

EDITOR'S COMMENTS

Riding the Wave: Past Trends and Future Directions for Health IT Research

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Goal of this Paper

Journals play a significant role in the dissemination of knowledge across research streams. Journal support can lead to a vibrant area that continues to make important discoveries over decades. When support is active, journals promote special issues in selected research streams, appoint editors and reviewers who are avid advocates of an area as well as participants in them, and, finally, publish editorials. Journal neglect can have the opposite effect, and may, at times, spell the doom of some streams (this occurs when journal editors take a passive role, merely waiting for submissions to come over the transom).¹

Healthcare information technologies (HIT), variously known as health informatics, health IS, and so on through all the permutations of these terms, has grown with the successful dissemination of information technology in the health arena. Lagging behind other sectors (in some cases by decades), HIT is now being actively diffused via systems such as EMRs, PHRs, CDSS, and CPOE.² With the exponential increase of scientific work in this stream (Chiasson and Davidson 2004) comes the concomitant desire to see where the work has taken us to date and how it is trending. This analysis should be useful to journal editors and reviewers in determining when submissions are being innovative and when they appear to be covering old ground.

Background

Before analyzing the HIT literature, it is helpful to underline the importance of this area, not simply from the standpoint of scholars, but from the standpoint of society as a whole. What are the practical ramifications of systems that monitor patient care, healthcare efficiencies, and all the other multifaceted ways in which technology today is impacting health?

¹Please note that we are not arguing that journals themselves are living, breathing entities. As argued in Straub (2010), the journal is not an individual, living being although the journal process works through the interaction of editors and authors, with the ultimate arbiter of acceptance being the senior editor, in *MISQ*'s case.

²Meanings of these acronyms: electronic medical records (EMR), personal health records (PMR), clinical decision support systems (CDSS), and computerized provider order entry (CPOE).

First, it is clear that health spending continues to consume the largest share of public spending in most of the 34 OECD countries, having reached 9.5 percent of GDP on average in 2010, according to the latest OECD report (issued on June 28, 2012; <http://www.oecd.org/health/healthdata>). The United States has continued to outspend all other OECD countries by a wide margin, with spending on health per capita of \$8,233 USD, or 17.6 percent of GDP, compared to the overall OECD average of \$3,268. Since OECD demographic trends confirm an aging society across better-off Western nations, thereby increasing stress on healthcare systems, leaders are looking for answers on both cost *and* quality dimensions. For instance, the widely cited Institute of Medicine report “To Err is Human: Building a Safer Health System” finds that between 44,000 and 98,000 preventable deaths occur each year in the United States alone, and the report specifically identifies health IT as a potential solution to the dilemma (Kohn et al. 2000). In fact, health IT has been identified as an enabler of improved clinical outcomes (Garg et al. 2005), and a potential mechanism for lowering costs (Hillestad et al. 2005), yet adoption of these technologies is halting and incomplete (Jha et al. 2009).

Given the importance of the healthcare industry, the promise of HIT, and the paradoxically slow progress with respect to adoption, Chiasson and Davidson enjoined IS researchers in 2004 to extend extant IS theory into the emerging health information research (HISR) domain. Covering the time period from 1985 to mid 2003, their broad literature review searched for and found papers where an IT artifact was studied in a healthcare environment. Covering 17 leading “healthcare friendly” IS and management journals, their search resulted in 165 papers; these papers represented just 1.2 percent of the total number of papers published in these journals during the time period. Given the relative size of the healthcare industry and an environment that provides a rich backdrop for IS research, they argued that, with a mere 1.2 percent representation, the published HIT research during the review period significantly underrepresented the societal needs and the needs of the field.

In the intervening eight years since 2004, significant changes in the health IT industry, government incentives, and a heightened interest by IS researchers have led to dramatic changes in the number of publications in leading journals. In short, as a result of the updated empirical findings shown below, we can report with some confidence the HIT research domain has been on fire since 2004.

Thus, this editorial extends the work of Chiasson and Davidson to include papers through the end of 2011, thereby establishing a more up-to-date literature base for HIT researchers. Scholars can use this to build on existing theory that is notably and contextually relevant to the health IT domain. As noted above, journal editors and reviewers may be able to gain insight into how new HIT research can fill gaps and avoid well trodden ground.

