Confidentiality in the waiting room:
an observational study in general practice

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ABSTRACT

An ethnographic study using overt non-participatory observation was used to investigate confidentiality breaches in 13 GP practice reception and/or waiting areas in Lincolnshire. Staff and patient behaviours were observed for 2 hours. Aspects of management systems and physical environment were also thematically analysed. Forty-four instances occurred where patient-identifiable information was overheard. Of these instances, 22 were initiated by staff, 22 by patients, 33 face-to-face, and 10 from telephone conversations. Breaches included name and address, symptoms, conditions, or test results. Interaction between systems and physical environment in relation to 'attention focus', 'sound' and 'layout', increased the likelihood of breach of confidentiality. Further research on the patient perspective is recommended.

Keywords

confidentiality; data protection; ethnography; general practice; observation; primary care.

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INTRODUCTION

Research in hospital settings in the US shows that patient confidentiality is often breached by inadvertent overheard disclosure.[1] This disclosure may result from staff-to-staff contact, staff-to-patient contact, and where the patient has initiated the breach.

Overheard disclosures adversely affect patients' trust and confidence and lead to a breakdown in the patient–doctor relationship.[2] The physical environment, such as room design, computer location, telephone position, and seating, also contributes to confidentiality breaches.[2]

There have been no recently published studies of confidentiality in UK general practice waiting rooms. The aim of this study was to investigate the extent and nature of breaches and to identify contributory factors.

METHOD

The Caldicott Committee review of patient identifiable information stated, 'all items of information which relate to an attribute of an individual should be treated as potentially capable of identifying patients and hence should be appropriately protected to safeguard confidentiality'.[3] Therefore, for the purpose of this study breaches of confidentiality were taken to mean anything that revealed more than the patient's name.

This was an ethnographic observational study; the observer was overt and non-participatory. The reception staff, although aware of the research, did not know the date or time of the visit. The nature of waiting rooms meant that the researcher was regarded by patients as 'one of them', transposing the observer into a participatory and covert role.

Invitations were posted to practices following a presentation to practice managers. Practice visits were organised in advance with the practice manager who was responsible for informing and obtaining agreement from all practice staff. In all cases they chose not to disclose the specific time of the visit. The researcher who was unknown to practice staff sat in the waiting room making observations during each 'field' visit.

Field notes recorded details of confidentiality breaches, including instances where the patient's name was revealed in case this was linked to other information later. These were systematically logged into a pre-piloted data collection schedule. Patient identifiable-information overheard was recorded for each patient, the latter anonymised as a case number.

The tick box schedule covered aspects of personal and medical data separately for telephone and face-to-face interactions and context. Sketches and notes were made on the location of reception systems and the physical environment. New observational data were added to the schedule as they emerged. Observational statements were themed using template analysis. The numbers of each type of patient-identifiable information disclosure were located in the data. Processes and environment were analysed in the same way. Anonymised data were fed back to each practice.

RESULTS

Person to person interactions

Thirteen out of 40 practices agreed to participate representing a mix of single-handed and group practices from rural and urban locations. Forty-four separate disclosures of patient-identifiable information resulting from person-to-person interactions were

How this fits in

Although there have been no recently published studies of confidentiality in UK general practice waiting rooms, previous research has shown that breaches within hospital settings have been frequent and have most commonly occurred in reception and waiting areas. The results of this study have shown that small changes would make a big difference in terms of improving confidentiality. Breaches could be minimised to enable practices to comply more closely with codes of practice for handling patient-identifiable information, which in turn would improve the patient-clinician relationship.

observed in 26 hours. Two main themes emerged; the first was the 'type of interaction taking place', which consisted of four categories; 'reception staff initiated'; 'patient initiated'; 'telephone call initiated' and 'doctor or nurse initiated'. The second theme, derived mainly from the schedule headings, was the 'type of information disclosed'. This information fell into 12

Table 1. Nature and frequency of patient-identifiable information disclosure during study.

Theme type of information disclosed	Type of interaction taking place when patient-identifiable information was disclosed		
	Reception and medical staff initiated (face-to-face)	Reception staff initiated (telephone)	Patient initiated
	Frequency		
Name only	7	3	18
Name and address	3	1	1
Name and condition	0	0	1
Name, address and condition	0	0	1
Name and phone number	0	1	0
Address	0	1	0
Phone number	1	0	0
Name and to see nurse	0	0	3
Advice offered	0	2	0
Asked for/gave results	2	0	6
Reasons for the appointment, name, address/phone number, date of birth	6	5	7
Medication	0	0	3
Examples from the original observational field where patient-identifiable information was revealed during person-to-person interaction	The patient informed the receptionist that they were there to see the nurse at 10.30 am; the receptionist asked the patient for their name and the patient then responded with 'haven't you got it down?' The receptionist then said that they had to ask. (P2) The patient informed the receptionist that they had an appointment to see their GP and the receptionist seemed to know the patient. This became apparent when they sounded surprised and asked if they were alright. The patient then informed the receptionist the reason for their visit. (P5) The practice nurse announced both the forename and surname when calling for a patient on four occasions. (P3)	The receptionist asked for the name telephone number of the patient and repeated them both. (P4) The receptionist asked the patient what was wrong and said that they would put them down for a visit and cancel their appointment. (P8) The patient asked the receptionist for a repeat prescription and informed the receptionist of both forename and surname. (P6)	A patient enquired about a set of test results and told the receptionist the condition they were enquiring about. They mentioned both their surname and address. [The researcher] was able to hear the concerns of the patient and there was one other patient present in the waiting room who would have been able to hear what was being said. The receptionist informed the patient that they had not received the results of the test but would let them know when they had. In this case the patient initiated the conversation and seemed to be comfortable talking to the receptionist about their condition. (P1)

Disclosure of patient name only was not considered a breach of confidentiality; data are included to indicate relative incidence.

