Anne Heikkinen, **PRIVACY IN OCCUPATIONAL HEALTH CARE – ETHICAL EXAMINATION**
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ABSTRACT

The aims of this study were to increase understanding on the concept of privacy in occupational health context, to investigate how privacy is maintained in occupational health practice, to identify the knowledge base used by the occupational health professionals in decision-making concerning privacy, and to produce a preliminary model for the realisation of privacy in occupational health care. The study was a cross-sectional study with a descriptive, explanatory and correlational study design.

Triangulation was employed in data collection. The interview sample comprised of occupational health professionals (n=15), employees (n=15) and employers (n=14). The informants were selected by convenience sampling, and data were collected between October 2004 and March 2005 by theme interviews and analysed by content analysis (inductive and deductive). On the basis of the interview findings, a semi-structured questionnaire was constructed and, following a pilot study, mailed to a randomly sampled group of 183 company physicians and 183 nurses in early 2006. The sample size was based on a power calculation with nQuery Advisor software. The overall response rate was 64%; 140 (77%) nurses and 94 (51%) physicians returned the questionnaire. Statistical analyses were performed using means, standard deviations, ranges, frequencies, percentages, graphic presentations, Pearson's Chi-Square Test, Fisher's Exact Test, Kruskal-Wallis test, and Mann-Whitney U-test. The reliability of the instrument was evaluated with Cronbach's alpha coefficient.

Privacy in the occupational health context proved a complex concept and is manifested in different ways: physically, socially, psychologically and informationally. In the challenging dual loyalty position, the ethical questions related to privacy crystallized in the occupational health services' diverse tasks, duties and roles towards the two groups of clients, employees and employers. The findings indicated that the simultaneous responsibilities of protecting and disseminating information constitute a critical combination, and a single lapse in confidentiality may lead to the loss of trust and termination of client relationship. *In an individual caring relationship*, occupational health professionals' competence to recognise patients' individual needs concerning privacy proved insufficient. They should better take into account patients' right to choose what, when, to whom and how much to tell about their personal matters, i.e., inquiries about any specific information shall be always justifiable. Over one half of the respondents took the view that patients' right to limit access to their medical records complicates the task of care provision. Nurses and physicians were very similar in their perceptions of privacy in caring relationships. The foundation for functioning *tripartite co-operation* must be established before any problems appear. Key factors in this regard included impartiality, confidentiality in co-operation, outside expertise, regularity in co-operation, and clear responsibilities in roles and tasks. The most valid course of action in dealing with sensitive issues, such as drug and work community problems, sexual harassment and sick leaves, was to rely on joint meetings. Nurses adopted this particular course of action more often than the physicians did. Both employees and employers thought they were entitled to a safe and sound work environment, but few were prepared to submit their own health-related information for the benefit of the 'common good'. Only the incorruptible occupational health nurse/physician who can properly argue his/her view and impartially explore issues both from the perspective of an employee and client company can gain the respect of both client groups. The most commonly reported knowledge base in decision-making concerning privacy was work experience. Ethical codes, legislation and research data were seldom used, and the respondents considered that the education they had received had prepared them insufficiently for solving the problems related to privacy.

Privacy is an important value in occupational health care, but if it is based on over-emphasised individualism, it may lead to a situation where everyone is acting for one's own interest only. The idea of shared responsibility has to be launched in occupational health so that everyone is provided with an opportunity to work in a healthy and safe work environment. Education and training on ethics needs much more investments than it so far has received.

KEYWORDS: privacy, occupational health care, ethics, caring relationship, tripartite co-operation