PATIENT CONFIDENTIALITY: AT WHAT POINT ARE HEALTH CARE PROVIDERS CONSTRAINED FROM KEEPING THE CONFIDENTIALITY PROMISE

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JULY 2019
DECLARATION

I solemnly declare that this thesis entitled “Patient confidentiality: At what point are healthcare providers constrained from keeping the confidentiality promise” submitted to the University of Ghana is a record of an original work done by me under the supervision of Gordon Abekah-Nkrumah (PhD). This thesis is submitted in partial fulfillment of the requirement for the award of a degree in MBA Health Services Management. The results embodied in this thesis have not been submitted to any other University or Institute for the award of any degree.

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CERTIFICATION

I hereby certify that, this dissertation was supervised in accordance with procedures laid down by the University.

………………………….       …………………………….

DR. GORDON ABEKAH-NKRUMAH       DATE

(SUPERVISOR)
DEDICATION

This project work is dedicated to God for life, his guidance and protection throughout the study and through whose grace I am alive to present this dissertation. I also dedicate this work to all nurse practitioners, to aspire to improve the nursing profession, for an investment in knowledge pays the best dividends. To my wonderful husband for his love and support, siblings and all my loved ones for their support during my entire MBA Health Services Management programme.
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LIST OF ABBREVIATIONS

ANA  American Nurses Association

CPM  Communication Privacy Management

EMRs  Electronic Medical Records
ABSTRACT

The confidentiality promise is technically complex, politically uncertain and scientifically ill-defined to address multiple patients’ needs. This is because patients’ confidentiality provides diverse perspectives which are yet to meet thorough academic examination. Therefore, the purpose of the study was to assess circumstances that may constrain healthcare workers from keeping the confidentiality promise. The study’s objectives were to assess the impact of knowledge level of healthcare providers concerning patient confidentiality, the current trends in keeping the confidentiality of patients and assessing circumstances healthcare workers may be constrained from keeping the confidentiality promise. The study sought to achieve its purpose by adopting quantitative approach with the cross-sectional explanatory design to gather data through a survey questionnaire using 141 respondents. The respondents included healthcare providers (nurses, medical officers, health specialists and surgeons) of Focos Orthopaedic Hospital Ghana. The data was analysed using correlation and simple linear regression via the application of SPSS. The results show that knowledge of public reporting, reporting child maltreatment and knowledge of patients’ threats to third parties significantly predicted patient confidentiality. However, knowledge of criminally inflicted injuries even though positive did not predict significantly predict patient confidentiality. The finding suggests that social media does support patient confidentiality negatively thus increase in social media activities lead to a decrease in patient confidentiality. In-service training, knowledge of patient de-identification and the use of electronic medical record system are current trends or practices are at FOCOS. The results imply that some circumstances may constrain healthcare providers from keeping the confidentiality promise, hence breaches. The study recommends that healthcare providers should be educated on the use of social media and breach of confidentiality.
CHAPTER ONE

INTRODUCTION

1.0 Introduction

In this chapter, the researcher discusses the background of the study, problem statement, the objectives of the study and hypotheses. In addition, the significance of the study, definitions of key terms and the chapter organization are discussed.

1.1 Background of the Study

The origins of professional confidentiality dates back to Hippocrates, who stated, “Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret” (Hulkower, 2016). From those ancient times, Stanberry (2006) suggest that, professional confidentiality and privacy for health care providers have become a legal as well as ethical obligation. Confidentiality is the central aspect of the physician-patient relationship (Brody, 1997). Confidentiality and whatever it stood for, was largely ignored in the past. Throughout the middle Ages, for example, patients with plague like diseases routinely had their privacy abrogated and their identities publicized. Similarly, those diagnosed with leprosy had to ring bells or clappers to warn others of their approach and condition (Liu et al., 2002).

It was not until the 19th century, according to Reamer 2013, that confidentiality finally became widely recognized as an important concept with moral and ethical obligations. The French Penal
Code of 1810, for example, imposed imprisonment and heavy fines on physicians who revealed medical secrets. In 1803, Thomas Percival established the first modern code of Western medical ethics, which states, "Patients should be interrogated concerning their complaint in a tone of voice which cannot be overheard. The American Medical Association's (AMEs) original Code of Medical Ethics, adopted in 1847, was a revision of Percival's work and formally included the principle of confidentiality. The current version of the AMEs Principles of Medical Ethics avows, "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law" (Corrigan, 2003). The Joint Commission on Accreditation of Healthcare Organizations also holds that the patient has the right, within the law, to personal and informational privacy. Modern healthcare practice continues to recognize the importance of confidentiality (Bastable, 2017), and have included it in various oaths, principles, and rules of professional conduct. This is also enshrined in the syllabus used in the academic training of healthcare workers. Most of these codes commonly hold that confidentiality may be breached only when required by law, when in the public interest, or when necessary to prevent harm to others.

In the health literature, confidentiality is discussed in relation to patients’ rights and is an essential aspect of the trusting relationship that patients have with their health-care providers (Dobrowolska et al., 2007, Neitzke 2007). There is an understanding that patients have the right to privacy and the right to expect personal information about them to be held in trust, with security of records, and that access to such information is in some way protected (Rock & Congress 1999, Frewer & Fahr 2007). Hulkower (2016), in his review of the Hippocratic Oath also supports that confidentiality is still essential to the formation of the therapeutic relationships for patient and health-care providers, and
by extension, to healthcare institutions, whereby there is an understanding that professional
individuals and organizations will maintain confidentiality of patient information.

1.2 Problem Statement

The maintenance of confidentiality is both a legal and an ethical duty of all healthcare workers, American Nurses Association. (ANA) (2001). Larkin et al. (1994) reiterate that, indiscriminate disclosure of patient confidences may disgrace patients, undermine trust, and seriously imperil patients' relationships with their doctors and others. Patients expect that physicians will honor the implied contract of silence and fulfil their obligation as patient advocates. Moral arguments for confidentiality are rooted in the principles of utility and duty according to Utilitarian principles and this is concurred by Hayry (2013), in the Liberal utilitarianism and applied ethics.

Breaching confidentiality may be thought to weaken society's faith in the greater institution of medicine and healthcare (Gilson 2013). The resultant distrust threatens the provision of detailed and accurate information necessary for correct diagnosis and treatment. Thus, possible long-term destruction of patient openness would continue to militate strongly against breaches in confidentiality (Cate, 2010). The ethical principles of the AMA and the American College of Physicians recognize certain exceptions to the rule of confidentiality. It is for this reason that this study intends to find out under what circumstances, are healthcare worker constrained to keeping the confidentiality promise.

1.3 Objectives of the Study

The study seeks to assess under what circumstances healthcare workers may be constrained from keeping the confidentiality promise. The specific objectives include the following;
Objectives:

i. To assess the knowledge level of healthcare providers on confidentiality at Focos Orthopaedic hospital in Ghana.

ii. To study the current trends in the practice of confidentiality at Focos Orthopaedic hospital in Ghana.

iii. To find out under what circumstances healthcare providers may be constrained from keeping the confidentiality promise at Focos Orthopaedic hospital in Ghana.

1.4 Significance of the Study

The findings of this study are important for government policymakers, health institutions and researchers. The study is relevant in these areas due to the fact that it provides insight in staff perception of patient confidentiality, it identified the prevailing trends in patient confidentiality practice in the study area which can be applicable to many health facilities in Ghana and Africa at large. The findings further provide useful information for Government and policymakers to formulate national and institutional policies on the storage and disclosure of patient information. This will help to curtail the indiscriminate disclosure of patient information either in news, print or over the social media.

The findings will help to remove barriers to patients-staff and staff-staff relationships which will translate into greater utilization of health services resulting in improved health outcomes. The findings have further enlightened clinical staff to be mindful when dealing with patient information. In addition, the findings of the study may further create an avenue for further studies to be conducted on patient confidentiality in other parts of the country, to create a ripple effect in respecting patient information in our society.
1.5 The scope of the study

The study covered health professionals in direct patient care in a private hospital in Pantang, Accra. The study was limited to clinical staff of the selected hospital and did not cover nonclinical staff or staff from other hospitals. Therefore, generalization should be done with caution. In view of the fact that the study was to assess patient confidentiality and under what circumstance healthcare worker may be constrained from keeping the confidentiality promise, the study made use of staff who mostly have direct interaction or contact with patients. Other facilities and other categories of staff were not part of the study due to resource and time constraints.

1.6 Operational Definitions

**Patient:** The person to whom the doctor or health facility owes a duty of care.

**Patient information:** Data given directly by patients to healthcare professional. This also includes data generated from other investigations or procedure details of the said patient.

**Confidentiality:** Confidentiality refers specifically to the handling of information that has been shared between doctor and patient

**Privacy:** May be the physical sphere within which others may not intrude, freedom of choice for important decisions (Autonomy), and privacy as control over personal information.

**Disclosure:** Giving out patient information

**Healthcare professionals:** Professionals trained to provide healthcare services to patients. Includes doctors, nurses, and members of allied health
1.7 Organization of the study

This study was organized into four chapters. Chapter One is the introduction to the study. It includes the background information, problem statement, specific objectives of the study, research questions, scope, significance of the study and operational definitions. Chapter Two is a literature review. Literature was reviewed in three sections; theoretical, empirical literature and a conceptual model on patient confidentiality. The literature review was done taking cognizance of the stated objectives of the study. Chapter Three covers the methodology which comprises the study design, the study type, the study variables (independent and dependent variables), the procedure used for data collection, sampling procedure and sample size, study population, data collection methods, quality control measure as well as plans for dissemination of the findings. Chapter Four comprise of data analysis, which made use of the findings obtained from the respondents to generate answers to the stated objectives and the reviewed literature. This is followed by a discussion of the findings with respect to the study objectives and literature review to find out whether the findings conform to literature or not. Then finally, Chapter Five presents a summary of the main findings, the implication of the study, conclusion and recommendation with regards to the findings.
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter intends to discuss the literature available on patient confidentiality, review the current practices on the subject, the benefits of upholding the confidentiality promise to patient care, and possible breaches in confidentiality. This discussion will be done under three main headings; theorizing the concept on confidentiality, empirical literature and conceptual framework.

