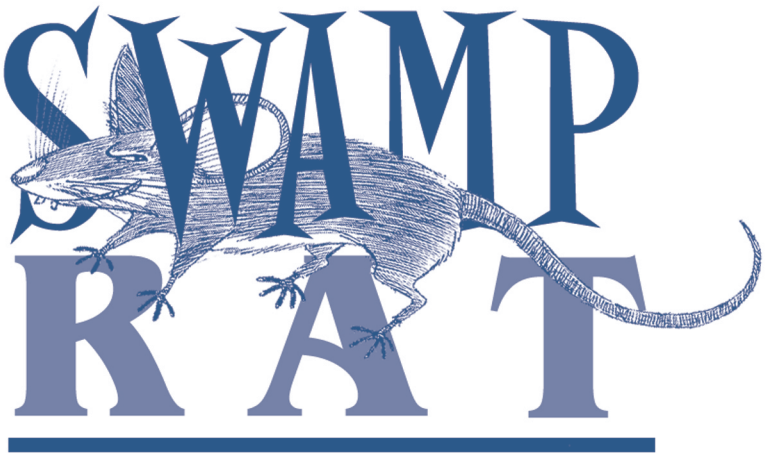

Swamp Rat Flies

Tim Gardner

I'm sitting at 30 000 feet in an American Airline's plane bound for Los Angeles ex-Chicago with only the occasional turbulence disturbing my Sudoku challenge. The seats in First Class are generous and comfortable, the service is excellent – and I'm far too PC to either notice or contemplate mentioning how stunning the female flight attendant's smile is.

Life, think I, is good!

I forget which philosopher spouted *'To be is to do'*...or which one suggested *'To do is to be'*, but I do believe Sinatra sang *'Scoobie doobie doo'*...which leads me to contemplate how I happened to be here!

In early high school I wondered briefly about becoming a computer programmer – the massive, building-sized computers festooning the Wellington Polytechnic on a fourth form study trip from Palmerston North Boys' High impressed me much! What impressed me more was rescuing my injured and drowning older brother from the swimming hole at Raumai Bridge in the Pohangina Valley north of Palmerston North later that year – by feebly splashing water into his face. All thoughts of computing went out of my head and I went on to study medicine! Instead it was my brother who (survived and) went on to computer programming and now runs his own successful software company.

Modern technology in the form of computerised records hit me as soon as I started my GP registrar year. So taken was I that I could play with computers AND save lives (well, sometimes!) that, soon after buying a completely paper-run, solo, semi-rural practice, I bought my first computer, complete with the latest technology – TWO floppy drives. I could now do my own spreadsheet accounts, GST and tax stuff and write the occasional referral letter in my practice. Around that time the RNZCGP GP Network started up – after some real GP information to populate their database, I soon had a generously provided new computer that I could once more write real patient notes on, write prescriptions and do appointments. There followed minor skirmishes with the local private and hospital labs and radiology as several of us like-minded GPs started developing our own forms to order.

Some years later as we changed our PMS vendor, systems improved, coding became useful with Read Codes

This is a column written from the swamp. The term is taken from the book by Donald Schon[1] where he talks about the crisis of confidence in professional knowledge thus:

In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solutions.

1. Schon DA. Educating the reflective practitioner. Jossey-Bass Publishers 1990.

Contributions

We invite amusing contributions to this column which should be relevant to the swamp and not more than 600 words.

Version 2, we could now do semi-standardised problem lists, long-term medications, email or fax rather than snail-mail referrals, collect measurements in our own individually created terms. Quite hooked on the possibilities for health information from a prior stint working in the RNZCGP Research Unit in Dunedin, I put my hand up for a College Information Group – which lapsed after a couple of years. One of that group (thanks Maryan) retired from a Classification Committee for Wonca (good name that!) and asked if I'd like to take up the reins. As soon as I discovered it could very well involve travel, I leapt at the chance and have since met these international colleagues and friends (all GPs or primary care researchers) in several different parts of the world – often self-funded or with some assistance from our local IPA.

