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## The challenges of maintaining patient confidentiality in pediatric settings

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## ABSTRACT

**Purpose:** The study investigated challenges encountered by healthcare professionals in complying with the duty of confidentiality in a pediatric department.

**Design and methods:** In this qualitative study, we conducted two focus group interviews with healthcare professionals from two pediatric departments in Denmark using the methodology described by Kvale and Brinkmann. **Results:** We identified three challenges related to maintaining confidentiality. 1) Time pressure and physical surroundings in the clinical setting. 2) Communication challenges (where and with whom). 3) Navigation in the clinical setting to uphold privacy. In general, nurses and physicians struggle to maintain patient confidentiality in a setting where sensitive information is shared quickly.

**Conclusion:** Pediatric nurses and physicians experience challenges related to patient confidentiality that impact their clinical practice. These challenges relate to privacy and dignity and communicating with children and their parents.

**Practice implications:** Building design or renovation of pediatric departments should underpin confidentiality and privacy issues. Our study makes an important and novel contribution to existing knowledge regarding healthcare professionals' experiences in maintaining patient privacy and confidentiality.

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## Background

Respect for confidentiality and privacy is a priority for all healthcare professionals caring for hospitalized children and young people (CYP) (Ceylan & Çetinkaya, 2020). Professionals receive much information about their patient in the interest of ensuring targeted high-quality care; such information is often very private in nature and must therefore be carefully handled to ensure that it is not passed on to outsiders (Ceylan & Çetinkaya, 2020; Noiseux et al., 2019). Unfortunately, this confidentiality is frequently breached in different ways (Beltran-Aroca et al., 2016; Hartigan et al., 2018; Kerr et al., 2014; Koivula-Tynnila et al., 2018), for example due to indiscretion or carelessness when speaking about a patient on the phone or in a public area (Beltran-Aroca et al., 2016). The physical hospital environment has also been identified as an issue that may compromise patient confidentiality as it can be difficult to ensure confidentiality during rounds in multi-patient rooms (Kerr et al., 2014). The consequences of such breaches of confidentiality include patients withholding information about

themselves or being embarrassed when they hear things about others (Koivula-Tynnila et al., 2018). Furthermore, avoiding such breaches can be particularly challenging when working with CYP and their parents. CYP are typically accompanied by at least one of their parents on admission to hospital which exacerbates the risk of overhearing sensitive information about others in the same room during rounds and procedures (Curtis & Northcott, 2017). Although guidelines for adolescent-friendly quality care recommend that inpatient settings should ensure private time for young people (aged 15–24 years) with health care professionals in the absence of family members (Sawyer et al., 2014), young people have reported that information about their condition is sometimes shared with their parents without their consent (Jensen & Eg, 2022).

Studies on the subject of confidentiality in healthcare are few and hardly any research has been devoted to the study of confidentiality in the pediatric setting. We therefore seek to fill gap by conducting a study identifying and describing situations in a pediatric setting where healthcare professionals find it difficult to safeguard patients' confidentiality, thereby hoping to underscore the importance of maintaining confidentiality and introducing hospital management to the best ways and means of maintaining information confidentiality ethically and professionally.

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## Purpose

The study aimed to investigate the challenges encountered by healthcare professionals in complying with the duty of confidentiality in a pediatric department.

## Design

To understand health professionals' experiences in a pediatric department in relation to their duty of confidentiality, we chose a qualitative design. As described by Halkier (2016), focus group interviews with a high degree of interaction between interviewees are appropriate for this purpose. The interviews were conducted with healthcare professionals employed in two pediatric departments in Denmark.

We analyzed the interview data using the methodology described by Kvale and Brinkmann (2014), focusing on the hermeneutic interpretation of meaning in a process comprising three elements: meaning coding, meaning condensation, and meaning interpretation.

## Planning of focus group interviews

### Recruitment and consent

Nurses and doctors from the two pediatric departments were invited to participate in the study. Management in both departments granted permission to conduct the investigation and sent emails to relevant professionals, inviting them to sign up. Any professional who expressed an interest in participating received a written invitation letter and information about the study.

### Structure of the focus group interviews

As the study was exploratory in nature, we developed a loosely structured interview guide as recommended by Halkier, beginning with a few broad open-ended questions (Halkier, 2016).

Each author moderated the focus group interview in the department where they worked, while the other author acted as an observer.