As part of their review, Chiasson and Davidson classified papers into four categories. Their intention was to highlight, and hopefully stimulate, research that focused on contextually relevant healthcare constructs in extant IS theory. Since the publication of this review, editors of several special issues, including *European Journal of Information Systems* in 2007 and *Journal of the AIS* in 2011, have specifically mentioned the Chiasson and Davidson paper, calling for submissions, or reporting on accepted papers which met the criteria as “Category 3, Healthcare-IS papers.” Based on a belief that the incorporation of emerging, contextual healthcare environment variables in the theorizing process is important for both IS researchers and healthcare IT practitioners, we coded the 218 papers previously mentioned according to the spirit of the original classification process. This updated coding process allowed us to test working hypotheses that Category 3 papers will in fact be the most numerous and the most highly cited over time.

A brief description of each of the original Chiasson and Davidson categories, as well as our slight modification of the categories,³ is provided in Table 1 and footnote 3.

Given that this editorial seeks to update the original Chiasson and Davidson review, we were motivated by the following research questions:

³Category 1. IS-Only: We have labeled these papers as having minimal HIT context incorporated into the theory development process in that authors do not attempt to leverage the healthcare context when generating the hypothesis, analysis, and/or discussion sections of their papers. Category 2. IS-Healthcare: We have labeled these papers as having moderate HIT context incorporated into the theory development process. Category 3. Healthcare-IS: We have labeled these papers as having high HIT context in that papers in this category incorporate contextual elements unique to the healthcare environment to extend our theoretical knowledge of constructs relevant to the IS community. Category 4. Healthcare-Only: We have labeled papers in this category as atheoretical, while recognizing that the paper is relevant to the HIT domain.

Table 1. Definitions

Category	Chiasson & Davidson Terms	Revised Terms	Definition	# of Papers 1985–mid-2003 (Period 1)
1	<i>IS-Only</i>	<i>Minimal HIT Context</i>	Focus of the paper is on testing or refining existing IS theories without regard for the healthcare context.	29
2	<i>IS-Healthcare</i>	<i>Moderate HIT Context</i>	Focus of the paper is on testing or refining existing IS theories with some regard for the healthcare context.	46
3	<i>Healthcare-IS</i>	<i>High HIT Context</i>	Papers that directly incorporate healthcare contextual influences to inform the analysis of the empirical results and to extend IS theory or concepts.	29
4	<i>Healthcare-Only</i>	<i>Atheoretical</i>	Papers that describe an IS or IT in a healthcare context without consideration of theory	61

RQ1: Has HISR grown with respect to the number of HIT papers published in IS journals?

RQ2: Are HIT journal articles incorporating domain-specific contextual considerations (Category 3) increasingly represented in the literature?

RQ3: When an HIT manuscript incorporates contextual considerations (Category 3) into theorizing and analysis, does it lead to increased levels of citations over time?

The Criticality of Contextualizing Theory in the HIT Literature

Prior to coding, we determined the core contextual variables which have emerged as influential in the ongoing discourse in the extant HIT literature. Armed with this set of constructs, we were able to make reasonable coding decisions with respect to the level of healthcare context incorporated into theory in each journal article. This approach, we believe, reconciles our data analysis approach with that of Chiasson and Davidson and enables us to draw inferences across the entire period of HIT literature (1985–2011) to date.

While the healthcare environment has numerous unique characteristics, we highlight: (1) privacy concerns, (2) interoperability, and finally (3) resistance to HIT.

1. *Privacy concerns.* Privacy concerns, and a subsequent lack of interoperability across institutional boundaries, are primary examples of core contextual (domain-specific) variables in HIT. Privacy concerns are a recurrent theme in the HIT literature (Anderson and Agarwal 2011; Angst and Agarwal 2009; Mercuri 2004; Rindfleisch 1997). While privacy concerns vary by individual, financial and medical data are viewed by individuals as more sensitive data, generally speaking (Malhotra et al. 2004). Digital patient records are often perceived to be more open to exploitation than their paper counterparts, and since the 1996 passing of the U.S. Health Information Portability and Accountability Act (HIPAA), providers in the United States who are found to be negligent of inadvertently disclosing patient records can face fines up to USD\$250,000 and 10 years in prison (Kluge 2004; Mercuri 2004).
2. *Interoperability.* Medical data is of the utmost sensitivity, but it is only useful when shared with our medical providers (Rindfleisch 1997). Yet due to the sensitive nature of patient records (and the potential for HIPAA violation fines levied against medical organizations in the United States), clinic and hospital decisions regarding access to records understandably raise difficulties. Some hospitals even deny physicians remote access to their own HIT systems due to legal liability concerns (Ash and Bates 2005), a result that eliminates one of the key benefits of CPOE (Niazkhani et al. 2009). Providers are especially hesitant to share medical information with clinicians outside their organizations, despite the supporting standards such as HL7 and the potential benefit to patients (Goldschmidt 2005). In addition, HIT performance with respect to interoperability continues to lag other industries, given that competitive forces in the marketplace encourage the continued use of proprietary systems and databases (Lumpkin and Richards 2002). As a result, acute care clinicians have to rely on

limited patient record data since relevant, potentially life threatening medical data is often locked away in silos of information guarded over by providers outside of the hospital network.

