Letters

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Editor's choice

I found Mica Skilton's *Dangerous Idea*[1] published in the February *BJGP* interesting and persuasive in a context of remembering my own inept attempts to interview and examine patients in the late 1960s. The app would have been invaluable to hone some skills before experimenting on patients. However, I don't agree with the conclusion that it would replace the need for patient contact. For the provision of health service to improve, the development of empathy of providers with their patients is essential, and avoiding contact with people early in clinical training won't further that goal. However, if some of the wasteful and misdirected patient contact time is diverted to sessions of diversionary therapy or personal care of patients in activities with which a student is familiar, the relationship would benefit both parties. It will impact on the student's understanding and acceptance of people and what it means to be ill through here-and-now issues, which are relevant and focused on the patient's needs.

I have always thought my privilege of a few months employment before starting medicine, as an assistant nurse in a psychiatric institution, was one of the most influential experiences of my career for helping me to absorb the reality of other people's lives which were very different to my own. The other, was 20 years later when I worked for 2 years on a Western Pacific Island.

It's never too late to add to life experience. Good luck in your career.

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1. Skilton M. Dangerous Ideas: Virtual GP. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X683689.

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GP recruitment and retention

The government still refuses to use the word 'crisis',[1] but I suppose that is not surprising a short time before an election. I am saddened that the College seems to be in some ways acting as a mouthpiece for the Department of Health, by trying to encourage students and postgraduates into a career in general practice; a speciality that currently is broken. Fortunately, our younger colleagues can use social media and get a true picture.

My wife and I both took early retirement from general practice, in our late 50s. The strain of trying to be 'all things to all people' was just getting too much. We were worried that we would start to make mistakes by just having too many balls to juggle.

A number of things have occurred to me: did no one think that scrapping seniority payments would be a disincentive for older GPs to stay on, and that introducing a contract with an open-ended workload for no extra money was unacceptable? The complaints culture takes up too much time and effort for doctors: the GMC is an organisation out of control, which we now find, according to its own report, has been involved in the deaths of at least 28 doctors under investigation. The Retainer Scheme needs a complete overhaul; our practice refused to have retainers as the rules meant we might have to pay redundancy to a retained doctor for all their previous NHS service! GPs have had years of pay cuts now. The CQC is an added burden, and as we see from the recent fiasco over the release of misleading statistics to the public, is not fit for purpose.

Many GPs are using their own strategy now to keep their sanity; 'RLE': Retire, Locum, Emigrate. A senior colleague recently said to me that the government has taken general practice back to the 1960s. What is proposed is too little, too late, but may just possibly make the public think something is being done until the election in May.

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Patients could provide initial differential diagnoses

The very interesting study by Kostopoulou and colleagues in the January issue[1] highlights the potential value of patients using symptom checkers and handing the results to their doctor at the start of the consultation. This would get over the current technical challenges of a system automatically producing a differential from more complex cases with multiple symptoms.

The study refers to a naturalistic trial of Isabel, a physician-triggered computerised decision support system (CDSS) that showed that junior paediatricians only sought and examined the system's advice 'around 2% of the time'. This study was carried out over 10 years ago in NHS hospitals where access to desktop computers was very poor and the use of mobile devices to access the Internet was almost non-existent. This partly explains the low rate, but the more significant issue relates to the standards set by the senior clinicians. In hospitals where Isabel is used and is easily available, and actively encouraged by senior clinicians setting a standard, we have found that it is accessed in about 10% of cases. CDSS can only be a means to help clinicians practise to a certain standard.

The Kostopoulou study is based on three cases all with just one clinical feature that made it technically easier to generate a differential diagnosis. In reality, many cases would have multiple clinical features that would necessitate a CDSS (such as Isabel) that could handle complex free text queries. The study showed significantly less improvement when the CDSS was provided 'late'. Readers may be interested to know that when we (Isabel) looked at the impact the use of Isabel had on users from