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ORIGINAL ARTICLE

Assessment of nurses' respect for patient privacy by patients and nurses: A comparative study

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Abstract

Aims: To determine whether nurses respect or violate patient privacy by comparing nurses' and patients' opinions.

Background: Although nurses want to respect patient privacy, they can sometimes violate patient privacy or not pay enough attention.

Method: This comparative and cross-sectional study was conducted with 357 patients and 305 nurses in 12 public hospitals in Trabzon, Turkey. Data were collected with an information form and the Patient Privacy Scale. Reporting is consistent with the STROBE checklist for cross-sectional studies.

Results: The total mean score of the patient privacy scale was 4.6 ± 0.39 for nurses and 4.5 ± 0.41 for patients, and no significant difference was found between their scores (U = 52999.0; p = .554). Further, the nurses (U = 14358.0; p = .000) and the patients (U = 13272.5; p = .006) in the public hospitals had statistically significantly higher overall privacy scores than those in the training and research hospitals. The overall privacy scale scores were higher and more statistically significant in the patients hospitalised in surgical clinics than those hospitalised in clinics for internal diseases (U = 8514.0; p = .005) and in single compared to married patients (U = 12364.5; p = .034).

Conclusion: Nurses respected patient privacy highly according to both nurses and patients, and there was no significant difference between their views. However, nurses working in training and research hospitals and internal diseases clinics need to improve their approaches to patient privacy.

Relevance to clinical practice: The results of this study could be used to reduce patient privacy vulnerabilities in complex hospitals and clinics such as training and research hospitals and to improve institutional policies and activities regarding patient privacy. By comparing the results of patients and nurses, the study provided more consistent and accurate data about patient privacy.

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1 | INTRODUCTION

Patient privacy and confidentiality are a consideration that healthcare professionals are responsible for and it should be respected in accordance with ethical codes and principles (Rosner, 2006). In other words, ensuring patient privacy and confidentiality is an ethical obligation (Hartigan et al., 2018), a fundamental professional norm, and the duty and responsibility of healthcare professionals and organisations (Erdemir, 2019; Bostan & Ünal, 2019; İzgi, 2014; Lin et al., 2013). Healthcare professionals must respect patient privacy and confidentiality in all settings (Hartigan et al., 2018). Many national and international nursing organisations such as the Canadian Nurses Association (CAN) (2017), American Nurses Association (ANA) (2015), Turkish Nurses Association (THD) (2009) place a high value on patient privacy and confidentiality. In their latest guidelines on ethical codes and principles, the protection of the patient's privacy and confidentiality rights was considered as one of the basic codes, and it was pointed out that nurses were responsible in this regard. The International Council of Nurses (ICN) (2012) also advised nurses and nurse managers to use registration and information systems that ensure confidentiality and declared that educators and researchers should introduce the concepts of privacy and confidentiality in nursing curricula, and include related issues in nursing ethics codes. The ethical codes of ICN were considered in the preparation of the nursing code of ethics of many nations including Turkey (Altun, 2020). Further, attempts have been made to secure patient privacy and confidentiality by many national and international legal regulations, contracts and universal legal norms (Akar et al., 2019; Bostan & Ünal, 2019) including all updates to patient rights declaration, the latest of which was in Sentiago (HHK, 2013), European Standards for Privacy and Confidentiality in Healthcare (Caural et al., 2009) and the 'Respecting Patient Privacy' circular published in Turkey (SB, 2016). Apart from these, several regulations including the constitutional law in particular, patient rights regulation and criminal law have been implemented to ensure patient privacy (Akar et al., 2019).

What does this paper contribute to the wider global clinical community?

- In contrast to some international and national studies, the results of this study demonstrated that nurses give a high level of attention to patient privacy.
- In this study, which aims to obtain more accurate and consistent results by comparing the opinions of the patients receiving service and the nurses providing service, there was no significant difference between the evaluations of both groups regarding the attention/respect for patient privacy.
- In this study, some weaknesses regarding patient privacy were identified in the hospitals and clinics. Identifying these weaknesses is important to take necessary precautions to protect patient privacy and ensure patient satisfaction.
- This study offers data on patient privacy in nursing services that similar countries can use for comparison and self-evaluation.

1.1 | Background

In healthcare organisations, securing the right to privacy and confidentiality, which is a basic need and human right, is important to prevent individuals from being embarrassed, offended and discouraged (Alpar, Bahçecik & Karabacak, 2013), judged, stigmatised and discriminated against (Klosek, 2011) while allowing them to communicate honestly and openly with the healthcare team (Alpar et al., 2013). Safeguarding human dignity, it ensures the development of communication between the patient and the healthcare team and the establishment of a trust-based relationship essential for quality care (Tehrani et al., 2018) which can save lives (Klosek, 2011). Since patients may be less willing to share information when they are concerned about privacy (Shen et al., 2019), or may not disclose their personal information completely and honestly, treatment may be delayed or not given at all (Klosek, 2011). Therefore, the confidentiality of medical records containing the details of patients' private lives and the most sensitive information they want to conserve, such as their physical and mental health, personal relationships and financial situation, needs to be ensured (Klosek, 2011).

However, privacy and confidentiality of patients can be violated due to the physical problems of health institutions (Akar et al., 2019; Hartigan et al., 2018; Lin et al., 2013) and healthcare professionals' lack of attention to patient privacy and confidentiality (Akar et al., 2019). Further, sometimes privacy of the patient can be sacrificed to protect them against environmental risks or to save their lives (Tehrani et al., 2018). Moreover, the technological advances that have taken place in the recent years have made it difficult to ensure patient privacy and confidentiality (Ak et al., 2020; Klosek, 2011). The transition to a digital recording system in healthcare services has increased the quality of service delivery but has also compromised the security of patient information (Akar et al., 2019). Cronquist and Spector (2011) explained in their study that nurses should protect patient privacy rights while they are using social media and that the potential impact of communication on patients, employers, professions and themselves should be taken into account. Similarly, Altun (2020) emphasised that healthcare professionals need to pay even further attention to patients' privacy when tape, video, computer and photography are used in healthcare institutions. In a qualitative study, the majority of healthcare professionals stated that the institution they work in qualified generally in terms of ensuring patient privacy, while some others reported that there were technical problems, that the institution was not suitable enough and that some important regulations need to be established (Arslan & Demir, 2017). In a study conducted by Özata and Özer (2017), it was found that

healthcare workers including nurses were careful or responsive about protecting patient privacy. In a study conducted by Öztürk et al. (2014) in a private hospital, the majority of nurses stated that they respected patient privacy, while 43.9% believed that patient privacy regarding private life and personal information was violated. Another study conducted by Öztürk et al. (2014) with nurses working in public and private hospitals found that nurses respected patient privacy in general, although less attention was paid to patient privacy in public hospitals compared to private hospitals (Öztürk et al., 2014). Some studies found that nurses respected patient privacy (Aktan et al., 2019; Aslan et al., 2019; Mersinlioğlu & Öztürk, 2015). In a study conducted by Candan and Bilgili (2018), nurses and midwives had a medium level of perception of privacy.

In some international studies, patients believed that their privacy was not adequately protected or was even violated (Roos et al., 2020; Eklöf et al., 2020; Nayeri & Aghajani, 2010). In their study with older patients, Hajbaghery and Zehtabchi (2014) found that the privacy of the patients was not respected for 15.2% of the patients and respected at a moderate level for 68.5%. In some studies in Turkey, patients stated that their privacy was not respected (Bostan & Ünal, 2019; Namlı, 2012), while in others, patients described that they were satisfied with the respect being shown for their privacy or thought that their privacy was respected (Akar et al., 2019; Utkualp &Yıldız, 2016; Aydemir & Işıkhan, 2012).

