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PRIVACY OF OLDER ADULTS

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Abstract

Introduction: In contrast to hiding specific things, privacy concerns protecting one's right to self-control and autonomy, which accompanies everyone's existence. In the healthcare sector, older adults' thoughts about privacy should be evaluated relative to those of nurses to understand how the concept of privacy is perceived and whether necessary attention is given to the subject.

Materials and Method: This was a descriptive study. A sociodemographic Information Form and Patient Privacy Scale were used. After the necessary institutional and ethical permissions were obtained, face-to-face data were collected from 926 older adults and 788 nurses from six public and four university hospitals.

Results: The mean scores of the Patient Privacy Scale were 4.78±0.14 for nurses and 3.78±0.32 for older adults, which were significantly different ($p \leq 0.001$). In addition, when the Patient Privacy Scale scores of the nurses were evaluated according to sociodemographic data, no significant differences were found between the Patient Privacy Scale scores and scale subdimensions and sociodemographic data ($p > 0.05$). In contrast, a significant difference was found between the scale and scale subdimensions in older adults ($p \leq 0.05$).

Conclusion: When nurses communicate with older adults, they create a healthier environment in terms of privacy by considering older adults' expectations of privacy, taking measures to protect privacy, and providing training on the subject.

Keywords: Privacy; Aged; Nurses; Ethics, Medical.

INTRODUCTION

Although the concept of privacy is well known, it is difficult to define. While privacy includes hiding certain things, it also refers to a person's right to self-control and autonomy (1). Especially in healthcare, privacy is defined as protecting information that includes the fundamental determinants of the patient's past, current, or future physical or mental health conditions, including providing and paying for these services (2). The right to privacy, which is a fundamental human right, especially in healthcare institutions, is emphasized in many ethical and legal documents such as the declarations by the World Medical Association, the Rights of the Patient, the Hong Kong Declaration on Elder Abuse, the Declaration of Ethical Considerations on Health Databases, and the Council of Europe Convention on the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Oviedo Convention on Biomedicine) (2).

Securing the right to privacy and confidentiality is important in preventing shame, offense, discouragement, judgment, stigmatization, and discrimination in healthcare institutions and medical practices. Privacy enables patients to communicate honestly and openly with the healthcare team (3). With the right to privacy, human dignity is protected, communication between the patient and healthcare team is improved, and the relationship is based on trust, which is necessary for quality care and positive outcomes. When a patient's right to privacy is mentioned, the patient should understand that they may determine or limit the amount of disclosure required for medical intervention. Patients should have a private space where they are not forced to share information they do not want third parties to know (5).

Perceptions of privacy may vary according to age and sex. While privacy is a concept that determines a person's social relationships for the benefit of the person, the situation may differ for older adults. Unfortunately, the limitations of old age may distort the boundaries of privacy to the detriment of older adults. Several studies have reported situations in which patients think their privacy is not sufficiently protected or even violated (6-8). Many studies have reported the opposite, in which nurses and patients feel that their privacy is protected (9-11). Hajbaghery and Zehtabchi (2014) reported that up to 15.2% of older adults felt that their privacy was not respected and that 68.5% of patients felt moderately respected (12). While several studies have considered the privacy of nurses and patients separately, few studies have investigated both groups simultaneously.

The right to privacy in health care is related to the prevention of disclosure of personal health information about individuals to others and to ensuring confidentiality, physical privacy, respect for personal choices and independence (13). Especially in health care institutions, the right to privacy can be ignored for many reasons, such as rapid patient flow due to overcrowding, working principles of health care staff, visitor policy of the institution, physical inadequacy, insufficient staff, meeting the care needs of older patients, assumption that older adults are unconscious, making care difficult due to difficulties in understanding and comprehending older adults, reluctance of nurses to work with older patients due to high risk of multiple diseases and complications (9, 13). In addition, because it is generally accepted as normal to reveal patients' private areas and to access/share some private personal information during treatment-related practices, patients may mostly remain silent, and older patients in particular may not complain because of fear of not receiving health care services, or because of normalisation of practices during service delivery, or because they do not have enough information about patients' rights related to privacy (13, 14). As a result, health care workers may not be aware of the violation and undesirable practices may continue (9, 14). These are the main rationale for studying this subject.

