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Broad consent is informed consent.
BMJ (Clinical research ed.) 2011 November 1; 343: d6900; author reply d6901
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Schonfeld, Toby; Brown, Joseph S; Amoura, N Jean; Gordon, Bruce
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Greenbaum, Dov; Gerstein, Mark
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Schwab, Abraham P; Frank, Lily; Gligorov, Nada
Saying privacy, meaning confidentiality.
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Graw, Matthias
[Are you obliged to report a bullet wound?]. = Ärztliche Schweigepflicht vs. Meldepflicht: Müssen Sie bei Schussverletzungen die Polizei rufen?
MMW Fortschrritte der Medizin 2011 Oct 20; 153(42): 40
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Document 7
Peschel, Oliver; Graw, Matthias; Unger, E M
[Medical confidentiality and when you must employ it]. = Ärztliche Schweigepflicht...und wann Sie doch reden müssen.
MMW Fortschrritte der Medizin 2011 Oct 20; 153(42): 41-2, 44
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Document 8
Cross, Michael
Plans for information collection from NHS put doctors in "impossible position".
BMJ (Clinical research ed.) 2011 October 11; 343: d6556
Georgetown users check Georgetown Journal Finder for access to full text

Document 9
O'Connor, Jean; Matthews, Gene
Informational privacy, public health, and state laws.
Abstract: Developments in information technology that make it possible to rapidly transmit health information also raise questions about the possible inappropriate use and protection of identifiable (or potentially identifiable) personal health information. Despite efforts to improve state laws, adoption of provisions has lagged. We found that half of states have no statutes addressing nondisclosure of personally identifiable health information generally held by public health agencies. Exceptional treatment of HIV, sexually transmitted infections, or tuberculosis-related information was common. Where other provisions were found, there was little consistency in the laws across states. The variation in state laws supports the need to build consensus on the appropriate use and disclosure of public health information among public health practitioners.
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Document 10
Rommetveit, Kjetil
Tackling epistemological naivety: large-scale information systems and the complexities of the common good.
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Document 11

Conn, Joseph

**Ubiquitous problem. Records of nearly 8 million patients exposed: HHS.**
Modern healthcare 2011 Sep 12; 41(37): 16

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Document 12

Kovach, Karen A; Aubrecht, Jill Ann; Dew, Mary Amanda; Myers, Brad; Dabbs, Annette Devito

**Data safety and monitoring for research involving remote health monitoring.**
Telemedicine journal and e-health : the official journal of the American Telemedicine Association 2011 Sep; 17(7): 574-9

**Abstract:** Investigators conducting research involving human subjects are obligated to safeguard the wellbeing of the study participants. Other than requiring investigators to establish procedures for ongoing monitoring and reporting of adverse events, federal regulations do not dictate how human subject safety should be ensured. A variety of data safety monitoring (DSM) procedures may be acceptable depending on the nature, size, and complexity of the study. However, practical guidance for establishing and implementing appropriate DSM plans for such studies are lacking. In this article, we provide a review of the DSM considerations associated with monitoring health remotely and describe the Pocket Personal Assistant for Tracking Health project as an exemplar for how to develop effective DSM plans for research that captures clinical data using remote health-monitoring devices. Protecting the safety and welfare of participants is one of the most important mandates for research involving human subjects. Investigators have an ethical and scientific responsibility to monitor the safety of research participants. Investigators typically fulfill this responsibility by monitoring and reporting adverse events.

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Document 13

Henrion, R

[Is anonymous childbirth a sustainable option?]. = L'accouchement sous x peut-il encore exister?
La Revue du praticien 2011 Sep; 61(7): 896-7

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Document 14

Cornock, Marc

**Confidentiality: the legal issues.**
Nursing children and young people 2011 Sep; 23(7): 18-9

**Abstract:** In children's nursing confidentiality is a principle that combines legal obligations and ethical standards. This article outlines how this principle applies to nurses in the course of their professional duties with children, young people and their parents and carers. There is also a discussion about 'Gillick competence' and exceptions where a nurse is obligated to breach confidentiality, such as in cases of suspected child abuse.

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Document 15

Sprague, Steven

**Preventing network breaches: trusted platform modules are the key.**
Health management technology 2011 Sep; 32(9): 32

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Duffy, Megen
*iNurse: patient privacy and company policy in online life.*
The American journal of nursing 2011 Sep; 111(9): 65-9

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Collier, Roger
*Software tool determines odds of breaching patient privacy.*

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Conn, Joseph
*Groups: revise disclosure rule.*
Modern healthcare 2011 Aug 1; 41(31): 14

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Document 19
London, Kim E
*Technology and privacy: four key questions to ensure responsible research data capture.*
Aviation, space, and environmental medicine 2011 Aug; 82(8): 831-2

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Document 20
Dick, Thom
*Betrayal. Protecting people's privacy on scene.*
EMS world 2011 Aug; 40(8): 16

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Document 21
Iedema, Rick A M; Piper, Donella A
*The implications of mandatory notification for clinician-researchers involved in observational research in health services.*
The Medical journal of Australia 2011 Jul 4; 195(1): 54

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Aronson, Stanley M
The myth of privacy.
Medicine and health, Rhode Island 2011 Jul; 94(7): 191
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Clark, David
Examining HIPAA's disclosure exceptions.
Abstract: HIPAA was enacted to protect the rights and privacy of patients. However, healthcare providers should be aware that there are disclosure exceptions without first obtaining the patient's permission. These exceptions are well defined and explained in the document referenced in this case study.
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Document 24
Long, Kurt
Proactive defense.
Trustee: the journal for hospital governing boards 2011 Jul-Aug; 64(7): 8-9, 1
Abstract: Make sure your hospital adheres to HITECH's privacy and security rules to avoid a compliance review.
Georgetown users check Georgetown Journal Finder for access to full text

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Carlson, Joe; Conn, Joseph
HIPAA indictment. Doc charged with disclosing patient info.
Modern healthcare 2011 Jun 27; 41(26): 9
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Collier, Roger
Ontario introduces "hospital secrecy clause".
CMAJ: Canadian Medical Association journal = journal de l'Association medicale canadienne 2011 Jun 14; 183(9): E552
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Conn, Joseph
The burden of privacy? Demands placed by proposed privacy rule could outweigh patient benefits.
Modern healthcare 2011 Jun 13; 41(24): 30, 32
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Williams, David; Clover, Ben
Privacy. 'Catastrophic' data risk.
The Health service journal 2011 Jun 2; 121(6259): 6
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Document 29
Paterson, Moira; Jones, Kay; Schattner, Peter; Adaji, Akuh; Piterman, Leon
Electronic care plans and medicolegal liability.
Australian family physician 2011 Jun; 40(6): 432-4
Abstract: Government policy encourages the use of care plans in general practice, and developments in information technology have the potential to facilitate their use via a shared electronic care plan. Sharing a comprehensive set of patient data raises privacy issues and questions about the nature and extent of potential liability.
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Kay, Laney
Handling confusion regarding electronic health records and HIPAA-governed breach of patient information.
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Rothstein, Mark A
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The Journal of law, medicine & ethics : a journal of the American Society of Law, Medicine & Ethics 2011 Summer; 39(2): 280-4
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Silbert, Maurice
Breaking bad news - ethical dilemmas for doctors attending to Jewish patients.
Georgetown users check Georgetown Journal Finder for access to full text

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Conn, Joseph
Asleep at the switch.
Modern healthcare 2011 May 23; 41(21): 6-7, 16, 1
Abstract: Two new reports had some harsh words for HHS' enforcement of the HIPAA security rule on guarding patient data. A lack of strong enforcement may be hindering providers' efforts in the area. "I continue to hear from folks who work in security, that as long as there is not visible enforcement, it hurts their chances to getting the
resources and budgets and employees they need," says Lisa Gallagher.

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**Document 34**

Abbing, Henriette Roscam

**A revival of the privacy protection of health-related personal information?**

European journal of health law 2011 May; 18(3): 247-54

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**Document 35**

Bongers, L M H

**Disclosure of medical data to relatives after the patient's death: recent legal developments with respect to relatives' entitlements in the Netherlands.**

European journal of health law 2011 May; 18(3): 255-75

**Abstract:** In the Netherlands the physician is still bound to professional confidentiality after the patient's death. However, in the legal doctrine and in case law some exceptions have been recognized, especially for circumstances where the relatives have a legitimate interest in the inspection of medical records of the deceased. Today developments as regards the Dutch proposal to new legislation on patients' rights, notably the proposed insertion of a provision stipulating the conditions under which the relatives have a right of access to medical records of the deceased, give cause for renewed consideration of this issue related to legal protection after death. This article explores whether the proposed provision corresponds to the prevailing principles regarding disclosure of medical data after death. It is concluded that there is a need to reconsider the provision's wording or to adhere to self-regulation of the Royal Dutch Medical Association in order to strike an appropriate balance between the various interests concerned.

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**Document 36**

Dunphy, K P

**Consent, confidentiality and curing sexually transmitted infection: an ethical trilemma.**

International journal of STD & AIDS 2011 May; 22(5): 281-5

**Abstract:** When treating contacts of patients with sexually transmitted infections (STIs), health professionals may face conflicting ethical imperatives. We surveyed middle grade doctors in genitourinary (GU) medicine and asked how they would manage a hypothetical clinical scenario. This was analysed on the basis of principles of respect for autonomy and beneficence/non-maleficence to assess how they weigh up duties of informed consent (autonomy of patient), partner confidentiality (autonomy of partner) and the need to achieve a good medical outcome. Responses indicated that the strategies that they employ in practice - what they actually say to patients (and what they leave unsaid) - balance the conflicting requirements of these ethical principles in quite different ways, some of which appear ethically problematic.

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Tannen, Antje

**[Information security in patient transfer]. = Informationssicherung bei der Patientenübergabe.**

Pflege Zeitschrift 2011 May; 64(5): 291

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Handelsman, David J; Turner, Leo A; Conway, Ann J
**Doctors breaching patient privacy: Orwell redux.**
The Medical journal of Australia 2011 Apr 18; 194(8): 403-4

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Document 39
Adeleke, I T; Adekanye, A O; Adefemi, S A; Onawola, K A; Okuku, A G; Sheshi, E U; James-Adeniran, J A; Francis, M; Elegbe, T R O; Ayeni, A M; Tume, A A
**Knowledge, attitudes and practice of confidentiality of patients' health records among health care professionals at Federal Medical Centre, Bida.**

**Abstract:** The quality of information shared with health care professionals depends on their ability to keep it confidential especially in this information technology age when unguided access is imminent. In view of this, the study described knowledge, attitude and practice of confidentiality of patients' health records amongst health care professionals at Federal Medical Centre Bida, Nigeria.

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Terhune, William B
**Confidentiality. 1961.**
Connecticut medicine 2011 Apr; 75(4): 239-40

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Taylor, Mark J
**Health research, data protection, and the public interest in notification.**
Medical law review 2011 Mar; 19(2): 267-303

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Bryson, David
**Ethical dimensions to reflection.**
Journal of visual communication in medicine 2011 Mar; 34(1): 36-7

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Berle, Ian
**Privacy and confidentiality: what is the difference?**
Journal of visual communication in medicine 2011 Mar; 34(1): 43-4
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Morfeldt, Linda

[National quality registries. Protect or sell out the patients' integrity?]. = Nationella kvalitetsregister. Värna eller sälja ut patienternas integritet?

Document 45
Degaspari, John

Protecting patient information. Much work remains to be done on the data security front.
Healthcare informatics : the business magazine for information and communication systems 2011 Mar; 28(3): 32-3

Document 46
Schell, Werner

[The confidentiality requirement for health care staff is the foundation of trust by patients]. = Die Schweigepflicht der Mitarbeiter im Gesundheitswesen ist das Fundament für das Vertrauen der Patienten.

Document 47
Rieger, H J

[Breach of confidential medical communication and personal rights as a result of a medical certificate from a tenured physician]. = Verletzung der ärztlichen Schweigepflicht und des allgemeinen Persönlichkeitsrechts des Patienten durch Attest eines beamteten Chefarztes.
Deutsche medizinische Wochenschrift (1946) 2011 Mar; 136(12): 597-8

Document 48
O'Dowd, Adrian

HIPAA violation? Sue me.
Journal of AHIMA / American Health Information Management Association 2011 Mar; 82(3): 68

Document 49
O'Dowd, Adrian

NHS reforms create threat to patient confidentiality.
BMJ (Clinical research ed.) 2011 February 25; 342: d1291
Document 50

**Lower anxiety. Most see no impact from privacy policies.**

Modern healthcare 2011 Feb 21; 41(8): S5

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Document 51

**Electronic consent channels: preserving patient privacy without handcuffing researchers.**

Science translational medicine 2011 Feb 9; 3(69): 69cm4

*Abstract:* Advances in health information technology and electronic medical records have the tremendous potential to accelerate translational and clinical research. However, privacy concerns threaten to be a rate-limiting factor. By recognizing and responding to patient privacy concerns, policy-makers, researchers, and information technology leaders have the opportunity to transform trial recruitment and make it safer to electronically locate and convey sensitive health information.

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Document 52

**Aspects of privacy for electronic health records.**

International journal of medical informatics 2011 Feb; 80(2): e26-31

*Abstract:* Patients' medical data have been originally generated and maintained by health professionals in several independent electronic health records (EHRs). Centralized electronic health records accumulate medical data of patients to improve their availability and completeness; EHRs are not tied to a single medical institution anymore. Nowadays enterprises with the capacity and knowledge to maintain this kind of databases offer the services of maintaining EHRs and adding personal health data by the patients. These enterprises get access on the patients' medical data and act as a main point for collecting and disclosing personal data to third parties, e.g. among others doctors, healthcare service providers and drug stores. Existing systems like Microsoft HealthVault and Google Health comply with data protection acts by letting the patients decide on the usage and disclosure of their data. But they fail in satisfying essential requirements to privacy. We propose a privacy-protecting information system for controlled disclosure of personal data to third parties. Firstly, patients should be able to express and enforce obligations regarding a disclosure of health data to third parties. Secondly, an organization providing EHRs should neither be able to gain access to these health data nor establish a profile about patients.

