Scenario 16 – How guidelines can hinder.

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You are a 69 year-old returnee GP, having retired five years ago. You have been accepted back into your old practice, with the role of overseeing home care for the elderly and frail who come down with Covid-19.

You find being back in the surgery is like putting on a familiar old dressing gown. You and your wife had been in partnership with one other doctor and had worked from a pretty Georgian house on the edge of a commuter village in the Home Counties. Now the beautiful building is looking rather scruffy. The remaining partner has been obliged to run the practice with two part-time assistants, as no-one was prepared to become a partner in a small village practice. He looks tired and disheartened, but you are relieved to see a couple of familiar faces among the staff.

On the day you start, several weeks into the pandemic, there is an online practice meeting to discuss palliative care at home for Covid-19. The practice manager has sent an email advising you to look at the Marie Curie list of guidelines; there are eleven of them. Your heart sinks. It takes you back to those busy days when you would get the new NICE guidelines which tended to leave you feeling both patronised and inadequate. You always found them to be long, difficult to apply to real life situations and hard to remember, and you would invariably resort to the summary. With time, as the guidelines built up, you felt increasingly like an automaton dancing to someone else's tune. Luckily, the joy and fascination of talking to patients and seeing them as individuals made up for this.

At the meeting, it proves impossible to agree which drugs to have in a 'just-in-case' pack, so it is decided that each doctor will choose for themselves which palliative drugs to carry with them in their case. The assistants say they cannot be part of an acute response team as they aren't paid for out-of-hours or home-visits. Although you are becoming a little doubtful about the way things are turning out, you and your old partner say you will both join the acute Covid response team rota being set up with neighbouring practices.

You also discuss whether the practice could send out a letter to all its Covid vulnerable patients, asking them to consider whether or not they would wish to be taken to hospital should they fall seriously ill with the virus, and perhaps even offering a virtual consultation to discuss this. But there is no enthusiasm for this and it is decided to leave it up to the patients to get in touch.

That afternoon you take a call from an old patient of yours. Her name is Molly and she is 87 years old. A retired district nurse, she used to live next to your old surgery, and you'd had one or two set-tos over things like the security lights in the surgery car-park coming on in the middle of the night and the state of the surgery garden - but over the years you had developed a mutual respect.

She has moved into the supported-living home in the village and tells you in no uncertain terms that she does not want to go into hospital if she develops Covid-19. She has had an annoying cough for about a week and has just taken the test. She says she has an advance decision in place, and asks what you can do for her if she stays at home, so you tell her about the acute response team and how to contact it in an emergency.

The following evening you get a call from the acute response team coordinator that Molly is very unwell. She had tested positive for Covid-19. When you arrive, you find Molly in distress - breathless, agitated and running a fever. A member of the staff has stayed on to look after her, though normally she would have gone home by now. You are told that Molly has been given some paracetamol and

they have put on a fan to cool her. She keeps repeating that she does not want to go to hospital and you reassure her that this will not happen.

As she becomes more restless and wide-eyed with panic, you look in your bag. You have some midazolam, diazepam and morphine, but no syringe driver, just butterfly needles and syringes. Suddenly you feel uncertain what to do and wonder if you made the right choices. The staff member says she needs to get back to her family, so you thank her and say you will stay with Molly.

You put a butterfly into a vein and give her an injection of a small dose of diazepam to calm her, but although she stops thrashing around she remains very breathless and distressed. You start searching the guidelines on your phone but can't decide which one to use, and end up scrolling down the version from NICE, through fever, breathlessness, then to agitation and delirium. The print is small and you struggle to find what will be most useful. '*Higher doses may be needed for symptom relief in patients with COVID-19. Lower doses may be needed because of the patient's size or frailty*'. You keep reading. '*Consider midazolam alone or in combination with levomepromazine if ...*' You only have midazolam. Maybe try the Scottish guidelines: '*morphine sulfate: subcutaneous or slow intravenous injection … 2 to 5mg … titrated…'* Your mind is beginning to race and you're not sure if the sweat trickling down your neck is entirely due to the PPE you are wearing. '*… subcutaneous 10-15mins … intravenous 3-5mins …*.' You decide to give 5mg morphine into the vein slowly, as you used to during night visits, before it became normal practice for everyone to be admitted to hospital for acute heart failure. It feels familiar. Molly relaxes and it gives you some breathing space.

You phone her son and explain the situation, but she is too drowsy to talk to him. He says he will drive over but it will take about two hours. After the call, you consider over-riding her wishes not to call an ambulance; but as soon as the thought enters your head, you know it's only because you feel trapped and want to find a way out of this situation. You begin to wish you hadn't returned to work. It reminds you vividly of being out of your depth as a junior doctor in the middle of the night. If only you had a friendly registrar to call for advice.

Molly resurfaces, becoming more distressed and incoherent, jerking about and shouting out as if in pain. She isn't able to hear what you are saying. In desperation you give her another 5mg of morphine into a vein, but more quickly than before. Half an hour later, she dies. You feel horribly guilty that your treatment may have hastened her death. You sit miserably waiting for her son to arrive. Naturally he is very upset that he didn't get a chance to talk to her towards the end, but the conversation with him doesn't go well. You leave under a cloud.

The following week there is a complaint from Molly's son. A critical incident meeting is called and you explain carefully what transpired at her death. Everyone listens in silence and you sense the response of 'there but for the grace of God go I' from the other doctors present. There are murmurs of sympathy from the rest of the team. You are advised to contact the law firm that the NHS is using for returnees. You hand in your notice to the practice and inform the GMC that you wish your temporary registration to be cancelled.

This is not the way you wanted to end your career. You know that it's probably impossible to gather all the fast-changing information about this novel virus and come up with a set of agreed guidelines at this time. But if only they had been clearer, shorter, and more consistent, perhaps you could have given your old friend the death she deserved.

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