

Between 9th and 30th of April 2020 we did a **short survey on “dealing with COVID-19 in GP practice”** among the EURACT Council Members. This survey revealed a lot of interesting data (analysis will be published soon on our website). We also asked our council members **to share some of their experiences, good practices or tips**. This can be supportive for all of us, for our daily practice. Here you can find those tips.



(Figure: Word cloud of all the gathered tips)

We get information daily on the radio at 14:00 - very detailed and educational from pandemic responsible and government. Every Thursday our National College (SFAM) has an interactive lunch-seminar. We keep having all our meetings but digitally. We don't meet between clinics. Right now, most care is in hospitals, so Family Medicine is mostly in a state of preparation. Our intensive care has doubled but we still have room for more. Our peak will probably come in a week or two. Military hospitals are built in Stockholm and Goteborg but are still not in use. (Sweden)

A 49 male diabetic patient of mine had been diagnosed by an after-hours service, of suspected pneumonia and sent home with some antibiotic treatment. It was also written "possible atrial flutter"? I called me the next day and I conducted a daily telephone follow up of his fever, cough, FBG -very high, and pulse - around 110. He had no history of contact with COVID patients nor had he been abroad. Following the instructions and finding that he was stable, I told him not to come until 48 hours after a return to normal temperature, though having a bad feeling about postponing the addition of a GLP-1 for his diabetes, an ECG+ treatment for his eventual Atrial Fibrillation and a physical examination for his "suspected pneumonia". He came as agreed after 3 days without fever, almost no cough, feeling very well, in normal sinus rhythm (thanks God), did blood and urine tests: normal apart from his FBG. Next day on the phone he told me that since that same night he had run a high fever, was trenched and felt extremely tired. Knowing that his lab tests and physical exam were normal, it became clear to me that now, having no origin for his fever, it must be COVID-19!! It took me 3 days to obtain a PCR test for him (because of the lack of epidemiologic history-now it is much easier), another 2 days to get a positive answer! And I have been confined to home isolation for the next 9 days as well as my nurse who had performed the ECG and the blood tests on him... Don't worry, we are both well (negative) and back to work, and the patient is slowly recovering at home. (Martine Granek-Catarivas, Israel)

Post-communist country - Czech Republic - is very prone to be deprived of its freedom in the interests of security!! (Jachym Bednar, CR)

Here are my tips/experiences:

1. As a SARS-COV-2 vaccine has not been produced yet, the only reasonable way to avoid spreading of COVID-19 is to stay at home and be properly informed, and that has to be very well understood both, by health care staff and citizens. It is vital, in any case, to keep low the dispersal in the community, as estimating the prevalence of asymptomatic cases in the population is difficult.
2. PHC and GPs have to act informing and supporting people (not discouraging them) to be consulted in the office if needed. It is important that GPs avoid in-person assessment of patients with suspected COVID-19 in primary care (when possible).
3. It is essential that +tested or symptomatic people in PHC setting, need serious assessment and ongoing support.
4. Facing such a deadly community infection presupposes properly equipped health structures, sufficient monitoring at home, common monitoring tools, well-trained HCPs and all these under the umbrella of great PPEs.

5. The most underhanded way of transmission is by touching contaminated surfaces (and that is underestimated), as people tend to be careful about cough or sneezing (masks, keep distance).
6. Older people, those with co-morbidities, children or immunocompromised may present with mild or atypical symptoms.
7. Quarantine (enforced or not) may have long-lasting consequences, affecting people (especially extremely vulnerable) in a psychosocial way. It is the GPs role to handle such conditions, supporting these people (recorded in the extremely vulnerable persons registry and in the special registry of suspected or confirmed cases, with phone communication at regular intervals, and home visits of PHC team if needed).
8. Last but not least, I would like to mention that in Greece we have a wise saying: "Great castles are fallen from inside" which came from the myth of "Trojan Horse". Sharing my recent experience, the Health Care unit in which I'm practicing, has been sealed-closed for 7 days, after two 'orphan' +COVID-19 staff members....  
So, take care to manage properly and protect your staff members, as these are the 'soldiers' of prevention in PHC...

