Communication in the age of digital healthcare

DANNY BUCKLAND

The surge of technology across healthcare is washing away labour-intensive practices and promises a cleaner, smarter future for GPs and prescribers. However, concern is growing that traditional lines of clinical communication could be drowned out by the race for progress across a troubled NHS.

SPL

The image of a doctor signing a scrip flourishing an heirloom fountain pen, his gold fob-chain glinting as he rises for lunch with faithful colleagues has long faded. Jokes about GPs' handwriting linger on in older generations but the modern medical cohort embraces technology and is comfortable with delivering healthcare digitally.

With the NHS groaning under budgetary constraints, any aid that can speed up care processes safely is welcomed. As internal systems migrate from paper to digital, the hope is that the crevices of inefficiencies and delays are being power-cleaned and the financial savings are ramping up.

The aim is to create a sustainable healthcare system with the newly-minted NHS Digital – an arms-length body of the Department of Health – being launched late in 2016 with the mission statement: "We aim to bring about a digital revolution in health and care. The exploitation of 21st century technology, the use of increasing quantities of data and the impact of richer information flows has the potential to fundamentally change how citizens look after themselves and how health and social care professionals do their work. We are working with our partners to transform the quality of services and help secure a financially sustainable future for the universal system of health and care."[1]

It's a laudable mantra that is even more appealing when given a glossy sheen by high-tech companies such as Google and IBM, who are developing super-computers with tireless, ever-learning algorithms that claim to deliver pin-sharp diagnoses in a fraction of the time taken by a frazzled clinician.

The dwindling influence of formal letters circulating aimlessly around the NHS is welcomed by all, but the fear is that when the technical mountain of enabling computers to link to computers across the range of NHS outposts is scaled, it will mean that clinicians will stop talking.

Face-to-face contact

Professor Helen Stokes-Lampard, chair of the Royal College of General Practitioners (RCGP) welcomes the role new technology is playing in streamlining processes but is concerned about relationships across the primary-secondary care land-

scape and within GP and prescribing communities.

"Technology is having a largely beneficial impact on life as a GP. At practice level, the introduction of electronic patient records, appointment management and electronic prescriptions has been fantastic," she says. "If a patient goes on holiday to the Lake District and forgets their glaucoma eye drops, all they need do is call the surgery and I can send a prescription to the closest high street pharmacy at their destination, where they can collect it within an hour. It saves a lot of time and effort for everyone.

"New technology gives us e-learning and remote working, which is great in terms of efficiency, but what we miss out on is that face-to-face contact with colleagues. The collegiate approach is important; talking through a complex case with a trusted colleague is so powerful. In our practices, we get together to discuss difficult cases and that helps but we don't have that primary-secondary contact." Budget cuts and added bureaucracy have made named consultants less accessible while the trend of more GPs working part-time has further frayed strands of communication, she explains.

Professor Stokes-Lampard, who is also a GP in Lichfield, Staffordshire, adds: "Those lines of communication need to be protected because it is so easy to become more fragmented. If we want to deliver the best care, we want things to be joined up.

"Technology can help us but there is the anxiety that, although an algorithm and an app may do a great job of considering the physical issues, it can't usefully consider the much more complex factors of the patient's social and psychological situation and tailor plans for what that unique patient really needs. When I'm dealing with a patient, I am not just looking at the physical issues they present with but the whole patient and their life.

"A computer can factor in what drugs a patient is on but it is unlikely to know whether their social housing situation is secure, and although guidelines may say they should be taking a certain medication three times daily, you know that twice a day is the best you can hope for because they need a carer to help them or they are a carer themselves and neglect themselves; it is those sort of 'human-touch' things. A good clinician will use guidance as guidelines not tramlines to force a decision; that is the real art of the GP.

