

《電子健康紀錄互通系統條例草案》委員會

政府當局就2014年6月16日會議的跟進事項作出的回應

本文件載述政府當局就委員於2014年6月16日會議上所要求資料的回應。

(a) 醫護接受者的代決人 – 優先次序

2. 如條例草案第3條所述，當醫護接受者屬(i)幼年人(16歲以下)¹或(ii)精神上無行為能力/無能力處理其本身事務/無能力在有關時間給予參與同意/無能力在有關時間給予互通同意的人士²時，則某些人士會有資格成為他們的代決人，而當中會有優先次序。

3. 以上的代決人安排，完全是為電子健康紀錄互通系統(互通系統)的參與/互通同意的給予/撤銷而設的，與目前就為病人給予治療時作決定的安排無關，亦對該種安排沒有影響。

4. 一般而言，向病人提供的治療是基於病人的知情同意。不過，對於無能力給予同意的病人，根據基於普通法原則或其他現行法例(例如《精神健康條例》(第136章)的第IVC部)的某些特定情況下，在沒有該病人的同意下仍可向其進行治療。不過，即使在沒有病人的同意下仍可

¹ 有資格成為該類醫護接受者的代決人是在有關時間陪伴該接受者的(a)父母、(b)根據《未成年人監護條例》(第13章)委任或以監護人身分行事，或由法庭以其他方式委任的監護人，或(c)由法庭委任處理醫護接受者事務的人士。如沒有(a)至(c)所述人士，合資格的代決人是(d)在有關時間陪伴該醫護接受者的家人。如沒有(a)至(d)所述人士，合資格的代決人是在有關時間提供，或即將提供醫護服務予該醫護接受者的訂明醫護提供者。

² 有資格成為該類醫護接受者的代決人是(a)在有關時間陪伴該接受者，並根據《精神健康條例》(第136章)委任的監護人；(b)交由監護該接受者的社會福利署署長或任何其他人士；(c)轉歸監護該接受者的社會福利署署長或任何其他人士；(d)執行監護人職能的社會福利署署長或任何其他人士；或(e)在有關時間陪伴該接受者，並由法庭委任處理醫護接受者事務的人士。如沒有(a)至(e)所述人士，合資格的代決人是(f)在有關時間陪伴該醫護接受者的家人。如沒有(a)至(f)所述人士，合資格的代決人是在有關時間提供，或即將提供醫護服務予該醫護接受者的訂明醫護提供者。

提供治療，這情況並非等於由有關醫療專業人員已代表病人給予“同意”。

5. 我們預期合資格的代決人在代表病人決定會否給予參與或互通同意而言，在大部分情況下都不會是緊急情況。在我們的代決人安排下，若沒有其他合資格代決人，最後的選擇是由醫護提供者代表病人給予參與或互通同意。這做法與在沒有同意下進行治療的安排性質並不相同。再者，決定會否進行治療的權力只適用於某些特定的情況，而並非一般情況。我們認為我們現時的代決人安排已適合地照顧到在參與互通系統及向醫護提供者給予特定的互通同意時，無能力給予同意的醫護接受者的需要。此安排在2011-12年期間進行的公眾諮詢中獲得普遍的支持。

6. 香港法律改革委員會曾就有關無能力在實行相關醫療行動時作出決定的人士，在《醫療上的代作決定及預設醫療指示》的報告書中提出建議。至於我們所建議的代決人安排是否與該報告書的建議一致，我們的理解是該報告書是關於病人因處於昏迷或植物人狀況而不能自行作出醫療上的決定之時，該等醫療決定如何作出。報告書中探討以下情況：當病人處於昏迷或植物人狀況時，另一人(例如醫生)代該病人作出醫療上的決定(稱為“代作決定”)。報告書亦研究下述情況：病人在仍然有能力作出醫療上的決定時，就他日後一旦失去此能力之時所欲接受的醫療而作出指示(稱為“預設醫療指示”)。正如上文解釋，我們在條例草案中建議的代決人安排，是處理就互通系統所給予/撤銷的參與/互通同意(即是關乎計劃的參與和讓特定的醫護提供者取覽紀錄方面)，與報告書中所提及有關作出醫療決定的“代作決定”安排於本質上並不相同。

