ASSESSING POTENTIAL THREATS TO THE CONFIDENTIALITY OF EMPLOYEE HEALTH INFORMATION IN OCCUPATIONAL HEALTH NURSING PRACTICE IN MANITOBA

by

Beverley J. Cann

A thesis submitted to the University of Manitoba
in partial fulfillment of the requirements for
the degree of Master of Nursing at the University of Manitoba

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Abstract

This descriptive cross-sectional survey examined potential threats to the confidentiality of employee health information in occupational health nursing practice in Manitoba. Nurses' perception of a problem maintaining confidentiality was probed. Objective measures of the difficulty of maintaining confidentiality included sources and frequency of inappropriate requests for information and methods of occupational health records handling. Factors related to the nurse or his/her working environment which may affect ethical decision-making were explored.

Data were collected using a self-administered mail questionnaire developed by the researcher. Ninety-four nurses were surveyed. An 86.2% response rate was achieved.

Over half of the nurses surveyed indicated that they perceived maintaining confidentiality of employee health information to be a problem. Those who perceived this to be a problem were more likely to receive requests, particularly inappropriate requests, from employers. Subjects identified remedies for improving the protection of privacy. Resources used by nurses when making difficult ethical decisions were identified. Most respondents tended toward a patient advocacy role conception rather than a bureaucratic role conception in ethical decision-making. Other factors which may affect ethical decisions such as colleague support, decision-making authority, confidence, education, experience, and power-lessness were explored. Based on this study's findings,

recommendations for nursing practice and further nursing research are suggested.

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To Leonard, Duncan, Kelly and Mom.

Chapter 1

Introduction

Free and open communication is vital to the therapeutic relationship between health practitioner and client. A widely held assumption among health professionals is that individuals seeking care and advice will speak more freely and openly if they are confident that information will not be revealed to outside parties (Gallop, 1977). Moreover, the public has come to expect that personal and medical information, gathered during the course of events in a doctor's office or hospital, will remain confidential. Increased technological capabilities to record, store, retrieve, and move information as well as increased access to records sought by insurers, attorneys, employers, and government has generated concern over inappropriate disclosures of information (Warshaw, 1976; Westbury, 1985).

Against this backdrop of general concern, specific interest in the confidentiality of employee health information has precipitated long-standing discussion and debate in the occupational health literature. Beyond being a matter of simply dealing with rapid technological developments, maintaining the confidentiality of employee health records is a matter of moral consequence. Hospitals and similar institutions, private doctors' offices, clinics, and government health departments are assumed to be committed to maintaining confidentiality of medical records. To this end, health care institutions take great care to protect the

privacy of health information. Although breaches of confidentiality sometime occur, this is clearly not an expectation of the public and health care providers. The expectation to maintain the privacy of health information, however, is not necessarily attendant in work sites where occupational health services are provided. In fact the expectation may be just the opposite. It is commonplace for managers to expect access to employee health information (American Association of Occupational Health Nurses, 1988; Rogers, 1988).

The ultimate goal of industry is production for profit. The work of occupational health professionals is logically viewed as ancillary to this goal (Rogers, 1988; Rosenstock & Hagopian, 1987). As a result, nurses employed in industry may encounter pressure to divulge employees' personal and medical information to help the company protect its business interests (Rest, 1988). This poses an ethical dilemma for occupational health nurses, the resolution of which may have significant consequences for their clients and for nurses themselves.

From the worker's (the client's) perspective, the inappropriate release of health information constitutes not only an invasion of privacy, but also it may cause harm if the information is shared unadvisedly (Rosenstock & Hagopian, 1987). As for nurses, they are being asked to do something which may be against individual conscience and which breaches a professional code of ethics. They may be forced to choose between principled behaviour on the one hand, and the fear of

reprisal for that same behaviour on the other hand. Professional reputations among co-workers, employees, and employers can be enhanced or sullied. On a more personal level, nurses' actions can affect employment, income, status in the professional community, and the respect gained from those for whom and to whom they are responsible (Rest, 1988).

The occupational health literature, most of it emanating from the United States, frequently discusses the legal and ethical obligations of occupational health professionals to employers and workers concerning medical information (Annas, 1976; Bundy, 1969; Gallivan, 1963; Miller, 1977; Rabinow, 1988; Rosenstock & Hagopian, 1987). General consensus has emerged on two points. The first is that the employee/worker must provide written informed consent before health information is released to the employer or other third party (American Association of Occupational Health Nurses, 1988; Canadian Nurses Association, 1991; Ontario Occupational Health Nurses Association, 1987). The second point recognizes the need for employers to be provided with enough health information about an employee to make administrative decisions. Such information, however, is to be limited to that describing work capabilities or limitations and must not include information of a more specific nature such as diagnosis or other particulars of the employee's health status (American Occupational Medical Association, 1983; Canadian Medical Association, 1982; Ontario Occupational Health Nurses Association, 1987).

Anecdotal evidence from informal discussions among occupational health nurses in Manitoba has suggested that maintaining confidentiality of employee health information is an ongoing concern. The literature has suggested that this is not a limited local problem. In an Ontario judicial inquiry, Krever (1980) found evidence of pressure exerted on occupational health professionals, especially nurses, to disclose information to employers. In the United States, Reif (1983) documented the indiscriminate and unauthorized release of medical information to employers by an occupational health clinic servicing industry.

Despite the plethora of general discussion of ethical issues and, in particular, confidentiality of employee health records, there has been little systematic study of general perceptions and practices regarding ethics in occupational health (Haines, 1989). A recent survey of members of the American Association of Occupational Health Nurses identified twelve research priorities. Of the twelve research priorities, "methods for handling complex ethical issues related to occupational health (e.g. confidentiality, truth telling)" (Rogers, 1989, p. 497) ranked third.

Those who have studied ethical conflicts found that these conflicts frequently involved confidentiality and that subjects used either a professional code of ethics or personal beliefs to resolve conflicts (Brandt-Rauf, 1989). Community health nurses (among whom occupational health nurses could be categorized) relied most heavily on nursing colleagues for

assistance when dealing with significant ethical problems. Other sources of guidance included religious values, life experience, laws, professional codes, and common sense (Aroskar, 1989).

Clearly, further study of the problem of maintaining confidentiality of employee health information was needed. No suitable instrument to assess the maintenance of confidentiality of employee health information by occupational health nurses existed. Moreover, although several instruments have attempted to measure moral judgement of nurses in ethical dilemmas (Crisham, 1981; Davis, 1981; Ketefian, 1981a, 1981b), none were appropriate for the proposed study. The purpose of this study was to develop a questionnaire to measure potential threats to the confidentiality of employee health information in occupational health nursing practice in Manitoba.

Study Objectives

The specific objectives of this study were:

1. to describe the magnitude of difficulty, among Manitoba occupational health nurses, of maintaining confidentiality of employee health information by determining:
   a) all sources and the frequency of requests for employee health information;
   b) the frequency of employer requests for employee health information which is unaccompanied by written authorization from the employee;

c) the frequency of employer requests for employee health information of a specific nature such as a diagnosis or other particulars of the employee's health status;

d) the type of specific employee health information that employers are most likely to request; and

e) the methods used by occupational health nurses to handle occupational health records.

2. to determine whether occupational health nurses perceive the maintenance of confidentiality of employee health information to be a problem, and, if so, to determine their self-identified solutions for improving the protection of confidential employee health information;

3. to identify resources used by occupational health nurses when faced with a difficult decision regarding the release of employee health information; and

4. to isolate characteristics of the individual nurse and the working environment which may be related to ethical decision-making regarding the protection of confidential employee health information.

Specific terms in the objectives are defined in Appendix I.

Assumptions Underlying the Study

Two basic assumptions operate in the study of maintenance of confidentiality of employee health information by occupational health nurses. The first is that privacy is highly valued in this society. The second is that nursing's

central moral concern is the welfare of human beings. The corollary of these two assumptions is that, since privacy is a positive human value, nurses would strive to protect individual privacy in their professional relationships with clients. In the present study, it therefore was assumed that occupational health nurses would endeavour to protect the confidentiality of health information of their clients (workers).

Significance of the Study

Research is limited on ethical issues in occupational health nursing. The present study contributes to an understanding of one ethical issue in occupational health - the confidentiality of employee health information.

The results of this study provide occupational health nurses practicing in Manitoba with insight into their own circumstances regarding the protection of confidential employee health information. An assessment of factors related to ethical decision-making among occupational health nurses was another outcome. Finally, the study provides support for changing practice and for strengthening current practice regarding the maintenance of confidentiality of health information.

Chapter 2

Literature Review

To appreciate the difficulty faced by occupational health nurses in protecting the privacy of their clients' health information, it is necessary to understand the source of their legal and ethical obligations to do so. Two associated factors must also be considered. One factor is the setting in which confidentiality is to be maintained, that is, the work site. The second factor is the role of nurses in protecting the privacy of health information. This review will begin with a description of the field of occupational health and the practice of occupational health nursing. The main discussion will review the legal and ethical dimensions of maintaining confidentiality of health information.

Occupational Health

As part of community or public health, occupational health is distinguished from other medical specialties by its focus on the environmental determinants of disease and methods of disease prevention. Prevention of occupational disease and injury is the primary objective of all activities in the practice of occupational health (Robbins, 1988), although disease recognition is also important. Recognition of occupational disease in individuals is accomplished primarily by taking an occupational history and, in populations of workers, by application of epidemiologic research methods.

Measures to prevent occupational disease and injury are divided into those that focus on the worker and those that focus on the workplace. The most effective disease prevention measures are those that affect the workplace, for example, engineering controls, changed work practices and substitution of less hazardous substances for more hazardous ones. Other measures primarily affect the worker by reducing the damage resulting from workplace hazards without actually removing the source of the problem. Examples are: education and advice, use of personal protective equipment, administrative measures, and screening for early detection of disease (Levy & Wegman, 1988).

Occupational Health Services

The resources and policies of any particular employer largely determine the existence and scope of occupational health services for that organization. With the exception of those associated with regulatory functions, occupational health services in Canada and the United States are provided almost wholly outside the traditional public health system. Employers independently develop and provide services of their own.

Important program elements in an occupational health service include: 1) ensuring a safe and healthful workplace through careful environmental monitoring and engineering controls; 2) matching the requirements of work with the capabilities and limitations of individual workers through job

design and selective job placement; 3) rehabilitation of ill or injured workers; and, in some cases, 4) health promotion programs such as blood pressure screening, smoking cessation and employee assistance programs which provide counselling services for workers experiencing substance abuse and other personal problems (Block, 1988).

In Manitoba, occupational health and safety is regulated under the Manitoba Workplace Health and Safety Act and applies to all workers and employers, save the federal government, federal crown corporations and their respective employees, which are subject to federal statutes. Historically the Act has been administered by a separate government department or by the Department of Labour. Although there is a general legal duty placed on the employer to provide a workplace that is safe and without risk to health, there is no specific legal requirement to provide occupational health services. The exception is in instances where the Minister may use his/her discretionary power to order such a service (Manitoba Workplace Safety and Health Act, R.S.M. 1987, c.W210, s.53, ss. 1-3).

Robertson (1987) argued that the provision of in-house occupational health services is infeasible for the majority of employers in Manitoba. She cited several reasons for this view. For example, the manufacturing sector contributed about 14% of the gross domestic product in 1982 making it an important contributor to the Manitoba economy. The manufacturing sector is comprised largely of small businesses,

with about 80% of companies employing fewer than 25 people each. Businesses in this sector tend to be independent rather than subsidiaries of larger firms. Also, the manufacturing sector is relatively diversified. Robertson (1987) suggested that the small size of these businesses makes it uneconomical for them to provide in-house occupational health services, and their diversified and independent nature prevents them from relying on the resources of a parent company or a dominant industry.

To be fully effective, occupational health services should be provided through an interdisciplinary team effort (Block, 1988; Brown, 1981; International Labour Organization, 1985). The scope of the field requires the knowledge and skills of a number of specialties. Core disciplines of the team include occupational physicians and nurses, industrial hygienists, and safety engineers. Ancillary disciplines are ergonomists, epidemiologists, and toxicologists. In reality, the interdisciplinary health care team exists infrequently in occupational health settings. In Manitoba, the potential for interdisciplinary occupational health teamwork is limited to a few large employers.

When a company can afford to provide occupational health services, an occupational health nurse is usually the lone provider. In 1984 in Canada, occupational health nurses numbered 4000, constituting the largest pool of occupational health professionals ("Test provides," 1984). In 1980 in Ontario there were approximately 1200 occupational health

nurses, 75% of whom worked in industry without collaboration with a physician (Krever, 1980). Approximately 90 occupational health nurses are employed in Manitoba (J. Dietrich, personal communication, February, 1990) and it is not known what percentage of these nurses function alone. Northrop (1987) estimated that in 75% of occupational health services in American work sites, the occupational health nurse was the sole provider. These statistics seem to indicate that nurses lack the support of nurse colleagues or other occupational health team members within the organization. This lack of support may have important implications for nurses in fulfilling their ethical and legal obligations.

Occupational Health Nursing

Historically, first aid was the primary service provided by "industrial nurses." Today the scope of services provided by occupational health nurses has broadened in breadth and depth. Using nursing knowledge and skills, the occupational health nurse's primary goal is to "...assist the worker to obtain and maintain optimal physical and psychological functioning" (Brown, 1981, p.4), a goal which is decidedly preventive in its orientation. Responsibilities may include: 1) administrative functions such as managing the occupational health service; 2) occupational health and safety program development; 3) provision of health education to individuals and groups; 4) health assessments such as pre-placement screening and return-to-work assessments; 5) emergency and

primary care such as response to life-threatening emergencies and treatment of minor illness or injury, as well as determining the work-relatedness of such events; 6) administration of employee assistance programs; 7) work environment assessments; and 8) disaster planning (Alberta Occupational Health and Safety, undated; Stewart, Searl, Smillie, May & Sayers, 1985).

Information gathering and documentation is an important component of nearly all occupational health nursing activities. Inevitably the nurse is involved in the private matters of individuals. Day-to-day long-term association with working adults allows the nurse access to information about the worker's health, domestic, financial, and social situation (Zachary, 1969).

Health Record

The term health record "... refers to all types of information on the health of an individual under treatment or care regardless of where it was collected or used.... It includes nurses' notes, occupational health files, consultations, diagnostic reports, etc" (Rozovsky & Rozovsky, 1984, p.2). The United States' Occupational Safety and Health Act (OSHA) more specifically defines the employee health record as:

> ...a record concerning the health status of an employee that is made or maintained by a physician, nurse, technician, or other health care personnel,

> including: questionnaires, histories, results of examinations (preemployment, preassignment, periodic, and episodic), laboratory test results, medical opinions, diagnoses, progress notes, recommendations, descriptions of treatments and prescriptions, and employee's medical complaints (Northrop, 1987, p.246).

The primary purpose of the health record is clinical - as a documented reminder to the person providing service of the course of an individual's care and as a means of communication among health care professionals about past, present, and future care (Canadian Health Record Association, 1980; Rozovsky & Rozovsky, 1984). Ancillary uses of the health record include: teaching, research, statistical analysis, insurance and funding, accreditation, and audit purposes (Rozovsky & Rozovsky, 1984).

Obligation to Maintain Confidentiality of Health Information

As a matter of ethical (and sometimes legal) obligation, health information cannot be transmitted by the health professional to anyone other than the client, except where required by law or with the consent of the client. This obligation springs from a long-held tradition in our society. As Mr. Justice Horace Krever of the 1980 Royal Commission of Inquiry into the Confidentiality of Health Records in Ontario noted:

> ... My starting point is a presumption that our society values privacy for health information, creating a need for the observance of, or respect for, confidentiality. To put it another way, ... we do not favour free and uninhibited disclosure of everyone's health information (Krever, 1980, p.7).

Controlling access to health information becomes more difficult as the complexity of the health care system increases, requiring the transfer of information from facility to facility and from practitioner to practitioner. By comparison, controlling access to occupational health records may be more difficult since these records are not usually subject to the same tight administrative and statutory controls as those in the traditional health care system (Rabinow, 1988).

Difficulty Maintaining Confidentiality of Employee Health Information

Anecdotal evidence has suggested that occupational health nurses encounter difficulty in maintaining confidentiality. Conversations among members of the Manitoba Occupational Health Nurses Interest Group often turn to this topic. During public consultation workshops of the Occupational Health Services Study conducted in Manitoba in 1987, one experienced nurse confessed her ignorance of her responsibilities regarding confidentiality of health information. In the United States, Reif (1983) documented the problems she found

when working for an occupational health clinic servicing industry. The problems she noted included: 1) indiscriminate release of medical information to employers, 2) employees were not informed when information was released from their files, and 3) the clinic obtained a so-called "blanket release" to cover themselves legally when releasing information. Furthermore Reif found that, in most instances, the employer did not have health care professionals on staff to supervise the use of medical information. Company secretaries and administrative assistants had access to health records and decision-making powers regarding dissemination and storage of health information (Reif 1983).

In files taken from the offices of private investigators in Ontario, Justice Krever (1980), during his Inquiry into the Confidentiality of Health Information, reported that health information was obtained from employers without the consent of employees on 408 occasions. (The total number of attempts made by private investigators to obtain information was not provided.) On 15 of the 408 occasions the information was supplied by occupational health nurses. As well Justice Krever noted:

> there is substantial evidence that often pressure is exerted on health professionals to disclose information to the employer. This is a special problem for the occupational health nurse who is not perceived by our society to have as high a status as the physician and, on the available

evidence, is therefore more likely to be subject to pressure from the employer to reveal confidential information (Krever, 1980, p.161).

In 1988, in response to the "...expressed need of members for guidance and support in this arena" (Williamson, 1988, p.5), the American Association of Occupational Health Nurses (AAOHN) published a position paper on confidentiality of health information. The AAOHN maintained that it is commonplace for individuals other than health professionals, such as managers and personnel directors, to have access to employee health records (AAOHN, 1988).

Legal Aspects of Medical Confidentiality in the Occupational Health Setting

Law respecting ownership of health records and confidentiality of client information is covered by both common law and statute. Client information may be protected by a number of provincial statutes such as those dealing with the health insurance program or certain types of health institutions. In Ontario the Health Disciplines Act and the Occupational Health and Safety Act provide some safeguards for confidentiality of health information generally, and employee health information, specifically. A nursing regulation under the Health Disciplines Act includes failure to exercise discretion in respect of disclosure of confidential health information in its definition of professional misconduct. As well, a recent amendment to the Ontario Occupational Health

and Safety Act specifically prohibits employers from seeking access to a worker's health record without the worker's written consent (R.S.O. 1990, c.7, s.33, ss.1a) This amendment broadens the scope of the Act from the previous situation in which, as Tremayne-Lloyd (1990) pointed out, protection of confidential employee health information was limited because the law applied only to information gathered for purposes of complying with the Act and not to information gathered by occupational health professionals for many other purposes in the occupational setting.

In Manitoba, no similar general protection is afforded employee health information by the Workplace Safety and Health Act. One exception is the Manitoba Hearing Conservation and Noise Control Regulation 103/88R, which requires that health professionals maintain the confidentiality and security of health records. However, this regulation is very specific and only applies to information regarding the worker's hearing obtained during the implementation of workplace hearing conservation programs.

In common law, court action against health practitioners and institutions for unwarranted disclosure of information has been minimal although jurists assume that there are grounds for legal action (Rozovsky & Rozovsky, 1984). The possibilities include: 1) an action for breach of an implied contractual obligation to maintain confidentiality, 2) an action for breach of confidence (though this is still uncertain as far as Canadian Common Law is concerned), 3) an

action for a breach of privacy (in the U.S. a tort has been developed for a breach of confidentiality but this has not happened in Canada), 4) civil action against someone who violates another's privacy which has been guaranteed by "privacy" legislation in Manitoba and some other provinces, and 5) an action against a health worker or institution on the basis of negligence in breaching confidentiality if injuries result. Although legal redress may be possible, civil suits and prosecutions are rare because breaches of confidentiality are difficult to prove (Rozovsky & Rozovsky, 1984).

Another route of redress lies in disciplinary action via professional licensing or registration bodies, but action is limited to those governed by such bodies. The client may not even be aware that there has been inappropriate release of information. The result is that enforcing confidentiality is very difficult (Rozovsky & Rozovsky, 1984).

Another issue is health record ownership. This matter is most frequently discussed in the context of <u>client</u> access to information contained in physician or hospital records. In at least one court decision, the principle upheld was that the information in the record belongs to the provider of health services and not to the client (Rozovsky & Rozovsky, 1984). In the case of employee health records, the issue is not one of ownership, per se, but whether the employer, as owner of the record, has access to and control of the records. During his Inquiry, Justice Krever observed that "a view often expressed is that ownership of records entitles the owner to

control over and access to them" (Krever, 1980, p. 168). Instances cited were employers who insisted on retaining keys to the cabinets in which health records were stored, employers refusing to allow nurses to keep health information in locked drawers and, ironically, hospital administrators who considered that health information kept on staff members should be available to administrators without restriction (Krever, 1980, p.168).

A related difficulty is confused and ambiguous loyalties resulting from the pressure to respond to competing obligations in occupational settings (Annas, 1976; Rosenstock & Hagopian, 1987).

> Strictly speaking, in the normal employer-employee relationship, what is known to the employee should also be known to the employer. The problem that arises when the employees are professional persons who have an obligation of confidentiality, whether that obligation arises under a regulation..., or whether the obligation arises because of a code of ethics to which they subscribe, is whether the employer can reasonably expect the employee to violate that confidentiality obligation.... It is questionable whether an employer has the right to require an employee with professional qualifications to violate his or her duty of confidentiality (Krever, 1980, p. 167).

Most of the occupational health literature published on the legal aspects of medical confidentiality is American. Application of legal principles to Canadian situations must be done with caution. It is, nonetheless, instructive to review this literature.

In the United States, the federal Occupational Safety and Health Administration (OSHA) enacted the Access to Employee Exposure and Medical Records standard (1980) to assure that occupational health records are preserved and to outline designated right of access. While the standard provides for direct worker access to his or her own record (with certain qualifications), the standard does not regulate corporate access to employee health records (Jennings, 1982, p.228).

Over the last two decades there has been much discussion over the rights of the employee as client. Once a nurse- or doctor-client relationship is established, any information obtained in that relationship becomes confidential (Bundy, 1969). However, a fundamental question endures. Is a nurse- or physician-client relationship established between an occupational health professional and a worker in a work setting (Annas, 1976; Bundy, 1969; Gallivan, 1963; Northrop, 1987; Rabinow, 1988)?