When evaluating the opinions of both patients and nurses, it appears from a study by Schopp et al. (2003) on the care of older people that patient privacy was protected the most in the UK/England and the least in Greece. In a study by Kim et al. (2017), nurses and patients stated that nurses' actual performance was lower compared to the importance nurses attach to patient privacy. Similarly, in a qualitative study of Akyuz and Erdemir (2013) on the opinions of both patients and nurses, patients were not sure enough about how efficiently the confidentiality of their personal data was protected, although most of them were content with how nurses respected their privacy. Likewise, in the same study, patients paid more attention to their conditions and healthcare personnel's approaches, while nurses were more focused on ensuring physical privacy. Furthermore, patients and nurses emphasised that single rooms should be arranged to make patients feel comfortable (Akyüz & Erdemir, 2013). However, in a study on patient rights conducted with both nurses and patients, respect for privacy and confidentiality were defined as the first priority that should be observed within the context of patient rights by 96% of the participants in both groups (Barati et al., 2019).

Considering the studies conducted on patient privacy from this context, the number of studies conducted with both groups seems to be limited, although there are several studies conducted separately with patients or nurses. Given that self-evaluation results are generally biased or overestimated (Kubat, 2012), evaluating whether patient privacy is respected by nurses comparatively from both patients' and nurses' perspective can provide more consistent results. It was therefore considered important to evaluate concurrently whether patient privacy is respected or neglected during nursing practices from both patients' and nurses' perspectives (Öztürk et al., 2014).

1.2 | Objectives

This study aimed to determine whether nurses respect or neglect patient privacy with evaluations of nurses and patients.

2 | METHODS

The study was consistent with the strengthening of the reporting of observational studies in epidemiology (STROBE) statement for cross-sectional studies (see Appendix S1).

2.1 | Study design

This study was a descriptive, comparative, and cross-sectional study.

2.2 | Setting and participants

The population of the study consisted of a total of 5100 patients for a day and 1480 nurses in 12 public hospitals, two of which were training and research hospitals affiliated to the Ministry of Health in Trabzon, Turkey. The sample size was calculated based on the average and standard deviation values in the study of Kim et al. (2017). Using the GPower program, it was determined as 408 participants (204 for nurses, 204 for patient) with 95% test power, 0.565 effect size and 95% confidence level, using independent t test and two-tailed test. However, the study was carried out with 357 patients and 305 nurses and the power of the test was identified to be 99.5% by post hoc power analysis. In study, nurses who were not on leave during the study period and who volunteered to participate at enrolment, and patients over 18 years of age who were able to communicate with the nurses, were receiving inpatient care, and who volunteered to participate were included in study.

2.3 | Instruments

The information form and Patient Privacy Scale were used to collect data in study.

The *Information Form* was prepared by the researchers. It consisted of 16 questions in total (8 questions about the socio-demographic characteristics of the nurses including age, gender, marital and educational status, professional experience, hospitals and clinics where they worked, and whether they have read the patient rights guideline, and 8 questions about the socio-demographic characteristics of the patients including patients' age, marital and

educational status, hospitals and clinics where they were hospitalised, duration of hospitalisation, number of patients in their rooms, and previous hospitalisation).

The *Patient Privacy Scale (PPS)* was developed by Öztürk et al. (2014). It consists of a total of 27 items and 5 subscales including confidentiality of private life/personal information (CIPL), sexual privacy (SP), privacy of those unable to protect themselves (PPT), physical privacy (PP) and providing a favourable environment (EFE). The 5-point Likert type scale is scored as 5 = Strongly agree, 4 = Agree, 3 = Could not decide, 2 = Disagree, 1 = Completely Disagree. The total score from the scale ranges between 27–135. A score approximating to 135 meant that the nurse observed patient privacy or personal confidentiality, while one close to 27 referred to not observing them. When these scores are divided by the number of items for comparison, a value between 1–5 is given at the level of scale total and subscales. In addition, the overall Cronbach's alpha value of the privacy scale was 0.93 (Öztürk et al., 2014). For nurses, the Cronbach's alpha values of its subscales and Patient Privacy Scale in the current study were 0.88 for confidentiality of private life/personal, 0.66 for sexual privacy, 0.83 for privacy of those unable to protect themselves, 0.92 for physical privacy, 0.86 for providing a favourable environment and 0.94 for the total of Patient Privacy Scale. For patients, Cronbach's alpha values (Cronbach's alpha if item deleted) and the values ranges of item to total correlations of Patient Privacy Scale' subscales were 0.88 (0.86–0.88), r = .387–0.793 for confidentiality of private life/personal, 0.54 (0.43–0.65), r = .271–0.504 for sexual privacy, 0.90 (0.88–0.91), r = .688–0.863 for privacy of those unable to protect themselves, 0.94 (0.91–0.93), r = .825–0.910 for physical privacy and 0.93 (0.90–0.95), r = .765–0.905 for providing a favourable environment, and 0.93 (0.93–0.95), r = .250–0.832 for the total of Patient Privacy Scale. Due to the high or acceptable level of these results, the same 27-item scale used for nurses was used for patients in this study, adhering to the original scale.

3 | ETHICAL CONSIDERATIONS

Written permission was obtained from Trabzon Provincial Health Directorate on 05 September 2018 to carry out the research in 12 public hospitals affiliated to the Ministry of Health. In addition, ethical approval was obtained from the Ethics Committee of KTU Medical Faculty with the letter number 24237859-123 and protocol number 2018/308 on 04 February 2019. The study was carried out with patients and nurses who volunteered and gave consent at enrolment.

3.1 | Data collection

After obtaining institutional and ethical permissions and asking whether the patients and nurses were volunteering to take part in the study and obtaining their approvals, data were collected with an information form and the Patient Privacy Scale using face-to-face interview method from patients in the patient's room by three researchers and from nurses in the nursing room by two different researchers between 10 February – 20 March 2019. In both cases, care was taken to have only the participant and the researcher in the room, while a companion was allowed at the request of the patient. The importance of reflecting their true and sincere thoughts and the purpose of the study was explained to patients and nurses, and they were reassured that their identity information would be kept confidential.

The data were entered alternately by the researchers between 20 March – 01 April 2019 and were analysed after checking the data and correcting the errors in consultation with a statistician.

3.2 | Statistical methods

The Kolmogorov–Smirnov test was used to determine the fit of the data with a normal distribution, and the variables did not show normal distribution. The frequency, percentage and means were used to examine the demographic characteristics of the nurses and patients, and the Kruskal–Wallis, Mann–Whitney U and correlation tests were used to compare demographic variables as the independent variables and Patient Privacy Scale's scores as dependent variables. The effect size was calculated in the results that were statistically significant according to the Mann–Whitney U test results. The effect size value was obtained by dividing the z value by the square root of the sample number and shown as "*r*." Values between 0.10–0.29 were considered small, values between 0.30–0.49 were considered moderate, and values greater than 0.50 were considered significant/large (Pallant, 2017). Furthermore, Cronbach alpha and item-total correlation analyses were used to test reliability of Patient Privacy Scale and its subscales for patients. All statistical tests were evaluated at 95% confidence interval and $p < .05$ significance level.

