

BODY PRIVACY IN GYNECOLOGY OBSTETRICS

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Abstract: This study aimed to develop a scale to ethically evaluate the privacy of the body in gynecology and obstetrics. It was carried out in a university research and application hospital and in a private hospital in Turkey. A stratified sample was adopted with a total of 2,159 participants, including physicians, nurses, and midwives, OB/GYN patients, surgical patients, internal medicine patients, and healthy individuals. The Lawshe method was used. The results showed that physical space is important in protecting privacy; the participants perceived privacy as a right; women, married people, primary school graduates, older people and those closest to rural culture are more sensitive to privacy than others; Among healthcare providers, physicians are more privacy conscious than nurses and midwives; no participant had in-depth knowledge of patient rights and relevant legislation. The body privacy scale in gynecology and obstetrics proved to be a valid and reliable scale. With it, the privacy of the body in obstetrics and gynecology can be evaluated in future research, as well as the perceptions of body privacy of those who receive and provide medical care. By applying this scale, the privacy of gynecological and obstetric patients can be protected and the results reflected in clinical practice. This scale can also be used in education and in improving ethical sensitivity in physicians.

Keywords: body privacy, gynecology, obstetrics

Privacidad del cuerpo en obstetricia ginecológica

Resumen: Este estudio tuvo como objetivo desarrollar una escala para evaluar éticamente la privacidad del cuerpo en ginecología y obstetricia. Se realizó en un hospital universitario de investigación y aplicación y en un hospital privado en Turquía. Se adoptó un muestreo estratificado con un total de 2.159 participantes, incluidos médicos, enfermeras y parteras, pacientes de ginecología y obstetricia, pacientes quirúrgicos, pacientes de medicina interna e individuos sanos. Se usó el método Lawshe. Los resultados mostraron que el espacio físico es importante en la protección de la privacidad; los participantes percibieron la privacidad como un derecho; las mujeres, las personas casadas, los titulados de la escuela primaria, personas mayores y los más cercanas a la cultura rural son más sensibles a la privacidad que otros; entre los proveedores de atención médica, los médicos tienen mayor conciencia de la privacidad que enfermeras y parteras; ningún participante tenía un conocimiento profundo de los derechos de los pacientes y de la legislación pertinente. La escala de la privacidad corporal en ginecología y obstetricia mostró ser una escala válida y confiable. Con ella, la privacidad del cuerpo en ginecología y obstetricia se puede evaluar en futuras investigaciones, así como las percepciones de privacidad corporal de aquellos que reciben y proporcionan atención médica. Aplicando esta escala, se puede proteger la privacidad de pacientes ginecológicos y obstétricos y reflejar los resultados en la práctica clínica. Esta escala también se puede utilizar en educación y en mejorar la sensibilidad ética en los médicos.

Palabras clave: privacidad del cuerpo, ginecología, obstetricia

Privacidade corporal em ginecologia e obstetricia

Resumo: Esse estudo objetiva desenvolver uma escala para avaliar eticamente a privacidade do corpo em ginecologia e obstetricia. Ele foi conduzido em um hospital universitário e em hospital privado na Turquia. Uma amostra estratificada foi adotada com um total de 2159 participantes, incluindo médicos, enfermeiras e parteiras, pacientes de obstetricia, ginecologia, cirúrgicos e de medicina interna, e indivíduos saudáveis. O método Lawshe foi utilizado. Os resultados mostraram que o espaço físico é importante para proteger a privacidade; os participantes consideraram a privacidade como um direito; mulheres, pessoas casadas, com escolaridade primária completa, pessoas mais velhas e aquelas mais próximas da cultura rural são mais sensíveis à privacidade que outras; entre os profissionais de saúde, médicos são mais conscientes da privacidade que enfermeiras e parteiras; nenhum participante tinha conhecimento aprofundado dos direitos de pacientes e da legislação relevante. A escala de privacidade corporal em ginecologia e obstetricia provou ser uma escala válida e confiável. Com ela, a privacidade do corpo em obstetricia e ginecologia pode ser avaliada em pesquisas futuras bem como as percepções de privacidade corporal daqueles que recebem e fornecem cuidados médicos. Aplicando essa escala, a privacidade de pacientes ginecológicos e obstétricos pode ser protegida e os resultados refletidos na prática clínica. Essa escala pode também ser usada em educação e em melhorar a sensibilidade ética de médicos.

