

Shared Electronic Medical Records

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Doctors treat patients most effectively when they have access to all the necessary clinical information. Patient safety and the quality of care will be improved if treating doctors can access and contribute to electronic medical information about the patients they are treating. This can be achieved through the sharing of electronic medical records (EMR) and information between treating doctors across all healthcare settings.

Health care of the patient is best served by the medical practitioner having access to the full health record.

The AMA supports individuals taking responsibility for their own health and recognises that 'person-controlled' electronic health records could empower and encourage patients to do this. A person-controlled health record could provide doctors with an additional source of patient information and could be a mechanism for ongoing communication between doctors and patients in the management of their healthcare. However a person-controlled health record has practical clinical limitations for the treatment of the patient in respect of the content, accuracy and accessibility of the information. Accordingly, there is a need for a shared EMR in addition to any person-controlled health record.

A shared EMR that links reliable and relevant medical information across healthcare settings would provide treating doctors with the information required to inform clinical decisions. The clinical information available from the shared EMR would include but not be limited to allergies, alerts, current medications, adverse reactions, recent test results, current ECG, blood type, vaccinations, infectious disease status, surgical operations, prostheses, clinical assessment, diagnoses, treatment pathways and referrals, advance directives and demographic data including details of a person to contact in an emergency.

With time, a more sophisticated EMR would also contain prescribing and dispensing details, key physiological measurements, screening results, procedure history, family and social history, lifestyle factors and event summaries.

The shared EMR would not include every aspect of the patients' medical record. This would continue to be held and maintained by each treating doctor and/or institution. Patients would continue to have access to their information as determined by relevant legislation.

There should be a simple consent mechanism to authorise doctors to access the medical record. There may be specific information which the patient may not wish to be generally available. If there is specific information which is not made generally available, this should be clear to treating doctors. In the interests of the patient in emergency situations, the AMA recognises that implied consent must sometimes be assumed to allow access to the full EMR. Audit provisions would apply and patients notified when emergency access has occurred.

A shared EMR could be achieved by making the range of existing information systems across the health care sector interoperable. A fully functional shared EMR should be aligned with current clinical workflows and integrate with existing clinical software. If there is a technical capacity to streamline business practices then this should occur.

The shared EMR will need to be supported by a privacy framework that ensures only people who are treating the patient have access to the shared EMR. The privacy framework should align with National Privacy Principles and the overarching NEHTA Privacy Framework.

Appropriate security measures are required for a safe and secure shared EMR. These security measures should include a range of policies, procedures and safeguards that help maintain the confidentiality, integrity and availability of information from systems across the health care sector and control access to their content. Identity mechanisms must be in place to protect access to the information through authentication processes. An audit trail would allow clinicians to ascertain the provenance of information, and patients to see who has accessed their information through the shared EMR.

Where the registered health profession board has policy on electronic health records, those health professions should be able to access and contribute to the part of the health record relevant to their scope of practice.

It is recognised that from time to time patient care is improved if non-registered health professionals e.g. paramedics, have access to and could contribute to the shared EMR and that the relevant authority consider mechanisms by which this may occur.

The enhancement to information sharing via the EMR raises potential legal concerns. These concerns must be recognised and addressed.

Sound governance of the system that enables the shared EMR, by a single national entity, will be essential to ensure it maintains its purpose. The governance arrangements must be transparent, accountable and developed in collaboration with key stakeholders. Existing arrangements protecting the public interest that allow use of de-identified medical data for epidemiological research must apply.

Federal, State and Territory Governments must drive and fully fund the development and implementation of a shared EMR. The AMA supports a staged implementation with the ability for further refinement over time. The medical profession and hospitals should be the first users of the shared EMR. Governance processes should be determined in close consultation with the medical profession.

The medical profession must be widely consulted in the development, implementation and evaluation of a shared EMR to encourage the participation and support. Government must provide appropriate incentives, education and training to ensure a practical and successful implementation.

Conclusion

The AMA supports a shared electronic medical record that:

- is supported by a person-controlled electronic health record;
- contains reliable and relevant medical information about individuals;
- aligns with clinical workflows and integrates with existing medical practice software;
- has appropriate security measures in place to protect patient privacy;
- is governed by a single national entity; and
- is fully funded by Governments and supported by appropriate incentives, education and training.

This Position Statement is part of the eHealth suite of position statements and should be read in conjunction with the following Position Statements:

Electronic Prescription Transfer Systems (2009)

Unique Healthcare Identifiers (2008)

Connectivity (2007)

Safety and Quality of eHealth Systems (2006)

Online and other broadband connected medical consultations (2006)

The AMA Economics and Workforce Committee has principal carriage of the Position Statement on Summary Electronic Health Records.

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