Global crisis: EM and EMJ respond

Richard Body,[1] Edward Carlton,[2] Simon Carley,[3,4] Mary Dawood,[5] Caroline Leech,[6] Simon S Smith,[7] Ellen J Weber [8]

Suddenly, the world is facing a threat that was only previously depicted in science fiction books and movies, and in simulation exercises of events we thought we would never actually see in our lifetimes. The COVID-19 pandemic has, within a few months, affected everyone on the planet in one way or another. Despite talk of "preparedness," we were not ready. Everyone feels underprepared and underprotected.

Emergency Medicine's role in this crisis is crucial. Each and every one of us has been called to contribute. We cannot deny we are frightened. Nevertheless, across the spectrum of emergency care, physicians, nurses, paramedics, advanced practitioners, administrative staff, technicians, transport and domestic support teams are all rising to the challenge. Wearing whatever personal protective equipment (PPE) we are told is the latest fashion, and fearing that we will catch the disease, or worse, spread it to our loved ones, we have assumed the front line for assessing, diagnosing, resuscitating and sorting the increasing number of equally frightened patients coming to us with what may or may not be COVID-19. In many institutions, it has been the ED that sounded the alarm that more space would be needed to manage these patients and keep those who are not infected separate from those who are. The combination of experiences and skills that emergency medicine professionals, many of who have voluntarily worked in disasters, limited income countries, the military and other challenging environments, as well as the more mundane but challenging work creating a safe and an orderly flow of care in crowded EDs, has served us well. Ever-changing directives about what to wear, who to test, how to clean do not bother us. We are used to a sudden surge in our volume due to a major car crash, terrorist attack or sporting event. We are used to being uncertain about a diagnosis, ducking and weaving, and changing course when we realise that the patient we thought had a myocardial infarction (MI) is actually septic. Emergency physicians are used to emergencies, and we have learnt the skill of keeping our heads 'when others around us are losing theirs'. A specialty that has often been thought of as 'jack of all trades', or the department that just creates work for others, now demonstrates its value. We react quickly and are proactive.

It would be tempting to write an editorial only lauding our profession for the role it is playing in this pandemic. Emergency medicine is the front line of defence in the hospitals across the globe, and we should be proud of how we are responding to the call. But in fact, we are not doing it alone. Non-emergency personnel have stepped up to man respiratory and fever clinics, and drive through swabbing stations. Then there are the nurses and physicians performing inpatient care in intensive care units (ICUs) and COVID-19 isolation wards. Outside the medical establishment, there is new sense of community and everyone is doing their part—some have sacrificed by lost wages when their places of work shut; others, in essential services, like our grocery store clerks, gas station attendants and pharmacists, go to work daily and face the public, often without any PPE. Thousands of people are responding to calls for volunteers by our governments, and neighbourhoods are organising to provide food, necessities and virtual company to those sheltering in place without help. Yes we should congratulate ourselves for putting our best foot forward, but we must recognise we are not the only heroes in this struggle.

Despite the tragic situation, we are seeing an amazing, rapid, and positive transformation of medicine none of us thought would ever happen. The medical profession is showing it can actually come together to allow everyone to do their job better. Unlike the very recent the past, the patient coming for care is not the 'ED's patient' or the 'oncologist's' patient, or the ICU's patient—from the moment they walk in the door, they are *our* institution's patients. Long-standing barriers to care are starting to vanish. There are institution-wide agreements on where and how patients should be seen, how quickly they should moved to their beds and limits to the number of providers they see. (At one hospital in the UK, we hear, neurosurgeons have agreed to evaluate patients with possible cauda equina without a scan first!) The surgeries that contributed to full hospitals, and ED crowding, have been reduced to provide bed space—and ventilators—for patients with COVID-19 . Managers are recognising that many of our hospital rules are not rules at all; yes, nurses can work in a variety of wards, and dermatologists can probably screen patients for infections and even take a swab. In the USA, where the market forces foster competition rather than cooperation between hospital chains, hospitals in the same city are joining forces to find and share bed space and equipment. In other countries, whole teams of emergency physicians, anaesthetists and nurses are leaving their own (unaffected) hospitals to serve at others. Indeed from primary to tertiary care, from public health to skilled nursing facilities, we have suddenly seen something which emergency medicine has been saying all along—we all have responsibility for the care of these patients.

