

Privacy Issues with Medical Records

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Privacy Rights

The delivery of medical care is much more than the intersection of human bodies with technology, medications, and surgical interventions; rather, it relies upon communication to exchange information, beliefs, feelings, and cultural worldviews in order to make effective diagnoses and to develop treatment plans that work. It is essential that healthcare providers keep an accurate record of their interactions with their patient, so there is a written historical record. Benjamin Franklin (as cited in Pagano, 2011), wrote a book in 1754, which first detailed how a physician is required to maintain a written record of patient visits in America's first hospital. As health care develops rapidly, with new doctors' offices and hospitals opening, all of the health care professionals need quick access to patient's medical records. Electronic medical records (EMRs) or electronic health records (EHRs) are optimally used to treat patients quickly and effectively. Health care providers have a strong tradition of safeguarding private health information. However, in today's world, the old system of paper records in locked filing cabinets is not enough. There are many privacy challenges both providers and patients are faced with in this electronic age of health care.

The history of the rise of privacy as a public issue in the United States may have started with an 1890 article by Samuel Warren and Louis Brandeis that spoke of "the right to be let alone." (Gangloff, 2007). It took decades for courts to begin articulating this right and comprehensive federal laws did not appear until the 1970s. However, it was not until the late 1990s and early 2000s that medical privacy became a right as a result of healthcare privacy legislation. Today there are stricter privacy laws in effect to regulate who has access to patients' medical records.

Today a patient's medical record is transmitted across not only health care providers, but to insurance companies, and potential third parties. Electronic forms of health communication are increasing rapidly, in forms of emails and websites. With information broadly held and transmitted electronically, privacy laws try to provide clear standards for the protection of personal health information. But what happens when authorized parties view your medical records? Are current privacy laws adequate to protect patients' privacy? Should patients have full access to their records at all times via the Internet? These questions and the impact of communication barriers, privacy concerns and its effect on patients' proper care are explored in this paper.

As stated by the U.S. Department of Health & Human Services (2003), the *Standards for Privacy of Individually Identifiable Health Information* (Privacy Rule) establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996, known as HIPAA. The Privacy Rule standards address the use and disclosure of an individual's health information—called “protected health information” by organizations subject to the Privacy Rule — called “covered entities,” as well as standards for individuals' privacy rights to understand and control how their health information is used (U.S. Department of Health & Human Services, 2003).

HIPAA and other privacy laws set rules and limits on who can look at and receive an individual's health information. According to the U.S. Department of Health & Human Services, (2003), information can be used and shared for one's treatment and care; to pay doctors and hospitals for one's health care and to help run their businesses; with one's family, relatives,

friends, or others an individual identifies who are involved with their health care or health care bills, unless they previously object in writing. Completed consent forms by the patient are a critical step in ensuring patient's privacy.

Other ways an individual's medical information can be shared includes protecting the public's health, such as reporting when the flu is in an area; and when information can be shared to submit required reports to the police, such as reporting gunshot wounds. Patients' health information cannot be used or shared without their written permission unless law allows it. For example, without written authorization, a patient's provider generally cannot give one's information to their employer; use or share one's information for marketing or advertising purposes; or share private notes about one's health care.

According to a recent national survey, 67 percent of respondents felt "somewhat" or "very concerned" about the privacy of their personal medical records (Angst & Agarwal, 2009). Since HIPAA was enacted in 1996, Congress mandates the establishment of Federal standards for the privacy of individually identifiable health information. When it comes to personal information that moves across hospitals, doctors' offices, insurers or third parties, the United States has relied on a variety of federal and state laws. Under the laws existing prior to adoption of HIPAA, personal health information could be distributed—without either notice or authorization—for reasons that had nothing to do with a patient's medical treatment or health care reimbursement. For example, unless otherwise forbidden by state or local law, patient information held by a health plan could, without the patient's permission, be passed on to a lender who could then deny the patient's application for a home mortgage or a credit card, or to an employer who could use it in personnel decisions (Garfinkel, 2001).

