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SHARED ELECTRONIC RECORDS

What have we really learnt?

Greenhalgh and colleagues see the shared electronic record as having to respond to existing ways of working and established practices, not the other way round.[1] My take is this:

- Powerful forces in established ways of working in the NHS are hostile to technological changes that threaten established and possibly dysfunctional and wasteful practices. As a taxpayer, this is not acceptable, especially when we need to explore better ways of using tax revenues when times are likely to be hard
- The scale of complex IT projects empowers dissident critics to feed political interest in their failings. That these projects frequently focus on purely internal (to the NHS) goals and objectives makes them largely inscrutable with respect to benefits that may accrue to patients and their failure more damaging as there are no milestones for delivering taxpayer value. It is better to think of flexible, networked, and distributed approaches—a school of fish adjusting easily to changes in its environment versus a supertanker that is much harder to control. Politicians would be better responding to the benefits that large scale IT projects bring to the public than to internal NHS efficiencies that may result
- Introducing new technologies must have some consequences, and these are not necessarily helped by protecting incumbents and legacy systems from threat.

The lack of a patient held smart card for health, for instance, maintains the control of information in the hands of the clinicians and the provider infrastructure. Giving patients complete and total ownership of their health record is a critical way of driving quality improvement.

My fear is that the sunk costs are already so great that a rethink is unthinkable and that we cannot cut our losses and start again. In politics this would be a U turn, requiring another innovation called courage.

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Disruptiveness of Google Health

Such is the pace of modern technology that the paper by Greenhalgh and colleagues is already out of date.[1] They did not mention the launch of Google's web based personal health record on 20 May 2008 or the collapse of the NHS records system.[2]

Web 2.0 technology will no doubt disrupt the grand aspirations of the NHS IT project. Techno-savvy patients using Google style applications might soon ask doctors to access their personal health records on the web.

Like the music industry, the NHS seems to have become self importantly complacent. We are deluding ourselves if we think that "the world is waiting to see" how the NHS IT programme unfolds. The world has already seen that, six years into the programme, NPfIT is overbudget and behind schedule. The NHS isn't the global gold standard. Instead, it is a hugely wasteful, inefficient, and bloated monopoly that needs some serious competition. Did record companies ever imagine that one day music could be downloaded for free?

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MANDATORY FLU VACCINATION

Patient care drives mandatory vaccination

Both sides debating mandatory flu vaccination for healthcare workers canvass central arguments,[1 2] but key issues require further exploration. Neither side acknowledged that health care differs fundamentally from other work. Its primary aim is not individual protection but protection of patients by reducing nosocomial flu. John Stuart Mills would support, not oppose, a mandatory programme.[2]

The autonomy argument focuses on individual rights of healthcare workers, ignoring the rights of others. Ethical assessment requires us to balance competing rights, and should include a patient's right to a safe healthcare environment. Australian States and Territories already require hepatitis B vaccination for those who are not immune and provide patient care. Individual autonomy is not catered for, with healthcare workers exercising their right to choose more fundamentally: either work in health care and minimise the risk of infecting patients or work elsewhere.

Increasing flu vaccine coverage among healthcare workers is possible using incentives and signed declination, but results are better[1] and cost less to implement with mandatory requirements. Better coverage at a lower price makes a mandatory programme dominant in health economic terms before consideration of improved outcomes.

Most developed industrialised countries have workplace health and safety laws that require workers to be "free from risk of death, injury or illness caused by any workplace."[3] Flu is an annual and predictable workplace danger that universal vaccination of healthcare workers can reduce. How can mandatory programmes not be required under such laws?

Given that vaccinating eight healthcare workers can prevent the death of one patient,[4] how can healthcare workers continue to oppose mandatory flu vaccination?

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ADDRESSING DOCTORS

Scandinavian solution

I recently started work in Sweden after a UK medical education and several years working in the NHS.

I find the Swedish solution of introductions very appealing: completely do away with titles and address everyone by their first and second names.[1] So my badge says "Alison Godbolt, doctor," and that's how I introduce myself.

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