Letters

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The Wass report: moving forward 3 years on

The editorial by Lawson and Kumar[1] on the lack of progress in implementing the recommendations of the 2016 Wass report is timely and welcome.[2] We would like to highlight the response in Scotland. In early 2018, Scottish Government Health Workforce Directorate established a short-life working group on increasing undergraduate medical education in primary care. The membership comprised senior civil servants from Health Workforce, Primary Care and Health and Care Analysis, NHS Education Scotland, Scottish Funding Council, Undergraduate Deans, RCGP Scotland, Scottish GPs' Committee of the BMA, NHS Scotland Health Boards, medical students, and all GP Heads of Teaching (HoT) or equivalent in Scottish medical schools. This group was supported by an NHS Education Scotland group examining Additional Cost of Teaching (ACT) in primary care in Scotland.

The issue of funding for practices, as discussed in the editorial, was crucial. The methodology of Rosenthal *et al*[3] was validated in Scottish practices, and a median figure of 85 GBP per student per session was identified.

The final report — *Undergraduate Medical Education in Scotland: Enabling More General Practice Based Teaching* — comprised 10 recommendations covering capital investment, improving digital access and connectivity, a rise in the tariff as set put above, growing the GP educator workforce, strengthening the leadership role of GP HoTs, and monitoring and research, and was published in October 2019.[4] It was endorsed by the Board for Academic Medicine and supported by Ms Jeane Freeman, Cabinet Secretary for Health.[5] Support includes the increase in funding for practices, which starts in April 2020.

This is an important step forward in Scotland. However, delivering on Professor Val Wass's report was always going to be challenging, and much remains to be done in Scotland and elsewhere. Evaluating the impact and monitoring the delivery of all 10 Scottish recommendations is under discussion but, of course, will have to await the resolution of the COVID-19 emergency.

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Video consultations in UK primary care in response to the COVID-19 pandemic

The COVID-19 pandemic has necessitated a rapid response from UK primary care services and has prompted practices to consider implementing alternative methods of remote consultation to minimise face-to-face visits. The recent guidance from Greenhalgh and colleagues[1] regarding the use of video consultations in primary care is therefore timely and has important practical implications.

The guidance offers a useful summary of situations in which video consultations may be appropriate for either 'COVID-related' or 'non-COVID-related' consultations and provides tips on which patients may not be suitable for video consultations. The authors also outline the steps involved in setting up a video consultation service and provide advice on how to perform an effective video consultation.

What is apparent from reading the guidance and its associated *BMJ* article[2] is that there is a paucity of high-quality data regarding the efficacy and safety of video consultations in primary care, particularly in the context of acutely unwell patients. An area that warrants further research is the utility of video consultations for remotely performing physical examinations. Moreover, the relative advantages and disadvantages of video versus telephone e-consultations remain unclear.[3]

However, given the exceptional circumstances we find ourselves in, it is our view that implementation of technology to facilitate alternative methods of remote consultation, including video consultations, needs to happen urgently to enable primary care practitioners to provide ongoing care to patients who are unable to attend in person.

At our practice, we have started performing video consultations via encrypted video link from smartphone to smartphone.

As highlighted by Greenhalgh and colleagues,[1,2] video consultations may offer advantages over telephone consultations in specific circumstances but should supplement, rather than replace, existing services. Managing the risks versus benefits of patient attendance versus non-attendance in primary care is complex and will likely continue to change based on our developing understanding of COVID-19 and as guidance from leading public health bodies is updated. The welcome guidance from Greenhalgh and colleagues[1] is the best we have to act on until further information becomes available on the efficacy and safety of video consultations in the context of the COVID-19 pandemic.

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As the profession soldiers on, all members hear the call to arms

Maximising workforce capacity is essential in the COVID-19 effort. As the pandemic continues, new sources of medical expertise to maintain service output will be needed. Meanwhile, COVID-19 has forced primary care into a digital revolution overnight. Routine and triage work is moving online with unprecedented speed. An unintended consequence of this may allow a previously untapped sector of the workforce to be mobilised, UK-trained GPs overseas.

There are no official figures for how many UK-trained GPs are overseas. The BMA Future of General Practice Survey 2015 found that 9% of GPs hoped to work overseas in the next 5 years, rising to 16% for those qualified less than 10 years.[1] Among those who have emigrated, some will be working in academia, some practising clinically in other healthcare systems, and some who have left medicine. However, there will be some GPs, like myself, who have undertaken great pains to maintain our UK practice, keeping up with CPD, appraisal, performers list, and registration requirements. In times of crisis we are eager to offer help. An informal poll of my personal network of UK-trained colleagues overseas shows that I am not alone. The shift towards remote consulting not only removes borders, but it also removes boundaries at a time when the primary care workforce needs a boost.