In addition, studies focusing on older adults–the group in which the concept of privacy is discussed the most–are limited. Moreover, the self-assessment results of nurses are usually biased or overestimated. Therefore, evaluating the perceptions of older adults regarding privacy relative to those of nurses will provide more consistent results. Therefore, it is important to simultaneously evaluate whether the privacy of older adults is respected or neglected in nursing practices from the perspective of both patients and nurses.

MATERIALS AND METHOD

Sample

This was a descriptive study. Data were collected from six public hospitals and four university hospitals in different provinces between January 15, 2024, and May 10, 2024, after the necessary institutional and ethical permissions were obtained. A total of 926 older adults and 788 nurses participated in this study. Nurses who worked with older adults or who had at least one year's experience of working with older patients were included in the study, and the older patients who agreed to participate in the study were older adults who were hospitalised in different departments of the hospital at the time of the study. While collecting the data, the researcher and participants were allowed to meet alone. They were assured that their identity would be kept confidential by explaining the importance of reflecting on their true and sincere thoughts and the purpose of the study.

Data Collection Tools

Sociodemographic data form: The researchers created two sociodemographic data forms for nurses and older adults. The sociodemographic characteristics of the nurses included age, gender, income, marital status, number of children, years of employment, educational status, professional experience, whether they read the patient rights manual, whether they had received any previous training on privacy, their thoughts about working with elderly patients, and the hospital where they work. The sociodemographic characteristics of the older adults included age, gender, income, marital status, having children, educational status, and whether they had ever received information about patient rights or privacy from any health professional.

Patient Privacy Scale (PPS): To measure patient privacy, the Patient Privacy Scale developed by Öztürk et al. (2014) (9), which consists of five subdimensions and 27 items, including confidentiality of private life/personal information (CIPL), sexual privacy (SP), the privacy of those unable to protect themselves (PPT), physical privacy (PP), and providing a favorable environment (EFE), was used. The 5-point Likert-type scale was scored as follows: 5 = strongly agree, 4 = agree, 3 = undecided, 2 = disagree, and 1 = strongly disagree. The total score obtained from the scale varied between 27 and 135. A high score indicates high awareness of patient or personal privacy (9).

Ethical Dimension of Research

Before initiating the study, ethical approval was obtained from the Burdur Mehmet Akif Ersoy University Non-Interventional Research Ethics Committee (No: GO2024/50).

Statistical Evaluation

The data obtained from the study were analyzed using the SPSS software (version 20.0; IBM Corp., Armonk, NY, USA). The Kolmogorov–Smirnov test was used to determine the fit of normally distributed data, and frequency, percentage, and averages were used to examine the demographic characteristics of the nurses and patients. Kruskal–Wallis, Mann–Whitney U (MWU), and correlation tests were used to compare demographic variables as independent variables and Patient Privacy Scale

scores as dependent variables. Cronbach's alpha and item-total correlation analyses were used to test the reliability of the Patient Privacy Scale and its subscales. All the statistical tests were evaluated at a 95% confidence interval (CI) and $p<0.05$ significance level.

RESULTS

The average age of the nurses was 33.94±4.7 years, 87.1% were female, 59.3% were married, and 74.7% had an associate degree or a bachelor's degree. Nurses had a mean of 12.18 ± 9.6 years of professional experience. In addition, 51.5% of the nurses worked in university hospitals, and 72.9% had an income equal to their expenses. A total of 78% of them had read the patient rights manual at least once, 92.2% received training on privacy in the course content during their nursing education, 100% did not receive any special training on privacy after graduation, and 67.7% preferred not to work with elderly patients if they had a choice. Nurses did not want to work with older adults for the following reasons: 1) Working with older adults takes much time because they do not understand the interventions and instructions (78.9%). 2) Working with older patients was exhausting because of limited mobility and physical inadequacies (72.4%). 3) Many older adults have more than one chronic disease; therefore, their physiological status can be highly variable, and this situation is very stressful (63.3%). 4) Problems related to personal hygiene among older adults (51.4%).