2.1 Conceptualisation of Patient Confidentiality

The relationship between a health care provider and patient is one characterized by intimacy and trust, and confidentiality is embedded at least implicitly in patient-provider interactions (Rørtveit et al., 2015). The notion of confidentiality in health care has a strong professional tradition that has suffered progressive erosion due to third party reimbursement schemes, managed care and other health care organizational structures, and the perceptions and culture of professionals within modern health care systems (Walker et al., 2014). The terms “confidentiality” and “privacy” are sometimes used interchangeably in literature, yet some distinction can be made between them. According to Boonstra (2010), confidentiality refers specifically to the handling of information that has been shared between doctor and patient. With the emergence of diversity in healthcare provision and practice, confidentiality may then extend to include patient information shared between the patient and the healthcare provider; the hospital, and all staff who may have access, either authorized or
Unauthorized. Resnik (2011) suggests three broad consensuses that the duty of confidentiality should cover. These are:

i. Respect for privacy.

ii. The relationship of trust between physician and patient.

iii. The assumption that a general respect for confidentiality is essential good for patient care because when it is present, patients will disclose more complete information.

The right of privacy of an individual in relation to all other people includes 3 aspects:

i. Privacy as a physical sphere within which others may not intrude,

ii. Privacy as freedom of choice for important decisions (Autonomy), and

iii. Privacy as control over personal information.

The principle of confidentiality is that, a health care professional may not reveal to others the information provided by a patient without the patient’s consent (Elger et al., 2015). Ferguson (2016) his work the “Evolution of Medical confidentiality” maintains that, confidentiality is both a legal and an ethical duty of healthcare personnel. Indiscriminate disclosure of patient confidences may disgrace patients, undermine trust, and seriously imperil patients’ relationships with their doctors and others. Patients expect that physicians will honor the implied contract of silence and fulfil their obligation as patient advocates. Despite patient confidentiality being a key priority, circumstances exist where information disclosure is demanded (Beauchamp & Childress, 2001). In the safeguarding of children or vulnerable adults, disclosure is required to prevent harm and similarly to prevent criminal activity from occurring.
2.2 Theorizing the Concept of Confidentiality

Morals and Ethics surround us in our daily lives and are even more important in healthcare (Van Manen, 2016). While all health practitioners need to be familiar with the general concepts of confidentiality and privacy, there are believed to be some conflicts of understanding within health care practice (Donabedian, 2002). The purpose of this section is to offer some information on the ethical principles of confidentiality which may help provide a base level of understanding to inform and underpin clinical practice. Ethical theory and varying individual morals can conflict. Held (2006) mentioned that within health service practice, there are checks and balances to combat ambiguities relating to differences in individual values and ethical theory which are enshrined within the seven ethical principles. These principles can significantly impact on patients, care givers and organizations alike. Challenges that arise in relation to confidentiality is managed using frameworks to help clarify difficulties in ethical practice.

Case law and “common law nature of confidentiality” ensures that the health providers constantly update and amend practice improvement policies. Health care providers are responsible for implementing associated changes and in so doing, constantly optimizing patient confidentiality. Confidentiality models acknowledge that changes in disclosure are necessary to improve services, so patients receive the best service with any necessary disclosure of their information occurring within the legal framework (Peterson et al., 2018). Petronio et al. (2004) reveal that the presence of ‘informal’ healthcare advocates during physician visits represents a unique privacy challenge. When these family members or friends participate in a patient’s visit with the physician, they are often confronted with numerous privacy dilemmas. The general principles of what is considered confidential have been outlined in common law. A duty of confidence arises when one person discloses information to another, Murphy 2017. For instance, with a patient to a doctor, there is
circumstances where it is reasonable to expect that the information be held in confidence. Murphy et al. (2017) outlines that, for an information to represent a breach, that confidential information must:

i. Have the necessary quality of confidence.

ii. Be imparted in circumstances importing an obligation of confidence.

iii. Be disclosed with the permission, otherwise leading to the detriment of the person originally communicating it.

iv. Not already be in the public domain.

v. Be in the public interest to protect it.

Petronio (2016) in her theory Communication privacy management (CPM), also argues that disclosure is the process by which we give or receive private information. Private information is what people reveal. Generally, individuals believe they own their private information and have the right to control said information. Management of private information is not necessary until others are involved. CPM does not limit an understanding of disclosure by framing it as only about the self. Instead, CPM theory points out that when management is needed, others are given co-ownership status, Petronio et al. (2017), thereby expanding the notion of disclosing information. The theory uses the metaphor of privacy boundary to illustrate where private information is located and how the boundary expands to accommodate multiple owners of private information. (Petronio et, al 2017). Thus, individuals can disclose not only their own information but also information that belongs to others or is owned by collectives such as families.

Acquisti (2015) also supports that making decisions to disclose or protect private information often creates a tension in which individuals stagger between sharing and concealing their private information. Within the purview of health issues, these decisions have a potential to increase or
decrease risk (Petronio, 2013, Acquisti, 2015). The choice of disclosing health matters to a friend, for example, can garner social support to cope with health problems. At the same time, the individual may have concerns that his or her friend might tell someone else about the health problem, thus causing more difficulties.

In a review of the communication privacy management theory (Petronio, 2016), understanding the tension between disclosing and protecting private health information by the owner is only one side of the coin. Because disclosure creates authorized co-owners, these co-owners (e.g., families, friends, partners, communities) often feel they have right to know about the owner’s health conditions (Petronio & Reierson, 2015). Rafferty et al. (2019) also discuss the privacy boundaries in their work health communication. They suggest the privacy boundary is used metaphorically to indicate where private information is located. This implies that individuals have both personal privacy boundaries around health information that expands to include others referred to as “authorized co-owners.” Once given this status, withholding to protect some part of the private information can risk relationships and interfere with health needs. Within the scheme of health, disclosure risks and privacy predicaments are not experienced exclusively by the individual with an illness (Petronio et al., 2017). Rather, these risks prevail for a number of individuals connected to a patient such as providers, the patient’s family, and supportive friends (Dapaah, 2016, Petronio, 2017). Everyone involved has a dual role. For example, the clinician is both the co-owner of a patient’s private health information and holds information within his or her own privacy boundary, such as worrying whether he or she diagnosed the symptoms correctly. Thus, there are a number of circumstances that can lead to health risks where privacy management and decisions to reveal or conceal health information are concerned (Dapaah et al., 2016).
With the communication privacy management framework in mind, the American Medical Association (AMA) in their principles of medical ethics Kaufman, et al. (2009), adds that physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient. In general, patients are entitled to decide whether and to whom their personal health information is disclosed to (Murphy, 2017). Equally, physicians should obtain the consent of the patient (or authorized surrogate) before disclosing personal health information. Wintemute (2016) suggests the contrary, in that specific consent is not required in all situations, and admonishes that when disclosing patients’ personal health information, physicians should:

i. Restrict disclosure to the minimum necessary information.

ii. Notify the patient of the disclosure, when feasible.

Physicians may disclose personal health information without the specific consent of the patient (or authorized surrogate when the patient lacks decision-making capacity):

i. To other health care personnel for purposes of providing care or for health care operations.

ii. To appropriate authorities when disclosure is required by law.

iii. To other third parties situated to mitigate the threat when in the physician’s judgment there is a reasonable probability that:
   a. The patient will seriously harm him/herself; or
   b. The patient will inflict serious physical harm on an identifiable individual or individuals.
2.3 Empirical Review

Medical confidentiality, despite its diminished state remains important to healthcare providers and patients, Murgic et al. (2015). Effective treatment requires accurate information, in that, patients are most likely to provide this information when they are not worried about public exposure, (Collins et al., 2015). For this dissertation, empirical review will be done under the following sub headings:

i. The current trends in the practice of confidentiality.

ii. Knowledge level of healthcare providers on confidentiality, and

iii. Circumstances that may constrain healthcare providers from keeping the confidentiality promise.

2.3.1 Current Trends in Patient Confidentiality Practice.

Moran (2003) in their review of patient perspectives on medical confidentiality reveal that many patients are unaware of, or misunderstand their legal or ethical right to medical confidentiality protections. The possibility that medical information might be revealed, intentionally or not, to acquaintances in a clinic or others in the community troubles patients (Collins et al., 2015). Campos-Castillo and Anthony (2019) suggest that a significant minority of patient’s distrust confidentiality protections, leading some to report they delay or forego medical care. Kaufman et al. (2009) equally suggest that there may be breaches in confidentiality through electronic health records. In the study, the strategic management of healthcare organizations, Ginter et al. (2018), reveal that, the enhanced availability of health information in an electronic format is strategic for industry wide efforts to improve quality and reduce the cost of health care. Again, electronic medical records (EMRs) facilitate increase in the accessibility and sharing of health records among authorized individuals. Yet it brings a concomitant concern of greater risk for loss of privacy among
health care participants, (Hargittai et al., 2016). Murphy (2017) also attest that privacy of information collected during health care processes is necessary because of significant economic, psychologic, and social harm that can come to individuals when personal health information is disclosed.

