

Running head: HEALTH CARE MANAGERS' PERSPECTIVES

Health Care Managers' Perspectives on Intercultural Privacy Concerns

Lynn Karounis

Annie McCarthy

Kara Meagher

Fairfield University

CO 420 Communication Research Methods

December 13, 2010

Abstract

Culture and language both have a strong influence on the quality of health care experiences that one may have. The purpose of this study was to interview health care managers from Bridgeport Hospital to gather data on their perspectives on intercultural privacy and associated concerns regarding the implementation of EMRs in a health care setting. Concerns include the adequacy of current laws to protect patient privacy, patient access to records via the Internet, and challenges of working through language barriers to ensure they understand their rights. Respondents focused mainly on the need for clear and adequate patient communication regarding the implementation of EMRs, and sensitivity to diverse cultures.

Keywords

Health care, culture, privacy

Health Care Managers' Perspectives on Intercultural Privacy Concerns

The delivery of medical care is much more than the intersection of human bodies with technology, medications, health care providers 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 health care providers keep an accurate record of interactions with their patient, so there is a written historical record. Benjamin Franklin (1754) first detailed the requirements of a physician to maintain a written record of patient visits in America's first hospital. Over the centuries, methods of health care communication have developed rapidly which has resulted in the need for professionals in the medical industry to have quick and easy access to patient's medical records. One such form of communication is through electronic medical records (EMRs) also known as electronic health records (EHRs), which are used to assist physicians in treating patients properly, quickly and effectively by providing a thorough medical history on individuals through sensitive information in electronic charts. EMRs are being mandated through president Obama's health care reform policy—requiring that all health care providers in America adopt EMR processes.

Health care providers have a strong tradition of safeguarding private health information, which has become increasingly important in the digital age. In the eyes of our president, the old system of paper records in locked filing cabinets is no longer sufficient. In the eyes of many citizens and health care workers, EMR's pose serious potential privacy issues for American patients. The widespread access that health care workers across the country would be entitled to, in addition to the degree of sensitivity held in the electronic records calls for enhanced laws and security minimizing or eliminating the opportunity for security breaches.

Today the Health Insurance Portability and Accountability Act (HIPAA) outlines strict federal health care privacy laws that regulate who has access to patients' medical records as well as what can be done with patient information. Patient medical records are transmitted among health care providers, as well as 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. Despite the efforts of privacy laws, patients often do not understand what these laws mean and cultural barriers make comprehension all the more difficult.

Culture and language both have a strong influence on the quality of health care experiences, healing, and wellness belief systems that one may have. They affect the behaviors of patients seeking health care, their attitudes toward health care providers, the delivery of services by the provider, and the ability to understand their health care experience.

Health care communication takes place before a patient exam. Families must make appointments, provide insurance information, and register with a patient account representative all before being escorted in to see the clinician. Families' experiences in obtaining health care services are affected as much by each of these interactions in addition to interactions with the health care provider. Privacy concerns start at the front desk. Angst and 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. Angst and 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). 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.

Given the large number of patients who speak little or no English in the United States, it is critical for health care professionals and their associates to ensure these patients receive adequate and ethical treatment that complies with established privacy laws. It is also important that patients understand their legal rights regarding use of and access to their medical records, both paper and electronic. The purpose of this study is to interview health care managers to gather data on their perspectives on intercultural privacy concerns related to HIPPA compliance and the use of electronic medical records. Concerns include the adequacy of current laws to protect patient privacy, patient access to records via the Internet, and challenges of working through language barriers to ensure they understand their rights. Gaining a better understanding of the intercultural privacy concerns faced by health care managers will provide a basic framework of potential areas to address in order to improve the caregiver and patient relationships. It will also help health care organizations and federal agencies be better prepared

for the difficulties to be addressed in relation to cultural barriers to understanding privacy laws while implementing EMRs.

HIPAA has both positive and negative effects on the release of patient information by health care facilities (Houser, Houser, Shewchuk, 2007). The intention of HIPAA was to protect patient privacy and to promote security and confidentiality of patient information. However, it has had unintended consequences for facilities, according to Houser, Houser & Shewchuk (2007). The authors studied 70 barriers related to release of patient information associated with the implementation of HIPAA. There are challenges that health information management (HIM) professionals face in order to properly safeguard the release of information especially with increased technology. Houser et al. (2007) found there is a need for additional clarification of the regulations governing HIPAA, standardized instructions, and extensive training of health care workers.

