

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.

Irfan Ahmed,

*GP/Sport and Exercise Medicine Registrar,
University College London Hospital, London.
Email: Irfan.ahmed5@nhs.net*

Aessa Tumi,

*GP ST1 Registrar, St Mary's Hospital,
London.*

REFERENCES

1. A'Court C, Shanmuganathan M, Leoni-Moreno JC. COVID-19 and cardiac considerations in the community. *Br J Gen Pract* 2020; DOI: <https://doi.org/10.3399/bjgp20X713141>.
2. Mahase E. Long covid could be four different syndromes, review suggests. *BMJ* 2020; **371**: m3981.
3. Nabavi N. Long covid: how to define it and how to manage it. *BMJ* 2020; **370**: m3489.

DOI: <https://doi.org/10.3399/bjgp20X713609>

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.

Douglas GJ McKechnie,

*Academic Clinical Fellow in Primary Care,
University College London, London.
Email: douglas.mckechnie.11@ucl.ac.uk*

Edward Snelson,

*Consultant in Paediatric Emergency
Medicine, Sheffield Children's NHS
Foundation Trust, Sheffield.*

REFERENCES

1. Maqsood N, Mahmood U. Herpes simplex ophthalmia neonatorum: a sight-threatening diagnosis. *Br J Gen Pract* 2020; DOI: <https://doi.org/10.3399/bjgp20X712973>.
2. National Institute for Health and Care Excellence. Conjunctivitis — infective: scenario: who should I refer to ophthalmology? 2018. <https://cks.nice.org.uk/topics/conjunctivitis-infective/management/who-should-i-refer-to-ophthalmology/> (accessed 10 Nov 2020).

DOI: <https://doi.org/10.3399/bjgp20X713621>

A good death is much more than anticipatory drugs

It is interesting to read Bowers *et al's* article¹ 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.

Pablo Millares Martin,

*GP, Whitehall Surgery, Leeds.
Email: pablo.martin@nhs.net*

REFERENCES

1. Bowers B, Barclay SS, Pollock K, Barclay S. GPs' decisions about prescribing end-of-life anticipatory medications: a qualitative study. *Br J Gen Pract* 2020; DOI: <https://doi.org/10.3399/bjgp20X712625>.
2. Department of Health. *End of life care strategy: promoting high quality care for adults at the end of their life*. London: DH, 2008. <https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life> (accessed 10 Nov 2020).
3. Millares Martin P. Electronic palliative care coordination system (EPaCCS): interoperability is a problem. *BMJ Support Palliat Care* 2017; **8**(3): 358-359.
4. Dinnen T, Williams H, Yardley S, *et al*. Patient safety incidents in advance care planning for serious illness: a mixed-methods analysis. *BMJ Support Palliat Care* 2019; Epub ahead of print. DOI: 10.1136/bmjspcare-2019-001824.
5. Whole Systems Partnership. *Independent evaluation of Electronic Palliative Care Co-ordination Systems (EPaCCS) in England. Final report*. 2016; https://www.thewholesystem.co.uk/wp-content/uploads/2015/11/epaccs_evaluation_report_final_

march_2016.pdf [accessed 10 Nov 2020].

6. Allsop MJ, Kite S, McDermott S, *et al*. Electronic palliative care coordination systems: devising and testing a methodology for evaluating documentation. *Palliat Med* 2017; **31**(5): 475–482.

DOI: <https://doi.org/10.3399/bjgp20X713633>

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.

Ana Luisa Neves,
Research Fellow in Clinical Analytics and

Patient Safety, Institute of Global Health Innovation, Imperial College London, London.
Email: ana.luisa.neves14@imperial.ac.uk

Anna Lawrence-Jones,
Patient and Public Involvement and Engagement Lead, Institute of Global Health Innovation, Imperial College London, London.

Lenny Naar,
Head of Design Strategy, Helix Centre, Institute of Global Health Innovation, Imperial College London, London.

Geva Greenfield,
Research Fellow in Public Health, Department of Primary Care and Public Health, School of Public Health, Imperial College London, London.

Frances Sanderson,
Consultant in Infectious Disease, Imperial College Healthcare NHS Trust, London.

Toby Hyde,
Deputy Director of Transformation, Imperial College Healthcare NHS Trust, London.

David Wingfield,
GP and Honorary Senior Lecturer, Hammersmith and Fulham Partnership, London.

Iain Cassidy,
CEO, Open Age, London.

Erik Mayer,
Institute of Global Health Innovation, Imperial College London, London.

REFERENCES

1. Blumenthal D, Fowler EJ, Abrams M, Collins SR. Covid-19 — implications for the health care system. *N Engl J Med* 2020; **383**(15): 1483–1488. DOI: [10.1056/NEJMs2021088](https://doi.org/10.1056/NEJMs2021088). Epub 2020 Jul 22. Erratum in: *N Engl J Med* 2020 Jul 23; PMID: 32706956.
2. Crawford A, Serhat E. Digital health equity and COVID-19: the innovation curve cannot reinforce the social gradient of health. *J Med Internet Res* 2020; **22**(6): e19361. Published 2020 Jun 2. DOI: [10.2196/19361](https://doi.org/10.2196/19361).
3. Watts G. COVID-19 and the digital divide in the UK. *Lancet Digit Health* 2020; **2**(8): e395–e396. DOI: [10.1016/S2589-7500\(20\)30169-2](https://doi.org/10.1016/S2589-7500(20)30169-2).
4. Sorensen K, Van den Broucke S, Fullam J, *et al*.

Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health* 2012; **12**(1): 80. DOI: [10.1186/1471-2458-12-80](https://doi.org/10.1186/1471-2458-12-80).

5. Dhama K, Patel SK, Kumar R, *et al*. Geriatric population during the COVID-19 pandemic: problems, considerations, exigencies, and beyond. *Front Public Health* 2020; **8**: 574198. DOI: [10.3389/fpubh.2020.574198](https://doi.org/10.3389/fpubh.2020.574198). PMID: 33072713; PMCID: PMC7536316.

Competing interests

Ana Luisa Neves, Anna Lawrence-Jones, and Erik Mayer are supported by the Imperial National Institute for Health Research (NIHR) Patient Safety Translational Research Centre, with infrastructure support from the NIHR Biomedical Research Centre. Geva Greenfield is supported by the NIHR Applied Research Collaboration Northwest London. The views expressed in this publication are those of the authors and not necessarily those of the National Institute for Health Research or the Department of Health and Social Care.

DOI: <https://doi.org/10.3399/bjgp20X713645>

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.

Gervase Vernon,
Retired GP, John Tasker House Surgery, Dunmow, Essex.
Email: gvernon@nhs.net