VIEWPOINT

COVID-19: Change is urgent

COVID-19: la urgencia del cambio

Jordi Delás, Núria Barrera

In March 2020, the COVID-19 epidemic changed the landscape of hospitals and especially emergency departments (EDs). Many Spanish hospitals became monographic of COVID-19 and reasons for consultation other than fever, extreme tiredness, respiratory distress, loss of smell or the diagnosis of presumption of COVID-19 proposed by another colleague disappeared from EDs.

The usual diagnoses disappeared for a multitude of reasons. From the responsibility -and fear- of the population that avoided going to the emergency department for matters that could be delayed, the novel alternative of telephone visits, the decrease in accidents due to confinement and the dangerous circumstance of not going to the emergency department for truly serious problems, with their repercussions and their transcendence.

There was no experience in treating this disease and there was a shortage of protective material. Often security or patient transfer personnel were better equipped than emergency personnel. By 14-5-20, 39,349 cases of COVID-19 had been reported among health personnel, 22.3% of the total number of cases. Sixty-five percent of health professionals had an epidemiological risk history of contact with people with respiratory infection and 69% had close contact with probable or confirmed cases of COVID-19[1]. Too many cases of contagion among healthcare personnel, who in a situation of adequate prevention, with properly adopted measures, should not suffer a higher incidence than the general population. The health profession should not lead to a greater number of infections.

It is often said that the ED is a hospital within a hospital. While in an admirable way, spaces and beds were made available for conventional hospitalization and critical patients, in the emergency department, dantesque situations were experienced with patients asking no longer for a diagnosis, but simply for water. When it was almost more important to isolate non-COVID patients from those infected, in a general environment of high viral load.

Residents, characterized by their youth and the generosity attached to that youth, showed up at the ED to fight the epidemic, feeling that it was their job and did not ask for compensation. They answered the call, as revealed in an attractive article by Dr. Suzanne Koven, family physician and writer-in-residence at Massachusetts General Hospital in Boston[2], and as an opportunity for growth, as defined by Dr. Jane de Lima Thomas, director of a comprehensive palliative care program in Boston[3]. It is not uncommon for residents to be organized into long shifts in the ED, interspersed with periods of work and rest-where little could be done other than to be confined to the home-and changes in sleeping schedules.

All the professionals who have worked and lived through those days of March, April and May 2020 will agree that there was a sense of catastrophe[3] and chaos. The emergency department was the real front line and the scope of the decision on who to limit intensive care to when the need exceeded the availability of beds or mechanical ventilation equipment[4]. A feeling of intense work, of proximity between different professionals, between staff and residents and the perception that the professionals themselves could become ill and die. Roles were mixed, and often doctors had to care for other physician friends[3].

The New England Journal of Medicine recently published the need for a national strategy to protect the well-being of physicians who treated patients with COVID-19. At the same time, it compared them with the protagonists of other great performances that should lead them to be remembered as heroes. Five high priority actions were suggested, of an organizational and financial nature, aimed at the health of professionals[5].

These actions towards physical and mental health are probably very important. In our environment, where first-year residents earn about 1,170 euros per month[4]. It would be necessary that some of these measures be directed at changing the impoverished situation of many professionals, especially residents. They have been exposed to the epidemic on the front line of the ED with compensation that is not commensurate with their delivery. They have even, in some cases, stopped receiving the guard fees, due to the redistribution of their schedules. Among the other four measures, there should be adequate provision of health resources, health research, patient safety and staff safety.

Author affiliation: Department of Medicine, Hospital Universitari del Sagrat Cor, Universitat de Barcelona, Barcelona, Spain.
Contribution of the authors: The authors have confirmed their authorship in the document of responsibilities of the author, agreement of publication and cession of rights to EMERGENCIAS.
Corresponding author: Jordi Delás. ordi Delás. Department of Medicine. Hospital Universitari del Sagrat Cor. University of Barcelona. Carrer de Viladomat, 288. 08029 Barcelona, Spain.
E-mail: jdelas@ub.edu
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We should go back to the spirit of those mornings on the way to the hospital with empty streets, when the population alluded to the error of the health cuts, in beds, means, personnel and professional's salary. The need for social change, with investment in research and health. Immense praise for the essential personnel that had to be compensated, even economically. Tomorrow had to be different. There was a rare opportunity, also for physicians, to pause in the midst of chaos and deepen our empathy, change our practice habits, and improve our care systems[3]. Other voices said that society soon forgets, that we would not be more social, nor more preventive, when the longed-for desire for the epidemic to cease or decrease significantly is fulfilled.

Now that emergency medicine specialization is being debated and seems ever so close, let this hard experience and need for training be engraved on the senior physicians and the walls of the EDs, so that they are prepared and that what they have experienced is not a refusal to dedicate themselves to the wonderful and exciting field of emergency medicine.

Professionals, associations, schools, scientific societies, publications: we must all advocate for change. Actions against this hangover of disenchantment, in view of the risk that in the next pandemic, nobody wants to be in the front line. Let them go!, some will say, not without reason.

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