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Pandemic lessons

Australia is in the midst of its traditional influenza season. This year the spectrum of viral respiratory infections has been joined by a newcomer as feared as any previous variation of influenza. Human swine flu, a novel influenza A H1N1 virus (now known as 'H1N1 09'),[1] emerged from the Americas into the full glare of western media and the World Health Organization (WHO) spotlights. Improvements in global public health infrastructure since the 20th century pandemics were set to be challenged by 21st century advances in worldwide travel. The southern hemisphere is the theatre; the stage is primary care; general practitioners are the key players in the first act.

There has been some confusion between the elevated levels of public health awareness, as evidenced by the highest WHO pandemic alert level declared in mid June,[2] and the perceived severity of the disease itself. We now know mortality from the H1N1 strain is considerably less than 1% of confirmed laboratory isolates and hospitalisations more common in those with pre-existing chronic diseases. The Australian Federal Government has recently amended its own pandemic management plan with an annex acknowledging the clinical pattern of infection as 'mild in most but severe in some and moderate overall'.[3]

All GPs can recall winters past punctuated with a spectrum of viral illnesses and their impost upon practice activity. It would come as no surprise to most of us that once community spread of pandemic influenza was recognised, the burden of diagnosis and management would fall to primary care. Advice has varied with the developments in knowledge of the virus regarding who to swab, who to isolate and who to treat. Though general practice deals daily with uncertainty, here is a situation to test the skills of the most seasoned generalist.

The initial gripes came from those due to travel overseas who struggled to obtain their antivirals to pack before departure to the Americas. What to expect from these panaceas? Hardly used in seasonal flu by many GPs, were they useful at all for swine flu? There was barely time to put up the posters reminding us of proper cough etiquette. Then the arrival of the worried well: the returned traveller, the anxious mother, the hypochondriac. No sooner had they left the waiting room to be wiped down with sodium hypochlorite than the next gathering appears. Only now it's a little closer to the expected notion of coughing, febrile and fatigued. Consultations increase in depth and by degrees. We correct the misuse of the terms isolation and quarantine. There are mutterings in the practice of personal protective equipment (PPE), of stockpile distribution and changing case definition. Where were the masks coming from? Why has my coughing febrile diabetic patient got to attend the local emergency department before they can get an antiviral from the stockpile? Eventually the worried sick seek further reassurance, their employers seek certificates confirming the absence of swine flu and our staff wonder if they should turn up for work at all.

It may be that this pandemic threat arrived in time for the cooler months just as our seasonal flu emerged much earlier than usual. The existence of pertussis and respiratory syncytial virus in some regions has added to the sudden burden of infectious disease seen in primary care. That common community infection control measures are overtaken by desire for a pharmaceutical solution might have reduced the GPs time for the rest of their core business as they debated the pros and cons of antivirals, masks and tests for swine flu.

Victoria was the first state to experience community spread of pandemic H1N1 09 in Australia and some of their primary care and specialist experience has already been published.[4,5] Feedback to state and federal governments, and their respective plans, needs to include input from all primary care practitioners, especially GPs and include: difficulties obtaining PPE and antivirals, lines of communication to practices from public health units, the strategy behind and coordination of testing, and the synchronised distribution of information to health professionals and public alike.

Individual practices and practitioners need to examine their response: was telephone triage effective, were 'walk in' emergency surgeries able to cope with demand, has business continuity been maintained, and how would we do it at all next time?

All dramatic events receive the wisdom of critics. This production still has considerable time to run but that should not stop us from reviewing and amending our performance in light of the best available information.

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