The mean age of the older adults was 73.7±10.4 years, 62.2% were female, 37.8% were primary school graduates, 65.5% were married, 68.6% had an income equal to their expenses, 23.1% had read the manual on patient rights, and 86.2% had never been informed about patient rights and privacy by any healthcare staff.

The mean total scores of nurses and older adults on the PPS were 4.78±0.14 for nurses and 3.78±0.32 for older adults, and the mean scores of the scale subdimensions are shown in Table 1. When the total scale scores and scale subdimension scores for

Table 1. Comparison of total and subscale scores of nurses and older adults on the Patient Privacy Scale

Nurses (n=788)						
	CIPL	**SP**	**PPT**	**PP**	**EFE**	**Total**
Mean ± SD	4.82±0.18	4.68±0.12	4.79±0.12	4.78±0.16	4.76±0.12	4.78±0.14
Median	4.8	4.6	4.8	4.8	5.0	4.7
Q1, Q3 (IQR)	4.3–5.0 (0.7)	4.0–5.0 (0.9)	4.2–5.0 (0.8)	4.5–5.0 (0.6)	4.2–5.0 (0.8)	4.2–4.8 (0.6)
%95 CI	4.6–4.9	4.5–4.7	4.7–5.0	4.5–5.0	4.5–5.0	4.8–5.0
Older Adults (n=926)						
Mean ± SD	3. 88±0.48	3.63±0.58	3.68±0.52	3.76±0.42	3.87±0.46	3.78±0.32
Median	3.9	3.7	4.0	4.0	4.0	3.7
Q1, Q3 (IQR)	2.0–5.0 (0.7)	2.7–4,0 (0.1)	2.6–5.0 (0.1)	3.0–5.0 (1.1)	2.0–5.0 (1.0)	2.0–4.0 (0.3)
%95 CI	4.8–4.9	4.2–4.6	5.8–5.0	4.6–5.0	4.4–5.0	4.6–5.0
MWU;P	**9084.0 0.001**	**9352.0 0.001**	**9658.0 0.001**	**9837.0 0.001**	**10236.0 0.001**	**9999.0 0.001**

CIPL, confidentiality of private life/personal information; SP, sexual privacy; PPT, privacy of those unable to protect themselves; PP, physical privacy; EFE, providing a favorable environment; SD, standard deviation; IQR, interquartile range; CI, confidence interval; MWU, Mann–Whitney U

Table 2. Comparison of nurses' total and scale subdimension scores from the Patient Privacy Scale according to sociodemographic data (n= 788)