Later, I completed a postgraduate Diploma in Health Informatics (now part-way through my Masters). Gradually I was developing a sense of frustration at the inconsistencies and lack of standards in our PMS systems in medical records, the endless duplication of effort with lost lab results and lack of useful and/or timely information from the hospitals and emergency departments. While coding seemed natural to me, it was at best haphazard and often inaccurate. It was frustrating when on-call to try to admit someone when the computerised records on the neighbouring practice had no long-term drugs, problem lists, allergies recorded, or immunisations up to date. For years I grumbled over the inability to electronically transfer or import medical records into my PMS – 200 sheets of printed out computer notes no longer seemed adequate or reasonable. How could I continue enjoying playing with my beloved computers and delivering care when I knew that care was not as good as our systems should allow? I even wrote a wee note that was published in *GP Pulse* outlining my concerns.[1]

Opportunity sometimes comes a-knocking and I was encouraged to apply for a newly forming organisation called the Health Information Standards Organisation (HISO), a ministerial appointment was made, and the last four years I've spent as the College's rep on HISO, the Health Practitioner Index (HPI) steering group and the Health Information Strategy Action Committee (HISAC, which morphed from HISO). It turned out many others were also concerned over much the same issues (and many more besides), from all across the sector – from primary care to hospitals, to DHBs, nurses, pharmacists, and several different departments within the Ministry of Health. Real live Health Information Strategies had been worked on for years and I believe are starting to bear fruit. The national identifiers – the National Health Index unique identifier (NHI) and now the HPI are real entities and help form the core of the standards required to realise how standards can actually lead to improvements in patient care – by reducing errors from the imperfect systems we use both in and out of hospital, to enabling the flows of information necessary: 'the right information in the right place at the right time'. One of the exciting aspects to me is that the standards developed and developing are from true sector engagement – all input from the ground up is listened to, people are starting to take ownership of the standards that result. Some complain that we don't move fast enough, while realising that the process of sector engagement must take place. One significant win is the process of having implementation of standards taking place at the same time as the standards are being built – for example, the Referral and Discharge Summaries process coming out of the Hutt Valley DHB. Another is the recognition through the Key Directions programme that a well developed and supported Primary Care core dataset appropriately applied with significantly improved PMS interfaces, will allow for all the current requirements of Chronic Care, Performance Management and Care Plus to fall out of GPs, nurses and associated primary health care teams simply doing their jobs. You can google HISAC and take a peek at the processes, standards, and workstreams in place by following the links.

Last year, through my Wonca Classification Committee contacts it was suggested that I attend a meeting in Chicago where a beast called SNOMED CT was being unveiled. Put simply, SNOMED CT is a whopping great complex, structured terminology now owned by a consortium of nine countries, including New Zealand, to answer the need for a common international coding system. New Zealand until now has had Read Codes v2 in primary care – not supported or updated since 1992. Hospitals report in ICD.10.AM. There are strong business cases for upgrading, requiring vast amounts of work to deal with mapping, migration into our PMS systems and developing improved interfaces that do not disadvantage those of us not so enamoured by the effort of coding. That first meeting was in 2007 – and I missed my flight back!

This year, I not only made the flight leaving Chicago but I managed to also see a Cubs baseball game, revisit the Field Museum, dine out at the Howard Centre, attend an excellent production of the musical *'Wicked'* and attend an amazing blues club until 2am this morning. All this on top of networking and working hard on the computer-y side of the Primary Care Special Interest Group for SNOMED CT. I'm heading home to family, loved ones and a firm belief that this playing with computers thing I do really makes a difference. Yup, life is good!

Swamped Rat! (coming in to land!)

References

1. Gardner T. Computers in general practice. GP Pulse 2004; Nov: 8-9.