Table 2. Systems in the waiting room/reception area in relation to confidentiality breaches.

Calling patient to consultant	Receptionist's initial contact with patient/ queuing area	Professionalism of practice staff
Positive		
Patients were allocated a coloured number card on arrival.	There was a bell to ring for attention at both the reception desk and the dispensary which prevented patients from waiting at the reception desk for long periods of time. Reception desk was small and separated from the waiting room by a window which the receptionist closed each time they had seen a patient. This prevented the patients in the waiting room overhearing conversations taking place behind the reception desk.	Receptionist rarely asked the name of the patients, they did not ask for more information than was needed. Receptionist did not repeat any information they were told over the telephone. Receptionist spoke very quietly.
Negative		
The GP announced both the forename and surname of each patient. The nurse called out the patient's name more than once. Patients were given their medical notes when called to see their GP.	Practices with no bell to ring for attention meant that patients were waiting at the reception desk encouraging patients to look for reception staff.	Receptionist repeated the information they were told over the telephone on many occasions. The receptionist spoke quite loudly.

categories. Table 1 shows categories, frequencies and selected field notes.

Of the 44 disclosures, 22 were initiated by the patient and 22 were initiated by staff, of which 34 were face-to-face in the reception area, with a further 10 overheard from telephone conversations. The disclosing interactions revealed information ranging from patient addresses to medical information that could be linked to a person's name.

Observation of systems used in the practice reception area

The three themes identified reflect management processes for registration for appointments and consultations, receiving results or obtaining prescriptions.

Within these themes 'calling patient to consultation', 'receptionist's initial contact with patient/queuing area', 'professionalism of practice staff', systems were

Table 3. Physical factors in the waiting room/reception area in relation to confidentiality breaches.

Attention focus	Sound	Layout
Positive		
Magazines and books, posters, and television/radio/music. Chairs faced away from the reception.	Music/radio. Children's play area when occupied	Telephone located away from the reception desk. Barrier was present to structure queue away from the desk. Waiting room located separately from reception. Computer monitor faced away from the queuing area. Screen present at reception. Fax machine located away from reception desk.
Negative		
Lack of magazines and books, posters and television/radio/music. Chairs not facing away from the reception.	Lack of music/radio	Reception area in the same room as the waiting room. Chairs were close to the reception desk. No barrier to structure the queue, hence patients queued alongside the desk. Computer monitors could be seen at certain angles. No screen at reception, therefore patients more inclined to lean over the reception desk.

likely to lead to the disclosure of patient-identifiable information, or negative, more likely to lead to breaches in confidentiality. Observation notes from which the categories and themes were derived, and their relationship with the processes in the waiting and/or reception area are shown in Table 2.

Observation of the physical environment

Three themes were identified; 'attention focus'; 'sounds' and 'lay out'. These were categorised as positive or negative in their relationship to disclosure of confidential information (Table 3).

DISCUSSION

Breaches of confidentiality in general practice waiting rooms varied from addresses to medical information such as symptoms, conditions, or test results.

Half of the occasions where patients themselves revealed confidential data were a direct result of staff requesting information. It was evident in at least one instance that the receptionist did not pick up a cue that the patient was uncomfortable with their disclosures (Table 1). In support of this, Howell, found that the nursing staff thought they had breached confidentiality far less than the patients believed to be the case.[4]

Bias was minimised by focusing observations on recording clear-cut events rather than perceptions. The researcher was unknown, unannounced, and perceived to be waiting; reducing the impact of their presence. The study included a sample of rural, urban, small and large practices making the findings more likely to be generalisable to similar settings in the UK. Revealing the full name of a patient was considered acceptable but it is acknowledged this is not always the case, for instance if the venue, such as a sexual health clinic, conveys indirect information.

Communication issues interacted with the built environment to produce breaches in confidentiality. Some facilities were organised to enhance confidentiality by drawing the focus of attention away from the communication, by masking conversation with alternative sounds or using room layout to minimise being overheard. Examples included television, chairs placed at a distance or facing away from the reception. Books, magazines and radio all detracted from reception desk activities. A children's play area acted as a focus for waiting patients. Background music provided auditory privacy and barriers prevented noise transmission.

Locating telephones and fax machines away from the reception desk reduced breaches. Although more commonly associated with people being able to read confidential information, having the computer monitor faced away from the queuing area also avoided the patient verbalising what they read. Reception areas equipped with screens or geographically separated from waiting areas prevented queuing patients overhearing other people's information. It also allowed the patient greater freedom to decide how much they want to share with the receptionist.[5] This highlights that confidentiality issues should be considered when designing health facilities.[6]

Systems to manage patient flow were frequently dependent on the structural layout of the practice. Closing windows and using a bell for attention prevented overhearing receptionist-to-receptionist breaches, as well as those overheard during queuing. The allocation of a number to patients upon registration eliminated some breaches and was independent of the reception layout. It may be the case that not addressing patients by name may make surgery visits more impersonal and could have additional costs.

These observations provided evidence of breaches in confidentiality from human interactions, practice systems and the physical environment. Primary care teams can use this to assist greater compliance with the NHS Code of Practice. However, patients themselves have a mutual responsibility with practice staff not to breach confidentiality.

Practices should consider conducting patient surveys on aspects of confidentiality as a means of looking for ways to improve management of patient identifiable information. Because patients initiated confidentiality breaches themselves, it was assumed that they were willing to disclose such information. Further research is recommended to explore patient perceptions and expectations with regard to confidentiality in general practice and other settings.

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