Les aventures d'un «general internist» suisse en Europe

Les liens avec l'industrie

Daniel Widmer

Que dirait Boucle d'Or (cf. son billet du jour) si elle m'avait vu à Bruxelles entouré d'industriels de l'information pour donner le point de vue des généralistes au meeting du COCIR (European Coordination Committee of the Radiological, Electromedical and Healthcare Industry)?

Que ce soit au niveau cantonal, fédéral ou européen, l'unanimité des responsables de la santé publique se fait autour de systèmes d'échange d'information interopérables. L'Union européenne lie clairement son action pour «la santé en ligne» à sa stratégie pour le marché unique numérique. Les enjeux économiques sont immenses pour «la stimulation de la croissance et de l'emploi» et les industries l'ont bien compris. On peut s'attendre qu'à l'avenir, comme ce fut le cas avec l'industrie pharmaceutique, les objectifs de l'industrie informatique puissent interférer avec ceux de la santé en créant de la surmédicalisation. Les systèmes de mobile-health avec applications d'auto-dépistage et auto-monitoring pourraient générer des angoisses et un recours inutile au système de santé. Une attention particulière devra être portée à ce qui est utile et à ce qui ne l'est pas. Comme pour les médicaments, il ne faudra pas mettre sur le marché des dispositifs pour la santé sans une évaluation préalable. Voici donc une réflexion sur le sujet que j'ai travaillée avec mon collègue français à l'UEMO, Patrick Ouvrard.

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).

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