A major goal of the Privacy Rule is to assure that individuals' health information is

properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being (U.S. Department of Health & Human Services, 2003). A balance needs to be met that permits important uses of information, while protecting the privacy of people who seek medical treatment. The recent growth of electronic records in healthcare has spurred further privacy regulations.

EMRs create conflict among several legal and ethical principles. They are suggested to increase access to health care, improve the quality of care and health, and decrease costs.

Research, however, has not consistently demonstrated access for disadvantaged persons, the accuracy of EMRs, their positive effects on productivity, nor decreased costs (Layman, 2008).

Angst & Agarwal (2009) described privacy as an elastic concept, and it is most often researched in the context of how to protect or preserve it. Privacy is critical to safeguard personal information against unauthorized or unjustified disclosure. It is a foundational protected right that respects personal dignity and protects patients from embarrassment, stigma, and discrimination. Scott (2000) stated that under current federal law, the records of which videos you rent are given more protection from police snooping than your medical records. Privacy also has societal value because it encourages individuals to participate in socially desirable activities, including research and public health activities.

Health care workers may view patient's records for various reasons including curiosity (e.g., about friends, neighbors, relatives, or celebrities), perversity (e.g., sexual interests), anger (e.g., an employee who is about to be or has been fired), or a desire for financial or political gain (Scott, 2000). Unauthorized browsing of medical records effects the relationship of the "browser" to the patient which can lead to distrust, and is an abuse of privileges. Many times the viewing of patient records is not detected. As Scott (2000) explained, distinguishing between an

abuse of medical privacy from a legitimate need to see a patient's records is often a difficult question. Although physicians, nurses, and other health care professional's ethical codes protect patient's privacy, privacy is valued in principle but is not considered an absolute ethical right.

The American Medical Association's (AMA) Medical Ethics Code begins with a clear affirmation of the privacy right and a strong prohibition against disclosures: "The patient has a right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient ..." (Scott, 2000). However, the code moderates this language with a qualification on the privacy principle: "...Unless provided for by law or by the need to protect the welfare of the individual or the public interest." (Scott, 2000) This exception has proven contradictory in many cases, and not always in the best interest of the patient.

Patient-doctor communication is essential to effective care of the patient. Scott (2000) stated that in a recent study, one in six Americans reportedly engaged in privacy-protecting behaviors, such as switching doctors, paying for health care out of pocket, asking a doctor to not write down certain information in their record or to record a less serious or embarrassing health condition. Another common practice is for a patient to not give accurate information about their medical history, or to not seek medical attention at all for a problem. Although these tactics or privacy-protecting behaviors raise obvious health risks, many Americans feel their medical privacy is jeopardized if they reveal too much information. There is an ethical intuition that an individual feels—that one is entitled to have their medical information be kept private unless an individual gives express consent. The following ten literature reviews seek to explain privacy concerns with medical records, the shift to EMRs, and its effect on patients' proper care.

Literature Review

Firouzan & McKinnon (2004) set out to solicit feedback from healthcare information management (HIM) directors regarding implementation issues of the HIPAA privacy rule requirements in Pennsylvania healthcare facilities. The researchers developed a 20 question survey that was sent in the mail to HIM directors with questions focused on “gathering basic demographic data, information on HIM involvement with the privacy rule requirements, the procedures whereby facilities were meeting the privacy rule requirements, occurrences of confidentiality breaches, and respondents' perceptions about the privacy rule” (p. 2). “Of the 268 surveys mailed, 128 of them were returned, with a response rate of 48 percent” (p. 4). It is alarming how many facilities are not compliant with HIPAA. “When asked to estimate their current level of compliance with the privacy rule, only 28 percent of respondents estimated they were 75 percent or more compliant with the HIPAA requirements” (p. 4).

