Sound privacy for patients

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Editorial

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Recently, a patient sent to a consultant in a private office complained that her history was easily audible to the patient in the adjoining cubicle, just as the other patient's history was audible to her: the divider between them did not extend to the ceiling, though the building was new. The hospital outpatient departments where physicians see patients often have similar incomplete rooms, which make overhearing unavoidable. When physicians see critically ill patients in hospital emergency wards, other patients in adjacent curtained cubicles are potentially able to overhear.[1] Fortunately, the days of 40-bed, barnlike wards in teaching hospitals are long gone, and patients are now more comfortable in smaller rooms. But on the wards where patients are admitted, the history is routinely taken by the house officer in a 4-bed room where the only "privacy" is afforded by a curtain drawn around the bed. On rounds, physicians evaluate patients' progress in a similar environment. When they need to speak with family members, they often resort to a public corridor.

Although architecture presents obvious difficulties, carelessness is often the cause of indiscretion. It is still possible to hear physicians discussing a case, albeit in the abstract, in public places such as elevators and hallways. A recent study of hospital elevators found that inappropriate comments were made during 14% of public elevator trips; of these, the largest proportion represented violations of patient confidentiality.[2] Medical receptionists are often seated in a part of the waiting area where patients are forced to listen to the telephone conversations. As the receptionist decides whether or not to grant urgent access to the physician, the calling patient may be named and quizzed about symptoms ranging from dyspnea to dyspareunia. What must patients and visitors think when they overhear such conversations? They must wonder what is said, and where, about their own cases. Patient trust is not earned in this way.

Certainly physicians appear to discuss cases in an inappropriate setting about 3 times more frequently than patients think they do. Such was the finding of a study that examined the frequency of naming patients to physicians not concerned with the case or to nonmedical personnel.[3] Similar findings applied to discussion of a case at a party or with a spouse and other intimates.[3]

Patient confidentiality is a guiding principle of the physician–patient relationship. Yet the CMA Code of Ethics treats confidentiality only in general terms, without spelling out its elements.[4] There are regulations to control access to patient files. Patients are examined in special rooms or, at the least, in screened cubicles so that no one may see. Recent commentaries on confidentiality focus on violations of the privacy of the medical record, giving only passing mention to the aspect of overhearing.[5–7]

What explains physicians' assiduous attention to documentary and visual privacy and their lack of same to auditory privacy? Absorption in a case, the need to fit a discussion with a colleague into a busy day and lack of awareness of surroundings may partially explain the overheard conversation. The time and effort involved in moving a patient to a special examining room may deter the physician from using it. The expense of constructing soundproof rooms (or even rooms with full rather than partial walls) may be prohibitive in these days of cost-cutting. Many older hospitals were built at a time when auditory privacy was even less of an issue, and those working in such hospitals are left to do their best with a legacy of offices and examining rooms that are little more than cubicles.

These are some of the reasons that may explain current sloppy practice, but there can be few to justify why this sloppiness is still tolerated.

So what is to be done?

The first step is to become aware of the extent of the problem. Physicians must educate themselves and their students to be sensitive to auditory surroundings.[6] An effective exercise is for the physician to imagine that it is he or she who must provide intimate personal details in such surroundings. Simple gestures showing that physicians are in fact providing sound privacy for patients — leading colleagues to a private area before speaking or indicating that a conversation should wait until privacy is found — are behaviours that guide and teach.

The second step is to take action. Physicians should spell out the elements of confidentiality — written, visual and auditory — in their Code of Ethics. In offices and in the hospital, they should insist that any design or renovation take account of patients' need for auditory, as well as visual, privacy. These actions should go a long way to justifying the trust physicians ask their patients to place in them.

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