4 | RESULTS

In the study, nurses had a mean age of 35.94 ± 8.2, 92.1% were women, 67.2% were married, and 61% had bachelor's and postgraduate degrees. They had an average of 14.03 ± 8.4 years of professional experience. Further, 56.1% of the nurses worked in public hospitals, 67.9% worked in internal diseases clinics, and 83% reported that they read the patient rights guidelines.

The patients had a mean age of 63.9 ± 17.3, 55.7% were male, 45.1% were primary school graduates, 78.7% were married, 50.7% of them were hospitalised in a public hospital and 78.4% in internal diseases clinics. Hospitalisation details showed that 35.9% of the patients had been in the hospital for 1–3 days, 59.1% had stayed in the same room with two or more people, and 88.2% reported that they have previously been in the hospital. Furthermore, 62.7% of the patients reported that they were aware of patient rights, and 98.6% believed that nurses respected patient privacy.

Nurses' total mean score from Patient Privacy Scale was 4.6 ± 0.39 and the mean scores of the subscales were as follows: 4.6 ± 0.42 for confidentiality of private life/personal information, 4.4 ± 0.53 for sexual privacy, 4.6 ± 0.43 for privacy of those unable to protect themselves, 4.7 ± 0.42 for physical privacy and 4.6 ± 0.43 for ensuring a favourable environment. Patients' total mean score of the patient privacy scale was 4.5 ± 0.41, and the mean scores of the subscales were as follows: 4.6 ± 0.43 for confidentiality of private life/personal information, 4.3 ± 0.56 for sexual privacy, 4.6 ± 0.52 for privacy of those unable to protect themselves, 4.6 ± 0.49 for physical privacy and 4.6 ± 0.52 for ensuring suitable environment (Table 1). However, the comparison of the results yielded no statistically significant difference between the patients' and nurses' scores from the overall scale and subscales ($p > .05$) (Table 1).

When the Patient Privacy Scale scores of nurses were evaluated according to the hospitals, the total score (*MWU* = 14,358; $p < .0001$) and the scores of all subscales of the nurses working in the public hospitals were found to be statistically significantly higher than the nurses working in the training and research hospitals ($p < .05$). These significant differences had a small effect ($r = .14–0.21$) (Table 2).

Compared to the nurses working in the internal clinics, the nurses working in the surgical clinics had higher scores only on the subscale of privacy of those unable to protect themselves (*MWU* = 8462.5; $p = .010$; $r = .14$) (Table 2). In terms of the clinics, no statistically significant difference was found between the other subscales and total scores of the patient privacy scale according to the nurses ($p > .05$) (Table 2).

No statistically significant difference or correlation was found between nurses' age, gender, marital and educational status, professional experience, and whether they have read the patient rights guideline and the total and subscales scores of the Patient Privacy Scale ($p > .05$).

When characteristics of the patients and their Patient Privacy Scale scores were compared, married patients were found to have statistically significantly higher scores than single patients in the total score (*MWU* = 12364.5; $p = .034$), in the privacy of private life/personal information (*MWU* = 12430.5; $p = .021$), privacy of those unable to protect themselves (*MWU* = 12433.0; $p = .012$) and physical privacy (*MWU* = 12514.5; $p = .009$) subscales. These significant differences had a small effect ($r = .11$, $r = .12$, $r = .13$, $r = .13$, respectively) (Table 3). No statistically significant difference was found between the marital status of the patients and other subscales scores ($p > .05$) (Table 3).

The patients hospitalised in the training and research hospital had statistically significantly higher scores compared to those in public hospitals in the total of the Patient Privacy Scale (*MWU* = 13804.5; $p = .029$) and the sexual privacy subscale (*MWU* = 13272.5; $p = .006$), and these significant differences had a small effect ($r = .11$, $r = .14$, respectively) (Table 3). No statistically significant difference was found in the other subscale scores according to hospitals ($p > .05$) (Table 3).

Compared to the patients hospitalised in the clinics for internal medicine, the scores of the patients hospitalised in the surgical clinics were statistically higher in the total Patient Privacy Scale (*MWU* = 8514.0; $p = .005$) and in the sexual privacy, privacy of those unable to protect themselves, physical privacy and providing a favourable environment subscales ($p < .05$). These significant differences also had a small effect ($r = .12$ – $r = .15$) (Table 3). There was no statistically significant difference in the confidentiality of private life/personal information subscale ($p > .05$) (Table 3).

The total and subscale scores also did not differ significantly by patients' age, gender, educational status, the number of days they stayed in the hospital, the number of patients in their rooms, previous hospitalisation history and knowledge of patient rights ($p > .05$).

TABLE 1 Comparison of nurses' and patients' total and subscale scores from the patient privacy scale (n = 662)

	CIPL	SP	PPT	PP	EFE	Total
Nurses						
M ± SD	4.6 ± 0.4	4.4 ± 0.5	4.6 ± 0.4	4.7 ± 0.4	4.6 ± 0.4	4.6 ± 0.3
Median	4.8	4.4	5.0	5.0	5.0	4.7
Q1, Q3 (IQR)	4.3, 5.0 (0.7)	4.0, 5.0 (1.0)	4.2, 5.0 (0.8)	4.5, 5.0 (0.5)	4.2, 5.0 (0.8)	4.2, 4.8 (0.6)
95% CI	4.7–4.9	4.4–4.6	4.7–5.0	5.0–5.0	5.0–5.0	4.7–4.8
Mean Rank	327.0	335.1	332.2	340.0	332.8	336.2
Patients						
M ± SD	4.6 ± 0.4	4.3 ± 0.5	4.6 ± 0.5	4.6 ± 0.4	4.6 ± 0.5	4.5 ± 0.4
Median	4.9	4.4	5.0	5.0	5.0	4.7
Q1, Q3 (IQR)	4.3, 5.0 (0.7)	4.0, 5.0 (0.1)	4.0, 5.0 (0.1)	4.0, 5.0 (1.09)	4.0, 5.0 (1.0)	4.2, 4.5(0.3)
95% CI	4.8–4.9	4.2–4.6	5.0–5.0	5.0–5.0	5.0–5.0	5.0–5.0
Mean Rank	335.3	328.4	330.8	324.1	330.3	327.4
MWU; *p*	53074.0; .561	53343.0; .649	54213.5; .918	51827.0; .221	54020.0; .845	52999.0; .554

CIPL, Confidentiality of Private Life/Personal Information; EFE, Providing a Favourable Environment; PP, physical privacy; PPT, Privacy of Those Unable to Protect Themselves; SP, sexual privacy.