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Document 53

**Views on health information sharing and privacy from primary care practices using electronic medical records.**


*Abstract:* To determine how patients and physicians balance the perceived benefits and harms of sharing electronic health data for patient care and for secondary purposes.

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Document 54
Hsiao, Allen L; Bazzy-Asaad, Alia; Tolomeo, Concettina; Edmonds, Diana; Belton, Beverly; Benin, Andrea L
Secure web messaging in a pediatric chronic care clinic: a slow takeoff of "kids' airmail".
Abstract: Although e-mail may be an efficient clinician-patient communication tool, standard e-mail is not adequately secure to meet Health Insurance Portability and Accountability Act (HIPAA) guidelines. For this reason, firewall-secured electronic messaging systems have been developed for use in health care. Impact and usability of these secure systems have not been broadly assessed.
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Document 55
Thompson, Lindsay A; Black, Erik; Duff, W Patrick; Paradise Black, Nicole; Saliba, Heidi; Dawson, Kara
Protected health information on social networking sites: ethical and legal considerations.
Journal of medical Internet research 2011 January 19; 13(1): e8
Abstract: Social networking site use is increasingly common among emerging medical professionals, with medical schools even reporting disciplinary student expulsion. Medical professionals who use social networking sites have unique responsibilities since their postings could violate patient privacy. However, it is unknown whether students and residents portray protected health information and under what circumstances or contexts.
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Document 56
Malin, Bradley; Benitez, Kathleen; Masys, Daniel
Never too old for anonymity: a statistical standard for demographic data sharing via the HIPAA Privacy Rule.
Abstract: Healthcare organizations must de-identify patient records before sharing data. Many organizations rely on the Safe Harbor Standard of the HIPAA Privacy Rule, which enumerates 18 identifiers that must be suppressed (eg, ages over 89). An alternative model in the Privacy Rule, known as the Statistical Standard, can facilitate the sharing of more detailed data, but is rarely applied because of a lack of published methodologies. The authors propose an intuitive approach to de-identifying patient demographics in accordance with the Statistical Standard.
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Document 57
Simões, José Augusto
[System of biometric identification: by the way of control]. = Sistemas de identificação biométrica: a propósito do controlo.
Acta médica portuguesa 2011 Jan-Feb; 24(1): 163-8
Abstract: The ethics and morals make the line between lawful to unlawful, the right and wrong, acceptable from the unacceptable. Furthermore the purpose of ethics in the field of profesional practice is, in particular the application of moral standards based on honesty, courtesy and honour. But they are not the only ones. Confidentiality should be the first of duties the professional has no right to disclose information that was only reported in their work and because it was necessary to run it. This requirement aims to protect the recipient of the service and avoid damage to society. The professional should also encourage members of his team, because solidarity is a very effective way to improve the intellectual and moral qualities of work partners and ensure their involvement. When you have an honest professional conduct within and outside of professional practice, you attract confidence and prestige, which is an incentive to drive, with safety, the proper course of his career. The purpose of the biometric control based on the need to expedite the fulfilment of a goal whose integration is recognized by law under the control of the employer's: the setting of working hours, monitoring the attendance and registration of working time. This record is also the accounting and control of additional work. To consider the biometric control as an appropriate mean to ensure a
'«legitimate purpose», the Law 67/98 requires the National Commission for Data Protection, in each case, to ascertain whether the prevailing interests the rights and freedoms guarantees data subjects on the interest for the treatment of data relied upon by the employer. This procedure seems to be the best fit to the principle of proportionality and therefore the processing of data should be refused where it appears unjustified, inappropriate and excessive, or when, by their lack of reliability, it undermines the purpose of determining it.

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Document 58
Antomás, J; Huarte del Barrio, S

[Confidentiality and the medical record. Ethical-legal considerations]. = Confidencialidad e historia clinica. Consideraciones ético-legales.
Anales del sistema sanitario de Navarra 2011 Jan-Apr; 34(1): 73-82

Abstract: Confidentiality is a key aspect in the relationship between health professionals and patients. It involves the cession by the patient of a reserved part of herself and the ethical principles of autonomy and non-maleficence that are closely linked to its preservation. There are also numerous legal regulations that make professional secrecy obligatory, in some cases imposing hard sanctions that are often not known about. As the medical record is the document where the relationship with the patient is recorded, it requires extraordinary protection due to the especially sensitive nature of the information it contains. It should be compulsory that the professional who works with it should know some basic aspects of the fundamental laws that regulate it in different aspects. This article reviews questions that at times are only known in the abstract, but that are contained in the legal regulations, such as ownership of the medical record, subjective annotations, its custody and rectification or who can have access to it and why.

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Document 59
Younggren, Jeffrey N.

Three-prong approach to risk prevention
Ethics & Behavior 2011 January-February; 21(1): 88-90

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Lehman, Kenneth W.

Norman ninja - student clinician hypothetical
Ethics & Behavior 2011 January-February; 21(1): 83-88

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Appelbaum, Paul S.

Avoiding premature judgments about the duty to protect
Ethics & Behavior 2011 January-February; 21(1): 82-83

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Document 62
Richards, Jaime L.; Walker, Rashada N.
**Document 63**
Lehnbom, E; McLachlan, A; Brien, J

**E-Health: what are we talking about?**
Internal medicine journal 2011 Jan; 41(1a): 72

**Abstract:** Clinician time alone with an adolescent has a major impact on disclosure of risk behavior. This study sought to describe primary care clinicians' patterns of delivering time alone, decision making about introducing time alone to adolescents and their parents, and experiences delivering confidential services.

**Document 64**
McKee, M Diane; Rubin, Susan E; Campos, Giselle; O'Sullivan, Lucia F

**Challenges of providing confidential care to adolescents in urban primary care: clinician perspectives.**
Annals of family medicine 2011 Jan-Feb; 9(1): 37-43

**Abstract:** Clinician time alone with an adolescent has a major impact on disclosure of risk behavior. This study sought to describe primary care clinicians' patterns of delivering time alone, decision making about introducing time alone to adolescents and their parents, and experiences delivering confidential services.

**Document 65**
Muller, Lynn S

**Case managers in the crosshairs.**
Professional case management 2011 Jan-Feb; 16(1): 39-42

**Document 66**

Health Information Technology for Economic and Clinical Health Act: modifications to the HIPAA privacy, security, and enforcement rules (Document ID HSS-OCR-2010-0016-001).

**Document 67**
Buckley, Brian S; Murphy, Andrew W; MacFarlane, Anne E

**Public attitudes to the use in research of personal health information from general practitioners' records: a survey of the Irish general public.**

**Abstract:** Understanding the views of the public is essential if generally acceptable policies are to be devised that balance research access to general practice patient records with protection of patients' privacy. However, few large studies have been conducted about public attitudes to research access to personal health information.
Is the biggest security threat to medical information simply a lack of understanding?

Studies in health technology and informatics 2011; 168: 179-87

Abstract: Connecting Australian health services and the e-health initiative is a major focus in the current health environment. Many issues are presented as key to its success including solving issues with confidentiality and privacy. However, the main problem may not be these issues in sharing information but the fact that the point of origin of such records is still relatively insecure. This paper highlights why this may be the case. Research into the security of medical information has shown that many primary healthcare providers are unable to create an environment with effective information security. Numerous factors contribute to this complex situation including a trustful environment, the resultant security culture and the capability of individual healthcare organisations. Further, the growing importance of new directions in the use of patient information is considered. This paper discusses these issues and positions them within the complex environment that is healthcare. In our current health system infrastructure, the points of origin of patient information are our most vulnerable. This entwined with progressively new uses of this information expose additional security concerns, such as re-identification of information, that require attention.

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Personal health data: patient consent in information age.

Studies in health technology and informatics 2011; 169: 58-62

Abstract: In this paper we report on findings related to treatment of patient consent in various circumstances and geographic domains; explore transfer of health data between custodians and geo-political entities; and emphasize importance of educating general public about issues related to handling health data. A specific set of questions about consent/legislation and related issues in the Canada, the USA and the EU are addressed in an attempt to answer them systematically. This comparison identifies similarities and differences along a set of dimensions.

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Sharing sensitive personal health information through Facebook: the unintended consequences.

Househ, Mowafa
Studies in health technology and informatics 2011; 169: 616-20

**Abstract:** The purpose of this paper was to explore the types of sensitive health information posted by individuals through social network media sites such as Facebook. The researcher found several instances in which individuals, who could be identified by their user profiles, posted personal and sensitive health information related to mental and genetic disorders and sexually transmitted diseases. The data suggest that Facebook users should be made aware of the potential harm that may occur when sharing sensitive health information publicly through Facebook. Ethical considerations in undertaking such research are also examined.

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Document 73

Legemaate, Johan

[Who really 'owns' images made of patients?]. = Van wie zijn medische beelden eigenlijk?

Nederlands tijdschrift voor geneeskunde 2011; 155: A3061

**Abstract:** Images made of patients as part of the delivery of care (photographs, x-rays, scans, histopathological images) are part of a patient's file. All legal rules pertaining to a medical record also apply to these types of images, including the patient's right to obtain a copy as well as the right to have the record (partially) destroyed. It is not useful to speak about images in terms of ownership. The issue actually relates to who has control over these images, not who owns them. Those who provide health care as well as the patient have combined control over the images.

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Document 74

McCurdy, David B; Fitchett, George

**Ethical issues in case study publication: "making our case(s)" ethically.**

Journal of health care chaplaincy 2011; 17(1-2): 55-74

**Abstract:** As chaplains develop richly detailed case studies for publication, ethical questions about case study construction and publication are emerging. Concerns about seeking patients' permission to publish material about them suggest additional questions and raise broad confidentiality and privacy issues. Confidentiality-related practices in health care and psychotherapy provide the most extensive guidance for chaplains, but healthcare chaplaincy has roots in religious and professional traditions with distinct notions of confidentiality that deserve consideration. Single case studies do not appear to be "research" requiring informed consent, yet their publication exposes patients to some risk of harm. Obtaining the patient's/"case study subject's" permission to publish, disguising non-essential information, and allowing the patient to review the case study can mitigate the risks. Striking a balance between protecting patients and providing sufficient detail to make case studies useful is a central ethical challenge of case study publication.

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Document 75

Bolka, Anka; Zadel, Blaž; Zorko, Martina

**Personal information protection - exceptional challenges of integrated systems of eHealth.**

Studies in health technology and informatics 2011; 165: 74-9

**Abstract:** Informatization has been bringing important, quick and extensive changes into the healthcare environment for years. Individual systems still represent isolated information islands; however, the need for interconnectivity and mutual accessibility has become more pronounced. On the one hand, integration of systems brings numerous, financially measurable advantages, and on the other hand, personal information in such systems becomes more vulnerable. Providing personal information protection is therefore the permanent task of informatisation and, with elimination of national borders and integration of national systems, it is becoming a challenge from the legal, organisational, technical and financial standpoints.

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Document 76

Vinson, Devin D

No more paper tiger: promise and peril as HIPAA goes HITECH.

Abstract: The HITECH Act, passed in 2009 by the federal government, deepens the concerns for patient privacy faced by healthcare organizations subject to HIPAA. This article examines the law and demonstrates that healthcare entities are facing greater duties to safeguard patients' protected health information, as well as severe civil and criminal penalties should they fail to do so. In recognition of this heightened liability, healthcare entities must reassess their methods for handling patient data and take action in key areas to ensure that risk is contained.

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Document 77

Bennett, Kylie; Bennett, Anthony James; Griffiths, Kathleen Margaret

Security considerations for e-mental health interventions.
Journal of medical Internet research 2010 December 19; 12(5): e61

Abstract: Security considerations are an often overlooked and underfunded aspect of the development, delivery, and evaluation of e-mental health interventions although they are crucial to the overall success of any eHealth project. The credibility and reliability of eHealth scientific research and the service delivery of eHealth interventions rely on a high standard of data security. This paper describes some of the key methodological, technical, and procedural issues that need to be considered to ensure that eHealth research and intervention delivery meet adequate security standards. The paper concludes by summarizing broad strategies for addressing the major security risks associated with eHealth interventions. These include involving information technology (IT) developers in all stages of the intervention process including its development, evaluation, and ongoing delivery; establishing a wide-ranging discourse about relevant security issues; and familiarizing researchers and providers with the security measures that must be instituted in order to protect the integrity of eHealth interventions.

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Document 78

Conn, Joseph

FTC targets consent. Report addresses concerns over online health info.
Modern healthcare 2010 Dec 6; 40(49): 12

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Document 79

Harris, Andrew

Taking care with confidentiality.

Georgetown users check Georgetown Journal Finder for access to full text

Document 80

O'Keefe, Christine M; Connolly, Chris J

Privacy and the use of health data for research.
The Medical journal of Australia 2010 Nov 1; 193(9): 537-41
Abstract: We reviewed resources for researchers interested in privacy issues surrounding secondary use of health data for research. These included applicable privacy regulations and available information on privacy perception in Australia. The review is timely because the current Australian Population Health Research Network infrastructure investments are likely to attract new researchers to the field.

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Document 81

dos Santos, Regina Maria; Viana, Ivey Rayane M N; da Silva, Josefa Rita; Trezza, Maria Cristina Soares Figueiredo; Leite, Jose António Luzia

[The nurse and patient's nudity]. = A enfermeira e a nudez do paciente.
Revista brasileira de enfermagem 2010 Nov-Dec; 63(6): 877-86

Abstract: This is a qualitative study about the relationship among nurses of a university hospital and their patients when they need to undress those patients to take care. The purpose was to analyze speech of seven nurses in this situation. The information was taken by transcribing the semi-structured interviews which were analyzed according Michel Foucault's thought. The results demonstrated that the relationship among nurses and patients at the time when nudity is needed to perform nursing care is full of power, to which the nurses don't feel always prepared. Also the nurses don't think that, acting as they act, they exert power over the patients. It is suggested to Nursing schools to perform seminars about the care with the naked body.

