

# Protecting personal information (ppi): applicability in electronic medical record...

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## **Introduction**

Personal Information, formally known as Personally Identifiable Information (PII), encompasses information obtained by an agency, regarding an individual, which aims to serve two important purposes. Firstly, the information provides particulars of the individual that personally distinguish his/her identity; such as name, date of birth, family details and social security number, etc. Secondly, the information is closely linked (or can reasonably be expected to be linked) to an individual; such as medical and dental records, educational background, work experience etc. .

Over the past decade, virtually every company has invested heavily in computerization and modernization. The healthcare department was no exception to this rule of expansion. In recent times, the use of Electronic Medical Records has paved way for providing patients with access to new and improved quality healthcare facilities. Such records provide several advantages to the patients. Hand-written prescriptions are now replaced with electronically generated and signed and sequentially numbered prescriptions. Patients can now communicate with their doctors directly via email and can schedule or reschedule their appointments without going through the hassle of dialing up the hospital administration staff and receptionists. Furthermore, electronic medical records are easy to store and can be easily retrieved and automatically updated by posting any changes to the patient's history directly on his/her record by accessing the hospital database and data storage facility. In 2009, the Health Information

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Technology for Economic and Clinical Health (HITECH) was passed, as a part and package of the American Recovery and Reinvestment Act (ARRA). This legislation provided various incentives to private hospitals and venture capitalists for investment in upgrading the medical records book-keeping procedures and designing Electronic Health Records.

## **Electronic Medical Records**

The National Institute on Health defines Electronic Medical Records as a sequential electronic record encompassing the complete health information about the patient. Electronic Medical Records comprise primarily of the patient's vital signs, statistics and progress reports; such as past medical history, health issues, problems, diagnosis, medications, vaccinations history, prescribing doctors, laboratory data, radiology reports and details of doctor appointments and follow-up visits. .

Electronic Medical Records has three important functions when providing quality health care to the patients. Firstly, it acts as a Clinical Support Decision (CDS) tool. CDS provides the medical practitioner with information regarding the latest drugs and cross-reference reports of a patient tested for allergies against a particular drug, to enable them to make proper decisions with respect to medical diagnosis. Secondly, a Computerized Physician Order Entry (CPOE) is also provided. This allows doctors and physicians to prescribe relevant tests, medications and therapeutic measures to patient by simply entering the relevant data in to the patient's electronic medical record, instead of prescribing it on paper (often in an ambiguous handwriting!). Thirdly, such records provide a Health Information Exchange (HIE). This

application facilitates the sharing of information regarding a particular patient with other organizations, outside the hospital. The advantage of having a HIE system is that it ensures coordination between various hospitals and clinics. The medical data, radiology and laboratory tests and their respective reports are available on the patient's electronic record. This can reduce the need for further testing and save overall costs. Electronic Medical Reports, on the whole, ensures quality medical treatment, accurate and reliable diagnosis and overall patient satisfaction. However, the sharing of personal medical information with other organizations, via HIE, has often been criticized.

## **Personal Information and Confidentiality Issues**

Electronic Medical Reports, despite their financial and technical feasibility and operating effectiveness, have faced criticisms for their lack of confidentiality. Information System Analysts argue that since these reports contain private and confidential information regarding a patient's medical history and other particulars, it is susceptible to unauthorized access and illegal and unfair usage. .

The HIE application enables easy sharing of medical records between various health institutions and medical practitioners. This makes the electronic medical records prone to disclosures to unauthorized personnel, hackers and malware. The sensitive patient information obtained can then be used to employment and health insurance misuse and discrimination, embarrassment for the patients, personal attacks, social mistreatment and other forms of digital and binary harm. Similarly, such records, when used

with other institution based personal records, are also susceptible to leaks. In most cases, this information is only viewed by reputed medical practitioners, health insurance corporations and hospitals. However, there is an inherent risk of the information made accessible to un-regulated and un-registered commercial actors, fraudulent insurance companies and phony schemes and online (often fake) insurance mills. Furthermore, the information system used to create, maintain and update electronic medical records in hospitals and clinics is susceptible to hacking attempts and malware. The data could also be completely lost if inappropriate and untimely back-up procedures exist.

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