The theme of this issue is the application of information and communication technologies to health information systems and particularly the need to integrate primary and acute care information systems. Our reviewed articles cover three important and interrelated areas associated with this theme. The first two articles focus on electronic information systems: general practitioners’ satisfaction with electronic discharge summaries and perspectives on the evaluation of health information systems. Our final reviewed study explores current information systems used during disasters and asks the question – is a standard disaster health information system needed?

Traditionally patient information, whether manual or electronic, is created and stored in the site where it originates. This can be a hospital, community care centre, specialist or general practice surgery. Patients, however, do not limit themselves to one service area; moreover they move seamlessly through diverse health sectors in different locations. The clinical and administrative information relating to their various health care episodes is not necessarily communicated between these settings. The increased use of information and communication technologies, particularly clinical information systems, should facilitate information sharing between different health care organisations and diverse health professionals. Sharing health information electronically is not without difficulty with issues related to system interoperability, clinical terminologies, security and privacy which all need to be addressed. However, if electronic health information is shared in a secure and timely way patient care can be enhanced. Rather than perpetuate ‘information silos’ which encourage the hoarding of knowledge, there would be a move towards seamless care which should result in less duplication of tests and medical effort (Mann 2005).
A key means of communication between the hospital and the general practitioner is the discharge summary. Studies have shown that paper-based communication between health professionals can be of poor quality and is often too slow (Westermann et al. 1990; Mageean 1986). The first paper in this issue of HIMJ (Alderton & Callen 2007) provides evidence regarding general practitioners’ satisfaction with an electronic discharge summary system used in a small metropolitan public hospital. The study shows that the majority of GPs like electronic discharge summaries. However, although the discharge summary in the study was electronically created, it was not sent electronically to the GP: it was printed from the system in hard copy and transferred to the GP by facsimile or mail. One could argue that this defeats the purpose of creating electronic information if it then has to be transferred in manual form. A key recommendation from this study is that the secure electronic transfer of patient-related discharge information should be explored (Alderton & Callen 2007).

Hospital information systems, both administrative and clinical, pervade health care organisations today. With increasing government expenditure on these systems there needs to be evidence as to their value. Are there administrative efficiencies to be gained and what patient care improvements result? (Ammenwerth et al. 2004; van de Meijden et al. 2003). The paper by Shahmoradi et al. (2007) provides a useful review of evaluation methodologies and presents perspectives from healthcare and health industry professionals regarding which indicators they consider most relevant for evaluations in Iran. They recommend that information system evaluations should include multiple perspectives and be multi-method with a focus on technical, economic and organisational issues.

There have been a number of disasters involving Australians which have focused our thoughts on how well our current information systems respond to these situations. Smith and colleagues (2007) present a comprehensive survey of Victorian public and private hospitals in relation to this issue. The researchers pose a number of important questions to the respondents from the study hospitals: whether they have specialised information systems to be used during disasters; what form they take; how would they be activated, and whether they saw the need for a standard specialised disaster health information system. Smith et al. (2007) found that the majority of respondents agreed to the need for a standard specialised disaster medical record with patient identification and tracking a key concern during times of surged demand. The concern of unfamiliarity with specialised information systems expressed by respondents could be addressed by appropriate staff training and system testing. An interesting finding from this study was the incidence of electronic versus paper-based health information systems used in the Victorian study hospitals. Just over half (55%) utilized paper-based information systems with 45% responding that they used a combination (paper and electronic), with pathology and radiology as the main electronic information. This highlights the fragmented nature of electronic medical records in hospitals in Australia. Implementation of electronic health records in this environment needs to be viewed as a continuum whereby sections of the manual medical record move to electronic format. This presents a challenging mixed media environment for health professionals and health information managers. Where there are multiple sources and mediums for retrieving and recording information there are concerns about duplicated information and the risk that something could be missed (Callen, Westbrook & Braithwaite 2007).
Indeed, studies have shown that where parallel manual and computerised systems are used, inconsistencies in medical documentation can result (Stausberg et al. 2003; Mikkelsen & Aasly 2001). This presents an important and under-researched area for health information managers to consider.

Included is a report which reminds us of the landmark Rogers v Whitaker case on information provided to patients regarding risks of medical procedures (Cockayne 2007). Safdari & Meidani (2007) have reported on the development of an Iranian Classification of Diseases which will ensure the comparability of Iranian health data sets with others. Our ‘professional profiles’ section again reinforces the exciting opportunities available to health information managers.

We hope you find this issue thought provoking and informative. We encourage you to contribute to your journal. Reports and articles on the development, implementation, use and value of clinical and administrative information systems and the management of information services are welcome.

References