Based on topics that emerged from a systematic search of the relevant literature to identify key issues, we prepared an interview guide, which included the following questions.

- Can you give examples of situations where you have encountered challenges related to confidentiality?
- Can you describe any situations where you experienced a breach of confidentiality that did not necessarily involve you?
- Do you know how to behave with regard to the duty of confidentiality?

## Participants

The participating pediatric departments were located at two regional hospitals: one in the Central Denmark Region (population 1.321 million) and the other in the Capital Region (population 1.843 million). The pediatric department at the hospital in the Central Region has approx. 13,000 annual outpatient clinic visits and approx. 5000 annual admissions and treats patients from new-borns to 18 years of age. It has a pediatric ward capacity of 31 beds. The pediatric department in the Capital Region has approx. 26,600 annual outpatient clinic visits and approx. 12,000 annual admissions and also treats patients from new-borns to 18 years of age. It has a ward capacity of 76 beds. The department in the Capital Region treated young people up to 18 years and the department in Central Denmark was about to begin to offering treatment to children aged 15 to 18 years shortly after the focus groups.

As the goal of this study was to explore healthcare professionals' experiences of preserving patient confidentiality, the selected participants reflected the department's disciplinary mix and included both recent graduates and experienced professionals. Inclusion criteria: Health professionals with clinical experience from the two participating departments. Exclusion criteria: Participants had to be able to understand and speak Danish.

Focus group 1 included two doctors and eight nurses ranging in experience from 2 to 22 years, with an average of 9 years in paediatrics. Focus group 2 included five nurses ranging in experience from 6 months to 31 years, again with an average of 9 years in paediatrics. Both focus groups included a mix of nurses and doctors working in pediatric emergency and assessment units, in-patient pediatric departments, neonatal units, and outpatient clinics.

## Focus group interviews

The two focus group interviews were conducted in the autumn of 2018 in meeting rooms at each of the two departments. The focus group interviews had a length of 45 min to 1 h each and were planned in safe environment, where we created a relaxed atmosphere. Both interviews were recorded and transcribed.

## Analysis of focus group interviews

First, we read the interview transcripts several times to obtain an initial understanding of the contents. The process continued to distill condensed meaning units and construct themes and sub-themes (meaning condensation). The final phase (meaning interpretation) involved exhaustive interpretation of the findings, adding a hermeneutic layer to the original text to clarify the meanings embedded in the participants' statements. According to Kvale and Brinkmann (2014), the interpretive context can be described in terms of three levels: self-understanding, critical common-sense understanding, and theoretical understanding. To ensure interpretive validity and transparency, both researchers read the entire body of interview material and contributed actively to the analysis.

## Ethical considerations

Under Danish law, interview and/or questionnaire studies require no ethical approval from a science ethics committees. However, as the study addressed a sensitive topic, ethical principles were carefully applied. We followed the principles described in the Helsinki Declaration (World Medical Association Inc, 2009) which specify that participants should receive information about a study's purpose, method, and voluntariness. They were informed that their anonymity would be guaranteed and of their right to withdraw from the study at any time without any consequences. The interviews were conducted in a safe environment, and participants were informed that what emerged from the interviews would remain confidential and that their views would be received with respect and humility. In addition to the oral information provided before recruitment, the participants also received relevant written material. Before commencing, informed consent was obtained from all participants.

According to Executive Order no. 1083 of 15 September 2017 on the Executive Order on the Act on Ethical Treatment of Health Science Research Projects, this project need not be notified to the Science Ethics Committees for the Central Denmark Region, as it falls under the category of interview and/or questionnaire.

## Findings

Pediatric nurses and physicians encounter challenges related to patient confidentiality in a setting where information about illness

can be sensitive. Based on the participating professionals' accounts, we identified three themes that captured those challenges.

### Themes:

- Physical surroundings and time pressure in the clinical setting.
- Communication challenges (where and with whom).
- Navigation of the clinical setting to ensure privacy.

### Physical surroundings and time pressure in the clinical setting

#### Physical surroundings

In both departments, healthcare professionals expressed concern over the impact of the physical surroundings on their efforts to preserve work-related confidentiality. Even with screens between patients, everyone in the room could hear the conversation. *"They all come in with massive individual issues. They sit in a corridor separated by a cardboard screen and have to pour their heart out. They also have to state their social security number. I truly believe it is transgressive for them to sit out there"* (H2).