Current U.S. case law is not settled on this issue (Miller, 1977; Northrop, 1987; Rosenstock & Hagopian, 1987). There appears to be consensus that a "no relationship" situation exists when an applicant is being screened for a job (Annas, 1976; Gallivan, 1963; Miller, 1977; Rabinow, 1988;

Rosenstock & Hagopian, 1987). Regardless, some argue that the employer is entitled only to an opinion regarding fitness to work and not to a medical diagnosis or other personal information (Gallivan, 1963; Miller, 1977; Rosenstock & Hagopian, 1987). Otherwise the rights of employee as client are the same as they would be in any health care practitioner-client relationship (Miller, 1977).

To confuse the issue even further, in 1985 the College of Physicians and Surgeons of Ontario addressed the issue of confidentiality in the context of "third-party" examinations. In third party examinations, such as for insurance companies or for the Workers Compensation Board, the nature of the client/doctor relationship is changed. The physician acts primarily in the interest of the third party. In the College's view, occupational physicians have a different relationship to their worker clients because the employer is considered the third party to whom the physician is responsible. Therefore, it is the College's view that the physician need feel no professional conflict in unconditionally leaving medical records with a corporation when it discontinues its health care facilities (Tremayne-Lloyd, 1990).

Another important element for the legal disclosure of health information is the principle of informed consent. Confidentiality should be thought of as being controlled by the client and not by the health care practitioner (Bundy, 1969). Before a client consents to disclosure, he or she

should know what information is to be disclosed, the exact use that will be made of it, and the possible consequences of the release (McLean, 1976). The consent should be in writing (Gallop, 1977). Some workers are asked to give "blanket releases" for access to health records in order for them to receive benefits from insurance companies and Workers Compensation Boards (Northrop, 1987). However, experts in the management of the health records have condemned the use of such releases (CHRA, 1980; McLean, 1976).

The matter of who pays for the health services is also important in determining who may have access to resulting health information. Bundy (1969) and Gallivan (1963) argued that the client-physician relationship is established regardless of whether the employer has hired the physician and regardless of whether the purpose the employer has in mind solely benefits the employer. The U.S. courts have interpreted the situation differently, according to Rabinow (1988). She suggested that American courts have assumed that when a worker goes to a company-provided occupational health practitioner for screening tests, examinations or treatment, the worker does <u>not</u> intend to keep his/her records hidden from the employer (Rabinow, 1988, p.316).

The common law remedies for unauthorized disclosures of health information in the United States are similar to those in Canada. They include suits for breach of confidentiality, invasion of privacy and breach of implied contract (Annas, 1976).

The International Labour Organization, a tripartite body of the United Nations representing governments and employers' and workers' organizations, establishes conventions or guidelines on a large range of topics for its member nations. These guidelines are intended to be enacted into law by the "competent authorities" in each country. A convention published in 1985 concerns the establishment of occupational health services. Section IV (38) of this convention states that "each person who works in the occupational health service should be required to observe professional secrecy as regards both medical and technical information..." (ILO, 1985, p.9). This convention has not been made law as yet in any jurisdiction in Canada.

As with any general rule, there are certain exceptions to the obligation to maintain confidentiality. Sometimes access to medical information is granted by statute such as in the case of medico-legal investigations, workers compensation legislation, vital statistics legislation, and child abuse legislation (Rozovsky & Rozovsky, 1984). As well there may be a common law "duty to warn" which requires a health professional to break confidentiality in cases where a third party is in some danger as the result of a client's condition (Rozovsky & Rozovsky, 1984; Yorker, 1988). A court order to produce medical records or a judge's direction to a witness to divulge confidential patient information are other exceptions. The Canadian Security Intelligence Act allows access to health

records without a court order (Canadian Medical Association, 1985).

In summary, there are few specific Canadian statutes which protect the privacy of occupational health records, per se, and the possible common law remedies for breaches of confidentiality have been largely unused. This legal vacuum, however, does not relieve occupational health professionals of the general ethical obligation to maintain confidentiality of health information.

Ethical Aspects of Medical Confidentiality in the Occupational Health Setting

While the law may prescribe what nurses shall or shall not do in certain instances, their professional actions are governed, for the most part, by a professional code of ethics. Ethics are sets of values followed by individuals or groups which attempt to define moral principles so as to determine which actions are right and which are wrong (Rogers, 1988). Professionals develop ethical codes reflecting a consensus of opinion regarding minimal standards of conduct, moral duty and obligation for the protection of the public (Whorton & Davis, 1978). Generic codes of ethics exist for both nurses (Canadian Nurses Association, 1991) and physicians (Canadian Medical Association, 1990).

In 1991 the Canadian Nurses Association published a revised Code of Ethics for Nursing. A number of principles contained within the Code are directly relevant to the issues

of confidentiality and the potential conflict of interest situations in which occupational health nurses may find themselves. As for confidentiality the Code states:

> The nurse holds confidential all information regarding a client learned in the health care setting... The rights of persons to control the amount of personal information that will be revealed applies with special force in the health care setting. It is, broadly speaking, up to clients to determine who shall be told of their condition, and in what detail (CNA, 1991, p.5).

The Code also addressed conditions of employment for nurses. Specifically it said, "nurses accepting professional employment must ascertain, to the best of their ability, that employment conditions will permit provision of care consistent with the values and obligations of the Code" (CNA, 1991, p.17).

Sometimes specific codes are developed for the ethical concerns of more specialized groups. In the United States, where groups of occupational health specialists have a longer history and are more formally organized than in Canada, codes of ethics have been developed specifically for occupational physicians and nurses. No such nationally-recognized codes presently exist in Canada, although individual professionals may use the American codes for guidance.

Occupational health professionals have recognized that, although employees are entitled to privacy of their health

information, the employer, too, is entitled to some information regarding the employee's ability to perform the job. In an attempt to balance these two obligations, the American Occupational Medical Association (AOMA) and the American Association of Occupational Health Nurses (AAOHN) have provided guidance to their members regarding control of and access to employee health information. The AAOHN's Code of Ethics, adopted in 1986, states:

> occupational health nurses should safeguard the employee's right to privacy by protecting confidential information and releasing confidential information only upon written consent of the employee or as required by law (Rest, 1988, p. 187).

More recently the AAOHN has elaborated on the confidentiality of health records by providing more explicit guidelines. Essentially it recommended that disclosures not be made to the employer except in instances where information may help in human resource management, including information obtained from job placement examinations. Disclosure is made to management on a need-to-know basis with reference only to ability to work, and after the employee has given written authorization (AAOHN, 1988). Similar recommendations have been made by the American Occupational Medicine Association, the Manitoba Occupational and Preventive Medicine Section of the Canadian Medical Association, and the Ontario Occupational Health Nurses Association. These bodies advise that, while employers

are entitled to counsel about the medical fitness of individuals in relation to their work, they are not entitled to diagnoses or other detailed health information. No disclosures should be made without the written and informed consent of the worker (AOMA, 1983; Canadian Medical Association, 1982; Ontario Occupational Health Nurses Association, 1987).

Theoretical Basis for Confidentiality of Health Information and Informed Consent

The notion that persons are entitled to privacy and must give their permission before information may be released to third parties is rooted in deontologic theory (Rogers, 1988). Of the four main principles in deontologic theory - autonomy, nonmaleficence, beneficence and justice - autonomy is the principle which underlies the professional's moral obligation to maintain confidentiality and to obtain voluntary informed consent for release of information.

> Autonomy is a form of personal liberty of action where the individual determines his or her own course of action in accordance with a plan chosen by himself or herself. The autonomous person is one who not only deliberates about and chooses such plans but who is capable of acting on the basis of such deliberations, ... A person's autonomy is his or her independence, self-reliance, and self-contained ability to decide (Beauchamp & Childress, 1979, p. 56).

In matters of confidentiality, the assumption is that the autonomous individual may choose to confide in the health care professional who, in turn, has no moral right to divulge that information to anyone other than those involved directly in the person's care. The exceptions have been in cases where the rights of the group are believed to transcend individual rights.

Health care professionals are often faced with individuals whose autonomy is diminished due to illness. This sometimes provides justification for paternalistic actions. In occupational settings where the nurse's clients are generally healthy, rarely if ever, could breaches of confidentiality be defended on the basis of diminished autonomy.

The ethical obligation to obtain the client's permission to release information, in other words to obtain informed consent, is also related to the principle of individual autonomy. By requiring that informed consent be obtained, autonomy is protected because individuals are granted the right to make decisions regarding their own lives. Several elements comprise informed consent. These elements include: that the consent be voluntary, that the client be competent to consent, that the practitioner adequately disclose relevant information and that the client adequately comprehend what is being disclosed (Beauchamp & Childress, 1979). The issue of voluntariness is particularly delicate in occupational settings. Job applicants may be requested to sign blanket

consent forms authorizing any hospital or physician to release any or all information to the employer. If the choice is between obtaining a job or signing the form, the consent cannot be said to be truly voluntary (Krever, 1980). This places a special burden on occupational health professionals to mitigate coercive forces in client-practitioner interactions.

Ethical Basis of Nursing

Morality and ethics are central to nursing practice; the basic moral concern in nursing is the welfare of human beings (Curtin, 1978; Wilkinson, 1987/88). Whether nurses can be moral agents has been debated. Most ethical theory presupposes an agent who is free of undue coercion in decision-making (Curtin, 1978) yet the structure and process of organizations determine the degree to which employees, in this case nurses, can make decisions. Nurses are in a difficult position in the health care power structure with conflicting loyalties and responsibilities to employing institutions, licensing bodies, physicians, other nurses, clients and clients' families (Jameton, 1977; Wilkinson, 1987/88). The difficulty is compounded in occupational health settings where organizational and professional goals may be starkly contrasted, the former being directed toward production of a service or a product for profit, and the latter being directed toward client care.

Conflicting loyalties and responsibilities frequently place nurses in moral dilemmas. Moral dilemmas are defined as "situations of ambiguity and conflict with equally unattractive alternatives for choice, decision-making and action" (Aroskar, 1979, p. 38). Two major categories of ethical dilemmas have been identified for nursing: those which arise from institutional policies and physicians' orders regarding care, and those which arise from the usurpation of the legitimate authority of the nurse in decisions about nursing care (Curtin, 1978).

Ethical Decision-Making in Nursing

Considerable literature exists on issue-oriented aspects of nursing ethics, such as prolongation of life and truth telling. In contrast, little effort has been devoted to conceptualizing and operationalizing the construct of ethical decision-making in nursing. Given the early stages of the conceptualization process, it is not surprising that little nursing research empirically examines specific variables hypothesized to influence ethical decision-making. The following two sections explore 1) how moral reasoning and ethical decision-making have been conceptualized in nursing and 2) to what extent variables such as professional autonomy and role conception are thought to influence ethical decision-making.

Moral reasoning and ethical practice. To better understand the work of nursing scholars on the conceptualization of moral reasoning and ethical practice, a short discussion of work done outside of nursing is necessary. Blasi (1980) comprehensively and critically reviewed the literature on moral reasoning and moral action. He noted the difficulty of conceptualizing the two constructs, moral reasoning and moral action, and also the difficulty of studying the relationship between these two constructs.

Blasi observed two different assumptions underlying the study of moral action/behaviour. The preponderant assumption is that moral action results from behavioural traits, generalized action tendencies or habits and their interplay. Therefore, moral action is considered to be automatic and essentially irrational. Another view of moral action, that of cognitive-developmentalists such as Piaget and Kohlberg, is that moral action is indeed rational. This assumption stresses the cognitive processes that give meaning to morality. Actions beneficial to society or to an individual human being would not be considered moral unless they were performed willingly by an agent in response to values that he or she understood. The cognitive-developmental perspective assumes that moral reasoning is more than just a post hoc rationalization of one's actions. Without moral reasoning or judgement "...an action, no matter how beneficial, would not be moral" (Blasi, 1980, p. 4).

According to Blasi, the first assumption tends to deny a relationship between moral judgement and moral action. Blasi favoured the latter assumption and asserted that empirical research, although fraught with limitations, supports a relationship between the two constructs. He advised that more research is needed to identify the processes that fill the gap between a concrete moral judgement and its corresponding action.

Nursing scholar, Ketefian (1989b), has attempted to define the constructs of moral reasoning and ethical practice (moral action/behaviour) in a nursing context as well as to clarify the relationship between these constructs. Her work is influenced by Kohlberg, whose theoretical approach is favoured by Blasi (1980). Moral reasoning refers to the "...cognitive and developmental process of reasoning about moral choice" (Ketefian, 1989b, p. 509). She noted that moral judgement and moral development are synonyms. "Ethical practice refers to the decisions made and actions taken in ethical dilemma situations" (Ketefian, 1989a, p. 174). Suggested synonyms included moral behaviour, ethical behaviour and ethical decision-making. Henceforth the term ethical decision-making will be used to mean ethical practice, moral action or moral behaviour.

Ketefian (1981a/b, 1989a/b) and several other nursing researchers have advanced the theoretical understanding of moral reasoning and ethical decision-making in nursing. A relationship between moral reasoning and ethical decision-

making is assumed, the latter considered to follow naturally from the former.

Ketefian (1981a, 1981b) and Crisham (1981) have studied factors associated with moral reasoning in nursing. Using Kohlberg's theory of moral development, Ketefian (1981a, 1981b) conducted a descriptive study of 79 practising nurses using instruments to measure critical thinking ability and ability to define issues. An association between critical thinking and moral reasoning was found. Differences in moral reasoning between so-called professional and technical nurses was noted, and critical thinking and education together accounted for nearly 33% of the variance in moral judgement.

Crisham (1981) conducted a study of 225 subjects divided into groups of staff nurses with associate and baccalaureate degrees, nurses with masters degrees in nursing, college junior "prenurses" and graduate level "nonnurses." The primary purpose was to develop an instrument to measure nurses' responses to nursing dilemmas and the importance given to moral issues and practical considerations. Other objectives included a comparison between groups of subjects on moral judgements, both general and nursing-specific. Crisham found that the level of education for all five subject groups was positively related to the level of moral judgement about hypothetical moral dilemmas. As well, subjects with previous involvement in similar dilemmas scored significantly higher on the instrument's principled-thinking scale than subjects who were unfamiliar with the dilemmas.

Moral reasoning, and resulting ethical decisions, are not presumed to occur in a vacuum. Of the variables thought to affect ethical decision-making in nursing, perhaps role conception and general factors affecting nursing autonomy are the most useful for gaining insight into the ethical decision-making process.

Role conception. Thorough examination of ethical decision-making in nursing requires an understanding of how nurses conceptualize their role vis-a-vis clients and other players in health care. Winslow (1984) has documented the historical shift in metaphors which affects nursing ethics. One of the early powerful metaphors was nursing as military effort in the fight against disease. Virtues associated with this metaphor included loyalty, obedience to those of "higher rank" such as physicians and maintenance of confidence in authority figures. A more recent metaphor has been that of nurse as client advocate with attendant virtues such as courage and the defense of clients and their rights. The 1970's witnessed the integration of the ideals of advocacy into international and national nursing codes of ethics. For Winslow (1984), "...the central moral significance of the advocacy metaphor lies in its power to shape actions intended to protect and enhance the personal autonomy of patients" (p. 38). But, noted Winslow, the metaphor is not without attending problems. The nurse who accepts the responsibility of defending the rights of the client will often encounter

controversy. Furthermore, the nurse most certainly will be torn by conflicting loyalties - loyalties to clients, to professional colleagues, to employing institution and to him or herself.

Murphy (1982) suggested three role conceptions of the nurse in the nurse-client relationship, each with differing effects on ethical decision-making in nursing. The three role conceptions are: patient advocate, physician advocate, and bureaucratic advocate. In the "patient advocate model," the nurse's moral authority is equal to that of any other health professional. The nurse is not subservient to either physician or hospital administration. This type of relationship lends itself to the deontological model of decision-making in which an action is right if it is in accordance with a moral rule. In this model "... a moral relationship among nurses and patients is one in which the patients' autonomy, dignity, and worth are respected, precluding using the patient as a mere means to the ends of medical science or the bureaucracy" (Murphy, 1982, p.18).

In the "physician advocate model," the nurse is seen as an extension of medicine. The nurse's role is to enhance the client's confidence in the physician. As for moral decisions, the nurse is likely to be governed by the interests of maintaining harmonious relationships between himself or herself and physicians and other authority figures. In instances of ethical conflict, the claims of physicians and colleagues will win out over those of the client.

In the "bureaucratic advocate model" of the nurse-client relationship, the nurse is expected to advance the goals of the institution. The nurse's responsibility to individual clients is severely limited. The emphasis is on team work. The nurse's ethical obligation is to the physician, the leader of the team. The client is expected to give up individual rights and freedoms for the greater good of all the other clients and health care personnel. The ethical decisions of nurses who function in the bureaucratic model are governed by the rules of authority figures and institutions which makes it difficult or impossible to weigh competing claims of the individual.

According to Murphy, the bureaucratic and physician advocate models lend themselves to a moral consequentialist-utilitarian type of moral decision in which sole concern rests with the consequences of actions and not with the means of achieving good ends. In these models the client becomes the means to further the needs of the health care bureaucracy and medical science. "Compared with the patient advocate model the bureaucratic and physician advocate models are obviously deficient in almost all their dimensions in terms of the human rights of the patient" (Murphy, 1982, p. 16). Although Murphy's analysis of nurse-client relationship models presented clear-cut distinctions between each model, it is likely that there is considerable blurring of the distinctions as these tendencies are played out in real-life situations.

Using Murphy's (1982) nurse-client relationship models, Pinch (1985) tested the role of autonomy in ethical decision-making. Test subjects were first year students, senior students, and graduates of a baccalaureate nursing program. Results indicated that first year students were less likely to choose the autonomous model of the relationship (patient advocate model), were less likely to take risks and had lower scores on attitudes toward professional nursing autonomy than did the senior students or graduate nurses. Unfortunately these results are not very helpful for examining ethical decision-making among practising nurses since students are not likely to have encountered ethical dilemmas and the competing claims of various parties in the health care setting to the extent that practising nurses have. Therefore, study findings about student nurses cannot be generalized to the larger practising nurse population.

Further work on role conception was conducted by Ketefian (1985). She tested the relationship between professional and bureaucratic role conceptions and moral behaviour among 217 practising registered nurses representing different positions, areas of practice, education, age, ethnic affiliation, and work settings. Although there is bibliographic evidence that Ketefian was influenced by Murphy (Ketefian 1981), it is difficult to determine if Ketefian's definition of "professional" role would fit that described by Murphy's (1982) "patient advocate model." Inasmuch as Ketefian's "professional role" encompassed behaviour intended to serve

and protect the public and included practising according to the profession's code of ethics, it is assumed that there are common elements between this concept and Murphy's concept of patient advocate role. Similarly, it is assumed that there is congruency between Murphy's bureaucratic advocate and Ketefian's bureaucratic role conception, in that Ketefian viewed the bureaucratic role conception as loyalty to the employing institution and following administrative rules and routines.

Ketefian postulated that nurses' professional-bureaucratic role conceptions, and their perceptions of the discrepancy between ideal role conceptions and actual practice of the role would influence moral behaviour. A scale to measure professional and bureaucratic role conception and another scale to measure moral behaviour were administered. Moral behaviour was defined "as the respondents' assessment of the extent to which nursing actions in simulated ethical dilemmas that are in accord with the Code for Nurses ...are likely to be implemented in practice" (Ketefian, 1985, p. 249). Ketefian used Pieta's definition of role discrepancy as the " 'extent to which the perception of the ideal role conception of nursing differs from the perception of the actual practice of the role' " (Ketefian, 1985, p. 250).

Ketefian found that actual professional role conception was positively related to moral behaviour, while ideal professional role conception and professional role discrepancy were negatively associated with moral behaviour. Bureaucratic

role discrepancy was found to be positively associated with moral behaviour.

Factors affecting nursing autonomy. If ethical decisions require a moral agent unconstrained by coercive forces (Curtin, 1978), then it follows that factors having the potential to affect nursing autonomy should be investigated. Professional autonomy

> is a state created by society and by its institutions...whereby given professionals are left unhindered by members of other professions or by bureaucrats in the exercise of their professional competencies. ...professional autonomy involves the freedom to be moral (van Hooft, 1990, p.211).

In a qualitative study using constant comparative methodology and phenomenological inquiry, Wilkinson (1987/88) explored the phenomenon of moral distress resulting from constraints on moral action of staff nurses working in hospitals. Thirteen staff nurses and eleven non-staff nurses were interviewed. Moral distress was defined as "...the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision" (Wilkinson, 1987/88, p.16).

A number of contextual constraints to moral action were identified. External constraints included physicians, the law and/or lawsuits, nursing administration and hospital

administration and policies. Internal constraints included nurses being socialized to follow orders, futility of past actions, fear of losing their jobs, self-doubt, and lack of courage. The predominant feelings of these nurses were anger, frustration and guilt. Given the qualitative nature of this research and its express purpose to generate conceptual properties of the phenomenon of moral distress, generalization of the study findings is not possible.

Schutzenhofer (1988) presented a thoughtful review of social and historical processes which make professional autonomy in nursing problematic. The first is that nursing is a women's occupation. The socialization of women historically has promoted passivity, nurturance (putting others before self), identity formation based on relationships with others rather than defined by occupational role, and limits on decision-making experiences - all of which will affect women's ability to assert their autonomy. Socialization forces within nursing will also affect autonomous functioning. Such forces include the paternalism of medicine and institutional bureaucracy, lack of career commitment among nurses, the sense of other-centredness (doing for everyone, especially physicians), historically regimented and rigid learning experiences in nursing education, and factors in the work environment including hospital policies which constrain professional autonomy, indifference of administrators to nurses' needs and ideas, and inadequate staffing.

