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Report for the Association of Chaplaincy in General Practice on Spiritual Care During the COVID-19 Pandemic

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Abstract: Chaplaincy has been provided in primary care for over 20 years. There are various iterations across the United Kingdom, but their unifying purpose is person-centered holistic care delivered through listening and guidance. This report seeks to describe and analyse the impact of COVID-19 on chaplaincy services in primary care. Initial reflections highlight the range of presenting issues, old and new. Organizational factors such as logistical questions and virtual communication issues demonstrate the barriers faced by patients and chaplains, alongside new opportunities. As existing support networks and services have become less accessible, chaplaincy has a role to play in anticipating and responding to patients' unmet needs. These include "losses," both personal and communal, grief, both past and current, and questions of an existential nature. In responding to these challenges, chaplaincy should seek to be more visible, more intentional in identifying those at risk of loneliness, and more accessible to those less proficient in the new communication technologies, such as the elderly. This report suggests how chaplaincy will have a significant role in supporting patients with anxiety, lockdown traumas, loss of well-being, and the many socioeconomic effects of the pandemic.

Keywords: spiritual care, COVID-19, primary care, general practice

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Resumen (Español): Informe para la Asociación de Capellanías de Práctica General (Consultorios Médicos) sobre Cuidado Espiritual durante la Pandemia por COVID-19. La capellanía se ha brindado en atención primaria por más de 20 años. Hay varias y distintas iteraciones a lo largo de todo el Reino Unido, pero su propósito unificador es la atención integral centrada en la persona que se brinda a través de la escucha y la orientación. Este informe busca describir y analizar el impacto del COVID-19 en los servicios de capellanía de atención primaria. Las primeras reflexiones resaltan la variedad de problemas que se presentan: antiguos y nuevos. Factores organizativos - como preguntas logísticas y problemas de comunicación virtual - demuestran las barreras que enfrentan los pacientes y los capellanes, junto con nuevas oportunidades. Como las redes y servicios de apoyo existentes son menos accesibles, la capellanía tiene un papel en anticipar y responder a las necesidades no satisfechas de los pacientes. Estos incluyen "pérdidas", tanto personales como comunitarias, "dolor", tanto pasado como actual, y preguntas de naturaleza existencial. Al responder a estos desafíos, la capellanía debe buscar ser más visible, más intencional en la identificación de aquellos en riesgo de soledad y más accesible para aquellos menos competentes con las nuevas tecnologías de comunicación, como lo pueden ser los adultos mayores. Este informe sugiere cómo la capellanía tendrá un papel importante en el apoyo a pacientes con ansiedad, traumas de encierro, pérdida de bienestar, y con los efectos socioeconómicos de la pandemia.

Palabras clave: atención espiritual, COVID-19, atención primaria, práctica general.

Introduction

Chaplaincy in general practice (CGP), also known as primary care chaplaincy (PCC), offers prompt access and thoughtful listening for patients who wish to explore issues that impact their health and well-being. Patients are referred by their GP, or can self-refer, for a range of issues and complex needs, and they are seen promptly at their own GP surgery for an appointment of 50 to 60 minutes.

Amidst modern medicine, CGP/PCC seeks to maintain and develop the commitment of primary care to person-centered and holistic patient care (ACGP, 2019). As a "talking therapy," it has been shown to improve well-being scores and reduce repeat referrals to GPs for related issues (Macdonald, 2017a, 2017b, 2018). Chaplaincy has been provided in general practice for more than 20 years, and has been found to be effective, particularly for patients experiencing loss or change in their lives (Kevern, McSherry, & Boughey, 2015; McSherry, Boughey, & Kevern, 2016).