Findings of this study suggested that HIM professionals are involved with many areas of the privacy rule and have taken on new responsibilities to implement changes. Nearly half of the surveyed facilities experienced a breach of confidentiality in the last three years, and in facilities that experienced a breach, the majority of breaches (77 percent) were committed by employees (Firouzan & McKinnon, 2004, p. 4). Findings of this study suggested that respondents did not think the privacy rule would prevent future confidentiality breaches. Only half of respondents thought that the privacy regulations were even necessary. The researchers noted that results may differ in other parts of the country due to limitations of this study, including its small sample size of focusing only in Pennsylvania, and it was completed a few months prior to the deadline for meeting HIPAA privacy rule requirements.

The intention of HIPAA was to protect patient privacy and to promote security and confidentiality of patient information, but it has had unintended consequences for facilities. Houser, Houser, & Shewchuk (2007) examined some of these consequences by identifying 70 barriers related to release of patient information associated with the implementation of HIPAA. The perceived largest barriers included “increases in the public's misunderstanding about release of patient information, lack of regulation defining infractions and enforcement which allows individual institutions to make their own interpretations, and challenges to health information management professionals in controlling safeguards related to release of information given the transition to EHRs and the increased involvement of information technology” (p.1).

The authors surveyed fourteen HIM directors attending a conference, using the nominal group technique (NGT), which is a “consumer-oriented formal brainstorming or idea-generating technique that is assumed to foster creativity and to be particularly effective in helping group members articulate meaningful disclosures in response to specific questions. The format of each NGT meeting consists of five basic steps: generating ideas, recording the ideas, discussing the ideas, selecting and prioritizing the collection of responses individually, and aggregated individually ranked selections across participants” (Houser et al., 2007, p. 2).

When asked to focus on barriers and problems that have arisen because of the HIPAA privacy rule, respondents were able to “identify 70 responses that could be reduced to 25 nonredundant responses” (Houser et al., 2007, p. 4). A common theme of many respondents was the lack of knowledge of the new rules and conditions imposed by HIPAA. The authors noted that while HIPAA protects individuals' health information, it has the “potential to interrupt the flow of health information needed to provide and promote high-quality healthcare in a timely

fashion” (p. 1). The findings from this study suggest there is a need for additional clarification of the regulations governing HIPAA, and additional training of healthcare workers.

Angst & Agarwal (2009), explored how electronic health records (EHRs) constitute a significant technological advance in the way medical information is stored, communicated, and processed in health care delivery and widespread patient privacy issues. An electronic health record is defined as “information in electronic format that contains medical data about a specific individual. EHR systems are the software platforms that physician offices and hospitals use to create, store, update, and maintain EHRs for patients,” (Angst & Agarwal, 2009, p. 343). The researchers questioned 366 individuals via a web-based survey to see if they could be persuaded to change their attitudes toward EHRs, and allow their medical information to be digitized even in the presence of significant privacy concerns (p. 341).

The researchers used an integrated model by combining an individual's concern for information privacy (CFIP) with the elaboration likelihood model (ELM) to examine attitude change and likelihood of opting-in to an EHR system. The theory that issue involvement and argument framing interacts to influence attitude change, and the concern for information privacy further moderates the effects of these variables. The likelihood of adoption is driven by concern for information privacy and attitude. The results show that messages can be crafted to elicit changes in attitudes about the use of electronic health records, even under high concerns about privacy (Angst & Agarwal, 2009, p. 360). The researchers found that “exposure to messages related to EHRs shapes individuals’ attitudes toward their use, especially when exposed to an emerging technology for which attitudes are not well-formed. The extent to which the messages influence attitude is jointly determined by the way in which the message is crafted.” (p. 345)

This study found that an individual's CFIP interacts with argument framing affect attitudes toward EHR use. When people have high concerns for privacy, their attitudes can be positively altered with appropriate message framing and communication. The researchers discussed how there is limited knowledge related to the role that patients play in the health information technology arena, especially as it relates to patient involvement in the delivery, monitoring, and dissemination of information related to their health care.