A related factor likely to affect the nurse's ability to function autonomously is the degree of powerlessness perceived in the work environment. Fennell and Wood (1985) studied 101 employed occupational health nurses to determine the degree of perceived powerlessness among them. The researchers found that, overall, perceived powerlessness was lower among occupational health nurses than unspecified non-nurse groups. It was suggested that this low level of powerlessness may be attributed to the authority granted to professionals for specialized knowledge relevant to specific tasks and to the exercise of professional control over health care programs in the corporate structure. On the other hand, results indicated that staff nurses in occupational health perceived greater powerlessness than nurses in positions of greater decision-making authority. As well, the greater the number of occupational health nurses employed in an organization, the greater the degree of powerlessness reported. The researchers suggested that this may be due to the fact that nursing supervisors are granted decision-making authority in the corporate structure but that groups of nurses functioning at the staff nurse level may not be able to initiate or change programs without the supervisor's or group's concurrence. This unequal distribution of authority within the professional group and feelings of underutilization could lead to higher degrees of powerlessness. The size of the plant, years of experience and level of formal education showed no relationship to the degree of perceived powerlessness. A

three-fold increase in powerlessness score was found in nurses reporting little control in the health unit. A five-fold increase in powerlessness was reported by nurses with no employer support, compared to those with maximal employer support.

Summary: Ethical decision-making. Ketefian (1989a) reviewed the nursing literature on moral reasoning and ethical practice from 1983 through 1987. Because of the small number of published studies she included doctoral dissertations. She provided the following assessment. Various research designs and samples were used in the study of moral reasoning. The majority of studies were conducted on nursing students and examined the association of variables such as education, social climate, personal characteristics, and cognitive variables (e.g. critical thinking and intelligence) with moral reasoning.

Ketefian concluded that the construct of ethical practice (ethical decision-making) was not well conceptualized in the context of professional nursing practice and hence had not been consistently operationalized in research. Most of the measures of ethical decision-making were constructed by investigators with little attention to the validity and reliability of these measures. A variety of methodologies was used. In addition, Ketefian noted that methodological weaknesses included use of convenience samples and failure to control for intervening variables.

Findings on the relationship between education and moral reasoning were contradictory. Nurses' perceptions of their work environment was related to ethical practice in some studies but not in others. Social support and perceived work autonomy were positively associated with moral behaviour in some studies, while others found a negative association between perceived powerlessness and moral behaviour. Nurses were found to have difficulty in defining or describing ethical dilemmas. Nurses used the deontologic principles of nonmaleficence and beneficence most often. The majority of nurses exhibited a bureaucratic rather than a patient or physician advocate orientation in their ethical decision-making patterns (Ketefian, 1989a).

The foregoing discussion described some of the conceptual work on moral reasoning and ethical decision-making in nursing. These constructs are in the early stages of conceptualization in nursing as Ketefian has noted. Some preliminary research suggests that professional autonomy and role conception influence ethical decision-making in nursing.

Remedies for the Problem of Maintaining Confidentiality of Employee Health Information

Several recommendations have been put forward to alleviate the problem of maintaining confidentiality of health information. Jennings (1982) raised a fundamental question in the matter of abuse of occupational health information: should

corporate medical programs be conducted in-house or be controlled exclusively by management? He suggested that alternative modes of service delivery, sufficiently independent of direct management control and able to satisfy worker concerns (as exist in Sweden), could protect the privacy of occupational health records.

Another of Jennings's suggestions could be implemented as a compromise within the present systems in the United States and Canada. Jennings (1982) recognized that without a legal duty on the part of employers to maintain confidentiality of employee health information, there is no legal right of workers to have their health information kept confidential. He recommended that whenever a company wished to collect medical information from a worker, it should enter into a written contract which states the use to be made of the information and a promise of absolute confidentiality in exchange for the worker's willingness to provide the information or be subjected to a medical examination. Any breach of the contract would be subject to legal action and damages. He suggested that such a contract be made part of every collective bargaining agreement or employment relationship.

Justice Krever (1980) proposed a number of recommendations aimed at improving the privacy of employee health information. These included:

1) enactment of legislation outlining the duty of the professional employee to protect confidential health

information as transcending the duty to obey the employer's instructions;

2) storage of health information separate from other employee information in locked cabinets accessible only to those directly involved in administering the information;

3) establishment of written policies for the handling of employee health information;

4) obtaining written informed consent from the employee for release of health information even if information is being transferred between departments in one organization;

5) not allowing the employer access to health information without the consent of the employee; and

6) providing only a statement of fitness to perform the required work to a prospective employer after a pre-employment medical exam.

Professional organizations such as the Canadian Medical Association, the Canadian College of Health Administrators, the American Occupational Medicine Association and the American Association of Occupational Health Nurses have produced ethical guidelines for their members which are concordant with the recommendations proposed by Justice Krever. Guidelines cover such topics as database security, consent, written policies, record storage, and circumstances of disclosure. Although these codes govern the behaviour of

health professionals, they do not govern the behaviour of employers, nor do they carry the force of law.

Summary

The economic interests of employers and the interest of employees to maintain the privacy of their health information sometimes conflict. Sometimes health professionals, hired by industry to provide occupational health services, are expected to divulge confidential health information. Occupational health nurses are often sole providers of occupational health services, making them frequent recipients of such expectations.

There is little legal protection of the privacy of employee health information. When breaches occur, those legal remedies which do exist are rarely used. There is no question, however, that nurses have an ethical obligation to maintain confidentiality of health information. Role conception and factors affecting nursing autonomy may influence ethical decision-making. Certain constraints have been identified which may have implications for how easily nurses can meet their ethical obligations. External constraints originate from the bureaucratic structures in which nurses are employed. Internal constraints may be related to the socialization of nurses to follow orders, their self-doubt and fear of reprisal. As well it has been postulated that higher levels of moral judgement may be

related to education, past experience with ethical dilemmas and critical thinking capabilities.

Empirical investigation into ethical decision-making in nursing has been scanty and lacking in methodological rigor. Ketefian (1989b) noted the following limitations: 1) weak validity and reliability of measures of ethical reasoning and practice; 2) failure to control for cognitive variables that relate to moral reasoning; 3) little attempt at subsequent studies building on the findings of previous ones; 4) no replication of studies; and finally 5) short-sighted focus on the qualities of nurses rather than investigation of environmental and organizational variables which may affect ethical decision-making.

To date one Canadian judicial inquiry has explored the problem of maintaining confidentiality of employee health information (Krever, 1980). Recommendations to improve the privacy of employee health records were made. If acted upon, many of these recommendations might prove useful for occupational health nurses concerned about maintaining the confidentiality of employee health information. At this juncture, further research into problems of and solutions for maintaining confidentiality of employee health information is important. The intent of the present study was to assess potential threats to confidentiality of employee health information in occupational health nursing practice in Manitoba.

Chapter 3

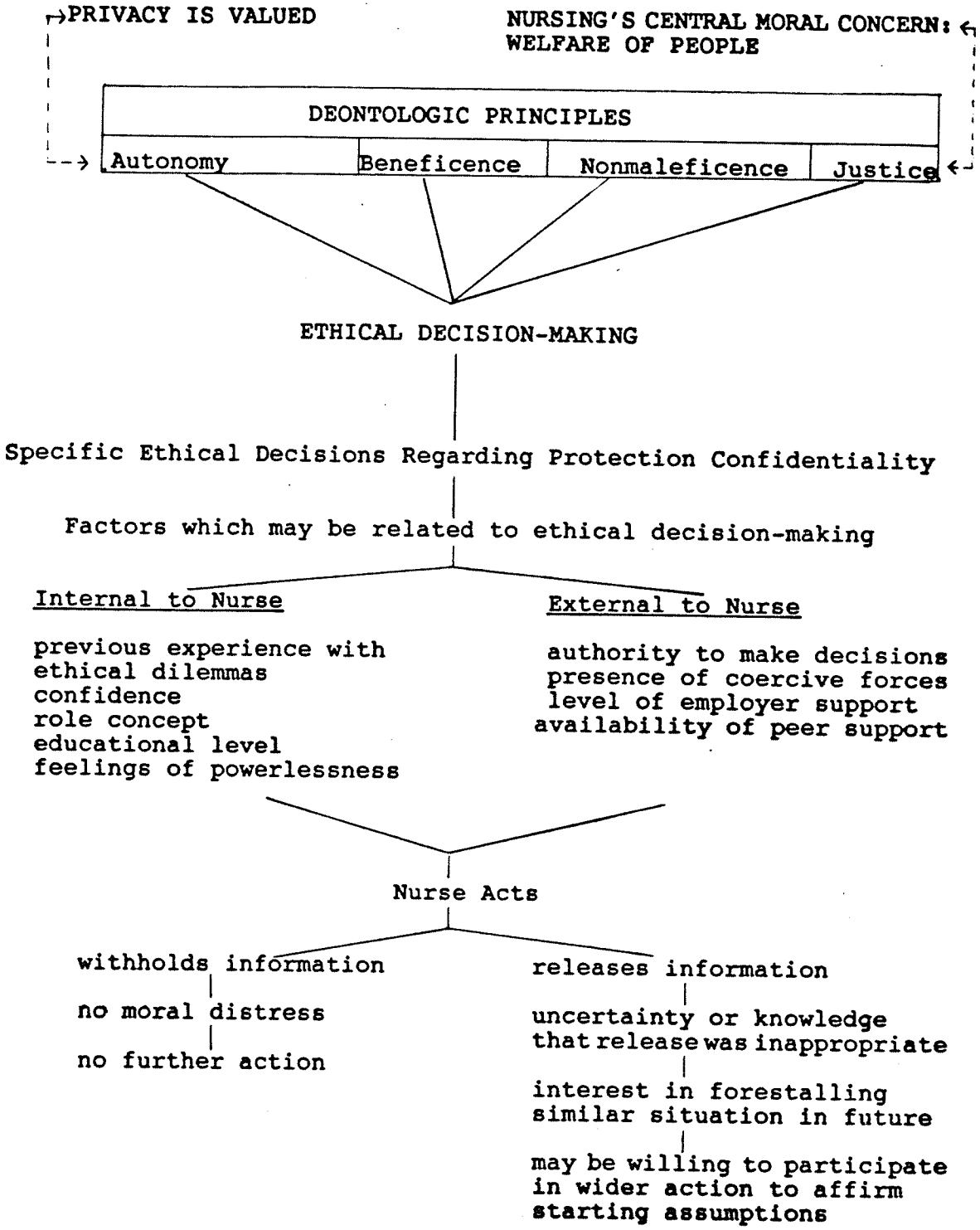
Conceptual Framework

The conceptual framework used in this study was synthesized from bioethical theory, scholarly discussions on nursing ethics, and empirical studies which explore ethical decision-making in nursing. Figure 1 illustrates the result of this synthesis. The purpose of this conceptual framework was to outline the theoretical justification for studying the maintenance of confidentiality of employee health information in occupational health nursing practice. This descriptive study did not attempt to examine all the relationships between concepts identified in the framework. Only factors external and internal to the nurse were explicitly examined for their relationship to ethical decision-making.

Two assumptions form the basis for studying confidentiality of employee health information. The first is that privacy is highly valued (Krever, 1980) and, secondly, that nursing's central moral concern is the welfare of human beings (Curtin, 1978; Wilkinson, 1987/88). Both assumptions are supported in deontologic theory.

Deontologic theory is comprised of four basic concepts - autonomy, beneficence, nonmaleficence and justice (Beauchamp & Childress, 1979). The autonomy principle supports the privacy value since individuals are considered autonomous, self-determining entities who can freely choose, in this case, with whom they wish to share health information (Rogers, 1988).

Figure 1. Conceptual Framework



The beneficence, nonmaleficence and justice principles are the basis for nursing's moral concern for the welfare of others.

In matters of confidentiality, the autonomous individual may choose to confide in the nurse who, in turn, has the moral obligation not to divulge that information to anyone other than those involved directly in the person's care. The exception is when individual information must be divulged to protect the health or safety of others (Rozovsky & Rozovsky, 1984; Yorker, 1988). Securing informed consent from clients for the release of health information grants individuals the right to self-determination and assures that autonomy is respected.

Just as ethical theory accords autonomy to the client, so too the obverse is that the nurse must be autonomous. That is, most ethical theory presupposes an agent free of undue coercion in decision-making (Curtin, 1978), yet the structure and process of organizations determine the degree to which employees, in this cases nurses, can make moral decisions. Nurses are in a difficult position in the health care power structure with conflicting loyalties and responsibilities to employers, licencing bodies, physicians, other nurses, clients, and clients' families (Jameton, 1977; Wilkinson, 1987/88). This difficulty is compounded in occupational settings where organizational goals may contrast with nurses' objectives, making moral choices difficult.

A specific example in which organizational goals and nursing objectives may clash is a situation in which an

employer may request that an occupational health nurse divulge confidential health information about an employee for which the employee has not given consent and to which the employer is not entitled. This may place the nurse in an ethical dilemma if a moral obligation to the client is recognized, and if certain constraints, coercive forces, or conflicting obligations are perceived regarding the structure of the organization in which she or he works. A number of factors, internal and external to the nurse, may be related to the ethical decision-making process.

Role conception, that is, how nurses conceptualize their role vis-a-vis clients and other players in health care (Ketefian, 1985; Murphy, 1982; Pinch, 1985), previous experience with ethical dilemmas (Crisham, 1981), educational level (Crisham, 1981; Ketefian, 1981a; Pinch, 1985), and perceived sense of powerlessness (Fennell & Wood, 1985) are internal factors which may influence ethical decisions. The work environment is logically the most influential of external factors influencing a nurse's ethical decisions. Regardless of the nurse's own role conception, there may exist conflicting role expectations (Jameton, 1977; Wilkinson, 1987/88). The employer may view the nurse as an employee whose actions should be subordinate to the needs of the enterprise (Krever, 1980). Level of employer support, authority to make decisions (Fennell & Wood, 1985), and availability of peer support may also affect the nurse's moral decisions.

Faced with the decision to release employee health information, the nurse chooses a specific action. She either releases or withholds the requested information. A decision to release the information presumably engenders certain feelings in the nurse. The nurse may be uncomfortable (Wilkinson, 1987/88) with her decision resulting from her knowledge that she has, or perhaps the uncertainty that she may have, released information inappropriately. In this case she may be anxious to forestall a similar situation in the future. Having implicitly recognized the value of privacy and her moral duty to protect the autonomy and welfare of her clients, the nurse may be willing to participate in some wider action to affirm the starting basic assumptions.

Chapter 4

Methodology

Design

A survey instrument was developed and refined to elicit descriptive, cross-sectional data from Manitoban occupational health nurses. The four main study objectives were: 1) to describe the magnitude of difficulty in maintaining confidentiality of employee health information; 2) to determine whether nurses perceive the maintenance of confidentiality to be a problem, and if so, to determine self-identified solutions for improving the protection of confidential employee health information; 3) to identify resources used by occupational health nurses when faced with a difficult decision regarding release of employee health information; and 4) to isolate characteristics of the individual nurse or the work environment which may be related to ethical decision-making.

The survey method was chosen for several reasons. The survey is a systematic approach for gathering information from a relatively large number of geographically scattered individuals on a topic about which they are likely to have feelings, thoughts, and knowledge (Backstrom & Hursh-Cesar, 1981). In this instance, subjects number approximately ninety, work primarily in Winnipeg but also in other parts of Manitoba. Occupational health nurses are assumed to have attitudes, beliefs, and knowledge about confidentiality of health information in occupational settings.

The survey design has several strengths. It follows a systematic set of operations. If properly selected, subjects are representative of the population and problem under study. The operations of the survey are guided by relevant theory of human behaviour, and analysis is guided by the laws of probability. Numerical values assigned to the data allows uniform interpretation of the characteristics being measured. Bias can be reduced or eliminated by careful design (Backstrom & Hursh-Cesar, 1981).

The Dillman (1978) Total Design Method (TDM) for mail surveys was used both for questionnaire design and in implementation procedures. The TDM is a set of guidelines for conducting mail surveys in order to maximize quantity and quality of responses.

A self-administered mail format was chosen over a telephone or personal interview survey. The occupational health nursing community is small in Manitoba and the researcher is known to most of the community. Since the topic under study is of a sensitive nature, the researcher was concerned that her physical presence in the data collection process might produce social desirability bias in the study. The removal of the interviewer from the scene, as in the case of mail questionnaires, decreases the probability of socially desirable answers (Dillman, 1978). Moreover, the assurance of anonymity of respondents was expected to further reduce social desirability bias.

Study Population

The study population consisted of all registered nurses in Manitoba who identified themselves, through the Manitoba Association of Registered Nurses' yearly registration and licencing procedure, as employed full or part time in direct patient care in occupational health as of December 1990. As well the Manitoba Occupational Nurses Interest Group membership list was used to supplement the MARN list with persons known to be occupational health nurses but who had not appeared on the MARN list. Because the occupational health nurse population in Manitoba is small (94); all 94 nurses were surveyed.

Access to Subjects

Access to subjects was obtained from the Manitoba Association of Registered Nurses (MARN) and the Manitoba Occupational Health Nurses Interest Group (MOHNIG). The access procedure followed was in keeping with the MARN policy entitled "Release of Membership Names for Research Purposes" (Appendix II) and the MOHNIG policy for release of membership names.

Instrument

A self-administered mail questionnaire (Appendix III) was developed to address the four study objectives. The questionnaire was comprised of 34 closed-ended items. Appendix IV illustrates how each objective was operationalized by questionnaire item(s). Also Appendix IV documents literature support for inclusion of the items. In addition, demographic questions solicited information about the respondent's employment situation and educational background.

The format of the questionnaire, including front cover, question order, and page formulation conformed closely to Dillman's TDM. The cover letter (Appendix V) addressed the subject personally, was dated the day of mailing, and was signed in blue ink. The content included the social value of the study, how the respondent was important to the study, and assurances regarding confidentiality.

The questionnaire was pretested with one occupational health nurse and two occupational physicians (chosen for the researcher's convenience and to prevent depletion of the small sample). Following the pretest, question order was changed and minor changes were made to question wording to improve clarity.

Validity and Reliability

Several measures were undertaken to increase the validity and reliability of the survey instrument. Two types of content validity - face and sampling (logical) validity

(Wilson, 1985) - were assessed by a panel of three experienced Manitoba occupational health nurses. Participants on the panel were selected using several criteria. Each panelist: 1) was a registered nurse; 2) had five or more years experience in occupational health nursing; and 3) had held a leadership position in occupational health nursing (e.g. teacher, member of interest group executive). It was assumed that at least five years of experience in the field and having taken a leadership role in occupational health nursing improved the likelihood that panelists had advanced knowledge of the topic under study. Panelists' participation in the validation process was solicited by written invitation (Appendix VI). A personal telephone call followed to determine whether the invitation was accepted, to answer possible questions, and to arrange a meeting time.

The panel was requested to complete two tasks (Appendix VII) in the validation process. The first task was to judge face validity, the clarity of individual items and the relevance of each item to the objectives under study. Secondly, the panel was asked to judge sampling validity for items related to objectives one and four, that is, to determine whether the major aspects of the topic under study were adequately operationalized by the questionnaire. Panelists were asked to judge whether the major categories delineated for objectives one and four adequately encompassed the aspect of the study covered by the objective and whether

questionnaire items matched to each category adequately represented the intent of that category.

Items in the survey instrument were to be retained if two of the three judges agreed that they met the criteria for face and sampling validity. This score approximated the 70% agreement requirement recommended for content validity (Topf, 1986). The result of the validation process was that all items achieved the two-thirds level of agreement. Several items which did not achieve 100% agreement were refined with the panelists' participation until 100% agreement was reached. No items were discarded. One item was added.

Procedures were also undertaken to increase the reliability of the questionnaire. The researcher coded the completed questionnaires to eliminate the problem of inter-coder or inter-rater unreliability. Reliability was further enhanced in the data analysis phase by checking for errors in data entry. Inspection of responses to the five-point Likert-type statements in question #19 revealed no response set. As well, although question #19 was not treated as a scale, responses to the items operationalizing bureaucratic and advocacy orientations were consistent. That is, respondents favoured one or the other orientations and not both simultaneously.

Data Collection Procedure

Distribution of the questionnaire followed the Dillman TDM using one of his suggested alternatives for protecting anonymity in surveys of sensitive topics. Instead of identifying the questionnaires (e.g. coding), a separate return post card was included in the mail out package (Appendix VIII). The cover letter asked the respondents to return the post card separately from the questionnaire. The post card contained only the respondent's pretyped name, a statement about the post card's purpose, and a check off for a copy of study results.

Twelve days following the initial mailing of the survey, all subjects received a post card thanking respondents and reminding nonrespondents to complete the survey (Appendix IX). The second follow up, a letter accompanied by a replacement questionnaire (Appendix X), was mailed approximately three weeks after the initial mailing.

Data Analysis Procedure

Although a total of 94 questionnaires were mailed, seven questionnaires were returned by individuals who disqualified themselves because they were not occupational health nurses. These disqualifications effectively reduced the population to 87. Seventy-five (75) eligible completed questionnaires were returned and analyzed, resulting in a response rate of 86.2%. After inspecting demographic variables and the names of nonrespondents, some of whom were known to the researcher, no

systematic differences between the sample and the population were detected. For instance, nonrespondents were not systematically different from respondents with respect to type of workforce served, number of workers served, or presence of a union. Therefore, the sample was assumed to be representative of the population.

Sample characteristics were summarized with descriptive statistics. Frequencies were reported for most variables. The measure of central tendency used for ratio variables in this study was the median. Several extraordinarily high values skewed the distribution on the ratio variables. Hence, the arithmetic mean did not accurately describe the central tendency of the data. In these instances, the median value was used to characterize "average" values. The small sample made measures of dispersion such as the standard deviation too unstable to be used meaningfully.

To investigate whether or not associations demonstrated between nominal variables were due to chance, the Fisher's Exact Test was applied. The Fisher's Exact Test is a test of statistical significance that may be used as an alternate to Chi square when numbers are too small to permit the use of Chi square (Hassard, 1991). For this study, the level of significance, or alpha level, was set at five per cent (.05). Kendall's Tau correlation coefficient was used to assess the relationship between other ordinal variables.

Study Limitations

This study described the reported thoughts, feelings and knowledge of occupational health nurses on the subject of confidentiality of employee health information. It did not attempt to explain or predict their feelings, thoughts or knowledge. Nor did this survey actually measure what nurses did to protect confidentiality of employee health information, only what they said they did. Findings of this survey are generalizable only to the population surveyed and not to populations of occupational health nurses living and working in other provinces or countries.

Missing data were not a major problem with the exception of question 11 which asked what type of specific information the employer is most likely to request. The instruction for this question did not clearly request only one answer resulting in many respondents providing multiple answers which were difficult to code.