The Association of Chaplaincy in General Practice (ACGP) has affiliated groups in England and Scotland and works with the NHS, the UK Board of Healthcare Chaplaincy (UKBHC), and the College of Healthcare Chaplains (CHCC) to provide training standards and accreditation for the delivery

Table 1: The "hubs" of primary care chaplaincy (1)

ID	*"Hub" location*	*Patient population*	*Surgeries*	*Chaplains*
D1	Littlewick Medical Centre, Derby	15,500	1	2 part time
D2	Dudley Primary Care Network	320,000	42	6 part time
K1	Karis Medical Centre, Birmingham	35,000	3	2 part time
R1	Regent Gardens Medical Centre, Glasgow	45,000	6	3 part time
Total	"Hubs" = 4	415,400 (2)	52	13 (P/T)

Note: (1) The "hubs" of primary care chaplaincy referred to in this report are referenced by letter and number; (2) approximate patient population figures at time of publication.

of chaplaincy in general practice. With over 90% of healthcare in Scotland being carried out in the community (NHS Scotland, 2016), and comparable rates in England, it is prudent to offer chaplaincy care in this setting, as well as in the traditional setting of hospital and hospices.

This report is based on the responses to a questionnaire, which was circulated to four CGP/PCC hubs where spiritual care is available to over 400,000 patients through chaplaincy services in 52 surgeries (see Table 1). Chaplains, both paid and volunteer, offer generous listening, usually in a non-clinical room at the GP site. These hubs all have associations with the ACGP. For evaluation purposes, ACGP chaplaincy services use the Warwick and Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al., 2007). The report details the effect of, and response to, the coronavirus pandemic in primary care chaplaincy during the spring of 2020. The questionnaires were completed in mid-May, when lockdown across all of the United Kingdom was still complete; details were representative of the chaplaincy in general practice response at that time.

Initial Effect of COVID-19 Pandemic on Primary Care and its Associated Chaplaincy Services

Within weeks of the outbreak of COVID-19, general practice in the United Kingdom changed radically and at unparalleled speed. Normal methods and patterns of consulting were replaced with "virtual" consultations by phone or video calls. Clinicians and allied services now triage every contact, in order to reduce the risk of COVID-19 transmission. Home visit rates have been substantially reduced. Concern has been raised regarding service delivery and equitable access for the more vulnerable patients – those with existing physical and mental health issues.

Just as much of the longstanding, seemingly secure infrastructure and delivery of general practice was dismantled at remarkable speed, so too was primary care chaplaincy. The result of the COVID-19 pandemic and resulting lockdown on primary care chaplaincy services has been, in the words of one chaplain, "dramatic" (D1). All appointments are now carried out by telephone. In each service, there has been a reduction in referral rates.

Anecdotal evidence suggests that more patients are now struggling with anxiety and a broad range of losses. These losses include the loss of normality, purpose, socialization, income or employment, and loved ones. There may also be observed differences in demographics – perhaps a greater proportion of younger people? Issues precipitating appointments are increasingly to do with the ramifications of lockdown and people's experiences, either caring for those who have had COVID or having been ill themselves. Those who have been ill speak of the wide-ranging and long-lasting effects of the illness.

One GP reflected that, as "with all events of extreme proportion some dig deep and survive, and some are broken even more than they were before" (K1). Predictably, many patients are struggling with the ongoing pandemic and its ramifications. A wide range of intra- and interpersonal issues are reported. Many issues are similar to those often seen in primary care chaplaincy – loss of many kinds, relationship difficulties, and matters relating to faith and wider spirituality. One new issue seems to be that grief from past loss is more challenging to deal with, and current bereavements are difficult to navigate in lockdown. Parents describe the challenge of the competing priorities of home schooling and employers' deadlines. Obsessive-compulsive disorder type conditions may have been exacerbated.

While contact with those directly affected by COVID-19 is not (yet?) the main focus, those who have been bereaved in the pandemic speak of the agony of not being able to visit or say goodbye in person, and the pain of isolation while grieving.

Chaplains anticipate that new concerns will emerge as lockdown is eased and the safe space of home is no longer the only venue that is expected to be inhabited. These challenges may lead to a lowering of general resilience and self-esteem. An increase in discussions about "spiritual" issues was reported by chaplains. Conversations about the purpose of life, sources of hope, and wondering "where God is" were reported. Requests for prayer or for scriptures to be read have also been more common.

