Health Information Privacy in the Philippines: Trends and Challenges in Policy and Practice

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ABSTRACT

Context. Evolution of the scope and context of privacy and confidentiality brought about by use of information and communications technology in healthcare.

Objective. To review the legal, professional and ethical landscape of health information privacy in the Philippines.

Methodology. Systematic review of literature and policy frameworks.

Results. Philippine laws jurisprudence recognize and protect privacy of health information as a general rule; impose upon individual practitioners and institutions the obligation to uphold such right; and may apply in both the traditional and eHealth milieu. There is no existing policy framework that addresses issues relating to [a] access to health information by non-health professionals, [b] use of health information for non-health purposes, and [c] rules relating to collection, storage and utilization of electronically-derived or -stored information. A privacy culture, on either the provider's or client's side, is also lacking in the country.

Conclusion. Technological developments have outpaced policy and practice. There is a need to unify the patchwork of regulations governing the privacy of health information; advocate for a privacy culture among professionals and patients alike; fortify the evidence base on patient and provider perceptions of privacy; and develop and improve standards and systems to promote health information privacy at the individual and institutional levels.

Key Words: privacy, confidentiality, health information, Philippines

Introduction

Privacy of personal information is a closely-guarded individual right, such that any unauthorized access or breach is considered a violation of this entitlement from both legal and moral perspectives. The value of protecting privacy is evidenced by the restrictions put in place regarding the people the information may be shared with—often, only immediate family members—and the care with which the physical repositories of such information are secured.

However, a person entering a health provider-patient relationship as the recipient of care is observed to willingly and automatically shed that veil of protection, and allow a health worker, who may be a complete stranger, access to the most intimate details, the very private thoughts, the core of his being, on the premise that this disclosure of relevant, though sensitive, personal information by the patient will help the health professional arrive at a logical and sound diagnosis and management plan.

Implicit in this interaction is the expectation that the patient's information will be held by the practitioner in strict and full confidence, and will not be unnecessarily shared with other parties, a reflection of the trust in the ethics of the profession. As Hippocrates was supposed to have said, *All that may come to my knowledge in the exercise of my profession or*

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a. Reprinted from Privacy in the Developing World - Philippines Monograph, 2012.

b. This paper is part of a series of monographs produced by the Foundation for Media Alternatives under the "Privacy in the Developing World" project in cooperation with Privacy Asia (Privasia) and Privacy International, with generous support from the Canadian International Development Research Centre (IDRC).

d. In addition to published literature, this paper also benefited from inputs of a diverse number of individuals (lay persons, health professionals, healthcare organization) who participated in various meetings/for a where an earlier draft version of this paper was presented. In particular, this is with reference to the [i] 103rd Philippine Dental Association Annual Convention Scientific Session; 2011 November 16-20; SMX Convention Center, Pasay City, Philippines; [ii] Philippine Privacy Rights Training and Validation Workshop; 2012 March 18-19; La Breza Hotel, Quezon City, Philippines; [iii] 1st Health Data Privacy Forum; 2012 March 22; Richmonde Hotel, Pasig City, Philippines; and [iv] Privacy.Rights@PH: Issues in the Philippine Information Society. A Public Forum; 2012 May 25; Information and Communications Technology Office – National Computer Center Building, Quezon City, Philippines.

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in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.[1]

Yet, over the intervening millennia, healthcare practice has become more complex, challenging conventional interpretations of this Hippocratic admonition.

Now more than ever, health professionals possess a certain sense of compulsion to document every detail of a patient consultation. Without doubt this has been brought about by the intricacy of insurance reimbursement claims processes, but a second factor is the rising amount of malpractice litigation being lodged against health workers. Pre-service training ingrains in the mind of future professionals this maxim: *That which is not written was not done*.

Technology is also changing the landscape of healthcare practice. The evolution of electronic medical records and the ubiquitous connectivity afforded by the Internet means that health information is more readily accessible to anyone with the right tools and can be easily linked across disparate databases, by contrast patient files locked in cabinets or drawers in individual physicians' offices or dentists' clinics.

Certain conditions, or even a constellation of signs and symptoms pointing to a highly communicable disease, are reportable to national health authorities. The growing field of research and the onslaught of new illnesses have seen the publication of case reports intended to educate other professionals. In schools and hospitals, trainees openly discuss details of patient cases with their seniors. Oftentimes, cases are also integrated in informal face-to-face or electronic conversations with colleagues to solicit advice for patient management. All these further complicate the issue of health information privacy.

In this paper, we examine the intricacies, boundaries and limitations of the protection of health information privacy in the Philippine context as seen from legal, professional, and ethical perspectives. In addition to providing a systematic review of the issue*, recommendations are presented pertaining to healthcare practice and the institution, or enforcement, of policies relevant to health information privacy.

Privacy and Confidentiality: Concept Clarification, Concept Mapping

While there is no one standard accepted definition of *privacy*, this paper will adopt the official definition used by the U.S. National Library of Medicine, to wit: "The state of being free from intrusion or disturbance in one's private life or affairs."[2] On the other hand, *confidentiality* refers to "[t]he privacy of information and its protection against unauthorized disclosure."[3]

In brief, privacy pertains to an individual's right to be free from unwanted external scrutiny; whereas confidentiality points to the duty that rests on those to whom private information has been entrusted, that is, that they will not unnecessarily disclose such privileged communication.

Rather liberal transfer of private information stems from the fiduciary nature of the clinician-patient relationship: patients (i.e., the holders of the right to privacy) trust that any and all details they may share with their healthcare provider (i.e., the bearers the duty of confidentiality) will be maintained as private information. Inherent in this framework, as was proposed by Croll[4], is that the information will be secured by the clinician from unauthorized access, and that ultimately the data gathered will be used to deliver safe, quality care that will benefit the patient (Figure 1). Implied in the model is the patient's consent to the storage, access, and sharing of his or her personal information.

