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EDITORIAL

Hospital medical emergency teams and fears of COVID-19: the double-edged sword of pre-alerts

In this issue of the *Internal Medicine Journal*, Subramaniam and colleagues[1] found a Code-95 pre-warning of suspected or confirmed COVID-19 infection to be well received by medical emergency team (MET) staff responding to deteriorating, aggressive and arrested patients at Peninsula Health, Melbourne.

Although four of five staff supported adding Code-95 announcements to MET and aggression management team activation, the notification remains a double-edged sword. Nine of 10 MET team staff members reported anxiety during resuscitation care or behavioural containment.

The fear of cross-infection as staff hurry to a Code-95 MET is to be expected. Whether anxiety in responding teams led to enhanced personal protective equipment (PPE) use, or could have impeded individual clinician and team level resuscitation performance, remains uncertain from this study.

Pre-communicated COVID-19 cross-infection risk could enhance staff well-being by alerting the impetus to take meticulous care with PPE donning and doffing, better adherence to COVID-19-safe advanced airway management,[2–4] and COVID-19-safe Advanced Life Support practice,[5,6] in the heat of the moment. In contrast, the 'to be fore-warned is to be fore-armed' Code-95 strategy could incite self-interested hesitation to respond to MET calls and the delegation of 'at the bedside' occupational risk to more junior doctors by team leaders. This worrying MET team psychodynamic, only able to be discerned in a cross-sectional anonymous survey,[1] runs contrary to recommendations that the most experienced clinician be tasked with intubating[2–4] and orchestrating advanced life support[5,6] in critically ill patients with suspected or confirmed COVID-19.

Usefully, Peninsula Health's COVID-19 prenotification reminds staff to be vigilant with PPE use and practice COVID-19-aware critical care during MET calls. However, potential benefits could be countermanded by the heightened anxiety degrading MET team performance, inciting a reluctance (even refusal) to respond to emergency calls, and inappropriate delegation to junior staff to respond to avoid personal risks of infection. Without a contemporaneous MET response cohort that did not incorporate a COVID-19 alert, the interplay of these positive and negative factors able to be attributed to a COVID-19 MET pre-alert, as it relates to team achievement and ultimately patient outcome, remains elusive.

The imposition of senior to junior hierarchical gradients that disrupt MET team dynamics could well be exacerbated by the lack of confidence in sufficient PPE provision, a prescient concern for 70% of the survey respondents at Peninsula Health during Melbourne's 2020 COVID-19 peak. Adequate PPE for intubating staff remains a global concern in a large international COVID-19 airway study.[7]

The solutions may be in meticulous PPE training, partnered and witnessed donning and doffing of PPE at MET calls, intensive COVID-19 critical care simulation, hospital trust in the equity of cross-infection risk distribution when responding to COVID-19 MET calls, and fair-minded adequately supervised rostering to COVID-19-red hospital zones.

Unfairly electing not to be part of a COVID-19 MET response due to fear of contagion, and the reverse situation of carelessly altruistic heroism, could both be mitigated by occupational health and safety assessment of baseline health risk and ongoing counselling to optimise mental and physical well-being during a prolonged global pandemic threat.

Importantly, COVID-19 pre-notifications could serve to increase MET staff awareness of early symptoms of cross-infection, improve systematic surveillance of MET responders for early testing and enhance the self-protective reflexes that help one's psychological and medical welfare during MET calls, as well as for the long run. Surely such assurances are also good for worried family members and staff keen to remain healthy to continue working into the future.

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Joseph Ting

School of Public Health and Social Work, Queensland University of Technology, Brisbane, Queensland, Australia

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