Intercultural Privacy Concerns

Communication in health care is essential. A leading cause of miscommunication in the health care setting arises when language barriers exist between patients and health care personnel. The growing population of different ethnic communities and linguistic groups presents a challenge to the health care industry in the United States. The clinician and the patient each bring their individual learned patterns of language and culture to the health care experience which must be transcended to achieve equal access and quality health care. These differences quickly become complicated while using technology as a medium for communication.

Although the quality of being technologically savvy is becoming a common trait among American citizens, accessing EMRs can be a confusing and seemingly threatening concept for many people. Because technology has become such an integral part of the health care process, it

is important to consider patient access to technology as well as the ability to understand technological processes as they directly impact the quality of patient experiences. According to Chang, Bakken, Brown, Houston, Kreps, Kukafka, Safran, & Stavri (2004), individuals are vulnerable to health care problems for various reasons including financial circumstances, location, age, ability to communicate effectively, race, ethnicity and gender. These identified “vulnerable populations” are among those who are expected to have the most difficulty transitioning to EMRs. It is important to explore these groups of people in depth in order to help understand issues impeding communication as well as developing processes to reduce miscommunications and enhance understanding and quality of care.

Individuals with cultural and language barriers may have the most difficulty out of the vulnerable populations due to their lack of ability to communicate on a very basic level with health care workers of different ethnic backgrounds. Without the ability to share basic communication transactions, cultural barriers stand as a roadblock for individuals needing to learn and understand the new electronic processes being put into effect. Individuals who do not speak English, or who use English as a second language, are considered to have Limited English Proficiency (LEP). Divi, Koss, Schmaltz and Loeb (2007) defined LEP as “the limited ability or inability to speak, read, write or understand the English language at a level that permits the person to interact effectively with healthcare providers or social service agencies” (p.1).

If a patient does not receive a proper explanation or tutorial of EMRs, they become at risk for privacy concerns simply because they do not have the level of understanding that English-speaking patients do. While health care disparities for individuals of different cultures and languages have been widely researched, Smith (2010) contended that none of the strategies suggested for improvement have been thoroughly evaluated. Smith suggested that there should

be an increase in the use of professional interpreter services as well as use of interpreters through telecommunication technologies.

At the very least, interpreters can ensure that patients with cultural and language barriers are made aware of and understand of privacy issues surrounding electronic health records. A majority of literature on the topic of health care reform and the conversion to electronic medical records discuss issues surrounding privacy concerns in the digital world. According to Goldberg (2000), privacy issues arise in “numerous instances where health-related information has been misused, both by those with lawful access and by unauthorized parties” (p. 65). Goldberg’s research identified the most common instances of breeches in privacy as discrimination by employers and insurers based on patient health information, damage to social, moral, financial or political reputations, and criminal activity in the form of practical jokes surrounding private health information, fraud, or other illegal uses of personal information. The potential for personal and sensitive information inside an individual’s health record to be accessed by an intruder with malicious intent is grounds for halting the implementation of EMRs—which has been exactly the case for years. Without some level of understanding of these potential privacy issues, individuals of different cultural backgrounds and non-English speaking persons risk not knowing to be alert for these potentially dangerous circumstances.

Schenker, Wang, Selig, Ng and Fernandez (2000) researched how the impact of language barriers affects informed consent among patients in a teaching hospital with on-site interpreter services. This study serves as a unique parallel to the expected need of interpreter services during the implementation and use of EMRs because the same services will be needed to keep LEP patients informed of their rights, uses of their EMR, access to their EMR and potential privacy issues in relation to the EMR. Findings of this study showed that English speaking patients were

nearly twice as likely to have documentation of informed consent for invasive medical procedures. This suggests that there is a significant disparity for LEP patients being informed of critical information. The researchers stress the importance of providers and hospital administrators needing to develop and follow procedures of informed consent across language barriers in order to practice ethical and safe medical practices. The same will certainly hold true for the use of EMRs.

