component of clinical competence. As most medical schools use objective structured clinical examinations to assess performance during training, earlier remediation of suboptimal level of performance could ultimately improve the quality of asthma management in practice. Because these skills sets are required to manage other chronic conditions, the establishment of minimum performance benchmarks during training could have an overall positive effect on the quality of chronic disease management.

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Smartphones in Clinical Practice, Medical Education, and Research

Cellular phone technology and additional hardware were integrated into personal digital assistants and they evolved into smartphones. The installation of high-speed cellular networks with near-universal coverage has allowed these devices to show their full potential, which also benefits users in the medical community. Long-term Evolution technology (LTE), the high end of the fourth generation (4G) of mobile networks, offers speeds up to a hundred times faster than 3G. Currently, 64% of US physicians own smartphones, but this is predicted to increase to 81% penetration by 2012.

Anatomy and Physiology of Smartphones. Hardware. Today's high-end smartphones feature capacitive (finger gesture enabled) or noncapacitive (stylus enabled) high-resolution touch screens, discrete or screen keypads, communication ports such as mini-USB, infrared, Bluetooth, wireless local area network radios, assisted global positioning technology, electronic compasses, accelerometers, gyroscopes, proximity and ambient light sensors, microphones and cameras for videconferencing, and inductive, cable-free battery charge technology.

Software. The most critical aspect of any computer is the software it is running, since it ultimately determines usability, usefulness, and user adoption (see eTables 1 and 2 and eFigures 1-3; http://www.archinternmed.com). Other important aspects include multitasking, adherence to industry standards, and availability of native software applications (Figure and eFigure 2 vs simple mobile Web pages (Web apps) (Figure and eTable 1).

Smartphone Applications. Clinical Practice. Most health care professionals desire current clinical information and decision support at the point of care. Smartphones can provide both by accessing traditional medical textbooks, professional society guidelines, drug references, and institution-specific therapy standards. Medical calculators simplify the bedside use of medical equations, scores, stratification, and risk prediction and prevention models. Smartphones can assist with physical examinations using applications to check hearing, eyesight, and color recognition; evaluate mental status; or photograph or video document physical findings.

Taking full advantage of current technology means wireless retrieving of the most up-to-date information anywhere anytime. The National Library of Medicine’s “PubMed for handhelds” engine and third-party applications offer searches structured by diseases and conditions, medical specialties, differential diagnosis, drugs and medications, and journals and medical news or use a latent semantic analysis framework.

Our patients expect information about their condition, the treatments, and procedures we offer them. Illustrations and videos formatted for mobile display can
assist obtaining informed consent at the office or bedside. Health care is affected by globalization and migration of people, resulting in the need to interact with them (and their relatives) in languages we may not speak or understand. Text-to-speech, speech-to-text, and speech-to-speech translation have become a reality. They could be particularly useful for deployment in disaster relief teams.

Smartphone solutions to fully access and edit electronic medical records including coding and billing have been deployed. They are no longer restricted to numeric or text data and allow viewing of "digital information and communication medicine" (DICOM) formatted 3-dimensional imaging data from "radiology information" or "picture archiving and communication systems" (RIS/PACS) in conventional radiology, ultrasonography, computed tomography and magnetic resonance imaging, or endoscopy. Sensors for both, radiofrequency device identification devices (RFID)—best known from electronic passports—and biometric data (user’s skin [fingerprint, handprint, palm print, knuckle print, blood vessel pattern], eye movement and face recognition, ear canal sensory, individual voice pitch recognition, odor, and DNA detection) are being considered for smartphone integration. RFIDs can also be injected or implanted (skin or molar teeth) to allow emergency responders identify and assist victims faster.

Smartphones can also be used to monitor patients outside the medical enterprise. Wearable real-time cardiovascular disease detectors are already available and electrocardiographic and arrhythmia monitoring may soon be fully integrated into smartphones.

Education. Software repositories are replete with multimedia rich educational applications covering virtually every biomedical subject. Board-certified health care providers who periodically need to revalidate their credentials can now earn Continuing Medical Education (CME) credits on the go. Smartphones can serve highly customized educational and scientific content through RSS feeds, podcasts (eTable 2 and eFigure 3), social media (eFigure 1), and other Web 2.0 technologies (CMS [content management system], LMS [library management system], or VLE [virtual learning environment]) (eFigure 2).

Research. There are applications to emulate scientific graphing calculators; render chemical compounds and proteins in 3 dimensions; help prepare standard laboratory solutions; view restriction enzyme information, tu-
Outlook. Real-time medical and scientific communication and information is already at our fingertips, literally. A breakthrough will be “biocommunicators” incorporating a whole new dimension of information. Feasible potential applications include population-based cancer screening; prediction of drug response for biological or targeted therapies using genetic polymorphisms; environmental monitoring; on-site and bedside detection of critical laboratory and drug values on house calls by emergency responders; as well as clinical research with home-based collection of real-life biomedical data and FDA (Food and Drug Administration)-demanded patient-reported outcomes.

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Online-Only Material: eTables 1 and 2 and eFigures 1, 2, and 3 are available at http://www.archinternmed.com; they provide categorized exemplary software applications and other Internet-based resources for the various use scenarios in clinical practice, research, and biomedical education discussed. They include a brief marketing description (drawn from the app vendor’s site) and clickable hyperlinks for easy access. No endorsement is made or implied. Trademarks, logos, and ad copy are the property of the respective owners.


Patients With Infectious Diseases, Overcrowding, and Health in Hospital Staff

The evidence on whether treating patients with infectious diseases increases the risk of ill health among hospital staff is limited to specific infectious agents, such as methicillin-resistant Staphylococcus aureus (MRSA). However, any infectious agent that can be transmitted by airborne transmission or during treatment contact can be acquired at the workplace. Therefore examined whether there is an association between patient overcrowding and prevalence of infectious diseases and whether the association between the prevalence of patients with infectious diseases and ill health in hospital staff is dependent on ward overcrowding.

Methods. Study participants comprised 993 physicians and nurses (mean age, 42.4 years; 93.7% female; 84.7% registered nurses) in 54 somatic disease hospital wards in 5 acute care hospitals in Finland. The assessment methods used have been described previously. Briefly, ward-level prevalence of infectious diseases (hospital and community acquired) and other patient characteristics were assessed from case records of the 1102 patients in these wards. Ward overcrowding was determined using routinely collected monthly figures on bed occupancy for each ward. These ward-level data were linked to individual records on the employee sickness absence and antibiotic medication use (purchases of medicine with the World Health Organization Anatomical Therapeutic Chemical Classification code J01) during the subsequent 150 days. The records were obtained from employers’ and nationwide health registers.

Binary logistic regression analysis with the SAS multilevel GLIMMIX procedure was used to study the associations of ward-level exposure to infectious diseases with individual-level employee sickness absence (yes/no) and recorded antibiotic use (yes/no). The models were adjusted for employee characteristics (sex, age, occupation, type of employment, and chronic disease) and ward-level characteristics (ward specialty, mean age of patients, number of patients, mean number of invasive devices in patients, prevalence of operated patients, and patient overcrowding). To examine whether the associations were dependent on the level of patient overcrowding at the ward, the interaction term “overcrowding × exposure to infectious diseases” was entered into the model after entering the main effects of overcrowding and exposure to infectious diseases.