Mlinek and Pierce (1997) talk about other forms of confidentiality breaches in their study; confidentiality and privacy Breaches in a University Hospital Emergency Department. This was a prospective, observational study of medical personnel behavior using direct observation techniques, with the objective of determining the frequency of visual and auditory confidentiality and privacy breaches in a university emergency department. All members of the health care team committed confidentiality and privacy breaches. Frequency of breaches was dependent on room location and design. Breaches in the triage/waiting area occurred for more than 53% of the patients. Breaches near the physician/ nursing station ranged from 3 to 24 per hour and 1.5 to 3.4 per patient hour. Other inappropriate comments also were noted. One hundred consecutive patients and family members were interviewed, with only 3100 having noticed the status board, although neither could recall any specific details.

2.3.2 Privacy and Confidentiality Concerns in Electronic Health Records

Electronic health record (EHR) is increasingly being implemented in many developing countries. It is the need of the hour because it improves the quality of health care and is also cost-effective (Ozair et al., 2015). Sulmasy (2017) believes in modern healthcare, technologies that aid the delivery of care are ubiquitous. EHRs have demonstrated value in features such as legible information, accurate prescriptions, remote access to information, and prevention reminders. Many patients use portals to check information and communicate with their health care providers. Instant retrieval and
information exchange through EHRs improve care and productivity a great deal (Groves et al., 2016).

McLeod (2018) suggests that this disruptive innovation is a double-edged sword, bringing both opportunities and risks. Ethical issues related to EHRs confront health personnel; the risk of unauthorized use, access, and disclosure of private patient information, raising confidentiality and privacy concerns. When patient's health data are shared or linked without the patients' knowledge, autonomy is jeopardized. Respect for patient autonomy requires that patient encounters and information is kept confidential and private, fostering trust and improving communication, (Sulmasy et al., 2018). Otherwise, patients might not disclose important information or may avoid seeking care, fearing denial of insurance, loss of employment, or stigmatization. While this is also true of paper records, concerns are heightened with EHRs because information is so readily transmitted and system breaches are not uncommon, (Wager et al., 2017), despite security measures breaches may occur accidentally, through cyber-attacks, or due to lapses in professional conduct, such as searching for test results of a family member or celebrity. All of this is easier to accomplish electronically.

2.3.3 Knowledge Level of Healthcare Providers on Confidentiality.

The American Medical Association (AMA) Code of Ethics implies that rights to confidentiality may be abrogated if they "infringe in a material way upon the safety of another person or persons (Dickson, 2017). Jackson et al. (2011) in their study reveals that confidentiality is not always directly connected to patient information and there are other ways that confidentiality is applied in the health environment. For example, confidentiality can be used to protect healthcare providers and organizations from public scrutiny, and this may mean the intentional withholding of information to protect either the interests of individuals or the organization itself. Jackson et al. (2001), in their work “exploring confidentiality in the context of nurse whistle blowing: issues for nurse managers”
revealed that wrong-doing in the health sector becomes public knowledge when health-care professionals report outside their organization, often because internal avenues of reporting have failed. In Australia, these incidents have become increasingly prominent owing in part to several high-profile cases reported in the media (Faunce & Bolsin 2004; Johnstone 2004; Van Der Weyden, 2005).

Whistle blowing has been broadly defined as reporting misconduct in the workplace (Ahern & McDonald, 2002). Firtko and Jackson (2005) propose whistle blowing as occurring when ‘parties take matters that would normally be held as confidential to an organization, outside that organization despite the personal risk, and potentially negative sequelae associated with the act. Contrarily and Blightman (2014) suggest that inadvertent breaches are potentially common. When medical notes are left visible or patient consultations and preoperative assessments are conducted in an open environment. The increased use of computerized documentation results in faster and wider distribution of information with an increased risk of unauthorized access. Unintentional breaches of patient information may occur when e-mailing colleagues. Data encryption e-mail services must be used by both the sender and recipient if patient details are communicated in this manner to prevent unauthorized interception of messages (Blightman, 2014). Confidential patient information maintained on personal computers must also be encrypted since password protection can be easily bypassed.

2.3.4 Constraints of the Confidentiality Promise.

2.3.4.1 Statutory Disclosures

Though inadvertent breaches in privacy and confidentiality are potential in-patient care delivery, sometimes, healthcare workers are required by law. This is known as statutory disclosures
(Blightman et al., 2014). If information is required by law, this will not amount to a penalty for a breach. This area can be confusing. It is important for clinicians to be aware that the police do not have automatic powers to demand disclosure nor has a lawyer rights to demand medical information. A court order is required for this purpose. However, a judge can penalize a doctor for contempt of court for failure to assist with the provision of necessary information. In addition, incorrect or misleading information must not be given to the police in their investigation (Blightman et al., 2014).

2.3.4.2 Prevention or detection of crime

The Police and Criminal Evidence Act 1984 considers a ‘serious offence’ a crime giving risk to national security, interfering with justice, and causing death or serious injury. The Act provides police with powers to access materials normally classified as excluded such as medical records, providing a warrant has been obtained by a circuit judge. Disclosure is demanded when national security is at risk, as defined by the Prevention of Terrorism Act 2005 where there is a duty to report suspicion of terrorist activity. Likewise, the Terrorism Act 2006 requests healthcare professionals to inform police of any information that may help prevent an act of terrorism, or assist in apprehending or prosecuting a terrorist. The Road Traffic Act 1991 requests medical practitioners to give patient details to the police when a driver is alleged to have committed an offence. Doctors may face prosecution for failure to disclose such relevant information (Hunter v Mann [1974] 2 All ER 414). Disclosures may be made for statistical purposes via secondary legislation, for example, Abortion Regulations 1991, or for the protection of individuals, for example, Misuse of Drugs (Supply of Addicts) Regulations 2001.
2.3.4.3 Disclosures in the Public Interest

Public interest ranges from public health to prevention or detection of serious crime. This justification is more subjective and in contentious cases, the courts may be required to decide. There is a distinction between ‘in the public interest and what the public are interested in (Blightman et al., 2014). Public health is the overarching aim of healthcare and there are circumstances where disclosure outweighs the benefits of individual privacy. Historically, doctors have been required to provide epidemiological information by compulsory reporting of specific communicable diseases or industrially related disease, governed by the Public Health (Control of Disease) Act 1982. HIV notably, although indisputably infectious and associated with criminal prosecutions for reckless transmission, remains a controversial area for disclosure, partly because of perceived stigmatization (Ghana AIDS Commission 2018). The AIDS (Control) Act 1987 states that the disease is not notifiable and so limits requirements to prevalence statistics only. Two other pieces of legislation provide additional guidance, but interpretation varies.

Doctors are required to be honest and full in their disclosure. If a serious communicable disease has contributed to a patient's death, this must be recorded on the death certificate. Information relating to serious communicable disease should be passed on to the relevant authorities, while preferably maintaining anonymity to improve control and maintain surveillance. This includes HIV, tuberculosis, and hepatitis B and C. Under the Coroners and Justice Act 2009, while the cause of death must still be recorded, a shortened version of the death certificate which is intended to protect the deceased patient's medical history will be available to be used by the family for administrative purposes (Blightman et al., 2014).
2.4 Conceptual Review

From the literature, I have observed and agree that confidentiality and privacy, as such, is valuable. We value privacy because it signals respect for human dignity. In honoring privacy, we also honor human dignity and individual autonomy. Confidentiality is a rule that all health professionals are obligated to follow except under carefully prescribed circumstances: when a breach is required by law (reporting communicable diseases and crime-related injuries) or when a breach is necessary to protect an identifiable third person who is at risk.

The transparent presence and impact of confidentiality helps maintain trust between a patient and this enables an important relationship to develop which facilitates the delivery of the best healthcare. Confidentiality guidelines provide transparency which in turn empowers and reassures patients at the same time keeping them informed and able to make free choice on the use of information. This trusting relationship and use of feedback allow patients to have an active role in delivery of their healthcare and in the use of their personal information. This is essential to fulfill the requirement for constant improvement of guidelines and process improvements which rely upon patient responses. Whilst these principles must be enshrined within hospitals policy, the enactment of them is equally important. All areas of clinical practice; the private, independent, voluntary and educational sectors of the healthcare profession, should encompass these principles in their own governance documentation. More importantly is the individual responsibility of all health care providers to embrace these policies in their daily conduct. Hence a combination of the practice of confidentiality and privacy leads to trust in the health care system. Patients are confident in divulging every information needed, this will lead to healthcare providers making correct diagnosis, safe treatments, leading to improvement in healthcare quality.
2.4.1 Conceptual Framework

2.4.1.1 The Hippocratic Oath

“Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.”

Figure 2.1: Conceptual Framework of Patient confidentiality using the communication management theory

Source: Author’s Construct (2019)
2.5 Chapter Summary

Confidentiality is central to the preservation of trust between healthcare providers and their patients. The moral basis is consequentiality, in that it is to improve patient welfare. There is a wider communitarian public interest in the protection of confidences; thus, preservation of confidentiality is necessary to secure public health. Failure to maintain this venerable obligation may result in suboptimal treatment. For centuries, doctors have upheld this ethical principle underpinned by the Hippocratic Oath that has been updated by the international community assenting to the Declaration of Geneva.

However, medical confidentiality is not absolute in modern medicine. There are occasions when there is a need to breach this idealism. The legitimate exceptions are specified by the professional code of conduct and the standards of operations of the healthcare facility: hence

- Disclosures should be with patient consent;
- Disclosures should be required by law; and
- Disclosures should be in the public interest.

