Respecting the privacy of hospitalized patients

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Published in:
Nursing Ethics

DOI:
10.1177/0969733018759832

E-pub ahead of print: 20/03/2018

Document Version
Peer reviewed version

Respecting the privacy of hospitalized patients: An integrative review

Abstract

Background: Privacy is a complicated and obscure concept, which has special meanings in the healthcare environment; therefore, it is essential for healthcare providers to fully understand this concept. However, there is no universally accepted definition for this concept in the texts, and it has been interpreted differently according to its application.

Aim: To analyze and provide a clear and scientific definition for the respect to privacy of hospitalized patients and identify common aspects of this concept.

Research design: This study was conducted using the Whittemore and Knafl's modified framework as a conceptual analysis method.

Ethical consideration: This study was approved by the Research Council of the University of Social Welfare and Rehabilitation Sciences. We have respected the ethical requirements required regarding the sources and authorship.

Research context and data sources: Using integrative review a search was performed using national and international databases, including CINAHL, Scopus, Medline, Web of Science, and ISI (with no date restriction). The keywords employed during the search process were: "privacy of patients", "confidentiality", "and patients' rights. In total, 1345 articles were retrieved from the databases. After the elimination of repetitive studies and with regard to the study objectives, 124 articles, 3 books, and 4 theses were entered into the study. The data were analyzed using a conventional content analysis approach.

Findings: The results were extracted in form of four, seven, and two themes related to the Attributes (Physical, Informational, Social, and Psychological), antecedents, and consequences of patient privacy, respectively.

Conclusion: Respect for hospitalized patient privacy Contains physical, informational, Psychological, and social dimensions. The factors affecting the achievement of this concept include individual backgrounds, nature of the disease, patriarchal behavior, and conflict between privacy and treatment. The fulfillment of patient privacy leads to such consequences as protection and improvement of human dignity as well as improved communication between the patient and the health team.

Keywords

Introduction

Privacy is one of the most important rights of each individual, and is associated with an individual's dignity.[1] This concept has been confirmed as the basic principle of care standards in the field of health and treatment by various international organizations and associations [2-4] However, little attention has been given to this concept despite the extensive emphasis on compliance with the respect to concept of patient privacy.[5, 6]

The results of the majority of studies are indicative of weak to medium patient satisfaction with maintenance of their privacy by the healthcare team. [7-9] In addition, the studies comparing the perception of the patients and various medical groups about respecting patient privacy have indicated significant differences between these groups. Respecting privacy of patients is crucial in the establishment of an effective and trusting relationship with patients and in promoting their calmness and satisfaction.[10-12] The Oxford English Dictionary presents two definitions for privacy, including "a state in which one is not observed or disturbed by other people" and "the state of being free from public attention."[13]

Privacy consists of several dimensions and has different definitions in various fields. For instance, Louis Brandeis and Samuel Warren, legal theorists, defined privacy as the "right to be let alone", and emphasize the importance of individuals' ability to control their personal lives. [14, 15] In addition, according to Altman, privacy is "a selective control of access to the self or to one's group."[16]

The majority of the studies on privacy have merely evaluated the level of maintaining respect to patient privacy. Accordingly, there are limited numbers of studies investigating the concept of privacy from the patients' perspectives.[7-9] According to the literature, privacy is a rather indefinite or relative concept since the cultural norms and values of each society and specific status of each individual in the community affect the definition and interpretation of this notion. [17, 18]

Privacy is therefore a vague concept, which is usually defined differently depending on the condition and context in which it is applied.[19] Currently, there is no consensus over the definition of privacy.[20-23] In addition, privacy and its associated dimensions must be defined in each specific field, such as the area of healthcare.[18, 20] Despite the presence of various

vague and intricate definitions in other fields, such as law and psychology, there is no clear definition for the privacy of hospitalized patients in the areas of medicine and nursing.

Accordingly, the review of available literature demonstrated no conceptual analysis on the privacy of the patients admitted to hospital. With this background in mind, these studies focused on inpatients and identify the dimensions, antecedents, and consequences of this concept.

Ethical consideration:

In line with the principles for ethical research, an approval was obtained from the Research Council of the University of Social Welfare and Rehabilitation Sciences with the ethical confirmation code of IR.uswr.rec1394.382. Furthermore, oral and written informed consent was obtained from each of the participants.

