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the international council on medical & care compunetics

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[A nice reminder why I did it in the first place, but where is the patient?](#)

On September 8 it was 4 years ago that I founded ICMCC, supported by my first, visionary board members. Medical and care ICT was something I had stumbled upon and knew little about in those days.

After the first 2 years, September 2006, we had a [final definition of the word compunetics](#), thus being the only global organisation dealing with patient-related ICT. Unfortunately, by that time my mentor and ICMCC co-founder [Swamy Laxminarayan](#) had passed away and I was diagnosed with a very aggressive form of Non-Hodgkin.

During the past 2 years, ICMCC has developed itself. Our [newspage](#), with an average of 6,000 unique visitors per month, has become an important source of information. Our [Record Access Portal](#) is still the only of its kind on the subject. *Compunetics* as a discipline is slowly entering other areas (e.g. behavioural compunetics), our [annual conferences](#) have become important meeting points, our *proceedings* are considered outstanding publications.

However, when you go through the emotional roller coaster that seems to be more or less obligatory after major treatment for a major kind of cancer, it is nice to read an article that reminds you of why you started it all in the first place. [Prescription for change](#), from professor Amar Gupta, published in the Wall Street Journal on 20 October 2008, is such an article.

“In the future, there will be three often overlapping modes of delivering health-care services: services performed in person by humans, services that can be performed by people at a remote location, and services performed by computers without direct human involvement. Offshore outsourcing in combination with a 24-hour work cycle will be appropriate when certain conditions are met — mainly, if the information involved in the task can be digitized, and if workers at different sites can do their jobs independently from one another.”

Prof. Gupta says:

“With robust IT networks, a single radiologist can support multiple hospitals, or large hospitals can serve as central image-reading sites, spreading the work among a staff of radiologists. Remote sites can be set up with just imaging equipment and technicians, extending radiology services to underserved regions.”

And not only radiologists. This should and could be the case for many medical fields as I said in my [ICMCC conference speech](#) in 2005 on the hospital of the future:

“Hospitals will split into two groups; there will be specialized clinics, probably run by industry. To exaggerate maybe a little bit, I see a Siemens clinic for cardio-vascular problems, and maybe also a Philips one. These clinics are fully specialized in these specific treatments. After-care and monitoring can be done in large “nursing” hospitals. They will be in touch via video and other tele-applications with the specialized clinic. These specialized clinics can be regional and will be competitive. The patient, in close contact with his insurer and his medical advisors can chose in which clinic he wants to be treated.”

Prof. Gupta:

“Globally integrated health-information systems are evolving, along with standardized formats for patient records — making the charts easier to translate. A detailed medical history can be critical if a person suffers an illness or accident far from home. Integrated information systems and records that translate easily would be of enormous help in natural disasters and other mass-casualty situations in which the victims come from many different places.”

Last July [I said it](#) in slightly different wordings at the [PHSCG Conference](#) in the UK:

“These days, people are travelling more than ever before. Every year, every country massively goes on exile for at least a couple of weeks to some warm and sunny country. And with the people go their medical conditions and physical problems. Only if we code a record in the proper way, a medical professional abroad will be able to understand what is in my record because, when based on the same ontological standard, he will get the information in his own language. The problem is, we still do not have a universal ontological standard. The only standard that gets close to it, SNOMED CT, has been accepted in only a quite small number of countries within Europe. Please note that I say accepted, not implemented. Another reason why proper coding is necessary is the fact that you would like to have your treatment abroad to be recorded in your record. But that is done in a language your own doctors would be unable to read.”

I very much like the fact that Prof. Gupta emphasizes the importance of standards, as he also does in the part dealing with drug safety. Monitoring adverse drug reactions is one of the examples of secondary data use of electronic patient data, which only can be done properly if standardised properly. These data are gathered from:

“companies or groups that tested or helped produce the drug; the FDA and equivalent agencies in other countries; and the doctor or organization that prescribed the medication. Individual pharmacies, too, would participate directly — a critical contribution, since they have the information about buyers, dates and quantities.”

Prof. Gupta then continues to one of my favourite subjects:

“The latest medical knowledge will appear on Web sites edited by eminent specialists in those fields. Doctors and scientists from around the world will contribute material, and automated search tools will capture updates from, say, a trusted clinical study. The reliance on IT and editorial workers in less-expensive countries, meanwhile, will help make such endeavors more economically viable.”

I call it “knowledge centers”, as I did in my [2007 article \[1\]](#) :

“There are ways to organise knowledge in a central semi-controlled, nevertheless open way, a knowledge centre. Avoiding the reinvention of the wheel as well as redundancy of science, research and experience, is a key argument in favour of those centres. We should develop the wheel, not reinvent it time and again due to the fact that we don’t know what knowledge and information is available. An inventory, a knowledge centre, could not only help to save billions of dollars a year by avoiding redundancy, could not only be an important source of knowledge to professionals, caregivers and policy makers, it could also be the basic information needed to assist in building new infrastructures.”

I’m immensely grateful to Prof. Gupta, for reminding me what the main reasons of existence of ICMCC were and are.


However, there is one thing that I dearly miss in his excellent article; **the patient as an active participant** in this “Prescription for Change”.

That the patient decides and benefits when seen by offshore doctors; that the patient will be able to access his medical record no matter where he is located; that essential input about adverse drug reactions is the patient’s input; that shared medical knowledge has only real value when shared not only between professionals but also with and between patients.

And that makes me realise once more why ICMCC needs to exist.

Lodewijk Bos

[1] Lodewijk Bos, *Medical and Care Compunetics - the Future of Patient-Related Care*, Medical and Care Compunetics 4, L. Bos and B. Blobel (eds.), IOS Press, 2007 ([PubMed](#))

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