3. *Resistance to change.* While resistance to IT occurs in many environments, a combination of factors unique to the healthcare domain augment clinician resistance to HIT. The literature has frequently highlighted clinician resistance to HIT (Bhattacharjee and Hikmet 2007; Kohli and Kettinger 2004; Lapointe and Rivard 2005). For instance, in 2003 physicians at Cedars-Sinai Medical Center in Los Angeles forced the withdrawal of a CPOE implementation that was already online in two thirds of the 870 bed hospital because the system was considered to be a distraction to their medical routines (Bhattacharjee and Hikmet 2007). CPOE can dramatically alter workflow within the hospital (Aarts et al. 2007; Ash et al. 2004; Ash et al. 2007), often impacting responsibilities and roles between clinicians and support staff. Physician resistance can be traced in part to the escalation of clerical tasks (order entry) that had been handled by other clinicians or administrative staff in the past (Aarts et al. 2007). Physicians appear to be hesitant to adopt the spirit of “cookbook medicine” inherent in order-set protocols and clinical decision support systems (CDSS) (Gittel 2002; Wright et al. 2009) and are wary of the potential administrative influence enabled by a CDSS (Kohli and Kettinger 2004; Lapointe and Rivard 2007).

The source of this resistance can possibly be traced to the manner in which knowledge workers such as physicians or attorneys are managed. Traditionally, the physician was organized and “controlled” through community, independent of hierarchical control. Given that most physicians are free agents, coordination has relied on collegial control. This model is slowly changing as physicians are increasingly hired by hospitals to avoid personal malpractice insurance and are thereby facing more hierarchical pressures (Adler et al. 2008; Kohli and Kettinger 2004). Yet the result of traditional coordination mechanisms is frequently highlighted in prior research, including differentiated workflow policy based on agency. Often, residents, who are hospital employees, were required to enter orders (CPOE) whereas attending physicians were not (Davidson and Chismar 2007). CEOs who mandate adoption of an HIT may find themselves forced out of the organization by a powerful physician-led lobby (Lapointe and Rivard 2007).

While other contextual considerations relevant to the healthcare domain could have been included among our factors, we were sensitive to other possible effects as we synthesized the literature according to the original Chiasson and Davidson categories. Analysis of these healthcare domain-specific contexts is beyond the current scope.

Method

To ensure consistency between our results and those of Chiasson and Davidson, we retained their original list of journals as well as the keywords and database search engines established in the original review. This notwithstanding, we innovated by also using the Senior Scholars basket of eight,⁴ which led to the addition of *Journal of the AIS*, *Journal of Information Technology*, and *Information Systems Journal* to the search criteria. Searches in these three journals covered the entire post 1985 period, resulting in the addition of 11 papers to the original Chiasson and Davidson list. In 2007, as part of her unpublished dissertation, Cho extended the earlier review for the period of mid-2003 until the end of 2006, adding 40 papers; this work was also incorporated into the present review. In total, the data set considered was 218 papers, listed in the Appendix⁵ by journal, which includes the 11 papers previously mentioned.

Each of the 20 journals was reviewed using ABI Inform, EBSCO Host, Science Direct, or Sage. Keywords matched the terms specified in Chiasson and Davidson, including physician, hospital, medical, health care, healthcare, as well as telemedicine. To determine consistency between two independent raters, an inter-rater reliability analysis was performed using Cohen's Kappa. The calculated Kappa of .804 ($p < .001$) exceeds the standard threshold of .60, indicating substantial agreement (Landis and Koch 1977).

⁴Basket of eight consists of *European Journal of Information Systems*, *Information Systems Journal*, *Information Systems Research*, *Journal of the AIS*, *Journal of Information Technology*, *Journal of Management Information Systems*, *Journal of Strategic Information Systems*, and *MIS Quarterly*. Source: AIS website as of December 2011.