"Technology can help us a lot with the science but a good GP is an artist as well as a scientist. Unfortunately, it seems we now have systems that divide us not unite us. The introduction of the 'choose and book' referral system actually put a big barrier between GPs and consultants by almost entirely stopping one-to-one named clinician referrals. I don't know the consultants that well in my area now whereas when I started my career I certainly did know them. If you don't speak to people, you don't get to understand their world, and if you don't communicate, you are going to create division and what divides you will get bigger."

Improving connectivity

Pharmacist Sibby Buckle, chair of the pharmacy digital forum hosted by the Royal Pharmaceutical Society (RPS), believes technological advances are being held up by lack of connectivity across the NHS and a patchwork take-up of innovation.

"I don't think we can be any worse that where we are right now in relation to the transfer of information between GPs and community pharmacists that happens by fax or phone," she says. "Our day-to-day interaction is pretty prehistoric when you consider the levels of sophistication in banking systems and other areas. The direction of travel is promising but we need to support that with better connectivity. We need the GP and the pharmacy systems to be able to talk to each other and that is not always the case."

Ms Buckle, who practices in Nottingham and is an RPS board member, sees great potential but feels that elements of practice such as transfer of care on discharge is "in the dark ages", so real-time transmission of information is desperately needed to fuse the medical and social wires of care.

"Communication is absolutely vital and it is important we get it right. The technology is there but we need the government to commit to the funding to make it happen. There is a climate of tight budgets and ever-increasing expenditure, but if we don't make changes to improve discipline and efficiencies between healthcare professionals, then we will not deliver for the NHS as we should."

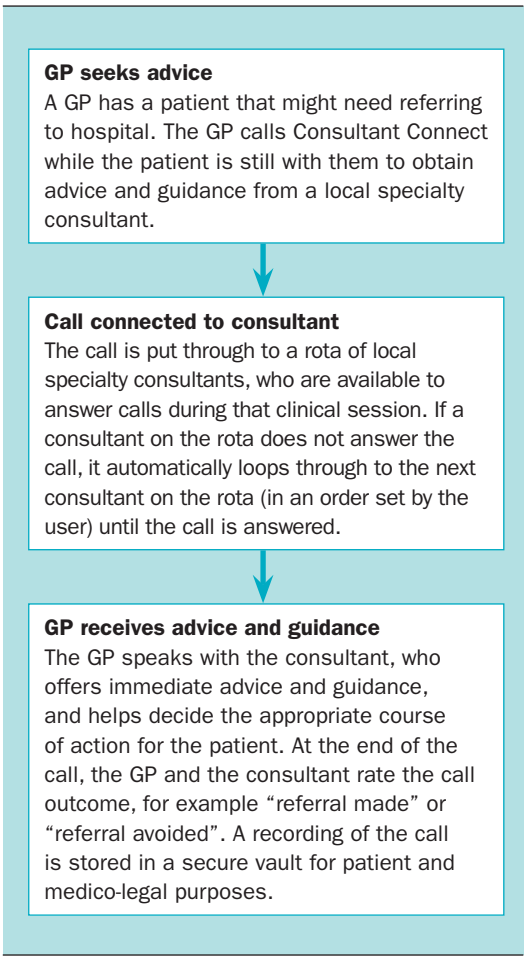

Figure 1. How Consultant Connect works[3]

Several schemes seek to address the communication breakdown. Hammersmith and Fulham CCG has set up a dedicated email service that links GPs to a consultant response within 24 hours; the Symphony Programme has brought in an enhanced collaborative approach to healthcare in the South West of England;[2] and Consultant Connect is championing a phone service between GPs and local hospital consultants (see Figure 1).[3]

"We looked at the area and discovered that GPs were harking back to a

> I don't know the consultants that well in my area now whereas when I started my career, I certainly did know them. If you don't speak to people, you don't get to understand their world, and if you don't communicate, you are going to create division and what divides you will get bigger.
> Professor Helen Stokes-Lampard, chair of the RCGP

time when you would have the consultant's phone number and could ring them directly, but more recently this had broken down so much it felt like barriers had been built up," says Jonathan Patrick, director of Consultant Connect, which is used by 1000 consultants and 1300 GP practices, covering 10.5 million patients across the UK.