TABLE 2 Comparison of total and subscales scores from the patient privacy scale for nurses by hospitals and clinics (n = 305)

Hospitals	CIPL	SP	PPT	PP	EFE	Total
Training and research hospitals						
M ± SD	4.6 ± 0.4	4.3 ± 0.5	4.6 ± 0.6	4.6 ± 0.5	4.6 ± 0.6	4.6 ± 0.4
Median	4.6	4.4	4.7	5.0	5.0	4.6
Q1, Q3 (IQR)	4.1, 5.0 (0.9)	4.0, 4.8 (0.2)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.1, 4.8 (0.7)
95% CI	4.4– 4.7	4.2–4.5	4.4–5.0	4.7–5.0	4.5–5.0	4.5–4.7
Mean Rank	133.3	136.8	133.2	140.7	138.10	131.35
Public hospitals						
M ± SD	4.7 ± 0.3	4.4 ± 0.5	4.7 ± 0.3	4.7 ± 0.3	4.7 ± 0.3	4.6 ± 0.3
Median	4.9	4.6	5.0	5.0	5.0	4.8
Q1, Q3 (IQR)	4.5, 5.0 (0.5)	4.0, 5.0 (1.0)	4.5, 5.0 (0.5)	4.5, 5.0 (0.5)	4.5, 5.0 (0.5)	4.5, 4.9 (0.4)
95% CI	4.8–5.0	4.4–4.8	5.0–5.0	5.0–5.0	5.0–5.0	4.7–4.9
Mean Rank	168.4	165.6	168.4	162.5	164.6	169.9
MWU; p	14090.5; <.0001*	13618.5; .004*	14101.5; <.0001*	13096.5; .013**	13454.5; .003*	14358.0; <.0001*
z; r***	−3.56; 0.20	−2.87; 0.16	−3.79; 0.21	−2.47; 0.14	−2.94; 0.16	3.81; 0.21
Clinics						
Surgical clinics						
M ± SD	4.6 ± 0.3	4.5 ± 0.4	4.7 ± 0.3	4.7 ± 0.3	4.7 ± 0.4	4.6 ± 0.3
Median	4.9	4.6	5.0	5.0	5.0	4.8
Q1, Q3 (IQR)	4.4, 5.0 (0.6)	4.2, 5.0 (0.8)	4.5, 5.0 (0.5)	4.5, 5.0 (0.5)	4.5, 5.0 (0.5)	4.5, 4.9 (0.4)
95% CI	4.7–5.0	4.4–4.8	5.0–5.0	5.0–5.0	5.0–5.0	4.7–4.9
Mean Rank	164.8	166.0	170.1	160.4	163.7	165.5
Internal diseases clinics						
M ± SD	4.5 ± 0.4	4.3 ± 0.5	4.6 ± 0.4	4.6 ± 0.4	4.6 ± 0.4	4.5 ± 0.4
Median	4.7	4.6	4.7	5.0	5.0	4.7
Q1, Q3 (IQR)	4.3, 0 (0.7)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.2, 5.0 (0.8)	4.1, 5.0 (0.9)	4.2, 4.9 (0.7)
95% CI	4.6–4.9	4.2–4.6	4.7–5.0	5.0–5.0	4.7–5.0	4.6–4.8
Mean Rank	147.3	146.8	144.8	149.4	147.9	147.0
MWU; p	8981.5; .095	8865.0;.071	8462.5; .010*	9415.0; .244	9088.5; .099	8910.5; .085
z; r***	-	-	−2.56; .14	-	-	-

*p < .01,

**p < .05,

***Effect size.

5 | DISCUSSION

The right to privacy in healthcare is related to preventing disclosure of individuals' personal health information to others and ensuring confidentiality (Ma et al., 2016) as well as physical privacy and privacy of physical space, and personal respect and independence in decision making (Tehrani et al., 2018). This right may not be optimally respected or may even be neglected in health institutions due to various reasons such as the design and layout of the clinic/unit or patient rooms, patient flow, crowd, personnel practices/behaviours, department policies and area usage affected by the culture of the team, visitor policies (Calleja & Forrest, 2011), individual misconduct, intense work pressure, unfairness in distribution of tasks and delegation of authority, unfavourable conditions in the work environment, physical infrastructure problems, lack of staff (Tosun & Aksoy, 2019), nurses' changing shifts at bedside (Calleja & Forrest, 2011), healthcare workers ignoring patient privacy while saving lives, meeting patients' basic needs in bed and with help and assuming that patients are unconscious in certain units (Öztürk et al., 2014; Öztürk et al., 2014). However, because it is generally accepted as normal that private areas of patients may be exposed during physicians' and nurses' interventions/practices and some private personal information may be accessed/shared (Öztürk et al., 2014; Petronio & Sargent, 2011), patients may remain silent and healthcare professionals may not become aware of the violation (Öztürk et al., 2014). In addition, patients do not file complaints about the violations of privacy occurring during provision of service with the concern that they will not be able to receive health services (Namlı, 2012). For

TABLE 3 Comparison of total and subscale scores from patient privacy scale for patients by the marital status, the hospitals and clinics (n = 357)

Marital Status	CIPL	SP	PPT	PP	EFE	Total
Married						
M ± SD	4.6 ± 0.4	4.3 ± 0.5	4.5 ± 0.5	4.6 ± 0.5	4.6 ± 0.5	4.5 ± 0.4
Median	4.8	4.4	5.0	5.0	5.0	4.7
Q1, Q3 (IQR)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.0, 4.9 (0.9)
95% CI	4.7–4.9	4.2–4.6	4.7–5.0	5.0–5.0	5.0–5.0	4.7–4.8
Mean Rank	172.7	175.9	174.68	172.7	172.4	173.0
Single						
M ± SD	4.7 ± 0.3	4.4 ± 0.5	4.7 ± 0.4	4.7 ± 0.3	4.7 ± 0.3	4.6 ± 0.3
Median	5.0	4.7	5.0	5.0	5.0	4.8
Q1, Q3 (IQR)	4.7, 5.0 (0.3)	4.0, 5.0 (1.0)	4.3, 5.0 (0.7)	4.6, 5.0 (0.4)	4.7, 5.0 (0.3)	4.4, 4.9 (0.5)
95% CI	4.8–5.0	4.2–4.8	5.0–5.0	5.0–5.0	5.0–5.0	4.7–4.9
Mean Rank	202.0	190.1	195.0	202.0	203.1	201.1
MWU; p	12430.5; .021**	11528.0; .278	11894.0; .088	12433.0; .012**	12514.5; .009*	12364.5; .034**
z;r***	−2.29; .12	–	–	−2.52; .13	−2.63; .13	−2.12; .11
Hospitals						
Training and research hospitals						
M ± SD	4.6 ± 0.4	4.3 ± 0.5	4.5 ± 0.5	4.6 ± 0.5	4.5 ± 0.6	4.5 ± 0.4
Median	4.9	4.2	5.0	5.0	5.0	4.7
Q1, Q3 (IQR)	4.2, 5.0 (0.8)	4.0, 4.8 (0.2)	4.0, 5.0 (0.1)	4.0, 5.0 (0.1)	4.0, 5.0 (0.1)	4.2, 4.8 (0.6)
95% CI	4.7–5.0	4.2–4.4	4.7–5.0	5.0–5.0	4.8–5.0	4.6–4.8
Mean Rank	178.0	193.6	183.4	181.8	185.5	190.7
Public hospitals						
M ± SD	4.6 ± 0.4	4.4 ± 0.5	4.6 ± 0.4	4.6 ± 0.4	4.6 ± 0.4	4.6 ± 0.4
Median	4.8	4.8	5.0	5.0	5.0	4.8
Q1, Q3 (IQR)	4.4, 5.0 (0.6)	4.0, 5.0 (1.0)	4.2, 5.0 (0.8)	4.0, 5.0 (1.0)	4.2, 5.0 (0.8)	4.2, 4.9 (0.7)
95% CI	4.8–4.9	4.4–4.8	4.9–5.0	5.0–5.0	5.0–5.0	4.7–4.8
Mean Rank	179.9	163.9	174.4	176.0	172.2	166.9
MWU; p	16100.5; .853	13272.5; .006*	15127.0; .358	15407.0; .540	14746.5; .166	13804.5; .029**
z; r***		−2.66; .14				−2.07; .11
Clinics						
Surgical clinics						
M ± SD	4.7 ± 0.3	4.5 ± 0.6	4.7 ± 0.3	4.7 ± 0.3	4.7 ± 0.4	4.7 ± 0.3
Median	4.9	4.8	5.0	5.0	5.0	4.8
Q1, Q3 (IQR)	4.6, 5.0 (0.4)	4.0, 5.0 (1.0)	4.7, 5.0 (0.3)	4.7, 5.0 (0.3)	4.7, 5.0 (0.3)	4.5, 4.9 (0.4)
95% CI	4.8–5.0	4.6–5.0	5.0–5.0	5.0–5.0	5.0–5.0	4.7–4.9
Mean Rank	191.1	206.0	201.5	203.5	201.6	208.4
Internal diseases clinics						
M ± SD	4.6 ± 0.4	4.3 ± 0.5	4.5 ± 0.5	4.6 ± 0.5	4.6 ± 0.5	4.5 ± 0.4
Median	4.8	4.2	5.0	5.0	5.0	4.7
Q1, Q3 (IQR)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.0, 5.0 (1.0)	4.0, 4.9 (0.9)
95% CI	4.7–4.9	4.2–4.4	4.7–5.0	5.0–5.0	5.0–5.0	4.7–4.8
Mean Rank	175.6	171.5	172.8	172.2	172.7	170.9
MWU; p	9843.0; .221	8701.0; .008*	9044.0; .015**	8887.5; .007*	9033.0; .013**	8514.0; .005*
z; r***		−2.642; .13	−2.42; .12	−2.70; .14	−2.49; .13	−2.83; .15