(Dimitrios Karanasios – GP/FP & Director in Greek PHC/NHS)

The restrictions of clinical practice direct asses. The special exceptions for pregnant women, ontological patients.

The COVID-19 pandemic caused a revolution in all areas of our daily activities. The implementation of IT processes to patients care and especially medical education planned for years, took place in just a few weeks. We learn in a battle. At first, remote contacts are extremely tiring and take more time. You can quickly gain experience and act effectively. Good time management is still extremely important. Lack of contact with the real patient, both during the consultation and in the teaching process, increases the sense of uncertainty, which you also need to learn to deal with. Social isolation is becoming more and more troublesome. The media are reporting the first cases of hate directed to medical staff, which I personally do not yet experience. Its sources should be traced to primitive fear and ignorance. However, it is difficult to come to terms with it, especially in view of the increasingly real threat of work orders to combat the epidemic. (Adam Windak, Poland)

We have had very good experiences with our GP App (called "my doctor") - and now it is also used as the video-consultation entrance.

I believe that one of my experiences which I am proud of is the new online teaching seminar in COVID 19 training of triage with online practical training that I provided for my residents. We had an opportunity to translate BMJ recommendations about triage algorithm shared by my colleges from EURACT council in a viber group. Residents were very enthusiastic to accept a practical tool and to apply their knowledge to train their skills first in virtual cases communicating online with one another. Then they are expected to share their experience with the doctors in the clinics and use it in a real life consultation. Their feedback was more than positive, We succeeded to share this algorithm also among doctors in the other regions of Ukraine. Some of my colleges made webinars using this strategy. It's worth mentioning that triage was not organised in my country everywhere before.

- prefer a telemedicine (phone, mail, chat)
- making triage by phone
- e-prescription
- schedule of patient visit

We are actively contacting vulnerable patients. Just to have a chat, to find out how they cope, if they need/have help, if they are healthy... Patients are grateful for that and enjoy the contact and attention. Also, for you as GP it gives a minimum feeling of controlling how your vulnerable patients are doing. (Nele Michels, Belgium)

Video-consultations can be very efficient: remember to inform the patient that privacy and a comfortable chair ensure a more constructive discussion. Working in partnership with patients and nurses has never been so rewarding. The trust in patients and in nurses is so important. GPs can really rely on good information to make clinical decisions in difficult situations during video consultations. Teaching medical students with zoom seminars is also possible. Small-group communication seminars are satisfying for both students and teachers as far as I have noticed. Maybe consulting and teaching will change in the future to include these new ways of doing our job. (Arabelle Rieder, Geneva, Switzerland)

My main experience is of the telephone triage service which has enabled retired doctors such as myself to return to practice. We work from home and are therefore not being put at additional risk of contracting COVID

19. This has been developed at speed in the past 5 weeks and is now working. It is integrated into the national telephone helpline that people ring for any health-related queries. Patients are initially triaged by an algorithm either online or by a call handler. The most urgent ones are sent either a paramedic or ambulance and we speak with the remainder that are identified as needing additional input and possible face to face assessment. The biggest problem is how to assess people, who have some symptoms of breathlessness over the phone, without a measure of oxygen saturation. We have a significant illness burden at the moment and do not want to overload the services. So, it is a balancing act and patients are encouraged to come back through the system if there is any deterioration. One does build up a good picture of the illness and course. Currently the response times in the sessions I have worked have been good. Patients appear to appreciate the opportunity to talk with an experienced clinician about this worrying illness.

Medical Professionals should be involved in all decisions related to COVID-19 management taken by the Central or local Governments.

Mild cases of infection could be not addressed at all to health professionals, that is why community screening is important.