Organizational Response to Delivery of Spiritual Care

In most surgeries, the cessation of face to face spiritual care appointments occurred in the weeks immediately before lockdown was announced on March 23, 2020. Remote access to surgery facilities has been or is being organized for chaplains, and a variety of proactive responses in chaplaincy provision arose. Reminders to referrers were issued, and some medical centers ensured that spiritual care services were visible on websites. An offer of staff care to local GP clusters was made. In some surgeries, chaplains contacted those on the "shielding" lists. Elsewhere, patients seen by the chaplain in recent months were re-contacted.

One chaplaincy service not only maintained but aimed to double its listening and guidance capacity (D2). This involved increasing some hours for existing staff and recruiting three additional new staff. However, by mid-May only one of the six primary care networks were fully utilizing the increased hours. Another surgery texted their patients, making them aware that chaplaincy services were still available, but uptake was limited. Some chaplains have facilitated a debriefing service for staff via Zoom meetings (K1). At present, there is a disparity between the generally perceived need for talking therapies and mental health support and actual referral rates for chaplaincy.

The most significant change for chaplains has been that all patient contact is now done by telephone, with visual cues and immediacy being lost. A small number of patients, however, appear to prefer telephone appointments, and some have accessed spiritual care who would otherwise not have been referred. One GP provided this quote from a patient who would not have been referred to, or attended, a face to face appointment, "I feel like a huge burden has been lifted off me. I didn't realize how heavy the burden was until it was removed" (D1).

Reflections on Organizational Change and Response

As 80–90% of chaplaincy appointments arise from a GP referral, the reduced footfall in GP surgeries unsurprisingly has led to a reduction in chaplaincy referrals. Some patients have assumed that chaplaincy services were suspended, or indeed a few seem to have believed that the GP surgeries were closed. Others are not able or willing to interact by telephone, due perhaps to lack of privacy at home. Others do not feel they justify this type of care at the moment.

A few patients have not needed as much support as before, reporting that "lockdown life" is beneficial for them. These people appreciate increased

support at home or a slower pace of life. Others find the reduction of social stresses and the reprieve from constantly "putting a face on" helpful in managing long-term challenges.

The unanimous response from chaplains is that working by telephone is hard work and not ideal for delivering the type of service that spiritual care in primary care aims to achieve. Loss of the usual cues leaves interactions less informed and not as rich. Primary care chaplaincy services may offer prayer either during or after the appointment, but the appropriateness of this is more difficult to judge when done via telephone. More detailed reflections reveal that chaplains find the pacing of conversations more difficult, especially when patients are upset, and some find the establishment of roles and boundaries more difficult to define.

This is detailed by Ambrose (2020), who references Croskerry and Nimmo's (2011) dual-process decision making and suggests that when GPs work on the phone they use more of the tiring "type 2" cognitive processing. Sharma (2020) suggests that working by phone is exhausting because it is new, and the narrowing of available information causes the listener to focus on sound and silence in new ways. Practically, there are also administrative hassles when patients do not answer a phone call or are interrupted by situations in their homes.

Chaplains, however, have noted the quick engagement and development of trust that has frequently been established during many telephone appointments, seen, for example, in the raising of spiritual issues. Both GPs and patients report that "help" is being received, and repeat appointments are being requested, suggesting that telephone chaplaincy is, at least in part, delivering the type of care and support that it aims to do. Unsurprisingly, those for whom this is a first engagement with chaplaincy seem more satisfied than those who previously had face to face appointments. Similarly, chaplains who began this work without prior experience of offering face to face appointments are less frustrated by this way of working than those who have worked with patients in person. Staff care is anticipated to increase over the coming months, as the busy peak of the pandemic passes and healthcare staff have time to reflect and seek help.

Issues Going Forward

In the longer term, there are questions which are currently difficult to answer, as the implications of COVID-19 are not yet known, and the shape of GP provision is not yet clear. The challenge for chaplaincy is the same as for other parts of general practice, where "primary healthcare systems need to be deliberate and have clear plans to ensure that this devastating

pandemic leaves a positive legacy" (Neves, Lygidakis, & Fontana, 2020). This could be an opportunity to listen to patients, reflect on established patterns, and innovate, based on current presenting issues, equitable access, and proactive care for the most vulnerable.