*p < .01,

**p < .05,

***Effect size.

this reason, this study evaluated nurses' respect for or neglect or violation of patient privacy by comparing concurrent evaluations of patients who were on average 64 years old, mostly hospitalised in public hospitals and internal clinics, shared their room with two or more patients, and nurses who were on average 36 years old and mostly had bachelor's degree, and worked in public hospitals and internal clinics.

In the present study, although nurses' total scores on the patient privacy scale were slightly higher compared to those of the patients, the total scores of both groups were found to be very high and there was no statistically significant difference between the scores as would be desired. In other words, according to the nurses and patients whose evaluations match each other's, patients' privacy rights were highly respected by nurses, that is, patient privacy is protected. However, in the study carried out by Kim et al. (2017) in Korea, the behaviour of nurses regarding privacy protection was not optimal although protection of patient privacy was deemed important by both nurses and patients. In another study, patients (95%) and healthcare professionals (67%) in a hospital in India had a high perception of ensuring patient privacy, but patients' perception of privacy was significantly higher than that of nurses (Thomas & AP, 2018). Consistent with the findings of the present study, the results of some studies carried out in Turkey demonstrate that patient privacy was respected and observed by nurses (Öztürk et al., 2014) or that nurses had positive attitudes and behaviours on patient privacy (Arslan & Demir, 2017). The study of Akar et al. (2019) showed that nurses working in the hospital and all other staff respected patient privacy in general. Another study noted that healthcare workers were sensitive in protecting privacy and they had highly positive attitudes towards privacy (Özata & Kubilay, 2017). In another study, nurses and physicians had a strong perspective on protecting patient privacy and confidentiality of patient information as a patient right (Demirsoy & Kirimlioglu, 2016).

When studies conducted with the patient perspective are analysed, more than half of the patients (53.8%) thought that employees respected patient privacy (Ünalan et al., 2008). In another study, it was found that the patients' evaluation of privacy was 81.6% on average, and inpatients thought that their privacy was respected by healthcare professionals (Akar et al., 2019). According to Aydemir and Işıkhan's study (2012), maximum attention was paid to patient privacy in all examination and treatment processes, and maximal respect was shown for the confidentiality of medical records of patients throughout the hospitals. While the results of all these studies indicate that patient privacy was respected, there were some studies that reported otherwise. As described in Namlı's report (2012) on privacy violations in hospitals, most of the participants thought that their privacy rights were not protected, or that their privacy was violated. In a study they conducted with patients, Bostan and Ünal (2019) determined that among healthcare professionals, nurses in particular paid less attention to the privacy of patients. The Istanbul Chamber of Medicine (2013) reported that due diligence was not shown in the current practice in protecting personal medical data: people were not informed sufficiently, individuals did not have the right to retrieve their own data from the system, and it was uncertain with whom such data would be shared. Similar results were found in studies conducted abroad. In a study evaluating patient privacy in the emergency room in Iran, half of the patients thought that their privacy was shown a low to moderate level of respect (Nayeri & Aghajani, 2010), and in a study in Norway, patients hospitalised in multibed rooms compared to patients in single-bed rooms stated that there were violations to their privacy. However, patients also had positive experiences about multibed rooms as this provided the opportunity for social interaction (Roos et al., 2020). Yazdanparast et al. (2016) determined that the privacy of patients was mostly not respected in their study with older patients in internal medicine and surgery services. Hartigan et al. (2018) found that women's privacy perceptions (21%) were low before the obstetric emergency service was physically restructured, while the perception of women's privacy increased to 89% after installing walls instead of curtains to patient cabinets. Similarly, in the study by Lin et al. (2013) patients' perception of general privacy and satisfaction increased in the redesigned emergency department. In another study, privacy was adequately respected in the emergency departments of some hospitals in Spain according to 64% to 92% of the patients (Mozota Duarte et al., 2013).

In the current study, considering all subscales of the privacy scale, it was confirmed by both patients and nurses that patient privacy was respected or protected to the utmost as there was no statistically significant difference in their opinions. However, although utmost care was taken, sexual privacy scores were found to be slightly lower, for both patients and nurses. Sexual privacy includes allowing companions in a room with more than one patient, not letting in people who are not allowed by the patient during interventions, knocking on the door when entering the room, keeping same-sex patients in the room, providing privacy with curtains and assigning helper staff with consideration to the gender of the patient. In this context, nurses may not always have gotten permission when entering the patient room, and it may not always have been possible to assign helper staff according to the gender of the patients due to staff shortage. In the study of Candan and Bilgili (2018), the nurses and midwives had a moderate level of perception of privacy, and this was also the case for confidentiality of private life and personal information, sexual privacy, privacy of those unable to protect themselves, physical privacy and providing a favourable environment subscales.

In the present study, it was the physical privacy of patients that nurses mostly protected or respected as evaluated by the patients although the difference was minor, and nurses reported no difference in this regard. This may be because privacy is often perceived as physical privacy. In Değirmen's study (2014), which confirms this view, almost all of the doctors (99.4%), nurses, and midwives (97.4%) responded to the question of "what is privacy" as "physical and information confidentiality." Further, since the present study was carried out with Muslim patients, physical privacy may have gained particular importance, and nurses may have been more careful when exposing the private parts of the patients and may have tried to prevent body exposure as much as possible. This may have led the patients

to think that more attention was being paid to their physical privacy. The results of the studies conducted by Ak et al. (2020) with student nurses, and Bostan and Ünal (2019) with patients also support these views. Similarly, in the study by Kim et al. (2017), it was reported that women may be more sensitive to physical and personal privacy than men. Moreover, both the nurses and patients reported that physical privacy was the most protected and respected privacy among the behaviours aimed at protecting patient privacy.

