

**AN EXPLORATORY STUDY ON THE USAGE OF ELECTRONIC MEDICAL
RECORDS (EMR) AMONG PRIVATE CLINICS IN KUCHING, SARAWAK**

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ABSTRACT

Most of healthcare centers that include the hospitals and clinics in the western countries already acknowledge the importance of implementing EMR to increase the efficiency and effectiveness of their services. In Malaysia, the use of EMR among hospitals and clinics is relatively low and there are very few study had been done about the trend of utilizing EMR in the country. In Sarawak in particular, it is unknown whether any study had been done to address this issue. This is one of the reasons that prompted us to carry out this study. As for the beginning, Kuching was chosen as it is the largest town in Sarawak with the most private clinics operating in city area. The purpose of this study is to examine the level of practices of EMR among private clinics in Kuching and the level acceptance and utilization of EMR among the clinicians and physicians.

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1.0 INTRODUCTION

1.1 Introduction

EMR systems are designed to replace the paper-based medical chart. By computerizing the medical record, EMR systems do away with illegible handwriting and eliminate the onerous chore of alphabetical filing. Key benefits of using this technology stem from the use of imbedded decision support systems that can assist clinicians, via reminders and/or alerts, to provide higher quality, evidence-based care (Agrawal, 2002; Menachemi and Brooks, 2006b). Moreover, by automating data entry using customizable templates, EMR systems are associated with improved charge capture and reimbursements.

An important advantage of EMR systems is their ability to interface with other health data sources that contain pertinent patient information needed at the point of care. For example, EMR systems can potentially connect with pharmacy and laboratory data and provide access to refill histories and test results to physicians. Additionally, EMR systems that connect to other providers' system enable physicians to access the treatment plans and diagnoses produced by other caregivers that may be participating in the care of the same patient (Bates et al., 2003). Electronic access to comprehensive patient information previously