This consent included participant permission to record their voice, having previously explained to them the steps being taken in order to ensure security and confidentiality regarding their personal information. Moreover, the participants were informed about their right to withdraw from the study at any stage. They were also told that they could learn about the final results of the research if they wished to, and that they might be approached for a subsequent interview in order to complete the data.

Methods

This study was conducted on the published studies investigating the Respect to privacy from hospitalized patient's perspective using the Whittemore and Knafl integrative review. Integrative review is a method for summarizing the existing evidence on a subject or health issue with diverse methodologies. The review consisted of the five stages including problem identification, searching the literature, data evaluation, analyzing the included studies, and presenting the results.[24]

Problem identification stage:

Privacy is a basic human right. The majority of the studies on privacy have merely evaluated the level of maintaining patient privacy. Accordingly, there are limited numbers of studies investigating the concept of respect to privacy from the patients' perspectives. An integrative review method was used to find the answers to the following research questions: What is the definition of respect for privacy, from the patients' perspectives? What are the

attributes of respecting privacy from the perspective of patients? What are the antecedents of respect for privacy from the perspective of patients? What are the consequences of respect for privacy from the perspective of patients?

Literature search

The search was performed using Persian databases, including Magiran(Database of publications Iran), and Med Lib(Comprehensive Bank of Papers and Medical Information), SID (Scientific Information Database) and international databases, namely, CINAHL, Scopus, Medline, Web of Science, and ISI, without any limitations on publication dates. In order to identify relevant keywords, Medical Subject Headings (Mesh) terms were used, as was information from key papers. The same keywords were then used when searching each of the databases. The keywords employed during the search process were: “privacy of patients”, “confidentiality”, and "patients' rights".

The inclusion criteria were: consistency with the study objectives, Persian or English publication, presence of the intended keywords in the abstract, title, or keywords, and qualitative, quantitative, and review research. Articles with English abstracts, but non-English or Persian content was excluded from the study.

Data evaluation stage:

Data evaluation was carried out through the evaluation of the answers provided by the articles to the study questions. To this aim, the abstracts of all studies were assessed, and in case of ambiguity in the abstract, the full texts of the articles were evaluated, First Two authors independently performed the primary article screening. Then their selected articles were categorized into three groups: relevant, irrelevant and unsure. Articles categorized as irrelevant by both reviewers were eliminated from the study. Then, each reviewer scrutinized all of the remaining articles, culminating in a list of articles to be included. Data was extracted from these papers and entered into data sheets independently by two reviewers. These two sheets and their differences were checked by the research team. From each article, the following information was extracted: author, publication year, journal title, format (summary, journal article), study design, study setting, and definitions for patient privacy, and antecedents, attributes and consequences concept of "patient privacy, tools type of participants, sample size, and geographical and time range of data collection.

Figure 1. Flowchart of literature search and evaluation.

Analysis and synthesis

In the integrative review method data analysis consists of several stages; data reduction, data display, data comparison, conclusion drawing, and verification.[24] Conventional content analysis was applied to analyze the content of the articles[25]. All of the texts were entered into MAXQDA software, and those without computer files were analyzed manually. Subsequently, each article was considered as a unit of analysis, the text of each article was studied several times.Words or phrases related to the concept of respect for patient privacy were extracted as meaning units. Then, meaning units were combined and reduced in number, with an emphasis on retaining the original quality of the comments. Each meaning unit was given a label called code. A group of code that had the same meaning was a category. Similar categories formed the theme. The themes and subcategories related to them are categorized as attributes, antecedents and consequences of respect for patient privacy.

Results

In the review, 1345 articles were retrieved from the mentioned databases; however, 876 cases were entered into the study after the removal of repetitive articles. After the assessment of the abstracts and checking for the inclusion and exclusion criteria, 752 articles were excluded from the study, resulting in the evaluation of 124 articles, 3 books, and 4 theses related to the subject of interest.

The review of the retrieved articles resulted in the identification of four attributes of privacy, including physical, informational, psychological, and social privacy. Furthermore, we found seven themes related to antecedents for privacy, namely ethical and legal backgrounds of privacy, design of a comprehensive privacy, informed consent, common understanding of the patient and the care providers, individual context and disease on perception of privacy, rule of paternalism, as well as conflict of privacy and care.