(b) 緊急取覽互通系統內醫護接受者的電子健康紀錄

7. 就需要緊急取覽醫護接受者在互通系統內的電子健康紀錄，以同步向該名醫護接受者進行緊急治療的個案而言，有關的醫護提供者可憑現時《個人資料(私隱)條例》(第486章)第63C條，在沒有獲得病人同意下取覽其電子健康紀錄。我們的代決人安排甚至不需要在此情況下起作用。上述的情況適用於所有醫護接受者(不論他們是否幼年人或精神上無行為能力人士)。為了保障醫護接受者的私隱，有關的醫護提供者需就其此類取覽提供合理解釋，而取覽亦會被記錄及可被審核。

(c) 代決人“陪伴”醫護接受者的要求

8. 代決人一般需要在“有關時間”“陪伴”有關的醫護接受者。有委員查詢“陪伴”的意思，及合資格作為代決人的人士能否透過電話，代表醫護接受者向醫護提供者給予同意。

9. 有關條例草案的第 3(2)條中“陪伴”一詞，我們採用了包含親身在場這元素的一般詞意。為了能妥善地進行代決人的身分認明及記錄，我們會要求代決人親身陪伴相關的醫護接受者。這是為了保障該名醫護接受者的個人私隱。代決人只需要在首次給予某一醫療機構同意時親身在場一次，而在醫護接受者往後向該醫護提供者求診的過程中並不需要親身在場。

(d) 公私營醫療合作—醫療病歷互聯試驗計劃(病歷互聯計劃)

10. 為測試電子健康紀錄互通的可行性和接受程度，醫院管理局(醫管局)自2006年4月起推行病歷互聯計劃，讓參與計劃的私營醫護專業人員在得到其病人同意的情況下，查看這些病人過往存於醫管局的醫療紀錄。

11. 參與計劃的統計數字反映病人對計劃的接受程度不斷增加。在2007年，即是病歷互聯計劃推出後的首年，有約一萬名病人參加計劃。但是截至2014年5月(即是推行的八年後)，已有超過360 000名病人和大約3 200名私營醫護專業人員參與計劃，而透過系統取覽病人紀錄的次數更超逾930 000次。在設計和開發互通系統時，我們已有參考由試驗計劃所得的經驗，及在2008年和2012至13年度兩次研究的結果和建議。

2012至13年度病歷互聯計劃調查

12. 醫管局委聘了香港中文大學賽馬會公共衛生及基層醫療學院在2012年年底至2013年年初就病歷互聯計劃進行調查。調查報告在2013年2月完成。

13. 調查的主要目的，是識辨和分析影響參與計劃的因素、認識和接受這計劃的原因、計劃被認為可帶來的好處，及一些人不使用這病歷

參考的原因。調查結果顯示76%參加計劃的病人和68%的醫生都對計劃感到滿意。我們隨後在設計和發展互通系統時亦有考慮到相關的調查結果及建議，並相應地注重：

- 如何不用大費周章，由病歷互聯計劃順利過渡到互通系統；
- 將來互通系統的界面方便易用；
- 讓醫生以簡單的程序參加互通系統，及為醫生提供訓練和技術支援；
- 讓病人以簡單的程序參加互通系統；以及
- 舉行大型宣傳活動，以推廣互通系統的好處。

14. 這項調查的行政摘要載於附件 A以作參考。

2008 年進行的質性研究

15. 進行上述調查前，醫管局亦在2008年委託一間私人市場的研究公司進行一項質性研究，收集參與計劃的醫護專業人員和病人的深入意見。研究的結果反映：

- 大部分病人都相當滿意病歷互聯計劃所帶來的好處，包括有助診斷準確及節省時間、金錢、麻煩和痛楚。
- 醫護專業人員認為病歷互聯計劃有用處，方便他們取得病人清晰的病歷，有助他們作出更準確的診斷和處方。亦有人認為計劃的宣傳不足。
- 由於病歷互聯計劃設有電話短訊提示，而且在登入程序中採用了雙重身分認證(醫生的權標及病人的密碼)，因此被病人和醫護專業人員視為保安程度很高。
- 病人和醫生都認為病歷所載的互通內容充足及適當。病人一般對披露其全部病歷紀錄的做法並沒有保留。有些醫生要求豐富病歷的內容，例如包括 X 光／電腦斷層掃描／磁力共振掃描影像；所有實驗室測試書面報告；門診、急症及程序紀錄等。