⁵The Appendix for this editorial is located in the “Online Supplements” section of the *MIS Quarterly*'s website (<http://www.misq.org>).

Table 2. Results Summary: RQ1 and RQ2

	Research Questions	Result	Papers published per year (Period 1)	Papers published per year (Period 2)
1	<i>Has HISR grown with respect to the number of HIT papers published in IS journals?</i>	Yes	9.2	25.9
2	<i>Are HIT journal articles which incorporate domain-specific contextual considerations (Category 3), increasingly represented in the literature?</i>	Yes	1.5	9.3

The Web of Science was used to calculate citations. The main limitation of this approach is that not all 20 journals in our basket are covered by the Web of Science. This limitation, however, is countered by the more consistent inclusion of peer reviewed journals compared to other citation lists, such as Google Scholar. As a result, there are many papers that have zero citations for the purpose of this study; however, the focus in this review is on citations *by category*, as mentioned earlier. We trust that the exclusion of citations from journals not covered by the Web of Science does not result in a systematic bias from one category to the next.

To answer RQ3 and test the prediction articulated earlier that Category 3 articles will receive the highest number of citations, we computed Web of Science citations per year, per journal article. Each of the four categories were summarized by calculating the total number of citations per year. The citation total across categories was normalized by dividing the total annual citations by the number of papers published in the category. Finally, the average number of citations per year were grouped by category, according to period 1 (papers captured from 1985 to mid-2003), and period 2 (papers published from mid-2003 until the end of 2011).

Data Analysis

What are the key results from the data analysis? With respect to RQ1 and RQ2, there has been a considerable increase in the number of publications over the course of the two periods (see Table 2). Overall, HIT publications increased from an average of 9.2 per year in period 1 (1985 to 2003) to 25.9 publications per year in period 2 (2004 to 2011), a 64 percent increase. While each of the four categories saw a raw increase in numbers of papers per year, there has also been a shift in the composition of the papers. Category 3 papers (Healthcare-IS or papers relying on contextual, healthcare-specific variables in their theorizing) have grown from just 16 percent to 36 percent in the more recent period, and match the number of atheoretical Category 4 papers on an absolute basis. Therefore we find that our response to RQ2, whether there have been increases across the board in HISR, is a resounding “Yes,” as demonstrated in Figure 1.

With respect to RQ3 and the hypothesis that Category 3 papers would be most highly cited, we report somewhat disturbing findings in Figure 2 and Table 3, showing that Category 3 papers failed to maintain their leadership status with respect to scholarly influence and in fact declined from period 1 (1985 to mid-2003) to period 2 (mid-2003 to 2011). The news, on the other hand, is good for overall citations, with the weighted average increasing from 1.2 in period 1 to 1.6 in period 2 across all categories. This demonstrates an encouraging 25 percent increase in the level of scholarly influence from HIT publications. In period 1, the reported Web of Science citations through May 31, 2012, confirm that on a per paper basis, where Category 3 papers are in fact the highest cited category, as predicted.

Our hypothesis that period 2 results would find that the most highly cited work emanates from papers extending theory by incorporating contextual HIT elements proved to be unfounded. Category 3 papers did increase in absolute numbers, yet Category 3 citations on a per unit basis were the *only* category to actually decline, as *per unit* citations per year fell from 1.7 in period 1 to just under 1.5 in period 2 (see Table 3). This decline in Category 3 citations undermines predictions that the incorporation of HIT domain and contextually relevant constructs in theory development will lead to the most highly *cited* journal articles. While interest in the HIT domain is confirmed by the 64 percent increase in the number of HIT publications, as well as an overall 24% increase in per unit citations, the apparent interest in Category 3 papers, as measured by citations, has waned by 12 percent from period 1 to period 2.