We might be a smaller group than those at the extreme ends of our careers, but we are skilled, experienced, and willing. We can consult fresh at unsocial hours, relieve the burden from overworked colleagues, and plug gaps when others fall ill or need to look after loved ones. Clearly the role overseas UK-trained GPs can play must be integrated into practice workflows to be viable. Appropriate ground support, both clinical and technical, is needed with challenges including set-up costs, electronic record access, and medical defence hurdles to overcome. However, these are minor in comparison to the benefits of a GP-trained workforce supplementing the primary care effort. With NHS England warning that GP trainees could be drafted into hospital service,[2] the position of primary care is precarious. In such exceptional times, every session counts.

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Managing patients with COVID-19 infections: a first-hand experience from the Wuhan Mobile Cabin Hospital

The editorial by Cairns is a reminder of the continuing challenges posed by infectious diseases.[1]

The 2019 novel coronavirus disease (COVID-19) has spread to many countries[2] and threatens to overwhelm healthcare resources. To overcome the shortage of hospital beds and to allow for a centralised management of confirmed mild cases in Wuhan, mobile cabin hospitals (MCHs), also known as square cabin hospitals, have been converted from a sports stadium and convention centres.[3] MCHs generally include a patient ward area, observation and resuscitation areas for severe cases, and areas for imaging and laboratory testing.[4,5] They are divided into contamination, semi-contamination, and clean areas and pathways. In the patient ward unit, beds are at least 1.2 metres apart from each other.[3]

The Sports Stadium Square Cabin Hospital in Wuhan started to admit patients on 12 February. Healthcare workers screened for patients with mild symptoms and asymptomatic carriers in the community by real-time polymerase chain reaction (RT-PCR) and chest CT. Patients were admitted to square cabin hospitals according to clear criteria.[4,5] Otherwise, social distancing at home was applied, with follow-up. After admission, patients received supportive care for COVID-19 and underlying medical conditions. Medical staff examined patients several times a day

to identify any deteriorating cases promptly and transfer patients to regular hospitals. Body temperatures were monitored four times per day, and respiratory rates, heart rates, and oxygen saturation twice per day. All patients were required to wear masks. Patients were followed up with chest CT and RT-PCR, and were discharged according to our discharge criteria.[4–6]

In the Sports Stadium Square Cabin Hospital, an open space for patients to perform physical and rehabilitation therapy including dancing, walking, and tai chi was established, and entertainment such as books were also available. Patients had free access to daily necessities, food, and medications, and access to homemade food sent by their families. A decreasing number of new patients and more discharged patients each day were also observed in our unit at the Sports Stadium Mobile Cabin Hospital, demonstrating the benefits of establishing such hospitals. We believe it would be helpful to share our experience with healthcare workers worldwide to combat COVID-19.

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An alternative COVID-19 checklist

COVID-related anxiety has spread quickly through all healthcare specialties and everyone is now working outside of their comfort zones.

I am a GP trainee. However, due to my previous anaesthetic experience, I have returned to help in my local district general hospital.

What is lost among the PPE and endless protocols is the lost, terrified, and lonely breathless patient in front of us. Alongside my anaesthetic skills, I will be taking my toolbox for managing difficult consultations because, as well as donning/doffing and pre-oxygenation, every checklist should also contain a pause to acknowledge, reassure, and provide hope. Our voice may be the last human connection they have.

We are doctors first, specialists second, and I am so proud to be taking my GP experience with me to the intensive care unit. This is a great opportunity for all of us to come together and work as one.

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Smoking pack years calculator

Clinical scoring systems have their limitations but they do create numbers that can be searched by computers or provide thresholds for clinical action. An example could be body mass index rather than using descriptive phrases of obesity. A primary care team wanted smoking use by patients to be easily numerically recorded on the patient records and devised a smoking pack years calculator to simplify this task. Primary care respiratory teams who saw the calculator wanted it widely available. This calculator was placed on the web and is freely available for use. Over 1 million calculations have been made worldwide, which suggests it is popular and useful. Lung cancer screening involves a pack year threshold to be passed to justify the use of radiological imaging. It is disappointing that numerical scoring systems for smoking use have not yet been placed in the UK computer record systems because they could assist with research, screening, and disease detection in general practice populations (https://www.smokingpackyears.com).

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Correction

In the Research by Willis BH, Coomar D, and Baragilly M. Comparison of Centor and McIsaac scores in primary care: a meta-analysis over multiple thresholds. *Br J Gen Pract* 2020; DOI: https://doi.org/10.3399/bjgp20X708833, an affiliation for Mohammed Baragilly was missing. The full affiliation details should be Mohammed Baragilly, Institute of Applied Health Research, University of Birmingham, UK, and Department of Applied Statistics, Helwan University, Cairo, Egypt. We apologise for this omission. The online version has been corrected.

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