This problem arose because multiple patients and parents were placed in the same room or corridor. Moreover, parents and children could also hear what went on in the office. *"...Our office is placed right where everyone sits and waits... they can hear a lot that they shouldn't hear"* (V3). Consequently, confidentiality was broken as parents and children could not avoid overhearing information about other patients when placed directly outside the office. Participants were aware of the problem but did not know how to solve it given the physical environment.

Participants also stated that this physical proximity between people could affect questions they asked or their comments on issues like test results. According to one participant, *"[when] a child or young person has gained weight or is not a very good blower [in lung functionality tests], or if ... the child or young person smells like smoke, it can be hard to talk about it while there are others in the room"* (H1). Participants described this as a major challenge; as one said, *"It would be better... if you could do this inside [the room]"* (H1). Instead, professionals had to wait to comment or ask relevant questions.

Several participants also explained that it could be difficult to resume conversations naturally when they finally got a private room. One physician described how she sometimes avoided specific questions when recording the journal because she could not bring herself to talk about sensitive topics while others were in the room: *"There are just some situations where you have to ask something very personal; you don't ask a 14-year-old girl with a stomach ache if she is sexually debuted, as we obviously can't ask everyone to leave the room first. This means we might miss important information needed to make a diagnosis"* (V10).

When patients were assigned to multi-bed rooms, a nurse or physician who was caring for one patient might be summoned by another as only a curtain separated them. A nurse described one such interruption: *"... Hey [name of the nurse], when you're finished, can you come over here?"* The nurse was unsure whether she should answer, as she was technically with another patient: *"... I was like ...umm, do I answer now ... I'm over here right now..."* (H5). According to the same participant, nurses sometimes sensed that other parents were listening; for example, they sometimes interrupted to ask *"Can you bring some for me too?"* or they would say *"that thing about the different types of formula, and what they do, you didn't tell us..."* This caused nurses to think *"... oh were you listening too, I wasn't aware of that"* (H5).

These and other comments suggest that the physical surroundings in these pediatric settings make the healthcare professionals' work more difficult.

#### Time pressure

Participants also noted that it could be difficult to preserve patient confidentiality because the clinics were so busy; for example,

*"... if you have a conversation on the way to where you need to be—because ... the faster we get it done, the faster we can move on to the next—there is a possibility that you'll walk past someone who then hears [something they] shouldn't have heard..."* (H3). Another participant explained that when the unit or department was busy or an acute situation arose, *"...then we forget all about [confidentiality]... it's almost yelled from one end to the other"* (H4). For example, when another child in the room became acutely ill, many things would happen at once; the room would suddenly become very crowded, and everyone would be working quickly, sometimes at the expense of confidentiality. Participants said that this really challenged them as they had to say more than they would want others to hear, and it was not always possible to get everyone else out of the room: *"It's very hard when a child in a multi-bed room collapses.....it becomes very intense [and] you obviously don't have time to get others out of the room"* (V6). Difficulties might also arise when a child had to be moved to a different room; for instance, other families in the same room might start to ask questions: *"the other kids' parents want to know what happened to the child who became ill"* (V6). In these situations, healthcare professionals were conscious of breaching confidentiality and often had to choose to be more dismissive than they would like to be because they understood the parents' concerns.

### Communication challenges: where and with whom

The participants discussed situations in which communication with CYP and parents was hampered and where they felt that their patients' or their own confidentiality was compromised or breached.

#### Communication in patient rooms

Nurses told that they felt uncomfortable if another healthcare professional entered the room asking questions about some other patient because they would then be torn between helping their colleague, protecting confidentiality, and shielding their patient from information about others: *"... standing with the parents and the child I'm with ... I know what child she is talking about [and I] have to ... talk about it, as she wants to go in and do something. I found that pretty uncomfortable because I felt trapped and I was sort of torn about what to do"* (H4).

Participants also reported that parents reacted to another patient's confidentiality being breached. One nurse described a parent's anger when another child's case was discussed over the phone while there were others in the room. Afterwards, the parents asked, *"So do you do this with our child too? ... that our child is in this room and ... has to have this done..."* (H5).