Another limitation may be the wording of questions soliciting information about resources used when making difficult decisions regarding release of employee health information to the employer, questions 14 and 15. As Aroskar (1989) noted, in ethical decision-making, it is important for study participants to distinguish between difficult decisions in which moral choice is required and decisions that are difficult because of legal, communication, or political problems. This distinction was not made for subjects in questions 14 and 15 of the present study. Hence, in the

analysis, the researcher was unable to make assumptions about whether the study participants defined a "difficult decision" within a moral, political, legal or communication context.

For purposes of the present study, validation of the instrument was limited to content validity. However, beyond content validity, at least one type of criterion-related validity or construct validity is needed to give minimal assurance of the instrument's overall validity (Wilson, 1985). These more sophisticated levels of validation will be completed if the instrument is used subsequently in other populations of occupational health nurses.

Few statistically significant associations between variables of interest were demonstrated. This may be because there was no difference among respondents or because the small number of respondents prevented true differences from being detected.

Protection of Subjects

Participants were informed in the cover letter that the survey was strictly voluntary and that consent to participate was indicated by completion of the questionnaire and its return. An explanation of how the researcher obtained the subject's name and address was provided. Because of the sensitive nature of the topic and the fact that the researcher is known to many respondents, respondents were guaranteed that their responses could not be linked with their names. The researcher believes that the inability to trace respondents'

identities successfully provided an atmosphere encouraging trust and candor since there was no indication (either by missing data or respondents' comments) that participants were unwilling to respond to the questions.

Questionnaires were sent to subjects' home addresses to avoid possible scrutiny by employers. Subjects were informed in the cover letter that when the results of the study were made public, data would be grouped so that individual responses could not be identified.

Each subject was offered a personal copy of the study results by mail. The separate post card accompanying each questionnaire for follow up purposes contained a check off for receipt of results. No other inducement to participate in the study was contemplated, the assumption being that the saliency of the topic for this special interest group was enough to encourage participation in the study. This assumption was borne out by the high response rate.

Only the researcher, a qualified data entry operator, the Manitoba Nursing Research Institute's statistical advisor, and the researcher's advising committee had access to the raw data. Raw data and the MARN membership list were kept in a locked file in the researcher's home. The list of participants' names and addresses and the completed questionnaires were destroyed upon completion of the study.

The study was approved by the University of Manitoba School of Nursing Ethical Review Committee. The researcher

anticipated no harm to individual subjects from their participation in this study.

Chapter 5

Findings

The study findings are divided into five sections. The first section describes some of the educational and practice characteristics of the sample. The second section (corresponding to the first and part of the second study objectives) estimates the difficulty of maintaining confidentiality of employee health information. It details the frequency and type of requests for employee health information. Methods of records handling are described. Whether respondents perceive maintaining confidentiality of employee health information to be a problem or not is discussed. Resources used by nurses when faced with difficult decisions regarding release of employee health information are enumerated in the third section (corresponding to study objective 3). The fourth section (objective four) focuses on ethical decision-making. Some factors about the individual nurse or her working environment which may be related to ethical decision-making are described. Remedies chosen by respondents for improving the protection of confidentiality (corresponding to part of the second objective) constitute the fifth, and final, section.

Practice and Educational Profile of the Sample

The typical occupational health nurse respondent in this study (Tables 1-3) is a diploma-prepared registered nurse who has a certificate in occupational health nursing and has been employed full time, part time or a combination of both in occupational health for ten years or less. She or he is most likely to deliver occupational health services, as part of a multidisciplinary team, to a unionized workforce of between 500 and 2500 workers in private industry.

Table 1

Educational Level of Occupational Health Nurses in Manitoba

Educational Level	n
RN Diploma Only	14
RN and Certificate in Occupational Health Nursing	31
RN, OHN Certificate and Other Nursing Certificate	10
RN and Other Nursing Certificate	8
BN and OHN or Other Nursing Certificate	5
Masters Degree in Nursing	1
Other combinations of education	4
Total	73

Table 2

Number of Nurses Employed in Occupational Health by Duration and Type of Employment

Duration (Years)	Type of Employment			
	Full Time (FT) Only	Part Time (PT) Only	Both FT and PT	Total
1-4	18	10	0	28
5-10	13	3	10	26
11-15	4	6	5	15
>15	4	1	1	6
Total	39	20	16	75

Table 3

Practice Profile of Occupational Health Nurses in Manitoba

Size of Workforce Served

No. of workers	n
<250	7
250-500	9
501-1000	17
1001-2500	18
2501-5000	9
5001-10,000	4
>10,000	2
Total	66

Type of Workforce Served

Type	n
Private Industry	27
Gov'ment/Crown Corp	23
Government-funded	19
Variety	2
Total	71

Unionization

Union	n
Yes	52
No	14
Half and Half	6
Total	72

With Whom Service Provided

Service providers	n
Multidisciplinary team	36
Alone	10
In-house physician	7
Consulting physician	7
Another nurse	7
Total	67

Difficulty Maintaining Confidentiality of Employee Health Information

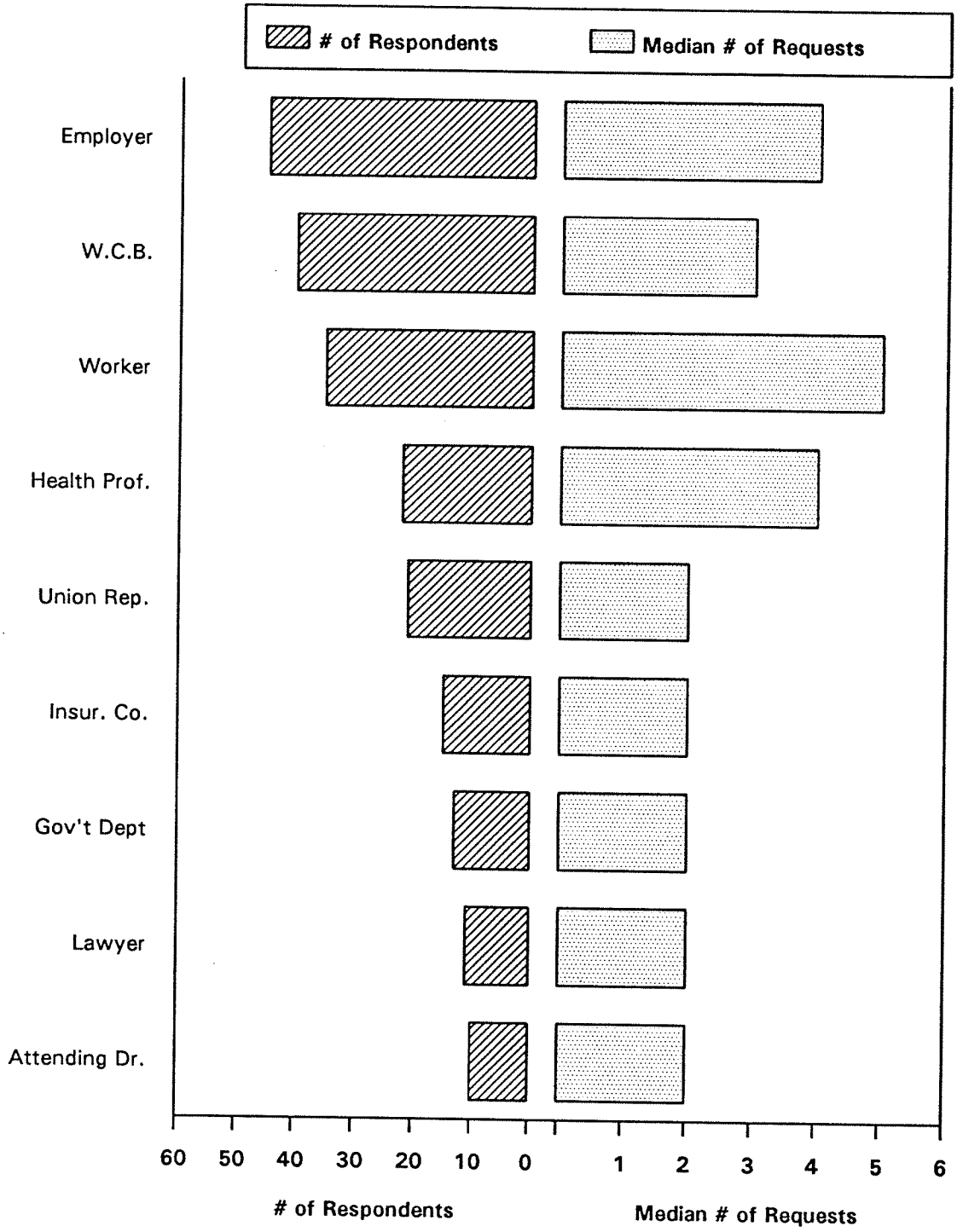
In order to judge how difficult it may be to protect the confidentiality of employee health information, respondents were queried about the sources and frequency of requests for employee health information, both generally and, more specifically, from within their employing organizations. Inappropriate requests for information received from the employer and methods of health records handling were also investigated.

Sources and frequency of requests for employee health information. Respondents were requested to identify the various sources from whom requests for employee health information were received both from within and outside the employing organization. Data were also gathered on the frequency of requests for employee health information from various sources within and outside the employing organization (Figures 2 and 3).

Figure 2 combines the number of respondents reporting requests from general sources and the median number of requests reported per respondent for each source. The most frequently reported source requesting employee health

Figure 2

Number of Respondents Reporting Requests from Each General Source and Median Number of Requests Received from Each Source During Previous Six Months



information, during the previous six months, was the employer (n=45; 60.0%)[1] closely followed by the Workers Compensation Board (n=40; 53.3%). Another important source of requests for 35 respondents (46.7%) was workers themselves (for their own information). Fewer nurses reported receiving requests from sources such as insurance companies, health professionals and others.

Of those respondents who indicated that they had received requests for employee health information from any particular source in the previous six months (Figure 2), the median[2] number of requests received was between 2 and 5 depending on the source. Nurses received a median of 5 requests in the previous six months for information from the worker himself or herself. Respondents received a median of 4 requests from the employer or a health professional other than the attending physician. The Workers Compensation Board made a median of 3 requests. Respondents receiving requests from an insurance company, government department, attending physician, lawyer or union representative typically got 2 requests from any one of these sources.

Employer sources were subdivided into categories. Figure 3 combines the number of respondents reporting requests

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[1] Unless otherwise noted, the total number of respondents, the denominator, is 75.

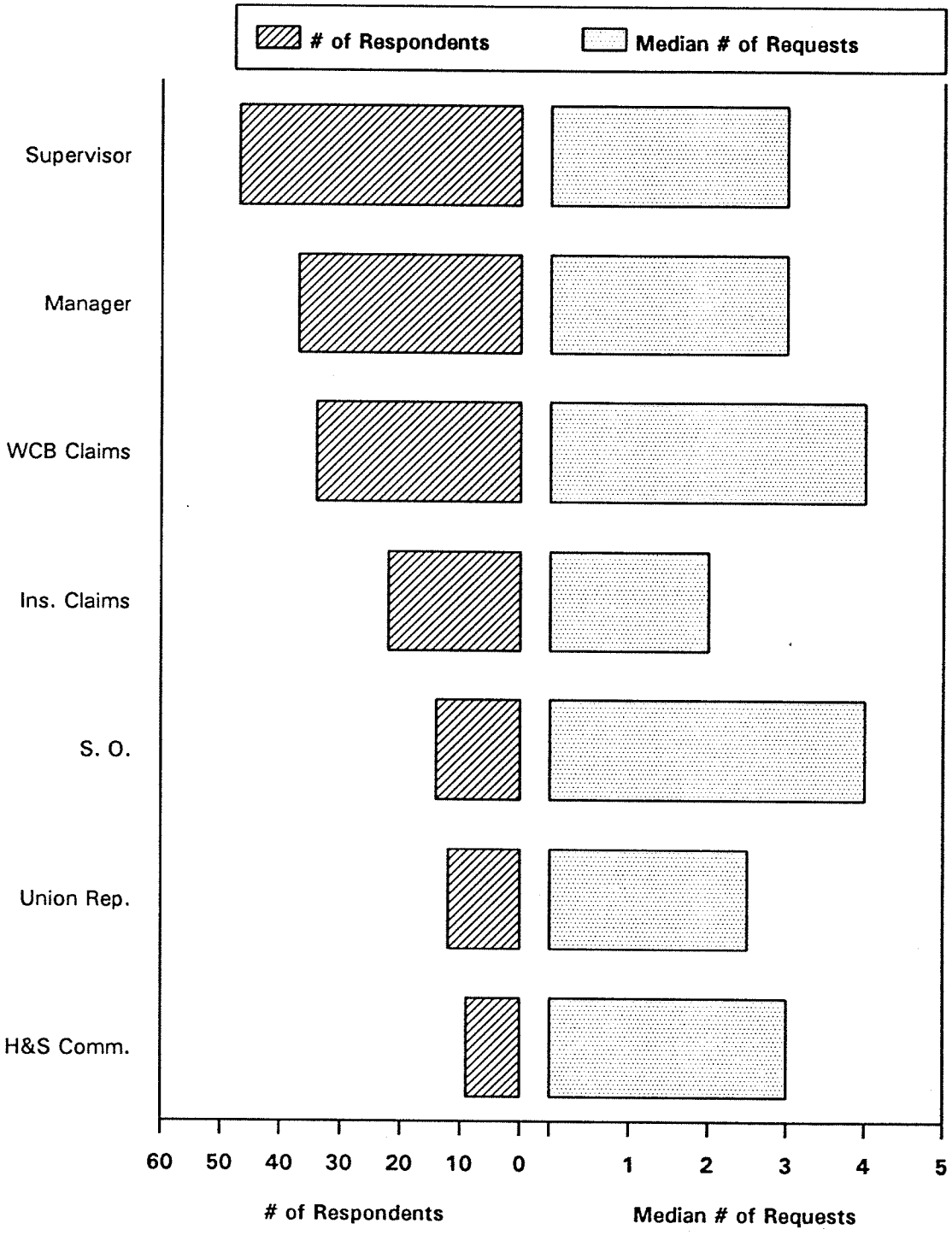
[2] The median, the middle value, is reported here because several respondents reported extremely high frequencies of requests which distorted the mean. The median reflects a more accurate "average" in this case.

from employer sources and the median number of requests reported per respondent for each source. Forty-seven individuals (62.7%) reported receiving requests, over the previous six months, from an employee's direct supervisor and 37 respondents (49.3%) reported receiving requests from a manager other than the employee's direct supervisor. Thirty-four respondents (45.3%) reported receiving requests from a person responsible for Workers Compensation claims. People responsible for insurance claims, safety officers, union representatives, and Health and Safety Committee members were other sources of requests from within the employing organization.

Respondents, who got requests from within the employing organization, received a median of between 2 and 4 requests depending on the source (Figure 3). The safety officer and the person responsible for Workers Compensation requested information a median of 4 times, according to respondents who had received requests from these sources. It was reported that the employee's direct supervisor, a manager other than the employee's direct supervisor, and Health and Safety Committee representatives were responsible for a median of 3 requests each. Respondents reported receiving medians of 2 and 2.5 requests respectively from union representatives and the person responsible for insurance claims.

Figure 3

Number of Respondents Reporting Requests from Each Employer Source and Median Number of Requests Received from Each Source During Previous Six Months



Inappropriate employer requests. Respondents were asked what proportion of employer requests for health information were not accompanied by the employee's written authorization for release and what proportion of employer requests were for health information of a specific nature (Table 4). These constitute inappropriate requests.

Table 4

Number of Respondents Who Indicated a Proportion of Inappropriate Employer Requests

	Inappropriate Requests	
Proportion	Unaccompanied by Written Authorization	Specific Information Requested
<25%	20	18
25-50%	4	4
51-75%	2	7
>75%	24	6
Total	50	35

When asked whether employer requests, during the previous six months, for employee health information were always accompanied by written authorization from the employee, 53 of the 58 respondents who answered the question said no. Twenty-four persons estimated that more than 75% of requests were unaccompanied by written authorization (Table 4).[3] It was estimated by 20 individuals that less than 25% of requests had no employee authorization and 6 respondents estimated that it occurred between 25% and 75% of the time. Most respondents (31) suggested that this feature of requests has remained the same compared to three years ago while 9 stated it has decreased and 7 stated it has increased. A further 22 were unable to assess the change over time.

Responses were nearly evenly divided with respect to receiving employer requests for information of a specific nature - 29 respondents indicated that they did receive such requests and 28 indicated that they did not. About half of the respondents (18) indicated that requests for specific information occurred less than 25% of the time and the other half (17) reported this type of request occured more than 25% of the time (Table 4). Unlike the number of requests which were not accompanied by written authorization, only 6 respondents reported that more than 75% of requests were for specific information. As to whether this characteristic of

[3] Totals do not always agree between tables and text due to missing values for one or more of the variables in question.

requests has changed over time, 25 respondents reported that it has remained unchanged, while 12 and 14 respectively stated it has decreased and increased. A further 18 were unable to assess a change over time.

As for the type of specific information the employer was most likely to request, only 22 individuals either responded at all or responded with a singular answer. Employers reportedly were most likely to request medical details justifying work absence (7) or restrictions (6). Confirmation of a suspected substance abuse problem (1) or individual biological test results (2) were requested less frequently. Six respondents suggested a variety of "other" categories.

Occupational health records handling. The policies and practices related to handling occupational health records is another dimension of assessing the difficulty of maintaining confidentiality of employee health information. Table 5 reflects the presence or absence of employer policies or practices affecting information and records handling.

Table 5

Number of Respondents Reporting Presence or Absence of Policies or Practices Affecting Handling of Employee Health Information

Policy/Practice	Present	Absent	Unsure	n
Written employer policy on confidentiality	37	25	11	73
Blanket authorization for release of information for new hirees	6	64	3	73
Nurse requires employee's written authorization	59	11	0	70
Health information stored in personnel files	3	68	0	71

Thirty-seven respondents (50.7%) reported that their employer has a written policy governing confidentiality of employee health information, 25 (34.2%) reported the absence of such a policy and 11 nurses (15.1%) were unsure of whether such a policy exists. Fifty-nine nurses reported that they require an employee's written authorization for release of employee health information but 11 reported not requiring written authorization. Three respondents reported that employee health information is stored in personnel files to which, it is assumed, more than just health professionals have access. Although 64 respondents indicated that their employer does not require blanket authorizations from new hirees for release of employee health information, 6 indicated that such a policy does exist at their workplace and three were unsure whether such a policy exists or not.

Those respondents who required written authorization for release of employee health information (n=59) indicated that forms used for this purpose contain most of the elements recommended by the Canadian Health Records Association (Table 6). The exceptions, time limit on validity of the authorization and purpose for which information is to be used, were reported absent by 36 and 22 respondents respectively.

Table 6

Number of Respondents Reporting Presence or Absence of Typical Elements of Forms Authorizing Release of Employee Health Information

Element	Present	Absent	Unsure	n
Who will receive information	55	3	0	58
Specific nature of information to be released	50	6	2	58
Date	58	0	0	58
Employee's signature	57	1	0	58
Time Limit	14	36	4	54
Purpose	33	22	0	55

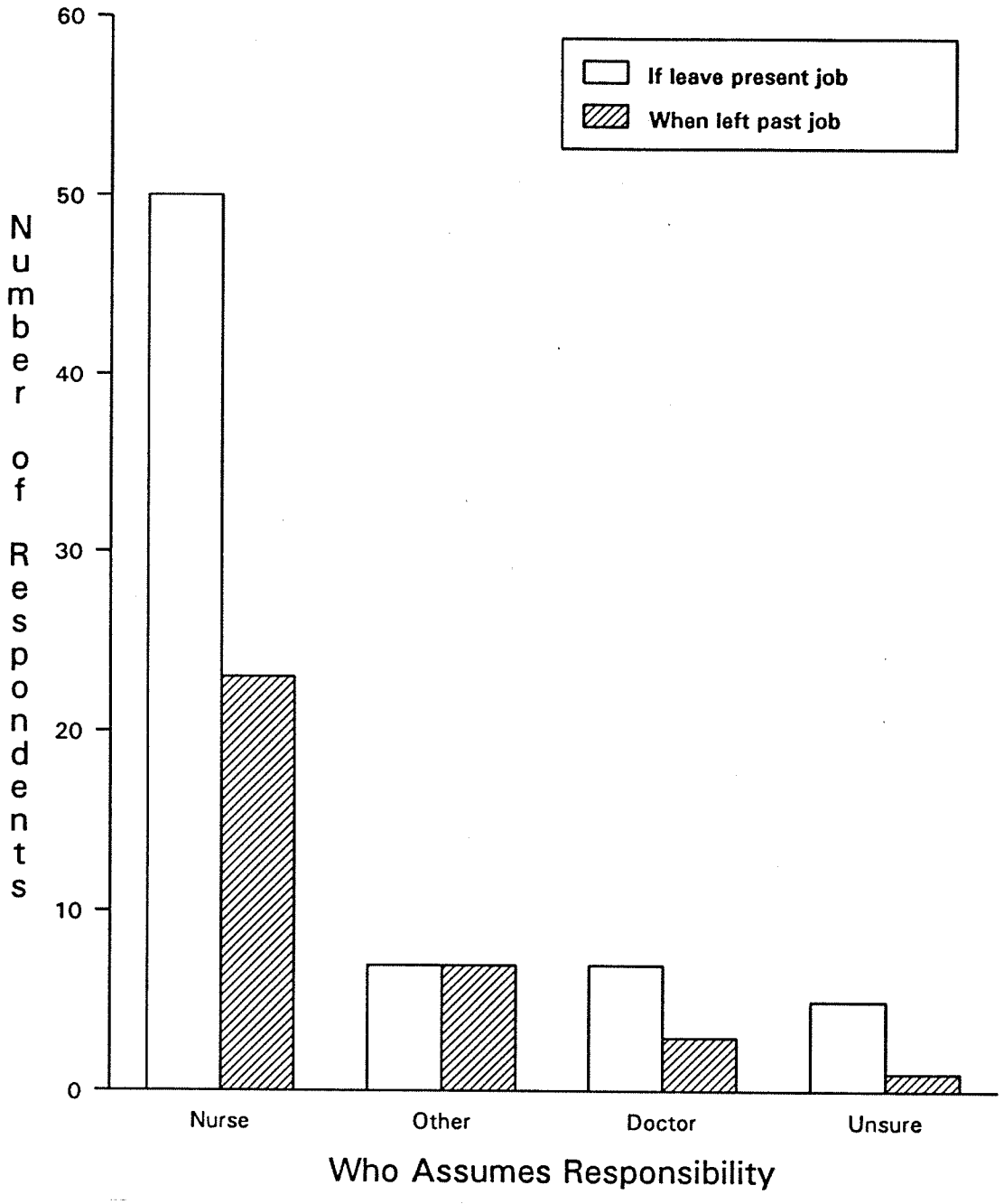
Employee health records are stored in a variety of locations, according to respondents. Of the 75 respondents, most reported that records are stored in locked files inside the health unit (n=54). Seven respondents indicated that records were stored in unlocked files inside the health unit. One reported that records were stored in unlocked files outside the unit and five people reported that records were

stored in locked files outside the health unit. One respondent added that supervisors had access to employee health records stored in locked file drawers outside the health unit.