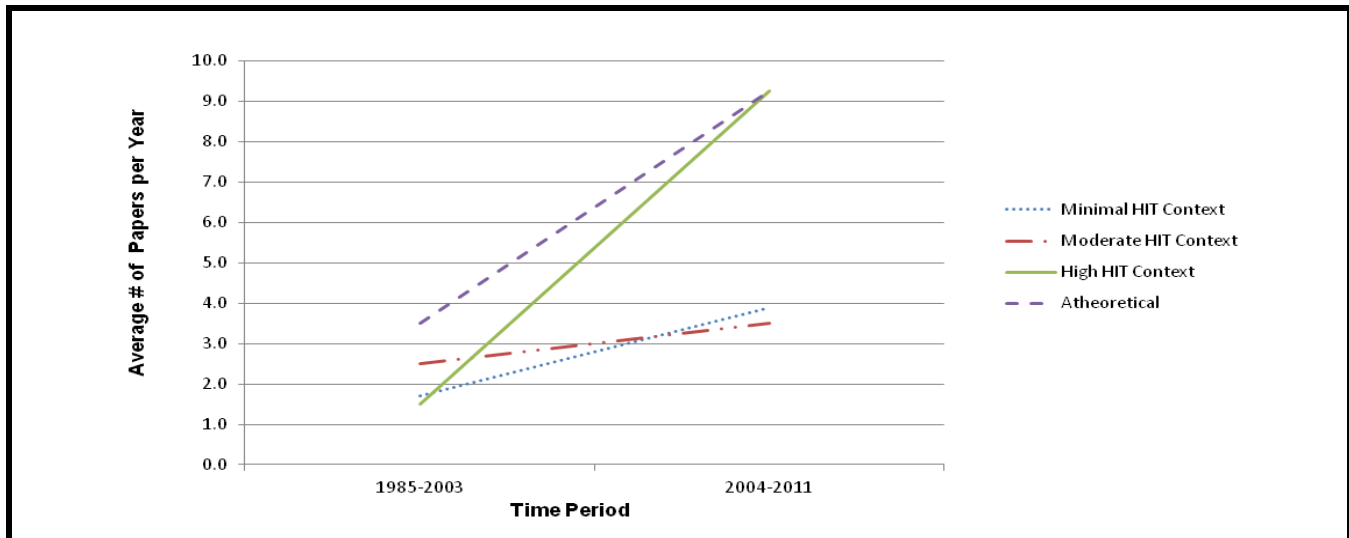


Figure 1. HIT Publications by Category

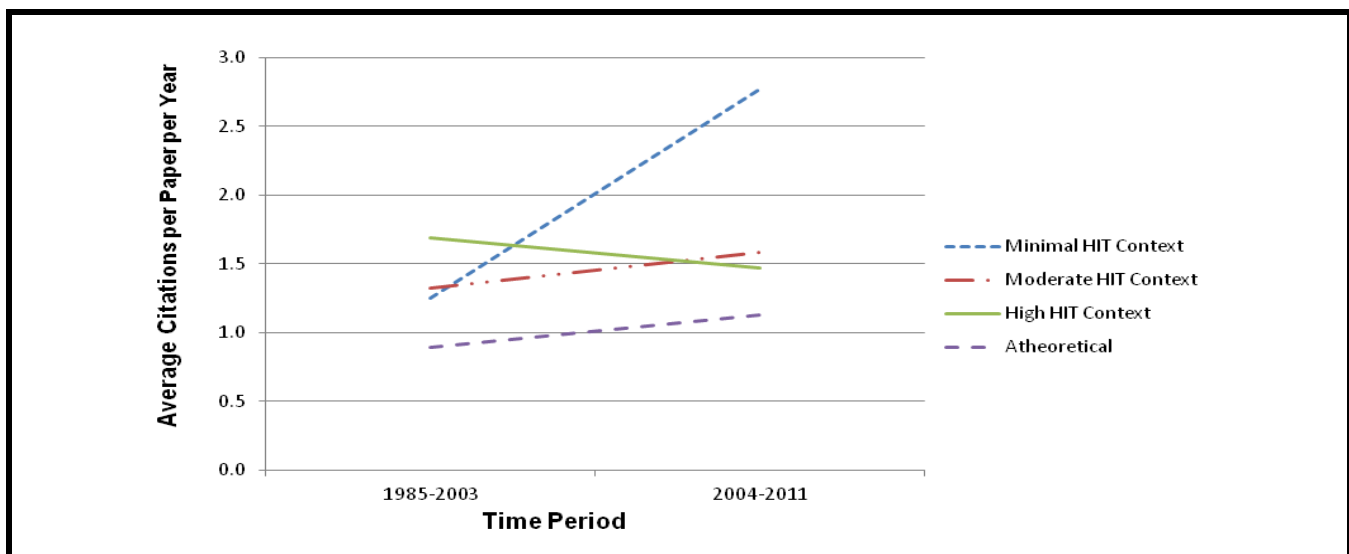


Figure 2. Average HIT Citations per Year by Category

Table 3. Results Summary: RQ3

	Research Question	Category	Citations per year per paper (Period 1)	Citations per year per paper (Period 2)
3	<i>When an HIT manuscript incorporates contextual considerations (Category 3) into theorizing and analysis, does it lead to increased levels of citations over time? Not supported.</i>	1	1.3	2.8
		2	1.3	1.6
		3	1.7	1.5
		4	.9	1.1
		Total	1.2	1.6