Socio-demographic data (Nurses)	n (%)	Patient Privacy Scale subdimensions				
		CIPL	SP	PPT	PP	EFE
		Mean ±SD	Mean ±SD	Mean ±SD	Mean ±SD	Mean ±SD
Age						
20–29	296 (37.6)	4.51±0.23	4.68±0.11	4.32±0.19	4.71±0.16	4.96±0.02
30–39	252 (32.0)	4.72±0.21	4.35±0.31	4.41±0.33	4.80±0.12	4.61±0.18
40 +	240 (30.4)	4.78±0.16	4.63±0.12	4.76±0.23	4.86±0.13	4.56±0.32
(p)		**(0.616)**	**(0.696)**	**(0.087)**	**(0.095)**	**(0.096)**
Sex						
Women	686 (87.1)	4.57±0.24	4.68±0.21	4.44±0.18	4.71±0.12	4.81±0.16
Men	102 (12.9)	4.68±0.22	4.61±0.38	4.54±0.32	4.84±0.11	4.75±0.12
(p)		**(0.762)**	**(0.153)**	**(0.404)**	**(0.513)**	**(0.235)**
Income						
Income less than expenditure	45 (5.7)	4.74±0.15	4.77±0.14	4.78±0.13	4.68±0.21	4.58±0.23
Income equals expenditure	575 (72.9)	4.65±0.16	4.85±0.13	4.64±0.32	4.76±0.22	4.64±0.31
Income more than expenditure	168 (21.4)	4.86 ±0.11	4.86±0.12	4.66±0.22	4.78±0.12	4.66±0.22
(p)		**(0.238)**	**(0.296)**	**(0.308)**	**(0.611)**	**(0.568)**
Marital status						
Married	467 (59.3)	4.74±0.22	4.68±0.22	4.72±0.14	4.24±0.35	4.88±0.08
Single	223 (28.3)	4.89±0.04	4.69±0.34	4.78±0.16	3.99±0.18	4.86±0.07
Divorced/Widow	98 (12.4)	4.78±0.18	4.64±0.31	4.71±0.26	3.68±0.27	4.84±0.08
(p)		**(0.404)**	**(0.615)**	**(0.216)**	**(0.412)**	**(0.635)**
Professional experience						
0–5 years	263 (33.4)	4.76±0.20	4.79±0.12	4.74±0.24	4.74±0.17	4.74±0.16
6–15 years	306 (38.8)	4.79±0.14	4.79±0.14	4.69±0.44	4.66±0.34	4.76±0.13
16 +	219 (27.8)	4.78±0.08	4.78±0.12	4.68±0.18	4.62±0.28	4.78±0.18
(p)		**(0.644)**	**(0.968)**	**(0.494)**	**(0.814)**	**(0.637)**
Hospital						
Public	382 (48.5)	4.74±0.12	4.72±0.13	4.64±0.28	4.74±0.19	4.74±0.06
University	406 (51.5)	4.72±0.16	4.78±0.16	4.68±0.32	4.82±0.14	4.80±0.08
(p)		**(0.459)**	**(0.654)**	**(0.214)**	**(0.619)**	**(0.426)**
Education						
High school	63 (8.0)	4.62±0.26	4.69±0.38	4.58±0.18	4.61±0.36	4.66±0.24
Associate/Undergraduate	589 (74.7)	4.64±0.16	4.75±0.36	4.87±0.11	4.74±0.12	4.72±0.16
Postgraduate	136 (17.3)	4.95±0.04	4.88±0.68	4.86±0.08	4.85±0.12	4.98±0.01
(p)		**(0.005)**	**(0.005)**	**(0.005)**	**(0.004)**	**(0.002)**
Total	788 (100.0)	4.82±0.18	4.68±0.12	4.79±0.12	4.78±0.16	4.76 ± 0.12

CIPL, confidentiality of private life/personal information; SP, sexual privacy; PPT, privacy of those unable to protect themselves; PP, physical privacy; EFE, providing a favorable environment

Table 3. Comparison of the total and subscale scores of the Patient Privacy Scale according to sociodemographic data (n= 926)