In addition two themes were found to be related to consequences of privacy. These themes included the protection and promotion of patient dignity, and meaningful relationships eventually, a comprehensive definition was provided for the respect of privacy for hospitalized patients based on the obtained themes.

Attributes of respect to hospitalized patient privacy

According to the literature, privacy consists of four dimensions, including physical, informational, mental, and social facets.[20, 26, 27](Table 1)

Physical privacy contains two general dimensions of Bodily and physical space. Bodily privacy is related to the accessibility of the patients' body for others. This concept signifies the avoidance of unwanted actions, such as invasion of personal space, touch of body parts, observation or monitoring of actions, observation through video surveillance, noises, and smelling.[27] For instance, a patient might be reluctant to be touched or monitored by a person with the exception of the related physician. On the other hand, physical space privacy corresponds to the concept of private territory and solitude. Personal space represents a series of patients' personal expectations about controlling the accessibility to their bodies and surrounding environment. The interactive space refers to the patients' temporary territory and their feeling of ownership to the room furniture, and consequently exertion of control over their territory.[20]

Informational privacy includes the patients' perceptions and experiences about the level of control over use, dissemination, and confidentiality of personal information. The patients expect that the information that is directly related to their health status should be used for interventional purposes. In addition, they desire to determine the method of control, time, and condition for information exchange with other individuals and organizations. Furthermore, they need to make sure that their information has been recorded properly in electronic and written formats. In some studies, the respect for informational privacy by healthcare providers has been considered as a key factor in patients' perceptions of respect for their general privacy.[20] With the emergence of electronic equipment for the registration of medical information, the integrated care system and internet have provided new opportunities for the improvement of health care. However, these technological advancements have challenged the preservation of patient privacy as well as the confidentiality, control, and accuracy of their personal health-related information.[28] Other factors likely to exacerbate the violation of patients' informational privacy include the complexity of professional team work, paper and electronic document formats and evidence in health care, as well as the email, telephone, and video contacts between patients and healthcare providers.[18, 29, 30]

In terms of social privacy, the well-known theorists in the field of law have defined privacy as the right to be let alone. They have emphasized on the importance of individuals' ability to control their personal lives.[15] According to Altman, privacy is "a selective control of access to the self or to one's group".[16]

Furthermore, Psychological privacy consists of two subcategories, namely self-respect and independence in decision-making. Currently, patients are expected to play an active role in

the decision-making about their treatment process.[31] Independence is an important aspect of privacy, defined as an individual's right for deciding about sharing his information with others. No one is allowed to have access to an individual's personal or private life information without his/her consent.[32] Personal values form the patients' perceptions about how well a physician respects the personal and cultural values of a patient. Personal values are important principles affecting one's behavior, motivation, and identity.[33] Moreover, these values are of paramount significance, especially when a person deals with health problems and needs professional help.[34]

Table 1. Attributes of hospitalized patient privacy based on the literature review

Main themes	Main subthemes
Physical privacy	Body privacy
	Physical space privacy
Informational privacy	Ownership of personal information
	Protection of patients' personal information ر
	Technology threatening the security of patient information
Social privacy	control over the condition of oneself

	Solitude and isolation
Psychological privacy	Self-respect
	Independence in decision-making

Antecedents of respect to hospitalized patient privacy

The antecedents of hospitalized patient privacy are divided into seven categories (Table 2). The first antecedent is the ethical and legal backgrounds of privacy. A large number of ethical commitments have been prescribed for healthcare providers to maintain the privacy of patients as well as follow codes of confidentiality and ethics.[2, 3] Privacy has a specific and important definition in health and treatment areas. The significance of this concept in health care is clearly indicated by the development of ethical codes for the physicians, nurses, and other healthcare providers committing them to respect the privacy of the patients.[2, 3, 35] One of the ethical commitments, which has been emphasized, is that healthcare professionals must respect patient privacy and the confidentiality of managing information within the framework of law.[2]