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Document 82

Tellman, Norisse; Litt, Eric R; Knapp, Caprice; Eagan, Aaron; Cheng, Jing; Radonovich, Lewis J Jr.

The effects of the Health Insurance Portability and Accountability Act privacy rule on influenza research using geographical information systems.
Geospatial health 2010 Nov; 5(1): 3-9

Abstract: The Health Insurance Portability and Accountability Act (HIPAA) privacy rule was enacted to protect patients' personal health information from undue disclosure. Despite its intention to protect patients, recent reports suggest that HIPAA restrictions may be negatively impacting health research. Quantitative, visual geographical and statistical analysis of zip code geographical information systems (GIS) mapping, comparing 3-digit HIPAA-compliant and 5-digit HIPAA-non-compliant simulated data, was chosen to identify and describe the type of distortion that may result. It was found that unmitigated HIPAA compliance with HIPAA mapping rules distorted the GIS zip code data by 28% leading to erroneous results. Thus, compliance with HIPAA privacy rule when mapping may lead investigators to publish erroneous GIS maps.

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Document 83

Lienhart, A;
Commissions d'éthique de la Sfar et de la Srif

[Confidentiality: from rules to medical practice]. = Le secret médical: des règles à la pratique.
Annales françaises d'anesthésie et de réanimation 2010 Nov; 29(11): 832-51

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Document 84

Luna, Jesus; Dikaikatos, Maríos; Marazakis, Manolis; Kyprianou, Theodoros

Data-centric privacy protocol for intensive care grids.
Abstract: Modern e-Health systems require advanced computing and storage capabilities, leading to the adoption of technologies like the grid and giving birth to novel health grid systems. In particular, intensive care medicine uses this paradigm when facing a high flow of data coming from intensive care unit's (ICU) inpatients just like demonstrated by the ICGrid system prototyped by the University of Cyprus. Unfortunately, moving an ICU patient's data from the traditionally isolated hospital's computing facilities to data grids via public networks (i.e., the Internet) makes it imperative to establish an integral and standardized security solution to avoid common attacks on the data and metadata being managed. Particular emphasis must be put on the patient's personal data, the protection of which is required by legislations in many countries of the European Union and the world in general. In this paper, we extend our previous research with the following contributions: 1) a mandatory access control model to protect patient's metadata; 2) a major security revision to our previously proposed privacy protocol by contributing with a "quality of security" quantitative metric to improve fragmented data's assurance; and finally, 3) a set of early results to demonstrate that our protocol not only improves a patient personal data's security and privacy but also achieves a performance comparable with existing approaches.
Document 88

Woodward, Cal

**United States medical privacy rules deemed inadequate.**


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Document 89

Løvseth, Lise Tevik; Aasland, Olaf Gjerløw; Fridner, Ann; Jónsdottir, Lilja Sigrun; Marini, Massimo; Linaker, Olav Morten

**Confidentiality and physicians’ health. A cross-sectional study of University Hospital Physicians in four European cities (the HOUPE-study).**

Journal of occupational health 2010 Oct 7; 52(5): 263-71

**Abstract:** To investigate how the subjective burden of confidentiality can act as a stressor that affects physicians’ psychological health and wellbeing.

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Document 90

Wolfson, Michael; Wallace, Susan E; Masca, Nicholas; Rowe, Geoff; Sheehan, Nuala A; Ferretti, Vincent; LaFlamme, Philippe; Tobin, Martin D; Macleod, John; Little, Julian; Fortier, Isabel; Knoppers, Bartha M; Burton, Paul R

**DataSHIELD: resolving a conflict in contemporary bioscience--performing a pooled analysis of individual-level data without sharing the data.**


**Abstract:** Contemporary bioscience sometimes demands vast sample sizes and there is often then no choice but to synthesize data across several studies and to undertake an appropriate pooled analysis. This same need is also faced in health-services and socio-economic research. When a pooled analysis is required, analytic efficiency and flexibility are often best served by combining the individual-level data from all sources and analysing them as a single large data set. But ethico-legal constraints, including the wording of consent forms and privacy legislation, often prohibit or discourage the sharing of individual-level data, particularly across national or other jurisdictional boundaries. This leads to a fundamental conflict in competing public goods: individual-level analysis is desirable from a scientific perspective, but is prevented by ethico-legal considerations that are entirely valid.

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Document 91

Harris, Andrew

**Disclosure and anonymity in patient confidentiality.**


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Document 92

Marks, Daniel J B; Smith, Philip J

**Can we justify the cost of information technology in the NHS?**

Document 93

Cushman, Reid; Froomkin, A Michael; Cava, Anita; Abril, Patricia; Goodman, Kenneth W

Ethical, legal and social issues for personal health records and applications.

Abstract: Robert Wood Johnson Foundation's Project HealthDesign included funding of an ethical, legal and social issues (ELSI) team, to serve in an advisory capacity to the nine design projects. In that capacity, the authors had the opportunity to analyze the personal health record (PHR) and personal health application (PHA) implementations for recurring themes. PHRs and PHAs invert the long-standing paradigm of health care institutions as the authoritative data-holders and data-processors in the system. With PHRs and PHAs, the individual is the center of his or her own health data universe, a position that brings new benefits but also entails new responsibilities for patients and other parties in the health information infrastructure. Implications for law, policy and practice follow from this shift. This article summarizes the issues raised by the first phase of Project HealthDesign projects, categorizing them into four topics: privacy and confidentiality, data security, decision support, and HIPAA and related legal-regulatory requirements. Discussion and resolution of these issues will be critical to successful PHR/PHA implementations in the years to come.

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Document 94

Carmack, Heather J

"What happens on the van, stays on the van": the (re)structuring of privacy and disclosure scripts on an Appalachian mobile health clinic.
Qualitative health research 2010 Oct; 20(10): 1393-405

Abstract: Over the past two decades, mobile health clinics have emerged to address the health needs of underserved populations. Mobile clinics offer curbside care in the primary settings of people's lives: churches, parking lots, grocery stores, and community centers. Drawing on 18 months of ethnographic fieldwork, I explore how physical and symbolic space helps shape the (re)writing of traditional health care scripts of provider-patient confidentiality and medical disclosure in a mobile clinic serving residents of 21 counties in southeastern Ohio. This analysis centered on how clinic staff members blurred the symbolic and physical space of privacy, merged personal and professional discourses, and triaged multiple patient disclosures in the face of social and spatial constraints.

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Document 95

Rosenbaum, Sara

Data governance and stewardship: designing data stewardship entities and advancing data access.
Health services research 2010 Oct; 45(5 Pt 2): 1442-55

Abstract: U.S. health policy is engaged in a struggle over access to health information, in particular, the conditions under which information should be accessible for research when appropriate privacy protections and security safeguards are in place. The expanded use of health information—an inevitable step in an information age—is widely considered be essential to health system reform. Models exist for the creation of data-sharing arrangements that promote proper use of information in a safe and secure environment and with attention to ethical standards. Data stewardship is a concept with deep roots in the science and practice of data collection, sharing, and analysis. Reflecting the values of fair information practice, data stewardship denotes an approach to the management of data, particularly data that can identify individuals. The concept of a data steward is intended to convey a fiduciary (or trust) level of responsibility toward the data. Data governance is the process by which responsibilities of stewardship are conceptualized and carried out. As the concept of health information data stewardship advances in a technology-enabled environment, the question is whether legal barriers to data access and use will begin to give way. One possible answer may lie in defining the public interest in certain data uses, tying provider participation in federal health programs to the release of all-payer data to recognized data stewardship entities for aggregation and management, and enabling such entities to foster and enable the creation of knowledge through research.
Document 96
Lane, Julia; Schur, Claudia
Balancing access to health data and privacy: a review of the issues and approaches for the future.
Health services research 2010 Oct; 45(5 Pt 2): 1456-67
Abstract: There has been a dramatic increase in the types of microdata, and this holds great promise for health services research. However, legislative efforts to protect individual privacy have reduced the flow of health care data for research purposes and increased costs and delays, affecting the quality of analysis.

Document 97
Conn, Joseph
Privacy, please. AHIMA voices concern over proposed privacy rule changes.
Modern healthcare 2010 Sep 20; 40(38): 17

Document 98
Rahmouni, Hanene Boussi; Solomonides, Tony; Mont, Marco Casassa; Shiu, Simon
Privacy compliance and enforcement on European healthgrids: an approach through ontology.
Philosophical transactions. Series A, Mathematical, physical, and engineering sciences 2010 Sep 13; 368(1926): 4057-72
Abstract: The sharing of medical data between different healthcare organizations in Europe must comply with the legislation of the Member State where the data were originally collected. These legal requirements may differ from one state to another. Privacy requirements such as patient consent may be subject to conflicting conditions between different national frameworks as well as between different legal and ethical frameworks within a single Member State. These circumstances have made the compliance management process in European healthgrids very challenging. In this paper, we present an approach to tackle these issues by relying on several technologies in the semantic Web stack. Our work suggests a direct mapping from high-level legislation on privacy and data protection to operational-level privacy-aware controls. Additionally, we suggest an architecture for the enforcement of these controls on access control models adopted in healthgrid security infrastructures.

Document 99
Ayer, Ariane; Richoz, Christophe
[Nothing is forbidden to ignore...the mandate of maintenance of medical records by health professionals]. = Nul n’est censé ignorer...les exigences en matière de tenue de dossier des professionnels de la santé.
Revue médicale suisse 2010 Sep 1; 6(260): 1615-8

Document 100
Rippee, Stephanie M
Talking to lawyers about patients: when is it really okay?
Document 101
Ashby, Homer U Jr.; Verner, David

Do pastoral counselors have a duty to report clergy sexual abuse done by their clergy clients?
The journal of pastoral care & counseling : JPCC 2010 Fall; 64(3): 2.1-11

Abstract: What does a pastoral counselor do when a clergy client reveals that he or she has been sleeping with a parishioner? Does the counselor have an ecclesiastical duty to report this offense to a church official; or does the pledge of confidentiality trump any disclosure? Some ecclesiastical bodies require their clergy to bring knowledge of these offenses to church authorities. Does this requirement apply to pastoral counselors? The authors have been confronted with these questions in their ministry of pastoral counseling and have struggled with producing a faithful, professional response. Along the way they have not received clear direction from judicatories or professional organizations. This article is the authors' attempt to answer the questions raised above as well as to challenge professional and ecclesiastical bodies to confront more forthrightly the dilemmas these situations cause for pastoral counselors who seek to protect the welfare of the Church as well as protect the pledge to maintain confidentiality.

Document 102
Heubusch, Kevin

Too much privacy?
Journal of AHIMA / American Health Information Management Association 2010 Sep; 81(9): 50-1

Document 103
Carey, Susan; O'Connor, Michelle; Waugh, Traci; Wiedemann, Lou Ann

Understanding the HIE landscape.
Journal of AHIMA / American Health Information Management Association 2010 Sep; 81(9): 60-5

Document 104
Elger, Bernice S; lavindrasana, Jimison; Lo Iacono, Luigi; Müller, Henning; Roduit, Nicolas; Summers, Paul; Wright, Jessica

Strategies for health data exchange for secondary, cross-institutional clinical research.
Computer methods and programs in biomedicine 2010 Sep; 99(3): 230-51

Abstract: Secondary use of health data has a vital role in improving and advancing medical knowledge. While digital health records offer scope for facilitating the flow of data to secondary uses, it remains essential that steps are taken to respect wishes of the patient regarding secondary usage, and to ensure the privacy of the patient during secondary use scenarios. Consent, together with depersonalisation and its related concepts of anonymisation, pseudonymisation, and data minimisation are key methods used to provide this protection. This paper gives an overview of technical, practical, legal, and ethical aspects of secondary data use and discusses their implementation in the multi-institutional @neurIST research project.
Document 105

Moore, Adam D

**Privacy, public health, and controlling medical information.**

*HEC forum: an interdisciplinary journal on hospitals' ethical and legal issues* 2010 Sep; 22(3): 225-40

**Abstract:** This paper argues that individuals do, in a sense, own or have exclusive claims to control their personal information and body parts. It begins by sketching several arguments that support presumptive claims to informational privacy, turning then to consider cases which illustrate when and how privacy may be overridden by public health concerns.

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Document 106

Ursin, Lars Oystein

**Privacy and property in the biobank context.**

*HEC forum: an interdisciplinary journal on hospitals' ethical and legal issues* 2010 Sep; 22(3): 211-24

**Abstract:** A research biobank is a collection of personal health and lifestyle information, including genetic samples of yet unknown but possibly large information potential about the participant. For the participants, the risk of taking part is not bodily harm but infringements of their privacy and the harmful consequences such infringements might have. But what do we mean by privacy? Which harms are we talking about? To address such questions we need to get a grip on what privacy is all about and aim for a fruitful perspective on the issues of property and privacy rights in the context of biobanking. This paper argues that the limits and handling of private matters is determined in specific social relations. The crucial point is thus to determine which information and activities are or are not the legitimate concern of others. Privacy and property rights should be seen as balanced by duties, that is as inherently relational interests extending into the public sphere, rather than to see these rights as the control of an object—for instance the participant's biobank material.