16. 有關的研究總結和建議摘錄於附件 B以作參考。

(e) “保管箱”功能

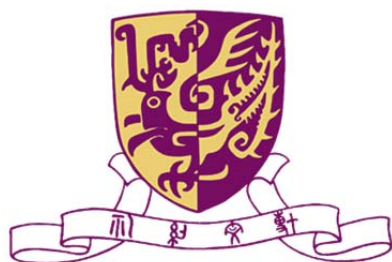
17. 我們將於2014年6月24日的法案委員會會議上以投影片進一步說明此事宜。我們已於就2014年5月13日、2014年5月19日，和2014年5月26日會議的書面回應中，概述了關於“保管箱”的一般概念，提供此類“保管箱”功能的好處及壞處，以及基於可獲得的資料所知的相關海外經驗。至於在2011年12月至2012年2月期間進行的“電子健康紀錄互通的**法律、私隱及保安框架**”公眾諮詢中所收集的意見，已載述於立法會CB(2)2279/11-12(05)號文件，並在2012年6月11日的衛生事務委員會會議上討論。有關文件的第10至18段特別與此事宜有關。

(f) 由電子健康紀錄專員發出的實務守則

18. 正如2014年6月16日的上一次法案委員會會議所同意，我們會於2014年6月24日會議後的一次法案委員會會議提供進一步資料說明實務守則的本質和內容，以及探討相關事宜。

食物及衛生局

2014年6月20日



Survey Report Executive Summary

Provision of Survey Service of Public-Private Interface- Electronic Patient Record Sharing Pilot Project (PPI-ePR)

(Contract No.: 8110-004-815)

Prepared for the
Hospital Authority



JC School of Public Health and Primary Care,

The Chinese University of Hong Kong

February 2013

Executive Summary

1.1 Background: The Hospital Authority (HA) enlisted the School of Public Health and Primary Care, Faculty of Medicine, at the Chinese University of Hong Kong, to conduct surveys about the experiences of patients and private doctors have had with the PPI-ePR programme; to ascertain the reasons why some of them are not using the programme; to explore strategies to address the barriers of using the PPI-ePR; and to enhance public acceptance of the PPI-ePR.

1.2. Survey Objectives: This survey aims to: (a) study the factors hindering private doctors and patients using the PPI-ePR; (b) evaluate the awareness, acceptance and perceived benefits of the PPI-ePR by private doctors and patients; (c) assess the reasons why some patients and doctors are not using the system after having enrolled; and (d) consolidate areas for service improvement to facilitate public acceptance and usage of the PPI-ePR.

1.3 Methods for Patient Surveys: These were conducted from December 2012 to January 2013 by telephone interviews based on an enrolment list provided by the HA for patients and a Hong Kong-wide directory for non-enrolled respondents. A simple random sampling methodology was adopted and 1,701 valid surveys were conducted. The response rates were 91.9% and 73.4% for enrolled and non-enrolled patients, respectively.

1.4 Methods for Doctor Surveys: These were conducted in the same study period by postal questionnaires sent to 10,285 registered doctors after exclusion of non-private postal addresses. A total of 610 valid questionnaires were received consisting of responses from 409 enrolled doctors and 198 non-enrolled doctors (three with unknown status). The response rate was estimated at 14.4% (610 surveys/4,229 private doctors).

1.5 Factors hindering patients and doctors from joining PPI-ePR: The most important factors hindering programme participation by non-enrolled patients included unawareness, and not enough clarity about the project and its objectives. As well as that, the enrolment procedure was perceived to be complicated. Many doctors were concerned about the workload involved in migrating paper records to a computer and felt that they lacked the technical expertise to operate the systems.

1.6 The awareness and acceptance of PPI-ePR: The majority of the enrolled patients and doctors were aware of the PPI-ePR, but only around one fourth of non-enrolled patients were aware of the programme. Family doctors and HA seminars were influential to encourage participation among enrolled patients, and so was the media and their peers. Among both groups of doctors, peers in the healthcare sector and posters or leaflets from the HA were the most common means to learn about the PPI-ePR. Non-enrolled patients had high levels of acceptance for joining the programme upon recommendation from their family doctor.

1.7 The commonly perceived benefits of the programme among enrolled patients were a) the ability of the PPI-ePR to reduce repetition of health assessment and information provision; b) physician recommendation; c) accurate and comprehensive health information which can be retrieved by doctors; and d) medical record referencing. Among enrolled doctors, these were a) timely access to patients' medical records; b) the programme's ability to deliver higher quality of healthcare service; c) continuity of patient care; and d) improvement of patient safety.

