Quarterly Letters

Shaping the Future of Telemedicine

I read with interest your recent article "Healthcare in Rural Nova Scotia," (*Hospital Quarterly*, Summer 1998) and found the description of the province-wide telemedicine project particularly thought-provoking. The enormous potential of telemedicine is finally being realized and the concept seems poised to enter the medical mainstream. As healthcare facilities, particularly health sciences centres, re-engineer under health reform, the concept of telemedicine must be incorporated into operational policy and facility design.

As we work our way up the telemedicine learning curve, we have discovered that the operational and physical requirements for a scheduled, static tele-education program, such as CME, are different from tele-psychiatry. Tele-radiology requirements are, yet again, different, and we are just now beginning to contemplate the support required for unscheduled, real-time, two-way teleconsults. For sending and receiving facilities, there remain many unresolved issues that must be addressed in order for telemedicine to be used to its full potential.

The situation will be exacerbated as the use of telemedicine expands beyond the support of rural and remote communities. As Korpman pointed out, in his article "Integrating Home Healthcare into your IT Strategy," (*Hospital Quarterly*, Spring 1998) the hospital/home care information interface is of increasing importance. As the healthcare system moves towards community-based care, an increasing number of seriously ill patients are being cared for at home. The hospital, through telemedicine, can provide much-needed support to patients, their families and home-care workers. This has the potential to reduce emergency department visits and readmission rates. Ambulance services have a long history of telemetry use. Occupational health staff in the work place could benefit from a telemedicine link. This raises operational questions: If vital signs, heart rhythms and oximetry etc. are transmitted to hospitals, who will receive them and where?

Responding to telemedicine referrals represents a new patient-care paradigm. On a given day, a specialist may travel from his or her office to an inpatient ward, ambulatory clinic, emergency department, lecture hall and research lab. Will we now add a telemedicine workstation or studio to the list? Will urgent telemedicine consults be treated the same as ones originating from the emergency department? Is telemedicine an add-on responsibility or does it replace the care of the transported patient? Where does a hospital locate telemedicine facilities to maximize clinical and spatial efficiency?

While the federal and provincial governments attend to the macro telemedicine issues, it is incumbent on individual healthcare facilities to develop the operational and physical frameworks to support local development. Health reform is reallocating dollars from traditional hospital programs to innovative initiatives like telemedicine, and this provides a fiscal window of opportunity. The proactive facility will be canvassing their community, referral network and their medical staff in order to assess their readiness to enter the rapidly evolving field of telemedicine. HQ

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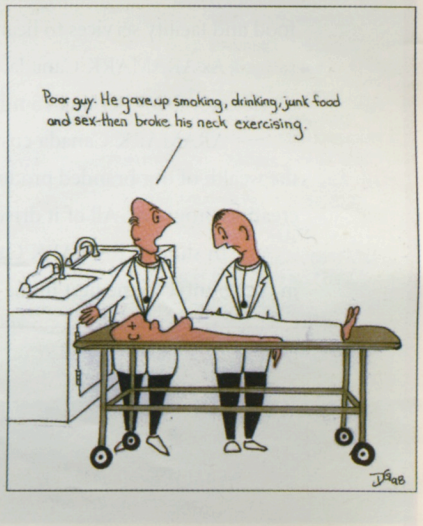
Responding to Physician Incompetence

In their article "Dealing with physician incompetence and impairment in a hospital," (*Hospital Quarterly*, Summer, 1998), Drs. Kline, Etherington and Bates have emphasized the need for due process using assessment criteria developed by medical staff and physician administrators through consensus. What was not emphasized in their description of the process, not yet tested at St. Paul's Hospital, is the critical role of medical department heads who, by legislation and professional ethics, have first responsibility to ensure the quality of care and safety within their departments.

Unfortunately, in respect to physician incompetence, medical department heads are often hampered by the lack of good data regarding physician performance such as: admission for adverse results of outpatient management; abnormal test results or physical findings not addressed; readmission rates; return to the operating room; inappropriate interventions; incorrect drug utilization; patient/family dissatisfaction; or inappropriate discharge planning. To



collect such data, even though almost all physicians generally would agree to its reasonableness, is costly, time consuming and best done concurrently by physician reviewers or nurses specially trained to identify opportunities where care may be improved. Such information must be privileged and blinded when discussed by peers in reviewing quality of care, and focused on education and/or improvement of clinical processes. It should not be developed primarily for the purpose of identifying bad apples amongst the medical staff of an institution.

However, Drs. Kline, Etherington and Bates do point out correctly that physician outliers should be identified in the interests of quality of care. If this is done in a confidential non-threatening manner amongst physician peers, as described in their article, legal confrontations at the level of the Medical Advisory Committee need not occur.

That better information concerning physician performance is required has been the subject of several recent publications (Leape 1996, Berwick 1996) including the classic report from Brennan et al. (1991) on approximately 20,000 admissions in New York State where 3.7 percent of all patients received minor or major injuries of which almost one-quarter were negligent. Patient safety in hospital has also received recent attention from the American Medical Association which is actively sponsoring the National Patient Safety Foundation (National Patient Safety Foundation 1997), the intention of which is to develop a national consortium of care providers and organizations with the primary objective of improving safety of care. HQ

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Berwick, D. 1996. "Taking Action: Leader in the Reduction of Error in Health Care." *Quality Connection.*; (5):1-3.

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National Patient Safety Foundation. 1997. *New Brief*. May 9, NPSF@ama-assn.org

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