The team at EMJ has considered how we as a journal can best inform and support of emergency physicians during these trying times. We are a monthly, peer-review journal, with a minimum of 6-week lead time from final proof to print publication. From a scientific viewpoint, papers going out for review now on COVID's epidemiology, pathophysiology, treatment or outcomes are likely to be out of date by the time they reaches publication. Moreover, all of us are emergency physicians, as are our reviewers, so bandwidth is limited for getting these types of papers appropriately and quickly reviewed. We are a specialty steeped in the practice of evidence-based medicine. And so it is critical that we maintain our high standards for the publication of scientific inquiry.

Where we can make a difference, we believe, is in sharing experiences and ideas for how emergency medicine can and has met the challenge of COVID-19. In early March, we put out a call for papers that describe innovative ways in which your departments, cities or country have addressed the logistic and safety challenges of screening, isolation

[1]Emergency Department, Manchester Royal Infirmary, Manchester, United Kingdom
[2]Emergency Department, Southmead Hospital, North Bristol NHS Trust, Bristol, UK
[3]Emergency Medicine, Manchester Metropolitan University - All Saints Campus, Manchester, United Kingdom
[4]Emergency Medicine, Central Manchester and Manchester Children's University Hospitals NHS Trust, Manchester, United Kingdom
[5]Emergency Department, imperial College NHS Trust, London, United Kingdom
[6]Emergency Department, University Hospitals Coventry & Warwickshire NHS Trust, Coventry, United Kingdom
[7]Emergency Department, Oxford University Hospitals NHS Trust, Oxford, United Kingdom
[8]Emergency Medicine, University of California San Francisco, San Francisco, CA 94143, USA

Correspondence to Dr Ellen J Weber, Emergency Medicine, University of California, San Francisco, San Francisco, CA 94143, USA; ellen.weber@ucsf.edu

and patient surge that has come with this pandemic. We are also looking for ideas about how we can sustain these efforts as long as necessary, which includes successful models for rostering, and wellness initiatives. The series, Reports from the Front, starts in this issue, with a description of how EDs have managed the outbreak in Singapore, and a linked podcast with two of the emergency physician authors. We also welcome personal thoughts, fears and experiences that can speak to colleagues across the globe in these unprecedented times. Some of these will be externally peer reviewed on a fast track basis; others may be more suitable as letters, the View from Here, or Concepts may be reviewed internally by our editorial team. We have also opened our blog for you to informally share what you have done, and ask and respond to questions of other emergency physicians (https://blogs.bmj.com/emj/2020/02/19/how-should-we-respond-to-coronavirus/).

Our other very important role is to steady the ship. Emergency medicine cannot focus solely on COVID-19; there are still patients that will have strokes, exacerbations of heart failure, new MIs, appendicitis, sepsis (without COVID) and trauma. These patients deserve as much of our attention as our respiratory patients and the application of cost-effective, high-quality, evidence-based care. So, our role is also to continue to solicit, review and publish scientific articles, commentary and reviews to further our knowledge on all the other fronts. We feel that this approach embodies the essence of what emergency medicine does each and every day—rising to the most pressing need but never taking our eye off all the other patients who need us.

In times like these, emergency medicine is absolutely fit for purpose, indeed uniquely suited to meeting the needs of the times. We are not alone in this work—or in our fears—but we are equipped for caring for patients in difficult conditions, and for transforming chaos to order and panic to calm. But we are also human, we must have concern for and protect our own physical and mental health. Leaders of our institutions should do all that is in their capacity to ensure that this work force feels valued and supported in order to foster our resilience. Take care of yourselves and of your colleagues.

Wishing everyone safe passage in the next months.

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ORCID iD
Ellen J Weber http://orcid.org/0000-0002-0094-1973