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NEWS2: supporting and enhancing clinical judgement?

My patient of two decades phoned me one Friday afternoon, saying she felt very ill. She travelled for an hour to my clinic. She has immunosuppression, multimorbidity including steroid-induced type 2 diabetes mellitus, and morbid obesity. Careful physical examination was entirely normal, including pulse, blood pressure, SpO2, temperature, and mental state. Prior to NEWS2 I didn't routinely measure all six physiological parameters.[1] Her respiratory rate was 28, NEWS2 score of 3. Doubting myself, I checked and rechecked her respiratory rate. This was the sole basis of my referring her to ED. Later that day, the CT thorax, abdomen, and pelvis revealed a large intra-abdominal abscess. She made a full recovery.

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COVID-19

The transformation that our GP practices have had to make during the COVID-19 outbreak has surpassed the entirety of changes I have seen in primary care over almost 30 years as a family doctor.

As a GP and Director of SSP Health, the largest GP federation in the North of England, I have been incredibly heartened by the positivity that our staff, and our patients, have shown towards these very necessary alterations to how community care is provided.

Along with many other GP surgeries across the nation, we moved swiftly to limit the number of face-to-face appointments our clinicians were carrying out to cut their potential exposure to coronavirus and also to keep our patients safe.

Within just a few days, almost all our appointments, be it with a GP, pharmacist, AP, ANP, practice nurse, or other clinician, were being done via the phone or through video. Many of these appointments are now carried out from home.

Some of our clinicians who previously had reservations about telephone appointments understood that the pandemic necessitated this new way to treat patients. Each has embraced and adapted to the changes with professionalism and positivity.

Despite the shift away from routine face-to-face appointments, vital services such as childhood immunisations and post-natal checks continue. We are pleased to report that we continued to be on target to achieve our usual high Quality and Outcomes Framework scores, with extremely low levels of exception reporting. For 2019–2020, 23 of our practices achieved 100%, four were above 99%, and one was on 97.5%. Our data team continues to track these quality standards and NHS targets as they will provide an invaluable measure of how telephone appointments have performed. Initial analysis — and anecdotal evidence from our GPs — shows they have been incredibly successful.

We are still in the middle of the pandemic and it is too early to consider how primary care may have permanently transformed due to COVID-19, but it seems likely that some of the changes that have been implemented could and should be here to stay.

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Child care in the primary care environment

Newson falls into his own trap of seeking 'evidence' to reinforce his own prejudices. There are many more possible explanations for his anecdotal diagnostic delays than training or skills of individual GPs. With regard to his case:[1]

- How many GPs were consulted?
- Crucially, what was the appointment system?
- Did he report as a significant event to the referrer?
- What were the lessons?

With regard to Duchenne's, I wonder if diagnostic delay has any relationship to the reduction in routine health checks, and a scarcity of health visitors.

I suspect any secondary care specialist could make what they feel is a justified case for taking their own area of work out of general practice. This is the kind of denigration of general practice that has been well recorded in medical schools.

Both Newsom and Ridd's articles[1,2] are doctor-centric, and ignore the critical issue of building personal continuity into appointments systems (though that is a challenge in an era of less than full-time professional working).

Sanjay Patel's article offers an interesting, alternative, constructive, and cooperative approach.[3]

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To ground or not to ground

In addition to diagnosis and treatment, the GP must sometimes make a last-minute decision whether to allow a patient to travel or to ground them, causing the loss of their non-refundable airline ticket. The physician can become annoyingly hesitant in making the correct decision.

An 80-year-old woman, who had been my patient for the past 30 years, had reserved a flight to France on Sunday at 8.00 am. She came to my clinic on Friday evening with a typical glossopharyngeal neuralgia, in a panicky state, and afraid to lose her $800 ticket should she be unable to travel on Sunday. She had been to an otolaryngologist who had found nothing wrong with her physically and had asked for an MRI of the brain, charging her $100. She said she could not spend more, and I assured her that I would not charge her.

I started her on carbamazepine 200 mg b.i.d. She called me on Saturday morning when I was at our summer home 60 km away, thanking and praising me for the 'miraculous' disappearance of her pain and her regained hope of travelling next morning. In the evening she called me again saying she had developed severe dizziness from the carbamazepine, and that her sons waiting in France had checked on the internet and told her that carbamazepine was for epilepsy. I explained to her that it was also the best drug for her neuralgia.

I told her to skip the next dose and also the Sunday morning dose, rest for the night, and ask for a wheelchair at the airport (which she had originally done already). I assured her that the side effect of the drug would be gone by the morning.

There was no further communication from her, nor from her sons in France, nor from her daughter in Australia after that evening call. My sleep was disturbed for two nights, not knowing whether she had made it to the airport, or had missed the flight and lost $800, or, worse, had gone to the emergency room.

On Tuesday morning, having come back to Beirut, I passed by her building and rang the interphone. There was no answer, and I was relieved. But could she be at the hospital instead of in France? Fortunately, the concierge was around and told me he had helped her to the taxi that took her to the airport.

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Chronic non-communicable diseases: a sacrifice on the altar of COVID-19?

Recently the United Nations Secretary General António Guterres characterised the COVID-19 healthcare crisis as the most challenging the humanity has faced since World War Two.[1] In line with primary care's strategic role in responding to health disasters effectively,[2] most of its human and material resources have been allocated in fighting this outbreak, postponing or even disregarding other patients' needs, including the prevention and management of chronic non-communicable diseases. To make things worse, patients may even avoid attending primary care appointments for fear of catching COVID-19.

Prevention and management of chronic non-communicable diseases are important to mitigate the risk of both morbidity and avoidable mortality, and limit severe acute and chronic complications; the latter may include cardiovascular disease, blindness, end-stage renal disease, and lower-limb amputation. Additionally, community-dwelling subjects harbouring underlying chronic non-communicable diseases, including cardiovascular disease, hypertension, diabetes mellitus, and chronic lung disease, carry an increased risk of adverse COVID-19 outcomes.[3] Therefore, a major concern is that the suspension of prevention and caring for chronic disease could elicit a deterioration of the global health status and a steep rise in hospital admissions and related healthcare costs, which may in turn overburden health systems and surpass their surge capacity.

The current shift from on-site to remote consultations might balance the need for maintaining continuity of care while containing COVID-19. However, reverting to virtual consultations may prove not only technically, logistically, and regulatorily challenging, but also clinically risky and ineffective for some patients.[4] Therefore, selection of candidate patients should be subject to a meticulous patient-centred risk–benefit assessment. Individuals unsuitable for remote consultations should be prompted to attend in person, after properly managing their worries over COVID-19 transmission. In case these cannot be effectively addressed, the alternative of a home visit may be contemplated, especially in high-risk individuals or patients with chronic mental disease, where sustaining continuity of care needs to be prioritised. Proactive strategies are necessary to maximise patient adherence to regular follow-up and minimise their anxiety or fears. Policymakers are urged to secure adequate human and material resources for chronic disease care, and ensure its uninterrupted provision.

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