Palavras chave: privacidade corporal, ginecologia, obstetricia

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Introduction

Privacy is a human right(1). Privacy is defined as a condition or information pertaining to an individual and requires permission from the individual concerned to be disclosed. Webster's New World Dictionary defines privacy as "The quality or condition of being private; withdrawal from company or public view; seclusion"(2). Privacy is defined as an individual's right to keep particular to himself/herself any ideas, points of view, behaviors and personal materials(3).

Privacy comprises the privacy of information as well as the privacy of body. It is commonly associated with intimacy, confidentiality, anonymity or seclusion from the society, solitude and timidity(1).

It is reported in literature that women are more concerned than men with regard to loss of privacy when they are hospitalized(4). When staying in hospital, women lose their control over of privacy and feel loss of privacy during physical care.

The literature suggests that healthcare professionals are not responsive to patients' psychological needs, emotions, culture, display stereotypical behaviors during routine procedures, tend to disregard patients' honor, and do not pay attention to patients' body privacy when providing care and treatment(1). Female patients are more concerned about the loss of privacy during examination and care of sexual organs and have reported difficulty in meeting their needs regarding preferring healthcare professionals(1-5).

The right to privacy has been included in ethical codes and has so far been a significant part of medical codes(6). From ethical perspective, the right to privacy contributes to building trust between patients and healthcare professionals. According to the principle of autonomy in medical ethics, it is unethical to perform any intervention on patients without taking informed consent. Respect to privacy is grounded on respect to persons, and falls under the scope of respect to patient honor. In medical ethics, protecting a patient's privacy in line with the principles of non-maleficence and beneficence reduces the risk of harming the patient(7).

The World Medical Association has included in all its Declarations on the Right of the Patient, Geneva in 1948, regarding "the confidentiality of patient secrets", "respect to the patient's privacy", and "respect to the patient's private life". In Turkey, Regulation on the Right of the Patient —adopted in 1998 and updated in May 24, 2015— includes the patient's right to privacy.

Medical ethics discussions on body privacy mostly concentrate on medical interventions without consent of the patient (compulsory and involuntary treatment), medical interventions not performed despite the patient's demand (e.g. abortion), ensuring an appropriate environment for medical examination, treatment and care (e.g. being examined or treated in a separate room, presence of others in the examination/treatment room), use of the patient's body for educational purposes, or the patient's gender preference for healthcare professionals. The problems related to the patient's body privacy have been increasing on account of computer and camera systems in healthcare centers, changes in patient room design, use of medical imaging devices for diagnosis(1-6).

This study's aim is the healthcare providers and receivers' perceptions of body privacy in gynecology-obstetrics and we planned to develop a scale.

Materials and Methods

The Lawshe method(8). was used for the analytical study. A draft quantitative research form was developed. Opinions of 10 experts were taken to calculate the content validity of items. The content validity for a group of 10 experts should be minimum 0.62. Thus, items with content validity ≥ 0.62 were included. As result, a scale with 37 items was obtained. The questionnaire was designed such that the name, surname and other identifying information of participants were not included. The Cronbach's alpha for the pretest with 30 participants was 0.85 (>0.70) thus the scale was considered valid and reliable.

The Sample

Based on stratified sampling, the study was conducted with a total of 2159 participants, including 161 physicians, 351 nurses, 297 patients of gynecology.

cology and obstetrics, 557 surgical patients, 515 patients of internal medicine, and 278 healthy individuals.

Outcome measures

1. Statistical analysis

Frequency analysis was used for analysis of socio-demographic data. The normality of distributions was tested via the Shapiro-Wilk test. Chi-square tests were performed to compare socio-demographic data related to groups. Descriptive statistics were expressed as numbers and percentages for categorical variables and as mean (standard deviation) for numerical variables. Variance analyses (ANOVA), post-hoc, and Tukey's honest significant difference analyses were used to determine the distribution of subcomponents among groups providing and receiving healthcare.

2. Ethical Aspect

Permission was received from the Board of Ethics for Non-pharmacological Clinical Research in the Faculty of Medicine at Eskişehir Osmangazi University. Written informed consents of the participants were obtained.