#### Communication with relatives

Healthcare professionals also faced challenges in terms of how much they could say when a child's parents did not have joint custody or if it was unclear whether a parent was lying about custody status. Participants described their sense of insecurity in these circumstances, and many referred to being contacted by an angry or threatening parent. This created ambiguity about how to act: *"What are the rights?... and how do I make sure, for example, that someone who calls and says he is the child's father actually has custody or is the child's parent ... at all. I did not actually know, but I could sense from the mother that he did not have [custody]. But she could have lied about that, too. He went crazy then ... my day was just ruined"* (V2).

Some participants said that they bought themselves time to check custody status by looking up the population register; others explained that they would not have time to obtain that information before finding out that they needed it. One nurse told us about a mother who wanted to make a complaint because the healthcare professional breached their confidentiality: *"The mother had explicitly demanded that the father should not be told why the child was here because there was a lawsuit in*

progress. [She] told us that he had done something truly awful that she could not elaborate on, and she had also written this on the information leaflet at admission. I was on a night shift where the mother was absolutely furious that the father got information about the child on the phone. When I checked the journal, I could see when the secretary had scanned the information from the leaflet ... after the father had already called" (H2). When healthcare professionals do not have the information they need, mistakes may be made that affect both patients and healthcare professionals.

In situations where other family members asked for a plan or for test results – for example, because they stood in for the child's parent – healthcare professionals might be unsure how to express themselves. This could happen if something acute occurred and a relative accompanied the child without having a prior agreement with the parent about their role: "Sometimes when children are admitted [and], for example, their mother is very ill, perhaps in the intensive care unit ... the mother's sister or some other family member [comes] with the sick child. And then there are others who are just there ... then ... there is ... doubt about what we can say" (H4). Similarly, participants referred to situations where parents had not told other family members (e.g., grandparents) the whole truth: "So [when] the grandparents come and ask what the plan is and you're standing there in the room, it can be difficult not to seem dismissive ... but they should hear the plan from the parents rather than from us" (V8). In summary, healthcare professionals often encountered situations on the pediatric ward that deviated from what was planned, and issues might suddenly arise that presented challenges in relation to their duty of confidentiality.

#### Language problems

The problem of language differences meant that several ethical issues would arise. For example, non-Danish-speaking parents might draw on relatives for the translation of everyday terms, but communication through a relative (as a go-between) would often become more difficult when the conversation turned to the disease or treatment: "Sometimes I felt it was difficult because of who was proposed as an interpreter—for instance, if a minor was being asked to interpret some right..." (H5). Even with interpreter interviews, professionals said that they did not always feel safe as they did not know what was actually being translated and whether family issues or something else might influence the relationship with the interpreter: "several times ... I have suddenly thought 'maybe I should not have said that.' As the parents do not know what the consultation is about, they may find themselves in an undesirable situation in relation to the interpreter" (V4).

Healthcare professionals found these language challenges difficult to deal with and said that they created many problems in relation to their duty of confidentiality.

#### Navigation in the clinical setting to uphold privacy

##### Strategies for promoting privacy

As healthcare professionals often encountered challenges in their efforts to comply with their duty of confidentiality, they developed strategies within the existing workplace framework. For example, many of them had a strategy for speaking with parents or colleagues on the phone. "I say ... 'Can I call you back when I'm done here?' ... so you don't have to talk about a child while others can hear..." (H1). Another participant described dealing with relatives who called to inquire about a child by referring them to the parents: "... then we ask for the number and say ... we can call you ... or you can talk to the child's mother or father..." (H2).

Doctors sometimes found it difficult to provide information over the phone without meeting the parent: "The safety of the person we are talking to.... we cannot always be sure if we are calling the right family. So if I reach an answering machine, then I might say, for instance, that

there is a prescription as promised or that I tried to reach you regarding test results, or that you'll get good news by letter ... I don't say too much when I'm talking to an answering machine if I have no idea who is checking it" (V10).

In this regard, current practice was changed at one of the outpatient clinics; the patient's social security number was no longer shouted out when patients were being picked up in the waiting room: "We always show the social security number in outpatients when we pick them up ... and ask them if it's their number" (V8).

#### Maintaining confidentiality

Participants said that they sometimes felt challenged when a patient told them something in confidence that they felt obliged to act on as a health professional. This issue arose in gray areas where a patient said something that might not be serious enough to require action but where a decision to act or not to act could not be taken without passing the information on to others. This could make it harder to maintain a good relationship with the patient: "It can also give us some problems when talking alone with the children... when, for example, a child feels responsible for a parent and seems to need help" (V10).