Table 4. Top 10 Cited HIT Papers from Selected Journals 1985–2011

Citations from Web of Science (from publication date to 7-31-2011 and sorted by citations per year)				
	Author(s)	Title	Total Citations	Citations per Year
1	Hu, P. J., Chau, P. Y., Shen, O., and Tam, K. Y. (1999)	"Examining the Technology Acceptance Model Using Physician Acceptance of Telemedicine Technology"	282	23
2	Lapointe and Rivard (2005)	"A Multilevel Model of Resistance to Information Technology Implementation"	124	19
3	Yi et al. (2006)	"Understanding Information Technology Acceptance by Individual Professionals: Toward an Integrative View"	97	15
4	Chau, P. Y. K., and Hu, P. J. (2002b)	"Investigating Healthcare Professionals' Decisions to Accept Telemedicine Technology: An Empirical Test of Competing Theories"	128	13
5	Corchado et al. (2008)	"Intelligent Environment for Monitoring Alzheimer Patients, Agent Technology for Health Care"	44	13
6	Strong et al. (1997)	"Data Quality in Context"	166	11
7	Paul and McDaniel (2004)	"A Field Study of the Effect of Interpersonal Trust on Virtual Collaborative Relationship Performance"	64	9
8	Devaraj, S., and Kohli, R. (2000)	"Information Technology Payoff in the Health-Care Industry: A Longitudinal Study"	98	9
9	Chau, P. Y. K., and Hu, P. J. (2002a)	"Examining a Model of Information Technology Acceptance by Individual Professionals: An Exploratory Study"	80	8
10	Anderson, J. G. (1997)	"Clearing the Way for Physicians' Use of Clinical Information Systems"	93	6

Discussion

While a detailed explanation for the unexpected results relative to RQ3 is outside the scope of this paper, Table 4 provides exemplars of heavily cited HIT papers for further discussion of this point. Table 4 presents the top papers based on the reported citations for all 383 papers, including the original 165 Chiasson and Davidson papers, as well as the 218 papers included in the Appendix. Table 4 captures the most frequently cited papers when normalized to an annual basis. It is interesting to note that three of the top ten HISR papers are coauthored by Chau and Hu, and the HIT artifact under study is telemedicine. Gaining insight into the underlying reason for the high citation count on these papers is beyond the scope of this paper. Nonetheless, their 1999 *JMIS* (Hu et al. 1999) paper is an early example of a study where the ease of use construct was modeled to be part of the ubiquitous TAM model, but was not a significant predictor of intention to use an IS by knowledge workers such as physicians. This connection to TAM may explain the unusually high number of citations.

While some papers in the IS field continue to generate significant numbers of citations over a long period of time (Davis 1989), most wane as newer methods or theoretical approaches gain a foothold. Yet more recently published papers, especially those published in the past several years, have not had enough time to establish their impact on the field, and even exceptional recent papers are handicapped by such short publication tenures.⁶ While it is unclear whether IS researchers have been motivated by the call from Chiasson and Davidson, references to their article and stated intentions to contribute meaningfully to Category 3 papers has specifically been made by several authors (Cho and Mathiassen 2007; Klein 2007). Reference to the Chiasson–Davidson categorization scheme has also been made by editors of the special issues on healthcare IS, including the *EJIS* editorial (LeRouge, Mantzana, and Wilson 2007) and more recently the *JAIS* call for papers for the December 2010 special issue on healthcare IT.

⁶While all methods are imperfect, we felt that the most equitable method of comparing citations across categories would be to normalize by converting total citations to citations per year. This change does impact the relative rankings of the impact of the paper on the field; for instance, the Lapointe and Rivard (2005) paper on multilevel resistance does, in fact, move to the number two position using the citations per year form of analysis.

