Editorials

COVID-19:

a danger and an opportunity for the future of general practice

For decades there have been calls for general practice to change established ways of working. In response we have seen pockets of innovation from a few, amid a cautious evolutionary process of adaptation from the majority. With good reason, many GPs were attached to their time-honoured working practices. No need was seen by most for radical transformation.

Over a few weeks between mid-March and early April 2020, general practice changed utterly, and voluntarily, in response to the COVID-19 pandemic. Before the crisis a minority of practices used doctor-led triage as the access point for services; within weeks nearly all were doing so. Royal College of General Practitioners (RCGP) analysis of general practice appointments data shows that before the crisis >70% of consultations were carried out face-to-face; within weeks the figure was 23%.[1] Before the crisis clinical workload had become unsustainable; within weeks year-on-year comparisons showed that the number of consultations carried out by practices had reduced by 24%.[1] Before the crisis administrative tasks and regulatory compliance diverted practices from direct patient care; within weeks year-on-year comparisons reported a 30% reduction in time spent on such activities.[1]

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GENERAL PRACTICE HAS CHANGED

The COVID-19 crisis has the potential to change general practice dramatically and permanently. Some of the changes will be for the better and will speed up the implementation of reforms, which the RCGP and others have been advocating for years.[2–4] Others may have a detrimental impact on the established and often evidence-based features of general practice, which have served patients, communities, the NHS, and society well for decades.[5]

The most striking of these changes is the greater use of remote consultations, utilising both older technologies, such as telephone and email, and newer technologies, such as online video interactions. The rapid and comparatively uncomplicated introduction of remote consultations, apparently acceptable to most patients and clinicians, has been enabled by a pragmatic approach to investing in technology and engaging with private sector entrepreneurs. Non-face-to-face consultations are useful for dealing with transactional presentations but are of uncertain and untested value for relational ones. This is a concern given the centrality of trusting relationships as one of the defining interventions used in general practice.[6] The optimum proportion of remote consultations, if there is such a thing, is somewhere between the pre-crisis and crisis levels.

Other changes have been no less dramatic. There has been a reinvention of the 'public health' model of general practice.[7] GPs have been more involved than ever before in activities such as population health planning, clinical pathway redesign, resource prioritisation focusing on those with greatest need, utilising the good will and assets that exist within communities, improving work across long-established sectoral boundaries, and emergency preparedness. This rebalancing of the psychosocial, biomedical, and public health models of general practice will be welcomed by many, though there may be associated risks if recent advances in the delivery of personalised care and shared decision making were to be lost.

In terms of more efficient use of limited resources, the reduction in time spent on non-patient facing activities, including contractual compliance, organisational and professional regulation, and annual appraisal has come as a relief to many clinicians who have long sought a return to a high-trust, low-checking ethos.[8] Many practices are starting to rethink how they use their buildings more efficiently, for example, by reducing 'waiting' space and increasing the number of clinical rooms for the expanding primary care team.

The engagement of practices in community-based research has also been a revelation at a time when practices might have been expected to be preoccupied with frontline care. There has been a big increase in practices signing up to research networks such as the University of Oxford/RCGP Research Surveillance Centre, in order to contribute to a better understanding of the epidemiology of the pandemic and to test therapeutic interventions.[9] This community-based research has the potential to massively impact on our ability to minimise the damage caused by the pandemic. A temporary relaxation in approaches to consent to access patient-level data, supported by the National Data Guardian, has helped this process.[10]

While the British public has never lost their admiration for the NHS, the COVID-19 crisis has released an unparalleled level of respect and passion for the institution and those who work in it. It has also led to a probably short-lived desire on the part of the public to use services sparingly, though this is one of the factors that risks the emergence of an epidemic of non-COVID-19 morbidity and mortality, and RCGP analysis of the Office for National Statistics mortality data suggests that this may already be happening.[11]

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HOW GENERAL PRACTICE NEEDS TO RESPOND

The medium- and longer-term response to the COVID-19 pandemic begs a fundamental question for our specialty; how does general practice identify, develop, and embed the positive changes that are being implemented as a consequence of the crisis? And how do we discard those that were necessary during the crisis but might be damaging if maintained?

Answering these questions will require urgent and wide engagement of frontline clinicians. It will also require exceptional leadership, a clear vision, and an ability to

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influence those who might prefer, by design or default, to stick with any damaging changes introduced during a crisis or to turn back the advantageous ones.

Before the pandemic even reached its peak in April, the RCGP launched an initiative to engage a wide range of stakeholders in a consultation process about the future. COVID-19, despite all the harm it is causing, will encourage general practice to rethink what is important. The Chinese word for crisis is said to comprise two characters, one representing danger and the other opportunity. The onus is now on those who work in and use general practice services to collaborate with other stakeholders to seize the opportunity presented by one of the most serious crises that the NHS and wider society has had to face.

Martin Marshall,
GP and Chair of Council, Royal College of General Practitioners, London.

Amanda Howe,
President, Royal College of General Practitioners, London; GP, Norwich.

Gary Howsam,
Vice Chair (External Affairs), Royal College of General Practitioners, London; GP, Peterborough.

Michael Mulholland,
Vice Chair (Professional Development), Royal College of General Practitioners, London; GP, Aylesbury.

Jonathan Leach,
Honorary Secretary, Royal College of General Practitioners, London; GP, Bromsgrove.

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ADDRESS FOR CORRESPONDENCE

Martin Marshall
Royal College of General Practitioners, 30 Euston Square, London NW1 2FB, UK.

Email: martin.marshall@rcgp.org.uk
@MartinRCGP

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