Similarly, Gibson and Zhong (2005) examined medical providers' ability to communicate across cultures as well as patient perceptions of medical providers' ability to communicate with a diverse patient population. A main focus of the study was intercultural communication competence (ICCC) which describes the importance of understanding different cultures and how to interact on an effective level. Gibson and Zhong (2005) showed that medical providers who possess the abilities to listen well and understand patient perspectives are motivated, knowledgeable, skillful, appropriate and effective when communicating across cultures. By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture, especially dealing with medical records in an age of new technology in health care.

Angst and Agarwal (2009) explored how EMRs constitute a significant technological advance in the way medical information is stored, communicated, and processed in health care delivery and widespread patient privacy issues. They found that exposure to messages related to EMRs shape individuals' attitudes, especially when exposed to an emerging technology for

which attitudes are not well-formed. These findings are significant for the purposes of this study because the design and implementation of EMRs need to match the needs of multiple cultural and linguistic audiences.

When people have high concerns for privacy, their attitudes can be positively altered with appropriate message framing and communication. Angst and Agarwal (2009) 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. This suggests that there is a missing link in the current EMR process, which needs investigation in order for health care reform to be successful across the nation.

Traditionally, medical ethics has viewed the duty of confidentiality as a relatively non-negotiable rule of medical practice. With the shift to EMRs many ethical questions arise relating to who can view and access to patient charts. Layman (2008) suggested that health personnel, leaders, and policy makers should discuss the ethical implications of EMRs before the occurrence of conflicts among the ethical principles.

Laws and ethics are closely related. 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 EMRs 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).

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. Privacy is a lot like reputation-once it is lost, it is very difficult to get back. 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).

Simon, Evans, Benjamin, Delano, & Bates (2009) explored patients' views about sharing of electronic health information. They found three dominant themes including concerns about privacy and security, the potential benefit to a person's health, and the desire for more information about the consent process. Over 85% of respondents in this study indicated that they would provide consent for their information to be shared electronically among their health care providers, given the materials they had reviewed. Patients are enthusiastic about electronic health information exchange, recognizing its capacity to improve the quality and safety of health care; however, they are also concerned about its potential to result in breached privacy and misuse of health data (Simon, Evans, Benjamin, Delano, & Bates, 2009).

Technology Implementation Challenges Within Health Care Organizations

Overcoming cultural barriers pertaining to EMRs is only one aspect of a larger dilemma. Overall, implementation of technology within health care organizations is largely seen as a

positive move in improving the provision of health care (Szydłowski, & Smith, 2009; Vishwanath, Brodsky, & Shaha, 2009; Vishwanath & Scamurra, 2007). However a large number of system-related projects have not been successfully executed (Vishwanath et al., 2009). In addition, implementation of health care technology in the United States has been slower than that of other countries. Vishwanath and Scamurra (2007) found that ten percent of physicians in different practices and settings in the US use EMRs and more than half of physicians in countries like Sweden, the Netherlands, Australia, and New Zealand have adopted EMRs.

Reasons for the slow rate of implementation and the failure of a majority of these projects are numerous. Deficient guidelines at the governmental level, lack of information technology standards, unwillingness of users to embrace new technology, and ineffective change management all contribute to the challenges of implementing and using electronic medical records systems (Szydłowski & Smith, 2009; Vishwanath et al., 2009; Vishwanath & Scamurra, 2007). Until these obstacles are dealt with and a strategy for change put into place, progress will be slow.

A key aspect of successful technology implementation is the willingness of users to employ it. Vishwanath et al. (2009) examined doctors' willingness and ability to adapt to using personal digital assistants (PDAs). They looked at how pre-existing opinions of technology usage, age, and position impacted doctors' usage of PDAs. Findings showed that pre-existing user beliefs did indeed affect physicians' likelihood of adapting to using a PDA. An optimistic attitude contributes to the likelihood of using PDAs. Doctors' perceptions on how easy PDAs are to use also affected their willingness to use them.

Vishwanath and Scamurra (2007) used concept mapping to gain a better understanding of the obstacles to technology acceptance and use by neighborhood doctors. Research identified

multiple reasons for why physicians choose not to implement technology solutions, including “(1) cost issues, (2) ROI issues, (3) integration issues, (4) logistics and regulatory issues, (5) concerns over customization, (6) herd mentality/social influence, (7) need for control, (8) reimbursement issues, (9) concerns over adopting new technology” (p.123). To overcome these implementation hurdles, it is necessary to define an approach that addresses each one.

