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Digital-first primary care: An ambivalent legacy of Covid-19?

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Abstract

The vast majority of GP appointments had to move from in-person to remote consultation during the pandemic. Rather than phasing this out now that the threat of the coronavirus has begun to ebb, the UK government has announced that digital-first primary care will continue for the foreseeable future. While remote consultation can be beneficial on several fronts, it can compromise professional identity, therapeutic alliance, patient safety and access to healthcare. A hasty push towards normalising digitally-enabled care may therefore increase the risk of misdiagnoses, medical negligence, unnecessary referrals and health inequity. To enhance the gains and iron out the challenges associated with IT-led triage and consultations, it is important to reflect on the lessons learned from the pandemic.

Keywords

Covid-19, primary care, remote consultation, misdiagnosis, medical negligence

Introduction

When the UK went into lockdown in March 2020, many aspects of life were swiftly and profoundly affected. The availability of information and communications technology (ICT), however, mitigated some of the harsher effects of enforced physical separation and allowed some semblance of normality. Education at primary, secondary and tertiary levels, court hearings, business meetings, counselling, mediation and conferences could carry on, albeit remotely. Provision of primary healthcare had also to operate differently with most GP appointments shifting from in-person to remote consultations. Buoyed by the seeming expedience and cost-effectiveness of remote GP consultations, the government subsequently announced that this approach is set to continue for the remainder of the pandemic and beyond. However, is digital-first primary care a positive or negative legacy of Covid-19?

Covid-19 and remote delivery of primary care

Primary care, the first point of contact for everyone who needs to access health service, has been described as the bedrock of the NHS. Just before the onset of the pandemic, it was reported that GP surgeries provided approximately 307 million face-to-face appointments every year. This high consultation rate not only increased GP workload but made it necessary for waiting lists to be put in place. To address these challenges, the government sought to move GP consultations away from face-to-face encounters on the basis that primary care should harness the benefits of ICT. It is expected that every patient, "from the most digitally literate to the most technology averse", will one day be able to access a GP digitally and opt for a virtual outpatient appointment.[1] The blueprints of digital-first primary care were drawn up with the aim of making all GP practices digitally-enabled to deliver care safely and effectively by 2023–2024. But before that projected moment arrived, the unprecedented impact of Covid-19 impelled its early delivery.

When the pandemic forced the nation into lockdown in March 2020, face-to-face interactions were no longer deemed safe in almost all spheres of life, social or professional, so in-person consultations in GP surgeries risked coming to an abrupt halt. To bridge the physical

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separation which suddenly developed between GPs and their patients, digital technology was promoted and GP practices were instructed by NHS England and NHS Improvement to implement a "total triage" model. Patients contacting a GP practice were asked about the nature of their medical problem, and for information on the reasons for contact, and were triaged before an appointment was made. In most cases, telephone and online consultations became the default access channel, with face-to-face consultations restricted to urgent clinical needs and for patients who usually needed home visits. This pattern of digital-first and hybridisation remained important throughout the lockdown period.

The development and roll-out of vaccines enabled some restrictions to be lifted with aspects of social and professional life beginning to return to a semblance of normality: "living with Covid". However, not only was primary care relatively slow to resume face-to-face appointments, the government also announced that digital-first would continue for the foreseeable future. A view was taken that it is important for the progress that has been made on digitally-enabled care to be accelerated.[2]

Digital first: Benefits and challenges

A move towards digitally-enabled care is, as observed above, part of the larger digital-first plan proposed by the government shortly before the onset of the pandemic. Remote consultation, a cornerstone, is not a new phenomenon. Modern technology has long offered alternatives to face-to-face medical consultation.[3–5] As far back as the 19th century, some doctors provided healthcare by telephone. Many more forms of remote consultation have developed with the arrival of the radio, video and now the internet. These enable both synchronous and asynchronous communications. Telehealth is therefore an important tool of modern medicine that has been particularly useful in helping rural and under-served patients access healthcare. However, during the pandemic, remote consultation increased at a scale and pace hitherto unknown. Digital-first had an initial projected delivery date of 2023–2024, but the pandemic was a catalyst for its wholesale and swift adoption in primary care. Over a million patients were "seen" by GPs in this way every day.[6] Doctors were thus simultaneously confronted with a new public health threat and a different method of interacting with patients. Borne out of necessity, is this approach sustainable now that the threat and impact of the coronavirus is beginning to ebb?