Results

Socio-Demographic Data

Among physicians, the mean age was 41.16 (9.44); the number of female participants was 83 (51.60%); and the number of married participants was 116 (72%). Among nurses and midwives, the mean age was 31.47 (7.30); the number of female participants was 316 (90%); and the number of married participants was 240 (68.40%). The difference in socio-demographic characteristics between the groups was not statistically significant ($p > 0.05$).

Among gynecology and obstetrics patients, the mean age was 33.38 (11.71); the number of married participants was 265 (89.20%); 121 (40.70%) participants were primary school degree holders; the income of 124 (41.80%) patients was fair enough; 233 (78.50%) patients were housewives; and 110 patients (37%) located themselves between rural and urban culture. Among surgical

patients, the mean age was 41.69 (13.96); 435 (78.10%) participants were women; the number of married participants was 429 (77%); 258 (46.30%) participants were primary school degree holders; the income level of 290 (52.10%) patients was moderate; 335 (60.10%) patients were housewives; and 155 patients (27.80%) located themselves between rural and urban culture. Among patients with internal diseases, the mean age was 42.85 (13.56); 390 (75.70%) participants were women; the number of married participants was 401 (77.90%); 216 (41.90%) participants were primary school degree holders; the income levels of 244 (47.40%) patients were moderate; 291 (56.50%) patients were housewives; and 30.1% of the patients located themselves between rural and urban culture. Among healthy individuals, the mean age was 31.70 (12.12); 220 (79.10%) participants were women; the number of married participants was 147 (52.90%); 119 (42.80%) participants were holding a high school degree; the income of 116 (41.70%) participants was fair enough; 105 (37.80%) participants were housewives; and 38.80% of the participants defined themselves closer to urban culture. The mean age of gynecology and obstetrics patients and healthy individuals was lower than the mean age of surgical patients and patients with internal diseases ($p < 0.05$). The difference in gender distribution was statistically significant because all gynecology and obstetrics patients were female ($p < 0.05$). The difference in other socio-demographic characteristics was not statistically significant between the groups ($p < 0.05$).

The Scale of Body Privacy in Gynecology and Obstetrics

The components of 37-item scale are "Privacy in General", "Rights and Privacy", "Ethics and Privacy" and "Clinical Privacy". All statements in subcomponents are positive. Each item is scored between 1 and 5. The items with the highest rating mean (4.60) were Item 21: "Hospital authorities should take measures for the protection of the right to privacy" and Item 24: "Paying attention to patient privacy improves patient satisfaction". The item with the lowest rating mean (3.81) was Item 5: "Privacy changes over time in the society" (Table 1).

The “Privacy in General” component of the scale, consisting of the first 9 items, has the Cronbach’s alpha of 0.85. The “Rights and Privacy” components comprises items 10 to 14 and has the Cronbach’s alpha of 0.71. The “Ethics and Privacy” component, consisting of items 15-19, has the Cronbach’s alpha of 0.62. The “Clinical Privacy” component is associated with items 20-37 in the scale. Its Cronbach’s alpha is 0.92 (Table 2).

The results suggest that physicians are more sensitive than nurses about the subcomponents of Privacy in General and Clinical Privacy and that physicians are more sensitive to Clinical Privacy than other subcomponents (Table 3).

The results indicate that surgical patients are more sensitive than other groups of patients with regard to Privacy in General (Table 4).

Total evaluation of frequency distribution of items in the Scale of Body Privacy in Gynecology and Obstetrics

About half of the participants were undecided about the statement “Confidentiality and privacy do not have the same meaning”, which leads us to think that they do not have a clear understanding of the concept of privacy. Almost all participants agree with the fact that “Death does not eliminate the right to privacy”, “It is possible to protect privacy by using various features of the physical space”, “We have values that shape our perception of privacy”, “There is a need to develop ethical values that are acceptable with regard to privacy”, “Hospital staff should be trained about patient privacy”, “Not observing privacy in women’s health affects the psychological condition of female patients”, and “Women need to know who takes part in the delivery process”; while about half of the participants agree with the fact that “Privacy is a requirement of respect to private life”.

