Reviewer's report

Title: Healthcare Provider Attitudes Towards the Problem List in an Electronic Health Record: A Mixed-Methods Qualitative Study

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Reviewer: David Hanauer

Reviewer's report:

This article focus in the problem list in the electronic health record, specifically related to the thoughts clinicians have towards the list, how it should be curated, etc. It is very timely and is still a very important issue given that the problem list is so central to clinical care and still so contentious in terms of a lack of agreement about many facets of it. I do believe this paper should be published, and I also think it can be improved with some additional edit and details.

- Major Compulsory Revisions

[1] Page 9. Regarding the vignette asking about a family history of cancer being added, I imagine the response will be influenced by what the EHR offers. For example, is there a family history section in the EHR? Is it used by clinicians? If not, why not? Among your respondents, did they have access to a family history section? I would think that such context would influence their answer.

[2] Page 11. The respondent pool was based on access to departmental e-mail lists. Did any departments not provide the lists? If so, which ones.

[3] Page 12. I am a bit unclear about how to interpret the "completeness measure" and the "majority measure". What is the advantage of reporting this as opposed to just the total number who agree versus disagree?

[4] Page 20. It is stated that "78% answered that the specialist should put a problem they diagnose in the problem list". Is there any breakdown available by speciality (any difference, for example between PCP and specialists?)

[5] Page 20. "a medical resident reported that nurses and doctors do not currently add new diagnoses to the problem list during inpatient care." Really? How do inpatient diagnoses ever get on the problem list?

[6] Page 21, "Non-residents answers with more 'yes' responses." Yes to which questions?

[7] Page 25. I am very perplexed about the HIPAA comments, and the concerns that adding some problems might be a HIPAA violation. You really have clinicians that are concerned about adding to the problem list because it might be a HIPAA violation? Perhaps it is me who doesn't understand HIPAA well enough, but as far as I know a clinician can add anything clinically relevant and true to the
medical record without worrying about HIPAA. HIPAA allows very unrestricted use for patient care. I believe the issues would come up if the decision was made to share data outside of a 'covered entity'. But for patient care within the confines of a single health system I would have thought this would be a non-issue. This may be worth addressing further because if it really turns out that many clinicians are concerned about this, then I think some major education is in order.

[8] Table 3. It is somewhat unclear why "problem list importance" is listed with the other 'demographics' measures. The table might be organized a little differently, and it might help to have tables 3 and 7 at least be formatted in a similar manner. Also, in terms of "Experience", Experience since when? residency? medical school? years working at the institution? self-defined for each participant?

[9] Table 5. Will this be included in the manuscript itself or referred to in an appendix? It is not clear from how it is included in the paper. "see additional files"

[10] I would like to refer you to a recent paper of ours that I think would be of great interest to you and which seems to have a lot of overlap in terms of the concepts covered regarding the problem list. It is not listed in PubMed as far as I know:


We would be happy to send it to you if you are unable to find it online.

- Minor Essential Revisions

[1] Page 10, change "medical accurate" to "medically accurate".

[2] Multiple pages, change "two prong approach" to "two-pronged approach"

[3] Page 11, for the sake of brevity, I don't think it's necessary to include that REDCap was hosted at Partners Healthacre

[4] Page 11, I would suggest re-wording the paragraph starting with "In formatting" to make it more clear.

[5] The word "data" is plural. Thus, for example, on page 12, it should read, "The data from the online surveys _were_ aggregated..."

[6] Page 15. possibly change "This category covers if content" to "This category covers whether content"

[7] Page 15, you can change "(No. 92%)" to simply "(92%)

[8] Page 23, change "questionnaire gave hard quantitative evidence" to "questionnaire provided quantitative evidence"
Page 23, "change "a decent sample size was that residents answered for less to be included" to "a decent sample size was that residents wanted for less to be included"

Page 24, Can delete the phrase "based on the study" and the sentence under recommendations will read just as well.

Page 26. change "include everything" to "all inclusive"

Page 27, remove the semicolon after "but in most situations"

- Discretionary Revisions

Page 3. Regarding the clutter. One person's clutter may be another person's 'treasure', which is certainly related to the 'no common approach' problem. But it is possible that there are differing needs from various clinicians. Certainly in our general pediatrics clinics we do want to know how many ear infections a child has had, because this might help us decide if tubes are necessary. Other clinicians think ear infections are temporary and minor and should not even be added to the problem list.

Page 5 I also believe a problem list may be a Joint Commission requirement.

Page 13: Top line. Was this about the importance of the problem list in general or specific aspects of the problem list (such as specific problem to be added)?

Page 13: "It was found that some non-clinicians were included in department mailing lists..." Any idea how many "some" represents?

Page 13: Any thoughts as to one one practitioner did not want to answer the vignettes? Was it a time constraint?

Page 13: "across a variety of disciplines and experience levels". I think this should refer to table 3 or 7 where this is detailed further. Also, is any more detail available about what specialties were included? And what kind of PCP? Mostly internal medicine? pediatrics? family medicine?

Page 17, I am unclear what is meant by "... they wished to include more
detail in the language used on the problem list than less". I think it would benefit from being re-worded and explained a little more clearly.

[11] Page 18, regarding the clinician that didn't want to add back pain because a patient may never ask about it again: what if the patient was hoping that the MD would bring it up again since it was already mentioned (i.e., "is your back pain any better") but just dropped the issue when it seemed like the clinician was not taking an interest in the issue. Out of sight, out of mind?

[12] Related to 15, there is an interesting point to make: Most of the people who responded were PCPs, and the majority seem to feel that the specialists should add a problem to the problem list. Yet later on it is stated that "most specialists expressed that adding to the problem list...would be an incursion on an area of the medical record owned by the PCP." So it begs the question: Do specialists not add problems because they think they should not be doing it, or because they think that the PCP does not want them to do it (which is apparently not the case based on the data).

[13] Page 21. I am unclear about the value of the section called "Analysis of the Completeness and Majority Measures". It might be better just to highlight some key points and make the section smaller.

[14] Page 22. The discussion mentions the idea that practitioners differ in what should or should not be added to the problem list. But was it at all considered that one might simply change the 'view' of what can be seen? For example, maybe there could be a 'specialist only' view, so that they could add their problems which the PCP could choose to view or not.

[15] Workflow issues do not seem to have been covered in this paper. However, they can be important in terms of how one might approach a problem list. For example, I think some EHRs allow users (at least on the ambulatory side) to add to the problem list based on their billing coding.

[16] Page 24. The quote on this page is perplexing. This clinician is stating that they would comply if told to do so by administration, but isn't their thought to be a need for patient care itself?

[17] Page 25. "Some practitioners found the information irrelevant to how they would treat her, ...". I believe a lot of these issues may stem from potential limitations on where else such data can be stored. That context may be important in understanding the responses in this paper. If there was a logical place to put such information elsewhere that was easily retrievable then that would be different if there was only a problem list for diagnoses and no other "lists" for other potentially clinically or socially relevant concepts. This is related to the sentence on page 26 which states "they want the option to include anything". Again, maybe more flexibility in EHRs would help solve the problem and reduce the conflict surrounding the problem list.

[18] Page 28: Any thoughts on what a policy should look like related to the problem list? And do we really need a common approach? Or could we support
multiple approaches with additional views and ways to slice the data in an EHR

[19] I am somewhat lukewarm about Table 6. If there is an issue of space I think it could go.

**Level of interest:** An article of importance in its field

**Quality of written English:** Needs some language corrections before being published

**Statistical review:** Yes, but I do not feel adequately qualified to assess the statistics.

**Declaration of competing interests:**

I declare that I have no competing interests