other peoples’ issues”. **4:3**

A few patients thought they could control the healthcare professionals’ discussions of their health information by forbidding them to do so. However, that would have

required them to be awake and to have enough courage to express their opinion to nurses. Some of the patients perceived they could have contributed more to the implementation of informational privacy in the recovery room if they had known how it was protected in the hospital.

Promoting factors related to the environment consisted of barriers of hearing and seeing, rules of society and the electronic patient data system.

Barriers of hearing and seeing indicated sufficient distance between patient beds, screens, soundproof spaces and limited entry to the recovery room. Sufficient distance and the screens between the beds in the recovery room prevented patients from seeing each other and prevented them from linking the health information to the right patient.

"They seemed to use screens in the recovery room and in here (the ward room). You get a feeling of a personal space." **1:56**

The patients suggested that nurses should have a soundproof office where they could discuss patient issues, for example consult the doctor. They also suggested soundproof areas where healthcare professionals and patients could have personal discussions.

"Space design is something you could promote. As I said, the curtains are quite cheap investment, and if the nurses had some kind of a soundproof box, where they could do the telephone calls like "mrs. Smith is ready to be picked up from the recovery room". Then nobody knows who is it, the names will not be disclosed to the others" **6:82**

Limited entry to the recovery room made the patients assume there were no outsiders. They also assumed that the nurses controlled the access to the patients' medical records from any irrelevant people in the recovery room.

I don't believe that anyone not belonging to the staff could even have access to the recovery room, nobody could get in there unnoticed **1:49**

Rules of society referred to the legal, ethical and organizational regulation on informational privacy and the sanctions of breaking the rules. The patients perceived that these rules promoted patients' informational privacy. In addition, the use of a checklist was suggested to ensure that informational privacy was maintained in the recovery room.

The patients perceived that an electronic patient data system, which was not in use at the time of the study, would promote informational privacy. It was assumed to hinder outsiders from handling patients' health information as the person who accessed them could be tracked afterwards.

I have understood that it can be seen that you have read someone's patient health information even though you are not taking care of that patient at the time. **7:110**