As the majority of participants agree with the items in the scale, they see privacy as a value.

Among the surgical patients, women are more sensitive than men to items in the Clinical Privacy (Table 5).

Among the gynecology and obstetrics patients,

the participants holding a secondary school degree are more sensitive with regard to Privacy in General, holding a university degree are more sensitive with regard to Ethics and Privacy, and holding a primary school degree are more sensitive with regard to Clinical privacy. Among the surgical and internal medicine patients, the participants holding a high school degree are less sensitive about Ethics and Privacy and Clinical Privacy. Among the healthy individuals, the participants holding a high school degree are less sensitive about Rights and Privacy, and those holding a university degree are more sensitive about Ethics and Privacy and Clinical Ethics.

Among the internal medicine patients, the participants that located themselves between rural and urban culture are less sensitive about Privacy in General and Rights and Privacy, and the participants from the urban culture are more sensitive about Ethics and Privacy and Clinical Ethics.

With increasing age, physicians have become more sensitive about Privacy in General, Rights and Privacy, Ethics and Privacy and Clinical Privacy. Among the nurses and midwives, elder participants are more sensitive about Rights and Privacy, Ethics and Privacy and Clinical Privacy. Surgical patients have become more sensitive about Privacy in General and Clinical Privacy as they got older.

Among the nurses and midwives, married participants are more sensitive about Rights and Privacy, Ethics and Privacy and Clinical privacy. Among the gynecology and obstetrics patients, married participants are more sensitive about Rights and Privacy and Ethics and Privacy. Among the surgical patients, married and single participants are more sensitive about Ethics and Privacy, and married participants are more sensitive about Clinical Privacy.

Discussion

Privacy is a significant in medical codes, healthcare services must be improved to ensure privacy, healthcare professionals must avoid the risks that harm patient privacy, the discipline of women health is a special field as it has a sexual aspect, and thus healthcare professionals are required to pay more attention to privacy in this field(9). The

Beijing Declaration and Platform for Action(10) underlines the need to offer healthcare services that respond to special needs of women and address differences in age, socio-economic status and culture. The Regulation on Minimum Technical Standards Regarding Healthcare Facilities of 2010(11) stipulates that patient privacy should be observed by hanging curtains between beds in examination and blood drawing rooms where there are more than one beds. The present study has yielded results similar to the studies cited in the literature.

Our findings show that physicians and nurses are sensitive to patient privacy, physicians are more sensitive than nurses with regard to Privacy in General and Clinical privacy, and physicians are more sensitive to Clinical Privacy compared to other subcomponents of the Privacy Scale. Colón-López et al.(12) explain the daughters' discomfort discussing sex-related topics and sensitive to the privacy of patients. Symon et al.(13), Kabakian-Khasholian(14), Miok(15), explain the nurses/midwives are sensitive to patient's privacy. The findings of our research are consistent with the results of studies cited here.

With respect to Privacy in General, the scores of surgical patients are greater than those of the scores of other groups. This is probably because they need treatment and care services more than other patients, they are more dependent on others for care, and have experienced violation of privacy because of the surgery. İzgi(16), Akyüz(17) and the Beijing Declaration Report(10) suggest that the need for privacy grows with the increasing dependence on others. Our finding, i.e. surgical patients attach more importance to privacy in general than other groups of patients, supports findings in the literature.

The present research has shown that patients have not developed a clear understanding of the concept of privacy. Yörükan(18) have reported that people fail to distinguish the concept of privacy from similar concepts. Patella-Rey(19) stated that a feminist approach was needed to bodily integrity. This is consistent with findings in the literature.

According to our findings, the participants support the arguments that “death does not eliminate

the right to privacy” and “privacy is a requirement of respect to private life”. This is consistent with the findings in Ross et al.(20) that they have reported that medical students said that ‘free time is private time’ and ‘I have the right to a private life’ and Makenzius et al.(21) argue that privacy is related to women's autonomy.

McNaughton HL et al.(7), underline that refer to the importance of ethics values for protection of privacy. This finds also support in our study with the following arguments advocated by the majority of participants: “We have values that shape our perception of privacy” and “There is a need to develop ethical values that are acceptable with regard to privacy”.