Another study to address health messaging is by Bourgeois, Simons, Olson, Brownstein, & Mandl (2008), who discussed health promotion programs using personally controlled health records (PCHRs), and found they can be used to target a large range of health issues. PCHRs, which are accessible via the Internet, allow individuals to maintain and manage a secure copy of their medical data (Bourgeois et al., 2008). These online records provide customized health recommendations to individuals based on their record content.

The authors evaluated a PCHR-based employee health promotion program using a randomized controlled trial design, with Hewlett Packard employees from eight locations. They used a PCHR program called PING, which is designed to enable patients to own secure copies of their medical record and to integrate information over time and across sites of care. The purpose of the study was to assess the value of a PCHR in an employee health promotion program for improving knowledge, beliefs, and behavior around flu prevention, cardiovascular health and sun protection and the usability of the PCHR-based program for employees (Bourgeois et al., 2008).

According to the researchers, of the 3540 employees at the eight work sites, 144 employees registered for the study and 125 completed the baseline survey. Of these, 119 (95%) completed between one and seven biweekly surveys, therefore there were limitations with the study's small sample size. Over half (54%) of the employees surveyed found the messaging

system “extremely” or “very” useful in providing information about influenza, and almost 80% of the employees surveyed found the PCHR easy to use, suggesting that it should be explored as a common medium for health promotion in the workplace (Bourgeois et al., 2008). This is the first study to examine the use of PCHR as a tool for health promotion in an employee health program. The researchers noted that the program did not significantly improve the knowledge, beliefs, and behaviors surrounding influenza prevention, but the results suggest a larger follow-up study over a longer period of time would be beneficial.

Weitzman, Kaci & Mandl (2009) also examined the significance of PCHR. Rapid technology development and potential for benefit from PCHR underscore the importance of understanding acceptability and potential barriers with their use. “PCHR are a special class of personal health records (PHRs) distinguished by the extent to which users control record access and contents. Recently launched PCHR platforms include Google Health, Microsoft’s HealthVault, and the Dossia platform, based on Indivo” (Weitzman et al., 2009, p. e14). The study participants included approximately 250 users, age 35 - 60 years of age with training in medicine and/or health care administration.

The researchers used data that was collected in three ways, “transcribed audio-taped focus group interviews conducted with stakeholders and pilot users; written observational notes of usability testing compiled by the study team; and text communication from email exchanges with demonstration participants” (Weitzman et al., 2009, p. e14). The study questions were about health information management, Internet use, and PCHR. Participants demonstrated low levels of awareness about personal health record technologies including PCHR. Participants expressed privacy concerns including: “intentional identify theft, disclosure and misuse of information by insurance companies, accidental mix-up of records and their contents, mismatch

of medical records data with personal health records, and misuse and inappropriate viewing, including “snooping” and attempts by health professionals to track or follow-up on outcomes of former patients and co-workers. Participants recognized the potential that privacy could be breached and that such breaches could result in serious harm” (Weitzman et al., 2009, p. e14).

Participants viewed strict user control of incoming and outgoing messages delivered through the PCHR as an essential factor of the system and a prerequisite to sustained use. The researchers found that “strict protection of autonomy was highly valued among PCHR users. Nevertheless, autonomy practices were intentionally subverted within some family and social relationships consistent with others’ reports about management of health information in the home” (Weitzman et al., 2009, p. e14).

This is the “first study about the acceptability to users in a community-based setting of a personally controlled health record” (Weitzman et al., 2009, p. e14). Limitations of the study included the fact that PCHRs are in the early stage of technology development. This limits study about the broader acceptability of the technology and impact of various barriers/facilitators. The study concluded that PCHRs have identified societal, interpersonal, and individual barriers with their use. Responding to these observations and continued evaluation may substantially advance the use and relevance of the PCHR platform model.