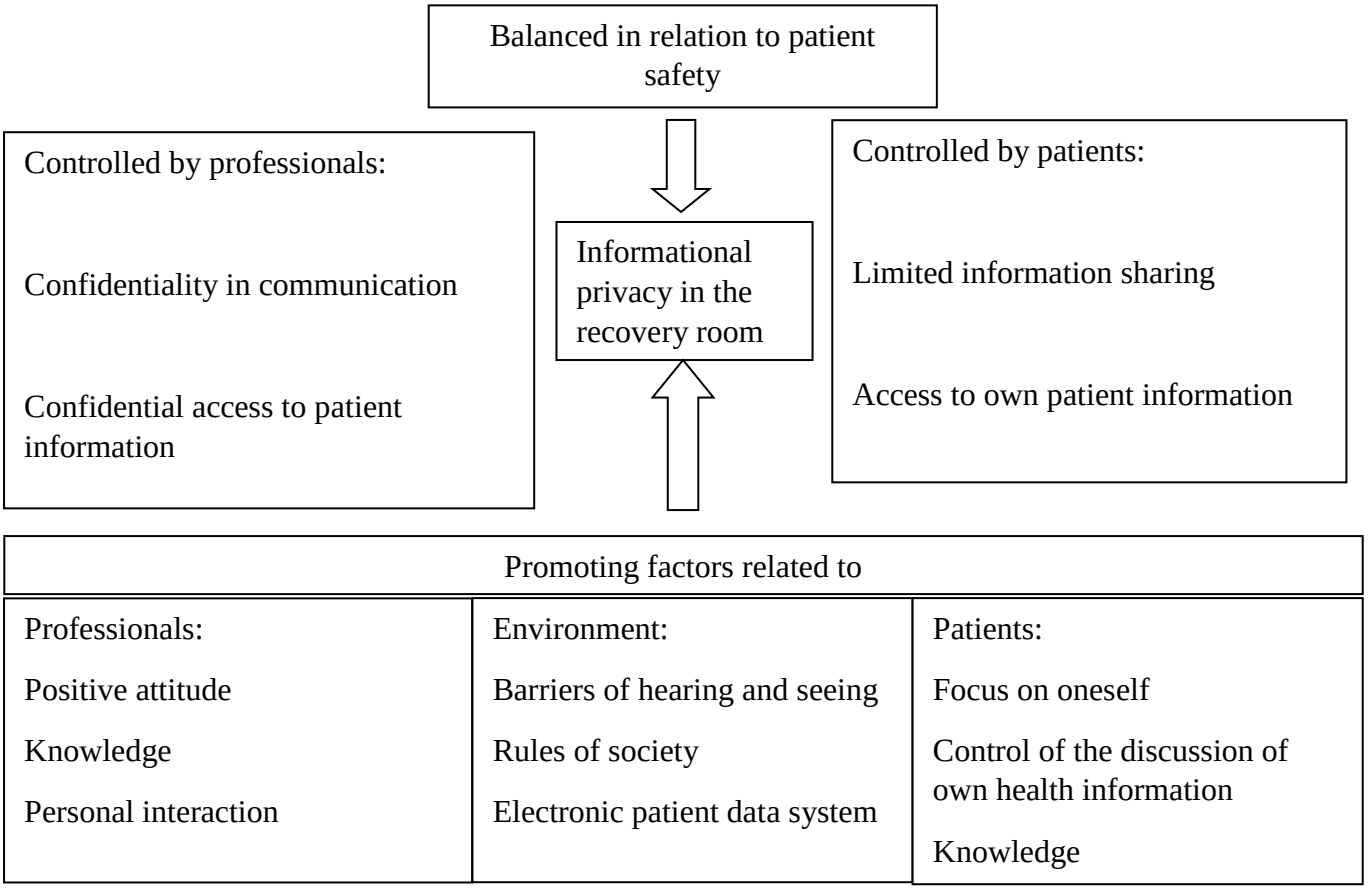

Figure 2. Patient perspective of informational privacy and the promoting factors in the recovery room

Discussion

This study suggests that patients' perspective of informational privacy in the recovery room relates to the control of their health information. This control is maintained by both healthcare professionals and patients. The concept of control emerged since the patients described informational privacy not only as protection of their health information but also as their active role in having access to it and making decisions about the disclosure of it.

The concept of informational privacy evolved with the results of this study. This study extends patients' former perceptions of the concept, confidentiality [22, 33-35] and access to health information,[33, 36, 37] to also encompass patients' active role in making decisions about the disclosure of their health information.

Patient safety was seen as a factor which in life-threatening situations overrides informational privacy. This point of view could have emerged due to the patients' acute situation after a surgical operation. Privacy as a situational concept [14, 38] can also be seen in this. The patients' desired level of privacy differed depending on how they were coping postoperatively. Healthcare professionals' high ethics and knowledge of informational privacy are especially highlighted in situations where patients lower their expectations for privacy due to their own safety, as was noted in this and an earlier study.[4]

Healthcare professionals' confidentiality in their clinical practice, especially in verbal communication, was seen as major contributor to the realization of informational privacy in the recovery room. This supports the earlier research conducted in emergency departments and medical and surgical wards. [4, 21, 22, 33, 39, 40] In this study, the patients were mostly satisfied with confidential communication. Healthcare professionals' careless disclosure of patient health information has been reported earlier in emergency and oncology wards and primary care.[8, 11, 37] The satisfaction with confidential communication seen in this study may be explained by patients' good satisfaction level with their care in the recovery room. In addition, sensitive issues that should be discussed privately [4, 41] were not discussed in the recovery room.

