Big things do come in small packages or rather a pandora's box. Its hard to even imagine that something as small as 0.00000012 m could be responsible for such wide scale mayhem. In the wake of the COVID 19 crisis the world seems divided between fear mongers' and skeptics. Every country seems to be gasping for air in the expanse of financial grief, limited infrastructure and overwhelming caseload of patients that seems to be drowning them. Developed nations of the west who long sat on the proverbial high horse have been equally humbled. That is the true nature of this disease the genesis of desperation. The only way to combat this is to develop strategies to refine, replace, or substitute medical or logistical practices on the basis of its sustainability during the current pandemic, and for the future, as a critical component to pandemic or disaster preparedness

India is one of the largest producers of doctors yearly but still fails to meet the adequate doctor to patient ratio. The inadequate facilities and overwhelming population hang as a noose on the country's healthcare system. The country struggles to battle each and every one of the many communicable diseases rampant due to gripping poverty, lack of basic sanitation and poor awareness on general hygiene practices. As the coronavirus spreads throughout the country the focus has shifted from the many diseases to just one. One must applaud the strict imposition of lockdown to help curb the spread of the virus, mandatory face masks and advocation of basic hygiene practice of hand wash which in the long run will also help weed out the other communicable diseases.Adequate investments in healthcare and research can contribute to the coordination, cooperation and creation of international networks to attain an appropriate response to outbreaks and pandemics. Efficient communication and quality information are essential throughout the pandemic process. A little knowledge maybe dangerous but disinformation is even worse and can weaken the correct collaboration of society and the global outcome of the crisis.

In hospitals, aligning operational and policy action is paramount. However, translation of operational and clinical demand into day-to-day activity under a pandemic situation is extremely challenging. While the containment and eradication of coronavirus is a foremost priority, there seems to be an acquired blind spot that other diseases have fallen into slumber and it is imperative that an equal amount of equity and resources be allocated to continue battling them. Telemedicine can help contribute to minimizing the risk of exposure. At present there is a greater importance in following strict infection control standards, smooth coordination with the staff and management, standardizing procedures and policies, providing education including for implementation of infection control measures, and supply preparation and logistics management which would ultimately help prepare for future pandemics, outbreaks, natural disasters, and mass casualty events that will continue to challenge hospital resource management..

A great deal of acclaim should go to the nurses and various clerical and janitorial workers who not only stand the risk of exposure by turning up for work each day but do as at the cost of reduced salaries. To most of the healthcare workers who are often the sole bread winner of the family, even a mild decrease in their regular paycheck has unmeasurable consequences but they do so due to their commitment to their job. It is the dedication and hard work of this entire workforce that inspires hope for a better tomorrow. In light of this, measures to enhance communication among physicians and other health professionals should be implemented and a direct channel to care for professionals who reported anxiety or presented signs of COVID-19 epidemic-related burnout.

Anaesthesiology finds itself again entwined with a global pandemic. As an anesthesiologist a majority of our life centers around damage control. Blink of an eye dilutions to achieve the impossible. As much as a stitch in time saves nine so does an intubation or two. The contagious and potentially devastating nature of COVID19 has violently disrupted anaesthesia practice which has shifted from elective procedures to a case by case priority of an emergent nature. The advocacy of regional anaesthesia has never been so resounding in the hope of avoiding any procedure that generates a lot of aerosols namely intubation, extubation or suctioning. But on the off chance that we do need to intubate the patient the preference for video laryngoscopy to distance ourselves from the larynx while also maintaining an adequate visualization is preferred, As an inherent design most hopitals lack negative pressure operation theatres and it's hard to follow stringent international guidelines of procedure in a country lacking the resources to do so but as necessity is the mother of invention, isolated theatres have been identified to handle suspect and positive cases in many hospitals which adopt small simple practices that on a large scale try to prevent the spread of aerosol generation including withholding the use of the air condition in the case especially during and after intubation, advocacy of personal protective equipment and postponing non emergent cases.. The use of personal protective equipment not only provides both a literal and figurative sound barrier in preventing the spread of the virus but also provides a barrier in demonstrating skill which can be particularly difficult especially with novice anesthesiologists. Disposable materials are ideally used with terminal disinfection after the end of the procedure.

As a resident in training, it is understandable that our education is not the utmost priority in a pandemic but the question lingers who will compensate us for the acute shortage of elective procedures that we get to experience and at the end of our course and who will make allowances for a gap in our learning. The introductory month of learning is highly structured with emphasis on bag and mask ventilation and direct laryngoscopy. Most hospitals have set up airway management teams, which exclude junior trainees. Some centres chose to keep first-year trainees away from clinical activity, prioritising their safety. The pandemic has disrupted the structure and content of curriculum compliant training programmes. Cancelled educational activities, postponed examinations, and altered rotations threaten progression through training. In response, anaesthetists have developed innovations in teaching and trainee support. New technologies support trainer–trainee interactions, with a focus on e-learning. The need for developing an adequate practice of simulation-based teaching could temporarily substitute formal education at least when it comes to honing skills, Attention to wellness, awareness of mental health issues and multimodal support can attenuate but not eliminate trainee distress.

The role of an anesthetist in the ICU is of paramount importance especially when it comes to airway, resuscitation, and ventilator management. The respiratory failure associated with COVID-19 has been observed to differ from conventional acute respiratory distress syndrome. We must therefore resort to our clinical acumen to modify ventilation protocols. Adoption of prone positioning may improve oxygenation and decrease mortality in awake, non-intubated COVID-19 patients with severe acute respiratory distress. Care must also be taken in the transport of the intubated patient to the intensive care unit via closed circuit ventilation and to avoid unnecessary disconnections. One can't help but be empathetic to the patients with COVID 19 that get admitted to the ICU, cut off from their family and whose only human interaction or source of comfort is by men and women in hazmat suits. The

challenging conditions of the intensive care unit has only increased due to the limited number of ventilators and the ever-increasing patient load. Decisions of turning patients away or allocating a ratio of ventilators to non COVID patients need to be made which is a logistical nightmare. How do we decide which disease has more value, which life is worth saving or how advanced must the disease be for to give up? If the disease doesn't kill you surely the isolation will. The hope for a cure though alluring is exhausting.

Anaesthesiologists have been pulled from behind the screen to the front lines, maintaining a tradition of ingenuity and dedication. The role of anaesthesiology in the COVID-19 response reflects the legacy of its pioneers. Just as the polio epidemics drew on anaesthesiologists from operating theatres for cardiorespiratory support, so has the COVID-19 pandemic. The vital role of anaesthesiologists will also be better appreciated by both colleagues and the public, with the realisation that anaesthesiologists are indispensable and adaptable physicians beyond the operating theatre. The practice of anaesthesiology, however, retains its fluidity from the operating theatre, ICU, and medicine/surgical ward. This uniquely interdisciplinary skill set has enabled our colleagues to continue researching treatments and improvising equipment in the midst of uncertainty. These may be unprecedented times, but our specialty has had a long and consistent history of confronting and overcoming epidemic and are uniquely able to influence the resumption of normal hospital activities and the preparation for future public health threats.