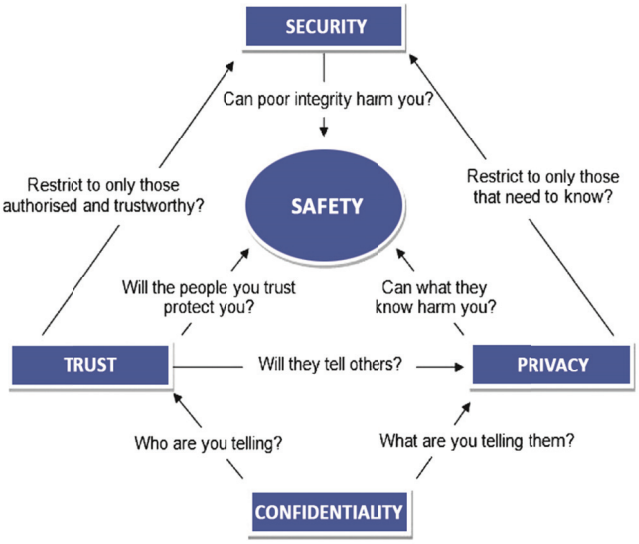

Figure 1. A model for privacy, confidentiality, and security within the context of health information.[4]

The evolution of the health information landscape, as well developments in the area of policy, however, has redefined the scope and context of the privacy and confidentiality of health information.

The Health Information Landscape

Exchange of health information traditionally occurs in clinics or offices of health workers and is documented in paper forms. Auditory and visual privacy considerations are taken into account in the construction and design of consultation rooms (e.g., by installing screens, curtains, and partitions and ensuring there is ample space between the office and the waiting area). Details of the patient encounter are recorded by the primary care provider in medical records, which are then carefully handled by staff, stored in secure rooms (or at least, in cabinets or drawers under lock and key), and accessed only by authorised persons.[5]

The physical setting of the clinic and handling of medical information thus evoke a sense of confidentiality and security, and assure patients that the information they are sharing will remain within the confines of the office and within the pages of their file. The in-person interaction of the patient with healthcare providers—from the admitting clerk to the dispensing pharmacist—allows for the development of a relationship of trust, and gives faces to the numerous people who may access, or are accessing, his or her medical record.

The evolution of technology is changing the landscape of privacy and confidentiality within the context of health information.

Telemedicine, or the delivery of health-related services and information via telecommunications technologies such as videoconferencing, email, phone calls or short messaging systems (SMS), now makes possible virtual patient consultations and specialist referrals involving parties separated by physical distance.[6] For instance, in many large tertiary hospitals, junior residents send SMSs or place calls to senior physicians (or even to co-residents in another department) to make patient referrals.

The development of *electronic medical records* (EMR), on the other hand, transcends the physical limitations of paper files and presumably facilitates access to, and sharing of, health information among providers of care; improves the accuracy and quality of recorded data; and, more important, improves the quality of care as a result of having health information immediately available at all times for patient care.[7] In addition, EMR possesses the theoretical advantage over paper records of being able to accumulate data that spans a patient's lifetime.

While in many ways these developments contribute towards enhancing the delivery of care to all people, they also tend to redefine the scope of privacy and confidentiality within the context of the provider-patient relationship.

First, there is now a broader audience for patient information: whereas previously, only the patient's primary provider had access to their record, the use of health information technology systems means that software developers, programmers, network operators, and other individuals operating behind the scenes to maintain the system can, but may not necessarily, peer into an individual's private data. The emerging use of telecommunications networks to interconnect healthcare professionals and clients (or other healthcare professionals, as in referrals) may also pose a threat to individual health data privacy in light of the non-uniform adoption and application of privacy policies by individual telecommunications companies and Internet service providers (*see* the discussion by Torres-Cortez in an issue paper in this monograph series).

Furthermore, the aggregation of patient data into large, networked databases, which are intended to facilitate access by, and link information from, different co-managing health providers, exponentially increases the number of individuals who may retrieve vital private patient information from different point-of-access terminals, which may be located in different geographic areas.[8] The case of the "leaking breast implant" discussed below shows that this threat is actually a real one.

Another gray area that may have to be further examined is the implication of the use of information and communications technology to disseminate private health data for non-health and non-educational purposes. Take for instance the "Cebu canister scandal" discussed below, where a video of a surgical procedure was posted on the Internet without the patient's consent.

Fourth, data transmitted through electronic channels (i.e., patient information, intended as well-meaning referrals to colleagues, sent via email or SMS; or discussions of patient cases on social networking sites by students and trainees in the health professions) may theoretically be stored indefinitely. There are even concerns that these types of data cannot be permanently deleted, especially if they have been posted to or shared on multiple sites.[9,10] In the 2008 incident referred to as the "Cebu canister scandal" attempts to ban the posting of the procedure on video-sharing sites, copies of the full-length footage can still be accessed online as of this writing (May 2012).