Confidential access to patient health information was perceived to be well realized in the recovery room. Medical records on a table by the patient's bedside did not expose confidential health information to other patients in the recovery room, unlike in an earlier study.[37] This is probably due the fact that in the recovery room patients normally stay in bed opposed to primary care setting where they can move more freely. Patients trust the healthcare professionals, also those not directly involved in their care, in the recovery room, as also seen in earlier studies.[3, 36, 39, 42-46] This trust the patients express in healthcare professionals indicates that professionals have managed to preserve the ethical demands implemented into the profession. However, this trust did not concern stigmatizing information, as indicated also in earlier studies.[33, 42, 45] This suggests that

also healthcare professionals' confidential access to patient information remains important to patients.[4]

Patients' awareness and active role in controlling their health information seems to be increasing. Patients limited the sharing of their health information, which has also been presented in earlier studies. [3, 4, 11, 22, 33, 47] Access to own information was seen as a prerequisite to be able to control its future disclosure in healthcare in this study. Limiting of the sharing of health information may cause risks to patient care. Patients are not always able to evaluate which information is relevant for their treatment which is why healthcare professionals have to maintain their trustworthiness in order to preserve patients' confidence in them. Their health problems may also remain unnoticed as a result of limiting the sharing of their health information, as shown also in an earlier study of former hospital patients.[4]

Environmental factors, such as sufficient distance and screens between the patients, played an important role in promoting patients' informational privacy in this study. Previously, patients have found curtains to be an insufficient protection for informational privacy in conversations.[4, 10, 11] Since environmental limitations make providing private space in the recovery room difficult, using all the available means to secure informational privacy is important. Information technology, for example electronic patient data systems, offers healthcare professionals new opportunities to

confidential communication about patient health information. The possibilities of architecture should also be exploited. Some intensive care units have glass walls which are bright on top and dimmed at the bottom. These kinds of walls could provide the patients more privacy also in the recovery room as shown in the earlier studies in the emergency units. [10, 11]

Limitations

The limitations of the study have to do with credibility, dependability and transferability. [48]

Credibility of the study relates to the focus of the phenomenon of interest and how well the data and analysis processes manage to obtain relevant information about it. [48] Lack of a universal definition of the concept of informational privacy made the development of a structured interview guide challenging; therefore, a semi-structured interview guide with an inductive approach was chosen. In vivo coding and the indigenous concepts used in data analyses aimed to remain loyal to the patients' voice and resulted in an extended description of the concept as compared to earlier studies which had mainly focused on confidentiality. General anesthesia and other sedative medication could have had an impact on the patients' recall and may have affected on the credibility of the findings.

Dependability [48] of the interviews was assured with the semi-structured guide. This helped to maintain the structure and focus of the interviews in informational privacy but allowed additional questions at the same time. The researcher is familiar with ENT diseases and recovery room nursing. This helped her to interpret the patients' descriptions of the events in the recovery room and separate those from the events in the postoperative wards.

The transferrability [48] of the study has certain limitations. The lack of young, especially female patients, in the study may have affected the results, since they have the highest expectations for privacy in the hospital. [6, 33, 45] The youngest participant in the study was 20 years old while the others were aged between 36 and 83 years. ENT diseases were also found to be quite a non-sensitive illness entity. More sensitive health problems may result in more critical views on informational privacy.

Conclusion

This research has shown that means are needed to protect patient health information in the recovery room, especially from the other patients. There is a gap between informational privacy regulation and its realization. Realization of informational privacy affects patient safety if patients do not have the courage to share their health information with the healthcare professionals. Hospital architecture and the lack of privacy due to the demand of continuous observation of patients pose challenges to informational

privacy in the recovery room. The capabilities of electronic patient records and technological solutions (e.g. mobile applications) in patient information transmission between healthcare professionals as well as architectural solutions should thus be advanced.