Nurses and patients in the public hospital believed that patient privacy was more respected overall, compared to nurses and patients in the training and research hospital. The reason for this may be that the training and research hospital was larger, there were a greater number of patients, the number of employees and the workload was greater, and the procedures were more complex than in the public hospital. Thus, providing patient privacy may have been more difficult for nurses working in this hospital compared to the smaller public hospital. However, this was valid for all subscales according to the nurses, while it was significant only for sexual privacy for patients. In other words, patients in the public hospitals think that sexual privacy is more respected by nurses. Another study found that the employees working in private hospitals had stronger positive attitudes towards privacy than those working in public and university hospitals (Özata & Kubilay, 2017). In a study supporting this conclusion, patients who received healthcare from private hospitals were seen to be more satisfied than patients receiving healthcare from public hospitals (Demirer & Bülbül, 2014). In the study conducted by Bostan and Ünal (2019) with patients, it was determined that patient privacy was not respected enough by the staff, particularly in public hospitals when compared to private hospitals, as well as in emergency departments and emergency cases, followed by units such as intensive care units and operating rooms.

In the present study, clinics/units also affected the patients' and nurses' opinions on privacy. Compared to nurses working in internal clinics, nurses working in surgical clinics thought that nurses showed more respect for privacy of those patients unable to protect themselves. Similarly, overall, patients in surgical clinics also believed that nurses showed more respect for patient privacy in terms of sexual privacy, privacy of those unable to protect themselves, physical privacy and providing a favourable environment. A study conducted on surgical nurses determined a high mean score for privacy awareness (Aslan et al., 2019). This may be due to the higher levels of dependence on nurses in patients hospitalised in surgical clinics (Kılıç et al., 2017). In other words, nurses may have shown more respect for patient privacy in surgical clinics, especially since the patients had no consciousness or orientation for a certain period of time, and patients were generally naked during this period. In addition, postoperative patients are followed up more frequently and closely by the nurses working in surgical clinics; thus, possible privacy violations may have been avoided. In this sense, it can be said that respect for privacy is affected by physical environment and space. This was also seen in a qualitative study carried out with doctors, nurses, midwives and patients in the gynaecology and obstetrics clinics, where it was seen that physical space was important in protecting privacy, privacy was seen as a right, and women, married people, primary school graduates, those who were older and who consider themselves closer to rural culture were more sensitive about privacy (Değirmen, 2014). In the study of Kim et al. (2017), patients hospitalised in a clinics for internal diseases had higher regard for the protection of patient privacy when compared to patients hospitalised in the surgical clinics.

Furthermore, single patients paid more attention to privacy of private life/personal information, privacy of those unable to protect themselves and physical privacy overall. This may be due to the religion and culture of the society, since the society in which the study was conducted tends to regard single individuals, especially women, as virgins, and safeguard them more closely. Besides, it can also be thought that single individuals expect more safeguarding than those who are married. Supporting the findings of the study, Eklöf et al. (2020) stated in their study with Somali Muslim refugees in Finland that privacy was related to the cultures and religions of societies, and that it was important to protect the privacy of the individual and respect religion and society. The same study found that Somalian Muslim refugee women preferred female healthcare workers during physical examination and information sharing for their privacy, and that polite, respectful and helpful behaviour improved the perception of privacy (Eklöf et al., 2020).

The current study was limited only to the opinions of nurses working in public hospitals in a city in Turkey and patients receiving inpatient treatment in these hospitals. Nurses' age, gender, marital and educational status, professional experience, and whether they have read the patient rights guideline had no effect on patient scores on the privacy scale. Further, patients' age, gender, education status, the number of days they stayed in the hospital, the number of patients in their rooms, previous hospitalisations, and whether they were familiar with patient's rights also had no effect on their scores on privacy scale. However, in a study by Ceylan and Çetinkaya (2020), nurses who had a high education level, received training on patient privacy and who read the legal directives on patient rights were more attentive to or interested in patient privacy. In a study by Kim et al. (2017), married nurses, nurses with university degree/higher education, charge nurses or higher-level nurses gave more attention to behaviours aimed at protecting patient privacy.

6 | CONCLUSION

Patient privacy and confidentiality are the responsibility of nurses and all other health professionals and are a concept that deserves attention. Confidentiality, one of the determinants of patient care and patient satisfaction that affects the trust between the patients and nurses and the therapeutic interaction, is also an important value for patients.

The nurses in this study highly respected and observed patient privacy. This was also confirmed by the patients, meaning that expectations for privacy were met. However, there are some deficiencies in the importance given to privacy in the training and research hospital, internal diseases clinics, and in the caregiving process

according to married patients. In this regard, trainings can be organised, and mixed sensitivity meetings can be arranged to improve patient privacy behaviours of nurses working in training and research hospitals and internal diseases clinics, and their ethical approaches can be strengthened through weekly case sessions. Health institutions and their managers should improve their policies in selecting hospital attendants with due diligence to patients' gender, as well as their visitor reception policies. The policies for determining the number of the helper staff and the manner they will be assigned, as well as the policies to reduce the workload of nurses and the number of patients in the patient's room also needs to be revised. Apart from this, nurses should ensure confidentiality of the private lives and personal information of not only single but also married patients. Furthermore, nurses should safeguard the physical privacy, provide a favourable environment for privacy and should watch out for the rights of patients, especially those who are unable to protect themselves in internal clinics as well as in surgical clinics. Thus, nurses can be made a little more attentive in their daily practice.

For all this, executive nurses can monitor the nurses closely in their clinics and provide guiding feedback and information regarding their behaviour. Results of related research can be shared on the bulletin boards or on the computers used daily. Nurses in other clinics can be encouraged by rewarding the clinics that show the highest respect for patient privacy.

7 | RELEVANCE TO CLINICAL PRACTICE

Since the opinions of both nurses and patients were evaluated concurrently and comparatively in the study, the results show that the high level of respect shown by nurses to the privacy of patients is consistent and accurate. In addition, this study is one of the limited number of studies that report the opinions of nurses and patients together, contributing to the literature by providing data to researchers to compare their results with national and international scales. The results of the study have once again revealed that nurses and administrators should build an appropriate hospital environment and implement practices that ensure confidentiality of private life/personal information by respecting not only physical but also sexual privacy and privacy of patients unable to protect themselves, and provides suggestions for improving these aspects. In addition, they can be useful to reduce patient privacy vulnerabilities or weaknesses in complex hospitals and clinics such as the training and research hospitals and internal diseases clinics, and to enhance institutional policies and activities regarding patient privacy.

8 | AUTHOR CONTRİBUTİONS

Havva Öztürk involved in the conception and design of the study, acquisition of data, analysis and interpretation of data, drafting the article, revising it critically for important intellectual content and final approval of the version to be submitted. Çiğdem Torun Kılıç, İlknur Kahriman, Buket Meral and Bahar Çolak involved in acquisition of data, analysis and interpretation of data, drafting the article, revising it critically for important intellectual content and final approval of the version to be submitted. However, the authors in the article are listed according to their contribution rates to the study.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

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REFERENCES

Altun, İ. (2020). Etik ve Değerler [Ethics and Values]. InT. A. Atabek & A. Karadağ (Eds.), *Hemşirelik Esasları [Fundamentals of Nursing]* (p. 84–89). : Akademi Basım ve Yayıncılık [Academy Printing and Publishing].