Yörükan(18) argue that privacy is mostly associated with women's private sphere. Ndirima et al.(22) argue that gender of the physician is important for women in gynecological examination. Woolner et al.(23), argue that mothers are more sensitive to privacy in clinic. In the present study, we found that female surgical patients are more sensitive than men to Clinical Privacy. Our findings also suggest that privacy is associated with being a woman and women's private sphere.

The present study shows that, in the group of gynecology and obstetrics patients, the patients holding a secondary school degree are more sensitive with regard to Privacy in General, patients holding a university degree are more sensitive with regard to Ethics and Privacy, and patients holding a primary school degree are more sensitive with regard to Clinical privacy. In the group of surgical and internal medicine patients, high school graduates are less sensitive with regard to Ethics and Privacy and Clinical privacy. In the group of healthy individuals, high school graduates are less sensitive to Rights and Privacy, and university graduates are more sensitive to Ethics and Privacy and Clinical Ethics. The findings of our study support Gezinski et al.(24) women with low educational level were unconcerned with potential physical-psychological side effects of egg donation. Kumbani(25) et al., and İzgi's(16) arguments that individuals tend more to protect their privacy as they develop a higher level of education.

Harrington(26) argues that idealized relation-

ships with rurality call upon health and privacy for city's individuals. Akyüz(17) indicate that the perception of privacy may differ according to socialization, privacy behavior and ethical awareness become more common as the level of culture gets higher. This finds support in our results: The participants that locate themselves between rural and urban culture are less sensitive to Privacy in General and Rights and Privacy, and the participants from the urban culture are more sensitive to Ethics and Privacy and Clinical Ethics.

Hoendervanger et al.(27) argues that improving privacy for older workers and for workers high in need for privacy. Chen et al., İzgi16, Mansfield et al.(28), and van Lonkhuijzen(29) found that middle aged physicians were sensitive to privacy. Our findings suggest that with the increasing age, physicians have become more sensitive to Privacy in General, Rights and Privacy, Ethics and Privacy and Clinical Privacy. In the group of nurses and midwives, elder participants are more sensitive to Rights and Privacy, Ethics and Privacy and Clinical Privacy. Surgical patients have become more sensitive to Privacy in General and Clinical Privacy as they got older. The results of our study regarding the relationship between age and privacy are consistent with studies in the literature.

In the nurser's group and midwives, married participants are more sensitive to Rights and Privacy, Ethics Privacy and Clinical privacy. In the gynecology's group and obstetrics patients, married participants are more sensitive to Rights and Privacy and Ethics and Privacy. In the group of surgical patients, married and single participants are more sensitive to Ethics and Privacy, and married participants are more sensitive to Clinical Privacy. Makenzius et al.(21) and Connor et al.(30) highlighted a sexually culture and privacy is related to marriage. Yörükan(18) said that married individuals tend more to protect their privacy than divorced individuals. These finding support the results of our study.

Conclusions

We have shown that physical space is important in protection of privacy; all participants consider privacy in integrity with its subcomponents; the participants see privacy as a right; women, married individuals, primary school degree holders, elder individuals and individuals that define themselves closer to rural culture are more responsive to privacy than others; among healthcare providers, physicians have greater awareness of privacy than nurses and midwives; and none of the participants have thorough knowledge of patient rights and pertinent legislation.

The scale of body privacy in gynecology and obstetrics developed with this study has been designated as a valid and reliable scale. With this scale, ethics assessment sequentiating body privacy in gynecology and obstetrics can be evaluated in future research, and perceptions of body privacy of those who receive and provide health care will be evaluated. Patient privacy can be protected in gynecology and obstetrics patients by applying this scale by clinicians and reflecting the results to clinical practice. This scale can also be used in education and ethical sensitivity can be improved in clinicians.

Acknowledgements

The authors thank Prof. Dr. Zeki Yildiz from Eskişehir Osmangazi University, Faculty of Science and Literature, Department of Statistics for controlling the statistical methodology of this work and fruitful discussions.

Author Disclosure Statement

No competing financial interests exist.

