Editorial

Welcome to the world of Informatics

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Welcome

Welcome to the new-look Informatics in Primary Care. You will find several differences, although the quality and relevance of the material have not changed. It is still the journal of the Primary Health Care Specialist Group (PHCSG) of the British Computer Society and, as such, it will continue to provide for the needs of our members.

One change is that Radcliffe Medical Press, the leading publisher in primary care, is now publishing the journal. This means that we have a new look and we believe that the new arrangements will ensure that the journal, having a long history of supporting primary care informatics, will be published regularly and consistently. It is provided as part of the group’s services to PHCSG members. Other organisations can negotiate to do the same for their members and it can be obtained by subscription. Details are on the inside front cover of the journal.

The other major change is the increased emphasis on international primary care informatics. The journal has always had some international input but this has now been developed by links with international bodies. The International Medical Informatics Association (IMIA) primary care working group, the American Medical Informatics Association (AMIA) Primary Care Informatics working group, the IT working party of the World Organisation of National Colleges and Academies (WONCA), and the primary care working group of the European Federation of Medical Informatics (EFMI) have all joined together with the PHCSG to use this journal as their major publishing outlet. In this edition there are articles from world experts in the field from Australia, the USA and Europe, as well as the UK contributions.

The format will continue to be a combination of peer-reviewed papers, articles, news and views about activities within our field and reports and notices about conferences and meetings. We are always interested in contributions on any of these.

The international experience

It is quite noticeable when exploring various international experiences that we are all dealing with the same issues. The details may vary but the underlying problems are common from country to country.

How do we get clinicians to use the information systems that we know can improve individual patient care, as well as streamline healthcare administration? In some countries the major issue is financial; in others it is culture. Everywhere there is a need to overcome the understandable reluctance of a necessarily conservative profession in getting to grips with new technology. New entrants to the clinical disciplines have few anxieties, but the established professional will need to learn new skills to cope with the new information age, and will have reasonable concerns that IT might damage the fragility of the fundamentally important clinician–patient relationship.

Another issue for clinicians is an anxiety that administrators are using IT and the information derived from its use to control care and reduce costs. In the past it was impossible to know what care was being given to whom. Now clinical information systems collect those data as part of the electronic patient record (EPR). The real purpose of the data is for the care of the patient who provided it. In some countries such data are also used to generate patient charges.

No-one disputes that clinical data should also be used, anonymously, for ongoing research. This is one of the major benefits of using information systems for patient care. We can learn more about disease as we have more data. Perhaps we can resolve the old primary care physician’s dilemma that ‘the diseases we deal with have not read the textbooks? The problems come when these data are used to monitor care, drive down costs and assess the performance of clinicians. Used properly, the information derived is of benefit to all. In an increasingly litigious world many worry that it will be used against the clinician. However, much of the evidence shows that properly designed systems with adequate and comprehensive audit trail facilities have just as often been used to defend clinicians. The best defence against a lawyer or health service administrator is adequate records.
The other major issue is confidentiality of medical data – this concerns everyone. In some countries it is already a part of their culture that personal information is sacrosanct. In these cases the use of IT can be hindered by this restriction. Information cannot be shared within health systems even though it would help patient care. In such countries, the use of patient-held data on smart card has been used extensively – but that means the overview needed by a health service is missing. In other countries, there is a history of sharing information about health care; here the danger is that the implementation of information systems can extend such openness beyond what is legally or ethically acceptable. Politicians and healthcare administrators can, and do, like to have access to what is very sensitive information. Much work has been done on setting up secure means of data sharing, but the culture and our political masters can make this difficult. It is vital that we do not damage patient trust if we allow unrestricted dissemination of what they tell us.

Health informatics as a profession

Health informatics is a young discipline. Those involved have come into it from many varied starting points. Some are clinicians who have developed an interest in IT and information. Some are managerial or administrative staff who have taken their need to understand the issues beyond the basics. Others are computer scientists who have developed an interest in health care. It is only just becoming clear what health informatics really is. It is not about computers per se. It is not just about local use of data by the doctor. It is about all aspects of information within health care: generating, manipulating, using and communicating those data within the context of health care. The health context means that it is separate from normal computer science, so practitioners do not find a professional home within the standard computer science environment. Its technical nature means than conventional medical, nursing and managerial organisations do not cater for it. As a result, practitioners are often disadvantaged, with no appropriate career path, no recognition of their value and no natural 'home'. In several countries this has led to the concept of developing health informatics as a profession. In Australia, they are considering an institution. In the UK, discussions are taking place about a joint body between the computer science and the medical professional bodies. It is our gift to the future and this journal will report on these initiatives as they progress.