necessary in a crisis represents what patients or clinicians want or need beyond.

The consultation *really matters*. It is not simply an exchange of facts, diagnoses, and prescriptions. Done well, the consultation is of therapeutic value, especially when embedded within an enduring relationship. If, as Hancock suggested, we are to *'encourage and celebrate generalist skills'*,[1] then we must retain the consultation at its centre.

We urge caution in mandating a wholesale shift towards teleconsultations without thorough evaluation. Existing research suggests that telephone triage increases workload with no cost savings, and the value of e-consultation and video-consultation remains controversial.

GPs and patients across the UK are on a steep learning curve, working out how to 'do' remote consultations out of necessity, and it is highly likely they will find their place within mainstream practice. However we do believe that some *'bad old habits'* may be worth holding on to.

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Could checklists support teams in stressful situations?

We welcome Grieg *et al*'s debate article about checklists.[1] Any activity that supports GPs in delivering safe, effective care in time-critical situations is greatly welcomed. However, we would like to take the opportunity to encourage practitioners to adopt a more critical approach when considering the use of checklists.

As Greig *et al* suggest, the rise of checklists in health care has largely followed their use in the aviation industry, where they provide a safety layer that protects against classic human failings like forgetting, particularly when working under pressurised conditions. But differences between health care and aviation present a challenge for this cognitivist way of understanding checklists.[2] For example, patient complexity makes healthcare delivery much less amenable to standard operating procedures than aviation. Managing healthcare emergencies relies on seamless functioning of multiple staff members across a wide range of roles — from GPs to practice nurses to receptionists — rather than just pilots and cabin crew. Practice treatment rooms and equipment vary from place to place much more than standardised aeroplane cockpits do. This means that checklists may not always be effective, may not transfer well between contexts, or may work in different ways than expected.[3]

We remain convinced about the potential usefulness of checklists, particularly in pressurised, infrequently occurring situations such as emergencies. However, faced with the complex, contextualised nature of health care, we recommend qualitative, sociocultural research to develop a deeper understanding of how they can be made to work effectively and in what contexts. We also recommend road testing of checklists — a process that may be supported by the emerging field of *in-situ* simulation[4] to ensure that they work within the realities of real-world general practice.

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Correction

In the Research paper by Hayward G, Verbakel JY, Abakar Ismail F, *et al*. Non-contact infrared versus axillary and tympanic thermometers in children attending primary care: a mixed-methods study of accuracy and acceptability. *Br J Gen Pract* 2020; DOI: https://doi.org/10.3399/bjgp20X708845, the numbers listed in Table 3 did not tally with Table 4. The authors discovered a coding error for the calculation of secondary outcome of diagnostic accuracy in Table 3, leading to missing values being counted as fever positives. In addition, the total number of participants in Table 2 was incorrect, but all analyses were correctly conducted and reported. To summarise the changes: 1) the total number of participants in Table 2 has been corrected, 2) the analyses in Table 3 have been corrected. Numbers in the text of the results have been adapted accordingly. The Discussion has been modified to reflect these changes (prevalence of fever was lower than reported, sensitivity of the NCITs for fever based on the axillary reading as a reference standard was better than initially reported and equivalent to other literature, but confidence intervals were very wide). No changes were needed to the abstract.

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