COVID-19: one threat, one world, one response (magical thinking)

Òscar Miró

European Journal of Emergency Medicine 2020, **27**:165–166

Emergency Department, Hospital Clínic, Barcelona, Catalonia, Spain

Correspondence to Òscar Miró, MD, Hospital Clinic de Barcelona, Centro de investigación IDIBAPS, Universidad de Barcelona, 08036 Barcelona, Spain
Tel: +34 93 2279833; fax: +34 93 2275693; e-mail: omiro@clinic.cat

At the time of writing this editorial piece (18 March 2020), 155 countries have detected patients infected by SARS-Cov-2, and nearly 200 000 people have been affected by this new human virus. Right now, many countries in Europe and worldwide are facing a health and economic catastrophe. The former will be stopped, hopefully, in months; the second, in years.

Although there are some particularities in every country fighting SARS-Cov-2, there are also a handful of common circumstances in this global crisis. First, as human beings, we tend to commit the same mistakes over and over again. For every real problem that we see threatening our neighbour, we act as if this problem was not going to affect us. It is the ancestral magical thinking (*I am different*) that accompanies us from our beginnings. And, even though we consider the problem might become ours, we believe that we are better prepared to successfully face such a threat (or in other words, that the neighbour is not as well prepared as we are). In any case, we miss the possibility of taking advantage of previous experiences, and this is especially fatal when immediate response is needed. And in the end, a mixture of arrogance, self-confidence and stupidity bites us.

The SARS-Cov-2 started as an epidemiological fight, trying to contain the number of infected people into reduced numbers by people confinement and protection of the rest of the population against the infection. Some strategies aimed at by this proposal have been put forward, ranging from the most aggressive (all citizens confined at home, no working activity allowed beyond that which is essential) to the most conservative (no general confinement, just the population at highest risk – elders and chronically sick people – and let's allow the rest of the people to get infected and create immunity as soon as possible). Midway, there is a range of strategies which, in addition to health targets, have been somewhat influenced by economic issues. All of these have been considered with the belief that the population will follow the instructions of the leaders (again, magical thinking).

As scientists, we would like to have experimental data from trials (randomised, if possible) in order to make the best decisions on this essential point. But this is simply impossible in this scenario, and we have to move according to inductive thinking to decide which strategy is perceived as best in every moment. The expert efforts in decision making with loads of uncertainty has been laudable. Some instructions will have served the general objective (limiting the spread of the virus), while others will have not. The heterogeneity seen among countries' decisions speaks for itself about the difficulty of knowing what the right decision is, as well as about how individualist we still are in believing that we will manage the crisis better than our neighbours. Nonetheless, it does not matter which strategy your country has adopted to contain virus dissemination, general failure has been the rule. Maybe, again, magical thinking has dragged us the wrong way.

With the ball already rolling in the field of the healthcare system, community medicine and hospitals have become full of protagonists. With regard to the former, the contention that infected patients with minor symptoms and no systemic disruption to stay at home is valuable. In the hospital, three main areas take leadership in the SARS-Cov-2 fight: the emergency department (ED), the hospitalisation wards (mainly in internal medicine, infectious disease, and respiratory departments) and the intensive care units. The latter two are crucial structures, and their ability to quickly increment their functional and structural capacities will have played a major role when the final count of the disease is presented to the citizens. During decades, Europeans have been proud of their public health system, and we have convinced ourselves that it will protect us against any health insult we face (another expression of magical thinking).

Clearly, as emergency physicians, we are playing a major role in this pandemic. Hundreds of extra patients are coming daily to our EDs looking for counselling and treatment. They come to a usually overcrowded ED and, during most working hours, functioning at close to 100% of their possibilities [1–4]. In addition, although European EDs are not homogeneous, either in spaces or in workforce organisation [5–9], the adaptive capacities of EDs and emergency physicians are huge [10,11]. Some examples of the adaptations made in the Spanish EDs in response to the SARS-Cov-2 pressure on our system include an increase in areas dedicated to emergency care,

0969-9546 Copyright © 2020 Wolters Kluwer Health, Inc. All rights reserved. DOI: 10.1097/MEJ.0000000000000707

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

the creation of differentiated pathways for patients with suspected SARS-Cov-2 disease, preparation of specific spaces for testing patients suspected of infection, training of emergency professionals on the use of self-protective equipment, the development of specific protocols for diagnosis and treatment, facing with very difficult and unanticipated decision-making, adaptation of the workforce to the surges of patients and of professional sick leaves, and rapid patient transition to general wards, despite the results of nasal/pharyngeal swap testing for SARS-Cov-2 still pending. These are probably not far from what other colleagues have implemented in their European EDs. And new situations will come and will put all of us in need of implementing other never before seen changes in our ED routines.

