

Guest editorials

A question of trust: the introduction of a national electronic patient record

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On 8 December 2003, Health Secretary, Dr John Reid announced that by 2010 every patient in England will have an individual electronic NHS care record.¹ At the moment most patients have a number of different paper and computer records that cannot necessarily be quickly accessed. Patients can appear for hospital clinic appointments and their records are not available. This is time wasting and very frustrating for both patients and staff. In future an accurate, up-to-date record of the health and healthcare history of a patient will be immediately available to authorised healthcare staff. Eventually these records will include more detailed patient information online such as x-rays and, in due course, integrated health and social care records.² These cradle-to-the-grave e-health records will replace consultants' letters, pathology reports and other paper communications moving between hospital and general practitioner (GP).

How will this e-health record affect primary care where already GPs hold a lifelong record for the majority of patients? And, in particular, how may patients be affected?

The first part of the plan is electronic booking where hospital appointments can be directly booked by GPs and where patients will be given a choice of hospitals and information on waiting times. If patients do not want to book their appointment at the surgery they will be able to do so through a call centre or online. Another early development is that prescriptions will be transmitted by GPs electronically to pharmacies.²

There are clearly considerable advantages for patients, and for their GP too, when a hospital appointment can be booked during a consultation. A problem has been identified and the need for further investigations established. The date can be confirmed quickly and the patient has choice in where and when this appointment will take place. The patient leaves the surgery knowing that something has been done.

The electronic transmission of prescriptions directly from GP to pharmacy is interesting. Currently patients are given the prescription by the GP to take to a pharmacy of their choice. In the new system, patients will presumably still have a choice of which pharmacy but that decision will need to be taken when the

prescription is being written rather than being left for the patient to decide when they have left the surgery. This is a change in the pattern of patient choice.

A comprehensive and accurate health record containing relevant medical history and current medication, as is envisaged in the e-health record, would be of enormous value when caring for patients in the community. General practice records, current medication with known reactions, contemporary nursing notes, pathology reports and hospital records, all readily available from one source, would be extremely helpful when caring for the frail elderly at home. In the situation described by Wilkie and in a short paper elsewhere in this journal, several records of important information about the health of the patient were in existence.³ These included:

- GP medical record
- nursing notes kept at the patient's home
- hospital records
- accurate and contemporaneous medication record kept by the carer.

Furthermore the carer had copies of recent letters from NHS consultants to the GP and some pathology reports. In addition the carer kept a daily 'diary' about the welfare and progress of the patient. From the perspective of the patient, and in order to give quality, holistic care, it is essential that doctors, nurses and the carer have access to a relevant and up-to-date single medical and health record to which all involved in the care of the patient have input.

This is simply common sense. How frustrating it is for the patient and their carer when GPs do not seem to be up to date in their knowledge of what is happening to the patient, when nurses do not appear to have communicated with the GP staff, when doctors do not appear to give much importance to the nursing notes and when professionals do not appear to accept what the carer has to report. In these circumstances a single e-health record, also accessible in the home, could help focus all those concerned and bring cohesion to the care of the patient.

However, this requires trust. Perhaps the existence of the e-health record may encourage the development

of trust so that doctors will learn to trust in the skills and competencies of other non-medically qualified health professionals, and all healthcare staff will trust the patient and their carer, all of whom are important partners in the care of the patient.

Part of this trust involves who should have access to the medical record. Indeed if doctors had trusted patients, it is arguable that all patients would now be holding their own medical record rather than only certain categories of patients in specific situations! The medical record is of particular interest to the individual patient and while the e-health record does not give ownership of the record to the patient, it should enable much easier and non-problematic access to what is, after all, a personal medical record. Patient (and carer) access in this way can encourage a sense of involvement and of individual responsibility.

In this editorial, the discussion about who is contributing information to a patient record has been confined to doctors, the carer and nurses. There are many other professionals, including those from social services, who are involved in the care of patients in

primary care and whose contribution to the healthcare record may well be important. However, this raises yet more issues around confidentiality as well as trust and is surely the topic of another article.

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Received 12 April 2004

Accepted 20 April 2004