

**Medical Library Association
Informationist Conference
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Action Agenda Discussion Panel

Speaking toward the end of an exploratory, formative conference like this has its advantages and disadvantages. The advantage is I learned a lot during the conference. The disadvantage is that the comments I prepared before the conference became irrelevant.

So here are my thoughts on three issues that emerged during the conference which relate to the Joint Commission's emphasis on the importance of knowledge-based information in a health care organization. The first issue is:

What is an informationist, and why do I need one?

This relates to the Joint Commission's view of an organization as a system.

We've heard a number of success stories about the integration of knowledge-based information services within teams for clinical care (including the patients and families), research, and education. In each case, the innovative librarian clearly identified the user and the user's needs - and then met them.

The question we face is, from these individualized cases, is there a generalizable role that can be systematically applied across multiple, diverse settings? The definition of that role would define an "informationist."

It seems to me that the generalizable features of this role within a health care organization have been:

- Proactively identifying the information needs for a specific user or group of users.
- Retrieving the information relevant to those needs.
- Transforming that information into actionable knowledge by sifting for relevance and synthesizing.
- Pushing the knowledge in usable form to the user at the site of use.

If we want this role to be disseminated within the system of a health care organization, we will need to demonstrate its value to three groups:

- The users of the information in the system: clinicians, researchers, educators, managers, patients, students.

- The stakeholders in the information management of the system: the users are stakeholders, but so too are others, and the ones you need to worry most about are those who make the purchasing decisions – the CEO, who will be looking for the return on investment (the ROI).
- The third group are the ultimate beneficiaries of improved information in the system: the patients, the users of research results, and, if the cost of health care can be reduced, the ultimate payers – employers, the government, and insurance companies.

Just as with any innovation that you wish to disseminate, it is necessary to

- Convince the user he or she has a need that perhaps isn't yet recognized.
- Enlist early adopters and enterprise influences.
- Demonstrate the return on investment – or “value added” – of examples of success, from both the users and the other stakeholders' viewpoints.

The second issue that emerged during the conference is:

How do we keep up with the future?

This relates to the Joint Commission's focus on functions, rather than structures. The stories of success we have heard are basically the introduction of an informationist innovation into existing structures. This is as it should be. We've heard that compatibility with the context – which includes the existing structures – is a facilitator for the spread of innovation.

But we also need to pay attention to where the context is likely to go. We've already realized that “library services” are not necessarily linked to the structure of a room or building. We are also seeing health care organizations themselves becoming unlinked from a building or complex of buildings. That is, the future is likely to bring us virtual organizations, and virtual teams. We see increasing use of contracting and of telehealth. The question, for the future, therefore, is “What knowledge-based information system would meet the needs of a virtual team in a virtual organization?”

A system consists of both processes and structures. Structures, because of their stability, are a barrier to innovation and adaptability. So health care leaders and policy makers have a preference for creating systems that are less dependent on inflexible structures. Specifically, with respect to the informationist, I would caution against defining the role in such a way that it requires being at the site of care with clinician or at the site of research with the researcher. By site, I mean the site in space (the same room), and the site in time (synchronous interaction).

This structural model is inapplicable even today to smaller settings (rural hospitals, clinics, physicians' offices) and on a 24/7 basis in any setting. But, in addition it will be out of step with the coming virtual teams in virtual organizations. So I would suggest defining the informationist role as the design and maintenance of knowledge-based information systems that are available onsite, and on time, even in the absence of the informationist.

The third issue that emerged during the conference is:

Two wrongs don't make a right.

This relates to the Joint Commission's focus on reducing risk to patients. We are just now slowly acknowledging that physicians can't – and don't – remember everything they need. It turns out that a physician's "memory machine" is not deficient compared to that of other people – including a librarian's. It turns out that the human "memory machine" is unreliable:

- It may never be exposed to the information: "I didn't read that article."
- It may not store information it is exposed to: "I didn't pay attention to the statistical error in the paper."
- It may not retrieve what is stored. "It's on the tip of my tongue."
- It may be distorted in its retrieval.

Informationists are people too; an informationist's (or clinical pharmacist's) memory is as unreliable as a physician's. Adding another unreliable "memory machine" to the clinical or research team does not reduce the unreliability of the collective "memory machine." The concept of informationist, therefore, must include integration with reliable "memory machines" – computerized databases.