This notwithstanding, inadvertent breaches are potentially common, place on wards if medical notes are left visible or patient consultations are conducted in an open environment. The increased use of computerized documentation results in faster and wider distribution of information with an increased risk of unauthorized access. Unintentional breaches of patient information may occur when colleagues inadvertently overhear or view patient consultations, preoperative assessments are conducted in open environments. Data encryption email services must be used by both the sender and recipient if patient details are communicated in this manner to prevent unauthorized interception of messages. Confidential patient information maintained on personal computers must also be encrypted since password protection can be easily bypassed. Confidential
patient documents, including theatre lists, should be discarded by paper shredding, while electronic data shredding should be used when disposing of computer hardware. Photography and video forming part of patient records must be subject to strict control using only hospital trust equipment, obtaining consent for the recording and minimizing identification where possible. Images of internal organs, pathology slides, or radiographic images can be taken under the proviso of implicit consent for the investigation or treatment. Put simply, any information, written or electronic, which can identify a patient directly or indirectly, is subject to the duty of confidence.
CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This section of the study discusses the various processes and procedures that were engaged in collecting, entering and analysing empirical data. This section is divided into sub-sections namely: research approach and design, study area, population, sample size and sampling technique, data collection procedure, instrumentation, method of data analysis, ethical consideration in data collection and conclusion of the chapter.

3.1 Research Approach and Design

Based on the objectives of the study, a quantitative research approach was adopted. The emphasis of this study was to quantify the variables of the study by assigning numbers to perceived qualities of constructs adopted in the study (Babbie & Mouton, 2007). The study’s focus was to estimate the associations between constructs which were: knowledge level of confidentiality, current trends and breaches of confidentiality. In light of this, the study adopted the quantitative approach to collecting and analysing data which can be reduced into statistical representations. The purpose of this research approach enabled the use of questionnaires in collecting data from a large number of respondents for analysis. Additionally, Creswell (2014) upholds that quantitative research has two major advantages. First, if the data is rigorously and legitimately collected, it becomes more dependable to use for analysis and generalization. Secondly, it can be carried out and evaluated quickly as responses can be tabulated within the shortest possible time.
This study collected data from workers of Focos Orthopaedic Hospital in Ghana at a given time period. This survey design ensures that the data collected from the respondents were used to test the hypotheses of the study. Neuman (2011) suggests that this survey design is suitable for making generalisations from a sample to a population. It is also generally quick, easy, and cheap to conduct cross-sectional survey design (Sedgwich, 2014). Therefore the study adopted a cross-sectional survey design which is deemed appropriate in undertaking the study.

3.2 Study Area and Population

The study’s population and area covered Focos Orthopaedic Hospital Ghana Head office located in the Greater Accra Region of Ghana. Focos Orthopaedic Hospital in Ghana is among the most reputable Hospitals in the health sector. The choice of the Hospital was as a result of the fact that its employees are perceived to be among the best health service providers in the health sector in Ghana, responsible in ensuring efficiency and effectiveness of high quality healthcare delivery in the country. Also, Focos Orthopaedic Hospital in Ghana is perceived to contribute to the development of societies through its healthcare delivery.

The target population comprises healthcare providers at the Focos Orthopaedic Hospital in Ghana, with their head offices in Accra. Employees (health professionals) comprising upper, middle and lower level managers at Focos Orthopaedic Hospital in Ghana is perceived to have knowledge and experience of the patient confidentiality activities. The population is characterised by three levels of employees such as the senior level, middle level and lower level health professionals or healthcare providers. The numerical strength of permanent employees of Focos Orthopaedic Hospital in the Greater Accra region of Ghana is estimated to be about 292, excluding workers on a contract or part-
time basis, who are usually outsourced from other organisations to provide ancillary services to the Hospital.

3.3 Sample Size

Sekaran (2000) indicates that a sample is a subset of a study’s population that is chosen for a particular study using various techniques. Based on the estimated total population, the sample size (168) was determined based on and guided by Miller and Brewer (2003) sample size determination on the population of Focos Orthopaedic in Ghana head offices. The sample size for this study was 168 healthcare providers; based on the sample size proportion formula by Miller and Brewer (2003) given as:

\[ n = \frac{N}{1+N(\alpha^2)} \]

thus, \[ \frac{292}{1+292(0.05^2)} = 168.25 \]; hence 168 employees were sampled for the study.

Where \( n \)=sample size, \( N \)= Target population, and \( \alpha \)=error term.

Although the sample size constituted only a fraction of the total population, it is considered significant for the purpose of the study in the view of Baxter and Jack (2008). Again, considering the constraints of time, the sample size, to all intents and purposes would constitute a fair representation of the population under study.

3.4 Sampling Technique

The study employed two sampling techniques (purposive & convenience) in selecting the firms as well as the departments or work units and the participants in the data collection process. The purposive sampling technique is used to select the various work units such as wards, records, consulting units (Penneerselvam, 2010). The purposive sampling technique is appropriate because these selected departments can directly influence by patient confidentiality and responsible for
aiding or ensuring quality healthcare delivery at Focos Orthopaedic Hospital in Ghana to patients. The purpose of this study was to examine what influence healthcare providers’ inability to keep the confidentiality promise. Moreover, the convenience sampling technique was also employed to complement the purposive sampling technique in selecting health workers from the various work units during the data collection process (Babbie, 2008, Boateng, 2014). Convenience technique was suitable because employees are generally difficult to access because of their busy schedules.

3.5 Data Collection Procedure

Based on previous consultation and approval by the human resource manager of the Hospital, the researcher then proceeded to submit the required number of questionnaires to the various departments for the data collection. The questionnaires were delivered by hand to the various departments and potential respondents. After submission, several follow-ups were made to retrieve the filled questionnaires.

3.6 Study Instrumentation

The study used both structured and self-developed questionnaires in collecting data for the analysis. The independent variables, thus knowledge of confidentiality, current trends, and breaches of the confidentiality promise scales were self-developed by the researcher. The items were initially developed using a deductive approach for generating items based on the literature and guiding definition presented earlier in this study. For the dependent variable (patient confidentiality) is measured using an adopted scale developed by Thom et al. (1999) with Cronbach alpha value of 0.90.
3.7 Method of Data Analysis

In the present study, each questionnaire was given a code number for easy identification and fed into Statistical Package for Social Service (SPSS) Version 21. The results was analysed using simple descriptive statistics to describe the data, including frequencies, percentages and simple linear regression to be able to find answers to the research hypotheses. The relationships between independent variables and dependent variables were tested using correlation and simple linear regression.

3.8 Ethical Consideration

Participants were assured of the privacy of their information, thus their identities would not be revealed. The information provided by employees will be voluntary and they have the full authority to withdraw if they changed their mind about responding at any time in the course of the study. The respondents were also informed that the purpose of the study was purely academic and no information provided would be used against them. Moreover, they were assured that the information collected from all other departments taking part in the study would be combined for analysis. Therefore, information on individual work units would not be revealed in any form.

3.9 Profile of Focos Orthopaedic Hospital

Foundation of Orthopedics and Complex Spine (FOCOS) was established as a not –for- profit organization to provide comprehensive, Orthopaedic care to underserved populations throughout Africa. FOCOS Founder, Prof. Oheneba Boachie- Adjei, and teams of medical volunteers travel to West Africa, Ghana in particular, several times each year to evaluate patients and perform surgeries.
For years, FOCOS volunteers coordinated with local hospitals to provide services to patients, but constant barriers led to the development of a permanent facility of its own.

The Hospital is a project of the Foundation of Orthopedics and Complex Spine (FOCOS), a nonprofit organization established in 1998 by Prof. Oheneba Boachie-Adjei and as an auxiliary of the foundation. FOCOS Hospital is sustained by donations, sponsorships and revenue generated internally through its outpatient and surgical operations.

3.9.1 Vision

Until recently, most Ghanaians who have suffered from extreme orthopedic ailments and injuries have had to be flown abroad for quality medical care. FOCOS identified this trend and upgraded its facility from a clinic to that of a hospital. The Hospital’s mission is to provide comprehensive orthopedic services including diagnostic, imaging, laboratory, outpatient consultation, pharmacy and surgical care to adult and paediatric populations in Africa and our goals are focused around the needs of our patients, as we strive to deliver high quality health care efficiently and in a manner that meets the expectations of patients and their families. The Hospital is committed to providing medical care that is linked to a continuum of care to anyone, regardless of status and our patients benefit from the presence of on- site imaging, diagnostic and laboratory testing capabilities. Ultimately, FOCOS Hospital intends to be an independent, orthopedics and rehabilitation hospital with a charitable mission, providing free care to needy patients.

3.9.2 Mission

With its ultra-modern state of the art equipment and facilities, and well-trained, experienced medical staff, the quality of service provided by the FOCOS Orthopaedic Hospital is comparable to that of the advanced countries. Our 50-bed Hospital is situated at Pantang in Accra, the capital city
of Ghana, this 50 bed, state of the art center of excellence has been recognized as one of the most premiere of its kind in all of Africa and creating a standard for quality patient care.

3.9.3 Core Values

i. **High Level Expertise** - FOCOS over the years has cultivated a solid reputation regarding its expertise, skill and compassion. We employ world class medical professionals and other medical service providers and have an immense operation success rate on modern hip and knee replacements and complex spine surgeries. We also offer arthroscopic procedures, pain management and some trauma cases.

ii. **Modern Diagnostic System** - Since FOCOS is a specialist hospital, we have the advantage of knowing exactly how to diagnose and treat various conditions, whether complex or minor orthopaedic ailments, traumas or injuries.

iii. **Adoption of H.I.S** - Since IT is the backbone of every business, FOCOS has recently moved all aspects of its operations unto an ultra-modern IT platform called Hospital Information System (H.I.S). This is provided by Eastern Software Systems in New Delhi, India.