The interruptions occurred at a time when many patients had experienced the dismantling of external structural supports, with the consequent exposure of their potentially unmet internal or spiritual needs. We know anecdotally and through early research that footfall through primary care has fallen dramatically (Thornton, 2020). It is emerging that those with mental health conditions are describing greater levels of anxiety, perhaps heightened by reduced access to their usual networks (Rajkumar, 2020). It seems, then, that chaplaincy must be more aware of and responsive to the increased vulnerability and needs of our patients during this COVID-19 pandemic. This presents both opportunities and challenges.

As existential concerns arise, or resurface, chaplaincy may have a role in helping patients to acknowledge these issues and receive the support and guidance they need. This will require discernment and time, but it offers the prospect of truly person-centered care. The interruption of patients' external sources of significance, security, and self-esteem by COVID-19 may also highlight their unmet transcendent or spiritual needs (Macdonald, 2019; Maslow, 1943). Chaplaincy should be an important means of accompanying patients through these questions.

There are also new challenges of access. Will this be a further example of the inverse care law, where "good medical or social care tends to vary inversely with the need of the population served" (Hart, 1971)? Might it be that patients who require the most spiritual care will be least able to access it at this time? Could it be that COVID-19 is confronting patients with existential issues for the first time, yet they are unaware of the existence of healthcare chaplaincy? These patients may, however, represent those in greatest need of support.

It is known that access to any service is determined not simply by levels of provision, but in part by permeability and candidacy (Dixon-Woods et al., 2006). It could be argued that our chaplaincy provision must therefore be more accessible than usual. Might we need to raise awareness of our existence and function? Perhaps self-referral pathways need to be more visible to patients? Perhaps we need to reach out to those with least candidacy, such as those "shielding" or the most elderly? It might also be useful for chaplains to become part of virtual multidisciplinary meetings, in order to facilitate referrals. Finally, the use of technology to engage with patients is a tremendous opportunity for those with the requisite IT skills. Once again,

however, we must guard against the inverse care law and ensure equitable access for those with fewer IT skills.

Challenges

Based on the current situation and previous knowledge, there is anticipation of some particular challenges, including the following.

- Large numbers of people who may require help to process the immediate trauma of lockdown, change, exposure to risk, and grief.
- Long-term implications for older and vulnerable patients, requiring a strategy beyond waiting for the most stringent aspects of lockdown to be lifted. What might a meaningful provision of primary care chaplaincy for these people look like?
- There is an anticipation that for some a return to the new normal will raise anxiety levels, as people have been made to feel safe only at home these past months, perhaps especially those who have been shielding.
- Well-being and mental health post-COVID-19 may be adversely affected by the unfolding economic crisis. It is a well-established fact that financial concerns are detrimental to mental well-being (NHS Inform, 2020). Previous research shows that financial concerns are not a common presenting issue at GP chaplaincy (Bunniss, Mowatt, & Snowdon, 2013; McSherry, Boughey, & Kevern, 2016), but anticipating an increase in this as a reason for attending is reasonable.
- It is known that loneliness and social isolation are challenges experienced by those attending primary care chaplaincy (Giffen & Cowey, 2020), but it seems clear that this issue will have worsened for many as a result of the lockdown measures.
- It could be argued that elderly patients may be most at risk (Macdonald, 2020). They may have less social capital, more physical ailments, and less capacity to navigate and access the new systems in primary care. Specifically, they may be less able and inclined to make use of the new technologies to consult the chaplain.
- Research has shown the importance of chaplains being part of the wider healthcare team at a GP surgery (Bunniss, Mowatt, & Snowdon, 2013; Giffen & Cowey, 2020). How a chaplain can remain a meaningful part of the broader team while working from home requires some creative thought.

- Both new and re-emerging grief will be a challenge for many; this is especially complicated by the need for isolation, no access to hospitals for "goodbyes," and small funerals.

Fledgling Ideas

Some fledgling ideas in response to these challenges include the following.