Design of a comprehensive privacy process requires that all aspects of privacy must be respected. For instance, in terms of the patients' personal information, healthcare managers must provide domestic policies and adequate education to the professionals and others who are involved in the collection of individuals' personal information. One way to make sure of respecting patient privacy and dignity is to properly educate healthcare personnel regarding the use of equipment and improve their knowledge and skill in terms of the standards related to the privacy of patients.[21, 22, 36] Respect for privacy is based on the right to choose. Independent decision-making by patients in contemporary healthcare is a personal right. Therefore, wall color, furniture, temperature, and necessary equipment for the patient's room must fit with the patient's expectations. In addition, sound separation measures should be taken to determine the interactive boundaries. [20, 23]

Informed consent includes the professional behavior of healthcare professionals with patients. In this regard, when the practitioners respect the physical privacy of the patients, they obtain the patients' consent for using their personal data. For instance, a practitioner

must obtain the permission of the patients before performing any physical examination, and the patients must be prepared for actions of the practitioner. Informed consent can be synonymous with decision-making, in this case the patient is fully informed about the conditions of intervention and participation in research.[37, 38] This is indicative of a change from a Paternalism care model of healthcare delivery to an independent model, where the patient has a central role in determining his/her destiny. In general, people want to be involved in their health-related decision-making and to have informed choice regarding their own treatment. An independent person has the right to choose their treatment, accept or reject professional recommendations, and act based on his/her personal and cultural values.[38].

In terms of the existence of a common understanding of patient privacy the studies have shown that the patient's perception of privacy is, in general, different from the reports made by healthcare team members.[39, 40] In this regard, in a study conducted by Akyüz and Erdemir in Turkey, it was revealed that while the nurses focused on the physical dimension of patient privacy, the information and mental dimensions of privacy were more important for the patients.[41]

Moreover, individual backgrounds and the nature of diseases are among the factors affecting the patient privacy.[22, 23, 42] It could be stated that the value of privacy increases for the patients along with the improvement of their performance and health. Nevertheless, Mazar concluded that this is a unique process occurring within the patient.

According to the literature, Paternalism behavior is the underpinning foundation for respecting patient privacy. When a person gets sick and requires the care of others, such as nurses, his/her dependence would increase.[21] In order to obtain professional assistance, such individuals have to share their personal information, and the professionals must have access to this sensitive information.[43] From the patriarchal model perspective, the healthcare team members have the best professional knowledge and ability to determine what benefits the patients.[38]

In terms of the conflict between privacy and care, studies have shown that healthcare team members occasionally sacrifice patient privacy in order to protect the patient against environmental risks and , at times, to save their lives.[44] Healthcare professionals must respect the rights of patients regarding their privacy in circumstances that often strongly test that.[45] It is sometimes inevitable to enquire about very sensitive issues. For instance,

following the emergence of AIDS, asking about the history of sexual relationships has become very common.[20]

In the profession of medicine, some medical interventions are intrusive and consequently can violate the privacy of patients.[46] The patient deserves a certain degree of privacy when treated by a physician. On the other hand, the physician often needs to obtain a scope of sensitive personal information from the patient. This creates an ambiguity in maintaining the privacy of patients in the healthcare system. Therefore, it is necessary to ensure and prepare the patients in this regard to reduce their dissatisfaction with violation of privacy, where that violation is a necessary part of their treatment. In addition, physicians must provide sufficient emphasis around discussing sensitive issues when performing interviews with their patients. It has been suggested that healthcare professionals routinely share information on patients in order to achieve optimal care.[47]

Table 2. Antecedents of hospitalized patient privacy based on the literature review

themes	**subthemes**
Ethical and legal backgrounds of privacy	Ethical right of privacy
	Legal right of privacy
Design of a comprehensive privacy	competence Healthcare team
	Management structure
	Privacy Architecture
	Suitable environment
Informed consent	disclose information
	Informed choice
common understanding of the patient and the providers	The perceived privacy of the patient
	Providers view of privacy
Individual context and disease on perception of privacy	Individual factors
	Condition of the disease and patient

Rule of Paternalism	Hierarchy in the hospital
	Patient dependence
	Reduced patient control
Conflict between privacy and care	Privacy, essential for care
	Keep balance in privacy
	Privacy Victim Care
	Routines that violate privacy

