Lessons from the COVID-19 pandemic

We read with interest the excellent editorial 'Postnatal care: new NICE guideline for the "Cinderella service"'.[1] GPs' involvement in the care of women in the perinatal period has never been so important as currently, during the COVID-19 pandemic.

Pregnant women affected by COVID-19 are at higher risk of developing serious complications,[2] especially women of Black, Asian, and minority ethnic backgrounds, and those with underlying medical conditions.[3] MBRRACE-UK reported that the maternal mortality rate due to COVID-19 was 2.4 per 100 000 between 1 March 2020 and 31 March 2021.[4] In a recent study, only 28.7% of 1328 pregnant women had received at least one dose of the COVID-19 vaccine, with the majority of women who declined the vaccine expressing concerns about safety as a reason for declining.[5] Up to 31 August 2021 in England, 81 000 pregnant women were reported to have received at least one dose of the COVID-19 vaccine. Given that around 600 000 women give birth each year, this is likely to represent a similarly small proportion of women.[6]

Initially when the UK COVID-19 vaccination programme commenced, only pregnant women at highest risk were eligible; this position later changed when the Joint Committee on Vaccination and Immunisation advised that all pregnant women should be offered the Pfizer or Moderna vaccines.[2] This policy change and conflicting advice received by pregnant women contributed to vaccine hesitancy in these women.[7]

The GP's role in vaccinating pregnant women cannot be overemphasised. GPs frequently discuss the risks and benefits of COVID-19 vaccination with their patients, including pregnant women. Through the call and recall system, GPs can identify unvaccinated pregnant women, invite them to book their vaccination, and direct them to useful resources (Box 1).

The majority of pregnant women admitted to hospital with symptomatic COVID-19 remain unvaccinated.[8] COVID-19 vaccine uptake in the pregnant population can and must be improved. Proactive GPs can be instrumental in this process and need to be recognised for their positive influence on maternal and infant health. UK health care needs GPs empowered to be involved in policy and research in this area as the pandemic continues.

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Box 1. Useful links

- UK Health Security Agency. *Pregnant? Have your COVID-19 vaccines!* [Poster]. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1007400/PHE_12073_COVID-19_pregnancy_poster.pdf (accessed 11 Nov 2021).
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Safety netting in the COVID-19 Clinical Assessment Service

We complement and contrast your granular study of routine face-to-face GP consultations[1] with our experience of unscheduled remote GP assessments in the COVID-19 Clinical Assessment Service

Table 1. Review of safety netting

Safety-netting domain	Total remote consultations reviewed, *n* (%)	Fully done, *n* (%)	Partially done, *n* (%)	Inadequate, *n* (%)	Not applicable, *n* (%)
Clearly gives advice about when and who to call back	5738 (100)	4623 (80.6)	664 (11.6)	291 (5.1)	160 (2.8)
Records advice given (worsening instruction)	5738 (100)	4011 (69.9)	929 (16.2)	558 (9.7)	240 (4.2)

(CCAS). A small clinical assurance team reviewed the recorded audio and written clinical notes for 5738 consults undertaken between April 2020 and May 2021 against a standardised, COVID-19-adapted version of the Royal College of General Practitioners Urgent and Emergency Care Clinical Audit Toolkit.[2] Approximately 1500 GPs throughout England spanned all career stages and included those returning from retirement to support the pandemic response (Emergency Registered Practitioners). Patients across the age span presented possible COVID-19 symptoms. Safety netting was reviewed taking account of the context of the individual consult (Table 1). Integrated NHS Pathways safety-netting templates were available.[3]

Safety netting may be better done here for the reasons the authors suggest: acute, first presentations, and single-problem consultations are all more likely in unscheduled settings. The 80% fully verbalised and 70% fully documented rates compare favourably with 47%–65% and 20%–32%, respectively, in routine consultations, reflecting the additional clinical and medicolegal risk profiles of unscheduled work. We still think there is a significant continuing professional development need, with safety netting inadequately verbalised or documented in 5%–10% of calls. Disparity between verbalised and documented safety netting persists and, although narrower in our data, echoes the additional value of audio review. In common with unscheduled care settings, CCAS consultations were longer (20–25 minutes) than routine GP appointments. We think consultation length influences GP capacity to provide quality care, including safety netting.

Reviewers were also GPs and participated in standardisation processes. Clinicians were unaware which consultations would be reviewed; hence these data reflect 'real-life' practice. We approached the problem of defining unwarranted variation in safety-netting practice by considering proportionality in the context of the individual consultation.

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A medical student's perspective on current 'GP bashing': what are we signing up for?

I would like to start this letter by expressing my full solidarity with primary care professionals, who are receiving verbal and physical abuse from patients, and constant attacks by the mainstream media and government. While I sympathise with anybody struggling to access primary care services in the way that they need or want, and I have experienced this as a patient, the current rhetoric is hugely concerning and entirely inappropriate.

My intention is not to centre students in this issue, as the victims are the GPs and other professionals. But as a medical student and a future healthcare professional, the way GPs are being vilified makes me wonder about my future career path. This culture of hostility towards GPs is not an attractive prospect when considering specialty training. When the NHS is already facing a workforce crisis with a shortage of thousands of GPs,[1] surely the aim should be to make the profession as enticing as possible for newcomers. This is not to say that GPs should be exempt from genuine criticism or accountability, but the deliberate misrepresentations in the media are far from this.

Even if medical students and junior doctors decide to abandon training in general practice and train in other specialties, there is no guarantee that other areas of the healthcare workforce won't face similar treatment in the future. If GPs can be denigrated in this way after historically being seen as respected pillars of their communities, then I worry what our future careers may hold.

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