1.8 Reasons why enrolled patients and doctors did not use the system after joining: Many patients did not use the PPI-ePR after enrolment mainly due to the fact that they didn't have a need to use it. Some doctors claimed there was no clinical indication, and a significant proportion reported forgetting the login password and patient factors.

1.9 Perceived strategies to increase the awareness of eHRSS: Those reporting satisfaction with the programme were mostly enrolled patients and enrolled doctors. Media, such as newspapers, television and magazines were regarded by enrolled patients as effective strategies to increase programme awareness, whilst doctors regarded medical newsletters as effective means.

1.10 Recommendation to enhance doctor enrolment: There is clearly a need to enhance promotional initiatives using strategies which are perceived as both attractive and effective by doctors and patients. The HA may consider to enlist enrolled doctors to clarify the simplicity of the enrolment procedure and share their experiences. In addition, the HA may formulate and implement a series of on-site clinic visits to facilitate participation by non-enrolled doctors. Also, a significant proportion of non-enrolled doctors were concerned about the migration of paper records to the computer system and also their lack of IT expertise as barriers to join the programme.

The PPI-ePR programme office may consider individualised recommendations for these doctors by providing technical expertise and educational seminars to address particular difficulties.

1.11 Recommendation to enhance patient enrolment: To enhance enrolment rates among non-enrolled patients, a series of advertisements could be planned for television, newspapers and magazines, which were perceived by patients as highly effective promotional means. As family members and friends were important sources of information about the PPI-ePR among non-enrolled patients, those who have already been enrolled could be encouraged to promote the PPI-ePR to their non-enrolled family members and friends. Also, since the surveys showed that most non-enrolled patients would join if recommended by their doctors, family physicians should be encouraged to promote the PPI-ePR programme in their private practice to patients who have not yet joined to further enhance patients' enrolment rate.

1.12 Recommendations for use of PPI-ePR after joining: Most enrolled patients did not use the PPI-ePR after enrolment because they didn't have a need for it, but some didn't use it due to non-participation by their family doctors and due to forgetting their login passwords. To enhance patients' use after enrolment, it is crucial for non-enrolled doctors to participate in the programme alongside their patients. Simpler and quicker strategies to facilitate memory retention of login passwords could be considered. For doctors who have enrolled yet did not access the medical records via the PPI-ePR after enrolment, the major reasons were forgetting their login passwords and non-participation of the attending patients. Measures to salvage forgotten passwords should be consolidated to help quick retrieval. Since a sizeable proportion of patients failed to provide login details to authorise access, support for retrieval of patient login details should be available in the doctors' private practice.

1.13 Recommendations to prepare for the future eHRSS initiative: The PPI-ePR programme office could leverage on the advantages of their computer system to further increase the programme's enrolment rates. Major barriers of enrolment reported by doctors, such as perceptions of complicated procedures and lack of technical expertise, will need practical support from the office. The impact of future measures to promote the programme's usage and the effectiveness of educational initiatives should be formally evaluated. The benefits of the PPI-ePR perceived by doctors and patients in this survey could be considered for inclusion as the main messages in the PPI-ePR's promotional initiatives.

Extract of Qualitative Research Study in 2008

Conclusion and Recommendation

PPI-ePR is well received by both patients and medical professionals. It is valuable as it is a platform that allows for better patient care with timely and accurate medical records, which in turn could save the pain and agony of patient and their lives.

Both patients and medical professionals are quite satisfied with the pilot esp. on speed, security and content, and expect it to see full launch of the program to all private hospitals and doctors in future. Bi-lateral information flow is also welcome and expected from private hospitals. They are receptive in using HA [Hospital Authority]'s CMS [Clinical Management System] as it is a sophisticated and comprehensive software.

Patients expect the program to be free-of-charge, but are willing to pay a small amount to cover the admin cost if really required. Medical professionals would transfer the fee to the patients if there is a fee to use the program in the future.

To fully achieve cooperation between public and private hospitals, the priorities lie on extensive user coverage and bilateral information flow. Below is a summary of the three key areas of improvement from the perspectives of both patients and medical professionals:

1. Publicity

- Extensive promotion to mass public
- Participation of more private doctors

2. Bilateral information flow

- Medical records at private hospital / clinics to be retrievable by HA

3. Enriched content

- (Must) All written lab test reports
- (Nice to have) “New” or “Updated” icon for new lab test results
- (Nice to have) Out-patient / emergency / procedure records
- (Nice to have) X-ray / CT scan / MRI images