Sociodemographic data (Older Adults)	n (%)	Patient Privacy Scale Subdimensions				
		CIPL	SP	PPT	PP	EFE
		Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD
Age						
65–74	574 (61.9)	4.21±0.52	3.98±0.68	4.12±0.19	4.01±0.16	3.96±0.29
75–84	259 (27.9)	3.51±0.26	3.15±0.31	3.41±0.32	3.21±0.21	3.41±0.48
85 +	94 (10.2)	2.60±0.18	2.85±0.51	3.06±0.21	2.96±0.13	2.96±0.32
(p)		**(0.001)**	**(0.001)**	**(0.004)**	**(0.005)**	**(0.005)**
Gender						
Women	576 (62.2)	4.17±0.74	4.28±0.61	4.01±0.16	4.11±0.12	3.81±0.29
Men	350 (37.8)	3.08±0.22	3.01±0.38	3.24±0.52	3.04±0.19	3.01±0.42
(p)		**(0.001)**	**(0.001)**	**(0.004)**	**(0.001)**	**(0.005)**
Income						
Income less than expenditure	211 (22.8)	3.44±0.45	3.77±0.44	3.58±0.63	3.98±0.24	3.08±0.23
Income equals expenditure	635 (68.6)	4.05±0.46	3.95±0.48	4.04±0.52	3.86±0.32	3.94±0.41
Income more than expenditure	80 (8.6)	4.56 ±0.44	4.26±0.55	4.66±0.22	4.76±0.42	4.36±0.22
(p)		**(0.001)**	**(0.001)**	**(0.001)**	**(0.001)**	**(0.001)**
Marital status						
Married	607 (65.5)	4.14±0.52	4.18±0.62	4.32±0.69	4.24±0.35	4.18±0.56
Single	21 (2.3)	3.89±0.42	3.59±0.74	3.68±0.60	3.99±0.18	3.86±0.47
Divorced/Widow	298 (32.2)	3.58±0.26	3.39±0.71	3.51±0.41	3.68±0.27	3.28±0.28
(p)		**(0.004)**	**(0.005)**	**(0.005)**	**(0.005)**	**(0.005)**
Education						
Elementary school	350 (37.8)	3.21±0.26	3.09±0.88	3.46±0.63	3.31±0.56	3.66±0.54
Intermediate school	325 (35.1)	3.74±0.66	3.85±0.76	3.87±0.74	3.64±0.66	3.92±0.66
High school	156 (16.8)	4.55±0.38	4.18±0.68	4.46±0.57	4.75±0.42	4.78±0.48
Undergraduate and above	95 (10.3)	4.73±0.17	4.20±0.53	4.35±0.10	4.70±0.48	4.73±0.47
(p)		**(0.001)**	**(0.001)**	**(0.001)**	**(0.002)**	**(0.004)**
Total	926 (100.0)	3.88± 0.48	3.63±0.58	3.68±0.52	3.76±0.42	3.87±0.46

CIPL, confidentiality of private life/personal information; SP, sexual privacy; PPT, privacy of those unable to protect themselves; PP, physical privacy; EFE, providing a favorable environment

nurses and older adults were compared, a significant difference was found between the two groups (p≤0.001) (Table 1). The results show that nurses' total scores on the PPS were higher than those of older adults, it means that patients' privacy rights were respected and patients' privacy was protected by nurses. However, the PPS total score and the total scores of all subgroups of older patients were significantly lower than those of nurses. This is an important result that older patients think that the health care profesionals do not pay enough attention to their privacy.

When the nurses' PPS scores were evaluated according to sociodemographic data, no significant differences were found between the PPS scores and the subdimensions or sociodemographic data (p>0.05), except for education level (p ≤0.05)((Table 2).

When PPS scores of older patients were evaluated according to sociodemographic data, significant differences were observed between PPS subdimensions and sociodemographic variables (p≤0.01, Table 3). Accordingly, although privacy awareness decreased significantly with increasing age, total and subgroup scores of privacy awareness were found to be significantly higher in women (p ≤0.05). In addition, it was found that the privacy scores of married persons and those with higher education and income levels were statistically higher in all subgroups and in total (p ≤0.05).

DISCUSSION

Many studies have used the PPS to investigate nurses' awareness of privacy. Nevertheless, none have compared the perceptions of nurses and older adults, who are a vulnerable group, during health service delivery. In our study we found that nurses and older adults had significantly different scores on the PPS, with the nurses scoring higher. This study makes an important contribution to the literature in this context.