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Document 107

Greely, Henry T

**To the barricades!**

*The American journal of bioethics: AJOB* 2010 Sep; 10(9): 1-2

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Document 108

Rothstein, Mark A

**Deidentification and its discontents: response to the Open Peer Commentaries.**

*The American journal of bioethics: AJOB* 2010 Sep; 10(9): W1-2

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Document 109

Rothstein, Mark A

**Is deidentification sufficient to protect health privacy in research?**

*The American journal of bioethics: AJOB* 2010 Sep; 10(9): 3-11

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Document 110

Moros, Daniel A; Rhodes, Rosamond

**Privacy overkill.**
The American journal of bioethics : AJOB 2010 Sep; 10(9): 12-5

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Document 111

Brothers, Kyle Bertram; Clayton, Ellen Wright

**"Human non-subjects research": privacy and compliance.**
The American journal of bioethics : AJOB 2010 Sep; 10(9): 15-7

Georgetown users check [Georgetown Journal Finder](#) for access to full text

Document 112

Angrist, Misha

**Urge overkill: protecting deidentified human subjects at what price?**
The American journal of bioethics : AJOB 2010 Sep; 10(9): 17-8

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Document 113

Callier, Shawneequa L; Schmidt, Harald

**Managing patient expectations about deidentification.**
The American journal of bioethics : AJOB 2010 Sep; 10(9): 21-3

Georgetown users check [Georgetown Journal Finder](#) for access to full text

Document 114

Francis, Leslie Pickering; Francis, John G

**Group compromise: perfect cases make problematic generalizations.**
The American journal of bioethics : AJOB 2010 Sep; 10(9): 25-7

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Document 115

Nelson, William A

**Health care ethics and rural life. Stigma, privacy, boundary conflicts raise concerns.**
Health progress (Saint Louis, Mo.) 2010 Sep-Oct; 91(5): 50-4

Georgetown users check [Georgetown Journal Finder](#) for access to full text

Document 116

Hader, Amy L; Brown, Evan D
Patient privacy and social media.
AANA journal 2010 Aug; 78(4): 270-4

Abstract: Healthcare providers using social media must remain mindful of professional boundaries and patients' privacy rights. Facebook and other online postings must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), applicable facility policy, state law, and AANA's Code of Ethics.

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Document 117
Seitz, Esther
Privacy (or piracy) or medical records: HIPAA and its enforcement.
Journal of the National Medical Association 2010 Aug; 102(8): 745-8

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Document 118
A first peek at the privacy regulations.
Journal of AHIMA / American Health Information Management Association 2010 Aug; 81(8): 46

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Document 119
Esen, Umo
Online postings and medical professionalism.

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Document 120
Keegan, Michael; Levenson, Ros
Patient confidentiality.

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Document 121
Stansbury, Carlton D
Accessibility to a parent's psychotherapy records in custody disputes: how can the competing interests be balanced?

Abstract: One of the issues that commonly arises in custody disputes is whether one parent or the court may obtain access to the records of the other parent's mental health treatment. The answer to this question varies across jurisdictions given that states do not treat the medical/psychological therapeutic privilege uniformly. These differences demonstrate the competing interests whenever a party's mental health records become an issue in a custody proceeding, and the attempt to balance the interests when the therapeutic privilege is asserted. This article will examine the balancing challenge, review the scope and function of the psychotherapist-patient privilege, discuss different states' approaches to the balancing challenge, and propose that preserving the privilege creates the most effective, long-term balance. The article concludes with strategies on addressing privilege issues in custody cases.
Document 122

Park, Young-Joon; Kim, Sujin; Kim, Aeree; Ha, Seung-Yeon; Lee, Young-Mee; Shin, Bong-Kyung; Lee, Hyun-Joo; Park, Soojin; Kim, Han-Kyeom

A study of bioethical knowledge and perceptions in Korea.

Abstract: This study assessed the knowledge and perception of human biological materials (HBM) and biorepositories among three study groups in South Korea. The relationship between the knowledge and the perception among different groups was also examined by using factor and regression analyses. In a self-reporting survey of 440 respondents, the expert group was found more likely to be knowledgeable and positively perceived than the others. Four factors emerged: Sale and Consent, Flexible Use, Self-Confidence, and Korean Bioethics and Biosafety Action restriction perception. The results indicate that those who are well aware of the existence of biobanks were more positively inclined to receive the Sale and Consent perception. As a result of the need for high quality HBMs and the use of appropriate sampling procedures for every aspect of the collection and use process, the biorepository community should pay attention to ethical, legal, and policy issues.

Document 123

Rowlands, Sam

Sharing personal information: how to decide whether to or not.
The Journal of Family Planning and Reproductive Health Care / Faculty of Family Planning & Reproductive Health Care, Royal College of Obstetricians & Gynaecologists 2010 Jul; 36(3): 161-5

Document 124

Phillips, Win; Fleming, David A

Moral and prudential considerations in adopting electronic medical records.
Missouri medicine 2010 Jul-Aug; 107(4): 234-9

Abstract: One might argue that beneficence entails a moral obligation for health care providers and systems to adopt electronic medical records (EMR). But this argument is thwarted because EMR systems are currently not required to meet existing standards of care for health care services. Yet using EMR systems may still be prudent if benefits of adoption significantly outweigh burdens. Future moral questions regarding EMR systems will shift from obligations of adoption to that of proper use.

Document 125

Griffith, Richard; Tengnah, Cassam

Access to health records: the rights of the patient.
British journal of community nursing 2010 Jul; 15(7): 344-7

Abstract: From time to time patients will ask to see or request a copy of the records made about them and the treatment they received from district nurses and other health professionals. While district nurses can informally allow a patient to see the content of the records they use, a request to view or have a copy of the wider health record requires a formal request for access under the Data Protection Act 1998. This article considers the requirements for requesting and granting access to a patient to view and obtain a copy of their health record.
Document 126
McDavid, Jan P
Privacy and security become financial concern under HITECH Act.
Revenue-cycle strategist 2010 Jul-Aug; 7(7): 6-7
Georgetown users check Georgetown Journal Finder for access to full text

Document 127
Kostorz, Peter; Ostermann, Rüdiger
[Implementing new information technologies in nursing: legal aspects] = Implementierung neuer Informationstechnologien in der Pflege: Juristische Aspekte.
Pflege Zeitschrift 2010 Jul; 63(7): 411-4
Georgetown users check Georgetown Journal Finder for access to full text

Document 128
Ewald, Fia
[How much do health care services need to know about us?] = Hur mycket behöver sjukvården veta om oss?
Läkartidningen 2010 Jun 9; 107(23): 1561
Georgetown users check Georgetown Journal Finder for access to full text

Document 129
O'Connell, Tom
GMC guidance on confidentiality.
Georgetown users check Georgetown Journal Finder for access to full text

Document 130
Pinta, Emil R
Tarasoff duties in prisons: community standards with certain twists.
The Psychiatric quarterly 2010 Jun; 81(2): 177-82
Abstract: Because inmates' actions are restricted by incarceration, Tarasoff duties in prisons have certain unique aspects. There are two broad situations: (1) when the potential victim is located within the prison community; and (2) when the potential victim is located outside of prison. Although responsibilities vary widely from state to state, this paper discusses general principles of exercising Tarasoff duties in prison settings. In addition to duties to protect potential victims, correctional mental-health professionals have an ethical duty to protect patient confidentiality. Professionals should chose Tarasoff options that protect confidentiality to the fullest extent possible, and prisoners should be informed of situations where confidentiality does not exist. A caveat is that no Tarasoff statutes can be relied upon to offer tort protection to correctional clinicians until they have been tested in appellate courts.
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Document 131
Gibson, Mike
**Mental illness and the workplace.**

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Document 132
Forbes, Thomas L
**Informed consent: what level of risk to disclose with carotid artery endarterectomy?**

**Abstract:** You are asked to see a 65-year-old man with an asymptomatic high-grade carotid artery stenosis. He is otherwise quite healthy, is receiving appropriate medical management, and has no contraindications for surgery. You recommend a carotid endarterectomy (CEA) as the best prophylactic measure against stroke. During the informed consent process, the patient asks for a specific estimate of the risks. What specific level of risk should you quote to your patient?

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Document 133
Lau, Catherine K; Schumacher, Hagen H A; Irwin, Michael S
**Patients' perception of medical photography.**

**Abstract:** INTRODUCTION: With the advent of digital medical photography, a balance between technological possibility and ethical acceptability is necessary. An understanding of patients' perception is vital in maintaining a healthy doctor-patient relationship and the avoidance of unnecessary medico-legal consequences. To explore this, an anonymous patient questionnaire survey was conducted. METHODS: Ethically approved questionnaires were distributed in our plastic surgery clinics. The questionnaires examine patients' acceptability of the use of identifiable and non-identifiable photography for different purposes including teaching, presentation, publication and internet. Patients' preferences on equipment used and who should view their images were also recorded. 205 completed questionnaires were analysed and statistically assessed. RESULTS: There was a low level of acceptability to the use of personal cameras (16%) and phones (12%) compared to hospital equipment (75% p<0.001). The use of non-identifiable photographs was more acceptable for all purposes (p<0.001). Electronic distribution was less favoured (p<0.001). Patients agreed to have their photographs used by treating doctors (98%), other doctors (74%), for student teaching (82%) or patient education (88%). CONCLUSION: Medical photography is acceptable to most patients. Appropriate consent and equipment would maximise patient compliance and clinical benefits. Our discussion with medical professional and defence organisation provide a portrait of current perspectives.

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Document 134
Slovak, Andy
**GMC guidance on confidentiality.**
Occupational medicine (Oxford, England) 2010 May; 60(3): 236

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Document 135
Document 136

Raymond, Colette

Taking aim at medical identity theft. Document security key element to comply with government regulations.

Abstract: Sensitive paper documents, such as patient records, customer data, and legal information, must be securely stored and destroyed when no longer needed. This is not only a good business practice that reduces costs and protects reputations, but also a legal and regulatory imperative. According to some experts, medical identity theft is the fastest-growing form of identity theft in North America. The Federal Trade Commission's Red Flags Rule, due to take effect June 1, 2010, requires banks; credit card companies; and, in some situations, retailers, hospitals, insurance companies, health clinics, and other organizations to store confidential personal information that can expose consumers to significant identity theft risks. This also includes healthcare providers and other organizations that are considered creditors according to their billing/payment procedures. This article highlights the steps healthcare providers must take to ensure data security.

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Document 137

Clark, John R

Social media and privacy.

Air medical journal 2010 May-Jun; 29(3): 104-7

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Document 138

Elger, Bernice; Michaud, Katarzyna; Mangin, Patrice

When information can save lives: the duty to warn relatives about sudden cardiac death and environmental risks.

Abstract: In certain cases of sudden death, forensic experts may discover during an investigation or autopsy that family members of the deceased are also at risk of harm-from genetic disease, for instance. But do they have a duty to warn them? Looking at similar duties of physicians and researchers to warn third parties of risk suggests they do.

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Document 139

Elger, Bernice; Michaud, Katarzyna; Mangin, Patrice

When information can save lives: the duty to warn relatives about sudden cardiac death and environmental risks


Abstract: If a physician realizes somebody is at genetic risk for a potentially fatal, genetically caused condition, she not only has a duty to warn that person about the risk. She may even have a duty to warn the person's relatives that they may also be at risk. But genetic testing is not the only way we learn about such conditions, and doctors are not the only people who acquire such knowledge. At least in certain cases, forensic experts also acquire important medical knowledge and shoulder a similar burden: they, too, can have a duty to inform family members that they may be at risk for serious harm from, for example, cardiac disease or exposure to environmental toxins. In cases of
sudden death and exposure to toxic agents, for example, the forensic expert-who, depending on the country, may be called a medical examiner or a forensic pathologist-is usually the first and only person aware of the risk for family members.

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Document 140
Gallagher, Lisa A
**Revisiting HIPAA.**
Nursing management 2010 Apr; 41(4): 34-9; quiz 39-40

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Document 141
Popovits, Renée M
**Confidentiality law: time for change?**
Behavioral healthcare 2010 Apr; 30(4): 11-3

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Document 142
Satkoske, Valerie B; Parker, Lisa S
**Practicing preventive ethics, protecting patients: challenges of the electronic health record.**
The Journal of clinical ethics 2010 Spring; 21(1): 36-8

Abstract: Implementation of guidelines regarding breaches of electronic health information requires an anticipatory stance and physician and patient education regarding security and monitoring measures and methods of redress. Adopting a preventive ethics, rather than a crisis management, model may also increase physician awareness of how the information they choose to include and privilege within the health record may expose patients to added harms if not done mindfully.

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Document 143
Sade, Robert M
**Breaches of health information: are electronic records different from paper records?**

Abstract: Breaches of electronic medical records constitute a type of healthcare error, but should be considered separately from other types of errors because the national focus on the security of electronic data justifies special treatment of medical information breaches. Guidelines for protecting electronic medical records should be applied equally to paper medical records.

Georgetown users check [Georgetown Journal Finder](http://www.thehastingscenter.org/Publications/HCR/Archive.aspx) for access to full text

Document 144
Hoffman, Sharona
**Breach notification and the law.**
Abstract: The American Medical Association Council on Ethical and Judicial Affairs (CEJA) has written a position paper on physicians' ethical responsibilities in the event that the security of patients' electronic health information has been breached. The report offers compelling ethical and practical justifications for notification requirements and articulates guidelines for clinicians. This commentary addresses a gap in the report. It outlines the new legal duty to disclose security breaches, established by the 2009 HITECH Act, which is only briefly mentioned in the report. The commentary also analyzes the CEJA recommendations in light of the legal mandate and suggests that the guidance would benefit from further clarification.