The magnitude and consequent impact of this health information data exchange can be gleaned from information technology usage patterns among Filipinos:

- There are an estimated 29,700,000 (a penetration rate of 29.7%) Internet users as of June 2010.[11]
- While the numbers vary from anywhere between 25% to 95%, surveys indicate that utilization of social networking sites in the Philippines is high compared to other countries, not only in the Asia-Pacific region but also globally, earning the country the moniker "The Social Networking Capital of the World."[11,12,13,14]
- In 2005, a total of 34.8 million cellular mobile telephone subscribers (CMTS) were registered, translating to a CMTS density of 41.3 per 100 population.[15] Mobile penetration in 2009 was estimated at 80%, or about 73 million subscribers.[16]
- The National Telecommunications Commission (NTC) estimates that an average of 250 million SMS messages were sent per day in 2005, giving rise to claims that the Philippines ranks number one globally in SMS usage (although recent trends indicate that due to the rise of social networking sites and app messaging the United States has "unseated Philippines as the king of TXT messaging").[15-17]

In the light of the fiduciary nature of the provider-patient relationship, as well as the consent inherent in such

contracts, the vital issues, therefore, with respect to these technological developments[a] are:

1. Are health workers and patients aware of the extent to which private health information is available to and accessible by people other than the patient and the provider?
2. Will information regarding the use of health information technologies (in item 1 above) adversely affect patients' willingness to disclose relevant personal information and damage the quality of care that patients receive?
3. How will existing statutory and ethical guidelines be applied in the context of health information system use in patient care?
4. Are current local legal frameworks sufficient to guide stakeholders on health information privacy and if not, what gaps in policy need to be filled?
5. Should non-health professionals involved in handling patient data be bound by codes of ethics similar to healthcare workers?

Legal and Ethical Framework[18-21]

The Philippines is at the gateway of a changing health information landscape. The shift towards the use of health information technology has been a global trend. The impact of these changes on traditional notions of privacy and confidentiality between health provider and patient is a challenge. The international community has responded to the requirements of the 21st century by adopting measures that regulate or serve as guidelines in the utilization of technology in healthcare, with many countries passing legislation to address issues of data protection and the confidentiality of medical records.

The value of using electronic medical records is recognized by governments in other parts of the world.[22,23,24] While the World Health Organization (WHO) does not provide a standardized system for keeping medical records, it has already provided guidelines particularly directed at developing countries for the use of medical records and electronic health records[b,5,7] Laws that failed to protect patient privacy in the past are being updated to increase patients' health professions control over their medical information as well as allow for damages in case of breach of confidentiality (e.g. American Recovery and Reinvestment Act of 2009 (ARRA), which updated the Health Insurance Portability and Accountability Act). Data protection laws have been enacted in many countries over the past twenty years.[25]

The reliance of world economies on electronic commerce and the recognized importance of protecting information privacy led to the endorsement of the Asia-Pacific Economic Cooperation (APEC) Privacy Framework in 2005, which provides guidelines for balancing the right to privacy of individuals and the promotion of electronic commerce. The framework is intended to regulate the flow of information in developing market economies for socio-economic growth but it contains principles that may be applicable in the health sector, which admittedly deals with collection and storage of personal information.

Another pivotal point is telehealth services. Telemedicine, intended to bridge the gap in accessibility of healthcare, is being advocated in the Philippines as a national agenda. The experiences of other countries that have earlier used telemedicine show that privacy issues remain a central concern.6,26 There is emphasis on the need for patient consent as well as patient information, particularly as to the nature of a telehealth consultation, and awareness of who will have access to consultation and to whom patient information will be disclosed.

Using health information technology and telemedicine, and storing patient data in electronic form all amplify the privacy issues in the context of the relationship between health provider and patient.

The tradition of privacy and confidentiality within the context of patient care is attributed to Hippocrates of Cos around the 4th century B.C. when he admonished his followers: *All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal*.[1]

This proceeds from the distinct position of honour conferred upon the physician as a "friend of mankind", the implicit understanding that full disclosure of information on the part of the patient is a prerequisite to quality care and better health outcomes, and that some of this information may be sensitive or may lead to irreparable injury—physical or moral—to the patient should it be shared with outsiders.

The duty of confidentiality for health providers and the rights of patients to privacy are uncontested and universally recognized.[27,28,29] The same principles have been adopted by the Philippine Medical Association[30,31] and similar associations in other countries.[32,33]

Physicians in the Philippines pledge a more modern version of the oath upon being admitted to professional practice of by the Professional Regulation Commission (PRC), and are similarly bound to uphold the

[a] In addition to the items mentioned previously, emerging issues in health information privacy include [i] access to health information of applicants/workers by their employers, usually through a health maintenance organization (employers justify that they have a right to access information since they paid for the services of the consulting physician, as well as because the health status of their worker may affect his/her performance on the job); and [ii] collection of information by pharmacies/pharmaceutical companies on the purchasing practice of patients as well as prescription patterns of healthcare providers (through monitoring of information encoded in store discount cards). There have been anecdotal reports of these issues, but there is no sufficient documentary evidence available that will allow extensive discussion of the above-mentioned concerns in this paper.

[b] The World Health Organization is slated to issue a guidance document on health data privacy in 2012/2013.

confidentiality of patient information by the Code of Ethics of the Board of Medicine[34] and the Philippine Medical Association (PMA).[30]

The principles of ethics are clear. Patients have a right to expect that any information that may be obtained by a healthcare provider will be kept confidential. The critical question is how laws and government regulations should respond to protect patients' rights.

In the Philippines, a person's right to privacy is enshrined in no less than fundamental law. The Philippine Constitution provides:

> *Section 3. (1) The privacy of communication and correspondence shall be inviolable except upon lawful order of the court, or when public safety or order requires otherwise, as prescribed by law. xxx*

This guarantee encompasses all aspects of a person's privacy, including the confidential nature of the relationship between health provider and patient. The right of any person to privacy is the general rule and it is only by way of exception that this right is to be limited. Thus, unless a specific law or order allows the disclosure of private information, a person can always invoke the guarantee of the Constitution to the right of privacy. Any statute, rule or regulation must be consistent with the declarations of the Constitution.

A person's general right to privacy is affirmed in the Civil Code (Republic Act No. 386). It provides that every person shall respect the dignity, personality, privacy and peace of mind of another. The Civil Code likewise makes any person who abuses the rights of another liable for damages. A physician may be held liable for failing to observe the general mandate of the law that every person, in the performance of his duties, act with justice, give everyone his due, and observe honesty and good faith. Since a physician has an acknowledged duty to maintain patient confidentiality, any injury that a patient may incur as a direct result of the violation of this duty will make the physician liable for damages.