"By speaking to someone directly, both ends of the phone call are enriched. We have had feedback from GPs who said the call to a consultant gave them an understanding that meant they wouldn't need to call when other patients presented with the same symptoms. The first area to adopt the service was North East Essex, which was making its monthly fees back within two months and has made significant six-figure savings over the year."

Dr Michael Banna, who is a GP at the Grove House Surgery in Bognor Regis, West Sussex, which is in a CCG signed up to the scheme, says: "It's a system where you can communicate as normal people rather than this hierarchy of inaccessibility where you refer someone to a clinic and they wait three months to be seen. It is good to have a normal conversation. It is not just about preventing referrals, it's about knowing what you can do while you are waiting for a referral. It's helpful if you can do something vaguely sensible in the meantime before the patient sees the specialist or try out a few different treatments rather than putting the person's health on hold.

"I don't see any downsides and I think that consultants would agree because we all want better outcomes for the patient, and working together, discussing things can only help that. If we avoid filling up their clinics with people who don't need to be seen, then we can have easier and faster access for those who do need to see them.

"There are a lot of drugs that I don't have experience prescribing but I would prescribe if a consultant said this is what you need to do and explained the details to me. There are some drugs that are traditionally prescribed by specialists and they feel comfortable doing so because they prescribe them every day. We may feel uncomfortable, not because they are less safe but because we don't have that experience. More knowledge enhances what you can do; if you have a specialist telling you it is fine and will work, giving their reasons, then that is easier than looking up the 300 different options to treat angina in the *BNF* and trying to figure out which might be the best one for your patient."

Transforming care models

Crispin Ellison, of management consultants Oliver Wyman Health & Life Sciences and Public Policy practice, believes issues of poor communication pre-date digital. "It has been eroded over the past two decades as primary and secondary care have become more distant. Current challenges reflect pressure on clinicians as a result of inefficient care models. Where digital is used to replace traditional communications and information sharing in existing care models, it can erode direct clinician-to-clinician interaction. However, much of that interaction is currently unnecessary and/or inefficient. The power of digital in the future is to enable complete transformation of care models, in particular to allow primary care doctors to focus on their time with the patient. These changes are delivering real results in other healthcare systems."

Dr Sarah Jarvis, a medical broadcaster, GP and clinical director at the medical advice site Patient (patient.info) agrees that technology has resulted in more communication across different channels but crystalises concern about the straining links between primary and secondary care. "Consultant-led clinics have gone, you have to book in with a clinic and I think there is a real danger of patients losing the personal touch of GPs being able to say: 'I rate this consultant, go and see them.' It worries me that so much of the continuity has gone – you no longer have a GP that has known you since the year dot, who would know which consultant is right for you. Some consultants are fantastic clinicians but with the wrong patients they are rubbish."

She uses the Hammersmith and Fulham email link between GPs and consultants. "When it works, it is absolutely magic and it shows you can get a lot out of technology," she says. "It has significantly reduced my referral rates and I've got to know my consultants more over the last two years with this system than I did in the previous 20 years because we are communicating regularly. But we have to preserve some form of personal contact at all costs. Sadly, the days of continuity of care from cradle to grave, with the same GP working in the same practice from the day they qualified to the end of their career, are numbered, if not in the last chance saloon."

References

1. Health and Social Care Information Centre. Annual report and accounts 2015/16. Available from: https://digital.nhs.uk/article/938/Annual-report-and-accounts-2015-to-2016
2. Symphony Programme. https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/primary-acute-sites/south-somerset/
3. Consultant Connect. https://www.consultantconnect.org.uk/

Declaration of interests

See http://www.mjauk.org/author/bucklandd/

Danny Buckland is a freelance health journalist