Ak, B., Tanrıkulu, F., Gündoğdu, H., Yılmaz, D., Öner, Ö., Ziyai, N. Y., Erol, F., & Dikmen, Y. (2020). Cultural viewpoints of nursing students on patient privacy: a qualitative study. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-020-01062-z

Akar, Y., Özyurt, E., Erduran, S., Uğurlu, D., & Aydın, İ. (2019). Hasta mahremiyetinin değerlendirilmesi [Evaluation of patient confidentiality]. *Sağlık Akademisyenleri Dergisi [health Care Academician Journal]*, *6*(1), 18–24.

Aktan, G. G., Eşer, İ., & Kocaçal, E. (2019). Hemşirelerin hasta mahremiyetini koruma ve sürdürme durumları ile etkileyen faktörler [The status of nurses' protecting and maintaining patient privacy and affecting factors]. *Koç Üniversitesi Hemşirelikte Eğitim Ve Araştırma Dergisi [journal of Education and Research in Nursing]*, *16*(4), 301–305.

Akyüz, E., & Erdemir, F. (2013). Surgical patients' and nurses' opinions and expectations about privacy in care. *Nursing Ethics*, *20*(6), 660–671.

Alpar, Ş. A.N. Bahçecik & Ü. Karabacak (Eds.) (2013). *Çağdaş Hemşirelikte Etik [Ethics in Contemporary Nursing]*. Istanbul, Turkey: İstanbul Tıp Kitabevi [Istanbul Medical Bookstore].

Arslan, E. T., & Demir, H. (2017). Sağlık çalışanlarının hasta mahremiyetine ilişkin tutumu: Nitel bir araştırma [Attitudes of health workers related to patient confidentiality: A qualitative research]. *Bolu Abant İzzet Baysal Üniversitesi Sosyal Bilimler Enstitüsü Dergisi [bolu Abant İzzet Baysal University Journal of Graduate School of Social Sciences]*, *17*(4), 191–220.

ANA (2015). *Guide to the code of ethics for nurses with interpretive statements*. M. Fowler Ed, 2nd ed. American Nurses Association, Maryland: Silver Spring.

Aslan, F. E., Çınar, F., & Es, M. (2019). Cerrahi hemşirelerinin mahremiyet bilinçlerinin incelenmesi [Investigation of the privacy consciousness of surgical nurses]. *Kocaeli Medical Journal*, *8*(3), 95–103.

Aydemir, İ., & Işıkhan, V. (2012). Sağlık Bakanlığı'na bağlı hastanelerde hasta hakları uygulamalarının değerlendirilmesi [Assesments of patient rights applications at the hospitals of ministry of health]. *Eskişehir Osmangazi Üniversitesi Sosyal Bilimler Dergisi [eskişehir Osmangazi University Journal of Social Sciences]*, *13*(2), 67–86.

Barati, F., Atarodi, A., Asghari, B. A., & Atarodi, A. (2019). Awareness and observation of patients' rights from the perspective of patients and nurses. *Journal of Research and Health*, *9*(4), 315–323.

Bostan, S., & Ünal, C. (2019). Hastaların Hasta Mahremiyeti Hakkında Farkındalık ve Tutumları. *Türkiye Klinikleri J Med Ethics*, *27*(3), 239–249.

Calleja, P., & Forrest, L. (2011). Improving patient privacy and confidentiality in one regional emergency department–a quality project. *Australasian Emergency Nursing Journal*, *14*(4), 251–256.

CAN (2017). *Code of ethics for registered nurses*, Ottowa: Canadian Nurses Association.

Candan, M., & Bilgili, N. (2018). Hemşire ve ebelerin hasta mahremiyetine ilişkin görüşlerinin değerlendirilmesi [Evaluation of nurse and midwives' opinions on patient privacy]. *Gazi Sağlık Bilimleri Dergisi*, *3*(3), 34–43.

Canural, R., Gökalp, N., Ekici, G. (2009). Sağlık hizmetlerinde hasta mahremiyeti: Hasta sağlık bilgilerinin paylaşımı [Patient privacy in healthcare services: sharing of health information of patient]. In H. Kırılmaz (Ed.), In: *II. Uluslararası Sağlıkta Performans ve Kalite Kongresi Bildiriler Kitabı [Presentations Book of II. International Congress on Quality and Performance in Healthcare]* Vol: 2 (p. 55–59). Turunç Yayıncılık [Turunç Printing].

Ceylan, S. S., & Çetinkaya, B. (2020). Attitudes towards gossip and patient privacy among paediatric nurses. *Nursing Ethics*, *27*(1), 289–300.

Cronquist, R., & Spector, N. (2011). Nurses and social media: Regulatory concerns and guidelines. *Journal of Nursing Regulation*, *2*(3), 37–40.

Değirmen, N. (2014). *Jinekoloji ve obstetride beden mahremiyeti: Kütahya örneği [Body confidentiality in gynecology and obstetrics: Kütahya example]* (Doctoral Thesis). Eskişehir, Turkey: Eskişehir Osmangazi Üniversitesi, Sağlık Bilimleri Enstitüsü [Eskişehir Osmangazi University, Institute of Health Sciences].

Demirer, Ö., & Bülbül, H. (2014). Kamu ve özel hastanelerde hizmet kalitesi, hasta tatmini ve tercihi arasındaki ilişki: Karşılaştırmalı bir analiz [The relationships between service quality, patient satisfaction and preference in public and private hospitals in Turkey: A comparative study]. *Amme İdaresi Dergisi*, *47*(2), 95–119.

Demirsoy, N., & Kirimlioglu, N. (2016). Protection of privacy and confidentiality as a patient right: physicians' and nurses' viewpoints. *Biomedical Research*, *27*(4), 1437–1448.

Eklöf, N., Hupli, M., & Leino-Kipli, H. (2020). Factors related to privacy of Somali refugees in health care. *Nursing Ethics*, *27*(2), 514–526.

Erdemir, A. D. (2019). Klinik Uygulamalarda Etik İlkeler ve Önemi [Ethical Principles and Their Importance in Clinical Practice].In A. D. Erdemir, G. Sezgin, Ö. Usmanbaş, & Ö. Şaylıgil. In: *Çağdaş Klinik Etik (21 yüzyılda Olgu Örnekleri) [Contemporary Clinical Ethics (Case Examples in the 21st Century)]* (p. 45–61). İstanbul, Nobel Tıp Kitapevleri [Nobel Medical Bookstores].

Hajbaghry, M., & Zehtabchi, S. (2014). Evaluation of elderly patients' privacy and their satisfaction level of privacy in selected hospitals in Esfahan. *Medical Ethics*, *8*(29), 97–120.

Hartigan, L., Cussen, L., Meaney, S., & O'Donoghue, K. (2018). Patients' perception of privacy and confidentiality in the emergency department of a busy obstetric unit. *BMC Health Services Research*, *18*(978), 1–6.

HHK (2013). *Hasta Hakları Klavuzu [Patient Rights Guide]*, *Santiago Bildirgesi*. Retrieved from http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=984:hasta&catid=26:etik&Itemid=65

ICN (2012). *The ICN Code of Ethichs for Nurses*. Retrieved from https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfor_nurses_eng.pdf

İzgi, C. (2014). Mahremiyet kavramı bağlamında kişisel sağlık verileri [The concept of privacy in the context of personal health data]. *Türkiye Biyoetik Dergisi [turkish Journal of Bioethics]*, *1*(1), 25–37.

