In this issue

In this issue of *Informatics in Primary Care*: ethnicity, learning and diabetes

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Editor

Introduction

This issue of *Informatics in Primary Care* addresses three themes: ethnicity data and where best to look for it, using technology for learning and four papers which collectively ask us to look very critically at how we record information to support care in diabetes.

Ethnicity

The quality of routinely collected data in UK primary care is high and provides great opportunities for research and quality improvement. Its strengths and weaknesses are well known, and extensively described within the pages of this journal and elsewhere.[1] Recording of ethnicity data has been a relatively recent addition to routine coding; but good progress has been made particularly in some inner-city areas. This allows routinely collected data to be used to help describe ethnic differences in disease management and ensure equity in service provision, in a way that would not have previously been possible.[2] This is despite complex and overlapping hierarchies for data recording.[3]

The study by Hull *et al*, is important because it suggest that there is now better agreement between GP and hospital ethnicity data than with census data.[4] This finding if repeated more widely suggests that there may be a greater role for GP data than suggested in the Department of Health's Equity Rights Group editorial.[5] The quality of census data unsurprisingly falls as it gets older – we are now eight years since the last census (2001) – however, this will inevitably be repeated with each 10 yearly cycle of data collection. However, GP data will perhaps better reflect the inevitable and repeated waves of migration and movement that take place across this country.

Using technology for learning

We are publishing two papers about the use of technology to promote learning. The first by Wang *et al*, looks at the characteristics of brief synopses of evidence sent by email.[6] Physicians gave the highest ratings to the more complex synopses, which had more results, and more comparisons. Perhaps suggesting that clinicians like detail in order to appraise evidence rather than evidence-based bullet points! Possibly there is a useful message here for people involved in creating summaries of evidence? The second, by Tempelhof *et al*, is a randomised control trial of attending lunchtime seminars or receiving the same lecture by iPod.[7] The outcome measure was a knowledge test. It was interesting to read that the 'bleep' or 'pager' is still alive and well and called at least half of the residents away from their seminar – but more importantly both groups did equally well in the quiz. We should be making more use of technology in both undergraduate and postgraduate education.

Fundamental issues in diabetes

The final section of the journal contains four papers on diabetes. Diabetes is a condition which should be readily enhanced by the use of information technology. The quality of care in diabetes depends on the management of a number of numerical risk factors: glycated haemoglobin (HbA1c), blood pressure, cholesterol, smoking, and body mass index (BMI). However, these papers set out where there are still important gaps to close and that information systems in current use are not a panacea. Simply implementing an information system does not *de facto* improve quality.

The first paper by Chaudhry *et al*, reports how a clinical information system to promote diabetes care led to a significant improvement in LDL cholesterol (the 'bad' fraction of cholesterol) and whilst there were improvements in the process of care and other improvements the other changes were not statistically significant.[8] Our next paper offers another sobering lesson. Morin *et al*, report how provision of telemedicine to support diabetes management in underdoctored areas was not facilitated by whether the attending family physician worked using paper and fax or a computerised medical record system.[9]

The final two papers bring us back to the UK. Rollason *et al*, explore problems with diagnostic data labels in diabetes.[10] She describes a number of problems with diagnostic data: the use of vague diagnostic terms which can't be linked to the WHO classification of diabetes; and picking lists in GP computer systems which continue to reinforce the use of codes that can't be mapped to the WHO classification.[11] However, she also demonstrates that as we move (in the UK) from 4-byte Read version 2, to 5-Byte, then some to Clinical Terms version 3 (Ctv3) and finally on to SNOMED CT how the proportion of codes which can't be mapped to the WHO classification falls. This may be a justification for moving to a more contemporaneous classification system?[12] However, in the meantime she calls for the use of a more limited coding list. Such a move would enable clinical audit and monitoring of standards of care to be more effective. The final paper by Bagheri *et al*, is complimentary. It looks at surrogate marked for diabetes: test results (e.g. raised blood glucose), therapy (e.g. prescribed insulin), and other pointers towards the type of diabetes (e.g. age, obesity and ethnicity).[13] These markers both individually and in combination can predict a diagnosis of diabetes. This offers the allure of creating algorithms to validate or refute diagnostic labels within GP clinical records.

Letters and back pages

The back pages include a letter challenging the location and hierarchy of the CKD terms within the Read 5-byte hierarchy. It rightly criticises their location and arrangement.[14] Whilst we all cope with potentially worse arrangements within the respiratory, osteoporosis and ethnicity parts of the hierarchy it is right that these issues get an airing, in the hope these things will improve!

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