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Employees' work environment and patients' rights, conflicting responsibilities when implementing patient online access to their EHR

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Abstract:

This paper is based on an interview study examining the implementation of the eHealth service *patient online access to electronic health records* in two county councils in Sweden. Our aim is to present and discuss the two councils' implementation processes and the differences between them, with particular focus on the implementers' consideration of caregivers' work environment. A theoretical aim is to shed light on the complicated situation that arises when a county council is responsible for both the implementation of an eHealth service and the effects it has on the work environment of the employees (professionals). The results from the total of 16 semi-structured in-depth interviews show that the two county councils differ in the following areas: 1) whether the implementation is interpreted as a threat for the work environment; 2) who the interviewees consider as responsible for the work environment; and 3) if it was considered important to build trust between the implementers (the county councils) and the professionals – and how this trustbuilding was accomplished. It is concluded that the differences between the two implementation processes was due in part to the difference in how the service was framed and labelled in the two respective county councils, and that one of the county councils has encountered difficulties in taking dual responsibility towards both patients and the work environment of the employees. This implies, according to Bovens' (1998) classification, that one of the county councils takes active responsibility for the work environment while the other takes passive responsibility for the work environment.

Keywords: Electronic health record (EHR), eHealth, responsibility, online access, implementation

1. Introduction

In Sweden, as in many other European countries, the government and public agencies have promoted the expansion of eHealth over the past ten years. The rapidly increasing use of modern information and communication technologies in the field is commonly described as a paradigm shift for Swedish healthcare. The intention guiding the deployment of eHealth-services is a perceived need to give patients increased access and influence over their health situation, and arguments such as "patient authorization", "patient transparency" and "patient empowerment" often feature in the debate. The development has the potential to reform and alter the relationship between citizens and healthcare organizations. In early 2013, an "Action Plan" for the period 2013–2018 (Cehis 2012) was launched as part of a national strategy for eHealth services. Within this strategy document, the implementation of patient online access to electronic health records (online EHR) is noted as being one of the most important services in eHealth.

In the autumn of 2012, the Uppsala County Council (UCC) in Sweden launched a pilot project consisting of twelve eHealth services, including patient online access to EHRs. Region Skåne (RS) followed in March 2014 as the second county council in Sweden to make EHRs accessible online for patients. Even though the motivation for the service is similar in both county councils, the implementation process has been quite different and, most of all, the reactions among doctors have varied between the two county councils. In Uppsala, a conflict arose in 2012 when medical professionals actively initiated a public media debate in conjunction with the transition from implementation project to full-scale deployment in UCC. The main standpoint of the local medical association was to oppose any and all online access of patients to their EHRs, and the profession stressed several parallel arguments in the debate. A lot of the attention was directed towards

physicians' work environment. Firstly, the doctors argued that the health records were their working instruments, and that patients' immediate and easy access would challenge the functionality and integrity of these instruments. Secondly, the local medical association was concerned that patients would lack sufficient knowledge to fully understand the information in their medical records. In addition to causing unnecessary fear and anxiety for the patients, the local medical association claimed, this also could negatively affect the doctors' work environment because they could be inundated by questions from alarmed and/or inquisitive patients (Erlingsdóttir & Lindholm 2015). Contrary to the turn of events in the UCC, the deployment in RS has, been rather unproblematic, at least in terms of public debate between the local medical association and the county council. This aroused the curiosity of the authors: what differs between the implementation processes in the two county councils? What was the reasoning of key actors in UCC and RS, respectively, regarding how patient online access to EHRs would affect care professionals' work environment?