3.9.4 Services and Capabilities

The Hospital provides the following services: OPD services (general medicine, urgent care, minor procedures, trauma services, ambulatory services etc), specialist services and consultations (neurology, neurosurgery, orthopaedic surgery, rheumatology, epidural injections etc), surgical services include Orthopaedics (joints, knees & the hips as well as the pelvis, long bones, tibia and fibula) and Spine (cervical, thoracic, and lumbar), physiotherapy and rehabilitation (orthopaedic rehabilitation, neuromuscular rehabilitation, manual therapy, ergonomics, body mechanics and postural education) and other services.
3.10 Conclusion

This section of the study concentrated on the methods used to collect and analyse data for this study. The targeted population of the study was mainly Health Workers of FOCOS located in Accra. The purposive and convenience sampling techniques are used to sample the respondents from the targeted population. This section of the study also highlighted how data was analysed, using descriptive statistics, correlation and regression analysis to find the relation among the independent variables and the dependent variable (patient confidentiality). The next chapter discusses the findings of the data analysis in detail.
CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION

4.0 Introduction

This section of the study concentrates on the findings based on the data analysis. The presentation of results makes use of frequencies, percentages and linear regression estimates. The order of presentation in this section includes a background of data analysis, demographic profile of the respondents, correlation analysis and linear regression analysis to test the hypothesized relationships. The results of the study are subsequently discussed.

4.1 Background of the Analysis

The study initially chose a sample size of 168 respondents. However, 141 responses were used for the data analysis, giving a response rate of 84%. The 141 respondents used for the study were made up of employees (senior, middle & lower employees) of Focos Orthopaedic Hospital in Accra, Ghana. After the data had been entered into SPSS software and screened for missing values, the demographic characteristics of the respondents were analyzed, using frequencies and percentages. Correlation analysis was conducted to serve as basis for the regression analysis. The relationships between the independent variables (knowledge level, social media & breaches in confidentiality) and the dependent variable such as patience confidentiality were tested using linear regression through the use of SPSS (version 21) software.
4.2 Demographic Analysis

The demographic characteristics of respondents were represented in terms of their gender, age, relationship status, academic status, profession, work experience and current position at the workplace. The frequencies and corresponding percentages of these demographic variables are represented in Table 4.1:

The Table 4.1 shows that the majority of the respondents were females, representing 56% of the total sample size as against their male counterparts with 44%. This confirms the perception that the health sector is dominated by female health workers. The ages between 20 and 30 years dominated the total number of respondents with 94 representing 67%, while the ages between 31 and 40 years represented 28% of the total respondents. This indicates that a greater number of the respondents are youthful or young adults. Out of the 141 respondents who took part in the study, majority 55% of them are married as against 45% being single. It is observed that 57% of the respondents had first degrees and 23% possessed post-graduate degrees while the rest (21%) had diploma and secondary certificate respectively.

It is worth noting that majority (117) of the respondents signifying 83% of the respondents were nurses and the rest such as allied health, doctors and other health professionals represented 8% each. 67% of the respondents had worked with the organization between one and five years, while 15% of the respondents had worked for the organisation between six and ten years, 16% worked between 11 and 15 years, and only 10% of the respondents had worked the organization for 16 and above years. For the current positions of nurses, 52% of the respondents were nursing officers, 15% were senior nursing officers, 9% were health assistance, 4% were public health specialists, 3% and 2% were medical officers and surgeons respectively.
Table 4.1: Profile of Research Respondents

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Frequency</th>
<th>Percentages (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>62</td>
<td>44</td>
</tr>
<tr>
<td>Female</td>
<td>79</td>
<td>56</td>
</tr>
<tr>
<td><strong>2. Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30 years</td>
<td>94</td>
<td>66.7</td>
</tr>
<tr>
<td>31-40 years</td>
<td>39</td>
<td>27.7</td>
</tr>
<tr>
<td>41-50 years</td>
<td>8</td>
<td>5.7</td>
</tr>
<tr>
<td>51-above years</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>3. Relationship status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>64</td>
<td>45.4</td>
</tr>
<tr>
<td>Married</td>
<td>77</td>
<td>54.6</td>
</tr>
<tr>
<td><strong>4. Academic Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate</td>
<td>12</td>
<td>8.5</td>
</tr>
<tr>
<td>Diploma</td>
<td>17</td>
<td>12.1</td>
</tr>
<tr>
<td>Degree</td>
<td>80</td>
<td>56.7</td>
</tr>
<tr>
<td>Post graduate</td>
<td>32</td>
<td>22.7</td>
</tr>
<tr>
<td><strong>5. Profession</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>117</td>
<td>83</td>
</tr>
<tr>
<td>Allied Health</td>
<td>8</td>
<td>5.7</td>
</tr>
<tr>
<td>Doctor</td>
<td>8</td>
<td>5.7</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
<td>5.7</td>
</tr>
<tr>
<td><strong>6. Work Experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>94</td>
<td>66.6</td>
</tr>
<tr>
<td>6-10 years</td>
<td>21</td>
<td>14.8</td>
</tr>
<tr>
<td>11-15 years</td>
<td>16</td>
<td>11.3</td>
</tr>
<tr>
<td>16-above years</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td><strong>7. Current Position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Officer</td>
<td>74</td>
<td>52.4</td>
</tr>
<tr>
<td>Senior Nurse Officer</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>Public Health Specialist</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Health Assistant</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Surgeon</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Others</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>141</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Fieldwork 2019

It is also noted that 13% of the respondent belonged to other health related professions.
4.3 Correlation Analysis

A correlation test was performed to ascertain whether the variables in the study have any relationships. A correlation analysis was (linearity test) conducted using Pearson’s moment correlation analysis. Linearity is said to exist when one variable has a significant relationship with another variable. As a prerequisite to using simple linear regression, there must be a significant relationship between the independent variables and the dependent variables (Fields, 2009). For the purpose of this study, the independent variables were knowledge level of patient confidentiality, current trends (social media) and patient confidentiality breaches while the dependent variable was patient confidentiality. Table 4.2 presents the results of the correlation analysis.

Table 4.2: Summary of Correlation Analysis

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Gender</td>
<td>.10</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Rel. Status</td>
<td>.03</td>
<td>.06</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. KL</td>
<td>.02</td>
<td>.68*</td>
<td>.10</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. SM</td>
<td>-.02</td>
<td>.12</td>
<td>.18**</td>
<td>.16*</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. BP</td>
<td>.05</td>
<td>-.03</td>
<td>-.14*</td>
<td>-.17*</td>
<td>.30**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7. PC</td>
<td>.09</td>
<td>.14*</td>
<td>-.05</td>
<td>-.26**</td>
<td>.34**</td>
<td>.57**</td>
<td>1</td>
</tr>
</tbody>
</table>

Author’s Construct (2019) Note: 0.00 (**), 0.05 (*); KL= Knowledge Level, SM=Social Media, BP=Breaches in patient, PC= Patient confidentiality

The Table 4.2 indicates that significant relationships exist between the knowledge level of patient confidentiality issues and patient confidentiality practice itself (r=-.26, p< 0.01). It is also observed that a significant relationship exist between current trends such as social media and patient confidentiality.
confidentiality practice (r=.34, p<0.01). Furthermore, the correlation analysis identified a significant positive relationship between breaches in patient confidentiality and actual patient confidentiality (r=.57, p>0.01). Thus, it can be said that linearity exists between the independent variables and the dependent variable; thereby meeting the assumption for regression analysis as proposed by Fields (2009) and Green (1991). It is noted that these variables (knowledge level, social media and breaches in confidentiality) were all seen to have some significant relationships with some of the demographic variables such as gender and religious status.

It should be noted that, the independent variables (knowledge level, social media & breaches) employed in the study were tested for correlation to find out if it had any significant relationship with the dependent variable (patient confidentiality practice). At this stage of the analysis, one can establish that there is a positive relationship between the independent variables and the dependent variable. Even though, this correlation analysis serves as an important preliminary condition for conducting regression analysis, the results also show that, the dependent variable (patient confidentiality practice) is largely influenced by the independent variables (knowledge level, social media & breaches in confidentiality). Therefore, there was the need to include this correlation analysis to ascertain the relationships among the variables in this study for further analysis.

4.4 Analyses Based on Objectives and Hypotheses Testing

The study sought to test three major hypotheses based on the three research objectives indicated earlier in Chapter One. The first objective sought to determine the influence of the knowledge level of patient confidentiality on patient confidentiality practice among health workers of Focos Orthopaedic Hospital in Ghana. The second objective was to examine the effect of current trends such as social media on patient confidentiality practice among health workers. The third objective
sought to determine the relationship between breaches in confidentiality and patient confidentiality practice among health workers at Focos Orthopaedic Hospital in Ghana in Ghana. Each of these objectives had hypotheses developed and tested using simple linear regression.

4.4.1 Knowledge Level of Healthcare Providers on Confidentiality

The first objective had one main hypothesis which in turn developed into four sub hypotheses in order to achieve the set objective. This is so because knowledge level of health worker had four dimensions and each of the dimensions were independently considered. The first sub hypothesis stated that: there will be a significant positive influence of knowledge of public reporting on patient confidentiality. The second sub hypothesis stated that: there will be a significant positive relationship between knowledge of child maltreatment and patient confidentiality. The third hypothesis stated that: knowledge of criminally inflicted injuries significantly relates with patient confidentiality. The fourth also stated that: knowledge of patient threat to a third party significantly and positively predicts patient confidentiality. These hypothesis were tested using simple linear regression, with knowledge of public reporting, child maltreatment, criminally inflicted injuries and patient threats being the predictor and patient confidentiality being the outcome variable. Gender of the respondents was used as control variable since gender was found to be significant with overall patient confidentiality. The Table 4.4 displays the summary of the results of this analysis.