Table 1. Items and rating averages in the scale of body privacy in gynecology and obstetrics. SD, Standard deviation

Items	N	Mean (SD)
1. Privacy is a concept that comprises various aspects.	2159	4.13 (0.90)
2. Privacy is important because of the respect to traditions.	2159	4.00 (1.00)
3. Confidentiality and privacy do not have the same meaning.	2159	3.83 (1.09)
4. The content of privacy differs from one person to another.	2159	4.14 (0.93)
5. Privacy changes over time in the society.	2159	3.81 (1.17)
6. I believe that the concept of privacy differs from one society to another.	2159	4.18 (0.86)
7. It is possible to protect privacy by using various features of the physical space.	2159	4.21 (0.80)
8. Privacy affects social life.	2159	4.25 (0.80)
9. Privacy is affected by social life.	2159	4.16 (0.88)
10. Death does not eliminate the right to privacy.	2159	4.36 (0.85)
11. Privacy is a right that has a legal aspect.	2159	4.26 (0.86)
12. Privacy is a requirement of respect to private life.	2159	4.47 (0.67)
13. Privacy is related to human rights.	2159	4.39 (1.34)
14. Observing a person is a violation of privacy.	2159	4.36 (0.79)
15. All societies have the understanding of protecting privacy.	2159	4.02 (0.95)
16. We have values that shape our perception of privacy.	2159	4.32 (1.69)
17. Legal regulations are not enough to protect privacy.	2159	4.35 (0.74)
18. There is a need to develop ethical values that are acceptable with regard to privacy.	2159	4.33 (0.70)
19. Protecting privacy ensures balance in interpersonal relations.	2159	4.33 (0.71)
20. Privacy should not be violated when a patient is transported in the hospital.	2159	4.55 (0.59)
21. Hospital authorities should take measures for the protection of the right to privacy.	2159	4.60 (1.62)
22. People that are not directly related to a patient's treatment should not be in the room during medical intervention.	2159	4.44 (0.80)
23. Hospital staff should be trained about patient privacy.	2159	4.52 (0.65)
24. Paying attention to patient privacy improves patient satisfaction.	2159	4.60 (0.59)
25. The relationship between healthcare professionals and the patient is based on trust with regard to privacy.	2159	4.44 (0.70)
26. Treatment and healthcare never constitute an excuse for the violation of privacy.	2159	4.31 (0.87)
27. Not observing privacy in women's health affects the psychological condition of female patients.	2159	4.46 (0.68)
28. Curtains should be used in delivery rooms to ensure privacy.	2159	4.35 (0.83)

29. Women need to know who takes part in the delivery process.	2159	4.49 (0.63)
30. Delivery rooms should be designed in a way to ensure privacy.	2159	4.56 (0.58)
31. The gender of patient should not disturb a healthcare professional.	2159	4.19 (0.96)
32. There should be breastfeeding rooms in hospitals to protect the privacy of mothers.	2159	4.57 (0.58)
33. The protection of patient privacy is so important that it cannot be left to individual awareness of healthcare professionals.	2159	4.49 (0.66)
34. No part of human body should be opened unnecessarily during gynecological examination and delivery.	2159	4.57 (0.61)
35. Covering the patient's body during gynecological examination ensures concentration on the body part examined.	2159	4.40 (0.74)
36. Patient privacy should not be violated during gynecological examination and delivery.	2159	4.56 (0.60)
37. Healthcare professionals are liable to protect patient privacy.	2159	4.53 (0.61)

Table 2. The highest and lowest scores, means and standard deviations of components in the Scale of Body Privacy in Gynecology and Obstetrics.

	N	S c o r e Interval	L o w e s t - Highest Score	Mean (SD)	Cronbach's Alpha
Privacy in General	2159	1-5	1.44-5	4.07(0.64)	0.85
Rights and Privacy	2159	1-5	1.80-5	4.36(0.59)	0.71
Ethics and Privacy	2159	1-5	1.80-5	4.27(0.65)	0.62
C l i n i c a l Privacy	2159	1-5	1.59-5	4.47(0.46)	0.92

SD, Standard deviation

Table 3. The distribution of statistical analyses related to subcomponents of the Scale of Body Privacy in Gynecology and Obstetrics by groups of healthcare providers.