2. State of the art

Research has shown that when technical systems evolve, professional groups often want to be involved in the process that takes place and influence how systems should be designed and used (Eriksson-Zetterquist, Lindberg & Styhre, 2009). Professionals in general and doctors in particular may find it difficult to embrace new ideas and technologies if these new concepts are not consistent with their own procedures and routines (Oliver 1991). According to Constantinides and Barrett (2006), numerous IT implementation projects in healthcare fail because they are not sufficiently anchored among key stakeholders (professionals). This is confirmed by While and Dewsbury (2011), for example, who describe how important it is that nurses are involved in the design and development of information and communication (ICT) systems – not only to ensure that the right features will be included but also to gain acceptance from the profession for introduction of the systems. It is therefore important that professionals are involved in developing the technologies they will use and that solutions are based on their own needs and wishes. The report "Disturbing or facilitating? On the usability of eHealth systems" (Scandurra, 2013) also notes the importance of adjusting digital systems to existing work processes so that they are adapted to the current tasks and work situation.

Our paper pivots around conflicting responsibilities, particularly in healthcare organizations guided by multiple goals and missions. Actors and groups of actors, in charge of governing and controlling the development, find themselves within a web of conflicting responsibilities, including legal, professional and managerial obligations (Roberts, 1991; Sinclair, 1995; Bovens, 1998; Cane: 2002; Messner, 2009). This is inherent to modern complex organizations such as county councils, where politicians, officials and professionals all have their different duties and responsibilities (Braithwaite & Roche, 2001). The politicians' role is to protect the rights and needs of the taxpayers (the citizens), while the county council also has legal obligations as to follow the Work Environment Act. This, of course, can lead to conflicting interests. Bovens (1998) also describes the difference between passive responsibility and active responsibility. In his terms, passive responsibility is a question of who is to be held responsible for the wrong that has been done in the past. Active responsibility, on the other hand, is taking responsibility for the future. In other words, active responsibility may be used to avoid harm or injustice.

3. Objectives and Methods

Our aim in the paper is to present and discuss research material and findings that reveal two implementation processes and the differences between them. A theoretical aim is to shed light on the complicated situation that occurs when a county council is responsible for both the implementation of an eHealth service and the effects the service has on the work environment of the employees (professionals).

An interview study was conducted with key actors in both county councils in 2015. A total of 16 semi-structured, in-depth interviews were conducted (eight in each county council); responses were recorded, transcribed and analysed. The interviews are part of a longitudinal study, encompassing a series of sub-studies, that has been conducted since 2012 on the development and deployment of the patient online access to EHR service. Background information on and in-depth understanding of the two cases has thus been gathered in previous interviews.

As the two implementation processes in the two county councils have been organized in different ways, we have used what can be described as a *snowball sampling* where the project leader in each county has provided names of key actors in the implementation process. All interviewees were then asked if they thought there was someone else we ought to interview. Politicians and legal counsels were involved in both counties, but some other functions differed. The project manager in UCC, for instance, is the technician who has been involved in the development of the technical solution, whereas the project coordinator in RS is a nurse and a strategist within the healthcare organization. Each interview was recorded and transcribed. The material was then coded, categorized and analysed.

4. Results & Discussion

The results from the 16 interviews show that the two county councils differ in the following areas: 1) whether the implementation is interpreted as a threat for the work environment; 2) who the interviewees consider as responsible for the work environment; and 3) if it was considered important to build trust between the implementers (the county councils) and the professionals – and how this trustbuilding was accomplished.

4.1 Was the implementation interpreted as a threat to the work environment?

In both the UCC and RS, there were some misgivings about patients having online access to EHRs. In both counties the comments revolve around the following aspects. 1) The medical records are understood as a primary work tool of care professionals, and patient access could negatively affect the professionals' way of making entries in the records. In addition, the immediate transparency, without time to edit or correct entries, was perceived as a problem. 2) Some saw a risk that patients would be harmed by the information that they could read in the EHR, as patients would either be frightened by it or would not understand it. 3) A risk was seen that patients would call and disturb healthcare professionals with questions about the entries in their EHRs.

In UCC, the implementers were clearly not aware that patients' online access to EHRs could be interpreted as a threat to the healthcare professionals' work environment. The project manager states that "this [service] is not aimed at the doctors; it is a service for the patients". In UCC the attitude, from the beginning, was thus that the implementation of the service would have no impact on the professionals' work environment; therefore, no special actions were taken to involve the professionals in the implementation. When the regulative framework for the service became known to the local medical association, representatives reacted strongly and contact between the implementation project and the medical association was broken. As a result of this lack of dialogue, the resulting – and fierce – conflict took place mostly in the media.