From the Table 4.3, the $R^2$ of .14 (14%) indicates that the overall regression model is statistically significant with the p-value of .000 which also indicates that the model was significant, thus showing a significant influence of the four independent variables on overall patient confidentiality ($p < 0.00$). Specifically, knowledge of public reporting significantly predicted patient confidentiality ($\beta = .36$, $p < .05$). The results indicated that child maltreatment also significantly predicted patient confidentiality ($\beta = .47$, $p < .05$). The equally proved that knowledge of patients threats positively
and significantly predicted patient confidentiality ($\beta = .30, p < .05$). However, knowledge of criminally inflicted injuries even though positive did not predict significantly predict patient confidentiality ($\beta = .27, p > .05$).

**Table 4.3: Summary of Regression Analysis of Knowledge level on Patient Confidentiality**

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardised Coefficients</th>
<th>Standardised Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\beta$</td>
<td>Std. Error</td>
</tr>
<tr>
<td>Constant</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gender</td>
<td>-.02</td>
<td>.04</td>
</tr>
<tr>
<td>CM</td>
<td>-.10</td>
<td>.04</td>
</tr>
<tr>
<td>CI</td>
<td>.05</td>
<td>.03</td>
</tr>
<tr>
<td>PT</td>
<td>.06</td>
<td>.02</td>
</tr>
<tr>
<td>PR</td>
<td>-.07</td>
<td>.02</td>
</tr>
</tbody>
</table>

*Author's Construct (2019); CM=child maltreatment, CI=criminally inflicted injuries, PT=patient threats, PR= public reporting; Note * Dependent Variable: Patient confidentiality, $R=.38 R^2=.14$, $F= 4.53$, $df (5, 135)$, $p< 0.01$.

Furthermore, the standardized beta value of .36 indicates that the influence of public reporting on patient confidentiality was positive. This means that, 36% of the variance among patient confidentiality of the respondents can be positively and significantly predicted by knowledge of public reporting statutes among health workers in Ghana. Similarly, the standardized beta value of .30 shows that the impact of knowledge of patient threats on patient confidentiality was positive. This further indicates that a percentage increase in the knowledge of patient threat to a third party will lead to a 30% increase in patient confidentiality. It is noted from the analysis that the standardized beta value of .47 indicates that the influence knowledge of child maltreatment on patient confidentiality was positive. This shows that 47% of the variance among patient confidentiality is influenced by the knowledge of child maltreatment issues in the hospital. The
findings also indicate that knowledge of criminally inflicted injuries do not necessarily predict patient confidentiality even though positive it shows positive relationship. Therefore, the sub hypothesis one, two and four except three were accepted. These findings imply that as health workers are getting aware of the confidentiality issues, it can increase patient confidentiality among health workers at Focos Orthopaedic hospital.

4.4.2 Current Trends in the Practice of Confidentiality

To measure the second objective, frequencies, percentages and linear regression analysis analyses was employed.

4.4.2.1 In-service Training and De-identification

The analysis of current trends in patient confidentiality practice established that health workers go through in-service training, patient de-identification and conference experience of de-identification. From the Table 4.4 indicates that 75% of the respondents see in-service training as one of the current trends in patient confidentiality. The result demonstrates that, 54% of the respondents recognized patient de-identification as a current trend as against 46% who do not recognize it patient de-identification as a current trend. Majority (74%) of the respondents expressed that they do not have conference experience of de-identification as a current trend in patient confidentiality.
Table 4.4: Summary of results showing Current Trends and Patient Confidentiality

<table>
<thead>
<tr>
<th>Current Trends</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-service training</td>
<td>106(75.2%)</td>
<td>35(24.8%)</td>
</tr>
<tr>
<td>Patient De-identification</td>
<td>65(46.1%)</td>
<td>76(53.9%)</td>
</tr>
<tr>
<td>Conference experience of De-identification</td>
<td>37(26.2%)</td>
<td>104(73.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>141</td>
<td>100</td>
</tr>
</tbody>
</table>

*Source: Fieldwork 2019*

4.4.2.2 Respondents’ Views on De-identification

Majority of respondents explain de-identification to mean a medium through which patient is known.

For instance,

*De-identification is the process used to prevent a person's identity from being connected with information. For example, data produced during human subject research might be de-identified to preserve research participants' privacy (Respondent 16).*

*Is the process used to prevent a patient or a person's identity from being connected with information or data. For example, data produced during human subject research might be de-identified to preserve research participant's privacy. It can be identifying patient by the use of patient information that makes him or her different from other patients eg. name, date of birth and hospital record number (Respondent 5).*

De-identification is also a means through which patients at the hospital are identified in a unique or coded way making it impossible for others to able to easily match the data with the person. For instance:

*Is the process used to prevent a person’s identity from being connected with information or preventing a patients’ identity to be linked to any information obtained. It is when a patients information, pertaining to his condition is discussed during a conference/case review but the identity of the patient is not revealed (Respondents 23 & 12).*
4.4.2.3 Patient Information and Confidentiality

From the results in Table 4.5, it shows the mode or form of collecting information from patient at the Focos Orthopaedic Hospital in Ghana. The results established that majority (59%) of the information of patient is collected through the electronic medical record. The results indicate that the hospital still uses the patient folder method (41%) of data collection. The rest of the forms of data collection procedures were not identified as practices used in the Hospital (Focos Orthopaedic).

Table 4.5: Summary of Results showing Forms of Data Collection

<table>
<thead>
<tr>
<th>Form of Data</th>
<th>No of Respondents</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Register</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Spread Sheets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Paper Tables</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Patient folder</td>
<td>58</td>
<td>41.1</td>
</tr>
<tr>
<td>Electronic Medical Record</td>
<td>83</td>
<td>58.9</td>
</tr>
<tr>
<td>Total</td>
<td>141</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Fieldwork 2019

4.4.2.4 How Patient Information is Stored

This section of the analysis demonstrates the how patients’ information is stored in the Hospital. The Table 4.6 shows that 71% of patients’ data is stored in the central saver used in the Hospital. The results also indicate that 16% of the data is stored in the file room while 12% of the data is stored in the cabinet.
Table 4.6: Summary of results showing How Patients Information is Stored

<table>
<thead>
<tr>
<th>Mode of Storage</th>
<th>No of Respondents</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cabinets</td>
<td>18</td>
<td>12.8</td>
</tr>
<tr>
<td>File room</td>
<td>23</td>
<td>16.3</td>
</tr>
<tr>
<td>Central Saver</td>
<td>100</td>
<td>70.9</td>
</tr>
<tr>
<td>Total</td>
<td>148</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Fieldwork 2019

4.4.2.4 Access to Medical Records

Respondents were asked to respond to the extent to which medical records are accessible.

Table 4.7: Summary of results showing Access to Medical Records

<table>
<thead>
<tr>
<th>Access to Medical Records</th>
<th>No of Respondents</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not easy at all</td>
<td>40</td>
<td>28.4</td>
</tr>
<tr>
<td>Not easy</td>
<td>50</td>
<td>35.5</td>
</tr>
<tr>
<td>Not certain</td>
<td>19</td>
<td>13.5</td>
</tr>
<tr>
<td>Easy</td>
<td>27</td>
<td>19.1</td>
</tr>
<tr>
<td>Very easy</td>
<td>5</td>
<td>3.5</td>
</tr>
<tr>
<td>Total</td>
<td>141</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Fieldwork 2019

The Table 4.7 indicates that 36% of the respondents noted that it is ‘not easy’ in accessing medical records and 28% of them indicated ‘not easy at all’ in accessing medical forms in the Hospital. This means that generally at Focos Orthopaedic Hospital, it is difficult accessing medical records. However, the results also exhibit that 19% of the respondents asserted that it is ‘easy’ and 4% asserted that it is very easy in accessing medical records at Focos ORthopaedic Hospital in Ghana.
4.4.2.5 Social Media and Patient Confidentiality

To achieve the second objective, the second hypothesis was set which stated that: *social media will have a significant positive influence on patient confidentiality among health workers.* This hypothesis was tested using simple linear regression where social media being the predictor and patient confidentiality being the outcome variable. Gender and age were used as control variables but none could significantly correlate well with the dependent variable.

**Table 4.8: Summary of Regression Analysis of Social Media on Patient Confidentiality**

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardised Coefficients</th>
<th>Standardised Coefficients</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>Std. Error</td>
<td>β</td>
<td>T</td>
<td>Sig. (P)</td>
</tr>
<tr>
<td>Constant</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Age</td>
<td>-.06</td>
<td>.03</td>
<td>-.18</td>
<td>-1.96</td>
<td>.053</td>
</tr>
<tr>
<td>Gender</td>
<td>.04</td>
<td>.04</td>
<td>.09</td>
<td>1.02</td>
<td>.309</td>
</tr>
<tr>
<td>Social Media</td>
<td>-.32</td>
<td>.09</td>
<td>-.32</td>
<td>-3.57</td>
<td>.001</td>
</tr>
</tbody>
</table>

*Author’s Construct (2019) Note* Dependent Variable: Patient confidentiality, $R=0.38$, $R^2 = 0.15$, $F=6.31$, df $(3, 110)$, $p< 0.01$, SM=Social Media

The results of the regression analysis presented in Table 4.8 which indicates that an $R^2$ of .15 (15%) of the model. Thus the model can be said to be statistically fit. The p value of the model was also seen to be less than .000 indicating statistical significance. With regard to the variables, social media was seen to have a negative influence on patient confidentiality (-.32); this influence was found to be significant ($p < 0.01$). Thus, hypothesis two was not accepted. This finding suggests that social media does support patient confidentiality negatively thus increase in social media activities lead to a decrease in patient confidentiality.
4.4.3 Breaches in Patients Confidentiality

The third objective was measured through the third hypothesis which stated that: *Breaches in patient confidentiality will significantly reduce the promise of patient confidentiality among healthcare workers.* This hypothesis was similarly tested using simple linear regression where breaches was the predictor and promise of patient confidentiality being the outcome variable. Gender and age of respondents were used as the control variable since they are perceived to have a significant influence on the dependent variable (Patient confidentiality). The summary of the results are presented in Table 4.6.

