

### Appendix 3. Summary of respondents' responses to the free-text questions

Key theme	Respondents' views	
<i>Record availability – Will I find that patient's record?</i>	A number of respondents indicated that they were disappointed by the percentage of patients their PMH system is likely to have a shared record for.	<p><i>"It is only useful if the patient has it activated. Many GPs I know have deleted their accounts due to security concerns, as have many patients."</i></p> <p><i>"Many patients do not have a record."</i></p> <p><i>"There is no significant communication between regions, i.e., the electronic data records are separated amongst the different regions."</i></p>
<i>System usability – Is the system intuitive to use and reliable?</i>	<p>Responses indicated that PMH users were finding a number of barriers to using their systems. These barriers included:</p> <p>-Connectivity issues</p> <p>-Information poorly set out and systems difficult to navigate</p> <p>-No ability to transfer information from the PMH into the ED or UC patient record.</p>	<p><i>"The system crashes regularly."</i></p> <p><i>"Currently we have had no access for approximately eight weeks because the whole system was hacked."</i></p> <p><i>"It is sometimes slow, has technical issues and we are unable to connect."</i></p> <p><i>"The link frequently crashes and will not load."</i></p> <p><i>"Any systems used need to be fit for purpose – information needs to be quickly and easily accessible, and in a format that is useable. i.e., summarised, with option to expand out any diagnoses/areas for investigation results, specialist opinions, management, medications."</i></p> <p><i>"It can be cumbersome and difficult to navigate."</i></p> <p><i>"Currently it's a brain dump where everything is just thrown in there with minimal organisation of information".</i></p> <p><i>"It would be helpful to be able to extract/export data directly onto current clinical system."</i></p>
<i>Information value – Will the information be of value to me/my patient?</i>	Respondents gave a list of additional information they would like to have access to:	<p><i>-The patient's goals of care</i></p> <p><i>-Advance directives</i></p> <p><i>-Patient's preferred language</i></p> <p><i>-Next of kin's name and contact details</i></p> <p><i>-Enduring power of attorney</i></p> <p><i>-Mental health records</i></p> <p><i>-Alcohol and drug records</i></p>

Key theme	Respondents' views
	<ul style="list-style-type: none"> <li>-A record of conditions treated or surgeries performed in private hospitals</li> <li>-The number of ED presentations</li> <li>-The number of hospital admissions</li> <li>-Surgery records</li> <li>-Methadone Clinics</li> <li>-Drug addiction services</li> <li>-Nursing homes – RE end of life decisions</li> <li>-Oncology services</li> <li>-Palliative care providers</li> <li>-Any cardiorespiratory diagnostic tests and spirometry</li> <li>Transthoracic echocardiograms (TTEs)</li> <li>-6 min walk tests</li> <li>-ECGs</li> <li>-Radiology, pathology and hospital summaries from interstate,</li> <li>-Most recent (dry) weight (children, dialysis patients and patients for aeromedical retrieval)</li> <li>-Physiotherapy, hand therapy, outpatient nursing/district nursing</li> <li>-ENT clinic or eye clinic visits</li> <li>-Non-government organisations</li> <li>-Information held by Aboriginal medical services</li> <li>-Tertiary cardiology services</li> <li>-Medication history (pharmacy dispensing records)</li> <li>-Direct access to GP notes</li> </ul>
<p><i>Integrity – Can I truly depend upon this information?</i></p>	<p><i>Has the information been curated in a manner that assists me to understand and interpret it?</i></p> <p><i>“The system is a central repository of secondary and incomplete structured information.”</i></p> <p><i>“Currently it is a brain dump where everything is just thrown in there with minimal organisation of information.”</i></p>

Key theme	Respondents' views	
<p><i>Am I being given information from records provided by another clinician that I can rely upon?</i></p> <p><i>Has the information been made available in an appropriately well –considered manner (and is not merely a hodgepodge of data).</i></p>	<p><i>“The system rarely has health summaries i.e. a list of past and current medical and surgical issues.”</i></p> <p><i>“Some medication lists do not have dosage and frequency of medications.”</i></p> <p><i>“The formatting can be atrocious, spitting out large amounts of redundant information. The medication lists should produce a current 'most recent' list every time a medication or allergy is altered, with the 'past history' of the list only visible if specifically requested. - In both cases the 'signal to noise' ratio needs to be optimised.”</i></p> <p><i>“Curation of PMH is essential to the usefulness of any system designed to help ED clinicians, but what is critical is- who does it? - it's a fairly high-end cognitive task and so can't be automated or easily contracted out. It needs someone with a thorough understanding of the situation. The term “appreciation” in the technical sense is on target; curation done by someone at a lower level can obliterate the value).”</i></p> <p><i>“In practice the best approach is to get information from someone at a reasonably high level who has put the effort in to understanding the situation for purposes other than providing a summary.”</i></p>	
<i>Masking/Redaction?</i>	<p><i>Concern that removal or masking of key pieces of information could mislead the ED or UC carer.</i></p>	<p><i>“I think it's completely unnecessary but if it makes patients feel better then that's fine. I would prefer if I knew something was hidden though.”</i></p> <p><i>“While it will reduce the usefulness of the information, patients have the right to choose who sees their medical information so this cannot be circumvented.”</i></p> <p><i>“Missing information could lead to diagnostic and prognostic errors.”</i></p> <p><i>“Redacting is costly in terms of time while relevant information is sought by other means.”</i></p> <p><i>“Redacting key information makes assessing patients with mental health presentations extremely difficult, especially when determining risk assessment.”</i></p>
<i>Advance care directives</i>	<p><i>In what circumstances would having an advance care directive be useful?</i></p>	<p><i>“Needed for all presentations!”</i></p> <p><i>“Any life-threatening circumstance.”</i></p>

Key theme	Respondents' views	
<i>Risk of framing bias</i>	<i>Concern that an ED or UC clinician might jump to a wrong conclusion on the basis of information created previously.</i>	<i>"Any patient I can't ask questions of."</i>
		<i>"Resuscitation cases or the very unwell."</i>
		<i>"Unconscious, post arrest, septic resus, ambulance pre-notification."</i>
		<i>"No next of kin contactable for proper history."</i>
		<i>"In ALL circumstances especially with nursing home patients and oncology/other palliative patients."</i>
		<i>"In a patient with an unsurvivable pathology e.g. terminal cancer."</i>
		<i>"Presenting in arrest/peri-arrest as an 'unknown'."</i>
<i>"When there is a lot of documentation and past history it can sometimes cause you to fall into fixation thinking regarding diagnoses."</i>		
<i>"I think the risks are lower than current risks of not having access to this information."</i>		
<i>"PMH can lead to bias but I think benefit far outweighs risk."</i>		
<i>"Less information is associated with significant risk. Even incomplete information might be put into context and be very valuable in patient care in ED."</i>		
<i>"I feel the errors would be worse by NOT knowing the information."</i>		