If the nurse was to leave the employer, 50 respondents suggested that another nurse would likely assume direct responsibility for employee health records, while 7 stated that a doctor would likely assume responsibility (Figure 4). Seven individuals thought that either no one, a secretary, someone from personnel or a manager would most likely assume responsibility for records. In other words, these 7 respondents suggested that the records would not be safeguarded by a health professional. Five respondents were unsure of who would assume responsibility for records. Responses from those who had actually left occupational health nursing positions (n=33) reflected a similar pattern as those who hypothesized about the fate of records in the event of their departure (Figure 4).

Figure 4

Persons Assuming Direct Responsibility for Employee Health Records if Nurse Leaves Employer

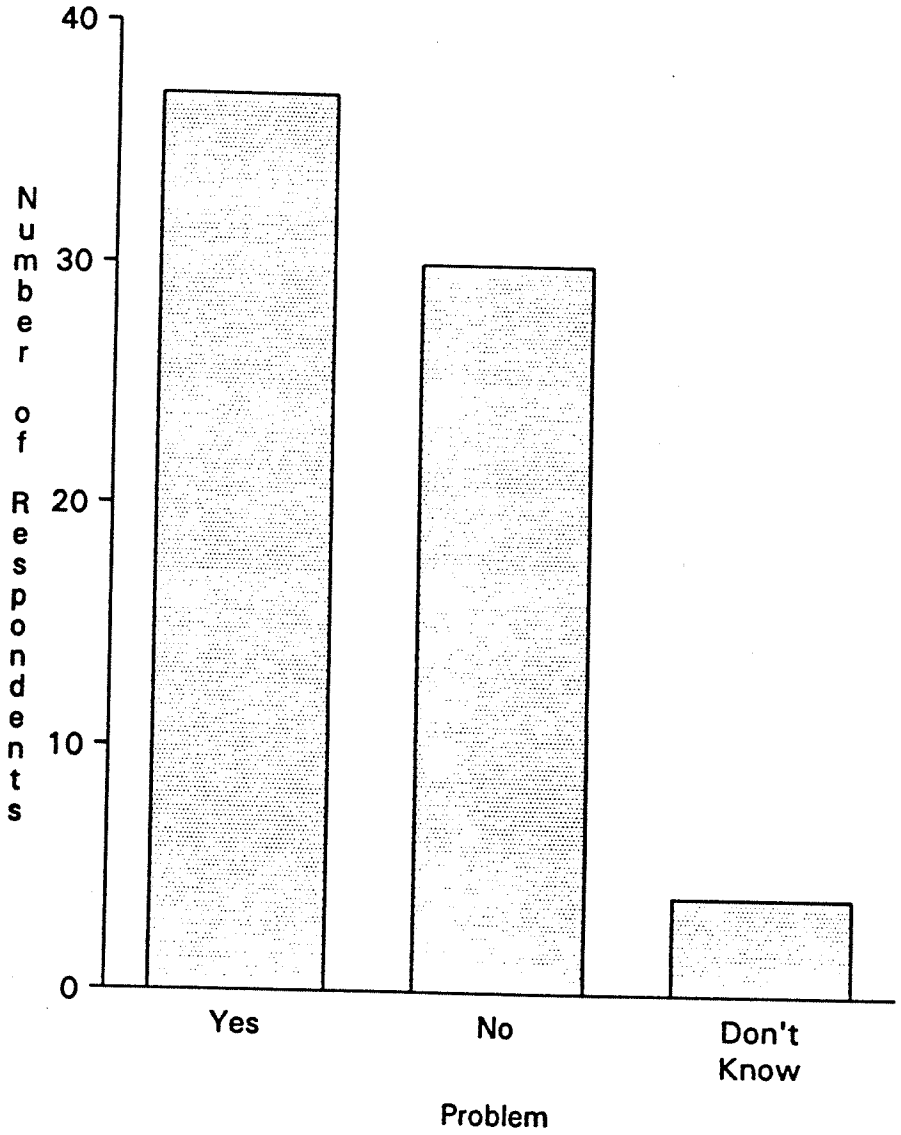


Note. "Other" = no one, secretary, someone from personnel or a manager

Respondents' perception of a problem. Maintaining confidentiality of employee health information was perceived to be a problem by 37 respondents (52.1%) while 30 (42.3%) did not perceive maintaining confidentiality to be a problem and 4 (5.6%) did not know if it is a problem or not (Figure 5).

Figure 5

Frequency of Respondents' Perception of a Problem Maintaining Confidentiality of Employee Health Information



Cross tabulations were undertaken to determine whether nurses' perception of a problem varied with their responses on several other variables. Respondents who received requests for health information from employers were significantly more likely to consider the maintenance of confidentiality to be a problem than respondents who did not receive requests from employers (Table 7). Of the respondents who did not perceive confidentiality to be a problem, 13 (45%) received requests for health information from employers; whereas, of the respondents who did perceive a problem, 28 (80%) received requests for employee health information from employers.

Table 7

Frequency of Respondents Indicating Maintaining Confidentiality is Problem or Not by Receipt of Employer Requests for Health Information in Previous Six Months

	Received Employer Requests		
Problem	No (%)	Yes (%)	Total (%)
No	16 (55.2%)	13 (44.8%)	29 (100%)
Yes	7 (20.0%)	28 (80.0%)	35 (100%)
Total	23 (35.9%)	41 (64.1%)	64 (100%)

Note. p=0.004 Fisher's Exact Test

As well, respondents who perceived the maintenance of confidentiality to be a problem were significantly more likely to have received a high proportion of unauthorized requests from employers (Table 8). Of those respondents who perceived confidentiality to be a problem, 19 (70%) received a high proportion (>75%) of unauthorized requests. Of those who did not perceive a problem, only 6 (33%) received a high proportion (>75%) of unauthorized requests.

Table 8

Frequency of Respondents Indicating Maintaining Confidentiality is Problem or Not by Proportion of Employer Requests which were **Not** Accompanied by Written Authorization in Previous Six Months

	Proportion of Requests Unaccompanied by Authorization		
Problem	<25%	>75%	Total (%)
No	12 (67.0%)	6 (33.0%)	18 (100%)
Yes	8 (29.6%)	19 (70.4%)	27 (100%)
Total	20 (44.4%)	25 (55.6%)	45 (100%)

Note. Six respondents indicated 25% to 75% of employer were unaccompanied by authorization.

p=0.02, Fisher's Exact Test

Whether respondents considered confidentiality to be a problem also varied significantly with the receipt of employer requests for employee health information of a specific nature over the previous six months (Table 9). Of those who perceived a problem maintaining confidentiality of employee health information, 20 (65%) received requests for specific information whereas, of those who did not perceive confidentiality to be a problem, only 7 (35%) had received such a request (p=0.04, Fisher's Exact Test).

Table 9

Frequency of Respondents Indicating Maintaining Confidentiality is Problem or Not by Receipt of Employer Requests for Specific Health Information in Previous Six Months

	Received Employer Requests for Specific Health Information		
Problem	No (%)	Yes (%)	Total (%)
No	13 (65.0%)	7 (35.0%)	20 (100%)
Yes	11 (35.5%)	20 (64.5%)	31 (100%)
Total	24 (47.1%)	27 (53.9%)	51 (100%)

Note. p=0.04, Fisher's Exact Test

No statistically significant differences were found between those who do and do not perceive confidentiality to be a problem and 1) frequency of requests for employee health information from employer subgroups; 2) size or type of workforce served; 3) presence or absence of a union, 4) presence or absence of written employer policy governing confidentiality of employee health information; 5) years of occupational health nursing experience; and 6) nurses' perceptions of powerlessness, decision-making authority, and collegial or employer support.

Other factors which may contribute to perception of a problem. The consequences for refusal to release information in a situation in which the nurse viewed the release as inappropriate could also contribute to difficulty maintaining confidentiality. Table 10 illustrates what consequences respondents reported they might expect. Fourteen of the 75 respondents indicated that they would most likely be met with begrudging acceptance, 18 were unsure of what the consequences might be and 3 felt they would likely be subject to some punitive measure. Twenty-three indicated that nothing would likely happen and 17 stated they would likely gain greater respect from their employer.

Table 10

Number of Respondents Reporting the Various Consequences of Not Releasing Information to the Employer

Consequence	n
No consequence	23
Unsure	18
Gain greater respect	17
Met with begrudging acceptance	14
Subject to punitive measure	3
Total	75

Respondents were asked whether the issue of confidentiality had ever contributed to the nurse's decision to leave an employer or to a termination by an employer. Approximately 70 respondents attempted the two corresponding questions. However, it was apparent these questions were not relevant to the majority of respondents when another question revealed that 42 nurses had never been previously employed as occupational health nurses. Of the 28 respondents who previously had left an occupational health nursing position, 4 (14%) indicated that the issue of confidentiality had contributed to their decision to leave an employer. Two (8%) of the 26 respondents who previously had been terminated from

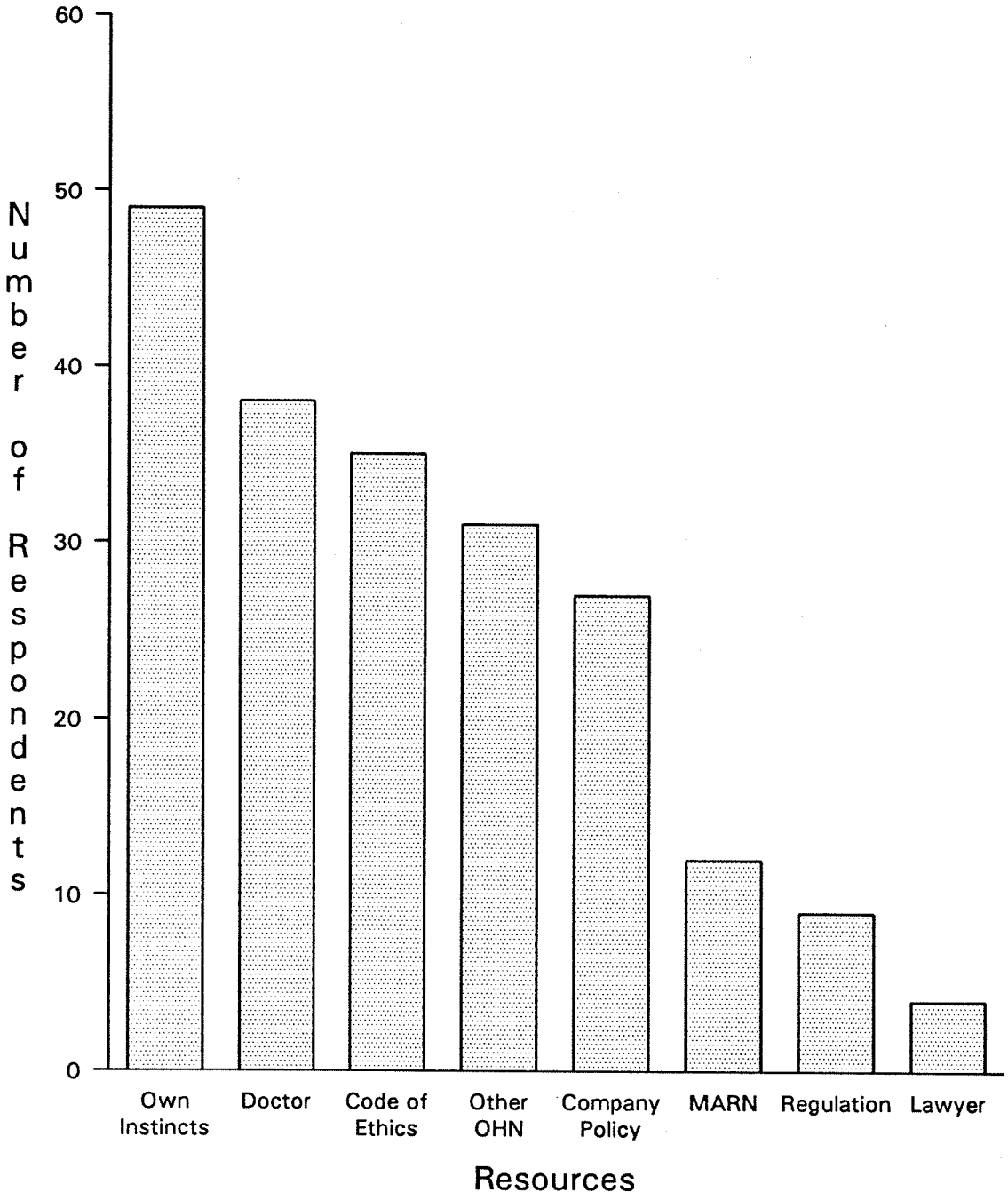
an occupational health nursing position indicated that, in their opinion, this issue had contributed to an employer's decision to terminate them. Three did not know whether this issue had contributed to their termination.

Resources to Occupational Health Nurses

Respondents were queried about which resources they have used when faced with difficult decisions regarding the release of employee health information. As shown in Figure 6 respondents were most likely to choose their own instinct/beliefs (49), followed by a doctor (38), a code of ethics (35), another occupational health nurse (31), or company policy (27) as a resource. When asked which resource they found to be most helpful, the relative order changed (Figure 7). Respondents reported that their own instincts/beliefs were most helpful (17). Other occupational health nurses (11) surpassed doctors (7) and code of ethics (8) in frequency. Nurses' professional association was one of the least favoured resources.

Figure 6

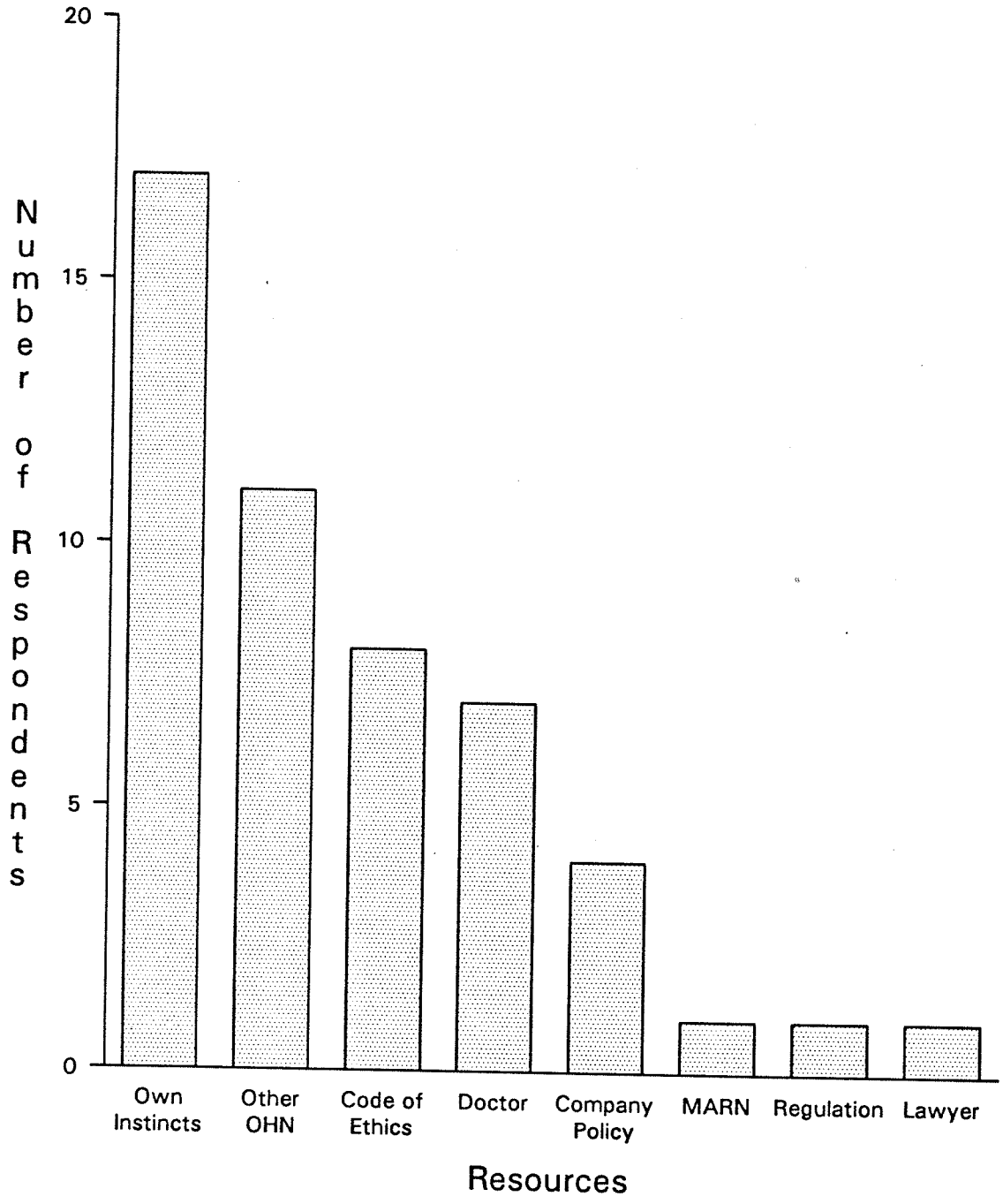
Resources Used When Faced with a Difficult Decision Regarding Release of Employee Health Information to the Employer



Note. An individual could choose more than one resource

Figure 7

Resources Found **Most** Helpful When Faced with a Difficult Decision Regarding Release of Employee Health Information to the Employer



Factors which may be Related to Ethical Decision-Making

To isolate some factors about the nurse or the working environment related to ethical decision-making and the protection of confidential health information, respondents were asked to agree or disagree with a number of statements using 5-point Likert-type response categories.

Table 11 illustrates the responses to statements reflecting either a bureaucratic or patient advocacy orientation in ethical decisions. Agreement with statements which favoured employer access to employee health information reflected a bureaucratic orientation. Agreement with statements expressing the nurse's willingness to protect the privacy of health information reflected a patient advocacy orientation. Most respondents strongly disagreed with the two "bureaucrat" statements [53 (73%) and 59 (82%) respectively] and most respondents strongly agreed with the two "patient advocate" statements [56 (76%) and 51 (70%) respectively]. This revealed a general tendency toward a patient advocate orientation among respondents. Nevertheless a few respondents agreed with employer access to employee health information and disagreed with nursing actions to protect confidentiality.

Table 11

Frequency of Responses to Statements Indicating Either Bureaucratic or Patient Advocacy Orientation

	Response Category*					
Statement	1	2	3	4	5	n
Bureaucrat						
To facilitate administrative decisions, the employer should have access to as much employee health information as he or she requires.	53	7	8	2	3	73
As the owner of the employee's health record, the employer should have access to information stored in the record.	59	8	3	0	2	72
Patient Advocate						
I have to be prepared to stand up for the employee's privacy when it comes to health information.	3	5	2	8	56	74
I would disobey a direct order from my employer before I would inappropriately release health information about an employee.	3	3	3	13	51	73

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

Table 12 illustrates the frequency of responses to statements reflecting factors internal to the nurse which may be related to ethical decision-making regarding release of employee health information. Respondents most frequently agreed or strongly agreed with statements indicating they are confident of their decisions, that their past education had adequately prepared them for this type of decision and that experience makes it easier to make decisions. Respondents were most likely to disagree or to disagree strongly with the statement that they feel powerless to prevent inappropriate access to employee health records. However, 18 (25%) respondents indicated that they did feel powerless to prevent inappropriate access to employee health records. Eleven (16%), 10 (14%) and 19 (26%) respondents respectively indicated a neutral stance on confidence, powerlessness, and educational preparation.

Responses to statements about the nurse's work environment which may be related to ethical decision-making are summarized in Table 13. Most often respondents indicated that they could rely on their occupational health nurse colleagues for advice in decision-making. However, 11 respondents (16%) indicated that they <u>did not</u> feel they could turn to OHN colleagues for advice and a further 18 (25%) were neutral. Respondents were most likely to agree or to agree strongly that their employer supports the principle of

protecting confidentiality and has delegated, to nurses, the authority needed to make decisions regarding confidentiality.

Table 12

Frequency of Responses to Statements Reflecting Factors Internal to the Nurse

Statement	Response Category* 1	2	3	4	5	n
Once I make a decision about releasing employee health information, I am usually pretty confident it is the right decision.	1	1	11	22	35	70
I sometimes feel powerless to prevent inappropriate access to employee health records.	23	22	10	8	10	73
My past education adequately prepared me to make decisions regarding issues of confidentiality in occupational health nursing.	3	6	19	25	21	74
As I gain more experience, it becomes easier to judge each situation and make decisions regarding release of employee health information.	1	4	6	25	36	72

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

Table 13

Frequency of Responses to Statements Reflecting Factors In Nurse's Work Environment

Statement	Response Category* 1	2	3	4	5	n
I can count on occupational health nurse colleagues for advice with decisions regarding release of employee health information.	4	7	18	21	22	72
I feel that I have a lot of support from my employer for protecting the confidentiality of employee health information.	4	5	14	20	29	72
I have been given as much authority as I need to make decisions regarding confidentiality of employee health information.	1	3	12	33	24	73

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

On the other hand, 9 respondents (13%) stated they did not feel they have their employer's support for maintaining confidentiality and a further 14 (19%) were neutral.

A statistically significant inverse correlation was found between level of employer support for protecting confidentiality and feelings of powerlessness (Kendall tau B -0.19,

p=0.05). Feelings of powerlessness were not found to be correlated with decision-making authority, years of experience as an occupational health nurse or size of workforce served.

