The Personally Controlled Electronic Health Record (PCEHR)

Background: This statement was first developed by Women’s Health Committee in March 2012 and reviewed in March 2015.

Funding: The development and review of this statement was funded by RANZCOG.

This statement has been developed and reviewed by the Women’s Health Committee and approved by the RANZCOG Board and Council.

A list of Women’s Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

Disclaimer: This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: March 2012
Current: March 2015
Review due: March 2018
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1. Summary of recommendations

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<th>Recommendation 1</th>
<th>Grade</th>
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| Medical practices and health care services should establish individual practice protocols for the use of the PCEHR. These protocols should include:  
• the way in which the medical practitioner will use shared electronic health records (e.g., read only, or read and upload);  
• policies on when practice nurses and other allied health practitioners employed or contracted by the practice will use electronic health records;  
• policies on when administrative and support staff are authorised to access shared electronic health records;  
• the practice’s policy and procedures regarding safety and confidentiality of electronic records; and  
• procedures for obtaining patient consent to use their shared electronic health record, and how this applies not only to the medical practitioner but all practice staff. | Consensus-based recommendation |

2. Introduction

The Personally Controlled Electronic Health Record (PCEHR) is an Australian Government program, under the governance of the Department of Health and Aging, implemented by the National eHealth Transition Authority (NeHTA). Information on the implementation, registration and utility of the PCEHR is available through the Department of Health eportal (www.ehealth.gov.au).

The PCEHR is a form of a shared electronic health record. Standardised information about health care events, such as hospital admissions, discharge summaries, referral letters or pathology may be included in the record. The PCEHR contains demographic information, in addition to clinical documents uploaded by healthcare providers or other authorised users, such as discharge summaries, pathology results, referral letters and information added to the record by the patient. Automatic feeds of information from sources such as the Medical Benefits Schedule may be included.

Importantly, the content of the PCEHR is under the control of the individual patient who may choose which elements he or she wishes to include in the PCEHR and share with a specified health service.

The PCEHR is an opt-in system for both patients and providers. Patients are not required to have or use the PCEHR and may opt-out at any time. Health care providers are not under any duty or obligation to use the PCEHR. Once registered for the system, medical practitioners may choose to opt out for any or all patients or components of the system at any time.

3. Discussion and Recommendations

3.1 What are the proposed benefits of the Personally Controlled Electronic Health Record (PCEHR)?

The PCEHR may empower and encourage patients to take responsibility for their own health. The PCEHR could provide practitioners with additional information and may be a mechanism for ongoing communication between doctors and patients in the management of their healthcare. The PCEHR may facilitate the management of transient or complex patients.

3.2 What are the concerns with regard to PCEHR Implementation?

There is limited data on the reliability and validity of the PCEHR. The PCEHR has practical clinical limitations for the treatment of the patient with respect to the content, accuracy and accessibility of the information. The medico-legal risks for medical practitioners and medical practices will be unknown until case law is developed as a result of actions. As with most medico-legal matters, the risk of exposure is low unless and until a patient experiences an adverse event. Shared electronic health records do not replace a medical practitioner’s patient file and, if a medical practitioner relies on information sourced from a patient’s shared
electronic health record to make a clinical decision, diagnosis or recommendation to the patient, that information should be downloaded or printed from the shared electronic health record and incorporated into the practice’s medical record.

3.3 What are the recommendations for Members and Affiliates of the RANZCOG?

It is recommended that medical practices and health care services establish individual practice protocols for the use of the PCEHR. These protocols should include:

- the way in which the medical practitioner will use shared electronic health records (e.g., read only, or read and upload);
- policies on when practice nurses and other allied health practitioners employed or contracted by the practice will use electronic health records;
- policies on when administrative and support staff are authorised to access shared electronic health records;
- the practice’s policy and procedures regarding safety and confidentiality of electronic records; and
- procedures for obtaining patient consent to use their shared electronic health record, and how this applies not only to the medical practitioner but all practice staff.


4. Conclusion

The implementation and utilisation of the PCEHR faces a number of challenges at the time of this statement. Until these matters have been resolved, practitioners should exercise caution in accessing or contributing to the PCEHR.

5. Links to Other College statements

Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)

6. Patient Information

A range of RANZCOG Patient Information Pamphlets can be ordered via:

https://www.ranzcoq.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets
Appendices

Appendix A Women’s Health Committee Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position on Committee</th>
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<tbody>
<tr>
<td>Associate Professor Stephen Robson</td>
<td>Chair and Board Member</td>
</tr>
<tr>
<td>Dr James Harvey</td>
<td>Deputy Chair and Councillor</td>
</tr>
<tr>
<td>Associate Professor Anusch Yazdani</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Associate Professor Ian Pettigrew</td>
<td>Member and Councillor</td>
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<tr>
<td>Dr Ian Page</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Professor Yee Leung</td>
<td>Member of EAC Committee</td>
</tr>
<tr>
<td>Professor Sue Walker</td>
<td>General Member</td>
</tr>
<tr>
<td>Dr Lisa Hui</td>
<td>General Member</td>
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<tr>
<td>Dr Joseph Sgroi</td>
<td>General Member</td>
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<tr>
<td>Dr Marilyn Clarke</td>
<td>General Member</td>
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<tr>
<td>Dr Donald Clark</td>
<td>General Member</td>
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<tr>
<td>Associate Professor Janet Vaughan</td>
<td>General Member</td>
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<tr>
<td>Dr Benjamin Bopp</td>
<td>General Member</td>
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<tr>
<td>Associate Professor Kirsten Black</td>
<td>General Member</td>
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<tr>
<td>Dr Jacqueline Boyle</td>
<td>Chair of the ATSIWHC</td>
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<tr>
<td>Dr Martin Byrne</td>
<td>GPOAC representative</td>
</tr>
<tr>
<td>Ms Catherine Whitby</td>
<td>Community representative</td>
</tr>
<tr>
<td>Ms Sherryn Elworthy</td>
<td>Midwifery representative</td>
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<tr>
<td>Dr Nicola Quirk</td>
<td>Trainee representative</td>
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Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in March 2012 and was most recently reviewed in March 2015. The Women’s Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the March 2015 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women’s Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women’s Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.
Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women’s Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

<table>
<thead>
<tr>
<th>Recommendation category</th>
<th>Description</th>
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<tbody>
<tr>
<td>Evidence-based</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Body of evidence can be trusted to guide practice</td>
</tr>
<tr>
<td>B</td>
<td>Body of evidence can be trusted to guide practice in most situations</td>
</tr>
<tr>
<td>C</td>
<td>Body of evidence provides some support for recommendation(s) but care should be taken in its application</td>
</tr>
<tr>
<td>D</td>
<td>The body of evidence is weak and the recommendation must be applied with caution</td>
</tr>
<tr>
<td>Consensus-based</td>
<td>Recommendation based on clinical opinion and expertise as insufficient evidence available</td>
</tr>
<tr>
<td>Good Practice Note</td>
<td>Practical advice and information based on clinical opinion and expertise</td>
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</tbody>
</table>

Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.
Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.