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Subject Response to Healthcare Reform Consultation Document (eHR part)

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This is in response to the part of electronic health record (eHR) of the consultation paper. According to the consultation paper, "An eHR encompasses general personal particulars (e.g. name, identification, date of birth, contacts, insurance enrolment, organ donation preference, etc.), personal health-related information (e.g. weight, height, blood type, diet, exercise habits, smoking habits, etc.), as well as medical records (e.g. diagnosis, prescriptions, test results and discharge summary), from different sources and locations." Looking at the description, we can ascertain that they are related to personal information. And it can be found that there could be cases those information is more than necessary in treating diseases. Although sharing all information can be efficient to medical practitioners, it also increases the change of abusing those more-than-necessary information.

Those information is all privacy data and pertains to the whole life history of a person from his/her birth to death. Those information should be confined in highest possible standard. The principle of need-to-know and least-to-know shall be upheld here.

All patients, effectively all HK residents, shall have the right to disclose part and which part of his/her medical history to doctors. This right is protected by Basic Law 39 that "The rights and freedoms enjoyed by Hong Kong residents shall not be restricted unless as prescribed by law." Under Personal Data (Privacy) Ordinance, a person has the right to disclose or not disclose his own privacy information. For example, a woman seeking treatment of common cold or dental illness should have the right not to disclose her medical records of abortion.

Besides the right to disclose the part and which part of medical history, the patient also has the right to let the clinic and hospital to retain this part of the record or not. This is also a lawful right of the HK resident. In the new eHR system, the patient shall have lawful right to set the retention period of his part of medical history in a certain clinic. This right cannot be restricted according to law. There shall be no compromise for operational efficiency. For example, it is legal that a patient demands his psychiatric treatment not to be recorded in any system although he affords the risk of not getting the best possible treatment in the future. This is a right protected by Basic Law and this right cannot be compromised.

Another issue is the ownership of the records. The eHR must be belonging to the patient himself/herself. As such, a patient shall have lawful right to demand that his/her records not to be kept by the eHR system (or by hospital authority) totally. It is a matter of freedom of choice and cannot unlawful deprived of. It is anticipated our society are looking forward to a balance of supply of public and private health care services. There is no reason or legal backing that Hospital Authority is the de facto or de jure keeper of all patient electronic records.

There will be a lot of problems for protecting the data from being abused. The Government should consult the mechanisms of eHR in details.