

access code was entered. I did telephone, but I might as well have tried to break into Gringotts.

I appreciate the diligence of your system in its determination to instigate invasive investigations for all, but from a clinical perspective may I suggest that this approach is not entirely justified.

Yours,
Dr Watkins

To: Dr Watkins
From: Dr Blakemore

Dear Dr Watkins,

I was surprised to see your patient, Mrs Perkins, on the endoscopy list for this morning. So was she.

Fortunately I had a few minutes to give her some reassurance about her symptoms, and I have discharged her back to your care.

Best wishes,
Dr Blakemore

To: Dr Watkins
From: APPOINTMENTS

AUTOMATED RESPONSE: PLEASE DO NOT REPLY TO THIS MESSAGE

This is to inform you that your patient: MRS PERKINS did not attend their appointment at the: ENDOSCOPY DEPARTMENT on: 08:10am 12/01/15

This appointment has been rebooked for: 10:20am 19/01/15

Password: onh823ts6vc

Reference number: 00074583433517341

Lydia Yarnott,
Final Year Medical Student, Oxford University,
Oxford.

Email: lydiayarlott@gmail.com

DOI: 10.3399/bjgp15X685741

JOINT 2ND PLACE

RATs: Quality not Quantity

Talk to any politician and they will tell you that the problem is one of access. 'GPs should be working 7 days a week', 'more appointment-slots should be available', 'better access equals a better service', they yell from their soapboxes. And with a growing population, which has ever-increasing expectations of what the NHS should do for them, you might be forgiven for thinking that the problem is simply one of quantity.

This attitude is evident in the government's recent approach to improving general practice. Development of effective telehealth in the UK has been a priority, with CCGs rolling out these services thanks to heavy financial backing. Telephone consultations were once the purported solution; increasing ease of access and therefore the quantity of consultations available was the goal, however, the results were far from satisfactory as the increased access simply led to greater demand. The telephone slots were used but those same patients too often still required a traditional consultation, hence the ESTEEM trial's conclusion that telephone consultations were not cost-effective.¹

CCGs are therefore turning to the next step in telecommunications and video consultations using Skype are now widely available. These continued attempts to pursue telehealth seem to ignore the lessons learnt on the telephone. Telehealth provides consultations at the click of a button, day or night, decreasing overheads for premises, administration staff, and the like. The goal is an increased number of consultations at low cost but as these services are not proving economical and have not tackled the previous issue of patients requiring a repeated consultation, what purpose do they serve?²

The digital age is, however, supplying technologies that are resulting in palpable improvements to health services. While telehealth receives the headlines and funding, the comparatively humdrum integration of Risk Assessment Tools (RATs) is leading to faster and safer consultations.

In broad terms, this utilisation of software to carry out important analysis of patient data can and does save GPs valuable time, which can be better spent elsewhere in the consultation.

The growing numbers of RATs available to GPs are small steps that can make a big difference to patients. ECLIPSE (Education & Cost-analysis Leading to Improved Prescribing Safety & Efficiency) is just one example of such a tool. The software analyses data on practice systems and uses algorithms to detect long-term trends in clinical entries, prescribing, and pathology results. ECLIPSE identifies patients who are overdue for monitoring tests or being put at risk by their medications and presents these findings via a traffic light system of alerts, with the aim being to prevent unnecessary hospitalisations. For example, a full blood count shows a haemoglobin of 13.5 g/dL, a rushed GP sees a normal result but ECLIPSE sees the bigger picture. This patient is on an NSAID and their haemoglobin was 16.0 g/dL 2 months ago, an ODG is ordered, a peptic ulcer is detected, and an outcome improved.

ECLIPSE has already been rolled out by several CCGs and more RATs are being added; for example, Nottingham's Qcancer[®] score and Professor Willie Hamilton's cancer prediction tools which aim to tackle an identified weakness of the NHS — early cancer diagnosis.^{3,4} This is not the story of a digital panacea, rather of incremental improvements that have the potential to improve general practice, and thus patient outcomes.

Talk to any GP and they will tell you the problem is not one of access. They will tell you the focus should not be on quantity but on quality. They will emphasise the importance of continuity of care and a safe and efficient service. RATs are helping to provide that service.