In a 2023 study conducted among 244 surgical nurses in Japan, the total score on the scale was found to be high. No relationships were found between nurses' age, education, marital status, years of work, or mean total score and PPS subdimensions (15). In a study conducted with 141 clinical nurses using the PPS, sociodemographic characteristics were not associated with the perceived importance of patient privacy. In contrast, the importance of privacy increased as education level increased (16). Another study involving 385 nurses and midwives using PPS reported that the perception of privacy increased with age and educational level (17). In a study targeting intensive care nurses, no significant difference was found between the median PPS scores according to the level of education, age, sex, marital status, duration of employment, intensive care unit in which the nurse was working, and duration of employment in the intensive care unit (18). In a study involving 105 intensive care nurses whose data were collected in 2018, the PPS score was 4.61±0.38 (19). In a study conducted with 110 nurses in a private hospital, most regarded privacy and personal confidentiality as fundamental rights. They showed care and respect for privacy and confidentiality, including the patient's privacy (20). No study has been conducted on nurses' perceptions of privacy when working with elderly individuals. However, in a study conducted with nursing home employees, the importance of patient privacy increased with increasing age and working time in nursing homes. No relationship was found with other sociodemographic variables (21).

In the literature, nurses generally have high total PPS scores, and, as mentioned above, some studies have described a relationship between sociodemographic characteristics and PPS scores. In contrast, other studies have reported that there is no relationship. In our study, the total PPS score was high, similar to that reported in the literature. However, PPS scores were not associated with sociodemographic characteristics. These findings are due to privacy being emphasized in nursing

education, and respect for privacy is internalized as a professional value. In fact, in studies conducted with nursing students, PPS scores were high (22, 23). For example, the mean PPS score (4.52±0.49) and the mean scores of all subdimensions were high in a study conducted with 190 final-year nursing students (24). Studies conducted among nursing students have confirmed that education effectively improves privacy perceptions.

In our study, unlike nurses, older adults' PPS scores differed significantly based on sociodemographic characteristics. We found that as participants' ages increased, their income and education levels decreased, and their perception of privacy decreased. Women's perceptions of privacy were also greater than those of men. We could not find any studies that used the PPS among older patients. However, in a study conducted with 400 people aged 20 years and over who applied to health institutions in Igdir and Aksaray with the data collection tool developed by Bostan and Ünal, perceptions of privacy and definitions of privacy violation changed with sociodemographic characteristics. Moreover, individuals from Aksaray who were older than 50 years, middle-income level, civil servants, and urban individuals had stronger perceptions of privacy and definitions of privacy violations. In addition, participants stated that, among healthcare professionals, nurses committed more privacy violations (8). Regarding our findings, we expected that the perception of privacy would increase as socioeconomic level increased. Similarly, it is understandable that women's perceptions of privacy are greater than those of men because of gender roles.

A study conducted in Greece compared nurses' perceptions of autonomy, informed consent, and privacy. According to this study, there were significant differences between nurses' and patients' perceptions of privacy. While patients strongly believe that their privacy is not protected, nurses feel the opposite (25). When the privacy perceptions of nurses and older adults were compared, we observed that nurses had higher PPS scores. Nurses are typically in a different position from patients in terms of knowledge, awareness, and practice because of their education.

LIMITATIONS

Our study might have yielded better results if it had been conducted over a longer period of time and with a larger sample. In addition, it is a limitation that the study was not conducted among older adults and nurses who provide health care to them. Another limitation of our study is the possibility that nurses who have been trained on privacy and older adults who have not had awareness and training on this issue may not understand the same thing.

CONCLUSION

Since the world's and Turkey's populations are aging, respecting and protecting the privacy of vulnerable older adults during health service delivery is the nurse's role in patient advocacy. Situations in which nurses who have close contact and an obligation to care for elderly patients according to their values and preferences have a perception of privacy that might conflict with those of patients may cause problems in practice. Although nurses argue that they respect privacy, patients may have the opposite view. Therefore, both parties must speak a common language.

Nurses create a healthier environment when communicating with older patients by considering their expectations about privacy, the measures taken to protect privacy, and providing training on the subject. Societal education to increase awareness of privacy is also essential. For more concrete conclusions, quantitative and qualitative studies should be conducted simultaneously with older patients and the nurses caring for them.

Conflict of Interest: The authors have declared no conflict of interest.

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