Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Pandemic

All models are wrong but some are useful.

—George Box

No matter how much falls on us, we keep plowing ahead. That's the only way to keep the roads clear.

—Greg Kincaid

Our understanding of the clinical and imaging manifestations of coronavirus disease 2019 (COVID-19) continue to evolve. Bao et al summarize the early literature on CT findings associated with COVID-19 infection [1]. Since the first reported case of COVID-19 in the United States, multiple projections of cases, deaths, and health system capacity have been devised and revised as states implemented physical distancing policies, the Centers for Disease Control and Prevention recorded confirmed and suspected cases, and hospitals sought to increase equipment and redeploy personnel. Although each model's estimate of future cases may have been inaccurate, each prediction spurred action.

And action we got. The rate and level of response of the medical and scientific community represents some of the most heroic and innovative interventions outside of war. Leadership at all levels accelerated response. Huang et al [2] and Goh et al [3] provide examples of Chinese and Singaporean institutional responses from countries initially hit by the pandemic. More locally, Myers et al frame the current coronavirus outbreak as a test of institutional mass casualty incident planning [4]. Prabhakar et al describe early strategies in an academic radiology department as the acuity of the outbreak increased [5]. Where lack of subspecialty expertise threatened to limit care, Davarpanah et al summarize Iran's experience with remote CT consultation using a social media platform [6].

Resource diversion, patient acuity, and increased stress in the work environment have consequences beyond patient care. Chen et al remind us of the toll of physical distancing on morale and suggest ways to promote team cohesiveness [7]. Slanetz et al discuss mitigating impact on the resident education [8]. Fessell and Chemiss provide micropractices to promote wellness [9].

To "flatten the curve" and reserve capacity for COVID-19 patients, practices rapidly moved to reschedule elective care and plan for staff redeployment leading to downstream economic concerns. The journal hosted a webinar to present the range of responses across a diverse group of practices, both academic and private, which is summarized by Lee et al [10].

By the time this editorial reaches you, the impact of the pandemic will have changed again. Our focus now should be on the crisis after the crisis as articulated by Kwee et al [11]. The current pandemic has changed us in profound ways that we are only beginning to quantify. Some represent expedited implementation of planned practice management change. Others are specific to or adapted for the pandemic. Many will have lasting impact on care provision and workflow, such as the expansion of telehealth and de-implementation of lower value care. None of us will remain unaffected.

Prior pandemics, such as Severe Acute Respiratory Syndrome, have taught us that we will have to do battle once again. Perhaps the most positive outcome from the current COVID-19 crisis is the development of systemic and individual resilience after having been severely tested.

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