

## Health-care-by-phone services spreading across country

Cynics in the crowd call telehealth “1-800-GO-TO-ER,” while doctors developing the services call them “enhancements” of traditional health care. Meanwhile, the public just keeps calling — a lot.

The concept of telehealth is about 6 years old in Canada. The process is designed to provide a buffer between patients and the services they seek. By the end of last year, 80% of Canadians had access to telephone triage after Ontario added the newest program, Telehealth Ontario. Canada’s telehealth services actually trace back to a New Brunswick ER doctor, Peter O’Hanley, and nurse Lois Scott. Ten years ago they started wondering about the “large numbers of people in our ER. Why were they all there?”

Now a medical director at privately owned Clinidata, Canada’s largest provider of telephone triage services,



**Dr. Peter O’Hanley, RN Lois Scott: The new Grandma?**

O’Hanley was working in the emergency department of the Moncton Hospital at the time and fielding questions like “What does chicken pox look like?” and “Is this a rash or a sunburn?” He realized that many of his patients needed information and reassurance, not emergency care.

The pair’s simple question coincided with the New Brunswick government’s plans to cut costs, and by 1995 Moncton was host of the country’s first centralized telehealth service. By 1997, it was available across the province.

Although the telehealth model was originally imported from the US, it was altered for use in Canada. Dr. Maurice St. Martin, medical director of Direct Health in North Bay, Ont. — which served as a pilot project before being folded into Telehealth Ontario — said telehealth in the US encourages callers to visit their doctors. In Canada, the aim is “patient education with the subsequent goal of self-care.” Despite these differences, Clinidata, which has been contracted to provide telehealth services in New Brunswick and Ontario, uses protocols and a software system developed by the Cleveland Clinic but adapted for use in Canada.

Registered nurses answer calls within 60 seconds and, using evidence-based protocols and software, provide stan-

dardized advice. Observers warn that the system must be used carefully. “What we don’t want happening is somebody thinking that they can diagnose a child with meningitis — over the phone,” says emergency physician Robert Johnston, telehealth project leader for the Calgary Regional Health Authority.

TeleCare and Telehealth Ontario calls are placed in 5 categories: priority (call 911 immediately), emergent (see a physician within hours), urgent (call a physician within the next 24 hours), referral 72 (call a physician within the next 72 hours) and self-care (you can tend to your own needs). David Jensen, a spokesperson for Ontario’s Ministry of Health and Long-Term Care, said that between Feb. 1 and Sept. 10, 2001, Telehealth Ontario’s 150 registered nurses handled 179 198 calls; 46% of callers were told self-care was suitable, 31% were told to see their FP, 13% were referred to an ER and 3% to a drug-information hotline, and 2% were told to call 911. The remaining 5% of callers were advised to seek other services.

In North Bay, some 30% of residents have used the service. “We complement the role of the family doctor,” explains St. Martin. “We’re essentially becoming Grandma.” — *Susan Lightstone, Ottawa*

## After a decade, psychiatrist agrees to misconduct charge

In 1992, Dr. Eric Hansen stepped outside the rules of doctor-patient confidentiality and told police that a man convicted of sexual assault might be innocent. The Halifax psychiatrist had information about the woman who made the original complaint against the man to police; she was a former patient and he believed she had post-traumatic stress syndrome. Now, nearly 10 years later, Hansen has agreed to a charge of professional misconduct for his actions and his licence was suspended for 2 months, effective Dec. 1.

Hansen and the College of Physicians and Surgeons of Nova Scotia agreed to the suspension before they were to appear before the Supreme Court of Nova Scotia. Hansen had appealed the college’s original 3-month suspension for professional misconduct in 1996, when

he became the first doctor in Nova Scotia to appeal a disciplinary decision.

*CMAJ* first reported on the case in 1994 (*CMAJ* 150[6]:960-2). “Hansen had doubts about the credibility of the woman’s account of the sexual assault. A month after the trial ended, he did something no other Canadian psychiatrist has ever done: he voluntarily revealed sections of the woman’s psychiatric file for use in court. On the basis of his medical opinion about the former patient, a 3-judge panel of the Nova Scotia Court of Appeal overturned the guilty verdict and ordered a new trial.”

According to the court, “the public interest in avoiding a miscarriage overrides any claim of privilege that might be advanced in these circumstances respecting patient-physician communications.”

In the agreement with the college, Hansen not only accepted the finding of professional misconduct and the 2-month suspension but also agreed to pay \$25 000 toward costs. The sudden resolution came as a surprise, given the polar-opposite views that both sides have maintained.

In its original 53-page decision, the college stated that Hansen had “failed to talk to his patient, failed to communicate with the referring physician, failed to attempt to verify the accuracy of newspaper accounts of the ... trial, failed to consult with any of his colleagues and failed to adequately consider the ramifications that his actions might have on his patient.” Hansen responded that the committee’s decision was “fundamentally misguided, misleading and wrong.” — *Donalee Moulton, Halifax*