A medical virtualist's skills

Daniel Oran and Eric Topol presented their Perspective[1] on patient care delivery from a distance, and the role of medical virtualists in this scenario. Over the past 2 years, our telehealth research group has been building the expertise required to work with remote eye care.

TeleOftalmo is a teleophthalmology strategy that offers comprehensive eye examinations to patients in the Brazilian public health system, as part of a large telehealth initiative in the country.[2] Ophthalmologists using TeleOftalmo deliver eye care through real-time virtual encounters.

As we launch the project, new knowledge and competencies are being incorporated, refining the skillset of our virtualists. This is because propaedeutics of telemedical encounters are diverging from the conventional in-person examination. One example of this diversion is in the detection of cataracts. Usually, this is a straightforward diagnosis, with direct visualisation of the lens using a slit lamp; however, this diagnosis becomes challenging when eye tests are done using telemedicine. Eye-care specialists might resort to astute ways of quantifying lens density, such as taking photographs of the anterior part of the eye with a retinal camera,[3] or measuring the amount of light that scatters through the lens.[4] Either way, these alternative tests are not common in the traditional ophthalmologist eye examinations.

Our expectation is that novel, validated methods will have a central role in remote diagnostics of eye conditions. The virtualist, as a medical specialist, will be required not only to interact with patients through telecommunication technologies, but also to master the application and interpretation of examinations specifically designed for telemedical approaches.

We declare no competing interests.

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Prioritising people with disabilities implies furthering rehabilitation

We fully agree with the Editors regarding the need to prioritise disability in universal health coverage,[1] but we want to emphasise that for WHO this implies also strengthening the rehabilitation health strategy.[2] Because of changing health and demographic trends, a growth in the number of people living with permanent disabilities, but also of people experiencing disabilities with the potential of recovery, has been observed.[2,3]

1 billion people live with disabilities,[1] while 2·4 billion people experience disabilities, generating 316·6 million years lived with disability, according to the Global Burden of Disease[4] estimates presented at the 2nd WHO Rehabilitation 2030 Global Meeting.[5] Rehabilitation serves both groups: by reducing the number of people transitioning from experiencing a disability to living with a disability, maximising the benefits of other health services, and reducing the overall costs.[2] WHO has included rehabilitation in the universal health coverage mandate together with other public health strategies including promotion, prevention, treatment, and palliative care. Nevertheless, the absence of functioning as the advocated third health indicator,[5] together with mortality and morbidity, impairs the description of people living with or experiencing disabilities, leading to underestimated rehabilitation needs. Paradoxically, the fundamental struggle for the rights of people living with disabilities somehow drove the attention to those with permanent and stable disabilities and social rehabilitation, without including those with evolving and changing conditions, who are the target groups of the rehabilitation health strategy. Rehabilitation strengthening advocated by WHO[2,5] is in line with disability prioritisation emphasised in the Editorial,[1] but will also reduce the burden of disability on the population and the costs of health services worldwide.

We declare no competing interests.

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