

3/6/97 Panel Cites Lack of Security on Medical Records

By WARREN E. LEARY

WASHINGTON, March 5 — The computerized medical records of millions of Americans are vulnerable to misuse and abuse, but few people recognize the extent of the problem and little is being done to improve the security of these personal files, a National Research Council panel said today.

The committee said numerous steps could be taken immediately to increase the privacy and security of electronic patient records. But it said there were few incentives to encourage those practices.

The committee's chairman, Dr. Paul D. Clayton, a medical information specialist at Columbia Presbyterian Medical Center in New York, said methods were available now to make electronic records even more secure than paper ones. "But today there are no strong incentives to safeguard patient information because patients, industry groups and government regulators aren't demanding protection," he said.

The panel said health organizations should impose controls to limit access to electronic records, like passwords for authorized users or electronic blocks called "firewalls" that deny entry to unwanted outsiders. In addition, it said, each record-holding group should have internal policies that track who obtains ac-

Warns Electronic Files Are Vulnerable to Being Misused

cess to records, limit it on a need-to-know basis and discourage behavior like leaving a record displayed on a computer screen after the user is done with it.

The National Research Council, the research arm of the National Academy of Sciences, had the 15-member panel look at electronic medical records because they are increasingly becoming the norm in health care and efforts are growing to link health records kept in different places.

Uneasiness over access to medical records has grown as more people receive health care outside of the traditional settings of doctors' offices and hospitals, and parts of their records are stored in many places and often shared by many health

care providers. People in managed care may see that several of their records are stored in many places and are often shared by many health care providers. People in managed care may see several providers, and have many tests and medical procedures performed at free-standing clinics and treatment centers. Further, more insurance providers and employers are monitoring records to cut costs.

"Most patients would be surprised at the number of organizations that receive information about their health record," Dr. Clayton said at a public briefing held to release the committee report.

Besides being viewed by doctors and hospitals, most patient records are also available to insurers, pharmacists, state health organizations and researchers, he said.

In addition, sometimes employers, life insurance companies, marketing firms, pharmaceutical companies and others see all or part of these

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Electronic Medical Records Need Protection, Federal Says

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records.

"Sharing of information within the health care industry is largely unregulated and represents a significant concern to privacy advocates and patients alike because it often occurs without a patient's consent or knowledge," Dr. Clayton said.

The panel said there should be a national debate on how best to balance a patient's right to privacy against other organizations' need for health information.

The panel concluded that electronic health information was essential to improving health care in the nation while controlling costs. "Efforts must focus on finding ways to maintain privacy rather than opposing the use of information technology in health care," Dr. Clayton said.

However, the committee said, there are issues of particular concern, like an aspect of the Health Insurance Portability and Accountability Act, a measure passed by Congress last year. The health reform law calls for "universal patient identifiers," or codes, that would provide a nationwide link of all a patient's files. The Department of Health and Human Services has a year to devise guides for protecting computerized records under the bill.

The committee said the identifier code could have many benefits, like assuring consistent care and pre-

were tried to get access to these records, Love said. "Some of the committee's suggestions are on the right track, but they don't go far enough in protecting privacy."

Richard H. Wade, senior spokesman for the American Hospital Association, said his organization supported many of the new report's recommendations and that many hospitals already followed privacy guidelines for patient information required by accrediting agencies. The association probably would support Federal standards for information access and privacy if they superseded state laws that often have widely different rules, he said.

Mr. Wade said that as health care spreads out of hospitals and doctors' offices, and involves more people and institutions, the records problem gets worse. "As we spread health care around, we spread information around, and more and more people have a piece of your medical records," he said.

The panel said it was not asked to calculate the costs of its recommendations, but felt they would be modest. Health care organizations spend about 2 percent of their budgets on information technology, which is constantly being updated, and many of the suggested safeguards could be phased in as new systems come into use, members said.

The Computer Science and Telecommunications Board, an arm of the research council, initiated the study by convening experts from a range of fields including medicine, computer science, information systems and public health.

The committee met with health care providers, insurers, pharmaceutical benefits managers, makers of health information systems, privacy advocates and representatives of consumer groups as well as officials of Federal agencies involved in health care and organizations that maintain health-related databases

A patient's right to privacy can collide with organizations' need to know.

venting medical problems like adverse interactions from using different prescription drugs. However, it said, collated health records could be used for things patients do not approve of — for example, disclosing the results of genetic testing — and might even allow health information to be linked to records outside the health care system.

John Glaser, chief information officer for Partners Healthcare System Inc., of Boston, another panel member, said the committee found little actual evidence of medical record abuse today. But he said this was probably because there was no system to collect information on the frequency or extent of unauthorized access or abuse.

Mr. Glaser said there was no Federal statute governing a patient's access to his or her own health records, and in some states an individual could not see his own file although other people could. While 34 states have laws covering use and dissemination of health information, only 28 explicitly protect and insure the rights of patients to review their records and correct any errors they find, the report said.

The panel said that many practices available to the information industry for handling financial and credit records could be applied to health information, including establishing audit trails to tell people who has had access to their records.

James Love, who directs the consumer project on technology at the Center for the Study of Responsive Law, a Ralph Nader-affiliated group in Washington that follows privacy issues, said the research council panel did not consider the option of not including medical records in large databases and allowing wide access.

"The committee didn't challenge the basic idea of databases of linked records, or whether too many people

In addition, it conducted in-depth surveys at six organizations that use computers to collect, process and store health-related information. "Sites were selected on the basis of their reputed leadership in the development of electronic medical records, networked clinical systems and privacy and confidentiality policies," the report said.

Besides Dr. Clayton, members of the panel were:

W. Earl Boebert of Sandia National Laboratories, Albuquerque, N.M.

Gordon H. DeFries, professor of social medicine, epidemiology and health policy and administration and director of the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Susan P. Dowell, executive vice president and chief operating officer, Medicus Systems Corporation of Evanston, Ill.

Mary L. Gennell, professor of sociology and community health, Brown University.

Kathleen Frawley, vice president legislative and public policy services, American Health Information Management Association.

John Glaser, vice president and chief information officer, Partners Healthcare System.

Richard A. Kemmerer, chairman, Department of Computer Science, University of California at Santa Barbara.

Carl E. Landwehr, head, Computer Security Section, Center for High Assurance Computer Systems, Naval Research Laboratory.

Thomas C. Rindfleisch, director, Center for Advanced Medical Informatics, Stanford University School of Medicine.

Sheila A. Ryan, dean of the School of Nursing and director, Medical Center Nursing, University of Rochester.

Bruce J. Sams Jr., executive director (retired), The Permanente Medical Group.

Peter Szolovits, professor of computer science and engineering, Massachusetts Institute of Technology.

Robbie G. Trussell, senior project manager, Pharmacy Information Systems, Presbyterian Healthcare System, Dallas.

Elizabeth Ward, Assistant Secretary of Epidemiology, Health Statistics and Public Health Laboratories; Washington State Department of Health.