**Table 4.6: Summary of Regression Analysis of Breaches and Patient Confidentiality**

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardised Coefficients</th>
<th>Standardised Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( \beta )</td>
<td>Std. Error</td>
</tr>
<tr>
<td>Constant</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Age</td>
<td>-.07</td>
<td>.03</td>
</tr>
<tr>
<td>Gender</td>
<td>.01</td>
<td>.04</td>
</tr>
<tr>
<td>Breaches in Confid</td>
<td>.03</td>
<td>.04</td>
</tr>
</tbody>
</table>

*Author’s Construct (2019) Note* Dependent Variable: Patient Confidentiality, \( R = .23 \) \( R^2 = .05 \), \( F = 2.62, df (3, 137), p > 0.05. BP= Breaches of patient confidentiality*

From Table 4.5, the \( R^2 \) of .05 (5%) indicates that the regression model is not statistically fit and the p-value indicates that the model was not statistically significant, thus showing an insignificant influence of breaches in confidentiality on patient confidentiality (\( p > 0.05 \)). Furthermore, the beta value of .08 indicates that the influence of breaches in confidentiality on patient confidentiality was insignificant even though positive. Additionally, the beta value also indicates that an insignificant 8% of the variance on patient confidentiality among healthcare providers can be positive and insignificantly predicted by breaches in confidentiality. Hence, breaches in confidentiality do not
necessarily impact patient confidentiality thus confirming the hypothesis. Therefore, hypothesis three was accepted. This finding implies that breaches in confidentiality can impede patient confidentiality which has to do with trust between two parties.

4.5 Discussions of Findings

The discussions of the findings are based on the research objectives as mentioned in Chapter One. The first objective sought to assess the knowledge level of healthcare providers on confidentiality. The second objective also sought to study the current trends in the practice of confidentiality. Finally, the third objective sought to find out the circumstances healthcare providers may be constrained in keeping the confidentiality promise at Focos Orthopaedic Hospital. Simple linear regression analysis, frequencies and percentages were employed in the data analyses.

4.5.1 Objective One: Knowledge of Patient Confidentiality

The first objective which sought to assess the knowledge level of healthcare providers on confidentiality was measured using four different hypotheses. Specifically, knowledge of public reporting significantly predicted patient confidentiality. This means that public reporting of statutes of patients regarding births and deaths, contagious diseases, child neglect and abuse, criminally inflicted injuries, mentally retarded patients among other do not affect patient confidentiality negatively. This also means that healthcare providers still maintain high level of confidentiality in the midst of public reporting statutes. These results confirm the assertion of the Disease Control Act (1982) that Doctors are required to be honest and full in their disclosure. If a serious communicable disease has contributed to a patient's death, this must be recorded on the death certificate. Information relating to serious communicable disease should be passed on to the relevant authorities, while preferably maintaining anonymity to improve control and maintain surveillance.
The results indicate that child maltreatment also significantly predicted patient confidentiality. This means that healthcare providers protecting the interest of maltreated children positively affect patient confidentiality. In order words, reporting physical, sexual, emotional and psychological abuses of children help improve patient confidentiality at the Focos Orthopaedic Hospital. The equally proved that knowledge of patients threats positively and significantly predicted patient confidentiality. The result means that providing information on patients with certain diseases that could pose threat to others help build an overall patient confidentiality. Providing information on behaviours such as bipolar disorder, genetic diseases and communicable diseases is very helpful in maintaining confidentiality between healthcare providers and patients. These findings support the view that incorrect or misleading information must not be given to the police in their investigation. According to Blightman et al. (2014) a judge can penalize a doctor for contempt of court for failure to assist with the provision of necessary information.

However, knowledge of criminally inflicted injuries even though positive did not significantly predict patient confidentiality. Thus reporting the occurrence of gunshot wounds and drunk driving have a positive relationship with patient confidentiality but is not significant enough to draw conclusions that reporting criminally inflicted injuries influences patient confidentiality. This supports the idea that disclosure is demanded when national security is at risk. As defined by the Prevention of Terrorism Act 2005, it is a duty of the healthcare provider to report suspicion of terrorist activity. Likewise, the Terrorism Act 2006 requests healthcare professionals to inform police of any information that may help prevent an act of terrorism, or assist in apprehending or prosecuting a terrorist.

In general, the knowledge level of the healthcare provider concerning public reporting statutes, child maltreatment, criminally inflicted injuries and patients who poses threats to others rather enhance
patient confidentiality positively. These findings support the assertion that the rights to perceived confidentiality may be abrogated if they "infringe in a material way upon the safety of another person or persons (Dickson, 2017; Johnstone 2004). Jackson et al. (2011) are of the view that confidentiality is not always directly connected to patient information and there are other ways that confidentiality is applied in the health environment. For example, confidentiality can be used to protect healthcare providers and organizations from public scrutiny, and this may mean the intentional withholding of information to protect either the interests of individuals or the organization itself (Jackson et al., 2011).

4.5.2 Objective Two: Current Trends in Patient Confidentiality

The second objective which sought to study the current trends in the practice of confidentiality was measured through frequencies, percentages and simple linear regression. The results revealed that the current trends in the practice of confidentiality consider in-service training in keeping confidentiality as important. Majority of healthcare providers have knowledge about patient de-identification but not from conferences. The sure ways of collecting and keeping data are through the use of electronic medical records system and central saver respectively. This finding support Sulmasy (2017) view that in modern healthcare, technologies that aid the delivery of care are ubiquitous. Electronic Health Records (EHR) system has demonstrated value in features such as legible information, accurate prescriptions, remote access to information, and prevention reminders. Many patients use portals to check information and communicate with their health care providers. Instant retrieval and information exchange through EHRs improve care and productivity a great deal, (Groves et al., 2016). The results noted that it is generally not easy to access medical records at the Focos Orthopaedic Hospital in Ghana. Again, electronic medical records (EMRs) facilitate increase in the accessibility and sharing of health records among authorized individuals. Yet it brings a
concomitant concern of greater risk for loss of privacy among health care participants (Hargittai et al 2016). Murphy (2017) also attest that privacy of information collected during health care processes is necessary because of significant economic, psychologic, and social harm that can come to individuals when personal health information is disclosed.

The results established that social media does support patient confidentiality negatively thus increase in social media activities lead to a decrease in patient confidentiality. This finding supports the idea that (McLeod, 2018) innovations (such as social media) are double-edged sword which brings both opportunities and risks. Ethical issues related to confidentiality confront health personnel; the risk of unauthorized use, access, and disclosure of private patient information, raising confidentiality and privacy concerns. When patient's health data are shared or linked without the patients' knowledge, autonomy is jeopardized. Respect for patient autonomy requires that patient encounters and information is kept confidential and private, fostering trust and improving communication (Sulmasy et al., 2018).

4.5.3 Objective Three: Breaches of Patient Confidentiality

The third objective which sought to find out the circumstances healthcare providers may be constrained in keeping the confidentiality promise at Focos Orthopaedic Hospital was measured using linear regression. The results indicate implies that circumstances healthcare providers may be constrained in keeping the confidentiality promise (breaches) in confidentiality can impede patient confidentiality which has to do with trust between two parties. This finding confirms the assertion by Blightman (2014) that inadvertent breaches are potentially common. When medical notes are left visible or patient consultations and preoperative assessments are conducted in an open environment. The increased use of computerized documentation results in faster and wider distribution of information with an increased risk of unauthorized access. Also, unintentional breaches of patient
information may occur when e-mailing colleagues. Data encryption e-mail services must therefore be used by both the sender and recipient if patient details are communicated in this manner to prevent unauthorized interception of messages (Blightman 2014).
CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This section of the study presents a summary of the study by indicating the key findings and providing adequate conclusions as well as proposing appropriate recommendations for practice and research.

5.1 Summary

The purpose of the study was to assess the impact of knowledge level of healthcare providers concerning patient confidentiality, the current trends in keeping the confidentiality of patients and assessing circumstances healthcare workers may be constrained from keeping the confidentiality promise. The study sought to achieve its purpose by adopting quantitative approach with the cross-sectional explanatory design to gather data through a survey questionnaire using 141 respondents. The respondents included healthcare providers (nurses, medical officers, health specialists and surgeons) of Focos Orthopaedic Hospital Ghana. The data was analysed using correlation and simple linear regression via the application of SPSS. The summarized results of the study are presented based on the objectives of the study.

5.1.1 Objective One: Knowledge Level in Confidentiality

The results show that knowledge of public reporting significantly predicted patient confidentiality. Also, the results indicated that reporting child maltreatment also significantly predicted patient confidentiality. The results equally proved that knowledge of patients’ threats to third parties...
positively and significantly predicted patient confidentiality. These results demonstrate the
total level of healthcare providers in reporting sensitive issues while maintaining anonymity
significantly enhances patient confidentiality. Again, knowledge of criminally inflicted injuries even
though positive did not predict significantly predict patient confidentiality.

5.1.2 Objective Two: Current Trends
The results revealed that the current trends in the practice of confidentiality consider in-service
training in keeping confidentiality as important. Majority of healthcare providers have knowledge
about patient de-identification but not from conferences. The sure ways of collecting and keeping
data are through the use of electronic medical records system and central saver respectively. It is
generally not easy to access medical records at the Focos Orthopaedic Hospital in Ghana. The
finding suggests that social media does support patient confidentiality negatively thus increase in
social media activities lead to a decrease in patient confidentiality.