In RS the implementers were aware of the problems that had occurred in UCC, and were determined to avoid a similar situation. Thus they made sure that representatives for the medical profession took part in different aspects of the implementation process, for example concerning adjustment of the regulation of the service in RS. The previously formulated UCC regulation served as a model, but it was adjusted to meet local needs as well as the opinions of the medical profession. Among other things, it was agreed that no EHR entries written before the day of the launch would be visible for patients. This was a requirement from the medical profession, as it was considered important that patients be given access only to entries written by medical professionals who were aware that patient

access was operational. A lot of effort was also put into informing the employees and responding to their concerns. This does not imply that there has not been any negative reactions in RS, but in this situation, the type of conflict that arose in the UCC could be avoided.

4.2 Who was considered responsible for the work environment?

In the interviews, it became quite clear that there was no clear consensus in Uppsala about who was responsible for possible effects of patient online access to EHRs on care professionals' work environment. Surprisingly, several of the interviewees thought that the implementation project should have been responsible, and even the project manager himself thought that he and the project were responsible for consideration of the effects on the work environment.

In RS there was more of a consensus that the operation managers or the HR department at RS were responsible for how the work environment would be affected. This is much closer to the legislation, which holds the employer responsible, than the UCC answers; many of the UCC respondents held the implementation project responsible for the work environment.

4.3 Was it important to build trust between the implementers and the professionals'?

As the implementers in UCC did not consider the professionals to be key stakeholders in the implementation of the service, they did not go to any lengths to build trust between the professionals and themselves in the beginning of the implementation project. When the implementers discovered that the negative reactions of the professionals and wanted a dialogue with them, it was already too late. The damage was already done, and the professionals – primarily the doctors – refused to negotiate with the implementers. Moreover, this forced the communications department in UCC to back down and hardly any information about the implementation was mediated to the healthcare professionals. This further impaired the trust between the two parties.

In RS there was a continuous discussion between the professionals' unions and the board responsible for the implementation. In addition, a thoroughly planned information campaign was launched to inform as many of the staff as possible. The campaign consisted of information meetings in all geographical areas of the region as well as published articles and films on the intranet. As the professionals felt that they could affect the formulation of service regulations, they were open to continuous communication with the implementers, and this never evolved into a controversy.

5. Conclusion & perspectives

From the above, it is obvious that significant differences can be found between the implementation processes in the two county councils. In UCC, the focus on delivering a new digital service to the patient/citizen seemed to prevail, while the responsibility for the work environment of employees was not considered to be an issue. The implementation project somehow seemed to become the main actor, closely knitted to the technicians in the project instead of a board comprising both representatives from the implementation project and officials from the remainder of the county council – as was the case in RS.

In RS, the board responsible for the implementation seemed to have an awareness that the region has dual responsibility for implementing new technology for the patient/citizen and monitoring the effects on working conditions of the employees. This may be due to the different framing or labelling of the implementation projects in UCC and RS, respectively. In UCC the implementers are the same as the developers of the civic service, and they see their duty first and foremost as meeting the needs of the patients/citizens. In RS the implementation project is in the hands of a composite board that sees its responsibility as more inclusive – to develop healthcare – and that this particular service is viewed as one step in a larger transformation.

As a consequence of the above, we conclude that RS takes what Bovens (1998) calls active responsibility –responsibility from the beginning of the implementation project to prevent future damage to the work environment of healthcare professionals – while UCC took on a more passive role and was blamed for not taking responsibility for the damage that the implementation might cause. The bottom line is that RS manages to take active responsibility and recognize that it has dual responsibility, while UCC is made passively responsible and does not recognize its dual responsibility. Moreover, through active responsibility, RS builds trust between implementers and professionals, while in UCC the controversy between the medical association and the implementers has created a lack of trust that will take a long time to repair.

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