

## Shared Electronic Medical Records - Revised 2016

### Rationale for electronic medical records

Doctors treat patients most effectively when they have access to all the necessary clinical information regarding their patients. Patient safety and the quality of care will be improved if treating doctors can promptly and easily access and contribute to accurate, reliable and comprehensive 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.

A shared EMR allows for the lodging of clinical information that will be useful for another unknown health practitioner providing clinical care in other circumstances at another time in the future.

The ultimate benefits of a shared EMR are for patients. Medical practitioners, who can benefit from better information enabling improved efficiency, actually perform the work of providing and uploading information to the shared EMR. This division of benefits and workload must be considered in the design and operation of the shared EMR system.

### Core clinical information

Health care of the patient is best served by their 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. The AMA also notes that in general patients are unlikely to be able to accurately understand clinical information in a person-controlled electronic health record. A person-controlled health record could, however, 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, to be useful for clinical care, a person-controlled health record must include core clinical information that is accurate, reliable and comprehensive. Limitations in terms of the content, accuracy and accessibility of the information in a health record significantly compromise its clinical usefulness. Any doubts about the completeness or accuracy of the information undermine the confidence of the user.

Accordingly, there is a need for a shared EMR that is person-focused and controlled to the maximum extent, while providing reliable core clinical information for clinical use.

Certainty that shared EMRs contain predictable core clinical information, which is not affected, conditioned or qualified by the application of access controls, is critical to the achievement of the legislated objectives for the My Health Record, ie to:

- (a) help overcome the fragmentation of health information; and

- (b) improve the availability and quality of health information; and
- (c) reduce the occurrence of adverse medical events and the duplication of treatment; and
- (d) improve the coordination and quality of healthcare provided to healthcare recipients by different healthcare providers.

While patient privacy is paramount, it should and can be balanced with the need for shared EMRs to achieve the above objectives and make healthcare safer, more efficient and more effective.

Core clinical information must initially include:

- medications;
- allergies and adverse reactions;
- discharge summaries;
- recent results of pathology and diagnostics imaging tests;
- recorded clinical observations such as height, weight, blood pressure; and
- Advance Care Directives, advance care plans and resuscitation plans.

Over time, the clinical information available from the shared EMR ideally should include allergies, alerts, current ECG, blood type, vaccinations, infectious disease status, surgical operations, prostheses, clinical observations, diagnoses, treatment pathways and referrals, care plans and health assessments, and demographic data including details of a person to contact in an emergency.

A more sophisticated EMR should also contain key physiological measurements, screening results, procedure history, family and social history, lifestyle factors and event summaries.

There should be a simple consent mechanism to authorise doctors to access the medical record. All healthcare providers involved in providing clinical care to a patient should have access to the core clinical information, provided their registered health profession board has a policy on electronic health records covering conditions for such access by their members.

Other than core clinical information available to doctors, 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 with a flag on the medical record indicating some information has been made unavailable to general view.

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 would be notified when emergency access has occurred in emergency 'break glass' situations.

As with all forms of electronic communication, there is potential for the shared EMR to swamp medical practitioners with data overload, making it unnecessarily time consuming if not impossible to become aware of and able to retrieve important clinical information. Medical practitioners acting in good faith should be protected if they miss or are unable to locate critical data because it is buried in a sea of

electronic documents and they could not have reasonably been expected to find it readily. The shared EMR should be designed to include effective filtering and search functions that allow appropriate information to be located quickly and easily.

### **EMR and the patient's medical record**

The shared EMR would not include every aspect of the patient's medical record nor would it replace the patient's medical record. In using a shared EMR, medical and other health practitioners should keep in mind the following:

- Not all of a patient's medical and other health providers may as yet use, or be connected to upload to, the shared EMR. This may be especially true in the development phase of the shared EMR;
- Information and documents uploaded to the shared EMR may contain the same errors and omissions of clinical information as for current paper documents; and
- Some information on the shared EMR may be the subject of patient access controls.

Therefore, the safe use of the shared EMR requires a realistic understanding that it should not be treated as the single and definitive source of "truth" regarding clinical information about a patient. The information contained in the shared EMR should be regarded and used with the same care and "clinical suspicion" as any other form of clinical documentation such as paper records or verbal information.

Instead, information on a shared EMR should be viewed as extra and bonus clinical information about the patient which is accessible at a point of care, which would not otherwise have been available.