References

1. Leino-Kilpi H, Välimäki M, et al. Patients' autonomy, privacy and informed consent, Biomedical and Health Research. IOS Press, Amsterdam; 2000.
2. Beauchamp TL and Childress JF. Principles of Biomedical Ethics. 6.th edition, Oxford University Press, New York; 2009.
3. Eklöf N, Abdulkarim H, et al. Somali asylum seekers' perceptions of privacy in healthcare. Nurs Ethics 2016; 25,5: 535-546.
4. Malcolm HA. Does Privacy Matter? Former Patients Discuss Their Perception of Privacy In Shared Hospital Rooms. Nurs Ethics 2005; 12, 2: 156-166.
5. Eloranta S, Katajisto J and Leino-Kilpi H. Potilas kirurgisen hoidon laadun arvioitsijana. Hoitotiede 2008; 20, 3: 115-125.
6. Bäck E and Wikblad K. Privacy in Hospital. J Adv Nurs 1998; 27: 940-945.

7. Merakou K, Dalla-Vorgia P, et al. Satisfying Patients' Rights: A Hospital Patient Survey. Nurs Ethics 2001; 8, 6: 499-509.

8. Søndergård Larsen L, Hedegaard Larsen B and Birkelund R. A Companionship Between Strangers – the Hospital Environment as a Challenge in Patient-Patient Interaction in Oncology Wards. J Adv Nurs 2013; 70, 2: 395-404.

9. Woogara JR. Patients' Privacy of the Person and Human Rights. Nurs Ethics 2005; May 12, 3: 273-287.

10. Nayeri ND and Aghajani M. Patients' privacy and satisfaction in the emergency department: A descriptive analytical study. Nurs Ethics 2010; 17, 2:167-177

11. Karro J, Dent A W and Farish S. Patient perceptions of privacy infringements in an emergency department. Emerg Med Australas. 2005; 17, 2: 117-123.

12. Leino-Kilpi H, Välimäki M, et al. Privacy – a review of the literature. Int J Nurs Stud. 2001; 38: 663-671.

13. European Parliament and Council. Protection of personal data. Directive 95/46. http://eur-lex.europa.eu/legal-content/EN/LSU/?uri=CELEX:31995L0046&qid=1458071691646; 2014 Accessed 28.10.15.

14. Westin AF. Privacy and freedom. Athens: New York; 1970.

15. Goodwin L, Courtney K, et al. A Pilot Study: Patients' Perceptions About the Privacy of Their Medical Records. Online J Nurs Inform 6(3). http://ojni.org/1002/courtney.htm ; 2002 Assessed 29.03.16.

16. International Council of Nurses. The ICN Code of Ethics for Nurses. http://www.icn.ch/images/stories/documents/about/icncode_english.pdf ; 2012, Accessed 21.05.14.

17. World Medical Association. WMA International Code of Medical Ethics. http://www.wma.net/en/30publications/10policies/c8/ ; 2012 Accessed 16.03.16.

18. European Court of Human Rights, Council of Europe. The European Convention on Human Rights. http://www.echr.coe.int/Documents/Convention_ENG.pdf ; 1950 Accessed 27.04.14.

19. United Nations. The Universal Declaration on Human Rights. http://www.un.org/en/universal-declaration-human-rights/index.html ; 1948 Accessed 16.03.16.

20. Woogara J. Patients' rights to privacy and dignity in the NHS. Nurs Stand 2004; 19, 18: 33-37.

21. Kerr K, McKay K, et al. Attitudes of Emergency Department Patients about Handover at the Bedside. J Clin Nurs 2013; 1-9.

22. Lin Y-K and Lin C-J. Factors Predicting Patients' Perception of Privacy and Satisfaction for Emergency Care. Emerg Med J 2010; 28,(7): 604-608.

23. Mincley B. Space and Place in Patient Care. Am J Nurs 1968; 68, 3: 510- 516.

24. Choromanski D, Frederick J, et al. Intraoperative patient information handover between anesthesia providers. J Biomed Res 2014; 28, 5: 383-387.

25. Cutugno C. Evolution of postanesthesia care units: a legacy of politics, funding, and patient safety concerns. Policy Polit Nurs Pract 2013; Aug- Nov, 14(3-4): 142-150.