A critical area to consider when developing a change management program is worker attitudes (Lewis, 2006; Nemeth, Feifer, Stuart, & Ornstein, 2008). Lewis (2006) found that understanding worker attitudes and opinions of prospective changes within the organization contributed to achieving a positive project outcome. Nemeth et al. (2008) developed a model for initiating change that identifies several components for success which assist in maximizing project results and ensure continued success.

Implementation of technology within health care organizations is only one aspect of government policy on the use of electronic medical records. Improved health care due to the use of technology also involves the patient. Health care organizations must provide a system for patients to retrieve information stored within their files and to participate in their treatment. Ralston, Coleman, Reid, Handley, and Larson (2010) studied patient access and usage of medical records at a health organization for a period of several years. Almost 60 percent of patients used the internet to obtain information from their medical records and communicate via e-mail with their health care providers. Potential issues identified centered on the likelihood that “online communication with providers and access to records may exacerbate current existing health care disparities related to race, literacy, socioeconomic status, and other factors” (Ralston et al, 2010, p. 608). Also noted was increased staff workload.

Adopting an EMR system within a health care organization that meets federal requirements and ensures privacy is a large undertaking. The needs of both health care workers and patients must be considered. Particular attention should be given to cultural barriers in medical transactions to ensure potential issues are resolved. This study seeks to better understand the of the intercultural privacy concerns faced by health care managers when implementing EMRs.

Methods

Since a primary goal of this study is to examine Health Care Managers' Perspectives on Intercultural Privacy Concerns, the following research question is offered:

RQ: Are health care managers aware of intercultural privacy concerns relating to the implementation of EMRs in a health care setting?

Targeted participants in this study were 17 clinical operations team managers at a 425-bed accredited metropolitan hospital in Connecticut. Additional managers were recruited for the study based on the relevance of their management positions in relation to the integration of EMRs. The areas of the hospital represented by the sample of managers who were interviewed included outpatient clinics, employee health unit, industrial medical center, ambulatory medical, radiology, laboratory, pharmacy, recreational therapy, physical therapy, occupational therapy, speech therapy, acute care rehab, inpatient rehab, respiratory therapy, sleep medicine, pulmonary function, emergency medicine, patient relations, admitting, and information science (IS).

Participants were part of a convenience sample identified by one of the authors of this study, due to membership in the clinical operations management team. The additional managers were recruited from outside the clinical operations team (patient relations, admitting, and IS) because of the integral role they will play during EMR implementation. Patient relations are

responsible for ensuring the satisfaction of all patients, including being sure that all patient needs are met. The admitting department has the first interaction with the patients, where registration is completed and privacy documents are signed. Finally, the IS department is responsible for ensuring optimal patient/employee interactions take place through technological means.

Instruments and Procedures

Interviews were conducted with health care managers from various departments at Bridgeport Hospital. The project used a qualitative design in which health care managers from various areas responded to predefined and open-ended questions on cultural aspects of the Health Insurance Portability and Accountability Act (HIPPA) compliance and electronic medical records. A consent form was presented to the participants before the interview commenced.

During the interview, participants read and signed the consent form prior to answering questions. Each consent form details the purpose of the study, procedures of participation, known potential risks to participants, possible benefits of research, and individual rights regarding the study. It is important to note that all participation was voluntary. Targeted interviewees were able to refuse to participate, and they could discontinue participation at any time without penalty or loss of benefits to which they might otherwise be entitled. No reports of subject identity were included in data analysis.

Participation was confidential and anonymous, therefore the authors of this study did not foresee any risks, discomforts, or inconveniences associated with taking part in the study. Nor were any issues of sensitivity readily expected. The information obtained was confidential.

Data Analysis

A qualitative analysis was performed to assess the data. Responses to interview questions were categorized by question. Similar answers were then be grouped together and common

themes identified and analyzed using a variation of the Developmental Research Sequence model. The goal of this analysis was to gain a better understanding of health care managers' perspectives of EMRs and the challenges involved in ensuring cultural issues are addressed when working with culturally diverse patients who have limited understanding of privacy laws and their rights.

