"Once more unto the breach, dear friends" – Reflections on the novel coronavirus disease and emergency medicine in Canada

Alecs Chochinov, MD*†

References to war abound, as our leaders describe the toll that the novel coronavirus disease (COVID-19) has taken on the world. With over 300,000 deaths worldwide and no vaccine in sight as of this writing, the UN Secretary-General has described this pandemic as the greatest threat to the world since World War II. In barely two months, the United States lost more people to COVID-19 than in the Vietnam war and, by summer 2020, the losses to COVID-19 will outnumber all of their soldiers who died in battle during World War I. Canada, perhaps less accustomed to war metaphors, is nonetheless embattled with thousands of new cases of infection per week and over 6,000 deaths.[1] The majority of Canadian fatalities have been in Quebec and Ontario, predominantly among the elderly in long-term care facilities; but, as we all know too well, COVID-19 spares no region or demographic entirely. It has been remarkable to witness the widespread adaptation of emergency departments (EDs) in response to the pandemic, with the advent of hot and cold zones, testing tents in hospital parking lots, the institution of new protocols, and the fundamental changes in practice. Emergency physicians across Canada now wear personal protective equipment (PPE) for the entirety of their shifts, have had to revise their approach to resuscitation, and use phones to take histories. Many shower at work and change clothes before coming home, worrying about the risk to their families.

This massive change in routine over a few short months has significantly impacted our already precarious collective well-being.[2] As many physicians in Toronto know too well in the aftermath of severe acute respiratory syndrome-related coronavirus (SARS-CoV) in 2003, such effects can be insidious but have a lasting impact. The recent tragic loss by suicide of Dr. Lorna Breen, Medical Director of an ED in Manhattan, underlines the need for attention to wellness and peer support during and beyond the current crisis. This must also extend to our nursing colleagues, aides, orderlies, and all other frontline "soldiers."

Yet, despite its terrible toll, COVID-19, in many ways, has united us more than ever before. Our colleagues continue to staff EDs 24/7, understanding the risks and adapting to them, supporting and encouraging each other, protecting older or vulnerable physicians whenever possible, communicating almost incessantly through various apps, heeding the exhortation of Henry V to step "once more unto the breach…."[3] We have seen their multifaceted skills come to light and shine, through advocacy, disaster medicine expertise, organizational leadership, and frontline clinical services. In a previous President's Message, we likened it to a symphony, with each of us playing a part. Within that symphony, the Canadian Association of Emergency Physicians (CAEP) has played the key role of orchestra leader, hosting weekly Town Halls, releasing 17 position statements, publishing 13 open access articles in *CJEM*, and participating in over 40 media events across the country. The theme for CAEP's ill-fated 2020 conference still rings true: we are truly *better together*.

The COVID-19 pandemic has not only impacted the way we practise, but also our healthcare system itself, perhaps permanently. ED patient volumes precipitously dropped by 40–60%, have not yet fully recovered, and we are seeing fewer of the time-dependent conditions that require emergency intervention. Where have these

From the *Department of Emergency Medicine, University of Manitoba, Winnipeg, MB; and the †Canadian Association of Emergency Physicians, Ottawa, ON.

Correspondence to: Dr. Alecs Chochinov, Department of Emergency Medicine, University of Manitoba; Email: ACHOCHIN@sbgh.mb.ca

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patients gone – are they too fearful to come to the ED, seeking care elsewhere, or have the antecedents that led to cardiovascular presentations themselves been affected by COVID?[4] These are among many urgent questions that must be answered by way of research, and our clinician scientists are already stepping into that breach.

Will COVID-19 help us re-imagine, then reconfigure, the future? Emergency medicine leaders across the globe are calling for this to be a turning point in the practice of our specialty, within the larger system.[5] Wait times to both ED care and admission have shortened to unprecedented levels; we must use this disruption as a catalyst for permanent change, lest we revert back to crowding and access block, with all of its attendant misery for patients and staff. Unnecessary patient transfers from the long-term care sector to the ED must be fewer in the future, but their management at the point of care must be better, leveraging technology, such as telemedicine. Protocols for intubation of COVID-19-suspect patients require a multi-disciplinary approach, which has challenged us to break down traditional silos and hierarchies. Emergency medicine has much to offer the organization of hospital intubation teams, in that we have always had an experienced attending physician performing or directly supervising the riskiest interventions and most difficult clinical decisions. In the context of an ongoing pandemic threat, it is important that all specialties offer similar expertise, to serve patients and protect staff at risk.

Perhaps the overarching lesson that COVID-19 has taught is that we live within a delicate, interdependent ecosystem, one that is subject to both predictable and unpredictable disruption, and that we have a role to play in both cause and response. We cannot carry on with business as usual, within or beyond the walls of our hospitals. As emergency and disaster medicine specialists, we must already start planning and training in earnest for the next existential threat, however it manifests. As stewards, we must ensure that patients feel safe coming to our EDs, that their exposure to the risks of overcrowding (including nosocomial infection) is minimized, and that staff are well-equipped with necessary pharmaceuticals and PPE but use them prudently. As professionals and citizens, we must not remain silent or resentful in the face of poor decision-making by political leaders, but rather offer our expertise without precondition. And we must try to live our lives in fashion that at least approximates the privilege of our position in society. We are not actually war heroes, any more than the subway workers in New York City or first responders in Montreal. But, for better or worse, we will be looked at as heroes of a different sort when this is all over. Let us embrace that role with humility, thoughtfulness, and resolve; then step, once more, unto the breach.

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REFERENCES

1. Worldometer. COVID-19 coronavirus pandemic. Delaware USA; 2020. Available at: https://www.worldometers.info/coronavirus/#countries (accessed May 11, 2020).
2. Lin M, Battaglioni N, Melamed MD, Mott SE, Chung AS, Robinson DW. High prevalence of burnout among US emergency medicine physicians: results from the 2017 National Emergency Medicine Wellness Survey. *Ann Emerg Med* 2019;74(5):682–90.
3. Shakespeare W. *Henry V*. Act 3, Scene 1. London, England. Folio 1; 1623.
4. Krumholz HM. Where have all the heart attacks gone? *The New York Times*; 2020. Available at: https://www.nytimes.com/2020/04/06/well/live/coronavirus-doctors-hospitals-emergency-care-heart-attack-stroke.html (accessed April 14, 2020).
5. The Royal College of Emergency Medicine. COVID-19: resetting emergency department care; 2020. Available at: https://www.rcem.ac.uk/docs/Policy/RCEM_Position_statement_Resetting_Emergency_Care_20200506.pdf (accessed May 11, 2020).

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