for Health Research recently suggested that patients with 'Long COVID' may well represent four subgroups of clinical syndromes, and therefore have different rehabilitation needs.[2]

Often patients report symptoms that are refractory, intermittent, or resolve before returning in episodic bouts (these include (muscle aches, chest pains, dyspnoea, and fatigue), many of which are relative contraindications to exercise.[3] The reality of COVID is that the clinical course of infection and recovery does not fit clearly defined categories (of mild, moderate, or severe illness) and symptoms rarely fit into the binary category of cardiac or non-cardiac. In addition to this, patients' rehabilitation goals are very individual and often relate to their pre-morbid status, and this requires a tailored approach that takes into account the physical demands of their day-to-day activities and occupation.

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Ophthalmia neonatorum and the role of primary care

We thank Maqsood and Mahmood for their article on herpes simplex keratitis in neonates,[1] which includes pointers on distinguishing HSV keratitis from other infective causes. While this is an interesting clinical point, we feel that it lacks a primary care perspective. 'Sticky eye' is a common presentation in newborns, and is usually due to immature nasolacrimal duct formation, which requires no treatment unless it fails to improve by 1 year of age. Ophthalmia neonatorum, whether bacterial or viral, requires urgent secondary care input for full assessment and treatment.[2] As discussed in the article by Maqsood and Mahmood, eye infections in the newborn are unlikely to present with features that clearly distinguish benign infections from more significant causes. While the frequency with which HSV causes eye infections in newborns is not stated, we presume that it is uncommon enough that many GPs will not see a case during their career. It is difficult to have a high index of suspicion for such a specific yet infrequently occurring event. We therefore suggest that primary care practitioners need only to distinguish infective from non-infective causes of ocular discharge in neonates, and urgently refer all neonates with suspected infection, while avoiding unnecessary treatment for a newborn with a blocked tear duct.

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A good death is much more than anticipatory drugs

It is interesting to read Bowers *et al*'s article[1] as it confirms general practice response in the UK is quite variable as regards end-of-life care. Over a decade ago, the Department of Health published its white paper on *End of Life Care Strategy*,[2] in it, four elements were considered (dignity in treatment, adequate symptom control, familiar surroundings, and people).

To achieve 'a good death', having the right conversation is paramount; equally is having adequate coordination among the different professionals looking after the patient, the origin of the Electronic Palliative Care Coordination Systems (EPaCCS) currently in use in different shapes and forms across the UK.[3] The ability to have early anticipatory drugs as part of advanced care plans shared among organisations (district nursing, out of hours, GPs) is a core element.[4–6]

The question is whether anticipatory drugs are the initial step, as it seems implied in the article, or whether it is the careful discussion with patients and families of the end of the road and the planning of all aspects of care, of sharing information, of required coordination, of support available.

The use of anticipatory drugs should not be discussed in isolation. Understanding the patient's preferences for end-of-life care, including preferred options for the place of care as well as the place of death, and any other personal views, must take place. A coordinated and holistic approach is the only way to achieve a good death.

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Multidisciplinary teams must work together to co-develop inclusive digital primary care for older people

The COVID-19 pandemic has abruptly changed healthcare service delivery.[1] In a few weeks, clinicians and patients were asked to transition from face-to-face contacts to 'digital-first' solutions (that is, telephone, video, online) wherever possible.

However, there is a real risk that innovation entrenches inequalities in care access, delivery, and patient safety.[2] The adoption of digital technologies is known to happen unevenly across different groups, therefore contributing to the so-called 'digital divide'.[3] Older people seem to be particularly underserved: evidence shows that increased age is associated with less access to technology and lower digital literacy,[3,4] which may contribute to lower adoption, less sustained use, and less access to care and treatment. Paradoxically, this same group was identified as high risk and is more likely to have comorbidities, physical disabilities, and be shielding,[5] and, therefore, they have most to gain from the regular and remote care that digital technologies can offer.

For these reasons, it is critical to work with a diverse group of older people, particularly from seldom heard groups. GPs and other healthcare providers, researchers, designers, and relevant voluntary and community organisations must come together to explore the main barriers and enhancers to access remote and digital care, and find innovative ways to translate these findings into high-quality solutions to improve the experience both for providers and patients — in order to deliver high-quality, patient-centred care that leaves no one behind.

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Competing interests

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Herd thinking

Thank you for your remarks on COVID vaccination in your October editorial 'Herd thinking'.[1] You are absolutely right that the positivist philosophical approach that some doctors might use to persuade patients of the benefits of vaccination is often not shared by the patients.

However, all is not lost. As I described in an article in your journal,[2] the way forward is to identify the patient's explanatory perspective and, having identified it, to respond within that perspective. This is a technique that every successful salesman has learnt and which I make no claim to have invented. In the case of immunisation, many of the papers quoted in that article come from the World Health Organization 'Sociology and Immunisation Project', which has sponsored relevant research all over the world.

Much has been written and well written about immunisation since,[3] but I do not think that this basic point has been superseded.

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