Consequences of hospitalized patient privacy

The consequences of respecting patient privacy in the hospital include Protection and promotion of patient dignity and Meaningful relationships (Table 3). One of the most important consequences of patient privacy is the preservation and improvement of human dignity. Privacy and dignity are interconnected concepts;[17, 30, 48-51] The review of the literature indicated that privacy and dignity are vital needs for healthy individuals and for patients.[21] Illness can decrease the level of privacy and dignity of patients.[52] In this regard, Lemadon et al has declared that from the patients' and nurses' perspectives, privacy includes respect, control, support, and dignity.[21] If the patients are assisted in the preservation of their privacy, their self-control, independence, self-esteem, and dignity would improve. Therefore, privacy is a concept that is interconnected with dignity.[51, 53]

The other consequence of respecting the privacy of the patient is the Meaningful relationships .[20, 36, 54, 55] When the privacy of the patients is threatened, the lack of control over personal information may affect the patients' ability to openly discuss their issues with physicians, negatively influencing the relationship between patients and physicians. If the patients refrain from sharing their information with their physicians, the physicians face difficulties in the diagnosis and treatment of the disease [56] In addition, an effective working relationship between healthcare professionals and patients could positively influence health consequences in the treatment of acute and chronic conditions and lead to a reduction of the impact of

detrimental economic and social influences, as well as provide encouragement for patients to make healthy choices, and promote positive changes in all aspects of their lives.[57]

The physician-patient interactions taking place within the healthcare environment can affect the patients' response to treatment. In this regard, studies have shown that effective interaction between physicians and patients could influence improvement of patient's blood pressure, blood sugar, and pain reduction, and accelerate their recovery process.[58]

The reviewed studies have indicated that privacy is directly related to the trust-based relationship between the patients and healthcare providers.[59, 60] Trust refers to positive expectations in terms of the physician's behavior toward the patient privacy.[61] Having trust in physicians and healthcare personnel helps patients deal with their problems and engage in beneficial health behaviors.[62] A trust-based relationship encourages patients to accept the help of healthcare staff, adhere to treatment recommendations, and participate in follow-up care.[20]

In addition, respecting the physical privacy of the patient leads to the creation of calmness, decreased anxiety, and the development of a sense of control in patients. Moreover, the preservation of physical privacy is a vital contributor towards the welfare and health of patients. In this regard, those receiving care have frequently identified that respecting their physical privacy results in a sense of ownership for them over their surrounding space, increased calmness and a sense of safety, as well as decreased trepidation and anxiety.

The preservation of patients' mental privacy helps them to reflect their internal feelings and thoughts when feeling ill and vulnerable. Consequently, this reflection enhances a sense of identity, empowerment, and independence in the patients.

Table 3. Consequences of hospitalized patient privacy based on the literature review

themes	Sub Themes
Protection and promotion of patient dignity	Respectful care
	Dignified care
Meaningful relationships	Adherence to treatment
	Sense of peace

	Feeling of trust
	Sense of autonomy
	Feeling of security

Definition Respect to hospitalized patient privacy

According to the results of the present study, the privacy of hospitalized patients is a dynamic concept with physical, informational Psychological, and social dimensions. This concept can be accomplished through the establishment of ethical and legal backgrounds, Design of a comprehensive privacy, informed consent, common understanding of the patient and the provider. The factors affecting the achievement of this concept include individual backgrounds, nature of the disease, Rule of Paternalism, and conflict between privacy and treatment. The fulfillment of patient privacy leads to such consequences as Protection and promotion of patient dignity as well as Meaningful relationships.

Discussion

The present study was conducted to provide a comprehensive and clear definition for Respect to privacy of hospitalized patients. According to the results obtained from the reviewed studies, patient privacy is a dynamic concept. Various definitions have been presented for privacy in the literature, each of which has been interpreted differently depending on their application.[19]

In addition, the analysis of Respect to patient privacy demonstrated that this concept consists of several dimensions, including physical, informational Psychological, and social, as well as a range of antecedents and consequences. This type of categorization is a simple and applicable modality for the analysis of patients' perceptions about privacy during treatment.[20, 26, 27] According to Serenko, such an approach allows accurate definition for the privacy of hospitalized patients through describing the components of privacy. The majority of the studies to date have focused on the physical and informational dimensions of patient privacy.[20]

The results of the present study indicated that Respect to privacy of hospitalized patients occurs under the influence of some antecedents, Accordingly, Rogers recommended that literature review must result in the detection of the antecedents and consequences of a concept, which help the clarification of the concept under investigation.[63]

In some studies, several factors were implicitly addressed as the antecedents of patient privacy. These factors include ignoring the patients' right, inattentiveness to patients' thoughts and feelings, mismanagement in accepting a large number of patients, a patriarchal approach from physicians, effective interactions, provision of patients with necessary information upon admission and discharge, and the professional role of healthcare staff.[22, 64-66]

In addition, in the reviewed studies, such factors as trust, improved health, sense of self-identity and empowerment, adherence to treatment, and satisfaction, were introduced as the consequences of privacy.[20, 31, 58, 67] There are a large number of studies investigating privacy; nevertheless, none of them have provided a clear definition of the dimensions, antecedents, and consequences of this concept.