The Revised Penal Code (Act No. 3185) criminalizes "Revelation of Secrets". Its provision protecting the secrets of any person may find application in cases of government physicians who have custody of patient records and who would reveal private information about patients or any other employee who may abuse their position to obtain confidential information. Specific laws guarantee the right to privacy of rape victims and minors in conflict with the law (i.e., Republic Act No. 8505, Rape Victim Assistance and Protection Act of 1998; Republic Act No. 9344, Juvenile Justice and Welfare Act of 2006).

The current legal framework readily shows that a person's general right to privacy is protected. This means that a person who violates this right may be made civilly or criminally liable. While these laws are not specifically directed the physician or healthcare provider, they may be applied to hold accountable any person who violates a patient's right to privacy.

In addition to general provisions protecting the privacy of all persons, doctor-patient confidentiality is an established doctrine. Communication between doctor and patient is generally considered privileged and should not be inquired into even by the courts. The provision is intended to make sure that information obtained by physicians in the course of treatment will not be used to blacken the reputation of a patient. Section 24, Rule 128 of the Rules of Court provides:

> *Rule 128, Section 24: Disqualification by reason of privileged communication. — The following persons cannot testify as to matters learned in confidence in the following cases: xxx*
>
> *(c) A person authorized to practice medicine, surgery or obstetrics cannot in a civil case, without the consent of the patient, be examined as to any advice or treatment given by him or any information which he may have acquired in attending such patient in a professional capacity, which information was necessary to enable him to act in capacity, and which would blacken the reputation of the patient. xxx*

The application of the above rule is very specific and is only applicable when the inquiry is made on the physician who managed the patient.

Specific reference to health information privacy can be found in Republic Act No. 8504 (handling of information, both the identity and status, of persons with HIV), Republic Act No. 9165 (confidentiality of records of those who have undergone drug rehabilitation), and Republic Act No. 9262 (confidentiality of records pertaining to cases of violence against women and their children), all of which clearly cater to specific populations of patients who may come under the care of health providers and which are, arguably, not applicable to all instances of the physician-patient relationship. These specific laws, however, extend the duty of confidentiality to those who may have access to the private information, including custodians of records.

It is, thus, apparent that the expectation of maintaining privacy extends even to other healthcare providers[c]. This may be attributed to the fact that hospitals have evolved, both in identity and function, throughout history. Modern hospitals no longer just provide facilities so that a doctor can treat the sick. The public's perception of the modern hospital is as a multifaceted healthcare facility responsible for the

[c] A review of the enabling professional laws and practice codes of other healthcare providers in the Philippines revealed that there is no specific mention of their duty in maintaining privacy/confidentiality of patient information. However, this paper takes the position that the Constitutional provision on the right to privacy is a sufficient general safeguard.

quality of medical care and treatment rendered. Hospitals now provide a wide range of services, and it is inevitable that they gain access to patient information. The same access is available to other stakeholders in health like health maintenance organizations and telehealth centers, which have likewise taken an active role in health care delivery. Having access to and storing patient records emphasize the need to extend the applicability of the rules of confidentiality to healthcare providers.

The duty to respect patient privacy may be derived from responsibilities that hospitals are expected to assume in accordance with standards of care expected from and accepted by other hospitals or other healthcare providers. In the absence of specific legislation addressing hospital duty and liability, the standards expected of hospitals may be based on accreditation standards or principles in the Hospital Code of Ethics.

The Hospital Code of Ethics[35] provides for the primary objectives of hospitals:

> *1.2 To provide the best possible facilities for the care of the sick and injured at all times;*
> *1.3 To constantly upgrade and improve methods for the care, the cure, amelioration and prevention of disease; and*
> *1.4* ***To promote the practice of medicine by Physicians*** *within the institution consistent with the* ***acceptable quality of patient care****. [emphasis supplied]*

The Court recognizes the inherent duties of hospitals and has adopted the doctrine of corporate responsibility imposing on hospitals the duty to see that it meets the standards of responsibilities for the care of patients (*Professional Services, Inc. v. Agana*, 513 SCRA 478, 2007). These standards should include respect for patients' right to privacy. As was pointed out by Ng and Po[19] and Bellosillo et al[21], the duty to maintain confidentiality does not rest solely with the medical provider but extends to the hospital or health facility.

In order to obtain a licence to operate, the Department of Health (DOH) requires that even prior to building the hospital, the applicant must first secure a construction licence.[36] At the planning stage and during the design of the hospital, the DOH considers whether the hospital seeking a licence adequately addresses the need to maintain patients' auditory and visual privacy.[37] Philippine Health Insurance Corporation (PHIC) Accreditation sets as a standard the need for the organization to document and follow policies and procedures for addressing patients' needs for confidentiality and privacy.[38] Similarly, accreditation standards such as that provided by Joint Commission International (JCI) Accreditation Standards for Hospitals[39] include the requirement of confidentiality of patient information:

> *Standard PFR.1.6. Patient information is confidential.*
> *Intent of PFR.1.6*
>
> *Medical and other health information, when documented and collected, is important for understanding the patient and his or her needs and for providing care and services over time. This information may be in paper or electronic form or a combination of the two. The organization respects such information as confidential and has implemented policies and procedures that protect such information from loss or misuse. The policies and procedures reflect information that is released as required by laws and regulations.*
>
> *Staff respects patient confidentiality by not posting confidential information on the patient's door or at the nursing station and by not holding patient-related discussions in public places. Staff are aware of laws and regulations governing the confidentiality of information and inform the patient about how the organization respects the confidentiality of information. Patients are also informed about when and under what circumstances information may be released and how their permission will be obtained.*
>
> *The organization has a policy that indicates if patients have access to their health information and the process to gain access when permitted. (Also see MCI.10, ME 2, and MCI.16, intent statement)*
>
> *Measurable Elements of PFR.1.6*
> *1. Patients are informed about how their information will be kept confidential and about laws and regulations that require the release of and/or require confidentiality of patient information.*
> *2. Patients are requested to grant permission for the release of information not covered by laws and regulations.*
> *3. The organization respects patient health information as confidential. (p. 63)*

The standards that a hospital should ideally meet may likely be imposed on other healthcare institutions providing health services with access to patient information.