26. Smith AF and Mishra K. Interaction Between Anaesthetists, Their Patients, And The Anesthesia Team. Br J Anaesth 2010; 105, 1: 60-68.

27. Huberman, AM and Miles MB "Data Management and Analysis Methods". In Denzin, NK and Lincoln, YS, eds. *Handbook of Qualitative Research.* SAGE Publications; 1994.

28. Sandelowski M. Whatever Happened to Qualitative Description? Res Nurs Health 2000; 23: 334-340.

29. Helander J. Report of operation room activities in the department of Ear-, Nose- and Throat diseases – Opera-statistics. Presentation, January 2013.

30. Patton MQ. Qualitative Research & Evaluation Methods. 3rd Edition, Sage Publications, Thousands Oaks; 2002.

31. Vimlati L, Gilsanz F and Goldik Z. Quality and Safety Guidelines of Postanaesthesia Care. Working Party on Post Anaesthesia Care. Eur J Anaesthesiol 2009; 26: 715-721.

32. Ministry of Education and culture. Education System in Finland. http://www.minedu.fi/OPM/Koulutus/koulutusjaerjestelmae/?lang=en 4.12.2016

33. Jantunen K, Puumalainen A, et al. Onko sairaalassa yksityisyyttä. Hoitotieteen laitoksen julkaisuja A:5, Turun yliopisto, Turku; 1994.

34. Cahill J. Patient's Perceptions of Bedside Handovers. J Clin Nurs 1998; 7: 351-359.

35. Lin Y-P, Tsai Y-F and Chen H-F. Dignity in Care in the Hospital Setting from Patients' Perspectives in Taiwan: a Descriptive Qualitative Study. J Clin Nurs 2011; 20: 794-801.

36. McMurray A, Chaboyer W, et al. Patients' perspectives of bedside nursing handover. Collegian 2011; 18, 1: 19-26.

37. Deshevy-Longhi T, Karpe Dixon J, et al. Privacy and Confidentiality Issues in Primary Care: Views of Advanced Practice Nurses and their Patients. Nurs Ethics 2004; 11: 378-393.

38. Burgoon JK. Privacy and Communication. Commun Yearbook 1982; 6, 2: 206-249.

39. Matiti MR, and Trorey GM. Patients' Expectations of the Maintenance of their Dignity. J Clin Nurs 2008; 17: 2709-2717.

40. Jenkins G, Merz JF and Sankar P. A Qualitative Study of Women's Views on Medical Confidentiality. J Med Ethics 2005; 31: 499-504.

41. Rosqvist E. Potilaiden kokemukset henkilökohtaisesta tilastaan ja sen säilymisestä sisätautien vuodeosastolla. Väitöskirja, PhD Thesis, Hoitotieteen ja terveyshallinnon laitos, Oulun yliopistollinen sairaala, Oulun yliopisto, University of Oulu, Oulu; 2003.

42. Stone MA, Redsell SA, et al. Sharing Patient Data: Competing Demands of Privacy, Trust and Research in Primary Care. Br J Gen Pract 2005; 55: 783-789.

43. Timonen L and Sihvonen M. Patient participation in bedside reporting on surgical wards. J Clin Nurs 2000; 9: 542–548.

44. Whiddett R, Hunter I, et al. Patients' Attitudes Towards Sharing Their Health Information. Int J Med Inform 2006; 74: 530-541.

45. Moore M and Chaudhary R. Patients' Attitudes Towards Privacy in a Nepalese Public Hospital: a Cross-Sectional Survey. BMC Res Notes 2013; 6, 31: 1-5.

46. Braunack-Mayer A and Mulligan EC. Sharing Patient Information Between Professionals: Confidentiality and Ethics. Med J Aust 2003; 178: 277-279.

47. Lämsä R. Potilaskertomus. Etnografia potiluudesta sairaalaosaston käytännöissä. Tutkimus 99, Terveyden ja Hyvinvoinnin laitos; 2013.

48. Graneheim UH and Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today 2004; 24:105-112.