Results

Seventeen health care managers were invited to participate in the study. Of these, 11 agreed to be interviewed. Participants were asked to complete a questionnaire consent form (see Appendix A). Upon successful completion of the questionnaire consent form, the participants answered eight questions regarding EMRs (see Appendix B). Responses were transcribed. Due to the limited focus of this study only those questions that provided insight on intercultural privacy and associated concerns regarding the implementation of EMRs in a health care setting were analyzed and included in these results. Key themes addressed four areas of interest: 1) Cultural and/or language barriers in adapting to EMRs; 2) Intercultural communication exchanges and privacy impacts of EMRs; 3) EMRs and the protection of patient privacy; and 4) Other concerns regarding culturally diverse patients and the implementation of EMRs.

Cultural and/or Language Barriers in Adapting to EMRs

The first key theme addressed whether patients with cultural and/or language barriers would have a more difficult time adapting to EMRs than English speaking patients. More than half of the interviewees did not think that culture and language barriers would significantly affect how culturally diverse patients adapt to the use of EMRs. However, the use of computers was identified as a key area for concern. Computer-related issues ranged from the likelihood that

non-English speaking patients would not possess adequate computer skills, translation of patient information to a different language, and system limitations.

The effective use of EMRs would require patients to share personal information with a health care worker who enters the data into a computer. Participant J shared, "Often patients who speak a language other than English are intimidated by the computer, especially if the patients are elderly." In addition, sharing captured data with patients requires them to be computer literate. Participant H noted, "Many patients do not know how to utilize a computer and will struggle with accessing information on-line."

Use of EMRs would not eliminate the need for interpreters or translation of data. As most EMR systems are based on English, health care workers would still need to ensure that data provided by non-English speaking patients is interpreted and entered into the system correctly. "We have language barriers now with our paper process," says participant C. "These same issues will be translated electronically." System limitations may also impact the ability to adequately capture and share patient data. Participant H shares, "Cultural barriers such as [a patient's] belief that a 'demon in his hip is causing the pain' [emphasize that] EMRs as tool are limited to the questions we have. It won't ask more about beliefs in demons and may not allow you to put the moment in the [defined computer] field."

Another concern mentioned was the added communication barrier of the computer itself. "Health professionals might be further detached from the patient if they are sitting at a computer typing while they are seeing the patient—which adds an additional dimension to the already potentially problematic communication situation."

Intercultural Communication Exchanges and Privacy Impacts of EMRs

The second key theme looked at intercultural communication exchanges between patients and hospital employees and how they impact privacy regarding the use of an EMR system. Overall participants did not anticipate any differences in communication interactions between patients and health care providers with the advent of EMRs. It was believed that current processes for conducting patient/health care provider interactions with culturally diverse patients and maintaining patient privacy would not change. An interesting comment centered on the potential for EMR technology to highlight topics for health care professionals to address with patients. Participant F offered, "If employees don't understand there is a cultural difference, they might not document the information in the chart. Having an EMR might be an easier way (programmed) to trigger a question that forces this questioning and documentation."

EMRs and the Protection of Patient Privacy

The third key theme examined whether patients' privacy is increased by the use of EMR technology. In general, responses reflected the opinion that patient privacy protections in place for EMRs are equal to protections offered by paper-based records. However methods used to secure patient data are different for EMRs, as are the means for breaching security. Positive aspects were the ability to require secure passwords in order to access data. Participant D suggested, "Privacy is better protected with the use of an EMR due to the ability to restrict access to require password protection." This view was shared and expanded on by participant F, who said privacy is protected "If it is properly monitored. If checks aren't in place, then it could further enable inappropriate access to information."

Respondents offered several ways data could be breached by the use of EMRs in comparison to paper-based records. Participant J shared, "I see computer screens displaying

patient information in hallways. I also see printed materials containing patient information lying around.” Participant B provided another example. “If some VIP were to be admitted to the hospital,” said participant B, “I could easily access their electronic medical record. If we were only using a paper-based chart, I would have to physically walk to the unit they are on, open his chart and read. It is less likely that a curious employee would do that.”

While privacy protections currently provided by EMRs are considered equivalent to those of paper-based records, respondents believed that steps are being taken to make them more secure. HIPAA now requires mandatory audits and breeches can be prosecuted. Participant B explained,

“The government is expanding HIPAA laws to actively look for breeches in privacy. HIPAA was a somewhat passive law prior to this. Now there will be mandatory audits that can determine who opened medical record files, what information was changed, and monitor printed documents.”

In addition, participant J said, “There must be a culture around the need to be cognizant of patient information. We need to turn off computer screens and make sure patient records are not left lying around.”