Desai & von der Embse (2008) is another study to examine electronic messaging, but they focused on ethical dilemmas and implications with electronic information (EI) management practices and activities. EI can be defined as “information that has been generated, stored, maintained, distributed, and used using computer technology” (Desai & von der Embse, 2008, p. 23). Using a Likert-type scale, the authors surveyed managers in 6 industries, who were asked to describe organization practices in 11 areas of ethical EI policy applications. The authors

explained a framework for handling ethical dilemmas in managing major EI activities through their study, which included the activity, description and ethical considerations. This can consist of any private EI data, including the management of EMRs.

EI can be stored in a computer and be available for others using network technology, therefore it is vulnerable to its improper access. The researchers found that in order to protect it from improper access, “the organization’s management must provide necessary measures such as proper firewalls and software controls—in this regard the ethics are of utmost importance” (Desai & von der Embse, 2008, p. 24). An organization that invests in ethical safeguards provides support and sees improvement in employee morale, performance, and ultimately sees growth in profits. The study found the assessment of ethics in EI supports the belief that ethical practices in this area impact the entire organization. Management operates within the larger organization’s context and the moral quality of its actions reflects the organization’s culture.

There is a growing need and demand for patient access to personal health records. Frost & Massagli (2008) investigated the ways in which patients respond to the shared use of their personal health data, by examining an online community called PatientsLikeMe, which is built to support information exchange between patients. “The site provides customized disease-specific outcome and visualization tools to help patients understand and share information about their condition” (Frost & Massagli, 2008, p. e15).

The authors analyzed member communications of patients diagnosed with amyotrophic lateral sclerosis (ALS), who posted data on their current treatments, symptoms, and outcomes to determine how personal health information within patient-to-patient exchanges are used by other patients (Frost & Massagli, 2008). At the time of this study the community contained “1570 verified patients and 852 user-created comments” (Frost & Massagli, 2008, p. e15). The study

focused on 123 postings by 95 users, and found that the “comments served to continue an exchange between the two users and initiate new exchanges” (Frost & Massagli, 2008, p. e15).

The authors noted that few studies examine the use of personal health information by patients themselves, without including their clinician. This study suggests how patients may benefit from the process of sharing health data within a community that may help with self-management of their disease. The authors suggested that future studies may want to integrate data into online platforms for health conversations by matching people with similar conditions and using similar treatments (Frost & Massagli, 2008).

It is possible to provide patients with secure access to their medical records using the Internet. An internet-accessible medical record may be particularly helpful for patients with the self-management of chronic diseases. Patients can review an online medical record repeatedly at their convenience, and utilize other resources to assist them in comprehending it. Ross, Moore, Earnest, Wittevrongel & Lin (2004) examined how a patient-accessible online medical record affects patient care and clinic operations. “The SPPARO (System Providing Access to Records Online) software consisted of a web-based electronic medical record, an educational guide, and a messaging system enabling electronic communication between the patient and staff” (Ross, et al., 2004, p. e12).

The researchers surveyed 107 patients and used a randomized controlled trial which was conducted in a specialty practice for patients with heart failure, utilizing SPPARO (Ross, et al., 2004). “Patients were eligible for the study if they were followed in the practice, spoke English, and were 18 years of age or older. They needed to have used a Web browser before, although they did not need to have access to the Internet at home” (Ross, et al., 2004, p. e12). Surveys assessing doctor-patient communication, adherence, and health status were conducted at the

baseline, 6 months, and 1 year. Use of the system, message volume, utilization of clinical services, and mortality were monitored. “All questionnaires included assessments of health status, patient satisfaction, and self-reported compliance” (Ross, et al., 2004, p. e12). The researchers found that respondents most commonly reviewed clinical notes and laboratory results, and did so repeatedly. Fewer subjects reviewed radiology results, but those who did also reviewed them repeatedly.