Benefits

As experience during the pandemic demonstrated, digital-first contact was invaluable in providing healthcare when it is unsafe to have face-to-face consultations. If continued beyond the pandemic, remote consultations will be beneficial for patients and doctors who suffer from conditions which render them susceptible to infections in a clinical environment. In addition, they can be convenient and expedient for both patients and doctors. Patients save on travel time and stress and related expense, avoiding the need to find and pay for a parking space, or to comply with strict train and bus timetables; leaving their home may require childcare or other care arrangements. The familiar home environment, as contrasted to the formal and structured setting of the GP surgery, may help patients feel more comfortable discussing their medical conditions. They are even able to have the consultation anywhere, whether at their place of work or away or abroad.

There are studies which demonstrate that digital consultations with GPs take less time.[7] which can free space for other patients, thus reducing the waiting list. This should help free up GP time to better manage their time and workloads, and prioritise more in-person support where it is needed. The reduced use of the physical space in the GP surgery allows other services to use it. With more time available, patients should not need to wait so long for an appointment and may avoid the frustrations of missing out on the basis of ringing in at 8 am for a first-come-first-served system.

Remote consultations also offer patients flexibility in how and when they see their GPs. Some of the main beneficiaries include people who live in remote or deprived areas or in under-doctored areas. Others include those with long-term health conditions for whom regular contact with a GP is crucial, like those with mobility issues who are unable to access the practice, parents of neuro-diverse children who find taking them to the GP surgery a distressing experience, and university students who are receiving ongoing care at home during semester breaks. Likewise for those who find it difficult to discuss conditions which they find embarrassing, or others who only need a simple explanation or reassurance over some issues. Further, since mediums like emails, online forms and text messaging offer asynchronous and a text-based approach, they can be useful for patients who are very anxious or who find face-to-face contact difficult; or those with hearing or communication difficulties; or individuals who struggle to express themselves verbally.[8–10] This would be one way by which health inequalities can be redressed.

Challenges

While digital-first can be beneficial, it comes with many challenges. In order to access a GP, patients would firstly undergo remote triaging which is conducted predominantly by receptionists or clerical staff. Known as care navigators, they determine whether the patient consults a GP and how soon, or is diverted to other healthcare professionals like physician associates, nurse practitioners or clinical pharmacists. They serve as gatekeepers to primary care and access to GPs. As their decision-making is predicated upon the patients' or their carers' self-description of symptoms, this requires disclosure of potentially sensitive or embarrassing information to personnel who are not medically trained. Patients who are anxious and those who wish to consult a GP rather than other healthcare professionals and/or want immediate attention may overstate their symptoms. Conversely, those who are unable to articulate their symptoms satisfactorily well might understate their symptoms. Accordingly, patients may not always be directed to the appropriate channel with urgent or serious cases not properly identified.