For example, under the Philippine AIDS Prevention and Control Act of 1998, the duty of maintaining patient confidentiality is imposed on all persons involved in handling and maintaining patient records. The law extends the duty not just to health professionals but also to health instructors, co-workers, employers, recruitment agencies, insurance companies, data encoders, and other custodians of medical records.

In view of the use of health information technology, electronic medical records, or computerized systems for storing patient information, the duty of hospitals or any other health provider institutions to maintain and keep medical records confidential entails greater responsibility. There is no

legislation specific to data protection in relation to medical privacy. There have been initiatives to enact laws providing for data protection and database security, in general (i.e. the proposed Personal Data Protection Act of 2007).[40]

Any law or order that would involve storing personal information in databases accessible to government would meet with obstacles. In the Philippines, moves towards a National Computerized Identification Reference System have been met with resistance due to the premium placed on a person's right to privacy. There is distrust of any government move to store personal information and while the Supreme Court ruled as valid an executive order that provides uniform data collection and format for their existing identification (ID) systems, these are limited to only government agencies and government-owned and controlled corporations with existing identification systems (*Kilusang Mayo Uno vs. Director-General, National Economic Development Authority*, 487 SCRA 623, 2006).

Implementation of any system that would collect, transmit and store private patient information should have safeguards in place. The current laws that protect in general electronic data may be applied to holders or custodians of medical records. The Electronic Commerce Act of 2000 provides that any person with access to electronic data messages or documents has the obligation of confidentiality or the duty not to convey the information to, or share it with, any other person. Under this law, unauthorized access to computer systems is punishable by a fine and mandatory imprisonment.

The anti-wiretapping law (Republic Act No. 4200) may also be applied where a person who is not authorized by parties to a private communication record or communicate its contents. The act would probably cover doctor-patient communication which is privileged and confidential, and which therefore should not be recorded or disclosed without consent.

From the preceding paragraphs, it is evident that the right to privacy is zealously guarded under the Constitution. The legislations, rules, and ethical principles address the right to privacy in general, including the protection of electronic data, and to a limited extent also provide for confidentiality in the context of a physician-patient relationship.

Under the Constitution, this right to privacy shall be inviolable except upon lawful order of the court, or when public safety or order requires otherwise, as prescribed by law. Thus, while the right of a patient to privacy is generally honored even after death, there are established exceptions. The limitations on the right to privacy proceed either from a voluntary waiver on the part of the patient, or are imposed by the State in the exercise of its police power to safeguard the general welfare of the people.

The rule of the confidentiality of physician-patient communication and patient records is not absolute; there are exceptions under the following circumstances:

1. *Upon patient consent or waiver:*
    a. *Upon waiver or authority of the patient to release such information.* This stems from the recognition that the information contained in medical records is the property of the patient, while the medical records themselves are the property of the hospital;
    b. *For purposes of insurance compensation.* In addition to the provisions of Presidential Decree No. 442, as amended (Labor Code of the Philippines), individuals availing themselves of insurance coverage also sign waivers allowing the health maintenance organization or insurer access to their medical records in exchange for claim of benefits (i.e. Republic Act No. 7875, National Health Insurance Act of 1995);
2. *In the interest of public order and safety.* Births and deaths should be registered as provided for in Republic Act No. 3753 (Law on Registry of Civil Status). Reporting of certain communicable diseases is mandatory under Republic Act No. 3573 (Law of Reporting of Communicable Diseases). Executive Order No. 212 requires medical practitioners to report treatment of patients for serious and less serious physical injuries. Likewise, by virtue of Presidential Decree No. 603, as amended (Child and Youth Welfare Code), practitioners are required to report cases of child abuse or maltreatment. Prescription and dangerous drugs dispensed by pharmacies are recorded and retained in books for inspection by appropriate authorities. The landmark U.S. case of *Whalen v. Roe* (492 U.S. 589, 1977), as discussed in the case of *Kilusang Mayo Uno vs. Director-General, National Economic Development Authority* (487 SCRA 623, 2006), provides an instructive case of the State's exercise of its police powers with respect to regulated drugs and substances.

Testing of certain populations for dangerous drugs is mandatory and reportable. Upon court order under very specific circumstances, a person may be compelled to be tested for HIV, or submit himself or herself to a mental and physical examination (as provided in the 1997 Rules of Civil Procedure). Under Republic Act No. 9745 or the Anti-Torture Act of 2009, a person claiming torture by the authorities is given the right to a physical examination and psychological evaluation, to be contained in a medical report; such reports are, however, to be considered public documents. The Code on Sanitation of the Philippines (Presidential Decree No. 856) authorizes the Court and police authorities to order the performance of an autopsy on the remains of an individual.