5.1.3 Objective Three: Breaches of Confidentiality
The results implies that circumstances may constrain healthcare providers from keeping the
confidentiality promise (breaches) and this can impede patient confidentiality which has to do with
trust between two parties.

5.2 Conclusion
To assess under what circumstances healthcare workers may be constrained from keeping the
confidentiality promise is technically complex, politically uncertain and scientifically ill-defined to
address multiple patients’ needs. This is because patients’ confidentiality provides diverse
perspectives which are yet to meet thorough academic examination. This study has contributed
largely to this on-going debate in how to keep patient confidentiality. The study concludes that reporting sensitive issues about patient actually help in enhancing confidentiality. Again, the study concludes based on the findings that social media does not help in keeping patient confidentiality promise and care should be taken in breaching the confidentiality promise as this impacts patient negatively. Overall, even though there is the need to keep the confidentiality promise, sensitive circumstances demand reporting the situation which may be beneficial to both the patient and others.

5.3 Recommendations

The recommendations of the study are based on the following:

5.3.1 Recommendation for Practice and Policy

First and foremost, the findings indicate that reporting sensitive issues concerning patient are helpful in the confidentiality promise. Therefore, the Focos Orthopaedic Hospital should encourage healthcare providers to report sensitive issues such as contagious or infectious disease while keeping the anonymity of the patient. This reporting behavior will help the Hospital keep track of spreading certain diseases, educate others to take precautionary measures and inform future decisions regarding healthcare delivery.

The study recommends that a full electronic health record system should be adopted in the Hospital. This will help the healthcare providers to keep full track of patients’ confidential information with encryptions. The electronic health record system also helps facilitate the processes in the Hospital and enhances efficient healthcare delivery.

The study recommends that healthcare providers should be educated on the use of social media and how social media should not interfere in their quest to keeping the confidentiality promise.
The study recommends that in breaching patient confidentiality, the situation must be well examined in order not jeopardized the patient. A breach of confidentiality may be required during sensitive situations which are determined by the healthcare providers (workers).

**5.3.2 Recommendation for Future Studies**

Future studies could replicate this study to examine the influences of knowledge of confidentiality and social media on patient confidentiality in other Hospitals. Also, this study was done using one Hospital within the Greater region in Ghana thus, future studies could extend this study to other Hospital and even compare public and private Hospitals. Furthermore, this study employed the quantitative method; future studies could employ other methods to unearth the underlying reasons for the findings in this study and also to reveal where the study falls short with regard to the variables used.

**5.4 Limitations of the Study**

As a result of the quantitative approach that was adopted, the underlying causes and reasons for the findings in this study were not revealed. Also, the generalisability of the findings to other Hospitals may be limited since the study concentrated on a single hospital with a sample that is not representative of the entire health sector of Ghana. These notwithstanding, the findings of this study are credible and the information provided is very useful.
REFERENCES


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American Medical Association (2016). AMA Principles of Medical Ethics: IV, VIII.


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APPENDICES

Appendix A: Questionnaire.

Demographic Data:

1. Age:
   - 20 - 30 [ ]
   - 31 - 40 [ ]
   - 41 - 50 [ ]
   - 51 - 60 [ ]

2. Gender:
   - Female [ ]
   - Male [ ]

3. Relationship status:
   - Single [ ]
   - Married [ ]
   - Divorced [ ]

4. Which of the following reflects your educational status?
   - Certificate [ ]
   - Diploma [ ]
   - Degree [ ]
   - Post graduate [ ]

5. What is your Profession:
   - Nurse [ ]
   - Allied health [ ]
   - Doctor [ ]
   - others, please specify ………………….

6. How long have you practiced or worked for in your profession? ……………………………

7. What is your current position or designation? ……………………………

Construct 1: Knowledge level

As a health practitioner, you are required by the ethics of your profession to provide patient information under the following: **Public Reporting Statues, Child Maltreatment, Criminally Inflicted Injuries and Patient Possess a Threat to a Third Party.** Please select or tick your perspective on the following statements using the ratings below

### Public Reporting Statutes

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td><strong>I will report patients’ Vital statistics</strong> [birth and death</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>certificates] as it occurs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>**I will report the occurrence of Contagious and dangerous</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>diseases [including AIDS].</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>**I will report the occurrence of Child neglect and abuse.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>**I will report the occurrence of Criminally inflicted injuries.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>**I will provide information on Mentally retarded patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>**I will provide information on Unconscious patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Judicial proceeding or court subpoena.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Child Maltreatment

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td><strong>I will report the occurrence of physical abuse.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>I will report the occurrence of sexual abuse.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>**I will report the occurrence of emotional and psychological</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>abuse.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>I will report the occurrence of neglect.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Criminally Inflicted Injuries

---

**University of Ghana** [http://ugspace.ug.edu.gh]
<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>I will report the occurrence of gunshot wounds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>I will report the occurrence of RTAs from drunk driving.</td>
<td></td>
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</tr>
<tr>
<td><strong>11</strong></td>
<td><strong>Patient Possess a Threat to a Third Party</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>A</strong></td>
<td>I will provide information on patients with Bipolar disorder.</td>
<td></td>
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</tr>
<tr>
<td><strong>B</strong></td>
<td>I will provide information on patients with Genetic diseases.</td>
<td></td>
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<tr>
<td><strong>C</strong></td>
<td>I will provide information on patients with communicable diseases.</td>
<td></td>
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<tr>
<td><strong>12</strong></td>
<td><strong>Statutes on cost and quality control (peer review organizations, utilization review)</strong></td>
<td></td>
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<tr>
<td><strong>A</strong></td>
<td>I will provide information regarding patient care during internal auditing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>I will provide information regarding patient care during external auditing.</td>
<td></td>
<td></td>
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<tr>
<td><strong>C</strong></td>
<td>I will provide information regarding patient care during quality assurance reviews.</td>
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</tbody>
</table>

**Construct 2: Current trends in the practice of patient confidentiality.**

13. Have you received any form of in-service training on how to maintain patient confidentiality?
   Yes [ ]  No [ ]

14. Which tools do you use to collect patient data?
   Register [ ]  Spread sheets [ ]  Paper tables [ ]
Patient confidentiality and social media.

The definition of “social media” is broad and constantly evolving. The term generally refers to Internet-based tools that allow individuals and communities to gather and communicate; to share information, ideas, personal messages, images, and other content; and, in some cases, to collaborate with other users in real time.

This section seeks to find out how social media affects patient confidentiality. Please answer YES or NO to the following statements.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>21  Have you ever goggled your patient?</td>
<td></td>
<td></td>
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<tr>
<td>22  Did the results influence the care you provided them in any way?</td>
<td></td>
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<tr>
<td>23  Have you ever posted information about a patient or person from your workplace on Facebook?</td>
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<tr>
<td>24  Has any of the staff you work with ever shared information about a patient or person in your care on Facebook or what sup?</td>
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<tr>
<td>No.</td>
<td>Question</td>
<td>Rating</td>
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<tr>
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<tr>
<td>25</td>
<td>Have you ever added patients as friends on Facebook or Myspace?</td>
<td></td>
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<tr>
<td>26</td>
<td>If you answered yes to question 6, have you ever discussed with the patient lab results, feedback on treatment or scheduling of appointment over Facebook or what sup?</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Have you ever added people from your workplace as friends?</td>
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<tr>
<td>28</td>
<td>Have you ever made a public comment online that could be traced back to a patient or your workplace?</td>
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<tr>
<td>29</td>
<td>Have you ever put up photos or videos of yourself and your patients online?</td>
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<tr>
<td>30</td>
<td>Have you ever taken pictures with patients which the patients put online and tagged you in?</td>
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<tr>
<td>31</td>
<td>Have you ever felt that friends have posted information online that may result in negative consequences for them?</td>
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<tr>
<td>32</td>
<td>If you answered yes to question 11, did you let them know?</td>
<td></td>
</tr>
</tbody>
</table>

**Construct 3: Breaches in Patient Confidentiality.**

The following statements represents some circumstances under which the healthcare personnel may not be able to keep the promise of confidentiality.

Please select or tick one of the ratings below as a reflection of your view.

1. **Strongly disagree**  2. **Disagree**  3. **Neutral**  4. **Agree**  5. **Strongly agree**

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>The knowledge of the patient’s prognosis and diagnosis would remain between my patient and me.</td>
<td>1</td>
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</tbody>
</table>

65
I would attempt to persuade the patient to inform any partners who might be infected.

The diagnosis but not the name, would be reported to the health department.

The name of the person and the diagnosis would be reported to the health department.

If the person would not inform any partners who might be infected, I would attempt to do so if the person identified them.

**Patient Confidentiality** (Five point response scale: 1, totally disagree; 2, disagree; 3, neutral; 4, agree; and 5, totally)

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<tbody>
<tr>
<td>38</td>
<td>I doubt that I really care about my patient (R).</td>
<td></td>
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<tr>
<td>39</td>
<td>I am usually considerate of my patients needs and put them first.</td>
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<tr>
<td>40</td>
<td>I trust my patient so much I always try to protect his/her interest.</td>
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<tr>
<td>41</td>
<td>If my patient tells me something is so, then it must be true</td>
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<tr>
<td>42</td>
<td>I sometimes distrust my patient's opinions and would like a second one (R)</td>
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<tr>
<td>43</td>
<td>I trust my patient's judgments about my medical care</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>44</td>
<td>I trust my patient to put his/her medical needs above all other considerations when treating his/her medical problems</td>
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<tr>
<td>45</td>
<td>I trust my patient to tell me if a mistake was made about my treatment</td>
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<tr>
<td>46</td>
<td>I sometimes worry that I may not keep the information we discuss totally private (R).</td>
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</tbody>
</table>
R = reverse scored items