Emergency Departments Aren’t Trained for Long COVID—and Patients Are Paying the Price

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I was bent over in a hard plastic chair, my heart aching, hands swollen, and felt like I had the weight of a brick pressing down on my chest. Every breath required energy I didn’t have, and it hurt to expand my lungs within the too small space inside my rib cage.

But the nurse at the triage desk in the emergency department said my oxygen looked fine. “That’s reassuring, so try to relax,” she told me, eyes fixed on the screen as her fingers tapped at the keyboard, never looking up.

I’d been diagnosed with pericarditis by my cardiologist, I told her, and something felt wrong. My symptoms weren’t normal for me. She glanced at me and shrugged. Hours later, when I finally saw a doctor, he told me the electrocardiogram results were normal and the hospital didn’t have the equipment to test me in more detail. He discharged me with a suggestion to follow up with my primary care doctor, or wait to see my cardiologist privately in a few weeks’ time.

By now, this pattern is as familiar to me as my own reflection. Ever since my initial SARS-CoV-2 infection three years ago, my body has never fully recovered. Now, at age 35, I live with long COVID. Complications like cardiac inflammation, chest pain, and breathlessness regularly flare, sending me back to emergency rooms — into the hands of doctors who aren’t trained to understand the fallout of the SARS-CoV-2 virus.

When I was finally able to afford an appointment, my cardiologist confirmed a recurrence of both pericarditis and pericardial effusions. I wasn’t imagining things. I started treatment. It helped — until this cycle repeated.

What do you call a system that doesn’t believe you’re sick until you’re dying?

Long COVID is a global health crisis, affecting over 400 million people worldwide. Its cumulative effect has overwhelmed unprepared healthcare systems.

While emergency clinicians are trained to handle acute medical situations, many lack even a basic understanding of long COVID and related diseases, such as myalgic encephalomyelitis (ME). Most are unprepared to recognize or manage post-exertional malaise, a key feature of ME and some cases of long COVID, which can turn a long wait in a loud, fluorescent-lit room into a debilitating crash. This gap in training is more than just an oversight, it's a critical failure — particularly when individuals with complex, long-term symptoms urgently need specialized care.

What's more, without mask mandates and clean air upgrades, many emergency rooms and hospitals actively put people at risk of getting infected with SARS-CoV-2 during the ongoing pandemic. Data from Australia, where I live, showed that hundreds of patients died after catching COVID-19 in hospitals. People with long COVID can't risk getting reinfected while seeking care.

Emergency departments weren't built for chronic illnesses. But the system is driving more and more of us through their doors. And without urgent investment in clinical education, EDs will continue to fail patients who can't afford to be dismissed. Many cardiac and clotting conditions, like deep vein thrombosis, often go overlooked, despite research showing COVID-19's impact on the cardiovascular system.

Like many others with long COVID, I'm mostly housebound, unable to work, and left navigating a maze of unconnected services that feel completely out of reach for people like me. When I land in the emergency room, it's usually not because it's the right place — but because it's the only place. For many of us, what should be a last resort becomes a repeat trauma.

The issue is, most doctors have little to no experience managing long COVID. And for those who do? Many are specialists whose fees aren't covered by public healthcare and who charge hundreds of dollars per appointment, making essential care inaccessible for many of us.

Those most affected — people like me, who can no longer work or support ourselves — are often living on disability pensions, struggling to afford the basics, let alone pay for these specialist appointments. As a result, countless people in our position are forced to seek help in emergency departments, even though we know this isn't where we belong.

There are potential solutions that could help bridge this gap and provide timely care. One crucial step is addressing the glaring lack of training among emergency department staff, ensuring they're equipped to manage the complex, long-term, and often serious symptoms of long COVID.

Such training is available, but it isn't reaching the right clinicians. In 2023, the nonprofit Emerge Australia ran a series of clinical education sessions for providers on ME and long COVID. Among the hundreds of attendees, only one worked in an emergency department.

"We don't have evidence of full [emergency] departments undergoing any of our training," said Kate Herbert, nurse educator at Emerge, in an email. "At a national acute care conference a few years ago, multiple ED nurses told us they'd never even heard of ME/CFS."

And without sustained funding, Emerge may not be able to continue these sessions at all, despite interest from the medical community.

“We deliver this clinical information on the smell of an oily rag and a lot of generosity from speakers,” said Herbert — using an Australian idiom that refers to extremely limited resources. “With ongoing, increased funding, there is so much more we could do.”

This gap in clinical education isn’t just an Australian issue — it’s global. In the U.S., training initiatives like Project ECHO have made strides in supporting providers but are now facing potential cuts under the Trump administration. Meanwhile, advocacy groups and research centers are stepping in where institutional systems fail.

For example, a campaign from the ME advocacy group #MEAction aims to educate healthcare professionals about ME and its connection to long COVID. The Bateman Horne Center, supported by the Open Medicine Foundation, recently developed a clinical care guide offering clinicians clear, actionable recommendations for managing ME, long COVID, and other infection-associated conditions. Still, without continued funding, even the most promising programs risk disappearing before they can create lasting change.

While long-term structural changes in medical education are essential, the immediate suffering of patients with long COVID and chronic illnesses demands action now. We cannot afford to be left behind or rendered invisible any longer.

A critical first step is focused, accessible training for emergency department staff and general practitioners. Short webinars or online modules — funded and taught through organizations like Emerge Australia, the Council of Medical Specialty Societies, and the Open Medicine Foundation — can provide essential, evidence-based knowledge on recognizing and managing long COVID and related conditions. These can be rolled out quickly, allowing clinicians to better understand symptom presentations and offer acute support.

In addition, healthcare professionals with expertise in chronic illness can establish rapid response teams within emergency departments. These teams could offer immediate support to triage patients effectively, provide on-the-spot advice, and ensure appropriate referrals to specialists if required. This would help alleviate the burden on emergency staff and improve patient outcomes in real time.

Expanding telehealth options is another immediate solution. Virtual care can help people in rural or underserved areas access specialist support without needing to turn to emergency departments. Recent research shows telehealth is already effective for long-term monitoring, early diagnosis, and treatment — particularly for people with complex diseases like long COVID. By combining these two strategies, we can begin to make real, practical improvements in how people with long COVID are treated — meeting immediate needs while working toward long-term systemic change.

Many of us are used to being disbelieved. Despite all the research on long COVID’s impacts on numerous organ systems, we’ve had our symptoms dismissed as anxiety. We’ve been told it’s

“just stress.” We’ve learned to question our own bodies. And when the very system meant to care for you continues to echo that doubt, it does more than hurt. It leaves you unsafe.

I’m not asking for miracle cures. What I want is simple: to be heard, to be taken seriously, and to have access to timely, informed care that recognizes the reality of these diseases. Because without that, people like me will continue to be failed by a healthcare system that isn’t just unprepared for us — but is unwilling to evolve.

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