The researchers found that “Nurses spent a total of 304 minutes answering computer messages over the course of the 12 months, a mean of 5.6 minutes per subject per year. In interviews, the physicians and nursing staff did not feel that providing SPPARO to the intervention group resulted in a perceptible change in their workload” (Ross, et al., 2004, p. e12). Providing patients with congestive heart failure access to an online medical record was feasible and improved adherence. However, “the overall impression from studies of patient-accessible medical records is that they can improve certain aspects of care, but they are unlikely to substantially improve health status. This probably reflects the inherent limitations of interventions that focus on information alone: a better-informed patient is not necessarily a healthier patient” (Ross, et al., 2004, p. e12). An effect on health status could not be demonstrated in this pilot study. Future studies need to integrate teaching patients and noting behaviors for the medical record to be presented to patients in formats that are more comprehensible, more useful, and more likely to empower patients with their healthcare knowledge.

Ross, Todd, Moore, Beaty, Wittevrongel & Lin (2005) researched the attitudes toward shared outpatient medical records among “socioeconomically disadvantaged patients in community health centers, insured patients in primary care offices, and a broad range of

physicians in outpatient practice” (Ross et al., 2005, p. e13). Written questionnaires with 16 questions were provided to patients in the waiting rooms of 6 primary care practices in the metropolitan Denver, Colorado area. Questionnaires were also mailed to primary care physicians in Colorado.

The authors found there was a 79% response rate for patient surveys (601 surveys returned) and a 53% response rate for physician surveys (564 surveys returned) (Ross et al., 2005, p. e13). Academic medical center patients and community health center patients were equally likely to endorse shared medical records and internet-accessible records. Community health center patients were more likely than academic medical center patients to anticipate the benefits of shared medical records. Shared medical records are almost universally endorsed across a broad range of ethnic and socioeconomic groups. A majority of patients are interested in Internet-accessible records. Over half of responding patients answered “yes” to “Have you reviewed parts of your medical records before?”

The authors found that physicians were significantly more likely to anticipate concerns than patients, and physicians were also significantly less likely to anticipate that shared medical records would be empowering for patients. Physicians were also asked two questions about their expectations if patients could routinely review their outpatient medical records. Sixty-three percent anticipated that their “workload would increase substantially,” and 45% anticipated that they “would document things differently in the medical record” (Ross et al., 2005, p. e13).

Several limitations of this study include incomplete representations of national opinions by the small sampling of the demographic and the attitudes of Colorado physicians and metropolitan Denver patients. The authors concluded that although the questions in the patient survey and the physician survey were linked, the differences in the way the questions were

framed may have accounted for some of the differences observed in the physician and the patient responses.

Grieger, Cohen, & Krusch (2007) examined the return on investment for implementing EHRs within the University of Rochester Medical Center, by examining five ambulatory offices with 28 providers. “The implementation of Touchworks EHR (Allscripts) was undertaken from November 2003 to March 2004, and measurements of key financial indicators were made in the third calendar quarters of 2003 and 2005” (Grieger et al., 2007, p. 89). The savings were compared with the costs of the first two years of EHR use to determine return on investment resulting in “total annual savings of \$393,662 (\$14,055 per provider)” (Grieger et al., 2007, p. 89). This study found that organizations who have staff devoted entirely to chart management generally report higher savings than those whose staff perform multiple duties.

Some limitations of this study included the fact that the data collected was initially intended for internal use, as a retrospective study, and the data was collected by office staff, rather than through observation by outside personnel. Much of the savings realized are soft savings, since the savings that are not immediately directly reflected in salary savings, but represent improved efficiencies in practices (Grieger et al., 2007). The authors found that with the EHR, it is possible to multitask around the same record at the same point in time since several people can use the medical record simultaneously; therefore the soft cost savings include a wide variety of savings, such as reduced time searching for records.