- It will be important to maintain, or work to increase, chaplaincy provision. And if chaplaincy is going to be busy, chaplains need to practice good self-care, and supervision and wider management must be robust, so the service and those that deliver it are equal to the task.
- Would a refresher in grief training for chaplains be judicious? And developing good awareness of other local services like debt counseling.
- As a result of observations that some patients have accessed chaplaincy because of the availability of telephone appointments, it is likely that telephone appointment provision will remain an option in GP chaplaincy provision.
- Facilitation of groups for healthcare workers to provide a forum to tell their "lockdown stories" and process the resulting challenges. Zoom groups for bereavements, staff care, and debriefing may be a possibility as many begin to process what the spring of 2020 meant for them.
- Would the establishment of a chaplain with specific responsibility for elderly care be an appropriate move? Perhaps as restrictions ease, there will be opportunities to create new ways of providing chaplaincy to our elderly? Conceivably, more home visits by the chaplain may be required. It may also be possible to form links with nursing homes and offer chaplaincy for these patients.

Measurement of Salient Issues

Chaplaincy research is important as the profession develops good practice and an evidence base (Fitchett, 2020; Kevern & McSherry, 2015). Responding to the effect and influence of the pandemic with some measurement of related issues is key. Issues for further examination could include the following.

- Presenting issues. Previous research suggests that bereavement, loss, relationship issues, anxiety, and depression are the most common

presenting issues for attending chaplaincy (Bennison, 2020; Giffen and Cowey, 2020; McSherry, Boughey, & Kevern, 2016). Do isolation and financial concerns now increase in frequency?

- Appointment length. Does working by telephone affect the length of appointment? It might be anticipated that appointments are shorter.
- Were video calls adopted? Why or why not?
- Demographics, especially the average age of the patient attending chaplaincy. Does the average age of patients fall due to elderly access problems?
- Grief issues. Did the isolation of lockdown, or other factors such as raised anxiety, cause past griefs to remerge? Did losing someone under lockdown conditions make grieving a more difficult process?
- Ascertain if WEMWBS is validated for telephone use, and if well-being scores are different after the pandemic.

Conclusion

COVID-19 is likely to be a defining moment in the lives of our patients and their biopsychosocial spiritual needs. It is also certain to be a re-defining moment in the way we deliver healthcare, and indeed chaplaincy, to our patients.

Presentations may be more complex, possibly involving more destabilizing socioeconomic factors. Elderly or more vulnerable patients might need more support, in order to ensure their equitable access to chaplaincy, especially if new technologies are to be used. There may be a hiatus in re-establishing mental health services, with the possible consequence of an increased requirement for chaplaincy. It is, however, possible with careful observation, reflection, and sensitive response that healthcare chaplaincy may provide hope and healing for many.

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References

Ambrose, L. (2020). Remote consulting: Recognising the cognitive load. *British Journal of General Practice, 70*(695), 295. https://doi.org/10.3399/bjgp20X710213

Association of Chaplaincy in General Practice (2019). Improving care through listening and guidance. *GP chaplaincy handbook: A practical guide to service provision*. http://acgp.co.uk/wp-content/uploads/2019/07/2019-ACGP-handbook.pdf

Bennison, T. P. (2020). Community chaplaincy listening: From interventions during ill health to enabling wellbeing and resilience. In E. Kelly & J. Swinton (Eds.), *Chaplaincy and the soul of health and social care: Fostering spiritual welling in emerging paradigms of care*. London: Jessica Kingsley Publishers.

Bunniss, S., Mowatt, H., & Snowden, A. (2013). Community chaplaincy listening: Practical theology in action. *Scottish Journal of Healthcare Chaplaincy*, *16*(1), 42–51.