3. *Upon lawful order of the court or a quasi-judicial body.* Release of health information may occur upon service of a valid subpoena, warrant, or adjudicative order from a court, a law enforcement agency, an administrative agency authorized by law, or an arbitration panel. However, disclosure in court of health information is limited by the provisions of the Rules on Evidence, as upheld in *Lim vs. Court of Appeals* (214 SCRA 273, 1992), and *Krohn vs. Court of Appeals* (G.R. No. 108854, June 14, 1994); and

4. *For research purposes*. The National Ethical Guidelines for Health Research permits review of medical records without consent for purposes of research provided the data are de-identified or anonymized and are non-sensitive. Ultimately, however, determining which data are non-sensitive rests upon the Institutional Ethics Review Committees, and not on individual investigators or researchers.[41]

A careful perusal of Table 1, which summarizes the legal and ethical provisions related to privacy and confidentiality of health information, leads to the following observations.

First, the right to privacy is a basic human right that is guaranteed by the Constitution that may be invoked even in the absence of specific legislation. Patients are protected by the Constitution from unnecessary disclosure of any privateinformation in their medical record. The right to privacy in general is nonetheless protected by existing laws. The collection, transmission, use, and storage of electronic data, which would include electronic medical records, are to be secured. Unauthorized use or access is punishable. The existence of provisions in specific statutes guaranteeing the confidentiality of patient information in special circumstances merely reiterates the boundaries laid down in the fundamental law concerning patient privacy, and adds to penalties that may accrue to violators.

Second, medical privacy, which includes the confidentiality of doctor-patient communication and health information, is recognized. Physicians adhere to a code of ethics that includes as a principle the right of patients to privacy and the corresponding duty of health providers to maintain patient confidentiality. Healthcare providers, including hospitals and health institutions, likewise have an ethical obligation to maintain the confidentiality of health information, and are expected to abide by standards that protect patient privacy. The codes of ethics intensify the protection of the right to privacy and confidentiality by providing for administrative sanctions that may be imposed upon professionals who engage in unethical conduct.

Third, there is no legislation that directly addresses the privacy issues specific to health information technology or inherent in telehealth services. Under the current legal and ethical framework, protection of patient privacy relies heavily on self-regulation by health providers.[d]

Case Studies: Gaps in Health Information Privacy Protection

Two relatively recent incidents brought the public's attention to the issue of health information privacy and are being discussed here to highlight the gaps in privacy policy and practice in the country.

The first pertains to the posting on the Internet of a video clip documenting the extraction of a metal canister spray from the rectum of a patient in Cebu City and the accompanying jeering and jubilation of health staff inside the operating room. The ensuing public outrage resulted in the preventive suspension of some hospital medical personnel, but the cases filed before the PRC failed due to a technicality. In addition, the person who first posted the video on YouTube was never identified, and to date (May 2012), the three-minute footage can still be accessed online.[42–58]

In what has become known as the "Cebu Spray Scandal" or "Black Suede Scandal" the obvious points of contention are [a] recording and dissemination of a medical procedure, and [b] presence in the operating theater of hospital staff other than those directly involved in the procedure, all of these [c] without the patient's consent.

Certainly, procedural lapses contributed to the violation of the patient's privacy, but the culpability of the persons involved in the incident is difficult to determine because the evidence (i.e., the video clip) itself does not clearly identify the extent of the participation of each person who was inside the operating theatre at the time. Complicating the matter further is the fact that there were other people inside the operating room were nursing interns undergoing training at the hospital, but who were not involved in the ongoing procedure.

Furthermore, the anonymity assured by the Internet, compounded by the availability of computer shops offering Internet access in almost every corner of the country and the rapid replication of the video by various media and Web sites, precludes identification of the hospital staff who first posted the video online, and of those who continue to disseminate the video even after the original has been taken down by YouTube.

Case Study 1: "Cebu Spray Scandal"[42–58]

In mid-2008, a three-minute footage went viral on the video-sharing website YouTube showing what appears to be an operation involving the extraction of a metal spray bottle canister from the rectum of an unidentified patient. The operating room was crowded with giggling medical staff, all of them shown on the video with their cellular phones on hand to document the procedure. While the canister was being extracted, somebody shouted "Baby out!" after which the room broke into laughter and applause. One medical staff even opened the canister and sprayed its contents inside the room, resulting to further laughter from those in attendance.

The circumstances related to the incident only became clear a few weeks after the video has circulated in emails and mobile phones and has been lengthily discussed in various Internet forums. A 39-year-old homosexual florist from Cebu City underwent minor

[d] As of this writing (May 2012), the proposed Philippine Data Privacy Act is being discussed in a Congressional bicameral conference to harmonize the versions emanating from the Senate and House of Representatives. Likewise, the Department of Health is in the process of drafting an Administrative Order on health information privacy.

operation on January 3, 2008 at the Vicente Sotto Memorial Medical Center (VSMMC) for extraction of a foreign body lodged in his rectum. He was allegedly asleep at the time of the operation, and was not made aware that the procedure was going to be filmed, nor was he informed *post facto* that the medical staff took a footage of his operation. He claimed that he only learned of the existence of the YouTube video when it was brought to his attention by their barangay captain, who saw the video on YouTube.

As a response to the public outrage generated by the incident, various investigating bodies were formed – the hospital, Department of Health (DOH), National Bureau of Investigation (NBI), House of Representatives – to determine the culpability of those involved in the operation, as well as to identify the person who first uploaded the video.

Without denying any liability, the hospital and relatives of medical personnel involved were quick to point out that the public should focus on the successful outcome of the operation; that those involved were, in fact, first rate health professionals and calling for a revocation of their licenses was an excessive punishment; and that the incident was an isolated case of mischief.

While some nurses and doctors were initially placed on a three-month preventive suspension, the case filed with the Professional Regulation Commission was eventually dismissed on the basis of a technicality. The identity of the person who first uploaded the video on YouTube[e] was never discovered, and the incident, which died a natural death, became a mere footnote in the annals of Philippine medical history.