Other Concerns Regarding Culturally Diverse Patients and the Implementation of EMRs

The final interview question addressed other concerns regarding culturally diverse patients and the implementation of EMRs. Respondents focused mainly on the need for clear and adequate patient communication regarding the implementation of EMRs, and sensitivity to diverse cultures. The importance of providing information at each stage of implementation and allowing all patients to provide comments, and offering training were seen as critical in the successful rollout of EMRs. Participant E elaborated, “Like every stakeholder, [patients] need to

be informed and have the ability to voice their ideas and concerns.” In addition, “If there is consideration for ALL patients when designing an EMR and we take into account different languages and cultures and how people learned,” said participant H. “There should not be problems with implementation.”

Discussion

The primary purpose of this project was to investigate the intercultural privacy concerns faced by health care managers when implementing EMRs. Adopting an EMR system within a health care organization that meets federal requirements and ensures privacy is a large undertaking. The needs of both health care workers and patients must be considered. Particular attention should be given to cultural barriers in medical transactions to ensure potential issues are resolved. Since a primary goal of this study was to examine Health Care Managers' Perspectives on Intercultural Privacy Concerns, the following research question was offered:

RQ: Are health care managers aware of intercultural privacy concerns relating to the implementation of EMRs in a health care setting?

We interviewed 11 health care managers from Bridgeport Hospital who provided insight on intercultural privacy and associated concerns regarding the implementation of EMRs in a health care setting. Key themes addressed four areas of interest: 1) Cultural and/or language barriers in adapting to EMRs; 2) Intercultural communication exchanges and privacy impacts of EMRs; 3) EMRs and the protection of patient privacy; and 4) Other concerns regarding culturally diverse patients and the implementation of EMRs.

We found that more than half of the interviewees did not think that culture and language barriers would significantly affect how culturally diverse patients adapt to the use of EMRs. However, the use of computers was identified as a key area for concern. Computer-related issues

ranged from the likelihood that non-English speaking patients would not possess adequate computer skills, translation of patient information to a different language, and system limitations. Participants said the effective use of EMRs would require patients to share personal information with a health care worker who enters the data into a computer. Participants were part of a convenience sample identified by one of the authors of this study, due to membership in the clinical operations management team.

It is important to note we did not receive any responses from the admitting department, so it was limiting to our study. The admitting department has the first interaction with the patients, where registration is completed and privacy documents are signed. We found the current level of the managers' level of knowledge of EHRs is unclear. To gauge their level of knowledge would require additional research.

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 EMRs 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. Health personnel, health leaders, health care managers, health policy makers and ethicists should continue to examine EMRs 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, health care administration at hospitals 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 attain the scientific knowledge, medical advances, and protection for the patient's overall 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).

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.

References

- Angst, C., & Agarwal, R. (2009). Adoption of electronic health records in the presence of privacy concerns: The elaboration likelihood model and individual persuasion. *MIS Quarterly*, *33*, 339-370.
- Chang, B., Bakken, S., Brown, S., Houston, T., Kreps, G., Kukafka, R., Safran, C., Stavri, Z. (2003). Bridging the digital divide: Reaching vulnerable populations. *Journal of the American Medical Informatics Association*, *11*, 448-457.
- Divi, C., Koss, R., Schmaltz, S., & Loeb, J. (2007). Language proficiency and adverse events in US hospitals: A pilot study. *International Journal for Quality in HealthCare*, *19*, 1-8.
- Franklin, B. (1754). *Some account of the Pennsylvania Hospital: From its first rise to the beginning*. Philadelphia: Franklin & Hall.
- Gibson, D. & Zhong, M. (2005). Intercultural communication competence in the healthcare context. *International Journal of Intercultural Relations*. *29*, 621-634.
- Goldberg, I. (2000). Electronic medical records and patient privacy. *Health Care Manager*, *18*, 63-69.
- Houser, S.H., Houser, H.W., & Shewchuk, R.M. (2007). Assessing the effects of the HIPAA privacy rule on release of patient information by healthcare facilities. *Perspectives in Health Information Management*, *4*, 1-11.
- Layman, E. (2008). Ethical issues and the electronic health record. *Health Care Manager*, *27*, 165-176.
- Lewis, L. (2006). Employee perspectives on implementation communication as predictors of perceptions of success and resistance. *Western Journal of Communication*, *70*, 23-46.

