In this issue: An innovative discipline needs a patient focus

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Health informatics has the potential to span the boundaries between health care professionals and patients.¹

This issue of the Journal of Innovation in Health Informatics opens with a powerful Editorial from Carol Bond reminding us that it is all about patients.² A theme of her article is that we should see our technologies as spanning the boundaries between professionals and patients, rather than serving some business need irrelevant to patients and their carers. Innovations and technologies that have failed to translate into benefits for patients rarely stand the test of time. Bond sees the principal opportunity for benefit from informatics innovations among patients with long-term conditions (LTC).

Muhammad contributes a research letter to this issue, making a point similar to Bond’s, but in the domain of Parkinson’s disease (PD).³ Muhammad stresses how modern technologies might not only aid the diagnosis and treatment of PD, but also promote self-management support.

When the leaders of our profession talk about family doctors managing more multimorbidity, they sometimes forget the cognitive load for both doctor and patient in conducting a successful clinical consultation in such a short time (most face-to-face primary care consultation are booked at 10-minute intervals).³ Ariza et al. have started to systematically classify the cognitive demands on general practitioners when completing tasks commonly conducted in a computer mediated consultation.⁴ This has the potential to open a fascinating line of research.

Lee et al. take us back to Bond’s theme of how patients are so often not included in the development of a technical process. Notwithstanding the structures already put in place to promote patient engagement with NHS hospitals, it is disappointing how little patient involvement there appears to be in the development of ePrescribing.⁵ Particularly as a systematic review suggests, patients do not have the opportunity to report their experience of adverse events.⁶ Continuing the prescribing theme, Brennan et al. report how ePrescribing adoption in primary care is more likely in those countries that have a state-run registration-based primary care system such as those found in the Nordic countries and the UK.⁷ There may have been scope for more patient involvement in the development of these processes.

Hayward et al. use a multichannel video technique, building on previous multichannel methods,⁸ to report on how GPs flexibly interact with their patient and computer during the consultation. Importantly, they show how use of a computer does not extend the length of the consultation.

The final article is one for debate. Your Editor et al. have set out how we should be much more joined up in how we deal with ethics and information governance. We suggest that it is time to link ethical and information governance reviews conducted prior to studies and that their output should determine whether and how access to health data should occur.⁹
Too often, research ethical approval, information governance procedures, and agreement for data access take place separately. We have argued previously for a more integrated approach and we feel it is time for this to be reviewed again. Comments on and critiques of the approach, the principles included, and questions are welcomed.

REFERENCES