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**Document 150**
Guo, Shesen; Zhang, Ganzhou; Zhai, Run; Mitchell, Tom

*Applying privacy guidelines [letter and reply]*
Science 2010 March 12; 327(5971): 1326-1327

Georgetown users check [Georgetown Journal Finder](http://www.sciencemag.org/content/vol327/issue5971/) for access to full text

**Document 151**
Dare, Tim

*Deceiving third parties.*

Georgetown users check [Georgetown Journal Finder](http://www.sciencemag.org/content/vol327/issue5971/) for access to full text

**Document 152**
Liu, H.

*Use and disclosure of health information and protection of patient privacy in Taiwan*

Georgetown users check [Georgetown Journal Finder](http://www.sciencemag.org/content/vol327/issue5971/) for access to full text

**Document 153**
Searson, Sheila; Hicks, Joan; Cole, Jennifer; Herzig, Terrell; Brooks, C Michael

*HIPAA for cancer educators: are you correctly using PHI?*

**Abstract:** Privacy and confidentiality policies and practices, including Health Insurance Portability and Accountability Act (HIPAA) policies, may vary from institution to institution because they are developed to be institution-specific. HIPAA privacy and security regulations represent the minimum standards, and the expectation is that institutions will develop policies and practices that are reasonable and appropriate for their institution. These privacy and information security safeguards impact the use of sensitive and protected data often used by cancer educators. Therefore, it is important for cancer educators to be familiar with the policies, rules, and guidelines their institution has developed to comply with HIPAA. However, despite institutional differences, certain principles related to the confidentiality, protection, and uses of a patient's health information remain consistent. HIPAA provides two sets of regulations that directly impact the work of many cancer educators: privacy and information security. The HIPAA Privacy Rule includes some security requirements, and HIPAA Security Regulations were designed to ensure privacy of the patient's protected health information (PHI). This paper focuses primarily on the privacy factors.

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**Document 154**
Klote, Mary; Brosch, Laura R

*Respecting our patients by respecting their records.*
Military medicine 2010 Mar ; 175(3): 136-7

Georgetown users check [Georgetown Journal Finder](http://www.sciencemag.org/content/vol327/issue5971/) for access to full text
**Document 155**

Benitez, Kathleen; Malin, Bradley

**Evaluating re-identification risks with respect to the HIPAA privacy rule.**


**Abstract:** OBJECTIVE: Many healthcare organizations follow data protection policies that specify which patient identifiers must be suppressed to share "de-identified" records. Such policies, however, are often applied without knowledge of the risk of "re-identification". The goals of this work are: (1) to estimate re-identification risk for data sharing policies of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule; and (2) to evaluate the risk of a specific re-identification attack using voter registration lists. MEASUREMENTS: We define several risk metrics: (1) expected number of re-identifications; (2) estimated proportion of a population in a group of size g or less, and (3) monetary cost per re-identification. For each US state, we estimate the risk posed to hypothetical datasets, protected by the HIPAA Safe Harbor and Limited Dataset policies by an attacker with full knowledge of patient identifiers and with limited knowledge in the form of voter registries. RESULTS: The percentage of a state's population estimated to be vulnerable to unique re-identification (ie, g=1) when protected via Safe Harbor and Limited Datasets ranges from 0.01% to 0.25% and 10% to 60%, respectively. In the voter attack, this number drops for many states, and for some states is 0%, due to the variable availability of voter registries in the real world. We also find that re-identification cost ranges from $0 to $17,000, further confirming risk variability. CONCLUSIONS: This work illustrates that blanket protection policies, such as Safe Harbor, leave different organizations vulnerable to re-identification at different rates. It provides justification for locally performed re-identification risk estimates prior to sharing data.

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**Document 156**

Kim, Daniel; Schleiter, Kristin; Crigger, Bette-Jane; McMahon, John W.; Benjamin, Regina M.; Douglas, Sharon P.

**A physician's role following a breach of electronic health information.**

Journal of Clinical Ethics 2010 Spring; 21(1): 30-35

**Abstract:** The Council on Ethical and Judicial Affairs of the American Medical Association examines physicians' professional ethical responsibility in the event that the security of patients' electronic records is breached.

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**Document 157**

Satkoske, Valerie B.; Parker, Lisa S.

**Practicing preventive ethics, protecting patients: challenges of the electronic health record.**

Journal of Clinical Ethics 2010 Spring; 21(1): 36-38

**Abstract:** Implementation of guidelines regarding breaches of electronic health information requires an anticipatory stance and physician and patient education regarding security and monitoring measures and methods of redress. Adopting a preventive ethics, rather than a crisis management, model may also increase physician awareness of how the information they choose to include and privilege within the health record may expose patients to added harms if not done mindfully.

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**Document 158**

Sade, Robert M.

**Breaches of health information: are electronic records different from paper records?**

Journal of Clinical Ethics 2010 Spring; 21(1): 39-41

**Abstract:** Breaches of electronic medical records constitute a type of healthcare error, but should be considered separately from other types of errors because the national focus on the security of electronic data justifies special treatment of medical information breaches. Guidelines for protecting electronic medical records should be applied.
equally to paper medical records.

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**Document 159**

Hoffman, Sharona

**Breach notification and the law.**

Journal of Clinical Ethics 2010 Spring; 21(1): 42-43

*Abstract:* The American Medical Association Council on Ethical and Judicial Affairs (CEJA) has written a position paper on physicians' ethical responsibilities in the event that the security of patients' electronic health information has been breached. The report offers compelling ethical and practical justifications for notification requirements and articulates guidelines for clinicians. This commentary addresses a gap in the report. It outlines the new legal duty to disclose security breaches, established by the 2009 HITECH Act, which is only briefly mentioned in the report. The commentary also analyzes the CEJA recommendations in light of the legal mandate and suggests that the guidance would benefit from further clarification.

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**Document 160**

Nayeri, Nahid Dehghan; Aghajani, Mohammad

**Patients' privacy and satisfaction in the emergency department: a descriptive analytical study.**

Nursing Ethics 2010 March; 17(2): 167-177

*Abstract:* Respecting privacy and patients' satisfaction are amongst the main indicators of quality of care and one of the basic goals of health services. This study, carried out in 2007, aimed to investigate the extent to which patient privacy is observed and its correlation with patient satisfaction in three emergency departments of Tehran University of Medical Science, Iran. Questionnaire data were collected from a convenience sample of 360 patients admitted to emergency departments and analysed using SPSS software. The results indicated that, according to 50.6% of the patients, the extent to which their privacy was respected was described as either 'weak' or 'average'. Spearman's coefficient indicated a significant correlation between respecting privacy and the patients' satisfaction about the various aspects of privacy studied. Considering the levels of privacy observed together with the patients' degree of satisfaction, it is imperative that clinical professionals address both aspects from conceptual and practical viewpoints.

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**Document 161**

Coggon, John; Wheeler, Robert

**Confidence and conflicts of duty in surgery.**


*Abstract:* This paper offers an exploration of the right to confidentiality, considering the moral importance of private information. It is shown that the legitimate value that individuals derive from confidentiality stems from the public interest. It is re-assuring, therefore, that public interest arguments must be made to justify breaches of confidentiality. The General Medical Council's guidance gives very high importance to duties to maintain confidences, but also rightly acknowledges that, at times, there are more important duties that must be met. Nevertheless, this potential conflict of obligations may place the surgeon in difficult clinical situations, and examples of these are described, together with suggestions for resolution.

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**Document 162**

Wartenberg, Daniel; Thompson, W. Douglas

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Privacy versus public health: the impact of current confidentiality rules.
American Journal of Public Health 2010 March; 100(3): 407-412

Abstract: Public health research and practice often have been facilitated through the evaluation and study of population-based data collected by local, state, and federal governments. However, recent concerns about identify theft, confidentiality, and patient privacy have led to increasingly restrictive policies on data access, often preventing researchers from using these valuable data. We believe that these restrictions, and the research impeded or precluded by their implementation and enforcement, have had a significant negative impact on important public health research. Members of the public health community should challenge these policies through their professional societies and by lobbying legislators and health officials to advocate for changes that establish a more appropriate balance between privacy concerns and the protection of public health.

http://ajph.aphapublications.org/content/vol100/issue3/ (link may be outdated)

Document 163
Health care organizations can report privacy concerns to Joint Commission.
Joint Commission perspectives. Joint Commission on Accreditation of Healthcare Organizations 2010 Feb; 30(2): 6-7

Document 164
Tamin, Jacques
GMC guidance on confidentiality: is it ethical?

Document 165
Rueff, Maria do Céu
Acta médica portuguesa 2010 Jan-Feb; 23(1): 141-8

Abstract: This paper deals with the historical development of the legal protection of medical confidentiality in Portugal. Situations that have lead to its relativization, and the present Portuguese legal framework (Criminal Code and the Code of Professional Ethics of the Ordem dos Médicos) are analysed. Finally, the paper focuses on the implementation of the legal framework, taking into account the specific situation of HIV/AIDS.

Document 166
Confidentiality in adolescent health care.

Document 167
Commentary: Tarasoff duties arising from a forensic independent medical examination.
Abstract: The question of whether a Tarasoff duty may emerge from a credible threat by an examinee during an independent medical examination has not been extensively addressed in the professional literature. This article analyzes that question and provides suggestions for how to respond to a perceived duty.

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Response. Nurse's professional misconduct regarding confidentiality.
Nursing Ethics 2010 January; 17(1): 133-134; discussion 135-136

Georgetown users check Georgetown Journal Finder for access to full text

STEDMAN'S GUIDE TO THE HIPAA PRIVACY & SECURITY RULES

MEDYCHNE PRAVO UKRAINY: PRAVOVE ZABEZPECHENNIA LIKARS'KOI TAIEMNYTSI: MONOHRAFIIA

LEGAL ASPECTS OF PATIENT CONFIDENTIALITY

The Medical Studies Act and allied medical societies: looking back at Niven v. Siqueira twenty-five years later.
Annals of health law / Loyola University Chicago, School of Law, Institute for Health Law 2010; 19(1 Spec No): 183-8

Status of the psychiatric duty to protect, circa 2006.
**Abstract:** States have responded to the Tarasoff duty to protect by passing statutes in all but 13 states. Such statutes either mandate or permit warning a potential victim. In this study, we analyzed 70 Tarasoff-related cases from a Westlaw-based search between 1985 and 2006. We determined the extent to which clinicians are being held liable for breach of the Tarasoff duty in statutory and nonstatutory states, whether there is language in the statutes that permits warning compared with statutes that mandate warning, and whether recent Tarasoff decisions better reflect the inherent ambiguities in clinical mental health practice. We found 70 appellate cases, and only 6 were plaintiff verdicts. Statutes that mandate warning a victim appear to be the most protective of clinicians. Seven of the 17 remanded cases came from the jurisdictions with permission-to-warn statutes, suggesting that permission rather than a strict mandate to warn may increase the liability for clinicians. Notwithstanding the language of statutes, the protections from Tarasoff are not extended to poor clinical judgment, particularly in the controlled inpatient setting.

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**Document 174**

Fox, Patrick K

**Commentary:** so the pendulum swings—making sense of the duty to protect.

**Abstract:** Psychiatry has been struggling for nearly 40 years to make sense of the duty to protect. The great jurisdictional disparity as to what constitutes the duty has been a significant contributing factor. The American Psychiatric Association (APA) released the Model Statute in 1987 to establish a framework to guide legislators and courts toward consensus, to some effect. In response to case law and statutory requirements in most states, psychiatric practice has incorporated the assessment of risk to third parties by patients as an essential element of psychiatric assessment and care. Although court cases shortly after the Tarasoff decision expanded the scope and breadth of the duty to protect, in recent years there appears to have been a shift toward a more narrow interpretation as to what conditions must exist to find a defendant psychiatrist guilty of failing to exercise the duty properly. The threshold for the duty to warn or protect often rests precariously beside the criteria permitting an exception to confidentiality, placing the psychiatrist in a tenuous position. If appellate verdicts continue to find for the defendant psychiatrist in cases claiming a breach of the duty to protect, it could have an impact on how psychiatrists assess and manage threats made by patients toward third parties.

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**Document 175**

Rodwin, Marc A

**Patient data: property, privacy & the public interest.**
American journal of law & medicine 2010; 36(4): 586-618

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**Document 176**

Boldt, Richard C

**Confidentiality of alcohol and other drug abuse treatment information for emergency department and trauma center patients.**
Health matrix (Cleveland, Ohio : 1991) 2010; 20(2): 387-422

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**Document 177**

Maehle, Andreas-Holger; Pranghofer, Sebastian

**Medical confidentiality in the late nineteenth and early twentieth centuries: an Anglo-German comparison.**
Medizinhistorisches Journal 2010; 45(2): 189-221
Abstract: Professional secrecy of doctors became an issue of considerable medico-legal and political debate in the late nineteenth and early twentieth centuries in both Germany and England, although the legal preconditions for this debate were quite different in the two countries. While in Germany medical confidentiality was a legal obligation and granted in court, no such statutory recognition of doctors' professional secrecy existed in England. This paper is a comparative analysis of medical secrecy in three key areas--divorce trials, venereal disease and abortion--in both countries. Based on sources from the period between c.1870 and 1939, our paper shows how doctors tried to define the scope of professional secrecy as an integral part of their professional honour in relation to important matters of public health.

Document 178
Walfish, Steven; Barnett, Jeffrey E.; Marlyere, Krista; Zielke, Robert
"Doc, there's something I have to tell you": patient disclosure to their psychotherapist for unprosecuted murder and other violence
Ethics & Behavior 2010; 20(5): 311-323

Document 179
European Commission
Consultation on the legal framework for the fundamental right to protection of personal data
Ethically Speaking 2009 December; 13: 59

Document 180
Privacy impact assessment in the design of transnational public health information systems: the BIRO project.
Journal of Medical Ethics 2009 December; 35(12): 753-61

Abstract: OBJECTIVES: To foster the development of a privacy-protective, sustainable cross-border information system in the framework of a European public health project. MATERIALS AND METHODS: A targeted privacy impact assessment was implemented to identify the best architecture for a European information system for diabetes directly tapping into clinical registries. Four steps were used to provide input to software designers and developers: a structured literature search, analysis of data flow scenarios or options, creation of an ad hoc questionnaire and conduction of a Delphi procedure. RESULTS: The literature search identified a core set of relevant papers on privacy (n = 11). Technicians envisaged three candidate system architectures, with associated data flows, to source an information flow questionnaire that was submitted to the Delphi panel for the selection of the best architecture. A detailed scheme envisaging an "aggregation by group of patients" was finally chosen, based upon the exchange of finely tuned summary tables. CONCLUSIONS: Public health information systems should be carefully engineered only after a clear strategy for privacy protection has been planned, to avoid breaching current regulations and future concerns and to optimise the development of statistical routines. The BIRO (Best Information Through Regional Outcomes) project delivers a specific method of privacy impact assessment that can be conveniently used in similar situations across Europe.
Document 181
Bilimoria, Neville M

**HIPAA Privacy/Security Rules: where we've been and where we are going.** Updates from the HITECH Act to dramatically impact HIPAA privacy/security.