Maintaining confidentiality was also identified as a problem at one of the two participating departments where health professionals with little practical experience felt that they were not equipped to offer split consultations, i.e. consultations where a young patient talks alone with the healthcare professional before the parents join the consultation. "When they turn 15 or 16, we're actually pretty bad at offering them the option of coming in alone .. to make them aware that this is actually their right" (V8). At the other department where professionals had more experience in dealing with young people, this was not seen as a problem, and it was considered a matter of course that they would offer split consultations.

Some disagreement was seen among participants in terms of what they told parents after a split consultation. According to one participant, "You do not have a duty of confidentiality to them... you have, of course, but if it is a child under 15, you should not keep anything from their parents" (V1). Other participants were fully aware of the rules that apply to young persons after they turn 15, but as one noted, "...you get more details when a parent attends the consultation" (V10). As special rules apply to young people aged 15 years, professionals must know the relevant legislation. While the department treating CYP older than 15 years had already integrated this knowledge, the other department seemed in need of new procedures to guide action.

#### Discussion

The main finding of the present study is that the healthcare professionals who participated in this study reported difficulties in fulfilling their duty of confidentiality. They reported that the physical surroundings made it impossible for them to perform their work without referring to and asking for patients' private information, knowing that others could overhear it. Indeed, they confessed that they failed to ask about very private matters if others were within earshot. They suggested that moving to a room with a single bed would allow them to talk to the patient and their family in more private surroundings. An earlier study in an emergency department (Olsen et al., 2008) reported that the percentage of overheard conversations about other patients or conversations health professionals overheard themselves fell from 36% to 14% when the department increased in size and no longer used rooms where patients were separated only by curtains. In recent years, the growing use of single- rather than multi-bed hospital rooms (Cusack et al., 2019; Krupic et al., 2018) has facilitated compliance with the duty of confidentiality. According to the participants in the present study, the difficulty of collecting essential patient data without being overheard by others was due primarily to the use of multi-bed rooms. However, evidence that patients benefit from peer support from

others in the same situation (Larsen et al., 2013) suggests that the use of single rooms may not be optimal, even if this makes it easier for staff to fulfill their duty of confidentiality. In a previous study from our group from 2022, we also found that parents and young people experienced that the duty of confidentiality was broken. Furthermore it turned out that it was different whether they experienced the duty of confidentiality as something negative or whether it was of no importance to them in relation to their stay and treatment in the pediatric ward (Jensen & Eg, 2022).

Participants reported that parents who overheard a doctor talking about another patient on the phone might become angry and suspicious that the same could happen to their child. One study found that smartphones are used much in hospitals for learning purposes and to exchange patient information (Thomairy et al., 2015), posing a possible threat to doctor-patient confidentiality. Like in the present study, the authors identified issues of patient safety and confidentiality associated with the use of mobile devices and anticipated increased oversight by regulatory agencies and accrediting bodies.

Participants in our study noted that the use of multi-bed rooms made it more difficult to protect patient confidentiality in the presence of other patients, their parents, and relatives. A Swedish qualitative study from 2018 based on focus group interviews with nurses (Krupic et al., 2018) echoes our finding that nurses found it difficult to maintain patient integrity and confidentiality when diagnoses and treatment modalities were discussed in the presence of other patients. Contrary to our findings, however, the Swedish nurses found that relatives were of great help to them when communication could be managed in a quiet and timely fashion.

Other studies also confirm the role of time pressure in relation to staff stress and errors – for example, where information is given to the wrong people or to colleagues (D'Esmond, 2017; Krupic et al., 2018). Our participants confessed that they did not always fulfill their duty of confidentiality or comply with ethical guidelines such as the ICN Code of Ethics for Nurses, which requires nurses to keep personal information confidential and to use their judgement in sharing such information (International Council of Nurses, 2012).

Language barriers can also present ethical challenges; for example when relatives act as interpreters. According to Sofia Sarfraz, Senior Clinical Fellow in Paediatrics and Medical Education, the gold standard is to use a professional interpreter for patients who speak a language different from your own. While she acknowledges that family members and other health professionals remain indispensable as interpreters in a multicultural society, especially in emergencies, she argues that non-professional interpreters should be used with caution and with due regard to the associated risks (Rimmer, 2020).