Limited in-depth qualitative studies have been conducted on the privacy of hospitalized patients. Therefore, the results of the present study can provide a clearer and more comprehensive definition for this concept, which can be the basis for further research. The provision of a definition for the privacy of hospitalized patients can facilitate the designing of a tool that can evaluate this practice.

The results of the current study along with the professional comments of nurses can be helpful in the elimination of the barriers to respecting the patient privacy. In addition, this study adds to the body of nursing knowledge. However, it seems necessary to conduct further studies in the future in order to learn more about the details of this concept in the social and cultural backgrounds of the clinical environments in Iran and other countries.

Conclusion

According to the results of the current study, the extracted dimensions, antecedents, and consequences can help better define the Respect to privacy of hospitalized patients. Increased level of awareness about patient privacy can lead to the improvement of the status, importance, and application of this concept in the nursing profession. On the other hand, our findings can clarify the concept of the Respect to hospitalized patient privacy and help

develop the theories about this notion since we believe that concepts are the constructing bricks of theories. In this study, according to the texts studied, this definition was achieved. However, there may be some restrictions. Further studies are recommended in different cultures.

Conflicts of interest and financial support

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding:

The financial supports of this study were provided by the University of Social Welfare and Rehabilitation Sciences.

Acknowledgements

Hereby, we extend our gratitude to all healthcare team members and book keepers at the library who cooperated us within the research process.

refrences

1. Matiti MR and Trorey G. Perceptual adjustment levels: patients' perception of their dignity in the hospital setting. *Int J Nurs Stud*. 2004; 41: 735-44.
2. Association. AM. Code of medical ethics of the American Medical Association [Adobe Digital Editions version]. www.ama-assn.org/ama/pub/physician-resources/medical-ethics/codemedical-ethics/code-medical-ethics.

2015.
3. Association AN. Code of ethics for nurses with interpretive statements. Retrieved from www.Nursebooks.org, ePDF: 978-1-55810-600-0

2015.
4. Nurse Ic. Code of Ethics for Nurses ICN 2012.
5. Atashzade shoredeh F and etal. *Principles of Patient Care: Comprehensive approach to nursing*. Tabriz: Golban, 2013.
6. Low LPL, Lee DTF and Chan AWY. An exploratory study of Chinese older people's perceptions of privacy in residential care homes. *J Adv Nurs*. 2007; 57: 605-13.
7. Adib-Hajbaghery M and Zehtabchi S. Evaluation of elderly patients' privacy and their satisfaction level of privacy in selected hospitals in Esfahan. *J Med Ethics*. 2014; ۸: 97-120.