Georgetown users check [Georgetown Journal Finder](http://www.bmj.com) for access to full text

Document 182
Gilliat, Jack

**GMC guidance on confidentiality** [letter]
British Medical Journal 2009 October 17; 339(7726): 877

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[http://www.bmj.com](http://www.bmj.com) (link may be outdated)

Document 183
Wertheim, Heiman F.L.; Farrar, Jeremy; Horby, Peter

**Online video sharing and patients' privacy** [perspectives]
British Medical Journal 2009 October 3; 339(7724): 782

Georgetown users check [Georgetown Journal Finder](http://www.bmj.com) for access to full text

[http://www.bmj.com](http://www.bmj.com) (link may be outdated)

Document 184
Cascardo, Debra

**Getting ready for identity theft rules: creating a prevention program for your medical practice.**

**Abstract:** Identity theft worries have found their way into medical practices. By August 1, 2009, all "creditors" must have a written program to prevent, detect, and minimize damage from identity theft. Any medical practice that bills patients is considered a creditor. Like HIPAA, these new Red Flag guidelines will serve to protect your practice from lawsuits as well as protect your patients from identity theft of their financial, personal, and medical information.

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Document 185
Petrini, Carlo

**A bibliography concerning informed consent and biobanking: documents from national and international bodies.**

**Abstract:** The article contains a list of national and international documents addressing the ethical aspects of biobanking, which were drafted by national bioethics committees; national ad hoc commissions; and national and international agencies, organizations, and societies. The greater part of the documents specifically focuses on questions involving the ethics of informed consent for biobanking. The documents are grouped according to the nature of the promulgating body, and are listed alphabetically within each group according to the promulgating body. Special attention is devoted to documents issued by the European Union and the Council of Europe.
Several organizations in the United States have a major interest in creating, testing, and using methods of data presentation that respect privacy and assure confidentiality. The following are among those that do so, and provide up-to-date information on these topics for the benefit of others who conduct human research: (1) The Committee on Privacy and Confidentiality of the American Statistical Association; (2) an interagency committee of the federal government, the Federal Committee on Statistical Methodology, and its subcommittees, the Confidentiality and Data Access Committee and the Committee on Privacy; (3) the Inter-university Consortium for Political and Social Research (University of Michigan), whose core mission is to archive important social science data, provide open and equitable access to data, and promote the effective use of data; and (4) Carnegie Mellon University's Department of Statistics, which has created an open-access online journal, the Journal on Privacy and Confidentiality. These resources are described, and URLs are provided to give readers web access to these resources.

http://caliber.ucpress.net/loi/jer (link may be outdated)
Abstract: Medical confidentiality is a core concept of professionalism and should be an integral part of pregraduate and postgraduate medical education. The aim of our study was to define the factors influencing attitudes towards patient confidentiality in everyday situations in order to define the need for offering further education to various subgroups of physicians. All internists and general practitioners who were registered members of the association of physicians in Geneva or who were working in the department of internal medicine or in the medical polyclinic of the University Hospital of Geneva in 2004 received a standardised questionnaire. Physicians were asked to indicate for seven vignettes whether a violation of confidentiality had occurred and whether the violation was not important, important or serious (scores 1-3; no violation = 0). 508 completed questionnaires were returned (participation rate 55%). Physicians who had worked in the hospital for more than 20 years identified violations of confidentiality more often than physicians with less hospital experience. Binary logistic regression showed that ethics education, total years of professional experience, being an internist, having a private practice, the length of working in private practice and gender were factors associated with correct identification of violations and their severity. However, each factor played a specific role only for single cases or a small number of situations (Cronbach alpha <0.6). Postgraduate education programs on confidentiality should be offered to a wide range of physicians and should address specific hypothetical situations in which there is a risk of avoidable breaches of confidentiality.

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**Document 191**

Nuffield Council on Bioethics

**Medical profiling and online medicine: The ethics of "personalised" health care in a consumer age: consultation paper**


[http://www.nuffieldbioethics.org/go/print/ourwork/personalisedhealthcare/introduction](http://www.nuffieldbioethics.org/go/print/ourwork/personalisedhealthcare/introduction) (link may be outdated)

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**Document 192**

Connors, Bill; Leipold, John

**The 42 CFR Part 2 and NHIN conundrum.**

Behavioral healthcare 2009 Jul-Aug; 29(7): 52-3

Georgetown users check [Georgetown Journal Finder](http://jme.bmj.com) for access to full text

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**Document 193**

Kandula, Namratha R; Hasnain-Wynia, Romana; Thompson, Jason A; Brown, E Richard; Baker, David W

**Association between prior experiences of discrimination and patients' attitudes towards health care providers collecting information about race and ethnicity.**

Journal of general internal medicine 2009 Jul; 24(7): 789-94

**Abstract:** Previously, we reported a high level of comfort among Californians for collecting race/ethnicity information by health care providers (HCPs). However, minorities were less comfortable providing race/ethnicity information and were more worried than non-Hispanic whites about the potential misuse of this information.

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**Document 194**

Crownover, Keith

**Implications of the HITECH Act of 2009.**

Caring : National Association for Home Care magazine 2009 Jul; 28(7): 40-2
Document 195

Couraud, Sébastien; Arpin, Dominique; Perol, Maurice; Guérin, Jean-Claude; Gérinière, Laurence; Deygas, Serge; Rhomer, Benjamin; Audras, Stéphanie; Bertoletti, Laurent; Cortot, Alexis; Coudurier, Marie; Girard, Nicolas

[Confidentiality in medical practice: tell no one] = Le secret médical à tout prix?
Bulletin du cancer 2009 July-August; 96(7): 791-795

Document 196

Ford, Paul J.; DeMarco, Joseph P.
Anonymous phone calls [case study and commentaries]
Hastings Center Report 2009 July-August; 39(4): 11-12

Document 197

Sheather, Julian
Confidentiality and sharing health information [editorial]
BMJ: British Medical Journal 2009 June 20; 338(7709): 1458

Document 198

Cole, Andrew
Sharing patient data should not be based on implied consent [news]
BMJ: British Medical Journal 2009 June 20; 338(7709): 1463

Document 199

Strous, R.D.
To protect or to publish: confidentiality and the fate of the mentally ill victims of Nazi euthanasia
Journal of Medical Ethics 2009 June; 35(6): 361-364

Abstract: In Nazi Germany, approximately 200,000 mentally ill people were murdered under the guise of euthanasia. Relatively little is known regarding the fate of the Jewish mentally ill patients targeted in this process, long before the Holocaust officially began. For the Nazis, Jewish mentally ill patients were doubly cursed since they embodied both "precarious genes" and "racial toxin". To preserve the memory of the victims, Yad Vashem, the leading institution dedicated to documentation of the Holocaust, actively collects information and documents the fate of victims in an open online database. Recently, a list of approximately 1200 names of Jewish mentally ill euthanasia victims has been compiled from hospital archives. Their fate remains unknown to surviving family members. Given the duty to preserve medical confidentiality, can this list be publicised for public interest and for notifying families—publicising
names and death circumstances, including where "killed" would immediately indicate that the person had had a mental illness? Does the right to medical confidentiality lapse upon death? Is time elapsed since death a factor? Can opposing obligations of preserving victims' memory over-ride medical confidentiality? What if a family member objects to a grandparent's name being exposed on the list of mentally ill patients? This article considers these issues as well as the "rational" and "non-rational" factors in ethical decisional making surrounding this unique dilemma. Several possible solutions are proposed including preserving the list in a locked database for access by families and researchers, publicising in the media that such a list exists, publishing the information online without any identifiers and submitting the information to historians, allowing them to process the data as they see fit.

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http://jme.bmj.com (link may be outdated)

* Document 200
Appel, Jacob
Must physicians report impaired driving? Rethinking a duty on a collision course with itself.
Journal of Clinical Ethics 2009 Summer; 20(2): 136-140
Georgetown users check Georgetown Journal Finder for access to full text

* Document 201
Toon, Peter D.
"I need a note, doctor": dealing with requests for medical reports about patients
BMJ: British Medical Journal 2009 May 2; 338(7702): 1072-1076
Georgetown users check Georgetown Journal Finder for access to full text

http://www.bmj.com (link may be outdated)

* Document 202
Witry, Matthew J.; Doucette, William R.
Obtaining patient test results from clinical laboratories: a survey of state law for pharmacists.
Journal of the American Pharmacists Association 2009 May-June; 49(3): 423-426
Georgetown users check Georgetown Journal Finder for access to full text

* Document 203
Georgia: Infected man sues CDC over release of medical information
New York Times 2009 April 30; p. A17

http://www.nytimes.com (link may be outdated)

* Document 204
Hoemi, B
Discretion = Discrétion.
Revue médicale suisse 2009 April 15; 5(199): 864

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* Document 205
Gostin, Lawrence O.; Nass, Sharyl
Reforming the HIPAA Privacy Rule: safeguarding privacy and promoting research.
JAMA: The Journal of the American Medical Association 2009 April 1; 301(13): 1373-1375
Georgetown users check Georgetown Journal Finder for access to full text

http://jama.ama-assn.org/ (link may be outdated)

Document 206
Birnbaum, Cassi L
Addressing California's new privacy laws.
Journal of AHIMA / American Health Information Management Association 2009 Apr 80(4): 50-1, 57
Georgetown users check Georgetown Journal Finder for access to full text

Document 207
Rakestraw, Eric
One size doesn’t fit all: why HIPAA should not be extended to cover PHRs
Journal of Legal Medicine 2009 April-June; 30(2): 269-287
Georgetown users check Georgetown Journal Finder for access to full text

Document 208
Gallo, Agatha M.; Angst, Denise B.; Knafl, Kathleen A.
Disclosure of genetic information within families.
American Journal of Nursing 2009 April; 109(4): 65-69
Georgetown users check Georgetown Journal Finder for access to full text

http://journals.lww.com/ajnonline/pages/default.aspx (link may be outdated)

* Document 209
Foy, Patrick J.
What are the ethical considerations surrounding a minor’s request for confidentiality?
Journal of the American Dental Association 2009 April; 140(4): 481-482
Georgetown users check Georgetown Journal Finder for access to full text

Document 210
Kmietowicz, Zosia
Government removes data sharing clause from coroners' bill [news]
BMJ: British Medical Journal 2009 March 14; 338(7695): 618
Georgetown users check Georgetown Journal Finder for access to full text
Document 211
Nathanson, Vivienne
Amendments to the Coroners and Justice Bill [editorial]
BMJ: British Medical Journal 2009 March 7; 338(7694): 555-556
Georgetown users check Georgetown Journal Finder for access to full text

Document 212
Nelson, Bruce; Eller, Tina
3 steps for improving 'red flag' compliance.
Georgetown users check Georgetown Journal Finder for access to full text

Document 213
Guedj, Marie-Jeanne
[2/6 Medical confidentiality] = 2/6 Le secret médical.
Soins. Psychiatrie 2009 Mar-Apr; (261): 45-6
Georgetown users check Georgetown Journal Finder for access to full text

Document 214
Marquard, Jenna L.; Brennan, Patricia Flatley
Crying wolf: consumers may be more willing to share medication information than policymakers think.
Journal of Healthcare Information Management 2009 Spring; 23(2): 26-32
Georgetown users check Georgetown Journal Finder for access to full text

Document 215
Gravely, Steve D.; Whaley, Erin S.
The next step in health data exchanges: trust and privacy in exchange networks.
Journal of Healthcare Information Management 2009 Spring; 23(2): 33-37
Georgetown users check Georgetown Journal Finder for access to full text

Document 216
Marshall, Glen F.; Gillespie, William; Fox, Steven J.
* Document 217
Guedj, Myriam; Sastre, Maria Teresa Muñoz; Mullet, Etienne; Sorum, Paul Clay
Is it acceptable for a psychiatrist to break confidentiality to prevent spousal violence?