Joseph Anthony,
4th Year Medical Student, University of Manchester,
Manchester.
Email: joseph.anthony-3@student.manchester.ac.uk

DOI:10.3399/bjgp15X685753

"This is not the story of a digital panacea, rather of incremental improvements that have the potential to improve general practice, and thus patient outcomes."

REFERENCES

1. Campbell JL, Fletcher E, Britten N, *et al*. Telephone triage for management of same-day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis. *Lancet* 2014; **384(9957)**: 1859–1868.
2. Henderson C, Knapp M, Fernandez JL, *et al*. Cost effectiveness of telehealth for patients with long term conditions (Whole Systems Demonstrator telehealth questionnaire study): nested economic evaluation in a pragmatic, cluster randomised controlled trial. *BMJ* 2013; **346**: f1035.
3. Rubin G, Vedsted P, Emery J. Improving cancer outcomes: better access to diagnostics in primary care could be critical. *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X572283.
4. Hamilton W, Green T, Martins T, *et al*. Evaluation of risk assessment tools for suspected cancer in general practice: a cohort study. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X660751.

* * * * *

JOINT 2ND PLACE

The Technophobe's Guide to the Digital Age

Douglas Adams had it right. In his *Hitchhiker's Guide to the Galaxy* series he perfectly encapsulates the way I feel about technology. I am one of those poor Earthlings who 'still thinks digital watches are a pretty neat idea,'¹ and wonders why no one has noticed that technology is only making life more complicated? Adams's infamous Nutrimatic-Drinks-Dispenser 'invariably delivers a liquid that is almost, but not quite, entirely unlike tea.'¹ And isn't it true? Machines can't even get tea right.

When the best part of technology is the 'sense of achievement you get from getting it to work at all,'² something is wrong. Despite having been born slap-bang in the middle of the digital age, I am dismayed to find myself a 'technophobe.' But when I look around at my colleagues-to-be, I don't believe I'm alone.

On every GP placement I have heard doctors bemoaning technology day in and day out. And why not, when all the patient notes spontaneously decide to reboot mid-surgery, when the electronic prescribing program takes itself out for a few hours, or when a glitch renames every patient in the system 'George' (alright that one didn't happen, although I bet it could). It causes chaos.

But technology is a wonderful thing. We should be exalting it, not quivering at the byzantine complexity of decrypting our own

"Cyberchondriacs, 'as some are affectionately nicknamed, are developing increasingly unusual diseases ..."

passwords. For goodness sake, people are printing pelvises; it's simply marvellous!

It's true, hospitals see the most dramatic breakthroughs — whereas on some of my GP placements I'd have been lucky to see a pulse oximeter — but even without the flashiest gadgets, over time, technology has changed the job of the GP in a subtle yet profound way. And the more I think about it, the more I am won over.

Gone are the dark days of paternalism where patients unassumingly followed advice. More and more, patients are feeling empowered by knowledge from the web. 'Cyberchondriacs,' as some are affectionately nicknamed, are developing increasingly unusual diseases and I think it's fun to be kept on our toes; having to explain why it's unlikely to be an amoebic liver abscess and more likely to be gallstones to someone who is alarmingly well informed. But all joking aside, technology is helping people to take responsibility for their health, which is fantastic news for everyone.

The development of health applications and online symptom checkers is part of this new age of patient empowerment. Of course they are currently far from perfect but their potential is incredible. Apps are being designed to make long-term conditions, such as diabetes, easier to manage at home, and apps that aim to improve diet and fitness could play an enormous role in the fight against obesity, a costly and growing concern.

I have come to realise that 'technology' is so much more than erratic computer systems and so what if I can't run HTML backwards while simultaneously lowering cholesterol? We all have our strengths and computers aren't mine: that doesn't mean I should condemn all technology and run from it terrified. Technology was never the problem, I was.

My GP placements have helped me to see technology for what it really is and for that I am incredibly grateful. Even though I may never know what 'the cloud' is, and I am still waiting for that perfect cup of tea, I am embracing technology at last and am happy I will be a doctor in a digital world. So for anyone out there who has ever felt like me, keep going, we'll get through it.

Rebecca Varley,

5th Year Medical Student, Lancaster Medical School, Lancaster.

Email: rebecca.varley@doctors.org.uk

DOI: 10.3399/bjgp15X685765

REFERENCES

1. Adams D. *The hitch hiker's guide to the galaxy*. London: A. Barker, 1979.
2. Adams D. *So long, and thanks for all the fish*. London: Pan, 2009.