In response to crisis, is versatility a reward or a necessity

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For many clinicians the feeling that there was to be a light at the end of the COVID-19 pandemic tunnel always felt illusory. The emphasis has been on adopting best clinical practice from rapid sharing of experience and deepening basic science understanding. This edition of *Clinical Medicine* includes a range of manuscripts demonstrating this versatility. One of the earliest molecular lessons from COVID-19 was that the virus utilised the angiotensin converting enzyme (ACE) 2 receptor axis to facilitate binding of the spike protein of SARS-CoV-2 and, hence, permit viral invasion. As with the pulmonary alveolar epithelial cells, endocrine organs also express this membrane-bound protease and may thus result in endocrinopathy. Mung and Edward present a literature review about this emerging disorder, highlighting the multi-organ involvement.[1] The article highlights the metabolic predictors of the disorder and signposts the guidelines that have been developed to identify and manage it.

The pandemic has presented a huge challenge for healthcare providers, nowhere more so than in acute medical units, which are the first point of management for most medical inpatients. The effect of COVID-19 on the function of these units, and how they reorganised their structure, is the subject of a study by Soong *et al* covering 10 hospitals in five countries and three continents during the first wave of the pandemic.[2] The success of these reconfigured acute medical services created operational learning that enabled prioritisation of resources during subsequent waves. There are also key papers looking at the service response in oncology, both in an acute setting as well as cancer outpatient care.[3,4] Peritoneal dialysis patients are another vulnerable group who have been less studied. Balson and Baharani report on a novel patient-reported questionnaire tool to document patient experience.[5] They identified unmet needs in this patient group that have implications for future care.

Narrainen *et al* report a retrospective cohort data analysis from a south Wales teaching hospital demonstrating the protective effect of previous infection in healthcare workers during periods of high prevalence of COVID-19 during the second wave.[6] Nevertheless, reinfection can occur, and supports the continuation of public health measures. The paper addresses the question of duration of protection, and this has implications for the vaccination programme. The authors speculate on the likelihood of reinfection with the emergence of variants with time and with progressing population immunity.

This edition's CME topic is obstetric medicine, and covers the increasingly complex management needs of women with pre-existing medical conditions who are successfully conceiving.[7–11] Presentations are often coloured by the cardiovascular and endocrine changes in pregnancy and the sequence of articles covers commonly encountered scenarios (cardiac, liver and metabolic). Clinical adaptability is key to early diagnosis and optimal management of medical problems complicating pregnancy.

A further aspect of flexibility relates to the way that regulators, like the Care Quality Commission (CQC), use data from national audits. Assessing standards of care against key benchmarks set by national clinical audit steering groups can be used to determine local quality improvement processes. A paper by Grote *et al* from the CQC describes how regulators can use outliers from national audits in the regulatory process.[12] The article sets out how the CQC uses data from national audits, and the statistical processes used to identify outliers. Learning from exemplars emerges as a key way that organisations and medical leaders can drive improvement in patient safety and outcomes. ■

Anton Emmanuel
Editor-in-chief

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