Electronic data management – a thief of time in health care?

Management of patient data occurs by electronic means within the Finnish Health Care System. Different kinds of slips of paper are, however, still used as checklists or intermediate storage for transferring data between incompatible information systems. If we encounter accidentally a short notice of a patient, it is more convenient to mark it on a slip of paper, unless we are not just sitting at our computer and the file opened which the notice concerns. The notice is then documented to the patient's electronic record afterwards, if it is deemed necessary or essential to remember. Additionally, it is more and more often necessary and should be remembered, because our security rules and juristication regulating the access and disclose of health information are developing to an increasingly more complicated direction.

A generation ago the time of an appointment for a patient at a doctor's office was 10 minutes, and the time spent for an examination was 10 minutes. While the patient had undressed the doctor had written the cause of appointment on a paper card, and while the patient finally dressed her/himself, the diagnosis and remedy had been documented and the prescription prepared. Later on the development of services and society induced the need for much more detailed documentation, data exchange between professional and different kinds of doctor's certificates resulting in the need to increase the time for an appointment to 15 minutes.

The implementation of the electronic health record brought about a further increase in the time needed for a patient appointment to 20 minutes. Can we then conclude that the electronic patient record has been devastating to the productivity of health care? It is important to realize the fact that the usefulness of information is directly proportional to its relevance and validity and inversely proportional to the work needed in order to obtain the information. Partially, the extra 10 minutes represents the price to be paid for access to relevant and versatile electronic information produced elsewhere, and for the opportunity to forward it easily. That is, no doubt, beneficial in terms of the quality and even the productivity of health care services. The additional minutes include, however, the extra time caused by the demands of data management: problems with usability of software and regulations of the authorities for managing health-related patient data.

The problems regarding the usability of electronic patient records are manifested as the well-known facts that finding and entering information is often time consuming and labour intensive. The structure of the present health records are just copied from the old paper-based record. The potential of electronic systems has not been exploited to its fullest extent. These problems can be solved only by improved collaboration of users, vendors, and decision makers.

Many health professionals feel that security and privacy protection rules and regulations guiding the use of patients' health information hinder effective and productive care. The way care is executed and verified is more pertinent than a patient's right for privacy and self-determination. Generally, in order to access patient data created and managed by another service provider the healthcare professional must have, with the exception of some overriding conditions, explicit, informed and signed consent from the subject of care. This is regarded as labourious and time-consuming, bringing about the danger of restriction of vital information needed for treatment. Access on the grounds of treatment relationship to all data which has not been opted out by the patient has been proposed as a better practise. This disputes calls for objective research on the positive and negative influences of these two afore-mentioned practises.

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