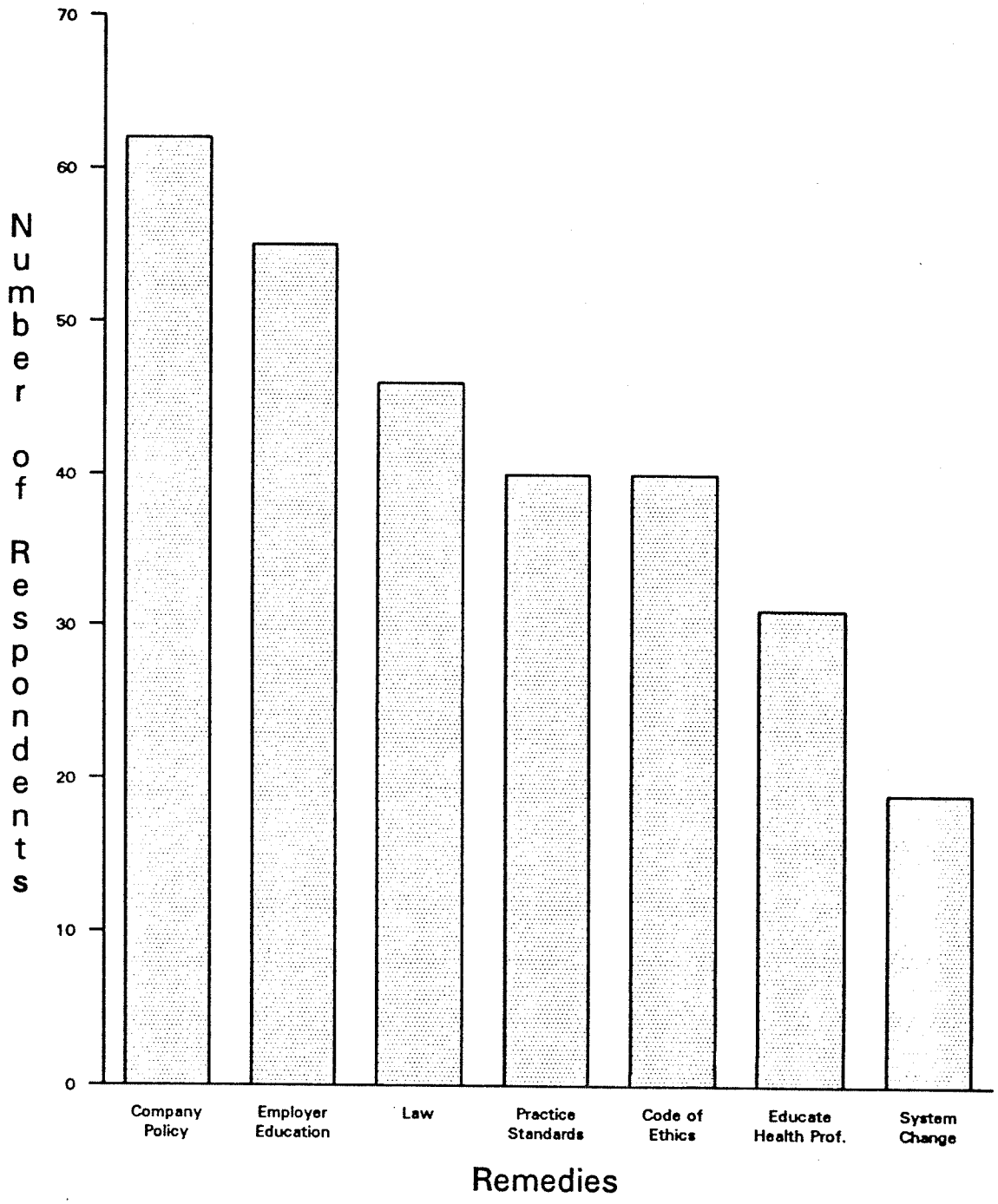
Feeling powerless to prevent inappropriate access to health records was not associated with whether respondents worked alone or with other professionals, or whether respondents had basic education or a post-basic certificate. Similarly, feeling powerless was not associated with consequences perceived to follow a refusal to release health information.

Respondents' Remedies for Improving Protection of Confidentiality

As reported above, 30 respondents did not view maintaining confidentiality to be a problem. However, along with those who did consider maintaining confidentiality to be a problem (37), many contributed their opinions to a list of possible remedies for improving the protection of confidentiality of employee health information (Figure 8). Nurses favoured actions focused on employers. Written employer policies on confidentiality of employee health information (62) and better education of employers and employees (55) on confidentiality of health information were the most frequently chosen remedies. The third most frequently chosen solution was a law or regulation specifically governing confidentiality of health information

Figure 8

Remedies Suggested for Improving the Protection of Confidentiality of Employee Health Information



in occupational settings (46). Other suggested remedies included remedies focused on the nurses such as practice standards, a specific code of ethics for occupational health nurses and better education regarding confidentiality of health information. As well a system of occupational health service delivery in which occupational health professionals are not directly employed by companies was supported by 19 respondents.

Summary

More respondents received requests from the employer than from any general source and more respondents received requests from the employee's direct supervisor and a manager than from any other source within the employing organization. Nurses who received requests reported a median of between two and five requests in a six month period from any particular source.

Approximately half of the sample perceived that maintaining confidentiality of employee health information was a problem. This perception was supported by objective criteria such as frequency of requests for employee health information, particularly from the employer and the proportion of time that requests were unaccompanied by written authorizations or were for information of a specific nature. Respondents were more likely to perceive a problem if they had received requests for employee health information from the

employer especially those requests that were unaccompanied by the employee's written authorization and were for information of a specific nature. Health records handling may contribute to the problem of maintaining confidentiality for those who reported no employer policy on confidentiality, those who do not require written authorization for release of information, and for those whose records are not secured from access by non-health professionals.

With respect to ethical decision-making, respondents were more likely to choose their own instincts or other nursing colleagues as the most helpful resources when making difficult decisions regarding release of employee health information. Most respondents gravitated toward a patient advocacy orientation in ethical decision-making regarding release of employee health information. Most respondents indicated that they are confident of their decisions, that past education has prepared them for this type of decision and that experience makes decision-making easier. Similarly respondents most often indicated that they could rely on OHN colleagues for advice and on their employer for support in maintaining confidentiality and for delegating decision-making authority.

Respondents recommended a number of remedies for improving the protection of confidentiality of employee health information. They favoured actions directed at employers but they also suggested actions focused on nurses.

Chapter 6

Discussion and Conclusions

In this chapter the study's key findings are discussed in light of previous research. Implications are considered for nursing practice stemming from the problem of maintaining confidentiality of employee health information. Respondent-identified remedies for improving confidentiality are reviewed. Recommendations are offered to address the problem of maintaining confidentiality individually, at the nursing practice level, and collectively, at a nursing organization policy level.

As well, certain findings are linked to the study's conceptual framework. Characteristics of the nurse and the work environment which may affect ethical decision-making are considered. Comments are made about the resources nurses use when making ~~ethical~~ difficult decisions. The study's strengths and limitations, from which come several recommendations for nursing research, are discussed.

Maintaining Confidentiality of Employee Health Information: A Problem

The problem: Implications for nursing practice. Perhaps the most striking finding of this study is that a large proportion (52%) of occupational health nurses perceive maintaining confidentiality of employee health information as

a problem. Moreover, nurses' perception of a problem was substantiated by data on sources and frequency of requests for employee health information and the proportion of inappropriate requests respondents reported. Although presaged by discussions in the literature (AAOHN, 1988; Krever, 1980), it nonetheless is surprising that such a high proportion of nurses perceive a problem. Consider if half the nurses working in institutions or the community in the traditional health care system were concerned that they could not adequately protect the privacy of their clients' health information. There no doubt would be widespread professional and public demands for reform of the systems for handling and storage of health information.

The explanation for public and professional silence on the problem of maintaining the confidentiality of employee health information is probably multifaceted. On the surface, one could reasonably suggest that most people are unaware of the frequency with which private health information is handled daily in the processing of insurance claims, workers compensation claims, absenteeism data, and biological monitoring data related to occupational health hazards. All of these instances can provide opportunity for breaches of confidentiality and for abuse of private health information. However, at a more fundamental level, the explanation for poor recognition of the problem, and indeed for the problem itself,

is more likely related to the social and economic relations between worker and employer.

Working people, as a group, recognize the need to sell their labour in order to maintain subsistence. This economic necessity provides the precondition for many indignities that workers endure in the workplace. Electronic monitoring, random drug testing, punching a timeclock, requesting permission to leave a workstation, and having private health information open to the scrutiny of the employer are all examples of these indignities. Workers, fearful of losing their means of living, put up with such conditions rather than protest and risk job loss.

Employers require tight control of the production process in order to keep their enterprises profitable. The ability to predict all of the inputs and outputs of the system of production are requisite conditions for a profitable enterprise. Because human beings are the "biological components" of the production process, employers feel justified in rigidly controlling the activities of people as they interact with the production process. This includes knowing everything possible about the individual worker, including health information, so that "weaknesses" in the system can be predicted and detected. In the view of employers, invading the privacy of individuals is merely a means of protecting their business interests. This view remains generally unchallenged because of the ideological

propensity in this society to hold profit-making and free enterprise in high esteem. Furthermore, their economic power over working people, that is the power to hire and fire, assures that this hegemony will not be easily broken. It is important for occupational health nurses to understand and acknowledge the role of power, economics and politics in the relationship between labour and management. Also, nurses, who are workers themselves, must recognize the potential impact that these forces may have on nursing practice in occupational settings.

In this discussion, attention is focused primarily on employer requests for employee health information for two reasons. Firstly, the employer was the most frequent source of requests reported by the greatest number of respondents. Secondly, the imbalance of power between employer and employees creates the potential for health information to be used against workers in the administrative decisions of the employer. It is not simply that the principle of privacy is broken; it is that the potential for harm to the client is real.

Employers were responsible for frequent requests to the largest number of respondents. It follows then that nurses who perceived maintaining confidentiality to be a problem were more likely to be those who received requests from the employer. This is significant given the direct effect that the illegitimate use of health information can have on the

economic and social well-being of the nurse's client, the employee. The number and sources of requests corroborate Justice Krever's (1980) view that nurses are likely to be subject to substantial pressure from employers to disclose information.

Other sources of requests for employee health information for a large number or respondents were either the Workers Compensation Board or a person responsible for administering Workers Compensation claims within the employing organization. The Workers Compensation Board has a legal right to request and receive health information related to the work-related illness or injury of claimants. On the other hand, persons responsible for administering Workers Compensation within employing organizations have no legal claim to employee health information. Part of their role is to prevent economic loss to the employer which, at times, requires that they gather evidence to police and to dispute workers' claims for compensation. Nurses who share information, authorized or not, with these administrators may place their clients' Workers' Compensation claims and hence, their clients' economic and social welfare in jeopardy.

A relatively small number of nurses were petitioned for employee health information by safety officers but those who did receive requests, on average, got as many requests or more than from other sources. Data were not collected on the type of information safety officers seek. Presumably it is

information related to work-related accidents and injuries, since the safety officer's role is accident investigation and prevention. Information in accident investigation is best obtained from sources at first hand to the incident, the worker him or herself and eye witnesses. The nurse, who renders first aid or treats the injury, is a second-hand source of information. Safety officers have no professional obligation to maintain confidentiality of health information. Furthermore, safety officers usually are considered to be less independent from management than health professionals.

The findings suggest that when nurses received requests for information from the employer, they often received multiple requests. Two explanations are plausible. Perhaps these nurses have not effectively communicated to the employer that unauthorized requests or requests for specific employee health information are not acceptable. Or perhaps, despite the best efforts of the nurse, the employer persists in trying to obtain information.

As for whether maintaining confidentiality will continue to be a problem, it seems that the majority of respondents believed that the situation has remained relatively unchanged over the last three years. Although this finding provides hope that the situation is generally not deteriorating, it could also be concluded that the situation will not improve unless action is taken by nurses individually or collectively.

Employer policies and practices: Implications for nursing practice. The findings bear out Rabinow's (1988) statement that occupational health records are not usually subject to the same tight administrative control as those in the traditional health care system. Although most of the respondents appeared to be handling records in a stringent manner, the exceptions are notable. The absence of a written employer policy on confidentiality (one-third of respondents) raises the question of individual employer commitment to this issue. Blanket authorizations for release of information for new hirees and storage of health information in personnel files, although present in only a small number of instances, practically guarantees unauthorized access and inappropriate use of health information. Also, some nurses contributed to the problem by not requiring the employee's written authorization for release of employee health information or by being uncertain of the presence or absence of an employer policy on confidentiality.

Time limit and purpose for which the information is to be used were the most likely elements absent on authorization forms for release of health information. These elements ought to be present, according to the Canadian Health Records Association (CHRA, 1980). Stating the purpose increases the likelihood of informed consent for the release of information. Stating a time limit reduces the possibility of the

authorization being used for purposes other than for what it was intended.

Secure storage of health records was a problem for a small number of individuals who noted that information is stored in unlocked files either inside or outside the health unit. Similarly, regarding responsibility for records if the nurse left her employer, a small number of respondents indicated that the records would not be safeguarded by a health professional. The number of respondents in these cases was small and perhaps the situations were isolated; nevertheless the number of workers who potentially are affected could be large. Instances of lax employer and nursing practices in handling, transferring and storing employee health information contribute to the overall magnitude of the problem of maintaining confidentiality.

Remedies for improving protection of confidentiality. Because the employer is the source of requests for most respondents, it is consistent and appropriate that most nurses would choose remedies that focus on employers. Employer-focused remedies as well as legislation governing confidentiality (the third most frequently chosen remedy) are consistent with the recommendations made by Justice Krever (1980). Nurses apparently recognize the need to "put their own house in order" by establishing practice standards and codes of ethics, and by educating themselves regarding

confidentiality of employee health information. A change in the present system of occupational health service delivery so that health professionals were more independent of direct management control was favoured by a number of individuals.

Recommendations for nursing practice. There is much that nurses can do, individually and collectively, to improve the protection of confidential employee health information. Probably the most effective means of protecting private health information today would be the provision of occupational health services independent of corporate control. However, this solution would require major reform of present service delivery methods. This reform would require extensive work by individuals and organizations over a long period of time. There are other practical, attainable solutions to this problem, many of which were identified by the study participants. The recommendations contained herein reflect the remedies identified by the study participants and are thought to be achievable in the short term (that is, less than five years).

Because solving the problem of maintaining confidentiality of employee health information is often beyond the capability of the individual nurse, recommendations are made for collective action by nurses. To enhance credibility and strength, collective action is best undertaken under the auspices of organizations which represent professional nurses.

The recommendations for collective action combine the influence, authority and resources of the provincial licensing body and professional association (Manitoba Association of Registered Nurses) with the content expertise and commitment of the Manitoba Occupational Health Nurses Interest Group.

As well, suggestions are made for changes in individual practice. It is imperative that nurses begin the process of improving confidentiality of employee health information in their own workplaces. This imperative is moderated by the recognition that nurses, as employees themselves, have to deal with sometimes intimidating corporate or bureaucratic structures. Therefore, each nurse will have to decide for her/himself the degree to which this issue can be tackled in individual workplaces.

Vigorous concerted and individual action is expected to improve the maintenance of confidentiality of employee health information in occupational health nursing practice in Manitoba.

Recommendations for collective action. It is recommended that:

1. a code of ethics be developed specifically for occupational health nurses based on the principles of the Canadian Nurses Association (CNA) Code of Ethics for Nursing but incorporating content which recognizes the unique practice features of occupational health nursing.

This code should be developed under the auspices of the Canadian Nurses Association with input from provincial occupational health nursing groups and the National Association of Occupational Health Nurses.

2. the Manitoba Association of Registered Nurses (MARN) and the Manitoba Occupational Health Nurses Interest Group (MOHNIG) collaboratively develop a position statement on confidentiality of employee health information which includes guidelines for appropriate disclosure of employee health information, stringent methods of records handling, and disposition of records at termination of employment.

3. the MARN and the MOHNIG develop and implement a strategy for educating employers of the importance of maintaining the privacy of employee health information. This education should include recommendations for the establishment of employer policies for protecting confidentiality, the establishment of secure information handling and storage facilities, and the elaboration of nurses' ethical obligations regarding health information. The education should be aimed at all levels of management.

4. the MARN provide resources for the development of an orientation package for nurses entering the field of occupational health which would include a special section on ethics, a section on provincial resources available

for nurses, standards of practice (currently being developed), and employment-related issues.

5. occupational health nursing practice standards currently being developed include a strong statement on the nurse's obligation to maintain confidentiality of employee health information.
6. the MARN provide moral and institutional support to nurses who request it in situations where the nurse is having difficulty protecting the privacy of employee health information.
7. the MOHNIG, in collaboration with the MARN, intensively lobby the provincial government to enact legislation for the protection of employee health information. This should include the establishment of a provincial depository for employee health information for employers who go out of business or for employers who no longer maintain physicians or nurses on staff.

Recommendations for individual occupational health nursing practice. It is recommended that:

1. where an employer policy on confidentiality of employee health information is absent, the nurse strive to have such a policy established.
2. the nurse effectively communicate to all levels of management and employees the nurse's role in protecting the confidentiality of employee health information.

3. the nurse follow the most recent Canadian Health Records Association guidelines for protecting confidential health information.
4. the nurse endeavour to eradicate such practices as storage of health records in personnel files, storage of health records in insecure facilities, use of blanket authorizations for release of information and access to employee health information by anyone other than health professionals and administrative personnel, such as secretaries, who have taken an oath of confidentiality.
5. the nurse ensure that the employer (including persons responsible for Workers Compensation for the employer) be provided only with a statement regarding an individual's fitness to work and then, only after the employee's written authorization to do so.
6. health information provided to safety officers, industrial hygienists, and members of the Workplace Health and Safety Committees be aggregate information (with no individual identifiers) to be used for epidemiological purposes in illness and injury prevention programs.
7. the nurse support the efforts of the MARN and MOHNIG to improve the protection of employee health information in Manitoba.

Factors which may be Related to Ethical Decision-Making

Because ethical decision-making does not occur in a vacuum, some effort has been devoted to studying factors which may affect this process. Factors included those internal attributes of the nurse such as role conception and attributes of the nurse's work environment which may constrain nurses' decisions. This study describes some factors which may affect the ethical decisions respondents make regarding release of employee health information.

Murphy (1982) has postulated how nurses make moral decisions through the conceptualization of their role vis-a-vis clients and other players in health care. Patient advocate and bureaucrat were two dominant nursing role conceptions in her work. Ketefian (1985) advanced Murphy's work through empirical study of role conception and its effect on moral behaviour. She found that the majority of nurses exhibited a bureaucratic rather than a patient advocate orientation in their ethical decisions. The current study, on the other hand, suggests the opposite. The majority of respondents favoured a patient advocacy orientation and disfavoured a bureaucratic orientation. This finding, however, is tempered by a number of observations. This study examined ethical decision-making in one circumscribed situation, that is, decisions regarding release of employee health information. Also it described what nurses report their orientation to be in decision-making, not observed

decision-making in actual situations. For these reasons, the findings may not be comparable to those of Ketefian's. It is nonetheless encouraging that occupational health nurses appear to favour a patient advocate role conception because role conception may colour their manner of handling confidential employee health information. However, there may be an element of social desirability bias operating here, perhaps more so in this study than in others because of the obvious ethical theme of the study. It must be questioned whether this preliminary work has successfully tapped the constructs of bureaucratic and patient advocacy orientations. Future research could improve this situation by developing a carefully validated multi-item scale to measure the two constructs.

Curtin (1978) suggested that ethical decisions require a moral agent unconstrained by coercive forces. Autonomy may be affected by internal or external constraints. Wilkinson (1987/88) identified self-doubt and lack of courage as internal constraints to moral action among nurses that she studied. Self confidence does not appear to be a problem for the majority of respondents in this study. Feeling powerless to prevent access to employee health information was not a problem for the majority of respondents in this study although a significant minority was either neutral or indicated that they did feel powerless. The inverse correlation between feeling powerless and employer support for protecting confidentiality is consistent with the findings of Fennell and

Wood (1985) who measured general feelings of powerlessness among occupational health nurses. Finding no association between powerlessness and years of OHN experience, level of formal education, or size of workforce served was also consistent with findings of Fennell and Wood (1985).

Ability to count on occupational health nurse colleagues for advice, level of support from the employer for protecting confidentiality, and decision-making authority do not appear to be important contextual constraints for ethical decision-making for most respondents. Contrary to what Northrop (1987) and Krever (1980) found, most respondents in this study are not in solitary practice. The majority indicated that they practice together with another nurse or in multidisciplinary teams. This may explain, to some extent, the finding that most respondents can count on occupational health nurse colleagues for advice. The weak inverse correlation between bureaucratic or patient advocacy role orientations and decision-making authority and reliance on OHN colleague advice is preliminary at best and awaits further research.

The presence of coercive forces which may affect nursing autonomy and hence ethical decision-making were found in questions related to the employer's response to a refusal to release information. A considerable group of individuals indicated that they would be met with punitive measures, begrudging acceptance or the unknown if they were to refuse to release employee health information. Unpleasant reactions to

a nurse's refusal to release employee health information may create uncomfortable, if not intimidating, encounters with employers. A small number of individuals indicated that the confidentiality issue was a serious enough matter to either contribute to their own or their employer's decision to terminate work. This is further evidence of the level of discomfort over this issue that some nurses may feel in occupational settings.

That the respondents, on the whole, have a patient advocate role conception is consistent with the perception of the problem of maintaining confidentiality of employee health information. It is logical that if the nurse's orientation is one that respects the autonomy of the client, then she or he would view attempted incursions into the privacy of health information to be a problem. The magnitude of the problem of maintaining confidentiality of employee health information is incongruent with how nurses view themselves with respect to internal and external constraints to ethical decision-making. If nurses are confident, feel powerful, have employer support for maintaining privacy, can count on colleagues and have as much authority as they need for making decisions regarding confidentiality, then why is maintaining confidentiality still considered to be a problem? The answer to this question lies beyond the scope of this study but it may be surmised that either respondents in this study are deluding themselves or the internal and contextual constraints to ethical decision-

making, identified in the conceptual framework, are incomplete. Further research potentially could identify other internal and external constraints to ethical decision-making. Such constraints might include differing role expectations between nurse and employer, the effect of sexism on nursing autonomy, and the effect of different corporate reporting structures on nursing decisions.