Looking at just the 1985–2003 period, we find that journal articles that incorporated HIT contextual implications to a high degree (Category 3) did in fact generate the most citations per year per paper, at roughly 1.7. While the occurrence of Category 3 papers has increased substantially over the 2004–2011 period, at this stage these papers have not generated the predicted citations, and in fact Category 1 papers far exceed other categories at 2.8 citations per year per paper. This can largely be attributed to several highly cited papers published in the 2004–2006 period, including Lapointe and Rivard (2005), and Yi et al (2006). Given that there have recently been a number of special issues in HIT with a high representation of Category 3 papers, it is likely that papers published in 2010 and 2011 are very much underrepresented in terms of citations due to their limited time since publication (even though all papers were normalized on a per year basis). Future research may in fact show that these papers will in time gain their expected scholarly influence.

Future Directions

We believe that the most fruitful theory development for the HIT area will occur in increases both in Category 3 papers and in citations to these papers. It is to be hoped that HIT-specific papers will come to dominate the field in the future, and we encourage continued focus in this direction. As the research and the technology mature, new HIT contexts will emerge at the margin. Why would this be so? The evolution of the medical field will likely demand it. For example, while genetics have long been recognized as an important predictor of an individual's predisposition to disease, unlocking the secrets of our genome remains nascent. Research to lay the groundwork for the incorporation of genetic predisposition with our medical records holds promise, and high levels of privacy and ethical concerns for individuals. Supportive technologies such as voice recognition sensitized to healthcare industry nomenclature will continue to improve with respect to accuracy, and thereby lessen the burden of manual entry by clinicians, or reduce the need for transcription. Despite the failure of the Google Health Personal Health Record in late 2011, patient centered e-health will continue to gain momentum. As HIT functionality such as clinical decision support systems extends to the patient portal, research questions investigating the importance of an engaged patient, through IT-enabled chronic disease management systems will emerge (Romanow et al. 2011). And as the field progresses, we expect the impact of Category 3 papers to accelerate, and that its defining attributes will continue to expand.

Conclusion

While Category 3 papers have increased dramatically in number on a per year basis, citations per journal article in this category have actually fallen. This is ironic and initially troubling in that in the earlier period, Category 3 papers were in fact the most heavily cited grouping. While the short duration since publication may partially explain the citation paradox in period 2, the field needs to embrace these Category 3 approaches to ensure the continued growth of the HIT body of knowledge and its importance in shaping IS theory as a whole. There is no question that the research streams in healthcare informatics are vibrant. The only question is whether they will sufficiently advance healthcare-specific, high HIT context theory or not.

References

All references, including the in-text citations and the articles used in the review, appear in the “References” section of the Appendix for this editorial, located in the “Online Supplements” section of the *MIS Quarterly*'s website (<http://www.misq.org>).

EDITOR'S COMMENTS – SUPPLEMENT

Riding the Wave: Past Trends and Future Directions for Health IT Research

Appendix: New Papers Since Chiasson and Davidson (2004) Included in the Current Analysis

<i>Communications of the ACM</i>		
	Author(s)	Title
1	Abraham et al. (2008)	"Ubiquitous Access: On the Front Lines of Patient Care and Safety"
2	Agrawal et al. (2007)	"Enabling the 21st century Health Care Information Technology Revolution"
3	Avison and Young (2007)	"Time to Rethink Health Care and ICT?"
4	Bala et al. (2009)	"Disaster Response in Health Care: A Design Extension for Enterprise Data Warehouse"
5	Cannoy and Salam (2010)	"A Framework for Health Care Information Assurance Policy and Compliance"
6	Cantrill and Stephen (2010)	"Computers in Patient Care: The Promise and the Challenge"
7	Chang, Yuan, and Li (2009)	"iCare Home Portal: An Extended Model of Quality Aging e-Services"
8	Chau and Hu (2004)	"Technology Implementation for Telemedicine Programs"
9	Egyhazy and Mukherji (2004)	"Interoperability Architecture Using RM-ODP"
10	Fu (2009)	"Inside Risks: Reducing Risks of Implantable Devices"
11	Goldschmidt (2005)	"HIT and MIS; Implications of Health Information Technology and Medical Information Systems"
12	Hoffmann (2009)	"Implementing Electronic Medical Records"
13	Horan and Schooley (2007)	"Time-Critical Information Services."
14	Hur and Kim (2010)	"The Future of Digital Imaging"
15	Johnson and Ambrose (2006)	"Neo-tribes; the Power and Potential of Online Communities in Health Care"
16	Kroeker (2011)	"Improving Brain-Computer Interfaces"
17	Kudyba et al. (2005)	"Enhancing Efficiency in the Health Care Industry"
18	Luo and Najdawi (2004)	"A Review of Consumer Health Portals"
19	Manduchi and Coughlan (2012)	"(Computer) Vision without Sight"
20	Mbarika (2004)	"Is Telemedicine the Panacea for Sub-Saharan Africa's Medical Nightmare?"
21	Mercuri (2004)	"The HIPAA-potamus in Health Care Data Security"
22	Pratt et al. (2006)	"Personal Health Information Management"
23	Savage (2011)	"Remaking American Medicine"
24	Savage (2012)	"Better Medicine through Machine Learning"
25	Tan et al. (2005)	"Health Care and Services Delivery Systems as Complex Adaptive Systems"
26	Thompson and Dean (2009)	"Advancing Information Technology in Health Care"
27	Venkatraman et al. (2008)	"Six Strategies for Electronic Medical Records Systems"
28	Whitten et al. (2008)	"Most Wired Hospitals" rate Patient Satisfaction"
29	Wilson and Tulu (2010)	"The Rise of a Health-IT Academic Focus"
30	Zhuge (2005)	"Exploring an Epidemic in an E-Science Environment"