- Nemeth, L., Feifer, C., Stuart, G., & Ornstein, S. (2008). Implementing change in primary care practices using electronic medical records: a conceptual framework. *Implementation Science* 3(3), 1-11. doi:10.1186/1748-5908-3-3
- Ralston, J., Coleman, K., Reid, R., Handley, M., & Larson, E. (2010). Patient experience should be part of meaningful-use criteria. *Health Affairs*, 29, 607-613.
- Schenker, Y., Wang, F., Selig, S., Ng, R., Fernandez, A. (2007). The impact of language barriers on documentation of informed consent at a hospital with on-site interpreter services. *Journal of General Internal Medicine*, 22, 294-299.
- Scott, C. (2000). Is Too Much Privacy Bad for Your Health? An Introduction to the Law, Ethics, and HIPAA Rule on Medical Privacy. *Georgia State University Law Review*, 17, 481-530.
- Simon, S.R., Evans, J.S., Benjamin, A., Delano, D., & Bates, D.W. (2009). Patients' attitudes toward electronic health information exchange: Qualitative study. *Journal of Medical Internet Research*, 11(3) e30. doi:10.2196/jmir.1164
- Smith, D. (2010). Health care disparities for persons with limited English proficiency: Relationships from the 2006 medical expenditure panel survey (MEPS). *Journal of Health Disparities Research and Practice*, 3, 57-67.
- Szydlowski, S. & Smith, C. (2009). Perspectives from nurse leaders and chief information officers on health information technology implementation. *Hospital Topics: Research and Perspectives on Healthcare*, 87, 3-9.
- Vishwanath, A., Brodsky, L., & Shaha, S. (2009). Physician adoption of personal digital assistants (pda): Testing its determinants within a structural equation model. *Journal of Health Communication*, 14, 77-95.

Vishwanath, A., & Scamurra, S. (2007). Barriers to the adoption of electronic health records:

Using concept mapping to develop a comprehensive empirical model. *Health Informatics*

Journal, 13, 119-134.

Appendix A

Questionnaire Consent Form

We are doing a study that gathers data on health care manager perspectives on intercultural privacy concerns related to HIPPA compliance and the use of electronic medical records. Your participation in the study consists of attending an interview session. The length of time of the interview discussion is approximately 30 minutes.

Please understand that your participation in the project is completely voluntary. You can choose whether to participate in this study or not, and refusal to participate will involve no penalty or loss of benefits to which you might otherwise be entitled. If you volunteer to participate, you may discontinue participation at any time without penalty or loss of benefits to which you might otherwise be entitled.

The investigators do not foresee any risks, discomforts, or inconveniences associated with participation in the proposed study. Nor are any issues of sensitivity readily expected. The information obtained will be kept in a secure place and be used for this study only. It will be extremely confidential and will not be released to any other party for any reason.

If you have any questions or concerns about the research, please feel free to contact: Kara Meagher at 203-336-7312 or bkmeag@bpthosp.org. If you have other concerns or complaints about your rights as a participant, contact the Institutional Review Board at Bridgeport Hospital at (203) 384-454 or necolo@bpthosp.org.

SIGNATURE OF RESEARCH PARTICIPANT

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been provided a copy of this form.

Name of Participant (please print)

Signature of Participant

Date

SIGNATURE OF INVESTIGATOR

In my judgment the participant is voluntarily and knowingly providing informed consent and possesses the legal capacity to provide informed consent to participate in this study.

Appendix B

Interview Questions

Note: Responses to questions 1, 3, 5, and 7 were analyzed and reported in study results.

1. Do you think that patients with cultural and/or language barriers will have a more difficult time adapting to EMRs than English speaking patients? If so, why?
2. Do you think that Bridgeport Hospital's current interpreter services are sufficient for the implementation for EMRs?
3. What other concerns do you have regarding the implementation of EMRs for culturally diverse patients?
4. Do you think EMRs are better than paper charts for patients of different cultures and languages?
5. Do you think providing patients with access to EMR technology will help the flow of the patient care process? Why or why not?
6. Do you think the use of EMR technology positively affects a patient's outcome? How?
7. Do you think patient's privacy is protected with increased EMR technology use? Why or why not?
8. What are your suggestions for making the implementation of EMRs easier for culturally diverse patients?