Order up!

"Dr Richardson speaking, how may I direct your call?"

"Um, this is Bob Smith and my mom is in room 408, bed 2, and I was wondering how she is doing?"

"I will page the nurse, Mr Smith, and ask her to speak with you."

"But aren't you a doctor?"

"Yes, but not your mom's doctor."

"Then why are you answering the phone?"

"Well, we don't have unit clerks anymore so each of us physicians takes a shift on ye olde switchboard."

I began thinking of this improbable situation when I was confronted by two helpful computer-friendly Fraser Health staff in my hospital mailroom the other day. From time to time they come around to answer questions about our hospital computer system or to try to engage physicians in some new program (considering what physicians are like, I feel sorry for them).

They encouraged me to sign up for a program whereby I would use the hospital system to order my own lab tests, X-rays, scans, etc. The idea being that instead of writing my requests in the "doctor's orders" area of the chart I would input these orders directly—a job that is currently done by the ward unit clerks.

In principle this doesn't seem like such a big deal as I already print test requisitions for my office patients using my EMR. So a system that was quick, easy, and accessible to complete my ordering in the hospital wouldn't be too onerous. However, I have watched unit clerks search the hospital system for long periods of time trying to find the correct test, form, and so on. Also, each nursing station has only a few computer terminals from which to log on. During morning rounds will physicians have to fight each other for priority, or will there be a sign-up sheet like at the gym for exercise equipment?

When I pointed out that this new program just seemed like more work for me I received responses such as other areas are doing it, many physicians like the process, and this is going to become mandatory anyway so I might as well get onboard early. I don't think they liked my suggestion that maybe they could ask those agreeable physicians from other locations to do my ordering until it was mandatory as my experience has been that getting onboard early is usually a mistake.

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I am curious which stakeholders decided that having physicians doing order entry is the best way to proceed? I can see a number of on-the-fence GPs finally throwing in the towel and giving up their hospital privileges after being asked to do even more work.

And what is going to happen to the unit clerks? Is this an attempt to phase them out? If so, who is going to answer the phone, arrange patient transfers, and interact with visitors? Are these tasks going to be heaped upon the shoulders of our already-overworked nursing staff?

If I fill out a request for an abdominal CT scan on the ward, is it going to be my job to make sure the patient arrives in radiology on the correct date and at the correct time? Maybe the plan is to phase out the hospital porters as well? I guess they could give me a cellphone to answer as I move patients around during my morning rounds. Heck, why stop there; I could drag a mop behind me as I push the stretchers down the hallways.

—DRR

Does telemedicine need stricter rules for engagement?

Until recently, with very few exceptions, MSP fee compensation for a patient service was contingent on a face-to-face patient visit, regardless of whether the visit was an efficient use of time for the patient or physician. Times have evolved and MSP will now compensate physicians for limited patient services delivered by telephone. In addition, it is possible to receive MSP compensation for virtual visits via telemedicine.

Telemedicine goes a step beyond the telephone—it is a combination of telecommunication and information technology, in varying degrees of sophistication, which allows for real-time voice and visual communication between the parties involved. At its most straightforward it involves contact through a service such as Skype or FaceTime, which should be compliant with the CMPA's legal advice and the College's standards regarding privacy and security. A more sophisticated type of real-time telemedicine captures vital signs and oxygen saturation and uses instruments such as otoscopes, ophthalmoscopes, and electrocardiography monitors. Some of these instruments provide a magnified image with clarity that is better than in real life. Telemedicine technology may one day be able to transmit tactile response, making the virtual visit almost indistinguishable from a face-to-face visit; however, only the real-life visit will convey the personal interaction so valuable as a therapeutic tool and in the creation of a good physician-patient relationship.

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The biggest challenges facing telemedicine today are not the gaps in technology but how telemedicine is applied. If telemedicine is allowed to flourish as a new form of medicine rather than as a tool that a physician chooses to optimize patient encounters, the risk is that it will become an industry in itself and lead to telewalk-in clinics and prescription-refilling services. And depending on how remunerative it is, it could potentially draw physicians away from clinic or hospital-based work. Should we not learn from the example of walk-in clinics eroding the traditional primary care home?

In some circumstances telemedicine can provide a valuable medical service to communities with scarce physician resources, despite its diagnostic and treatment limitations. However, the question remains: How should telemedicine evolve in urban settings and how should it be funded? In my opinion, it is up to the primary care physician to determine how best to provide care in specific circumstances, be it face-to-face, by telephone, by telemedicine, or by e-mail. Telemedicine has tremendous potential value in enhancing comprehensive longitudinal care and should not result in more fragmented care. The implementation of this technology deserves a sophisticated utilization strategy. As for public funding, would it not be best for physician remuneration to be based on comprehensive patient care rather than on the modality used to service patients?

—WRV