8. Moore M and Chaudhary R. Patients' attitudes towards privacy in a Nepalese public hospital: a cross-sectional survey. *BMC Res Notes*. 2013; 6: 31.
9. Erdil F and Korkmaz F. Ethical problems observed by student nurses. *Nurs Ethics*. 2009; 16: 589-98.
10. Mobach MP. Counter design influences the privacy of patients in health care. *Soc Sci Med*. 2009; 68: 1000-5.
11. Ansari B. Privacy and support the implementation of Islamic law and Iran. *Journal of Faculty of Law and Science*. 2008: 1-55.
12. Leino-Kilpi H, Välimäki M, Dassen T, et al. Privacy: a review of the literature. *Int J Nurs Stud*. 2001; 38: 663-71.
13. Stevenson A and Waite M. *Concise Oxford English Dictionary: Book & CD-ROM Set*. Oxford University Press, 2011.
14. Street AF and Love A. Dimensions of privacy in palliative care: views of health professionals. *Soc Sci Med*. 2005; 60: 1795-804.
15. Warren SD and Brandeis LD. The right to privacy. *Harv Law Rev*. 1890: 193-220.
16. Altman I. The Environment and Social Behavior: Privacy, Personal Space, Territory, and Crowding. 1975.
17. Eklöf N, Abdulkarim H, Hupli M and Leino-Kilpi H. Somali asylum seekers' perceptions of privacy in healthcare. *Nurs Ethics*. 2016; 23: 535-46.
18. Moskop JC, Marco CA, Larkin GL, Geiderman JM and Derse AR. From Hippocrates to HIPAA: privacy and confidentiality in emergency medicine—part I: conceptual, moral, and legal foundations. *Ann Emerg Med*. 2005; 45: 53-9.
19. BeVier LR. Information about individuals in the hands of government: Some reflections on mechanisms for privacy protection. *Wm & Mary Bill Rts J*. 1995; 4: 455.
20. Serenko N and Fan L. Patients' perceptions of privacy and their outcomes in healthcare. *International Journal of Behavioural and Healthcare Research*. 2013; 4: 101-22.
21. Whitehead J and Wheeler H. Patients' experiences of privacy and dignity. Part 1: a literature review. *Br J Nurs*. 2008; 17.
22. Heikkinen A, Launis V, Wainwright P and Leino-Kilpi H. Privacy and occupational health services. *J Med Ethics*. 2006; 32: 522-5.
23. Johnson M. Notes on the tension between privacy and surveillance in nursing. *Online J Issues Nurs*. 2005; 10.
24. Whittemore R and Knafl K. The integrative review: updated methodology. *J Adv Nurs*. 2005; 52: 546-53.
25. Graneheim UH and Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004; 24: 105-12.
26. Lothian K and Philp I. Care of older people: Maintaining the dignity and autonomy of older people in the healthcare setting. *BMJ: British Medical Journal*. 2001; 322: 668.
27. Burgoon JK, Parrott R, Le Poire BA, Kelley DL, Walther JB and Perry D. Maintaining and restoring privacy through communication in different types of relationships. *Journal of Social and Personal Relationships*. 1989; 6: 131-58.
28. Grace PJ. *Nursing ethics and professional responsibility in advanced practice*. Jones & Bartlett Publishers, 2013.
29. Rotenberg M, Scott J and Horwitz J. *Privacy in the modern age: The search for solutions*. New Press, The, 2015.
30. Chadwick A. A dignified approach to improving the patient experience: Promoting privacy, dignity and respect through collaborative training. *Nurse Educ Pract*. 2012; 12: 187-91.
31. Swan M. Emerging patient-driven health care models: an examination of health social networks, consumer personalized medicine and quantified self-tracking. *Int J Environ Res Public Health*. 2009; 6: 492-525.
32. Ramsay H. Privacy, privacies and basic needs. *The Heythrop Journal*. 2010; 51: 288-97.