Croskerry, P., & Nimmo, G. R. (2011). Better clinical decision making and reducing diagnostic error. *Journal of the Royal College of Physicians of Edinburgh*, *41*(2), 155–162. https://doi.org/10.4997/JRCPE.2011.208

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., … & Sutton, A. J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology, 6*(35). https://doi.org/10.1186/1471-2288-6-35

Hart, J. T. (1971). The inverse care law. *Lancet*, *297*(7696), 405–412. https://doi.org/10.1016/S0140-6736(71)92410-X

Fitchett, G. (2020). Advancing research in healthcare chaplaincy. Why, how and who? In E. Kelly & J. Swinton (Eds.), *Chaplaincy and the soul of health and social care: Fostering spiritual wellbeing in emerging paradigms of care*. London: Jessica Kingsley Publishers.

Giffen, S., & Cowey, E. (2020). Why GPs refer to chaplaincy: A qualitative study. *Journal of Health and Social Care Chaplaincy. Health and Social Care Chaplaincy. 8*(1). https://doi.org/10.1558/hscc.40236

Kevern, P., & McSherry, W. (2015). The study of chaplaincy: Methods and materials. In C. Swift, M. Cobb, & A. Todd (Eds.), *A handbook of chaplaincy studies: Understanding spiritual care in public places*. London and New York: Routledge.

Kevern, P., McSherry, W., & Boughey, A. (2015). *External report: Evaluation of the role and development of primary care "chaplains for wellbeing" in Sandwell and West Birmingham CCG*. Sandwell & West Birmingham Clinical Commissioning Group/Staffordshire UK.

Macdonald, G. (2017a). The efficacy of primary care chaplaincy compared with antidepressants: A retrospective study comparing chaplaincy with antidepressants. *Primary Health Care Research & Development, 18*(4), 354–365. https://doi.org/10.1017/S1463423617000159

Macdonald, G. (2017b). Primary care chaplaincy: A valid talking therapy? *British Journal of General Practice, 67*(655), 77. https://doi.org/10.3399/bjgp17X689221

Macdonald, G. (2018). Primary care chaplaincy: An intervention for complex presentation. *Primary Health Care Research & Development, 20*, 1–10. https://doi.org/10.1017/S1463423618000737

Macdonald, G. (2019). Spiritual needs assessment: The LOADS SHARED mnemonic. *British Journal of General Practice, 69*(688), 573–574. https://doi.org/10.3399/bjgp19X706505

Macdonald, G. (2020). Establishing "far end" practices in the wake of COVID-19. *British Jour-*

nal of General Practice Life. https://bjgplife.com/2020/05/06/the-far-end-of-coronavirus
Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370–396. https://doi.org/10.1037/h0054346
McSherry, W., Boughey, A., & Kevern, P. (2016). "Chaplains for wellbeing" in primary care: A qualitative investigation of their perceived impact for patients' health and wellbeing. *Journal of Health Care Chaplaincy*, *22*(4), 151–170. https://doi.org/10.1080/08854726.2016.1184504
Neves, A. L., Lygidakis, H., & Fontana, G. (2020). The technology legacy of COVID-19 in primary care. *British Journal of General Practice Life*. https://bjgplife.com/2020/04/15/the-technology-legacy-of-COVID-19-in-primary-care
NHS Inform (2020). *Coping with money worries*. https://www.nhsinform.scot/healthy-living/mental-wellbeing/stress/coping-with-money-worries
NHS Scotland (2016). *Driving and supporting improvement in primary care: 2016–2020*. Health Improvement Scotland. http://www.healthcareimprovementscotland.org/our_work/primary_care/programme_resources/primary_care_approach.aspx
Rajkumar, R. P. (2020). COVID-19 and mental health: A review of the existing literature. *Asian Journal of Psychiatry*, *52*. https://doi.org/10.1016/j.ajp.2020.102066
Sharma, S. (2020). Heightened listening in telephone consultations. *British Journal of General Practice Life*. https://bjgplife.com/2020/04/06/heightened-listening-in-telephone-consultations
Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., … & Stewart-Brown, S. (2007). The Warwick–Edinburgh Mental Well-being Scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes*, 5, a63. https://doi.org/10.1186/1477-7525-5-63
Thornton, J. (2020). COVID-19: How coronavirus will change the face of general practice forever. *British Medical Journal*, *368*, m1279. https://doi.org/10.1136/bmj.m1279