

SNOMED, for example, has 300,000 terms, says Rucker. Each time a physician wants to enter a diagnosis code, "do I pull down a menu of 300,000 items?"

• **Just like in nursery school, sharing doesn't come easy.** Interoperability and shared community-wide networks of data are definitely the goal, most EHR advocates agree. Nevertheless, many shoals, some quite treacherous, lie between here and there.

Just as with the Health Care Information Portability and Accountability Act transaction standards, it would be nice if everybody got to the same EHR standard together. In the real world, however, it never happens that way, a fact that will continue to complicate life in the world of e-health, says Intermountain's Whiting.

Intermountain is one of the country's largest integrated health-care systems, with overwhelming market share in many areas of its home state of Utah and a 15-year history of involvement with the Utah Health Information Network. "It's a unique opportunity that we have here. We have a very rich and living history of information," says Whiting. Utah is home to the vast genealogical databases — the largest and most comprehensive in the world — assembled in the state by the Church of Jesus Christ of Latter-day Saints.

All this gives the nonprofit organization a definite leg up in developing EHR, but it doesn't make implementation of a seamless system easy, Whiting says.

"We believe in standards, and we push for them. But you have the problem of having all these different systems and people that have to move together." Arranging things so that all players move to a new standardized platform simultaneously, for example, simply doesn't happen.

**During the inevitable transition periods 'I've got to be able to support both standards,'** Whiting says.

• **"Who's responsible?" and "Who's to blame?" will remain hot questions.** The vision of a community-wide network into which individual practitioners enter sharable health information about patients for use by others in both individual treatment and public-health efforts is a fine goal, says Whiting.

But **"you run into some very interesting policy and legal issues there when you talk about linking unaffiliated practitioners into a system that's interactive and interoperable."**

Suppose someone enters wrong information, and someone else treats based on that information. "Who gets sued?"

Near the top of Whiting's wish list for government policy makers is this request: "Somebody has to look at the shared risk issue. In order to get the community involved, you need a legislative structure to protect parties against disclosure and protect you from bad data."

Much more sophisticated security systems also are needed in the e-age, says Whiting. "In the old days somebody had to go around and touch a file to actually steal the data. Now it's much easier."

In a world of widely shared data that must be both secure and reliable, "the legal issues become much more problematic."

"Until we get these fixed," Intermountain gives unaffiliated physicians only limited access to its clinical databases.

**The movement toward EHRs that are sharable community wide also promises to resuscitate a highly contentious issue debated, then set aside, during development of HIPAA and the regulations that flowed from that 1996 law. For data to be sharable across the community for both personal-treatment and public-health reasons, "you have got to have a unique identifier" for patients and providers, says Whiting.**

"The need for Unique Patient Identifiers has become urgent and critical," wrote the National Committee on Vital and Health Statistics in 1997.

But, "while we know that many health plans and others want a single identifier to create a 'lifelong' record on individuals, the fact is, many patients have sincere personal reasons why they don't want Doctor A to know about their care from Doctor B," Twila Brase, president of Citizens for Choice in Health Care told NCVHS in 1998. "It is the right of individual citizens to protect themselves and their confidentiality from others."

Up to now, Congress has tentatively sided with the variety of groups from across the political spectrum who view unique medical identifiers as serious threats to individual liberties, patient rights, and individual privacy, repeatedly slowing federal initiatives.

As health care grows more complex and expensive and the heretofore slow shift to computerized systems moves faster, debate over the dicey question of how to keep track of an individual patient's data in ever-growing electronic networks may not be so easily shelved.

## PEOPLE

The Senate Finance Committee is expected this week to confirm **Michael O'Grady** as Health and Human Services assistant secretary for planning and evaluation and **Jennifer Baxendell Young** as assistant secretary for legislation.

O'Grady most recently has been a senior health economist for the Joint Economic Committee. Previously, he's been research director for Project HOPE and a health analyst for the Finance panel. Young most recently has been executive director of programs for the American Association of Health Plans. She's also been an analyst for Finance, the House Ways and Means Committee, and the National Governors' Association.