" COVID-19 PANDEMIC: LESSONS LEARNT AND THE NEW NORMAL AS I SEE IT"

As we stand face to face with one of the greater humanitarian tragedy of the corona virus disease 2019 (COVID-19) pandemic, we are currently grappling with several mighty questions regarding the possible return of Normalcy, or a complete change of what we would previously call as Normal? But from where I stand, I can see seismic shifts all around and probably this is what looks like the threshold of a new era, the road to **"The New Normal"**.

In March 2020, World Health Organization (WHO) declared the COVID-19 pandemic outbreak. Ever since, the pandemic has spread widely across the world. COVID-19 is not solely a health crisis, but rather a crucial issue affecting the social, ethical and economic dimensions of the human life, governments and countries.

Humans are not very good at valuing preventative measures, which inevitably means we underinvest in disaster prevention. This phenomenon is amplified in democracies. Roselyne Bachelot was a minister in the French government between 2007 and 2010. In the face of the H1N1 swine flu outbreak, she ordered 1.7 billion face masks and millions of doses of the vaccine. Only a fraction of these supplies was used, and the remainder were thrown out. Bachelot's political career was over, her reputation reduced to this single example of wasting taxpayers' money. This is a classic case of "outcome bias," in which people are judged by the outcome of their actions with the benefit of hindsight (in this case, buying supplies that were never used), rather than judging Bachelot's decision by the information available at the time it was made (the threat of a pandemic outbreak).

Imagine two neighbours with the exact same property buy an insurance policy of 100 rupees each. The next month the first house catches fire and this family gets covered for the entire damage. In the flip side, the other family pays the same 100 rupees for the next 40 years and never sees a dime in return. So, to judge either of them would be succumbing to outcome bias.

I may be asking the question impishly, but the pandemic disaster scenario looms large as most hospitals in our country are so unprepared that they do not even have enough respirators to treat their patients with severe symptoms. Such was the level of unpreparedness that the government was not even testing patients who claim that they have all the symptoms of the coronavirus The disease was brought in India by the 'have's and the sufferers are the 'have not's.

Asia can derive a simple lesson from the European experience. Make rapid and extensive tests and impose quarantine and reverse quarantine, especially for the vulnerable age groups which are either less than 10 years of age or are more than 60 years of age and also the ones with any comorbid conditions.. Therefore, all gatherings of more than 10 people except in public transportation and at work, should not be encouraged at all and, if possible, made illegal. People in quarantine should be monitored 24 hours a day.

As is witnessed in many countries, the vulnerable population is treated as second-class citizens with no future. Some of the examples in this regard are the tests that have not become routine for everyone (especially for the elderly), post-acute care services, long-term facilities decreasing the admission rate of the elderly, death of the elderly residents of the nursing homes due to the abandonment of work by their caregivers, and due to the lack of equipment, intensive care unit beds, and ventilators as the elderly are detached from the ventilator to give younger individuals a chance to live. The current situation is alarming due to insufficient medical equipment and shortage of medical staff, which will eventually lead to a moral dilemma in deciding who should be prioritized for the use of healthcare services and who should be detached from the ventilator. The social apathy and the stigma towards patients who tested positive is gut-wrenching and we, as intensivists are

looking at a future that will be plagued with anxiety and depressive mood disorders for us watching such unprecendented numbers of death, reminding us of those old, wide eyes, looking at us through those glass windows, silently asking us for some physical touch, without those rubber gloves, while slowly slipping away and becoming shadows.

Overzealous use of sanitisers will be the new cool in the coming years making sure that dermatologists do not go unemployed with an array of skin diseases at an all time high. Our wardrobes will now have various coloured, exquisite masks to go with our fanciest clothes.

The new normal has given rise to the rapid adaption of emerging new technologies which are becoming pervasive across industries and markets. There is an increased use of data and public cloud as more people are realising the speed, scale and security one can get from using them.

To quote the president of Microsoft India-"Better appreciation of what analytics , artificial intelligence and machine learning because in this space today, we are creating models from different parts of the world , bringing it together and then seeing how to tackle something of the Unknown."

More hybrid work culture i.e. neither complete work-from-home neither complete work-from-office has come into play. There is a pressure in commercial real estate market due to decrease in office space requirement. It is a digitally driven delivery market. Current economic disruption will make those with a strong balance sheet stronger and those lurking in the corners will slide away in anonymity.

The healthcare response to COVID-19 will remain a priority for an anticipated 18-24 months as countries implement phased relaxation and restrictions to suppress the virus, expand testing and treatment capacity and find better therapies,monitoring of indicators like proportion of quarantined people tested positive, positive predictive value, change in infection fatality rate etc should be strengthened and should be a multi-disciplinary approach involving various disciplines.

There are three key shifts that have been seen:

1. **New paradigms for infrastructure, geographic distribution of providers and care settings:**
   Designs that maximise infection control (for e.g.- more single, flexible HVAC systems) as well as how capacity for intensive/ critical care is integrated into hospital layout and user experience with the ability to quickly convert regular reds to intensive/crucial care beds, will be given more importance.
   Providers may need to examine their ability to scale up and create multifaceted resources.

   A shift towards virtual ICU (i.e. ICU) models is underway. Mercy virtual in Pennysylvania is an example where patients are at home and intubated with a nurse while critical care specialists monitor remotely.

2. **Operational excellence which will be crucial in the next chapter:**
   Dedicating specific areas, either within hospitals where COVID-19 patients are managed or in non COVID 19 facilities to be earmarked for delivering care for critical/ high risk patients such as cancer patients or any other elective cases. These facilities may become a permanent feature of the healthcare landscape.

3. **Emergence of new growth opportunities and diversification:**
   Numerous examples exist worldwide of virtual care sometimes supplanted with artificial intelligence.

A single digital first “front door” for health services is being established.
The journey stats with an app or online and is then redirected to the optimal care setting regardless of physical or virtual modality.

Growing categories of remote/online services will naturally require more input of clinical information. Some basic services can be fed through home-based devices, but more is expected to be collected through specialised facilities available in convenient locations such as pharmacies, imaging centre and pathology labs.
Accelerated transition to ambulatory care and day care surgery will be promoted. Inpatient stays will likely to be less desirable. Patient will have to avoid hospital stays whenever feasible, accelerating the transition to ambulatory care settings for increasingly complex care and procedures.Regional anaesthesia would be the mainstay for main procedures.
Governments are already exploring innovative partnerships with the private sector to manage the crisis. These partnerships may continue in the future and take many forms, including funded mandates for capacity.
Humanity, is moving through a war zone and where technology is taking an upper hand to human interactions, the rampant social distancing and the aggressive use of virtual mode of interaction will push the mankind to hide behind screens and masks and would once again paralyse our ability to show and express all forms of physical love.

India spends only 1.2% of its Gross Domestic Product on healthcare. And with that figure, the country ranks in lower than Singapore which has the lowest ranking in healthcare services. It is time the country resets its priorities.We must learn our lesson and discover the weaknesses of the healthcare systems and if there is one thing that I hope will slay beyond this challenging time, it is the way of looking at Anaesthesiology and critical care as a branch which hopefully will help combat other diseases in the future as it did with this notorious one.