The second case involved the public disclosure and discussion of circumstances surrounding the admission of a high-ranking politician to a tertiary medical centre, which was not part of the official press release from his office, nor the medical bulletin issued by the politician's attending physician. Investigation by the hospital and the National Bureau of Investigation (NBI) suggested that non-medical hospital personnel had accessed the patient's record and leaked these it to journalists. No conclusion has yet been reached in this matter.[59–73]

Case Study 2: "Leaked" News[59-73]

It was meant to be a critique of the possibility that the Palace is keeping information about the President's state of health from the public. Philippine Star columnist Jarius Bondoc wrote in his July 3, 2009 column:

"If Gloria Macapagal Arroyo can make secret a trip to Colombia, more so the real aim of her overnight stay at Asian Hospital. The post-travel self-quarantine for A(H1N1) is a handy cover for gynecological procedures. The President has been suffering dysfunctional bleeding, likely due to polyps or myoma in the uterus. She had first walked into the hospital one dawn in 2008 for D&C (dilation and curettage) and left at dusk. News then was that she had an executive check. She's had three follow-ups this year, the last in June. Menopause is inducing abnormal tissue growth and hormonal imbalance, a source said.

"Wednesday dawn Arroyo checked in again — for less serious causes. She needed mammoplastic repair of leaking breast implants done in the '80s. Occasion too to have doctors take out an inguinal cyst (in the groin), and laser off extra hair growth in that area and the armpits. Though a bit groggy, Arroyo was set to check out yesterday afternoon.

"Hospitalizing a President isn't easy. Patients in five rooms at the VIP 10th floor had to be moved, to billet bodyguards and cooks; P4,000@, or total P20,000 a day. Arroyo was given two connecting suites, P18,000@, or total P36,000 a day, one for her, the other for the family." (59)

The ensuing investigation initiated by the hospital and the National Bureau of Investigation pointed to the possibility that an obstetrician-gynecologist was the source of the information, and that she was able to access hospital records with the help of three other non-medical hospital staff (the hospital policy at that time was that doctors are not allowed to access computers; only non-medical staff are provided passwords and the clearance to access any patient's file).

The obstetrician-gynecologist, who was not part of the team attending to the President at the time, denied involvement in the case. Columnist Bondoc was also claimed to have said that Asian Hospital was not the source of the leak.

As of this writing, the case remains unresolved.

Whether or not information regarding the health status of the highly-placed public authorities is a matter of public concern (and hence should be disclosed) or of national security (meaning it is classified information) lies outside the purview of the current paper. But what the case of the leaked information highlights is the real possibility of unlimited access to patient files in a centralized electronic medical records database by outsiders who are not directly involved in the care of the patient. In fact, counsel for the physician accused of leaking the information pointed out that about 76 hospital staff had access to the politician's medical record during her confinement.[71]

Regardless of the intent—whether for educational or entertainment purposes as in the first of these cases, or out of

[e] Various versions of the video, as of this writing, can still be viewed on YouTube.

curiosity or in return for a sum of money as in the second—these two cases demonstrate that even in the presence of legal and ethical safeguards instances that result in violation of the patient's right to privacy still occur, though most are perhaps on a scale sufficient warranting media attention. The pervasiveness of *tsismis* (gossip) in Filipino culture[74,75,76] may lead a nurse assigned to a well-known celebrity to talk about her patient's case with her family and friends. A group of medical students, over the course of dinner at a public restaurant, may similarly discuss a novel case assigned to their care.

The fact that not one person has been held criminally liable for infringement of this fundamental human right, and that culpability is difficult to establish especially in large institutions where medical records are accessible by virtually all staff, does not aid the cause of privacy.

Towards an Action Agenda for Health Information Privacy

The foregoing discussion has brought to the fore the following key issues with respect to health information privacy in the Philippines.

First, while the right to privacy is guaranteed by the Constitution and protected by existing laws, there currently is no standard health information privacy policy in the Philippines. Instead, what is available are general statutory provisions (see the Legal and Ethical Framework section above) and guidance documents[5,7,38], which individual institutions and providers may adapt for use in their facilities. With respect to existing legislation, the provisions are either too generic (encompassing privacy of communication in general) or too focused (mandating privacy and confidentiality in specific circumstances). Implementation and enforcement are difficult to monitor, specifically because, as shown in Table 1, the policy is scattered across several statutes. On the other hand, the arbitrary nature of the adoption of policies concerning medical records poses a threat to maintaining the integrity of health records and of ensuring that breaches of confidentiality in the healthcare provider-patient relationship do not occur. This is even more true in the face of rapid technological advancements that are altering the health information landscape.

The Philippines could take a cue from developed countries that adopted a unified health information privacy policy, such as New Zealand's Health Information Privacy Code[77]; Australia's Privacy Act of 1998[78]; the Pan-Canadian Health Information Privacy and Confidentiality Framework[79]; and the United States' Health Insurance Portability and Accountability Act (HIPAA)[80].

These privacy policy codes lay down, in concrete terms, [a] the rules governing collection, storage and utilization of health information; [b] the roles and responsibilities of the different stakeholders; [c] the scope and limit of health information privacy; and [d] the safeguards (policy, administrative, institutional, environmental, and technical) to maintain health information privacy.

All of these instruments also share as common policies restrictions on the use and disclosure of identifiable patient information by, and to, individuals and institutions other than the patient and provider. In essence, health information, when necessary, is shared on a "need to know" basis, and the patient is informed of such disclosure. Administrative measures relating to implementation (e.g. designation of dedicated privacy officers, training of workforce) and enforcement (e.g. filing and resolution of grievance, penalties) are also covered in these instruments.

In the absence of such a law, and given that the process of enacting legislation involving such a contentious issue is so protracted, individual institutions and organizations utilizing health information may need to look at developing and instituting their own privacy policies.