Suggestions for Future Research

Healthcare providers are also authors who have responsibilities to communicate clearly and accurately—not only verbally to their patient, but in the patient’s medical record. Many conflicts in medical ethics are traceable back to a lack of communication. Communication

breakdowns between patients and their healthcare team, between family members, or between members of the medical community, can all lead to disagreements and strong feelings. These problems can be solved with open lines of communication.

Traditionally, medical ethics has viewed the duty of confidentiality as a relatively non-negotiable rule of medical practice. With the shift to electronic medical records many ethical questions arise relating to who can view them and who has access to patient charts. Laws and ethics are closely related. Whether we derive a code of ethics from religious beliefs, a study of history and literature, or personal experience and observation, we can all agree upon some basic values as humans. Many people tend to equate ethics with their feelings. But being ethical is clearly not a matter of following one's feelings. In fact, feelings frequently deviate from what is ethical. Being ethical is not always the same as following the law. The law often incorporates ethical standards that most citizens abide by. But laws, like feelings, can deviate from what is ethical (Layman, 2008). A patient's right to privacy can be, as research shows (Angst & Agarwal 2009; Layman, 2008), a feeling, an ethical right, or both.

The shift to EHRs presents conflicts among the ethical principles of beneficence, autonomy, fidelity, and justice. Autonomy is jeopardized when patients' health data is shared or linked without the patients' knowledge. Fidelity can be breached when health organizations do not take proper precautions to maintain the security of identifiable health data. Justice is breached when disparities exist in access to health information (Layman, 2008).

Health personnel, health leaders, health policy makers and ethicists should continue to examine EHRs and the ramifications of their implementation. Continued discussions need to occur to best use this technology to the benefit of patients and clients and support management and operations.

Conclusion and Implications

The practice of health communication has contributed to health promotion and disease prevention in several areas. One is the improvement of interpersonal and group interactions in clinical situations. The quality of provider-patient communication can affect numerous outcomes, including patient adherence to recommendations, public health laws, and the patient's health status. Health care professionals continue to need more and better training in effective communication skills to address both increasing cultural and language differences, and to better communicate medical terms, treatment issues, and their implications among all stakeholders.

Rather than seeing privacy and research as conflicting values, policy and law makers can improve both. To do so, they must move beyond formalistic rules towards fair information practices and uniform ethical oversight. They must also remove barriers to high-quality research, thereby attaining the societal benefits of scientific knowledge, medical advances, and protection of the public's health.

Ultimately, as the American culture becomes increasingly diverse, the importance of health communication, and adherence to patient privacy laws, will continue to increase as a critical issue in the delivery of medical care, impacting health care outcomes and resource utilization. While cultural competence is growing in awareness, a wide range of historical and cultural barriers to effective intercultural communication remain. Given the inherent power imbalances that exist in U.S. healthcare between provider and patient/family, the need to identify and openly address the dimension of health communication will only grow in importance in the future.

Your privacy is a lot like your reputation-once you lose it, it is very difficult to get it back (Scott, 2000). Both the ethical tensions and the legal debates have entailed considerable balancing of an individual's interest in privacy against other larger concerns of the community (Scott, 2000). We should be wary when someone (especially government) tells us that they are doing something for our benefit that "it's for our own good" that we are being asked to give up something that was ours, be it our liberty, our property, or our privacy (Scott, 2000).

Scott (2000) stated that medical researchers, HMOs, law enforcement officers, public health officials, and others all strenuously argue that it is just too much trouble to get the patient's voluntary and informed consent before they look at the patients' records. The potential problem with this argument is that we have heard it before, in cases of privacy breaches with celebrity's medical records, news stories, and other contexts that now we look back on and think how wrong it was not to have gotten the patient's consent.

Assurances of privacy may be the most important foundational element for promoting good health. Assuring privacy within the clinician-patient relationship encourages full and open dialogue, which is essential to appropriate diagnosis and treatment. The medical privacy debate will continue, but open communication among patients and providers, regardless of age or culture, and adherence to privacy laws, will give a patient the best medical care possible.

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