* Document 218
McGraw, Deven; Dempsey, James X.; Harris, Leslie; Goldman, Janlori
Privacy as an enabler, not an impediment: building trust into health information exchange
Health Affairs 2009 March-April; 28(2): 416-427

* Document 219
Dimitropoulos, Linda; Rizk, Stephanie
A state-based approach to privacy and security for interoperable health information exchange
Health Affairs 2009 March-April; 28(2): 428-434

* Document 220
Kendall, David B.
Protecting patient privacy through health record trusts
Health Affairs 2009 March-April; 28(2): 444-446

* Document 221
McDonald, Clement
Protecting patients in health information exchange: a defense of the HIPAA privacy rule
Health Affairs 2009 March-April; 28(2): 447-449

* Document 222
Greenberg, Michael D.; Ridgely, M. Susan; Hillestad, Richard J.
Crossed wires: how yesterday's privacy rules might undercut tomorrow's nationwide health information network
Health Affairs 2009 March-April; 28(2): 450-452
* Document 223
Diamond, Carol C.; Mostashari, Farzad; Shirky, Clay
Collecting and sharing data for population health: a new paradigm
Health Affairs 2009 March-April; 28(2): 454-466
Georgetown users check Georgetown Journal Finder for access to full text

* Document 224
Hey, Edmund
Keeping confidential information confidential. [letter]
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**Abstract:** CONTEXT: Anecdotal reports suggest that the Health Insurance Portability and Accountability Act Privacy Rule (HIPAA Privacy Rule) may be affecting health research in the United States. OBJECTIVE: To survey epidemiologists about their experiences with the HIPAA Privacy Rule. DESIGN, SETTING, AND PARTICIPANTS: Thirteen societies of epidemiology distributed a national Web-based survey; 2805 respondents accessed the survey Web site and 1527 eligible professionals anonymously answered questions. MAIN OUTCOME MEASURES: Responses related influences such as research delays and added cost after Privacy Rule implementation, frequency and type of Privacy Rule-related institutional review board modifications, level of difficulty obtaining deidentified data and waivers, experiences with multisite studies, and perceived participant privacy benefits under the rule. Respondents ranked their perceptions of Privacy Rule influence on 5-point Likert scales. RESULTS: A total of 875 (67.8%) respondents reported that the HIPAA Privacy Rule has made research more difficult at a level of 4 to 5 on a Likert scale, in which 5 indicates a great deal of added cost and time to study completion. A total of 684 (52.1%) of respondents identified a "most affected" protocol. Respondents indicated that the proportion of institutional review board applications in which the Privacy Rule had a negative influence on human subjects (participants) protection was significantly greater than the proportion in which it had a positive influence (P < .001). CONCLUSION: In this national survey of clinical scientists, only a quarter perceived that the rule has enhanced participants' confidentiality and privacy, whereas the HIPAA Privacy Rule was perceived to have a substantial, negative influence on the conduct of human subjects health research, often adding uncertainty, cost, and delay.  
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Gay, E. Greer
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Call number: RC267.C347 2007

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Francis, Theo
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Resident portfolio: breaking trust -- a reflection on confidentiality and minors
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Regan, Judy; Regan, William; Wright, Arvis

**Implied contract of confidentiality between patient and physician.**
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Gold, Liza H.; Metzner, Jeffrey L.

**Psychiatric employment evaluations and the Health Insurance Portability and Accountability Act**

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Olson, Karen L.; Grannis, Shaun J.; Mandl, Kenneth D.

**Privacy protection versus cluster detection in spatial epidemiology**

**Abstract:** OBJECTIVES: Patient data that includes precise locations can reveal patients' identities, whereas data aggregated into administrative regions may preserve privacy and confidentiality. We investigated the effect of varying degrees of address precision (exact latitude and longitude vs the center points of zip code or census tracts) on detection of spatial clusters of cases. METHODS: We simulated disease outbreaks by adding supplementary spatially clustered emergency department visits to authentic hospital emergency department syndromic surveillance data. We identified clusters with a spatial scan statistic and evaluated detection rate and accuracy. RESULTS: More clusters were identified, and clusters were more accurately detected, when exact locations were used. That is, these clusters contained at least half of the simulated points and involved few additional emergency department visits. These results were especially apparent when the synthetic clustered points crossed administrative boundaries and fell into multiple zip code or census tracts. CONCLUSIONS: The spatial cluster detection algorithm performed better when addresses were analyzed as exact locations than when they were analyzed as center points of zip code or census tracts, particularly when the clustered points crossed administrative boundaries. Use of precise addresses offers improved performance, but this practice must be weighed against privacy concerns in the establishment of public health data exchange policies.

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Büken, Erhan; Sahinoglu, Serap; Büken, Nüket Önek

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Brownstein, John S.; Cassa, Christopher A.; Mandl, Kenneth D.

**No place to hide – reverse identification of patients from published maps [letter]**

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Draper, Heather; MacDiarmaid-Gordon, Adam; Strumidlo, Laura; Teuten, Bea; Updale, Eleanor
*Virtual clinical ethics committee, case 3: confidentiality -- what are our obligations to dead patients?*
Clinical Ethics 2006 September; 1(3): 121-129

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Prudil, Lukas
*Privacy and confidentiality -- old concept, new challenges*

Abstract: This paper concerns a privacy and confidentiality problem in cases of exceptional situations. It is primarily aimed at using DNA samples, and at a breach of genetic data protection. European legal provisions are especially mentioned.

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Heikkinen, Anne; Wickström, Gustav; Leino-Kilpi, Helena
*Understanding privacy in occupational health services*
Nursing Ethics 2006 September; 13(5): 515-530

Abstract: The aim of this study was to gain a deeper understanding of privacy in occupational health services. Data were collected through in-depth theme interviews with occupational health professionals (n = 15), employees (n = 15) and employers (n = 14). Our findings indicate that privacy, in this context, is a complex and multilayered concept, and that companies as well as individual employees have their own core secrets. Co-operation between the three groups proved challenging: occupational health professionals have to consider carefully in which situations and how
much they are entitled to release private information on individual employees for the benefit of the whole company. Privacy is thus not an absolute right of an individual, but involves the idea of sharing responsibility. The findings open up useful new perspectives on ethical questions of privacy and on the development of occupational health practices.

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Wilson, Jennifer Fisher

**Health insurance portability and accountability act privacy rule causes ongoing concerns among clinicians and researchers**


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Neubauer, Richard L.; Cruess, Sylvia R.; Cruess, Richard L.

**Paranoia over privacy**

Annals of Internal Medicine 2006 August 1; 145(3): 228-230

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West, Darrell M.; Miller, Edward Alan

**The digital divide in public e-health: barriers to accessibility and privacy in state health department websites.**

Journal of Health Care for the Poor and Underserved 2006 August; 17(3): 652-667

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Thomas, N.; Murray, E.; Rogstad, K.E.

**Confidentiality is essential if young people are to access sexual health services**

International Journal of STD and AIDS 2006 August; 17(8): 525-529

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Levine, Carol

**HIPAA and talking with family caregivers: what does the law really say?**

AJN: American Journal of Nursing 2006 August; 106(8): 51-53

Georgetown users check [Georgetown Journal Finder](http://www.annals.org) for access to full text
Medical privacy and the public's right to vote: what presidential candidates should disclose

Streiffer, Robert; Rubel, Alan P.; Fagan, Julie R.


Abstract: We argue that while presidential candidates have the right to medical privacy, the public nature and importance of the presidency generates a moral requirement that candidates waive those rights in certain circumstances. Specifically, candidates are required to disclose information about medical conditions that are likely to seriously undermine their ability to fulfill what we call the "core functions" of the office of the presidency. This requirement exists because (1) people have the right to be governed only with their consent, (2) people's consent is meaningful only when they have access to information necessary for making informed voting decisions, (3) such information is necessary for making informed voting decisions, and (4) there are no countervailing reasons sufficiently strong to override this right. We also investigate alternative mechanisms for legally encouraging or requiring disclosure. Protecting the public's right to this information is of particular importance because of the documented history of deception and secrecy regarding the health of presidents and presidential candidates.

Understanding confidentiality: perspectives of African American adolescents and their parents

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Murderer loses attempt to keep his medical records secret [news]

Dyer, Clare

BMJ 2006 July 22; 333(7560): 167

Crime victims are given right to object to disclosure of their medical records to courts [news]

Dyer, Clare


U.S. shields doctor data in implants

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Whiddett, Richard; Hunter, Inga; Engelbrecht, Judith; Handy, Jocelyn

Patients' attitudes towards sharing their health information
International Journal of Medical Informatics 2006 July; 75(7): 530-541

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Guedj, M.; Muñoz Sastre, M.T.; Mullet, E.; Sorum, P.C.

Do French lay people and health professionals find it acceptable to breach confidentiality to protect a patient's wife from a sexually transmitted disease?
Journal of Medical Ethics 2006 July; 32(7): 414-419

Abstract: OBJECTIVE: To determine under what conditions lay people and health professionals find it acceptable for a physician to breach confidentiality to protect the wife of a patient with a sexually transmitted disease (STD).
METHODS: In a study in France, breaching confidentiality in 48 scenarios were accepted by 144 lay people, 10 psychologists and 7 physicians. The scenarios were all possible combinations of five factors: severity of the disease (severe, lethal); time taken to discuss this with (little time, much time); intent to inform the spouse about the disease (none, one of these days, immediately); intent to adopt protective behaviours (no intent, intent); and decision to consult an expert in STDs (yes, no), 2 x 2 x 3 x 2 x 2. The importance and interactions of each factor were determined, at the group level, by performing analyses of variance and constructing graphs.
RESULTS: The concept of breaching confidentiality to protect a wife from her husband's STD was favoured much more by lay people and psychologists than by physicians (mean ratings 11.76, 9.28 and 2.90, respectively, on a scale of 0-22). The patient's stated intentions to protect his wife and to inform her of the disease had the greatest impact on acceptability. A cluster analysis showed groups of lay participants who found breaching confidentiality "always acceptable" (n = 14), "depending on the many circumstances" (n = 87), requiring "consultation with an expert" (n = 30) and "never acceptable (n = 13)." CONCLUSIONS: Most people in France are influenced by situational factors when deciding if a physician should breach confidentiality to protect the spouse of a patient infected with STD.

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Erde, E.; Pomerantz, S.C.; Saccocci, M.; Kramer-Feely, V.; Cavalieri, T.A.

Privacy and patient-clergy access: perspectives of patients admitted to hospital
Journal of Medical Ethics 2006 July; 32(7): 398-402

Abstract: BACKGROUND: For patients admitted to hospital both pastoral care and privacy or confidentiality are important. Rules related to each have come into conflict recently in the US. Federal laws and other rules protect confidentiality in ways that countermand hospitals' methods for facilitating access to pastoral care. This leads to conflicts and poses an unusual type of dilemma-one of conflicting values and rights. As interests are elements necessary for establishing rights, it is important to explore patients' interests in privacy compared with their desire for attention from a cleric. AIM: To assess the willingness of patients to have their names and rooms included on a list by religion, having that information given to clergy without their consent, their sense of privacy violation if that were done and their views about patients' privacy rights. Methods and PARTICIPANTS: 179 patients, aged 18-92 years, admitted to hospital in an acute care setting, were interviewed and asked about their preferences for confidentiality and pastoral support. RESULTS: Most (57%) patients did not want to be listed by religion; 58% did not think hospitals should give lists to clergy without their consent and 84% welcomed a visit by their own clergy even if triggered from a hospital list. CONCLUSIONS: Values related to confidentiality or privacy and pastoral care were found to be inconsistent and more complicated than expected. Balancing the right to privacy and the value of religious support continue to present a challenge for hospitals. Patients' preferences support the importance of providing balance in a way that protects rights while offering comprehensive services.
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Rothstein, Mark A.; Schneider, Carl E.
**Is HIPAA flawed, or unnecessary? [letter and reply]**
Hastings Center Report 2006 July-August; 36(4): 6-7

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Rothstein, Mark A.; Talbott, Meghan K.
**Compelled disclosure of health information: protecting against the greatest potential threat to privacy**

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Stein, Rob
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Washington Post 2006 June 5; p. A1, A7

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Shaman, Jeffrey M.
**The right of privacy in state constitutional law**
Rutgers Law Journal 2006 Summer; 37(4): 971-1086

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**Consent, confidentiality and record keeping for the recording and usage of medical images**

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Cancer Causes and Control 2006 June; 17(5): 633-637
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Slowther, Anne-Marie
Sharing information in health care: the nature and limits of confidentiality
Clinical Ethics 2006 June; 1(2): 82-84
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Comerford, John D.
Competent computing: a lawyer's ethical duty to safeguard the confidentiality and integrity of client information stored on computers and computer networks
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Vermaas, Albert
Forced HIV-testing: a blessing for the physician or a worst case scenario for the patient?
Abstract: A ruling by the Court of Appeal in Amsterdam on 18 April 2002 has emphasized that a patient not only has rights but also responsibilities. The issue was whether a physician can violate his medical confidentiality in the patient-doctor relationship as a result of fear of infection with the HIV-virus after an accidental cut during surgery. The aim of the physician was for the award of his claim that the patient be forced to take an HIV-test. The ruling by the Court of Appeal has been noted by health lawyers and has been received positively (not unexpectedly) by the medical profession.
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Barrett, Geraldine; Cassell, Jackie A.; Peacock, Janet L.; Coleman, Michel P.

**National survey of British public's views on use of identifiable medical data by the National Cancer Registry**
BMJ: British Medical Journal 2006 May 6; 332(7549): 1068-1070

**Abstract:** Objectives To describe the views of the British public on the use of personal medical data by the National Cancer Registry without individual consent, and to assess the relative importance attached by the public to personal privacy in relation to public health uses of identifiable health data. Design Cross sectional, face to face interview survey. Setting England, Wales, and Scotland. Participants 2872 respondents, 97% of those who took part in the Office for National Statistics' omnibus survey, a national multistage probability sample, in March and April 2005 (response rates 62% and 69%, respectively). Results 72% (95% confidence interval 70% to 74%) of all respondents did not consider any of the following to be an invasion of their privacy by the National Cancer Registry: inclusion of postcode, inclusion of name and address, and the receipt of a letter inviting them to a research study on the basis of inclusion in the registry. Only 2% (2% to 3%) of the sample considered all of these to amount to an invasion of privacy. Logistic regression analysis showed that the proportions not concerned about invasion of privacy varied significantly by country, ethnicity, socioeconomic status, and housing tenure, although in all subgroups examined most respondents had no concerns. 81% (79% to 83%) of all respondents said that they would support a law making cancer registration statutory.

Conclusions Most of the British public considers the confidential use of personal, identifiable patient information by the National Cancer Registry for the purposes of public health research and surveillance not to be an invasion of privacy.