As previously stated, privacy of communications, which extends to health information, is a fundamental human right guaranteed by the Constitution. It also forms a basic bioethical principle that governs the provider-patient relationship.

There have been several attempts to introduce legislation on the Patient's Bill of Rights in the Philippines (Table 2 and Table 3), all of which have met with little success. In general, the blockage is concerns on the part of stakeholders, who either argue that the enactment of such laws is unnecessary (because existing laws sufficiently protect the rights of patients), or that the passage of these laws will lead to the practice of "defensive medicine" and a concurrent increase in healthcare costs to protect the interests of healthcare providers.[81]

While individuals and organizations have articulated their concern for upholding the right to privacy and confidentiality[31,82,38], it is highly likely that, as was shown in the case studies, adherence to this right is the exception rather than the norm[81]. Thus, codifying the patient's rights is essential[83]

> *Many of our rights as patients have already been articulated by the courts. Nonetheless, they often remain difficult for patients and providers alike to understand and especially difficult for sick people to exercise. Thus, it is helpful to collect all major patient rights into one document for both education and enforcement ease and to provide an effective and fair mechanism to permit patients to actually exercise their rights in the real world, with their physicians and hospitals (p. 101).*
>
> *xxx*
>
> *Once basic, uniform rights in health care are established, we can return to the urgent task of providing access to health care for all... It seems correct to view universal access to decent health care as our primary goal. But rights in health care are critical, since without them citizens may wind up with access to a system that is indifferent to both their suffering and their rights (p. 104).*

Second, the Philippines seems to lack a "privacy culture"[f]. The synergistic action of the culture of *tsismis* widely prevalent in the Philippines coupled with the ubiquity of Internet and cellular phone access throughout the country is a real and present danger to patient information privacy. Monitoring the actions of each health provider outside the workplace (i.e. emails, SMS, or postings to social networking sites) would prove to be difficult and impractical. What is needed is a change in individual behaviour that would result in self-regulation and self-censorship in the context of securing, or sharing, private information entrusted healthcare providers by patients.

This could mean the adoption of codes of ethics and conduct by professional organizations which recognize the wider scope of privacy and confidentiality of information in a wired world; or the education of trainees and professionals on health information privacy by integrating the issue into academic and continuing professional development courses (e.g. oral presentations at symposia, conduct of press conferences or publication and dissemination of information materials)[g].

Relevant to upholding privacy is the security of health information. Whereas paper-based records could easily be kept under lock and key, access restricted by providing only limited pages or sections to interested parties, electronic medical records accessible through a network of computers in a large hospital complicate the issue. Individuals and institutions transitioning to electronic medical records must understand and search for the presence of such security measures as role-based access control, data encryption, and authentication mechanisms in the systems they are purchasing or developing.[8,84] Positioning computer screens away from common or general areas, using strong access codes, and inculcating in health staff the habit of locking their access terminals are practical ways to reduce the chances of unauthorized access to medical records at the facility level. More importantly, however, developers of electronic medical records and operators of networks that transmit health information in the first place must ensure the security of information in systems they are developing.

The pervasiveness of the issue of health information privacy requires urgent, sustainable action at the national level coupled with implementation at the institutional and individual level. Adopting policies, developing standards, and promoting behavioural change all require a basis of public opinion that is sufficiently strong as to leverage action by the legislature, regulatory agencies, professional organizations, academia, healthcare institutions, and individual healthcare providers. The fact that numerous attempts at passing a patient's rights bill have all stagnated at the Committee level reflects the relatively low value of the issue of privacy as compared with other competing societal concerns. Advocating for health information privacy may not only mean raising the issue at press conferences or in legislative sessions, but also gaining the support of a wider base of stakeholders (e.g. patient advocacy groups and professional organizations). Giving the issue a credible face is also necessary to sustain and focus interest.

This paper appears to be the first attempt at defining the Philippine health information privacy context. While a trove of information was unearthed in the preparation of the manuscript, more questions arose that were left unanswered due to the exigency of the project.

In particular, the preceding discussion on health information privacy rests on an untested assumption: that the Filipino and Western concepts of privacy are identical. While upscale clinics and hospitals in urban areas take great pains to ensure that consultation rooms are separated adequately from common and waiting areas, the situation is very different in rural areas, where a thin sheet is all that shields a patient from the eyes (but not ears) of waiting folks. It goes without saying that generating critical mass is necessary to propel forward policy and behavioural change presupposing that the subject of change (i.e., privacy) is an issue which the object of change (i.e., patients) cares about and is concerned with.

Furthermore, there is a paucity of scientifically validated information on the perceptions, attitudes, and knowledge of patients and health professionals (both in individual practice and as part of health institutions) on health information privacy, particularly within the context of new information and communications technologies. In addition, while privacy and confidentiality are prescribed components of teaching curricula,[85,86,87] the integration and actual application of this concept into professional schools and teaching hospitals is unclear.

Conclusion

Health information privacy in the Philippines has evolved in parallel with advances in technology, but the underlying principle remains the same: health workers must ensure the protection at all times of their patient's privacy. Technological developments, however, have outpaced policy and practice. There is a need to unify the patchwork of regulations governing privacy; fortify the evidence base on patient and provider perceptions of privacy; and develop and improve standards and systems to promote health information privacy at the individual and institutional levels. Ultimately, it must be stressed that the quest for privacy is but one critical component in improving the overall quality of care available to Filipinos.

[f] There is concern that privacy may be a developmental or cultural issue, as can be gleaned from its prominence in the more developed economies and its relative absence countries where a strong sense of community (which effectively blurs the distinction between personal and communal ownership) is present.

[g] Promotion of privacy is a core competency in the Philippine nursing curricula, and is integrated as part of the course on jurisprudence and ethics for physicians and dentists.

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