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The Wass report: moving forward 3 years on

The editorial by Lawson and Kumar¹ 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 out 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 colleagues¹ 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* article² 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 colleagues¹ 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 countries² 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