While our participants said that they had developed strategies for coping with less-than-optimal working conditions, they made no secret of their frustration over violating patient confidentiality and privacy, potentially undermining care and treatment. In the Swedish study mentioned above (Krupic et al., 2018), nurses noted the difficulty of communicating with patients when there were others in the room, and patients struggled to ask their own questions. This dilemma caused some nurses to feel nervous and sometimes unsafe, which affected their self-confidence.

To address some of these issues, our participants said that they avoided calling out social security numbers in the waiting room and took steps to ensure that they were speaking to the right person on the phone. These strategies are an appropriate response to the 2018 EU's General Data Protection Regulation (GDPR) addressing the protection of personal data (GDPR, 2020).

Evidence suggests that young patients with diabetes are not routinely seen alone for confidential care (Duncan et al., 2014), possibly because parents or adolescents decline this option, because clinicians are time poor and/or lack the necessary skills; or because of a culture of uncertainty about the value of confidential care. In our study, participants said that some professionals favored joint consultations to ensure that

parents could support the treatment process. However, this approach assigns a lower priority to the young patient's independence and self-determination (Sawyer et al., 2012). In conversations with young people, the young patient may raise sensitive topics with the health professional. One study of physicians' ethical dilemmas in conversations with young people (Boisen et al., 2016) problematizes how young people tell health professionals things they do not want their parents to know—for example, that they have been drunk or had sex. However, it is important for young people to be able to talk privately to health professionals in this way as the topic might otherwise never be addressed, and confidentiality may for a time be crucial to the treatment alliance. The duty of confidentiality is a basic ethical requirement for physicians as mentioned, for instance, in the Danish Medical Association's ethical rules. Boisen et al. (2016) noted that the stricter notification obligation (cf. section 153 of the Social Services Act) means that CYP cannot be guaranteed unconditional confidentiality, and the National Board of Health's guidelines stipulate that parents (custodians) must be actively informed about their child's relationships until they turn 18 of age. This can create an ethical dilemma for health professionals if the duty of confidentiality is difficult to comply with or proves difficult to maintain.

Despite the fact that guidelines with recommendations on confidentiality and patients' rights do exist (Sawyer et al., 2014), these guidelines are often breached during admission. This situation calls for more attention to the problems that breaches of confidentiality create and, not least, to establishing a physical framework that allows health professionals to honor their obligation to maintain confidentiality and ensure patient privacy.

### Limitations

Our study would have been strengthened by recruiting more doctors, but we could include only staff who volunteered and showed up for the interview. It would also have been preferable to extend the study to university hospitals and patient groups. Although they are not clinicians, the two researchers who conducted the study were employed at the participating departments. To forestall any possible issues arising, each investigator moderated the focus group at the other's department. While the two departments differed geographically and in terms of patient profiles, we considered this a strength in terms of the range of participant experiences obtained. Finally, while these findings may be specific to Denmark, the rich descriptions may be transferable to other similar settings, (Lincoln et al., 1985).

### Conclusion

Confidentiality in pediatric departments is a complex issue and impacts clinical practice. This study elucidates the experiences of pediatric nurses and physicians in this regard and the impact of challenges related to privacy, dignity, and communication with children and their parents. Difficulties in complying with their duty of confidentiality related partly to health professionals' physical surroundings and time pressure in the clinical setting. Communication in multi-bed rooms means that other patients and relatives overhear everything, which undermines confidentiality and sometimes prevents doctors from asking sensitive questions. In addition, the fact that these settings are very busy compounds the problem.

Healthcare professionals also feel constrained in terms of how much they can say to relatives or a parent without joint custody. Language differences and translation can also raise ethical issues when engaging with young patients. Finally, in their efforts to navigate the clinical setting without breaching confidentiality, professionals develop strategies to comply as far as possible with their duty of confidentiality in conditions that are less than optimal.

Further studies are needed. More in-depth knowledge and a wider understanding of the subject in the field of pediatric care is required. The challenges experienced by the healthcare professional to obtain

privacy, and sound communication with patients should be taken into account in future hospital designs.

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### CRedit authorship contribution statement

**Marianne Eg:** Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing. **Claus Sixtus Jensen:** Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing.

### Declaration of Competing Interest

None.

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