		P h y s i c i a n s N=161	Nurses and Midwives N=351
Privacy in General	Mean (SD)	4.33 (0.61)	3.98 (0.61)
	Min-Max	2.33-5.00	2.22-5.00
	p	<0.05	
Rights and Privacy	Mean (SD)	4.53 (0.62)	4.39 (0.55)
	Min-Max	2.60-5.00	1.80-5.00
	p	>0.05	
Ethics and Privacy	Mean (SD)	4.46 (0.57)	4.29 (0.98)
	Min-Max	3.00-5.00	2.40-5.00
	p	>0.05	
Clinical Privacy	Mean (SD)	4.56 (0.53)	4.43 (0.48)
	Min-Max	2.76-5.00	2.18-5.00
	p	<0.05	

SD, Standard deviation; Min-Max, Minimum-maximum

Table 4. The distribution of statistical analyses related to subcomponents of the Scale of Body Privacy in Gynecology and Obstetrics by groups of healthcare receivers.

		Gynecology and Obstetrics Patients (N=297)	Surgical Patients (N=557)	Patients of Internal Medicine (N=515)	Healthy Individuals (N=278)
Privacy in General	Mean (SD)	4.01 (0.73)	4.15 (0.66)	4.08 (0.60)	4.00 (0.58)
	Min-Max	1.89-5.00	1.44-5.00	1.44-5.00	2.33-5.00
	p	<0.05			
Rights and Privacy	Mean (SD)	4.33 (0.61)	4.33 (0.64)	4.37 (0.55)	4.34 (0.58)
	Min-Max	2.60-5.00	2.20-5.00	1.80-5.00	2.20-5.00
	p	>0.05			
Ethics and Privacy	Mean (SD)	4.25 (0.61)	4.26 (0.56)	4.25 (0.57)	4.22 (0.50)
	Min-Max	2.20-5.00	2.20-5.00	1.80-5.00	2.80-5.00
	p	>0.05			
Clinical Privacy	Mean (SD)	4.51 (0.48)	4.50 (0.45)	4.46 (0.45)	4.40 (0.43)
	Min-Max	2.65-5.00	1.59-5.00	1.88-5.00	3.18-5.00
	p	>0.05			

SD, Standard deviation; Min-Max, Minimum-maximum

Table 5. The dimensions of the Body Privacy Scale in Gynecology and Obstetrics were analyzed according to the gender of the patients in the surgical sciences group.

		Surgical Patients					
Dimensions	Sex	%25	Median	%75	p	p	
Privacy in General	female	3.67	4.11	4.89	0.235	-	
	male	3.67	4.00	4.56			
Rights and Privacy	female	4.00	4.40	5.00	0.406	-	
	male	3.80	4.00	5.00			
Ethics and Privacy	female	4.00	4.20	4.80	0.109	-	
	male	3.80	4.00	4.80			
Clinical Privacy	female	4.12	4.53	4.94	*0.046	-	
	male	4.00	4.41	4.94			
		Gynecology and Obstetrics Patients					
	Education Level	%25	Median	%75	p	p	

Privacy General	in	1.literate	3.56	4.90	5.00	0.033	*(4-3) 0.050
		2.primary school	3.44	4.20	4.60		
		3.middle School	3.67	4.20	4.50		
		4.high school	3.44	4.00	4.40		
		5.university	3.56	4.00	4.40		
Rights Privacy	and	1.literate	3.80	4.10	5.00	0.275	
		2.primary school	4.00	4.40	5.00		
		3.middle School	3.80	4.20	5.00		
		4.high school	4.00	4.20	4.90		
		5.university	4.00	4.60	5.00		
Ethics Privacy	and	1.literate	3.80	4.00	5.00	0.003	*(5-2) 0.013
		2.primary school	3.80	3.90	4.00		
		3.middle School	4.00	4.00	4.40		
		4.high school	4.00	4.10	4.50		
		5.university	3.80	4.20	5.00		
Clinical Privacy		1.literate	4.06	4.00	4.60	0.015	*(4-2) 0.007
		2.primary school	4.18	4.40	5.00		
		3.middle School	4.24	4.00	4.40		
		4.high school	4.00	4.00	4.40		
		5.university	4.03	4.20	4.60		

* In the group of surgical patients, women are more sensitive than men to items in the Clinical Privacy.

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Received: June 9, 2020

Accepted: June 20, 2020