Kılıç, H. F., Cevheroğlu, S., & Görgülü, R. S. (2017). Dahiliye ve cerrahi kliniklerinde yatan hastaların bakım bağımlılığı düzeylerinin belirlenmesi [Determination of care dependency level of patients staying in medical and surgical clinics]. *Dokuz Eylül Üniversitesi Hemşirelik Fakültesi Elektronik Dergisi [dokuz Eylul University E-Journal of Nursing Faculty]*, *10*(1), 22–28.

Kim, K., Han, Y., & Kim, J.-S. (2017). Nurses' and patients' perceptions of privacy protection behaviours and information provision. *Nursing Ethics*, *24*(5), 598–611.

Klosek, J. (2011). *Protecting your health privacy*. Praeger.

Kubat, G. (2012). Öz değerlendirmenin 360 derece geri besleme yöntemindeki işlevselliği [Functionality of self-assessment in 360 degree feedback method]. *Hitit Üniversitesi Sosyal Bilimler Enstitüsü Dergisi [hitit University Journal of Social Sciences Institute]*, *5*(1), 51–65.

Lin, Y. K., Lee, W. C., Kuo, L. C., Cheng, Y. C., Lin, C. J., Lin, H. L., Chen, C. W., & Lin, T. Y. (2013). Building an ethical environment improves patient privacy and satisfaction in the crowded emergency department: a quasi-experimental study. *BMC Medical Ethics*, *14*(8), 1–8.

Ma, C. C., Kuo, K. M., & Alexander, J. W. (2016). A survey-based study of factors that motivate nurses to protect the privacy of electronic medical records. *BMC Medical Informatics and Decision Making*, *16*(3), 1–11.

Mersinlioğlu, G., & Öztürk, H. (2015). Acil servise başvuran hastaların hemşirelik hizmetlerinden memnuniyet düzeyi [Levels of emergency patients' satisfaction with nursing services]. *Sağlık Ve Hemşirelik Yönetimi Dergisi [journal of Health and Nursing Management]*, *2*(2), 70–82.

Mozota Duarte, J., Moliner Lahoz, J., Garcia Noain, A., Moreno Mirallas, M. J., Fernandez Moros, R. W., & Rabanaque Hernandez, M. J. (2013). Patients' perception of privacy during emergency department care in hospital in Argon, Spain. *Emergencias*, *25*, 445–450.

Namlı, S. (2012). *Hastanelerde yaşanan mahremiyet ihlalleri raporu [Report regarding violation of privacy experienced in hospitals]*, İstanbul, Turkey: Hasta Hakları Aktivistleri Derneği.

Nayeri, N. D., & Aghajani, M. (2010). Patients' privacy and satisfaction in the emergency department: a descriptive analytical study. *Nursing Ethics*, *17*(2), 167–177.

Özata, M., & Özer, K. (2017). Sağlık çalışanlarının hasta mahremiyeti konusundaki tutumlarının incelenmesi [Investigation of the attitudes of health care staff about patient privacy]. *Hacettepe Sağlık İdaresi Dergisi [hacettepe Journal of Health Administration]*, *20*(1), 81–92.

Öztürk, H., Bahçecik, N., & Özçelik, S. (2014). The development of the patient privacy scale in nursing. *Nursing Ethics*, *21*(7), 812–828.

Öztürk, H., Özçelik, S., & Bahçecik, N. (2014). Hemşirelerin hasta mahremiyetine özen gösterme durumu [Taking pains over patient privacy by nurses]. *Ege Üniversitesi Hemşirelik Fakültesi Dergisi [journal of Ege University Nursing Faculty]*, *30*(3), 19–31.

Pallant, J. (2017). SPSS Kullanma Klavuzu, SPSS ile Adım Adım Veri Analizi [SPSS Survival Manual A Step By Step Guide to Data Analysis Using IBM SPSS]. In Balcı, S., & Ahi, B. (Eds.), Vol *2* (pp. 252–253). : Anı Yayıncılık [Ankara Publishing]. (2017/2013).

Petronio, S., & Sargent, J. (2011). Disclosure predicaments arising during the course of patient care: nurses' privacy management. *Journal of Health Communication*, *26*(3), 255–266.

Roos, A. K. O., Skaug, E. A., Grondahl, V. A., & Helgesen, A. K. (2020). Trading company for privacy: A study of patients' experiences. *Nursing Ethics*, *27*(4), 1089–1102.

Rosner, F. (2006). Medical confidentiality and patient privacy: the Jewish perspective. *Cancer Investigation*, *24*(1), 113–115. https://doi.org/10.1080/07357900500449660.

T.C. Sağlık Bakanlığı Sağlık Hizmetleri Genel Müdürlüğü (SB) (2016) Genelge, Hasta Mahremiyetine Saygı Gösterilmesi

Genelgesi, [Circular for Respect for Patient Privacy]. Sayı: 54567092-641-99-3104

Schopp, A., Leino-Kilpi, H., Välimäki, M., Dassen, T., Gasull, M., Lemonidou, C., & Kaljonen, A. (2003). Perceptions of privacy in the care of elderly people in five European countries. *Nursing Ethics*, *10*(1), 39–47.

Shen, N., Bernier, T., Sequeira, L., Strauss, J., Silver, M. P., Carter-Langford, A., & Wiljer, D. (2019). Understanding the patient privacy perspective on health information exchange: A systematic review. *International Journal of Medical Informatics*, *125*, 1–12.

Tehrani, T. H., Maddah, S. S. B., Fallahi-Khoshknab, M., Ebadi, A., Shahboulaghi, F. M., & Gillespi, M. (2018). Respecting the privacy of hospitalized patients: An integrative review. *Nursing Ethics*, 1–13.

THD (2009). *Hemşireler için etik ilke ve sorumluluklar [Ethical principles and responsibilities for nurses]*, Ankara, Turkey: Türk Hemşireler Derneği [Turkish Nurses Association].

The Istanbul Camber of Medical (2013). *Kişisel Sağlık Verileri ve Mesleki Yaklaşımlar Çalıştayı [Personal Health Data and Professional Approaches Workshop]*. İstanbul, Turkey: İstanbul Tabip Odası. Retrieved from http://istabip.org.tr/3120-kiisel-salk-verileri-ve-mesleki-yaklamlar-caltay-yapld.html

Thomas, S., & AP, B. (2018). Patients' and health care personnel's perception of patient privacy. *International Journal of Health Sciences and Research*, *8*(5), 175–179.

Tosun, H., & Aksoy, N. (2019). Ebelik uygulamalarında mahremiyet [Privacy in midwifery practices]. *Sağlık Profesyonelleri Araştırma Dergisi [journal of Health Profession Research]*, *1*(1), 21–27.

Utkualp, N., & Yıldız, H. (2016). Awareness and attitudes of nurses working in a university hospital on patients' rights. *International Journal of Caring Sciences*, *9*(1), 185–197.

Ünalan, D., Öztürk, A., Tolga, Y., Taşdelen, C., Yazlak, Z., Öğüt, E., & Elmalı, F. (2008). Kayseri Devlet Hastanesinden poliklinik hizmeti alan SSK mensubu erişkin hastalarda memnuniyet durumu [The satisfaction of the ssk patients who recieve treatment at the outpatients clinic, at Kayseri state hospital]. *Fırat Sağlık Hizmetleri Dergisi [journal of Fırat Health Services]*, *3*(8), 85–98.

Yazdanparast, E., Davoudi, M., Ghorbani, S. H., & Abbaspoor, M. (2016). The observance of different aspects of patient privacy: Analysis of elderly views. *Med Ethics J*, *10*(36), 73–80.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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