Databases for Advances in Information Systems		
	Author(s)	Title
1	Sauter (2005)	"Competitive Intelligence Systems: Qualitative DSS for Strategic Decision Making"

Decision Support Systems		
	Author(s)	Title
1	Airoidi et al. (2011)	"An Entropy Approach to Disclosure Risk Assessment: Lessons from Real Applications and Simulated Domains"
2	Arora et al. (2010)	"Resource Allocation for Demand Surge Mitigation during Disaster Response"
3	Bansal et al. (2010)	"The Impact of Personal Dispositions on Information Sensitivity, Privacy Concern and Trust in Disclosing Health Information Online"
4	Ben Ayed et al. (2010)	"A User-Centered Approach for the Design and Implementation of KDD-Based DSS: A Case Study in the Healthcare Domain"
5	Berndt et al. (2007)	"The Role of Data Warehousing in Bioterrorism Surveillance"
6	Bielza et al. (2008)	"Explaining Clinical Decisions by Extracting Regularity Patterns"
7	Chatterjee et al. (2009)	"Examining the Success factors for Mobile Work in Healthcare: A Deductive Study"
8	Corchado et al. (2008)	"Intelligent Environment for Monitoring Alzheimer patients, Agent Technology for Health Care"
9	Delen et al. (2012)	"An Analytic Approach to Better Understanding and Management of Coronary Surgeries"
10	Hu et al. (2006)	"Evaluating a Decision Support System for Patient Image Pre-fetching: An Experimental Study"
11	Hung et al. (2010)	"Critical Factors of Hospital Adoption on CRM system: Organizational and Information System Perspectives"
12	Junglas et al. (2009)	"Mobile Technology at the Frontlines of Patient Care: Understanding fit and Human Drives in Utilization Decisions and Performance"
13	Kohli and Devaraj (2004)	"Contribution of Institutional DSS to Organizational Performance: Evidence from a Longitudinal Study"
14	LeRouge, Hevner, and Collins (2007)	"It's More than Just Use: An Exploration of Telemedicine Use Quality"
15	Liang et al. (2006)	"WebBbased Intervention Support System for Health Promotion"
16	Lin et al. (2006)	"A Decision Support System for Lower Back Pain Diagnosis: Uncertainty Management and Clinical Evaluations"
17	Lussier et al. (2007)	"Partitioning Knowledge Bases Between Advanced Notification and clinical Decision Support Systems"
18	Mangiameli et al. (2004)	"Model selection for Medical Diagnosis Decision Support Systems"
19	Meiller et al. (2011)	"Adaptive Knowledge-Based System for Health Care Applications with RFID-Generated Information"
20	Oztekin et al. (2010)	"An RFID network Design Methodology for Asset Tracking in Healthcare"
21	Rodger and Pendharkar (2007)	"A Field Study of Database Communication Issues Peculiar to Users of a Voice Activated Medical Tracking Application"
22	Rodríguez et al. (2011)	"Secure Business Process Model Specification through a UML 2.0 Activity Diagram Profile"
23	Sneha and Varshney (2009)	"Enabling Ubiquitous Patient Monitoring: Model, Decision Protocols, Opportunities and Challenges"
24	Song and Zahedi (2007)	"Trust in Health Infomediaries"
25	Tarakci et al. (2009)	"On the Staffing Policy and Technology Investment in a Specialty Hospital Offering Telemedicine"

Decision Support Systems (Continued)		
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