33. Parks L and Guay RP. Personality, values, and motivation. *Pers Individ Dif*. 2009; 47: 675-84.
34. Haslam SA, Jetten J, Postmes T and Haslam C. Social identity, health and well-being: an emerging agenda for applied psychology. *Applied Psychology*. 2009; 58: 1-23.
35. Friedman LA. Patient Experience of Privacy While Participating in Group Health Care: A Phenomenographic Description. Boston College. Connell School of Nursing, 2015.
36. Woogara J. Human rights and patients' privacy in UK hospitals. *Nurs Ethics*. 2001; 8: 234-46.
37. Scott PA, Taylor A, Vlimki M, et al. Autonomy, privacy and informed consent 4: surgical perspective. *Br J Nurs*. 2003; 12: 311-20.
38. Beauchamp TL and Childress JF. *Principles of biomedical ethics*. Oxford University Press, USA, 2001.
39. Kim K, Han Y and Kim J-s. Nurses' and patients' perceptions of privacy protection behaviours and information provision. *Nurs Ethics*. 2016: 0969733015622059.
40. Karimi R, Nayeri N, Daneshvari Z, Mehran A and Sadeghi T. Comparison of nurses and adolescents understand the importance of patient privacy and patient compliance. *Hayat* 2009; 15: 21-30.
41. Akyuz E and Erdemir F. Surgical patients' and nurses' opinions and expectations about privacy in care. *Nurs Ethics*. 2013; 20: 660-71.
42. Bäck E and Wikblad K. Privacy in hospital. *J Adv Nurs*. 1998; 27: 940-5.
43. Barron A. The right to personal space. *Nurs Times*. 1989; 86: 28-32.
44. Griffin-Heslin VL. An analysis of the concept dignity. *Accid Emerg Nurs*. 2005; 13: 251-7.
45. Birrell J, Thomas D and Jones CA. Promoting privacy and dignity for older patients in hospital. *Nurs Stand*. 2006; 20: 41.
46. Leigh H. *The patient: Biological, psychological, and social dimensions of medical practice*. Springer Science & Business Media, 2013.
47. Greene J. Behavioral health data in the electronic health record: privacy concerns slow sharing. *Ann Emerg Med*. 2013; 62: 19A-21A.
48. Rasmussen TS and Delmar C. Dignity as an empirical lifeworld construction—In the field of surgery in Denmark. *International journal of qualitative studies on health and well-being*. 2014; 9: 24849.
49. Manookian A, Cheraghi MA, Nikbakht Nasrabadi A, Peiravi H and Shali H. Nurses' lived experiences of preservation of patients' dignity. *Journal of Medical Ethics and History of Medicine*. 2014; 7: 22-33.
50. Lin YP and Tsai YF. Maintaining patients' dignity during clinical care: a qualitative interview study. *J Adv Nurs*. 2011; 67: 340-8.
51. Woogara J. Patients' rights to privacy and dignity in the NHS. *Nurs Stand*. 2005; 19: 33-7.
52. Chochinov HM, Hack T, McClement S, Kristjanson L and Harlos M. Dignity in the terminally ill: a developing empirical model. *Soc Sci Med*. 2002; 54: 433-43.
53. Walsh K and Kowanko I. Nurses' and patients' perceptions of dignity. *Int J Nurs Pract*. 2002; 8: 143-51.
54. Erickson J and Millar S. Caring for patients while respecting their privacy: renewing our commitment. *Online J Issues Nurs*. 2005; 10.
55. Glen S and Jownally S. Privacy: a key nursing concept. *British journal of nursing (Mark Allen Publishing)*. 1995; 4: 69.
56. Malcolm HA. Does privacy matter? Former patients discuss their perceptions of privacy in shared hospital rooms. *Nurs Ethics*. 2005; 12: 156-66.
57. Thomas RK. *Health communication*. Springer Science & Business Media, 2006.
58. DeVoe JE, Wallace LS and Fryer Jr GE. Measuring patients' perceptions of communication with healthcare providers: do differences in demographic and socioeconomic characteristics matter? *Health Expectations*. 2009; 12: 70-80.

59. Dodge B, Schnarrs PW, Goncalves G, et al. The significance of privacy and trust in providing health-related services to behaviorally bisexual men in the United States. *AIDS Educ Prev*. 2012; 24: 242-56.
60. Bansal G and Gefen D. The impact of personal dispositions on information sensitivity, privacy concern and trust in disclosing health information online. *Decision support systems*. 2010; 49: 138-50.
61. Lewicki RJ, McAllister DJ and Bies RJ. Trust and distrust: New relationships and realities. *Acad Manage Rev*. 1998; 23: 438-58.
62. Kaiser K, Rauscher GH, Jacobs EA, Strenski TA, Ferrans CE and Warnecke RB. The import of trust in regular providers to trust in cancer physicians among white, African American, and Hispanic breast cancer patients. *J Gen Intern Med*. 2011; 26: 51-7.
63. Rodgers BL and Knafl KA. *Concept development in nursing*. 2000.
64. Lin C, Song Z, Song H, Zhou Y, Wang Y and Wu G. Differential Privacy Preserving in Big Data Analytics for Connected Health. *J Med Syst*. 2016; 40: 97.
65. Ibrahim SA, Hassan MA, Hamouda SI and Abd Allah NM. Effect of patients' rights training sessions for nurses on perceptions of nurses and patients. *Nurs Ethics*. 2016: 0969733015625365.
66. Tetali S. The importance of patient privacy during a clinical examination. *Indian J Med Ethics*. 2007; 4: 66.
67. Nayeri ND and Aghajani M. Patients' privacy and satisfaction in the emergency department: a descriptive analytical study. *Nurs Ethics*. 2010; 17: 167-77.