Finally, protecting ourselves is crucial, and we feel that sometimes this protection is less than what is to be expected: shortage of protective material has been a general problem, slow microbiological tests for healthcare professionals have delayed the detection of asymptomatic cases, and cross infections among ourselves and our patients have occurred. This is not different from other previous pandemics [12]. This has not all been a problem of the system, and sometimes we have contributed to it. In fact, presenteeism (the opposite to absenteeism) is quite extended in healthcare providers [13] and has also played some role in the spread of the virus in certain settings. Indeed, although we sometime feel immune to diseases (magical thinking), we are, in fact, not. And psychological stress and fears accompanying us and perhaps suppressed during this crisis, may persist and have effects beyond it.

In the end, as emergency physicians and doctors, but especially as citizens, we would have liked to have seen other scenarios and other protagonists in this pandemic. But looking back at past human experiences, we are only going through a more than foreseeable expected response. Nonetheless, and again on the basis of our magical thinking, we all are absolutely convinced that we shall overcome. And as we will succeed, magical thinking will continue to endure.

Acknowledgements

Conflicts of interest

There are no conflicts of interest.

References

1 Miró O, Antonio MT, Jiménez S, De Dios A, Sánchez M, Borrás A, Millá J. Decreased health care quality associated with emergency department overcrowding. *Eur J Emerg Med* 1999;**6**:105–107.
2 Chouihed T, Wargon M, Yordanov Y. Are delays in emergency departments really harmless? *Eur J Emerg Med* 2019;**26**:462.
3 de Paula José Rivas-Clemente F, Pérez-Baena S, Ochoa-Vilor S, Hurtado-Gallar J. Patient-initiated emergency department visits without primary care follow-up: frequency and characteristics. *Emergencias* 2019;**31**:234–238.
4 Jiménez Moreno FX. Are we using our emergency services as if they were google? *Emergencias* 2019;**31**:225–226.
5 Bloom B. Work shifts in hospitals' emergency departments: the UK experience. *Eur J Emerg Med* 2019;**26**:392–393.
6 Philippon AL. Work shift duration for emergency physicians - the shorter, the better: the french experience. *Eur J Emerg Med* 2019;**26**:396–397.
7 Takagi K, Tagami T. Work-style reform of emergency physicians: the Japanese experience. *Eur J Emerg Med* 2019;**26**:398–399.
8 Freund Y. Extended shift worked in the hospital: we need protection from ourselves. *Eur J Emerg Med* 2019;**26**:389.
9 Zorrilla-Riveiro JG. Work shift in the hospitals' emergency departments: the Spanish experience. *Eur J Emerg Med* 2019;**26**:394–395.
10 Anderson JE, Ross AJ, Back J, Duncan M, Snell P, Hopper A, Jaye P. Beyond 'find and fix': improving quality and safety through resilient healthcare systems. *Int J Qual Health Care* 2020; mzaa007; doi: 10.1093/intqhc/mzaa007. [Epub ahead of print].
11 Delás J. Changes in hospital emergency physicians. *Emergencias* 2019;**31**:139–140.
12 Tazón-Varela MA, Ortíz de Salido-Menchaca J, Leibar-Loiti A, Muñoz-Cacho P. The health care system as a means of contagion during the 2016-2017 flu season. *Emergencias* 2018;**30**:209–210.
13 Sánchez-Zaballos M, Baldonedo-Mosteiro M, Mosteiro-Díaz MP. Presenteeism among emergency health care staff. *Emergencias* 2018;**30**:35–40.

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.