Resources to Occupational Health Nurses

Two points are notable about the resources that nurses find most helpful when making difficult decisions related to release of information. Firstly, nurses rely primarily on their own instincts or beliefs and their occupational health nurse colleagues. This finding is consistent with those of Aroskar (1989) in her study of resources used by community health nurses for difficult ethical decision-making. Relying on one's own beliefs is acceptable as long as these beliefs are based on sound reasoning and adherence to generally accepted standards of nursing practice and codes of ethics. Otherwise there may be cause for concern that decisions could be made in an uncritical, capricious and particularistic manner by individual nurses. Secondly, it is unfortunate that the professional association, which logically should be viewed as an important resource to nurses regarding practice issues, was not found to be a more helpful resource by occupational health nurses. Why this is so is open to conjecture. It may

be that the professional association lacks the expertise to help occupational health nurses deal effectively with their unique practice issues. Although the professional association should be able to offer consulting services on a wide spectrum of practice issues, it must be recognized that the majority of its membership practices in acute or chronic care institutional settings. By necessity, then, nursing practice consultants will be most comfortable dealing with issues related to the practice of the majority of nurses. Community health nurses in general, and occupational health nurses in particular, may find knowledge of their practice issues lacking.

A number of factors which may affect ethical decision-making were explored preliminarily in this study. The next section discusses the limitations of the present research regarding role conception and the internal and external constraints on nursing autonomy. Recommendations for further nursing research to address some of these limitations are offered.

Strengths and Limitations of the Present Study

Strengths. A suspected problem with maintaining confidentiality of employee health information has been confirmed in this study. Moreover, the high response rate (86%), and the fact that 75 individuals indicated they wished

to receive a copy the study findings, reflects the topic's saliency among occupational health nurses in Manitoba.

This study was able to quantify the magnitude of the problem of maintaining confidentiality of employee health information in occupational health nursing practice in Manitoba. It identified the sources and frequency of requests, particularly inappropriate requests, for health information. As well, it provided insight into practices and policies related to occupational health records handling. Finally, it discerned what solutions occupational health nurses, as a group, consider most useful for improving the protection of confidential health information. These findings provide a solid foundation for pursuing individual and collective strategies for improving the protection of confidential employee health information in Manitoba.

Limitations. Findings of this survey are generalizable only to the population surveyed and not to populations of occupational health nurses working in other provinces or countries. It would be useful to research the problem of maintaining confidentiality of employee health information in another province (such as British Columbia or Ontario) where industry is more heavily concentrated and occupational health nurses are more numerous.

Although the items developed for this survey were supported by the literature, the study would have been

strengthened by a preliminary qualitative research approach which sought to explore the day-to-day decision-making process of individual occupational health nurses regarding employee health information. This approach may have generated facets of the problem of maintaining confidentiality and of ethical decision-making not previously researched. Qualitative research was not undertaken prior to this survey for reasons specific to this researcher and the study population. The occupational health nursing community is small in Manitoba; most nurses (including the researcher) are known to each other. The researcher was concerned that probing, face-to-face interview techniques or intrusive observational techniques of qualitative research would hinder subjects' willingness to participate in the study or would enhance the problem of social desirability bias among those who did participate. Although it is possible that important insights into the study questions may have been missed, it is believed that this was necessary in order to gain greater participation in the study and, hopefully greater respondent frankness.

Perhaps the greatest limitation of this study is that it was unable to determine to what extent factors suggested in the literature affect the ethical decisions of the study respondents. The findings would also suggest that there may be influences on ethical decision-making, particularly in the practice of occupational health nursing, which have not yet been hypothesized.

It is anticipated that, through further research, knowledge of nursing role conception and factors influencing ethical decision-making will improve. When these concepts are more fully explicated, the resulting knowledge could be incorporated into nursing practice in order to enhance client and community care.

Recommendations for nursing research. The following recommendations are proposed to address the limitations identified in the present study. It is recommended that:

1. qualitative research be conducted on an occupational health nursing population in another province to establish research questions that are grounded in the day-to-day problem-solving and ethical decision-making of occupational health nurses as they respond to requests for employee health information.
2. after incorporating the findings of the aforementioned qualitative research, a survey be conducted on a larger population of occupational health nurses to determine the magnitude of the problem of maintaining confidentiality of employee health information elsewhere and to identify factors affecting ethical decision-making.
3. research continue on role conception in nursing including better delineation of various role conceptions, what factors contribute to the development of a particular role conception, and how role conception influences

ethical decision-making. Because of the obvious differences between client populations and service delivery settings, it is suggested that comparative research examine role conception in different types of nursing practice such as community health, occupational health and acute care.

4. individual and contextual constraints to nursing autonomy be further investigated.

Conclusion

This descriptive cross-sectional survey examined the potential threats to the confidentiality of employee health information in occupational health nursing practice in Manitoba. Maintaining confidentiality of employee health information was found to be a significant problem by occupational health nurses. The most likely major contributing factors to the problem were: 1) the frequency of employer requests, particularly those unaccompanied by written authorization or those which are for specific health information; 2) lack of stringent employer practices and policies for protecting confidentiality of employee health information; and 3) unpleasant employer reactions to nurses' refusals to release information.

Factors which may affect ethical decision-making were explored in a preliminary way. The degree to which any of these factors influence decision-making cannot be determined

from this study. Generalizations cannot be made to other populations or other situations requiring moral decision-making.

Findings of this study have implications for occupational health nursing practice, public policy, and nursing research in ethical decision-making, role conception and autonomy. Recommendations are made for nursing practice and research.

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Appendices

Note: Appendices have been photographically reduced to meet requirements for binding.

Appendix I - Definition of Terms

Definitions of Terms

Terms used in this study are defined as follows:

confidential: private

employee health information: any verbal or written information concerning the health status of an employee that is collected and/or maintained by a nurse, physician, technician, or other health care personnel. This may include, but is not limited to, questionnaires, histories, results of examinations, laboratory test results, medical opinions, diagnoses, progress notes, recommendations, descriptions of treatments and prescriptions, and employees' medical concerns (adapted from Northrop, 1987).

ethical decision-making: process of making a judgement regarding two or more courses of action in a moral dilemma. Moral dilemmas are "situations of ambiguity and conflict with equally unattractive alternatives for choice, decision-making and action" (Aroskar, 1979, p. 38).

request for employee information: any formal or informal, verbal or written, petition for employee health information which may come from a variety of sources, both inside and outside the nurse's employing organization.

request for employee health information of a specific nature: a verbal or written petition for detailed employee health information (e.g. medical diagnosis or other particulars of the employee's health status) other than a simple statement outlining the employee's capabilities or limitations to perform a given job.

unauthorized request: a verbal or written petition for employee health information <u>not</u> accompanied the employee's written authorization for the release of health information.

written authorization for release of health information: written consent (in the original) sought from the employee (patient) for the release of health information to a third party. The Canadian Health Records Association Code of Practice (1980) recommends that the following elements be present in a written authorization: name of the individual or institution who is to release the information; name of the individual or institution who is to receive the information; name, address and birth date of person whose information is being requested; purpose or need for information; nature of information to be released (blanket authorizations shall not be honoured); expiry date of the authorization; and date that the authorization is signed.

Appendix II - MARN Policy for Release of Membership Names

MANITOBA ASSOCIATION OF REGISTERED NURSES

POLICY:	General	SECTION: 9
SUBJECT:	Release of Membership Names for Research Purposes	NUMBER: 2.2
CURRENT REVIEW DATE:	January 20, 1988	APPROVED: March 8, 1988
PREVIOUS REVIEW DATE(S):	March 4, 1985	ORIGIN DATE: May 22 1981

STATEMENT OF POLICY

The release of M.A.R.N. membership names or labels on the roster for research purposes, excluding release for commercial or marketing purposes, may be granted at the written request of a M.A.R.N. Committee, M.A.R.N. members, or non-M.A.R.N. member(s) and following review and recommendation by the M.A.R.N. Research Committee.

1. The applicant will provide the Research Committee with 2 copies of:

    1. The research proposal
    2. Evidence of ethical committee review and approval
    3. Evidence of agency support
    4. In the case of graduate thesis, evidence of Thesis Advisory Committee approval
    5. Any additional information requested by the Research Committee.

2. For projects approved in the above manner, the researcher will sign a letter of agreement ensuring the M.A.R.N. that:

    1. The researcher will identify to each sampled individual that her or his name was obtained from the M.A.R.N.

    2. The reseacher will keep the membership list secure, private and confidential that all members of the research project team are bound by this assurance.

    3. The researcher will not duplicate the membership list and must return all unused membership material to the M.A.R.N.

    4. The researcher will pay for all expenses incurred by the M.A.R.N. in generating and providing the list.

    5. The researcher will not alter the original project as approved by the M.A.R.N. Research Committee.

3. Strategies for Release of Names for Approved Projects

    The Research Committee, after reviewing the applicant's specification of population, the sampling framework (procedures and numbers), will recommend the most effecient strategy for release of names, eg., entire roster, stratified computer or non-computer generated, etc.

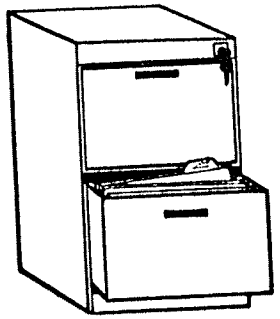
    BOARD APPROVED MARCH 8, 1988
    /ls March 31, 1988

Appendix III - Questionnaire

A Study of Confidentiality of Employee Health Information in Occupational Health Nursing Practice

by

Beverley J. Cann RN CCOHN



INSTRUCTIONS

From time to time occupational health nurses receive requests for health information about employees under their care. This survey explores the type and frequency of such requests, methods of health records handling, and ethical decision-making regarding release of employee health information.

Either a pen or a pencil may be used to complete this questionnaire. Most of the questions can be answered by circling the number beside your answer or by filling in a blank. There are no right or wrong answers. Answers will depend on your own experience. Additional comments are welcome. Please write them in the space provided at the end of the booklet.

Participation in the study is voluntary. You are assured of anonymity and individual responses will be grouped to maintain confidentiality.

Please mail the completed questionnaire back to me in the postage paid envelope. Then mail the postcard separately so that I may remove your name from my mailing list.

DEFINITIONS

Employee health information: is defined as any verbal or written information about the health status of an employee, collected by health care personnel, which may include, but is not limited to, medical diagnosis or opinion, employees' health concerns, histories, treatment, and results of examinations and laboratory tests.

Request for employee health information: is defined as any formal or informal, verbal or written, petition for employee health information which may come from a variety of sources, both inside and outside the nurse's employing organization.

First are a couple of general questions about the issue of confidentiality of employee health information.

1. Generally speaking, do you think maintaining confidentiality of employee health information is a problem or not? (Circle the number beside the answer which best applies.)

   1. NO, IT IS NOT A PROBLEM.
   2. YES, IT IS A PROBLEM.
   3. I DON'T KNOW.

2. What do you think might help to protect the confidentiality of employee health information? (Circle as many as apply.)

   1. A LAW OR REGULATION SPECIFICALLY GOVERNING CONFIDENTIALITY OF HEALTH INFORMATION IN OCCUPATIONAL SETTINGS
   2. A CODE OF ETHICS SPECIFICALLY FOR OCCUPATIONAL HEALTH NURSES IN CANADA
   3. STANDARDS OF PRACTICE FOR OCCUPATIONAL HEALTH NURSES
   4. BETTER EDUCATION OF EMPLOYERS AND EMPLOYEES REGARDING CONFIDENTIALITY OF HEALTH INFORMATION
   5. WRITTEN COMPANY POLICY ON CONFIDENTIALITY OF HEALTH INFORMATION
   6. BETTER EDUCATION OF NURSES AND OTHER OCCUPATIONAL HEALTH PROFESSIONALS REGARDING CONFIDENTIALITY OF HEALTH INFORMATION
   7. A SYSTEM OF OCCUPATIONAL HEALTH SERVICE DELIVERY IN WHICH OCCUPATIONAL HEALTH PROFESSIONALS ARE NOT DIRECTLY EMPLOYED BY COMPANIES
   8. NOTHING WOULD MAKE THE SITUATION BETTER
   9. OTHER, PLEASE SPECIFY _____

Next are a couple of questions about general requests for employee health information in your current occupational health nursing practice.

3. Please indicate whether or not you have received, in the last six months, requests for employee health information from any of the following possible sources: (Circle the number that applies for each category.)

		RECEIVED REQUEST IN LAST SIX MONTHS	
		NO	YES
a.	INSURANCE COMPANY.....	1	2
b.	WORKERS COMPENSATION BOARD.....	1	2
c.	GOVERNMENT DEPARTMENT.....	1	2
d.	WORKER'S ATTENDING DOCTOR.....	1	2
e.	HEALTH PROFESSIONAL OTHER THAN WORKER'S ATTENDING DOCTOR.....	1	2
f.	LAWYER.....	1	2
g.	WORKER'S EMPLOYER.....	1	2
h.	WORKER'S UNION REPRESENTATIVE.....	1	2
i.	WORKER HIM/HERSELF.....	1	2
j.	OTHER, PLEASE SPECIFY _____	1	2

If you answered YES to any of the above categories, proceed to question 4. However, if you answered NO to all of the above categories, proceed to question 5.

4. Of the total requests you received in the last six months, please estimate how many you received from each source. (Write the number in the appropriate blank(s)).

		NUMBER
a.	INSURANCE COMPANY.....	_____
b.	WORKERS COMPENSATION BOARD.....	_____
c.	GOVERNMENT DEPARTMENT.....	_____
d.	WORKER'S ATTENDING DOCTOR.....	_____
e.	HEALTH PROFESSIONAL OTHER THAN WORKER'S ATTENDING DOCTOR.....	_____
f.	LAWYER.....	_____
g.	WORKER'S EMPLOYER.....	_____
h.	UNION REPRESENTATIVE.....	_____
i.	WORKER HIM/HERSELF.....	_____
j.	OTHER, PLEASE SPECIFY _____	_____

Now for some questions about requests for employee health information originating within your present employing organization.

5. Please indicate whether or not you received, in the last six months, requests for employee health information from any of the following possible sources within your employing organization. (Circle the number that applies for each category.)

		RECEIVED REQUEST IN LAST SIX MONTHS	
		NO	YES
a.	INDIVIDUAL RESPONSIBLE FOR INSURANCE CLAIMS.....	1	2
b.	INDIVIDUAL RESPONSIBLE FOR WCB CLAIMS.....	1	2
c.	EMPLOYEE'S DIRECT SUPERVISOR.....	1	2
d.	MANAGER, OTHER THAN EMPLOYEE'S DIRECT SUPERVISOR.....	1	2
e.	UNION REPRESENTATIVE.....	1	2
f.	JOINT H&S COMMITTEE REPRESENTATIVE.....	1	2
g.	SAFETY OFFICER.....	1	2
h.	OTHER, PLEASE SPECIFY _____		

If you answered YES to any of the above categories, proceed to question 6. However, if you answered NO to all of the above categories, proceed to question 12.

6. Of the total requests you received in the last six months from within your employing organization, please estimate how many you received from each source. (Write the number in the appropriate blank(s)).

		NUMBER
a.	INDIVIDUAL RESPONSIBLE FOR INSURANCE CLAIMS.....	_____
b.	INDIVIDUAL RESPONSIBLE FOR WCB CLAIMS.....	_____
c.	EMPLOYEE'S DIRECT SUPERVISOR.....	_____
d.	MANAGER, OTHER THAN EMPLOYEE'S DIRECT SUPERVISOR.....	_____
e.	UNION REPRESENTATIVE.....	_____
f.	JOINT H&S COMMITTEE REPRESENTATIVE.....	_____
g.	SAFETY OFFICER.....	_____
h.	OTHER, PLEASE SPECIFY _____	_____

7. Of those employer requests for employee health information received in the last six months, were all of them accompanied by the employee's written authorization for release of the information? (Circle the number beside the answer which best applies.)

1. NO
2. YES (Please go to question 9.)

8. Please estimate what proportion of employer requests for employee health information were not accompanied by the employee's written authorization for release of information?

1. LESS THAN 25%
2. 25% TO 50%
3. 51% TO 75%
4. MORE THAN 75%

9. Of those employer requests received in the last six months, did any ask that you provide employee health information of a specific nature such as diagnosis, results of tests, etc.? (Circle the number beside the answer which best applies.)

1. YES
2. NO (Please go to question 12.)

10. Please estimate what proportion of employer requests for employee health information asks for information of a specific nature such as diagnosis, results of tests, etc.? (Circle the number beside the answer which best applies.)

1. LESS THAN 25%
2. 25% TO 50%
3. 51% TO 75%
4. MORE THAN 75%

11. When an employer requests employee health information of a specific nature, what type of information is he or she most often seeking? (Circle the number beside the answer which best applies.)

1. CONFIRMATION OF A SUSPECTED SUBSTANCE ABUSE PROBLEM
2. INDIVIDUAL BIOLOGICAL TEST RESULTS (E.G.HEARING TESTS)
3. MEDICAL DETAILS JUSTIFYING WORK ABSENCE
4. MEDICAL DETAILS JUSTIFYING WORK RESTRICTION
5. MENTAL HEALTH STATUS
6. OTHER, PLEASE SPECIFY _____

12. Compared to three years ago, would you say the number of employer requests for employee health information of a specific nature has increased, decreased, or stayed about the same?

    1. DECREASED
    2. STAYED ABOUT THE SAME
    3. INCREASED
    4. UNABLE TO ASSESS

13. Compared to three years ago, would you say the number of employer requests for employee health information which are not accompanied by the employee's written authorization has increased, decreased, or stayed about the same?

    1. DECREASED
    2. STAYED ABOUT THE SAME
    3. INCREASED
    4. UNABLE TO ASSESS

Decisions about whether or not to release employee health information to the employer are sometimes difficult. I would like to ask you some questions about making decisions regarding release of employee health information to the employer.

14. Which of the following resources have you used for guidance when faced with a difficult decision regarding release of employee health information to the employer: (Circle as many as apply.)

    1. MY OWN INSTINCTS OR PERSONAL BELIEFS
    2. ANOTHER OCCUPATIONAL HEALTH NURSE
    3. A PHYSICIAN
    4. A CODE OF ETHICS
    5. COMPANY POLICY
    6. A REGULATION
    7. THE MARN
    8. A LAWYER
    9. HAVE NEVER FACED SUCH A DECISION (Go to Q. 16).
    10. OTHER _____

15. Which one of the following resources did you find **most** helpful when faced with a difficult decision regarding release of employee health information to the employer? (Circle only one choice.)

    1. MY OWN INSTINCTS OR PERSONAL BELIEFS
    2. ANOTHER OCCUPATIONAL HEALTH NURSE
    3. A PHYSICIAN
    4. A CODE OF ETHICS
    5. COMPANY POLICY
    6. A REGULATION
    7. THE MARN
    8. A LAWYER
    9. HAVE NEVER FACED SUCH A DECISION
    10. OTHER _____

16. If you were to refuse to release employee health information to the employer, in a situation in which you believed it would be inappropriate to release the information, what is the most likely consequence you might expect? (Circle the number beside the answer which best applies.)

    1. I WOULD LIKELY BE SUBJECT TO SOME PUNITIVE MEASURE FROM MY EMPLOYER.
    2. I WOULD BE MET WITH BEGRUDGING OR DISAPPROVING ACCEPTANCE OF MY POSITION.
    3. NOTHING WOULD LIKELY HAPPEN TO ME.
    4. I WOULD LIKELY GAIN GREATER RESPECT FROM MY EMPLOYER.
    5. I'M NOT SURE WHAT WOULD HAPPEN.

17. Since becoming an occupational health nurse, has the issue of confidentiality of employee health information ever contributed to your decision to leave a specific employer?

    1. NO
    2. YES

18. Since becoming an occupational health nurse, in your opinion, has the issue of confidentiality of employee health information ever contributed to an employer's decision to terminate you?

    1. NO
    2. YES
    3. DON'T KNOW

19. Think about the way you generally make decisions regarding release of employee health information to the employer. Then for each of the statements below, please indicate whether you strongly agree, strongly disagree or feel something in between. (1 means strongly disagree, 5 means strongly agree.)

	STRONGLY DISAGREE				STRONGLY AGREE
a. To facilitate administrative decisions, the employer should have access to as much employee health information as he or she requires.	1	2	3	4	5
b. Once I make a decision about releasing employee health information, I am usually pretty confident that it is the right decision.	1	2	3	4	5
c. I can count on occupational health nurse colleagues for advice with decisions regarding the release of employee health information.	1	2	3	4	5
d. As the owner of the employee's health record, the employer should have access to the information stored in the record.	1	2	3	4	5
e. I feel that I have a lot of support from my employer for protecting the confidentiality of employee health information.	1	2	3	4	5
f. I have to be prepared to stand up for the employee's privacy when it comes to health information.	1	2	3	4	5
g. I would disobey a direct order from my employer before I would inappropriately release health information about an employee.	1	2	3	4	5
h. I sometimes feel powerless to prevent inappropriate access to employee health records.	1	2	3	4	5

	STRONGLY DISAGREE				STRONGLY AGREE
i. My past education adequately prepared me to make decisions regarding issues of confidentiality in occupational health nursing.	1	2	3	4	5
j. I have been given as much authority as I need to make decisions regarding confidentiality of employee health information.	1	2	3	4	5
k. As I gain more experience, it becomes easier to judge each situation and make decisions regarding release of employee health information.	1	2	3	4	5

Now for some questions about the general handling and storage of employee health <u>records</u> with your present employer.

20. Does your present employer have a written policy governing confidentiality of employee health information?

1. NO
2. YES
3. UNSURE

21. Does your present employer require employees under your care to sign a blanket consent form, at the time of hiring, for release of health information?

1. NO
2. YES
3. UNSURE

22. Do you require an employee's written authorization for release of health information?

1. NO (Please skip to question 24.)
2. YES

23. Does the written authorization form that you use happen to have any of the following components? (Please circle the number which best applies.)

