Information Update
CORONAVIRUS
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General Advice- Dr David Young Retired GP

In days gone routine GP work continued while seasonal 'flu was bolted on. Public information was available, but consultation rates and visits remained high due to persistent fears about persistent cough, fever and mild breathlessness. Triage was largely a feature of the on - call service and despite best efforts face to face encounters for mild illness were too numerous. There was little or no skill mix but some nurse triage. GPs did all the clinics and visits. Any vocational satisfaction was tempered by the inevitable fatigue.

Some things have changed for the better. Call handling and patient direction has evolved while acute care and chronic care are diverging, in turn enabling more focus in our consulting. Skill mix is evolving with work shared between paramedics, ANPs and doctors in reasonable proportion. Cooperative daily visiting services and expanded telephone triage are now accepted as normal.

On the minus side we face clinician shortage, hospitals acting at capacity, ageing and multi-morbidity, the chronic disconnect between health and social care, crowded care homes and increasing risk aversion among call handlers and clinicians. To cap it all PPE at this time is still in short supply adding to our logistical uncertainty.

We need to take steps to avoid the log jams caused by surges in demand over the coming weeks. Government has agreed finance and signaled a cessation in routine service provision while the regulator has promised a proportionate response to error or complaint. Professional leaders are mandating all first contact by telephone to enable better patient direction and obviate unnecessary viral contact.

We can help by selecting small teams within our practices to front patient contact in a diminished number of consulting rooms. These should ideally be well away from administrative offices with discrete access. Room arrangement should see about two meters of separation for seated consulting, with good ventilation, hygiene and waste disposal. Gloves aprons and masks will initially be routinely worn.

Clinicians and support staff not involved in front line rotation would handle the heavily expanded telephone and mail service. They need to ensure familiarize with a few incisive questions when dealing with suspected CV19 to ensure safety and rule out unusual complication, especially sepsis. They also need to pace themselves for a marathon rather than a sprint offering an economy of speech and intensity.

Home visits are likely to be needed at peak times to assess patients with borderline severity on initial triage. This would ideally sit with out of hours providers or visiting services within practice networks. Collaboration with neighboring practices would help with cross cover when clinicians need to take sick leave.

We know that in these uncertain times we must forge and maintain partnerships with patients. They will understand our need for speed and will certainly appreciate our safety netting. We must try to acknowledge their anxiety and respond with empathy and honesty. The sliding scale of CV19 mortality is now widely publicised and most older people will know the score only too well.

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