I don't want to be a call centre GP!

General practice has not just remained open during the COVID-19 pandemic but responded with extraordinary agility and speed. This is not surprising as one of the key strengths of our speciality is its ability to adapt and innovate. We have a long track record of doing so: multidisciplinary working, electronic GP records, e-prescribing, call and recall systems, and, more recently, remote consulting and the speed with which we can identify and provide care to high risk and vulnerable patients.

Continuity of care and knowledge of our patients and local communities have greatly assisted such a quick response. Although the majority of our consultations became remote,[1] *we* did not! On the contrary, by working within our local extended teams we enabled connections.

ASSESSING CLINICAL RISK REMOTELY REQUIRES DIFFERENT SKILLS

The overnight shift to remote working within general practice in mid-March[2] was introduced due to necessity in order to reduce the risk of exposure to the virus. However, research and evaluation of its intended and unintended consequences, outside the relatively narrow context of a pandemic, will need to inform the use of remote consulting in general practice going forward.

While for many patients the technological solutions offer convenience and improve access, for others, such as those without a smartphone or Wi-Fi, or those with poor health literacy and with complex needs, they can present additional barriers and therefore increase health inequalities.[3,4]

The impact of remote working on us as GPs also seems to be mixed. On one hand it allowed flexibility, which meant that shielded and isolating GPs as well as those at increased risk and with caring responsibilities could still work. But it also introduced challenges. Assessing clinical risk remotely requires different skills, and assumptions that remote consultations can be quicker than face-to-face or that GP telephone triage reduces workload are not supported by robust evidence.[5]

In fact, anecdotal reports suggest that sessional workload has increased significantly and 30–40 patient contacts in a clinical session are now the norm for some GPs.

REMOTE, QUICK, IMPERSONAL: CALL CENTRE MEDICINE IS NOT GENERAL PRACTICE

The conflation between triage and consultation has not helped. Let us not pretend that an online algorithm, often without any element of interaction with the patient, is a consultation.

Clinical complexity, compounded by the mental health consequences of the pandemic, cannot be addressed in three minutes. Even when used purely for triage purposes, short interactions with a large number of patients via remote consulting can be mentally exhausting and lack the connection that brings joy to what we do.

Remote, quick, impersonal — call centre medicine is not general practice. It may work for a subset of patient queries and for minor ailments, but for the rest, understanding the patient's needs, perspectives, and priorities as well as the context in which they live is fundamental for providing safe, person-centred care. Working within an integrated local health and care system is what enables the appropriate use of resources and the necessary support that make care cost-effective and compassionate.

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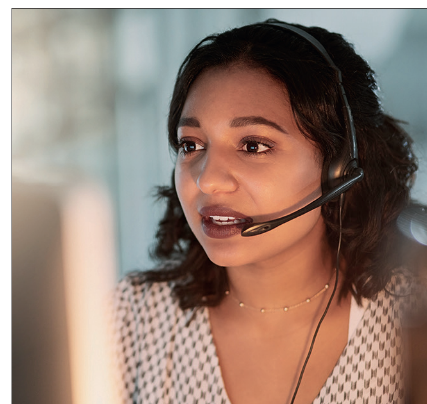

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REFERENCES

1. Pereira Gray D, Sidaway-Lee K, Harding A, Evans P. Reduction in face-to-face GP consultations. *Br J Gen Pract* 2020: DOI: https://doi.org/10.3399/bjgp20X710849.
2. MacAuley D. Asking questions. *Br J Gen Pract* 2020; DOI: https://doi.org/10.3399/bjgp20X710981.
3. Ashwell G, Blane D, Lunan C, Matheson J, on behalf of the RCGP Health Inequalities Standing Group. General practice post-COVID-19: time to put equity at the heart of health systems? *Br J Gen Pract* 2020; DOI: https://doi.org10.3399/bjgp20X712001.
4. Arroll B, Gill E, Roskvist R, Harwood M. COVID-19 in New Zealand: a move to online consultations in primary care could widen health inequalities. *BMJ Opinion* 2020; **25 Jun:** https://blogs.bmj.com/bmj/2020/06/25/covid-19-in-new-zealand-a-move-to-online-consultations-in-primary-care-could-widen-health-inequalities (accessed 9 Jul 2020).
5. Downes MJ, Mervin MC, Byrnes JM, Scuffham PA. Telephone consultations for general practice: a systematic review. *Syst Rev* 2017; **6(1):** 128.