I recently attended a workshop exploring the effects of switching to a “remote by default” model of general practice consulting. This was a concept favoured by the erstwhile health secretary Matt Hancock and made necessary for infection control at the height of the pandemic. The reasoning goes that if there’s no need to physically examine a patient to reach a diagnosis, why bother being in the same room? In the real world, a complex mix of factors should influence our choice of consultation method, not all of which are considered when setting up new models of care. In many surgeries, remote consulting has brought with it a triage system where appointments are allocated depending on information provided on an online form. This should enable practices to work out who really needs face-to-face GP interaction and where a phone call or help from another member of staff might be appropriate. Although always expressed in efficiency terms, this is more often about rationing access to a scarce resource—the attention of one of a shrinking number of GPs.

Although offering some sort of e-consultation is now compulsory, the extent to which this model has been adopted varies hugely, with some practices requiring an online form for every appointment and others burying the link on their website and carrying on as before. In the workshop we were asked to consider various scenarios where patients struggled to navigate new systems. Some described patients experiencing frustration that was interpreted as aggression or hostility by overburdened reception staff, already stressed at being unable to satisfy patients’ requests. In others the patients gave up, unable to fill in a computer form and lacking the time or phone credit to stay on hold for an hour for help to do so. The clear risk is that we miss a chance to cure, and the next presentation may be with a more serious illness or even an advanced malignancy.

There was consensus among the clinicians and patients present that most of the problems could be avoided (or at least ameliorated) by continuity of reception and clinical staff. However, I was disappointed to hear from some contributors that this was “not a realistic response.” Apparently, I have unrealistic expectations or rose tinted nostalgia when I describe my version of what good general practice looks like. It involves long term relationships with clinical and reception staff, along with easy communication and timely access. This is the service most people would like for themselves and their relatives.

So, when did we agree to settle for less? In whose manifesto did it say that general practice would switch to an impersonal service reached by an online form, where your stated problem would be allocated to a doctor you didn’t know or your request for help might result in generic advice delivered electronically?

I’m encouraged by the committed young doctors joining our profession, but if we’re to keep them, and to stem the flow of early retirements, we need an injection of hope. We need to feel confident that the things we value about general practice will be recognised and preserved—and that we, in turn, will be respected and listened to.

Competing interests: See www.bmj.com/about-bmj/freelance-contributors

Provenance and peer review: Commissioned; not externally peer reviewed.


Helen Salisbury: Adjusting our expectations

Helen Salisbury GP

Oxford
helen.salisbury@phc.ox.ac.uk
Cite this as: BMJ 2022;377:o1106

http://dx.doi.org/10.1136/bmj.o1106
Published: 03 May 2022