CHAPTER-10

PHYSICIANS' PERSPECTIVE FOR IMPLEMENTATION OF ELECTRONIC MEDICAL RECORDS AT ABEER FAMILY MEDICAL CENTER

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INTRODUCTION

Electronic medical records (EMRs) are undergoing continuous advancements as a technological solution in medical practices [1]. They serve as the preferred tool to streamline the patient care process. Although documenting certain aspects of patient records electronically may require a bit more time, the evident realization is that adopting an EMR system results in significant time savings for both physicians and staff when carrying out various daily tasks.

The electronic medical record (EMR) serves as a facilitative technology, empowering physician practices to implement more robust quality improvement initiatives compared to what is achievable with paper-based records. While it might be feasible for a physician to operate slightly more slowly than with a purely transcription-based system due to the increased efficiency and comprehensive documentation provided by EMRs, achieving quality improvement through their utilization is neither cost-effective nor straightforward [2].

When considering the state of electronic medical record (EMR) adoption in India, it is notable that despite advancements in various sectors, the utilization of Information Technology in healthcare services, whether in outpatient or inpatient hospital settings, remains considerably restricted. A study conducted by the Healthcare Information and Management Systems Society (HIMSS) indicates that the use of information and communication technology (ICT) in healthcare in India is lower than that observed in the majority of other nations [3].

RESEARCH OBJECTIVES

1. To comprehend various aspects of hospital operations associated with Electronic Medical Records (EMR) concerning the entire process flow of a patient's complete cycle.
2. To assess the viewpoints of physicians regarding the electronic medical record system.

3. To recognize the primary obstacles hindering physicians' utilization of EMR systems.
4. To propose policy interventions to address these barriers, informed by the findings.

RESEARCH METHODOLOGY

The study employed an Observational Cross-sectional approach to delve into and comprehend physicians' perspectives at a particular juncture. The examination was carried out at Al Abeer Family Medical Centre, Calicut, selected following extensive month-long scrutiny and observation. The primary focus was on physicians. A structured questionnaire, consisting of 16 questions, was employed to probe various domains. Additionally, in-depth interviews were conducted with physicians, including the Medical Superintendent. The study encompassed the period from February 2019 to April 2019. Fourteen physicians actively participated in the questionnaire, encompassing the entire physician population at the medical center. One hundred fifty patients were purposefully sampled to gauge the time required for the complete process or visit. This sampling process unfolded over 17 days, with an average tracking of nine patients per day.

RESULTS AND DISCUSSION

The patient flow process involved various stages, such as billing, vitals registration, waiting, consultation, and pharmacy billing, each with its average duration. Billing typically took around 7 minutes, occasionally experiencing delays due to software issues and patient traffic. Vitals registration averaged 5 minutes, with potential delays in the absence of nursing staff. Waiting time was notably high at 34 minutes, influenced by factors like the lack of appointments for 13 physicians and extended consultation times. Consultation time averaged 13 minutes, varying among physicians. Pharmacy billing consumed an average of 12 minutes, primarily due to understaffing. Identified issues included patient waiting times exceeding the standard average, technical glitches in billing software, insufficient receptionist availability during specific time slots, nursing staff shortages at the vitals recording desk,

and limited appointment systems for physicians.

All 14 physicians utilized Mediware for checking vitals and accessing patient records, but only 2 employed it for online prescriptions. The study participants believed that EMR enhanced efficiency, contributed to quality improvement in care, and offered cost-saving benefits, with 12 out of 14 physicians supporting these views. A consensus was found among all physicians that Mediware excelled in billing documentation compared to clinical documentation, and 12 and 6 physicians, respectively, highlighted the quicker and more accurate nature of EMR documentation. While 8 physicians believed Mediware aided patients, only 7 felt the organization actively encouraged EMR use, and 6 believed it enhanced productivity. A minority of 5 physicians deemed Mediware notes as accurate. The data indicated that 9 out of 14 physicians were satisfied with the provided EMR, with most suggesting changes in Mediware for greater benefits. In prioritizing EMR features, six physicians emphasized immediate access to patient records, seven prioritized easier navigation, one underscored standardization of care, and none considered electronically transmitting prescriptions as the most crucial feature.

CONCLUSION

The health information technology (HIT), including the EMR, holds the potential to enhance the safety, quality, and cost efficiency of healthcare services. Despite these potential benefits, the adoption of EMR across healthcare organizations has been sluggish, and many have yet to experience these advantages. The successful implementation of EMR relies heavily on the cooperation and acceptance of its users. This dissertation specifically concentrates on physicians as the primary users of EMR, recognizing them as key stakeholders, and endeavors to comprehend their adherence to EMR.

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