		NO	YES	UNSURE
a.	RECIPIENT OF THE INFORMATION..	1	2	3
b.	SPECIFIC NATURE OF THE INFORMATION TO BE RELEASED....	1	2	3
c.	DATE.....	1	2	3
d.	EMPLOYEE'S SIGNATURE.....	1	2	3
e.	TIME LIMIT ON VALIDITY OF AUTHORIZATION.....	1	2	3
f.	PURPOSE FOR WHICH INFORMATION IS TO BE USED.....	1	2	3

24. Are employee health records stored in the same file as personnel records in your present work setting?

1. NO
2. YES

25. Where are employee health records stored in your present work setting?

1. UNLOCKED FILE DRAWER INSIDE HEALTH UNIT
2. LOCKED FILE DRAWER INSIDE HEALTH UNIT
3. UNLOCKED FILE DRAWER OUTSIDE HEALTH UNIT
4. LOCKED FILE DRAWER OUTSIDE HEALTH UNIT
5. COMPUTERIZED DATA SYSTEM TO WHICH ACCESS IS NOT RESTRICTED TO HEALTH PERSONNEL ONLY
6. COMPUTERIZED DATA SYSTEM TO WHICH ONLY HEALTH PERSONNEL HAVE ACCESS
7. OTHER, PLEASE SPECIFY _____

26. If you were to leave your present position, who would most likely assume direct responsibility for employee health records?

1. NO ONE
2. ANOTHER NURSE
3. AN ON-SITE PHYSICIAN
4. AN OUTSIDE CONSULTING PHYSICIAN
5. A SECRETARY
6. SOMEONE FROM PERSONNEL
7. SOMEONE FROM MANAGEMENT
8. I'M NOT SURE

27. When you left your last occupational health nursing position, who assumed direct responsibility for employee health records?

1. NO ONE
2. ANOTHER NURSE
3. AN ON-SITE PHYSICIAN
4. AN OUTSIDE CONSULTING PHYSICIAN
5. A SECRETARY
6. SOMEONE FROM PERSONNEL
7. SOMEONE FROM MANAGEMENT
8. I'M NOT SURE
9. I HAVE NOT BEEN EMPLOYED PREVIOUSLY AS AN OHN

Finally, here are some statements to complete about yourself.

28. I have worked as an occupational health nurse for:

_____ YEARS (PART-TIME).

_____ YEARS (FULL-TIME).

29. I presently provide occupational health services in:

1. PRIVATE INDUSTRY.
2. GOVERNMENT OR CROWN CORPORATION.
3. GOVERNMENT-FUNDED ORGANIZATION (E.G. HOSPITALS/UNIVERSITIES).
4. A VARIETY OF WORK SETTINGS.

30. I presently provide occupational health services to a workforce of approximately:

_____ WORKERS.

31. I have worked with my present employer for approximately:

_____ YEARS.

32. The employees under my care are:

1. MOSTLY NON-UNIONIZED.
2. MOSTLY UNIONIZED
3. ABOUT HALF AND HALF.

33. I presently provide occupational health services:

1. ALONE.
2. TOGETHER WITH AN IN-HOUSE PHYSICIAN.
3. TOGETHER WITH AN OUTSIDE CONSULTING PHYSICIAN.
4. TOGETHER WITH ANOTHER NURSE(S).
5. TOGETHER WITH A MULTIDISCIPLINARY TEAM.

34. My past education and training include: (Circle as many as are apply.)

1. NURSING DIPLOMA.
2. BACHELOR'S DEGREE IN NURSING.
3. BACHELOR'S DEGREE IN OTHER THAN NURSING.
4. CERTIFICATE IN OCCUPATIONAL HEALTH NURSING.
5. CERTIFICATE IN OTHER THAN OCCUPATIONAL HEALTH NURSING.
6. MASTERS DEGREE IN NURSING.
7. MASTERS DEGREE IN OTHER THAN NURSING.

This completes the survey. Thank you very much for your interest and time. If you have any further comments please feel free to add them here.

Appendix IV - Operationalization

Table 1

Operationalization

Objective	Specific Dimension of Objective	Items Operationalizing Objective	Literature Support
1. to describe the magnitude of difficulty in maintaining confidentiality of employee health information among occupational health nurses by determining:	a) all sources and frequency of requests for employee health information;	3. all sources of requests received in last six months.	
		4. number of requests received in last six months from all sources.	
		5. all sources of requests received from within employing organization in last six months.	AAOHN, 1988; Krever, 1980; Rogers, 1988
		6. number of requests received in last six months from within employing organization.	
	b) the frequency of employer requests for employee health information which is unaccompanied by written authorization from the employee;	7. employer requests accompanied by written authorization.	AAOHN, 1988; AOMA, 1976; CMA, 1982; Krever, 1980; Reif, 1983
		8. proportion of employerrequests not accompanied by written authorization.	
		13. unauthorized requests changing over time.	
	c) the frequency of employer requests for employee health information of a specific nature such as diagnosis or other particulars of the employee's health status;	9. employer requests for information of a specific nature.	AAOHN, 1988; AOMA, 1976; CMA, 1982
		10. proportion of employer requests for specific information.	
		12. requests for specific information changing over time.	
	d) the type of specific employee health information that employers are most likely to request; and	11. type of specific information requested	

(continued)

Table 1 (continued)

Objective	Specific Dimension of Objective	Items Operationalizing Objective	Literature Support
	e) the methods used by OHNs to handle occupational health records.	20. presence of written policy governing confidentiality.	CHRA, 1980
		21. requirement for signing blanket consent form.	CHRA, 1980; McLean, 1976; Northrop, 1987; Reif, 1983
		22. nurse's requirement for written authorization to release information	CHRA, 1980
		23. elements of written authorization	CHRA, 1980
		24/25. record storage	CHRA, 1980
		26/27. record transfer	
2. to determine whether OHNs perceive the maintenance of confidentiality of employee health information to be a problem, and, if so, to determine self-identified solutions for improving the protection of confidential employee health information;	a) problem	16. perceived consequence of refusing to release information.	Rest, 1988
		17/18. contribution of confidentiality issues to resignation / termination	
	b) solution	1. perception of a problem	
		2. possible remedies	Jennings, 1982; Krever, 1980
3. to identify resources used by OHNs when faced with difficult decision regarding release of employee health information; and		14. resources used	Brandt-Rauf, 1989
		15. most helpful resource	

(continued)

Table 1 (continued)

Objective	Specific Dimension of Objective	Items Operationalizing Objective	Literature Support
4. to isolate some factors about the individual nurse or her working environment which may be related to ehtical decision-making regarding the protection of confidential employee health information.	a) bureaucratic role conception	19 a. attend to the needs of the employer	Ketefian, 1985; Murphy, 1983; Pinch, 1985
	b) confidence	19 b. confident decision is right	Wilkinson, 1988
	c) level of peer support	19 c. can count on colleagues for advice	Krever, 1980; Northrop, 1987
	d) bureaucratic role conception	19 d. employer owner of record has right of access	Ketefian, 1985; Murphy, 1983; Pinch, 1985
	e) level of employer support	19 e. employer support	Fennell, 1985
	f) patient advocate role conception	19 f. stand up for patient's privacy	Ketefian, 1985; Murphy, 1983; Pinch, 1985
	g) patient advocate role conception	19 g. disobey employer's direct order to release information	Ketefian, 1985; Murphy, 1983; Pinch, 1985
	h) feelings of powerlessness	19 h. feel powerless	Fennell, 1985
	i) level of education	19 i. level of education	
	j) authority	19 j. delegated authority to make decisions	Fennell, 1985
	k) past experience with similar situations	19 k. gaining experience makes decisions easier	Crisham, 1981
demographic information on employment situation and educational background		28. part time and full time experience in occupational health nursing	
		29. type of employer	
		30. size of workforce	
		31. years with present employer	
		32. unionized or nonunionized workforce	
		33. presence of other occupational health professionals at work site	
		34. nurse's education	

Appendix V - Cover Letter to Subjects

Beverley J. Cann RN CCOHN

May 29, 1991

1~ 3~ 2~
4~
5~, 6~
7~

Dear 1~ 2~:

Occupational health nurses face many challenges in day-to-day practice. Among these challenges may be a range of ethical issues which are related to the specific nature of occupational health practice. Although confidentiality of employee health information is frequently discussed in the occupational health literature, and informally among Manitoba occupational health nurses, little systematic research has been done on this important topic. A recent survey conducted for the American Association of Occupational Health Nurses identified ethical issues, such as confidentiality, as a priority area of study.

I am conducting such a study as part of the requirements of a University of Manitoba Masters Thesis in Nursing. The study's purposes are:

to describe the type and frequency of requests for employee health information;
to determine whether or not nurses regard maintaining confidentiality as a problem and, if so, to solicit possible solutions;
to identify resources used by nurses when faced with difficult decisions regarding confidentiality; and
to explore factors possibly related to nurses' ethical decision-making regarding release of employee health information.

You have been selected to participate in this timely study because, as an occupational health nurse, you can provide important insights into this topic. Your contribution will help to fill an acknowledged gap in our knowledge of this issue. Your name and address were obtained from the Manitoba Association of Registered Nurses after meeting the requirements of their policy on release of membership names for research purposes.

Participation in this study requires completion and return of a questionnaire. This will take approximately thirty minutes. Your participation is voluntary. Completion and return of the questionnaire will imply consent for your data to be included in the study.

Confidentiality of your responses is assured since the study results will be grouped so that individual responses cannot be identified. I ask that you mail the enclosed post card back separately so that I may remove your name from my mailing list. Only the questionnaire should be returned in the postage paid envelope. In this way it is not possible to trace from whom each questionnaire is returned.

As a gesture of my gratitude to you for your help, I am prepared to mail you a personal copy of the results of the completed study when they are available. Simply check the "results requested" box on the separate postcard to receive them. I do hope you will decide to participate. Your time and effort would be greatly appreciated.

Finally, my research is supervised by a Thesis Committee comprised of Professors K. Chalmers and L. Guse of the School of Nursing and Dr. K. Grant of the Department of Sociology. Please call me and/or my Committee Chairperson, Dr. Chalmers, if you have any questions regarding the study. My home telephone number is . Dr. Chalmers's work number is 474-9315.

Sincerely,

Beverley J. Cann RN CCOHN

Appendix VI - Invitation to Panelists

Invitation to Panelists

actual date

Ms. Jane Smith
111 Any Street
Any Town, Manitoba
HOH OHO

Dear Ms. Smith:

You are invited to participate in a University of Manitoba Masters thesis research project being conducted by me. You have been selected because of your direct experience and background in occupational health nursing which I believe enables you to provide valuable insight into various dimensions of occupational health nursing practice.

The general purpose of the proposed study is to determine whether occupational health nurses in Manitoba have difficulty maintaining confidentiality of employee health information or not. Specifically the study explores the type and frequency of requests of employee health information, methods of record handling, and nurses' ethical decision-making regarding release of employee health information.

As you know occupational health nurses face many challenges in day-to-day practice. Among these challenges may be a range of ethical issues which are related to the specific nature of occupational health practice. Although confidentiality of employee health information is frequently discussed in the occupational health literature, little systematic research has been done on this important topic. A recent survey conducted for the American Association of Occupational Health Nurses identified ethical issues, such as confidentiality, as a priority area of study. The time appears to be ripe for the present study.

Because of your knowledge and experience in occupational health nursing, the role I anticipate you playing is special and quite specific. A questionnaire has been developed to meet the study objectives, but before it can be sent to potential subjects it is necessary for the researcher to have some assurance that the questionnaire actually measures what it purports to measure, in other words, that it is valid. I estimate that this process would take about three to four hours of your time in a meeting with several other panelists and me. The meeting will be scheduled at the panelists' convenience. During your meeting you will be provided with all necessary materials and instructions for accomplishing the task.

If you agree to participate in this component of the research project, you will not be requested to participate in the study as a subject. As well, because the occupational health nursing community is small in Manitoba, it is important that you maintain

strict confidentiality regarding the contents of the study so as not to bias any potential study subjects. Finally, the formal criteria for your participation in this exercise are as follows: 1) you shall be a registered nurse; 2) you shall have five or more years experience in occupational health nursing; and 3) you shall hold or have held a leadership position in occupational health nursing in Manitoba (e.g. instructor or member of interest group executive).

My research is supervised by a Thesis Committee comprised of Dr. Karen Chalmers and Professor Lorna Guse of the School of Nursing and Dr. Karen Grant of the Department of Sociology, University of Manitoba. I will contact you by telephone in approximately one week to discuss this invitation. Subsequently, if you have any questions please do not hesitate to call me (949-0811 (w) or (h) or Dr. Chalmers, my Committee Chairperson, at 474-9315.

I look forward to meeting with you. Your time and effort are greatly appreciated.

Sincerely,

Beverley J. Cann RN CCOHN

Appendix VII - Steps in the Validation Process

Instructions to Panelists

Since this questionnaire has been newly constructed for this study, it is necessary for the researcher to have some assurance that the questionnaire actually measures what it purports to measure, in other words, to assure its validity.

The specific objectives of this study are:

1. to describe the magnitude of difficulty in maintaining confidentiality of employee health information among Manitoba occupational health nurses by determining:

   a) all sources and frequency of requests for employee health information;
   b) the frequency of employer requests for employee health information which is unaccompanied by written authorization from the employee;
   c) the frequency of employer requests for employee health information of a specific nature such as a diagnosis or other particulars of the employee's health status;
   d) the type of specific employee health information that employers are most likely to request; and
   e) the methods used by occupational health nurses to handle occupational health records.

2. to determine whether occupational health nurses perceive the maintenance of confidentiality of employee health information to be a problem, and, if so, to determine self-identified solutions for improving the protection of confidential employee health information;

3. to identify resources used by occupational health nurses when faced with a difficult decision regarding release of employee health information; and

4. to isolate some of the factors about the individual nurse or her working environment which may be related to ethical decision-making regarding the protection of confidential employee health information.

The task set out for you is to judge two types of content validity for this questionnaire, face validity and sampling validity. A format has been set out to assist in accomplishing this task.

Judging Face Validity

The object here is to determine whether each item on the questionnaire has been worded clearly and whether it is relevant to a specific study objective. Table 1 includes each study objective and indicates which questionnaire item has been developed to accomplish the objective. After referring to the items in the questionnaire, please indicate whether you think each item is stated clearly and whether each item is relevant to its study objective. Use Table 1 to record your answer in the appropriate column.

Judging Sampling Validity

The object here is to determine whether the major aspects of the topic under study have been adequately operationalized by the questionnaire. Judging this type of validity is particularly important for objectives 1 and 4. Tables 2 and 3 provide a method for judging sampling validity. Both objectives 1 and 4 have several dimensions. First you are asked to consider these dimensions and then judge whether, taken together, the dimensions adequately represent the intent of that objective. Next you are asked to consider the questionnaire item(s) which are matched to each dimension and then judge whether, taken together, each group of items represents the intent of that dimension. You may use the

Tables to record your judgements.

The following definition of terms will enable you to see how specific words and phrases have been defined for purposes of this study:

confidential: private

employee health information: any verbal or written information concerning the health status of an employee that is collected and/or maintained by a nurse, physician, technician, or other health care personnel. This may include, but is not limited to, questionnaires, histories, results of examinations, laboratory test results, medical opinions, diagnoses, progress notes, recommendations, descriptions of treatments and prescriptions, and employees' medical concerns (adapted from Northrop, 1987).

ethical decision-making: process of making a judgement regarding two or more courses of action in a moral dilemma. Moral dilemmas are "situations of ambiguity and conflict with equally unattractive alternatives for choice, decision-making and action" (Aroskar, 1979, p. 38).

request for employee information: any formal or informal, verbal or written, petition for employee health information which may come from a variety of sources, both inside and outside the nurse's employing organization.

request for employee health information of a specific nature: a verbal or written petition for detailed employee health information (e.g. medical diagnosis or other particulars of the employee's health status) other than a simple statement outlining the employee's capabilities or limitations to perform a given job.

unauthorized request: a verbal or written petition for employee health information <u>not</u> accompanied the employee's written authorization for the release of health information.

written authorization for release of health information: written consent (in the original) sought from the employee (patient) for the release of health information to a third party. The Canadian Health Records Association Code of Practice (1980) recommends that the following elements be present in a written authorization: name of the individual or institution who is to release the information; name of the individual or institution who is to receive the information; name, address and birth date of person whose information is being requested; purpose or need for information; nature of information to be released (blanket authorizations shall not be honoured); expiry date of the authorization; and date that the authorization is signed.

Table 1 Judging Face Validity

Objective	Specific Dimension of Objective	Item	Clear?	Relevant to Objective?
1. to describe the magnitude of difficulty in maintaining confidentiality of employee health information among occupational health nurses by determining:	a) all sources and frequency of requests for employee health information;	1		
		2		
		3		
		4		
	b) the frequency of employer requests for employee health information which is unaccompanied by written authorization from the employee;	5		
		6		
		11		
	c) the frequency of employer requests for employee health information of a specific nature such as diagnosis or other particulars of the employee's health status;	7		
		8		
		10		
	d) the type of specific employee health information that employers are most likely to request; and	9		
	e) the methods used by OHNs to handle occupational health records.	19		
		20		
		21		
		22		
		23		
		24		

(continued)

Table 1 (continued)

Objective	Specific Dimension of Objective	Item	Clear?	Relevant to Objective?
2. to determine whether OHNs perceive the maintenance of confidentiality of employee health information to be a problem, and, if so, to determine self-identified solutions for improving the protection of confidential employee health information;	a) problem	14		
		15		
		17		
	b) solution	18		
3. to identify resources used by OHNs when faced with difficult decision regarding release of employee health information; and		12		
		13		
4. to isolate some factors about the individual nurse or her working environment which may be related to ethical decision-making regarding the protection of confidential employee health information.	a) bureaucratic role conception	16a		
	b) confidence	16b		
	c) level of peer support	16c		
	d) bureaucratic role conception	16d		
	e) level of employer support	16e		
	f) patient advocate role conception	16f		
	g) patient advocate role conception	16g		
	h) feelings of powerlessness	16h		
	i) level of education	16i		
	j) authority	16j		
	k) past experience with similar situations	16k		

(continued)

Table 1 (continued)

Objective	Items	Clear?	Relevant?
demographic information on employment situation and educational background	25		
	26		
	27		
	28		
	29		
	30		
	31		

Table 2 Judging Sampling Validity for Objective 1

Objective	Specific Dimension of Objective	Do these five dimensions, together, adequately represent the intent of Objective 1?
1. to describe the magnitude of difficulty in maintaining confidentiality of employee health information among occupational health nurses by determining:	a) all sources and frequency of requests for employee health information;	Yes or no? _____ If no, would you be able to suggest other dimensions? _____ _____ _____
	b) the frequency of employer requests for employee health information which is unaccompanied by written authorization from the employee;	
	c) the frequency of employer requests for employee health information of a specific nature such as diagnosis or other particulars of the employee's health status;	
	d) the type of specific employee health information that employers are most likely to request; and	
	e) the methods used by OHNs to handle occupational health records.	

Table 2 (continued) Judging Sampling Validity for Objective 1

Objective	Specific Dimension of Objective	Items	Does the item, or group of items, matched to each dimension adequately represent the intent of that dimension? (Circle yes or no.)
1. to describe the magnitude of difficulty in maintaining confidentiality of employee health information among occupational health nurses by determining:	a) all sources and frequency of requests for employee health information;	1,2,3,4	yes / no
	b) the frequency of employer requests for employee health information which is unaccompanied by written authorization from the employee;	5,6,11	yes / no
	c) the frequency of employer requests for employee health information of a specific nature such as diagnosis or other particulars of the employee's health status;	7,8,10	yes / no
	d) the type of specific employee health information that employers are most likely to request; and	9	yes / no
	e) the methods used by OHNs to handle occupational health records.	19,20,21,22 23,24	yes / no

Table 3 Judging Sampling Validity for Objective 4

Objective	Specific Dimension of Objective	Do all theses dimensions, together, adequately represent the intent of Objective 4?
4. to isolate some factors about the individual nurse or her working environment which may be related to ehtical decision-making regarding the protection of confidential employee health information.	a) bureaucratic role conception	Yes or no?
	b) confidence	———
	c) level of peer support	If no, would you be able to suggest other dimensions?
	d) bureaucratic role conception	_____
	e) level of employer support	_____
	f) patient advocate role conception	_____
	g) patient advocate role conception	_____
	h) feelings of powerlessness	
	i) level of education	
	j) authority	
	k) past experience with similar situations	

Table 3 (continued) Judging Sampling Validity for Objective 4

Objective	Specific Dimension of Objective	Items	Does the item matched to each dimension adequately represent the intent of that dimension? (Circle yes or no.)
4. to isolate some factors about the individual nurse or her working environment which may be related to ehtical decision-making regarding the protection of confidential employee health information.	a) bureaucratic role conception	16 a.	Yes / No
	b) confidence	16 b.	Yes / No
	c) level of peer support	16 c.	Yes / No
	d) bureaucratic role conception	16 d.	Yes / No
	e) level of employer support	16 e.	Yes / No
	f) patient advocate role conception	16 f.	Yes / No
	g) patient advocate role conception	16 g.	Yes / No
	h) feelings of powerlessness	16 h.	Yes / No
	i) level of education	16 i.	Yes / No
	j) authority	16 j.	Yes / No
	k) past experience with similar situations	16 k.	Yes / No

Appendix VIII - Return Post Card

I have returned my questionnaire separately.

☐ Yes, I would like the results of the study when completed.

Thanks again for your help with this study.

Appendix IX - Follow-up Post Card

Last week a questionnaire seeking your input regarding confidentiality of employee health information was mailed to you. You were selected to participate in this study because, as an occupational health nurse, you can provide important insights into this topic.

If you have already completed and returned it to me, please accept my sincere thanks. If not, please do so today.

Because the number of occupational health nurses in Manitoba is small, it is extremely important that your contribution be included if the study results are to accurately reflect the experience of Manitoba OHNs.

If by some chance you did not receive the questionnaire, or it got misplaced, call me at and I will get another one in the mail to you today.

Sincerely,

Beverley J. Cann RN CCOHN

Appendix X - Follow-up Letter

Beverley J. Cann RN CCOHN

June 24, 1991

1~ 3~ 2~
4~
5~, 6~
7~

Dear 1~ 2~:

About three weeks ago I wrote to you seeking your input in a study regarding the confidentiality of employee health information. As of today I have not received your completed questionnaire.

I have undertaken this study because this topic is frequently discussed as an important ethical concern in the occupational health literature and among Manitoba occupational health nurses.

I am writing to you again because of the significance each questionnaire has to the usefulness of the study. In order for the results of this study to be truly representative of the experience of Manitoba occupational health nurses, it is essential that each person return their questionnaire.

In the event that your questionnaire has been misplaced, a replacement is enclosed.

Your cooperation is greatly appreciated.

Sincerely,

Beverley J. Cann RN CCOHN