The telephone triage service does not established in many countries, COVID -19 remote consultation model published by British Medical Journal <https://doi.org/10.1136/bmj.m1182> and free permission for translation could be received by request.

The treatment protocols does not include medicines to induce interferon production for antiviral effect, as well as antiviral prophylaxis for contact persons does not recommended.

Regular and preventive visits to Family Medicine practices were canceled in many countries that could lead to big amount of unmet needs and overload while crises will decrease.

(Natalia Zarbailov, Republic of Moldova)

The Ministry of Health and the Corona Scientific Committee are doing their best to control the pandemic. Minister of Health holds press conferences almost twice a week and the statistics (number of tests, number of total cases, number of new daily cases, number of deaths, number of COVID-19 patients in ICU (intensive care unit), number of intubated patients, number of discharged/cured patients are formally declared every day. Precautions are updated according the progress.

Since 13 March 2020, all schools, universities, shops, shopping malls, restaurant, cafes are closed.

Since last week everyone should wear a surgical mask while going out. People under 20 and over 65 must stay home. Everyone should stay home. Home-office working is common. The public services and banks are working with minimum staff and in shifts. Public transports can have limited number of passengers taking into account the rule of 2-meter social distance. All private and public drivers should wear mask. Penalty is quite high in case of violation. Number of patients in ICU and mechanical ventilation are decreasing.

Last weekend a curfew was implemented and it will be ordered next weekend as well (because the weather is nice and people would like to go out in week-ends). People obeyed the rule of curfew. The number of hospital and ICU beds and health care workers are sufficient.

(Esra Saatci-Turkey)

A positive aspect of this epidemic crisis is the rapid adaptation of some institutions in order to maintain social distance. For example, the implementation of remote consultations (some private medical software rapidly changing the interface to facilitate the patient's access to his / her prescription, on the mobile phone), acceptance of the prior telephone triage, transmission of other medical documents by electronic means. Also, the reveal of the desire for help and solidarity but also the effort of the medical organizations and the private sponsors to support through donations and protective equipment both the hospitals and the family medicine offices.

Test the people coming from abroad. Keep them self-isolated for 28 days. Keep in touch with other colleagues, inform your chronic patients by phone, viber, website to stay at home. Take care for your staff.

National lockdown and clear national guidelines on testing and management of COVID-19 patients seem to work. Information from the Norwegian Institute of Public Health: <https://www.fhi.no/en/id/infectious-diseases/coronavirus/>

Use your close proximity - patients, local authorities, other colleagues to install a strong network for e.g. organization (sewing of common face-masks, face shields), cooperation in patient-care with your local colleagues (take colleagues of higher personal risk into the back-office and contact-free patient care, leave them contact free so they can do home-visits of patients also in high-risk groups), think about health care

professions that can't work and have them support you e.g. for comforting patients and explanations about self-isolation etc.

We have been successful in Ireland in flattening the curve. Widespread early testing helped this -testing criteria later narrowed, but the lesson had been learned by the population.

Our GP national college has been very active in keeping all GPs, not just members informed. Our senior members have been on national radio often. This has strengthened our college.

We have also put a large effort into supporting our trainees which appears to be well received.

1. GPs and physicians must act together. No time for solo actions and "I don't think this is my job" attitude.
2. Get protective equipment and wear it. If you don't have it, refer the patient to someone who has it.
3. From the perspective of human and material resources (protective equipment), joint primary Covid-19 entry points are a good idea. GPs are needed there for examining the patients.
4. Think about non-Covid patients. They can easily be neglected. One-to-one consultations are still needed in some cases.
5. Taking time for reflection and relaxation helps me to keep a positive attitude.

Remember that FDs are the front line and must not be left without strong equipment and clear indications, leaving them out of what is not own competence, and allowing them to continue to safely take care of all other patients, acute and chronic and fragile.

(Francesco Carelli, Italy)