Die Abenteuer eines Schweizer «general internist» in Europa

Die Verbindungen zur Industrie

Daniel Widmer

Was würde «Boucle d'or» (siehe ihren Artikel auf der nächsten Seite) sagen, wenn sie mich in Brüssel umgeben von Vertretern der Informationsindustrie gesehen hätte, als ich den Standpunkt der Allgemeininternisten bei der Tagung des COCIR (European Coordination Committee of the Radiological, Electromedical and Healthcare Industry) darlegte? Bei der «Förderung von Wachstum und Beschäftigung» steht für die Wirtschaft sehr viel auf dem Spiel, und die Industrievertreter sind sich dessen bewusst. Es ist zu erwarten, dass sich die Ziele der Informationsindustrie – wie es schon bei der Pharmaindustrie der Fall war – in Zukunft mit jenen des Gesundheitswesens überschneiden und es zur Gefahr der Überarztung kommt. Die Mobile-Health-Systeme mit Applikationen zur Selbstdiagnose und -monitoring könnten Ängste nähren und zur unnötigen Inanspruchnahme des Gesundheitssystems führen. Besonderes Augenmerk sollte darauf gelegt werden, Nützliches von Unnützem zu unterscheiden. Wie bei Medikamenten dürfen derartige Produkte und Instrumente nicht ohne vorherige Beurteilung auf den Markt gebracht werden. Nachstehend einige Überlegungen zu diesem Thema, die ich mit meinem französischen Kollegen bei der UEMO, Patrick Ouvrard, angestellt habe.

COCIR 2016 eHealth Summit, Panel debate 2: Mainstreaming innovation across health and care systems for successful scaling up of innovations

Representing the European Union of General Practitioners / Family Doctors, I want to present the point of view of a practitioner confronted not only with new challenges, such as coordination of care for patients suffering from multiples diseases, but also with the unexpected effects of innovation – mainly disruptive innovation (as opposed to the continuing improvement of a technology answering the user's needs).

For me the question is not about accelerating providers' access to all innovative e-health systems. The question is to choose the useful and good ones. It is important to distinguish innovation for innovation's sake from necessary innovation. Innovation for innovation's sake is a process without consciousness of the consequences, such as overmedicalisation, loss of "patient-centredness" and discrimination against those without e-literacy.

For example, screening e-questionnaires used by patients or health professionals can induce overdiagnosis and overtreatment, as well as fear and anxiety for the patient. These consequences have to be considered.

Sometimes the initiative of an engineer meets a real need. I am living in a country where there is a lack of dermatologists to evaluate quickly suspect skin lesions. An engineer created a system of dermatoscopic telemedicine devices with which I can send a skin picture to a specialist in another country. But what about the responsibility if I am working in France, and the specialist is in Spain? What is the number of false positive or false negative tests? Is the result expert-dependent? Who should make and pay for the study before I adopt this system?

Identifying the necessity for innovation is not a simple matter. Different points of view can be in conflict. I give you the example of the RAI (Resident Assessment Instrument), a very important tool for health authorities to measure the burden of functional impairment in chronic disease and to evaluate the management of care. It is useful for future planning of healthcare to have such data. Here, we are at the macro or meso level. But at the level of the patient, of the home nurse or of the GP, the RAI is time-consuming and seems not directly useful. For the success of its implementation it is absolutely necessary to find how this system can also benefit persons working at the bottom level: the creation of alarms or domains of risk useful for practitioners is certainly a solution. Negotiation is necessary to find the best use of the new device.

Here is another example of necessity: many of us have had the experience that the lists of a patient's medicines in the hands of the pharmacist, the homecare nurse, the GP and the hospital doctor are not the same. In this kind of situation, a shared electronic health record (EHR) seems the solution. But how should we implement such a system in a country where each private GP has another computer system (if he or she has one)? It is certainly easier in a national health system, where the information system can be the same for everybody, to decide on a day where everybody must change system. In my example of the patchwork system, the model of implementation is like an epidemic where the system spreads progressively. How is it possible?

What kind of incentives, of advantages for the partners? Who should help each professional to adapt the interface of his or her own computer with the cloud? In my opinion, the process is impossible without the help of public health authorities.

Certainly solutions are context dependant in so many different countries but some elements of success can be listed:

- create a hierarchy of needs;
- begin with simple useful things before more complex changes, for example, a medication list before artificial intelligence;
- evaluate outcomes of a new system;
- consider minimal useful data for cross-border care: current medication, allergies, current diagnosis…
- avoid overmedicalisation and discrimination;
- be always patient centred and empower the patient (the data belong to the patient);
- consider confidentiality and security of data. There should be the possibility to break the window in the case of emergency, but follow-up of who has broken it and why;
- consider critical incidents. Information was sent but not received at the right moment by the right person (reminders are not the only solution; somebody must confirm having received the message – create alerts);
- consider that there are gaps not only between primary and secondary care and between health and social care, but also between practitioners and public health managers – collaboration and mutual understanding between macro- and microlevel is necessary;
- consider the importance of coding with some specificity. Coding is not the same for hospitals, GPs and nurses; it is necessary to create convergence between different coding systems.

At the EU level, what could be done specifically?

- definition of European minimal data requirements for cross-border care;
- common coding with transcoding;
- financial incentives for research and implementation (interoperability).

Korrespondenz:
Dr. med. Daniel Widmer
IUMG
2, av. Juste-Olivier
CH-1006 Lausanne
drwidmer[at]
belgo-suisse.com