Digital-first will also have a strong impact on professional identity and the therapeutic alliance. The core tenet of general practice is the relationship between doctor and patient as conducted predominantly through in-person consultations. Underpinning this is the hypothetico-deductive model of clinical decision-making which emphasises thorough history-taking as well as a physical examination of the patient when making a diagnosis. Studies have shown that the absence of physical proximity could lead to a psychological distance between the two parties which compromises trust and rapport, and the quality of their interaction.[11] Discussion may be less free-flowing with fewer relevant details extracted. Significantly, the reason remote consultations, particularly telephone conferences, are usually shorter than face-to-face consultations, is because patients disclose less and doctors pose fewer questions.[12] GPs are also deprived of some visual cues that are often important when making diagnoses. Even for video calls, physical appearance, demeanour, gait and non-verbal cues are altered or missing.[13] Instead, GPs will be partly reliant on patients' self-reporting, or their carers' or relatives' account of symptoms. Even where these could be supplemented by photographs of affected areas or readings from remote monitoring devices (e.g. blood pressure machines, glucometers and oximeters), some of the photographs are not sufficiently clear for a confident diagnosis to be made, and many patients either do not have the monitoring devices or struggle to use them and to report the results properly.[14–16] Most importantly, remote consultation deprives GPs of physical examination, which is a crucial tool in helping to reinforce or refute a diagnostic theory. They are also not able to work with sense data like sight and smell, nor with indicators which are relevant to mental health like affect, personal hygiene and evidence of self-harm, agitation and general demeanour.[17] All these will inevitably result in an increase in misdiagnosis and medical negligence. Indeed such harms have been reported during the pandemic and these have even included deaths.[18,19] Another related issue is that the move could place more strain on other parts of the system. When GPs are less confident of their diagnoses, they might refer on more patients. Not only would this lead to poor use and distribution of resources, it puts added pressure on an already stretched secondary care system.

In addition, concerns have been raised that telehealth would appeal more to younger patients who have access to and are well-versed in ICT, whereas older and more vulnerable people, and those living in deprived areas, have been identified as unlikely to have reliable or any access to digital technologies. Even for those with access to ICT, digital-first requires them to have an understanding of access and cross-referral pathways, and to interpret their own symptoms (including an assessment of severity and urgency).[17,20] All these may be especially challenging for those who are impacted by factors like digital illiteracy or general illiteracy, learning disability, neurodiversity, cognitive impairment, hearing impairment and lack of proficiency in the English language.[17,21,22] Uptake of service would therefore be from an uneven mix of patients. Further, although remote consultation may be convenient for patients who are comfortable to have the consultation from their homes or places of work, these settings may not suit everyone. Victims of domestic violence, for example, may find it very difficult to speak candidly about their condition or that of vulnerable people in their household if the abuser is in the same room or at home. Safeguarding concerns may not therefore be appropriately recognised and addressed. Privacy and confidentiality may also be compromised for patients who are having the consultation from their workplace. Given only a time range of when the GP will be in touch rather than a specific appointment time, such patients may find it difficult to find a private space where their discussions are not within the earshot of others. Consequently, discussions may be restrained, and accurate diagnoses and treatment options may not be made.

Similarly, many doctors are still not confident that they can deliver high quality remote consultation to diverse patient groups. Research indicates that GPs feel underprepared both in relation to the use of new digital technologies, and how best to conduct effective and safe remote encounters whilst ensuring that

ethical-legal concerns like consent and confidentiality are maintained.[23,24]

Conclusion

Remote-first was a strategy which preceded the onset of the pandemic. Its expedited wholesale deployment at the height of Covid-19 was mainly aimed at keeping both doctors and patients safe, without letting primary care come to a sudden halt. It has now been over four years since GP consultations underwent this transformation. Rather than scale it back, now that it is safer for patients to return to GP surgeries for consultation, the government has announced that it should continue. So, while patient consultation will retain its place at the heart of general practice, its main method of delivery will change. GP-patient meetings would be predominantly tele-consultations, which, it was reasoned, could enhance the accessibility of primary care and input both speed and efficiency into the process. Although the timing of this coincides with the projected delivery date of the pre-planned digital-first primary care, a hasty push towards normalising digitally-enabled care could adversely affect the doctor-patient relationship, the quality and safety of care, as well as accessibility itself as some patient groups do not find it user-friendly. In order to enhance the gains and iron out the challenges associated with IT-led triage and consultation, it is important to reflect on the lessons learned from the pandemic.

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