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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Defining the Recovery

All human wisdom is contained in these two words—wait and hope.

–Alexandre Dumas

The pandemic introduced new phrases, collections of words, that have seeped into our unconscious and define this period. Phrases like "flatten the curve," so pervasive that it has its own hashtag, or "shelter in place," which raises images of natural disasters. There are other words and phrases that personally define the pandemic.

"Hyperlocality," a neologism, emphasizes the unique coronavirus disease 2019 (COVID-19)-related experiences of each of the communities served by our radiology practices and health care institutions. In the State of Michigan, the number of deaths in Washtenaw County, including the city of Ann Arbor, is only 4% of that in neighboring Wayne County, including Detroit [1]. Intensity and duration of COVID-19 care delivery and the impact on ability to resume elective services vary immensely with downstream consequences on institutional and practice losses, potential reduction in staff, and compensation reduction. Although we seek to predict the future, models that project rates of service resumption make key assumptions that individual practices must validate for their own situation before implementing system responses. Multiple institutions present their data showing the magnitude and time course for imaging reduction rates that reflect their institution capacity, their local rate of COVID-19 infections, and state-level shelter-in-place regulations [2-5]. Although the shape of the curve is similar, hyperlocal variables introduce variability. One institution modeled service recovery informed by hyperlocal considerations [2].

"Time is elastic," as elastic as the waistband of my work-from-home pants. Stretching out to the horizon without change where we cannot imagine a life after COVID-19, then snapping forward in our race to reopen. Practices convert to a skeleton crew or a Lombardy model with teams alternating by weeks to decrease the probability or consequence of an infection. Working from home, normally a luxury, puts new demands on our time when coupled with new childcare and homeschooling duties and the need to protect those in our household who are most vulnerable. The situation highlights with uncomfortable clarity the persistent gendered expectations of home work, adding to the risk of burnout that each of us already has. Prolonged or repeated exposure to insult can transform that burnout into posttraumatic stress disorder [6]. Some of us ask, what is our ethical obligation to care for the sick and at what point does the risk become too great [7]?

"Patient-centered care" assumed a more urgent meaning as we sought to keep patients away from health care facilities to reduce their risk. The ACR provides guidance on safe resumption of routine care as we prepare to welcome patients back [8]. An expert panel also provides recommendations on management of lung nodules during the pandemic [9,10]. However, as much as we have guidance from professional societies, we have to convince patients to trust in our ability to protect them before elective service volumes will normalize. New communication and scheduling mechanisms as well as restructuring the physical space in the waiting room will go a long way toward reassuring them [5,10,11]. Less frequently represented in the radiology literature is the impact of COVID-19 on patients. What are the health consequences of delayed or foregone care? Economic shocks to the system have left patients even more vulnerable to costs of care and other barriers such as patient trust in the system to protect them. Although we can increase capacity, patients may continue to delay to seek imaging.

"Trust" and "transparency," recurring leadership themes in times of plenty, take a heightened importance in management during a time of great uncertainty. At all levels, we take on risks and make decisions under imperfect conditions in which one or more key variables governing the decision remain unknown or unknowable. Leaders who communicate early and often and with great transparency reassure us [12]. Leaders who trust those who work for and with them engender a spirit of camaraderie even under sacrifice. This spirit of camaraderie relies on inclusion; particularly as the venues in which we convene have become virtual, nuance of interaction has become more difficult to detect and communicate [13,14]. As public

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discourse becomes tenser, how do we maintain the trust in each other to constructively address fraught situations, such as a casual comment about the "Asian virus," or engage as allies to diffuse tension? We are relearning methods of communication as technological modes promote depersonalization of others.

"Rapid" as an adjective as become a benchmark for the adequacy of collective response to the pandemic, with rapid response tests, rapid issuing of shelter-in-place regulations, and rapid reopening of shuttered businesses. Much work on COVID-19 has been shared through preprint servers, non-peer-reviewed hosting services that allow for public comment and vetting of emerging data. The desire to introduce and share research through these services and the apparent success at least with regard to COVID-19-related data call into question the relevance of the scholarly publication that navigates a sometimes prolonged peer-review process. The *JACR* has responded quickly to the need for rapid review and dissemination of COVID-19-related information to help practices manage the acute phase of the pandemic and signpost the coming recovery by using an existing expedited peer-review process for high-impact manuscripts and fast-tracked online publication of preproofs.

Our time-to-online publication for these manuscripts averaged 10 to 14 days with a capability to publish preproofs online within 3 days of acceptance. At least for the content within our mission, our efforts have resulted in faster data and knowledge dissemination in a rapidly evolving situation. Necessarily, these materials appear in print up to 2 months after online publication, because of the publishing production process. Information on the acute stage of the pandemic become out of date between online and print publication. What then is the purpose of the print journal? A historical document for posterity? A device for institutional and practice reflection after the normalization? A need for those who rely on print to make science seem "real" or more tangible than online-only publication? The move to online-only journal publication has not gained much traction among established imaging journals, although many more discussions have taken place because of climate change. It is unclear if concern over print as a vector for COVID-19 infection will accelerate this change.

We wait to see if our prognostications about the recovery are useful. We hope that patient trust in the system overcomes fear so that we can atleast mitigate the inevitable crisis of undiagnosed illness such as stage shift in breast cancer from delayed screening or surveillance and deaths from acute conditions such as heart attacks or strokes. Regardless of the V-, L-, W- or any other letter that one thinks is the shape of economic and practice recovery, we will be digesting the consequences of the pandemic for years to come.

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