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Traditional diabetes education programmes – an endangered species?

The Internet is increasingly the first stop for medical information, with one in twenty searches for health-related topics. Unfortunately, this can lead to neurosis and panic about trivial symptoms believing this could herald the onset of some decidedly unpleasant and invariably lethal condition in the mind's eye of the searcher. To counter this, last year the Belgium authorities launched a campaign to dissuade their citizens from using Google as a source of medical information, but given that Wikipedia is already the most searched site by doctors for health information, this type of approach is likely to be unsuccessful (Lee, 2014). Recognising that there is a problem and with the hope of improving the quality and value of internet searches, Google recently announced a new search feature that plans to, according to their spokesman on their blog, “show you typical symptoms and treatments, as well as details on how common [a] condition is – whether it's critical, if it's contagious, what ages it affects, and more” (Ramaswami, 2015). Google has partnered with clinicians in the United States to curate and check the content for accuracy, with each piece of medical information being validated by 11 different clinicians (Gibbs, 2015).

There may be significant opportunities for the NHS in general and UK diabetes services in particular, to work with the likes of Google to add value to this approach. After all, much of diabetes care is fairly standard and generalisable, such as setting targets, screening for complications, structuring self-monitoring, providing guidance on the timing and frequency of commonly used medicines, and encouraging physical activity and smoking cessation. The “Google approach” could potentially reach far more people than currently available face-to-face education programmes, which are also often costly. The so-called “Digital Divide” is narrowing and smartphone use continues to increase as the cost of devices decreases. When using very low-quality technology by today's standards, it has been shown that it is possible to deliver diabetes education using a phone that is as effective as the traditional approach but has the benefit of saving a great deal of time (Rossi et al, 2010). By necessity, for this radical approach to work, online information will have to be created with

health clarity in mind – avoiding the existing barriers that some people face due to literacy and numeracy challenges. However, providing the information is understandable and actionable, then technology-based education may have an added benefit of encouraging personal responsibility when it comes to accessing health information. It would also free individuals from the tyranny of current appointment systems that often reflect the interest of the teacher rather than the student.

I suspect that for some, this approach will smack of heresy and will be a step too far on the pathway of considering “patients as consumers”. A hybrid version of the traditional supported by the technological may be more acceptable, at least in the short term. Diabetes is a very long-term condition and individuals with diabetes interact with the NHS only on an infrequent basis. At the very least, the onus is on the professional diabetes community to make sure that the information available on the Internet is accurate, effective and easily obtainable at a time suited to the individual – that is the beginning of personalised medicine. ■

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