The patient's medical record will continue to be held and maintained by each treating doctor and/or institution. Patients will continue to have access to their information as determined by relevant legislation.

### **EMR integration with other information systems**

A shared EMR could both benefit from and contribute to initiatives to make 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. Shared EMRs should be able to be accessed through the range of technology platforms used in medical practice, including mobile systems and tablet devices. If the EMR provides opportunities to streamline business practices then this should occur.

A shared EMR does not replace the need for the development of good electronic point-to-point communication between medical practitioners, medical practices and other health care providers through secure message delivery (SMD).

Shared EMRs will work better if they are part of a coherent and integrated ehealth system that includes other key enabling functions, such as secure message delivery (SMD), health provider registries, telehealth capacity, and standardised terminology (Australian Medicines Terminology (AMT)) to support extraction and aggregation of medical data into useful and accessible forms e.g. compiled medication or allergy lists compiled from data contributed by several doctors.

### **EMR privacy and security**

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 Australian Privacy Principles and be consistent with the privacy requirements applying to patient information in other formats. Any temptation to introduce more onerous requirements and penalties should be resisted. Where medical practitioners access patient information in good faith as part of providing clinical care they should not be liable to penalties.

Appropriate security measures are required for a safe and secure shared EMR. These security measures should include 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. Security measures should not be so onerous as to impede or constrain safe clinical use of the EMR.

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

### **Governance of EMR system**

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, including the NHMRC's *Principles for accessing and using publicly funded data for health research*<sup>1</sup>.

The EMR is a clinical tool, primarily for use by clinicians with and for the benefit of their patients, with Government facilitating its operation through the provision of infrastructure, standards and incentives. Given the different roles of these parties,

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<sup>1</sup> National Health and Medical Research Council, *Principles for accessing and using publicly funded data for health research*, 2016

implementation and operation of shared EMRs must be based on a cooperative and collaborative approach, rather than compulsion and coercion.

The EMR is reliant on the good will of the private sector healthcare provider community. These healthcare provider organisations and individual healthcare providers are already experienced and proficient at handling a wide range of sensitive information and making timely and accountable decisions on the basis of it, including in relation to clinical information about the needs and treatments for their patients, and responsible referral of patients for other healthcare services, including access to scarce and expensive health resources.

Federal, State and Territory Governments must fully fund the ongoing development, implementation and operation of a shared EMR. The development of the EMR and its place in the broader health system will be a continuing focus over time. The AMA supports a staged initial implementation with recognition of the continuing need for further development and refinement over time. The medical profession, including GPs and other medical specialists, and hospitals should be the first users of a shared EMR. Medical specialists in particular must be a priority focus for support, adoption and use of the shared EMR.

Governance processes must provide effective mechanisms for ongoing involvement and input from the medical profession. These processes must recognise that while governments fund the infrastructure required for the operation of the shared EMR, the usability, usefulness and value of the shared EMR depend and impact on medical practitioners.

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

### **Resources to support use of EMR**

The implementation and operation of a shared EMR must be supported by a single point access to information for doctors that is effective, accurate, up to date, concise, and layered for the needs of different users and different levels of detail. This information should be developed and road-tested with intended users and available through different media and platforms as required.

Individual doctors should be able to familiarise and experiment with the SMR in safe test environments.

### **Conclusion**

The AMA looks forward to shared EMRs operating universally with optimum ease of use and seamless integration across health care providers. At this point there will be a universal, automatic and effective incentive for all clinicians to participate in shared EMRs.

The AMA supports a shared electronic medical record that:

- has universal coverage for the eligible population;
- contains reliable and relevant core clinical information about individuals that is not subject to access controls;
- aligns with clinical workflows and integrates with existing medical practice software;
- recognises and rewards additional activity required by clinicians providing information to the EMR
- has appropriate security measures in place to protect patient privacy, consistent with privacy of patient information in other forms;
- is governed by a single national entity which actively engages with medical and other stakeholders;
- is supported for implementation and operation across medical and other healthcare providers, starting with support and incentives for use by medical specialists; 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)*

*Technology-based patient consultations (2013)*

*Medical practitioner responsibilities with electronic communication of clinical information (2013)*

The AMA Medical Practice Committee has principal carriage of the Position Statement on Shared Electronic Health Records.

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