Electronic Health Records- A private practitioner's perspective

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HKMA IT Survey 2006

- 7250 + 9880 copies of questionnaires sent out in April and May 2006
- July 2006 6772 copies of redesigned questionnaires sent to HKMA members
- 398 respondents, 50 were annonymous.
- Response rate 5.88%.

Demographics of respondents

- 54% age 46-65
- 32% GP and 37% specialist
- 47% solo private practice
- 12% group private practice
- 91% use the computer at home
- 86% use computer at the work place for a mean of 10 years
- 43% use the computer to record patient clinical data

Demographics of respondents

- 55% do not use a management package in the workplace.
- Clinic Solution was the most commonly used commercial package 29%
- Majority 70% use internet access in the office and 81% use Broadband.
- 87% are interested in accessing patient's records in HA via internet

The real situation

- The HKMA IT Survey 2006 has obvious flaws.
- The number of private doctors using eHR can be tallied by counting the number of clients that local computer software firms are serving.
- A gross estimate would be 20%

The vast majority

- The vast majority of local private doctors are not using computers to store their records and the eHR has a long way to go
- Except for those doctors who migrate into private sector in the recent decades, those who have been working in the community are not necessarily interested to migrate their paper records into computer records

Missed Opportunity

- 10 years ago, when doctors from HA started to migrate to private sector
- HKMA suggested to HA administrator:
- Give them free of charge a soft ware package they have been using (CMS) so that they will start off to use computers in their clinic
- HA's reply: Software is for sale in future`

Advantages of eHR

- Paperless records
- Less storage space
- Clarity and legibility of records
- Less chance of losing records, can retrieve and locate records based on ID, name, telephone no., address etc.
- Confidentiality – need to login before one can read the charts

Other uses of computer in clinic

- Referral letters
- Account management
- Drug labeling
- Issuing sick leave certificates
- Drug inventory
- Internet Access
- Research requiring patients' demographic

Disadvantages of eHR

- Computers can be down and records loss
- May still require hard copy especially for legal purposes e.g. Dangerous Drugs Register
- Other people can heck into the system if the user name and password are known
- Backup system required and user may not know how to do it

Other cons

- Training required for both doctors and clinic staff
- Service fee for maintenance required for use of package
- Get stuck when any one component is down e.g. label machine, LCD, printer etc.
- Requires IT backup at times such as 9 pm when these IT people are not available
- Loss of data on memory sticks

Problems of eHR

- Doctor-patient relationship is not improved by focusing on the computer
- Patients have complaint that the doctors' eyes are on the screen and not on them
- Time spent in typing and printing may actually increase the consultation time.
- A lot of the material stored or typed are just copied and paste from past records and mistakes can be perpetuated.

Information sharing

- In using eHR, patients may need to understand that their data may be shared by more than one doctor e.g. doctors in HA GOPD/SOPD, in group practice. They may need to be so informed and they are suppose to give whatever information they wish to. For private solo practice, the doctor may need to ask the patient whether the information provided can be shared.

Optional

- Patients should have discretion to elect to join, and to what extent.
- No user should automatically know whether the eHR is complete or not
- Tool to facilitate health care and not to facilitate pricing of insurance industry.
- Not a tool to deprive individuals of their privacy.

Secret Box

- Once there is a secret box, it is no secret.
- Insurance companies, employers, law enforcement units etc. will force open these boxes and find ways to do it.
- Medical user should be mindful that NOT all the patient's information will always be totally present in the eHR.
- Patients should be educated to include useful emergency information such as allergies, medications, asthma, angina etc.

A doctor's comment:

- What is the purpose of including the history of gastritis at 16 year old before HKCEE when the patient is now 40 year old, except to allow an insurance company to exclude all gastric conditions from claim?

Sharing between public & private

- In future, if there is a platform to share information between private and public sector, certain discrete information that the patient provided to his/her doctor may no longer remain a secret between the patient and his/her doctor. A patient may not like certain information to be revealed to other sources like insurance companies or even relatives of the patient.

Doctors' concern

- Once documented, the computer record may be disseminated to a thousand doctors
- If a physical finding, a diagnosis, or a drug treatment or injection is erroneous, it will be scrutinized by many doctors involved in the management of the patient and the doctor may be prone to harassment and assessment and prosecution.