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Sokol, Daniel; Car, Josip

**Protecting patient confidentiality in telephone consultations in general practice**
British Journal of General Practice. 2006 May; 56(526): 384-385

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FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health

**Confidentiality, privacy and security of patients' health care information**
International Journal of Gynecology and Obstetrics 2006 May; 93(2): 184-186

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MacIntosh, Tracy

**Ethical considerations for clinical photography in the Global South**
Developing World Bioethics 2006 May; 6(2): 81-88

**Abstract:** Clinical photography is an important tool for teaching practitioners and field workers about the clinical manifestations of famine and undernutrition, particularly with respect to the Global South. Current international guidelines for clinical photography are not consistently applied or enforced, which has led to violations of privacy and rights, particularly for patients and victims of disaster in the Global South. Combining existing clinical photography guidelines from the North with ongoing clinical ethics debates in the South, this paper explores approaches to establishing photography guidelines throughout the world that will be sensitive to the privacy and dignities of all patients and victims of emergencies.

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Dimond, Bridgit

Legal aspects of continence: disclosure of a medical condition
British Journal of Nursing 2006 April 27-May 10; 15(8): 467-468

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Ferguson, Angus H.

The lasting legacy of a bigamous Duchess: the benchmark precedent for medical confidentiality.
Social History of Medicine 2006 April; 19(1): 37-53

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Herget, Greg

Federal health information privacy cases from 2005

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Cross, Michael

GPs' leader sets conditions for electronic care records [news]
BMJ: British Medical Journal 2006 March 18; 332(7542): 627

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Kaiser, Jocelyn

Rule to protect records may doom long-term heart study [news]
Science 2006 March 17; 311(5767): 1547-1548

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Trachtman, Howard

The secret sharer [letter]
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Kipnis, Kenneth
**A defense defended [letter]**

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Duncan, Rony E.; Newson, Ainsley J.
**Clinical genetics and the problem with unqualified confidentiality**
American Journal of Bioethics 2006 March-April; 6(2): 41-43

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Baker, Robert
**Confidentiality in professional medical ethics**
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**Addressing an ethical dilemma dialogically rather than (merely) logically**
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Abbo, Elmer D.; Volandes, Angelo E.
**Rare but routine: the physician's obligation to protect third parties**
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Boylan, Michael
**The duty to rescue and the limits of confidentiality**
American Journal of Bioethics 2006 March-April; 6(2): 32-34
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Robertson, Christopher
**The consequences of qualified confidentiality**
American Journal of Bioethics 2006 March-April; 6(2): 31-32
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McGregor, Joan
**No moral absolutes**
American Journal of Bioethics 2006 March-April; 6(2): 29-30
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Banja, John D.
**Qualifying confidentiality obligations**
American Journal of Bioethics 2006 March-April; 6(2): 28-29
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Klitzman, Robert
**Qualifying confidentiality: historical and empirical issues**
American Journal of Bioethics 2006 March-April; 6(2): 26-27
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Berg, Jessica
A qualified defense of legal disclosure requirements
American Journal of Bioethics 2006 March-April; 6(2): 25-26
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Gibson, Elaine
Medical confidentiality and protection of third party interests
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Hodge, James G.
The legal and ethical fiction of "pure" confidentiality
American Journal of Bioethics 2006 March-April; 6(2): 21-22
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Balint, John
Should confidentiality in medicine be absolute?
American Journal of Bioethics 2006 March-April; 6(2): 19-20
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Platt, Priscilla
The individual's right of access to his or her own personal health information
Health Law in Canada 2006 March; 26(3): 44-59
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Keith, Brian C.
Health information network providers: the compliance basics
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Collins-Nakai, Ruth
"Patient information -- sacred trust"
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Fitzpatrick, Erin Elizabeth
Special privacy issue: introductory article from the editors [editorial]
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Han, Juliana
The Tenth Circuit finds a constitutionally protected-right to privacy in prescription drug records
Journal of Law, Medicine, and Ethics 2006 Spring; 34(1): 134-136
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Carlisle, J.; Shickle, D.; Cork, M.; McDonagh, A.
Concerns over confidentiality may deter adolescents from consulting their doctors. A qualitative exploration
Journal of Medical Ethics 2006 March; 32(3): 133-137

Abstract: Young people who are concerned that consultations may not remain confidential are reluctant to consult their doctors, especially about sensitive issues. This study sought to identify issues and concerns of adolescents, and their parents, in relation to confidentiality and teenagers' personal health information. SETTING: Recruitment was conducted in paediatric dermatology and general surgery outpatient clinics, and on general surgery paediatric wards. Interviews were conducted in subjects' own homes. METHODS: Semistructured interviews were used for this exploratory qualitative study. Interviews were carried out with 11 young women and nine young men aged 14-17. Parents of 18 of the young people were interviewed separately. Transcripts of tape recorded interviews provided the basis for a framework analysis. RESULTS: Young women were more concerned than young men, and older teenagers more concerned than younger teenagers, about people other than their general practitioner (GP) having access to their health information. Young people with little experience of the healthcare system were less happy than
those with greater knowledge of the National Health Service (NHS) for non-medical staff to access their health information. As they grow older, adolescents become increasingly concerned that their health information should remain confidential. CONCLUSION: Young people's willingness to be open in consultations could be enhanced by doctors taking time to explain to them that their discussion is completely confidential. Alternatively, if for any reason confidentiality cannot be assured, doctors should explain why.

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Danino, Annie  
**Dodging the issue of physician assisted suicide: the Supreme Court's likely response in Gonzales v. Oregon**  

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Conti, A.  
**The recent Italian consolidation act on privacy: new measures for data protection**  
**Abstract:** In the light of the new Consolidation Act on privacy, in effect since January 2004, the author has made some observations in relation to the protection of data concerning health. Special focus has been given to an overall view of the new regulations. "Sensitive data" are seen as differing from health data, while always respecting the rights, the fundamental freedom and the dignity of the person involved. A central role continues to be played by the Controller, who has regulating and control powers.

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Lutz, Jeff  
**Ignore privacy? Unpardonable [letter]**  
Hospitals and Health Networks 2006 March; 80(3): 14,16

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Gilbert, Robert E.  
**Coping with presidential disability: the proposal for a standing medical commission**  
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de Wolf, Virginia A.; Sieber, Joan E.; Steel, Philip M.; Zarate, Alvan O.
**Part III: meeting the challenge when data sharing is required**

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Carter-Pokras, Olivia; Zambrana, Ruth Enid
**Collection of legal status information: caution! [letter]**
American Journal of Public Health 2006 March; 96(3): 399

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Montello, Martha
**Confessions and transgressions: ethics and life writing [review of An Ethics of Life Writing, edited by Paul John Eakin; Vulnerable Subjects: Ethics and Life Writing, by G. Thomas Couser]**
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Cooper, Michael; Altman, Lawrence K.
**Governors take 2 tacks on releasing medical data**

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Rogers, Wendy A.
**Pressures on confidentiality [opinion]**
Lancet 2006 February 18-24; 367(9510): 553-554

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Shumak, Steven L.; Sen, Mithu; Gregson, Daniel; Lewis, James; Hoey, John
Unnecessary exposure? [letter and response]
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**Abstract:** Privacy and confidentiality have long been recognised as essential elements of the doctor-patient relationship. Patients should feel free to disclose the most intimate and private medical facts about themselves to their physicians in order to facilitate optimal patient care. Medical records, whether hand-written or electronic, also play an important role in other contexts, such as medical research, health care management and financial audit. In South Africa there is little consistency in approaches to patient confidentiality. There are also no national standards or policies on patient confidentiality, apart from specific ethical rules, some ad hoc statutory provisions and general constitutional provisions not directly related to the intricacies of the doctor-patient relationship. A closer look at the relevant statutory provisions reveal the existence of conflicting standards, most notably in respect of parental access to a minors' health records. The purpose of this paper is to examine the discrepancies and contradictory provisions relating to the access to and disclosure of health information, in particular parental access to health records of minors. In the final instance, some recommendations will be suggested.

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Potential impact of the HIPAA privacy rule on data collection in a registry of patients with acute coronary syndrome

Archives of Internal Medicine 2005 May 23; 165(10): 1125-1129

Abstract: BACKGROUND: Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule has the potential to affect data collection in outcomes research. METHODS: To examine the extent to which data collection may be affected by the HIPAA Privacy Rule, we used a quasi-experimental pretest-posttest study design to assess participation rates with informed consent in 2 cohorts of patients eligible for the University of Michigan Acute Coronary Syndrome registry. The pre-HIPAA period included telephone interviews conducted at 6 months that sought verbal informed consent from patients. In the post-HIPAA period, informed consent forms were mailed to ask for permission to call to conduct a telephone interview. The primary outcome measure was the percentage of patients who provided consent. Incremental costs associated with the post-HIPAA period were also assessed. RESULTS: The pre-HIPAA period included 1221 consecutive patients with acute coronary syndrome, and the post-HIPAA period included 967 patients. Consent for follow-up declined from 96.4% in the pre-HIPAA period to 34.0% in the post-HIPAA period (P<.01). In general, patients who returned written consent forms during the post-HIPAA period were older, were more likely to be married, and had lower mortality rates at 6 months. Incremental costs for complying with the HIPAA Privacy Rule were $8704.50 for the first year and $4558.50 annually thereafter. CONCLUSIONS: The HIPAA Privacy Rule significantly decreases the number of patients available for outcomes research and introduces selection bias in data collection for patient registries.

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Nursing Ethics 2005 May; 12(3): 273-287

**Abstract:** The UK Government published various circulars to indicate the importance of respecting the privacy and dignity of NHS patients following the implementation of the Human Rights Act, 1998. This research used an ethnographic method to determine the extent to which health professionals had in fact upheld the philosophy of these documents. Fieldwork using nonparticipant observation, and unstructured and semistructured interviews with patients and staff, took place over six months in three acute care wards in a large district NHS trust hospital. Applying the principles of phenomenology and grounded theory, the data were analysed and the contents organized into 11 key categories, leading to the formulation of a privacy model. The level of intrusion into patients' privacy by health professionals was measured against the benchmarking of the 'dignity and privacy' factors contained in the Department of Health's The essence of care document and Article 8(2) of the Human Rights Act. The findings established that patients had little privacy in the wards, and that the terms 'privacy of the person' and 'dignity' are interrelated.

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British Journal of Nursing 2005 April 14-27; 14(7): 391-392

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**HIPAA and patient care: the role for professional judgment**


**Abstract:** Federal health privacy regulations, commonly known as the Health Insurance Portability and Accountability Act (HIPAA) regulations, came into effect in April 2003. Many clinicians and institutions have relied on consultants and risk managers to tell them how to implement these regulations. Much of the controversy and confusion over the HIPAA regulations concern so-called incidental disclosures. Some interpretations of the privacy regulations would limit essential communication and compromise good patient care. This article analyzes misconceptions regarding what the regulations say about incidental disclosures and discusses the reasons for such misunderstandings. Many misconceptions arise from gaps in the regulations. These gaps are appropriately filled by professional judgment informed by ethical guidelines. The communication should be necessary and effective for good patient care, and the risks of a breach of confidentiality should be proportional to the likely benefit for the patient's care. The alternative for communication should be impractical. We offer specific recommendations to help physicians think through what incidental disclosures in patient care are ethically permissible and what safeguards ought to be taken. Physicians should work with risk managers and practice administrators to develop policies that promote good communication in patient care, while taking appropriate steps to protect patient privacy.

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Nursing Ethics 2004 July; 11(4): 366-377
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on the value and acceptability of three current research scenarios, each describing access to data without patient consent. RESULTS: Among focus group participants, awareness of research in primary care was low, and the appropriateness of general practitioners as researchers was questioned. There was general support for research but also concerns expressed about data collection without consent. These included lack of respect and patient control over the process. Unauthorised access to data by external agencies was a common fear. Current data collection practices, including population based disease registers elicited much anxiety. The key informants were equally critical of the scenarios and generally less accepting. CONCLUSIONS: This exploratory study has highlighted a number of areas of public concern when medical records are accessed for research without patient consent. Public acceptability regarding the use of medical records in research cannot simply be assumed. Further work is required to determine how widespread such views are and to inform those advising on confidentiality issues.
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clinical situations in which a breach of confidentiality might be considered, a clear majority of subjects believed that doctors should disclose information in two of the situations, but subjects were not confident that doctors would do so. In three situations, about half felt that disclosure was justified—these included the only scenario in which disclosure was clearly mandated by statute. There was little change in patients' general attitude to confidentiality after considering the scenarios. However, the views expressed were often inconsistent with responses to the clinical scenarios, suggesting that complex opinions were not accurately reflected in the responses. The format of the questionnaire has been amended, and the study will be repeated with other groups of patients.

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[Germany; United Kingdom]


**Abstract:** While there is widespread agreement that medical confidentiality is a principle worth protecting, problems arise where the physician holds confidential medical information which might help to prevent the commission of a criminal offence by a potentially violent patient. Neither Germany nor the UK have succeeded in providing consistent guidelines by which physicians can orientate their decision of whether or not to disclose such information to the relevant authorities and/or the potential victim. This article will evaluate the principles according to which a breach of medical confidentiality by a physician can be justified for the purpose of preventing the commission of criminal offences by potentially violent patients. It will be submitted that a breach of medical confidentiality in such a case should not be justified, unless the risk is imminent, sufficiently specified, and disclosure would exceptionally be an appropriate means to avert the danger.

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**Medical confidentiality after a patient's death, with particular reference to The Netherlands**


**Abstract:** This article concerns medical confidentiality after a patient's death. At international level there is an agreement that medical data of deceased patients should continue to be treated as confidential and therefore be protected by law. In the Netherlands, courts have ruled along the same lines. After death, the physician is bound to confidentiality and if necessary should invoke his right to remain silent. However, it is also accepted by the courts that circumstances can occur in which a doctor may disclose confidential information to third parties such as relatives. Disclosure of medical data is justified when the agreement of the deceased can be presupposed, or (if this is impossible) if there are such important interests of third parties involved that the obligation to maintain confidentiality may be put aside. According to present Dutch jurisprudence, confidentiality of medical data is regarded as a personal right that is not inherited by the relatives. Whether the position of the latter should be reinforced by introducing statutory provisions, is to be further explored.

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