**INTRODUCTION**

Warning bells and alarms are ringing all over the world since SARS CoV-2 invaded the World in 2020. Arguments in favour of harsh control measures are flying in from all directions. This communication is aimed at finding the plausible reason for the panic which SARS CoV-2 has generated. Crude death rates of 2019 [Table 1] from select countries of the present interest in terms of mortality or scale of spread may help us understand the same. The crude death rates were related to the proportion of senior citizens in a country and developed countries had more disease burden on that account alone. Medical care had gone from primary care to specialized care in most of these countries. The unavoidable deaths were distributed evenly across multiple levels of health care and region. The apparent numbers of deaths per year were staggering as shown in Table 1. The medical fraternity was able to take care of the load as it was spread across 365 days, even after taking into account, the seasonality of some of the diseases.

The manpower requirements in the sub-specialties were met, in an average year, so that the numbers became manageable without panic. A country like India, which had about 10 million deaths per year, was managing the situation reasonably well in 2019, with about 27487 deaths per day, spread across hospitals and multiple specialties. The year 2019 was pre-COVID. Now we realize that SARS CoV-2 has upset the balance of care across hospital settings. To quote another country exemplar, 1756 expected deaths per day in Italy has become distributed differently now. On 28th of March 2020, there were 887 deaths in Italy due to SARS CoV-2 which was about half of the expected number of deaths per day in the country (Table 1). Instead of the deaths happening across multiple sub-specialties and in different settings, there is a rush for emergency medicine rooms (or Emergency Rooms (ER)) and critical care units (or Intensive Care Units (ICU)). Even if we were to deploy the internists into the fray, the hospitals have limited number of ER and ICU beds. The surge had become unmanageable. Patients were not able to get to their doctors. The short supply of the needed specialty was too small against the huge demand.

The seeming lack of proportionality stunned the World in general. Specifically, Spain clocked Proportional Mortality Rate (PMR) of SARS CoV-2 (CoVID-19) of 70-59% in a given day on 28th of March 2020. Since, the hospitals were not fully ER/ICU oriented, the routine services were affected.
severely. Italy fared behind Spain with 50.51% of all expected deaths ascribed to COVID-19 as was indicated earlier. The ER/ICU oriented sub-specialties were not staffed adequately for this surge. Every other patient with co-morbidity belonging to various other sub-specialties was congregating in these two areas of the make-shift hospitals with under-trained staff. Over the succeeding week, the proportional mortality rate (PMR) due to COVID-19 seemed to fluctuate, as exemplified by United Kingdom and France (Figure 1). United States of America seemed to struggle with a PMR of 5.32% due to COVID-19 which rose quickly to 14.6%. Over 90-day-periods preceding the corresponding dates, which were shown in Figure 1, the PMR stayed more or less steady in all countries (Figure 2). The variations between countries seemed to be due to extraneous factors such as existing percentage of all-cause-deaths from old age (F = 5.244, degree of freedom = 1; p = 0.045) as per repeated measures ANOVA.

India and other countries are, now, gearing up for the worst! China seems to have conquered the infection after the fight which lasted for 3 months. The lesson is clear; all doctors must be intensivists! The hope is that we will be able to handle the surge with adequate preparedness in the coming months. Hospitals have to turn into COVID-19 centres where specialties merge in the spirit of One-Health that World Health Organisation adopted in order to fight the emerging zoonotic diseases. A single enemy cannot afford to monopolize the body counts in the face of a low proportion of trained people for such specialized areas. This virus pandemic is making it necessary for the health profession to bring down all specialty barriers, and has made us pivot to orient ourselves as Corona virus specialists. A rapid orientation is needed to enable this training, including the management of critically ill. Such management teams in the hospital shall be led by a critical care specialist, but all sub-specialists and generalists may be enlisted to manage patients in groups. The front-line dispatches from Italy/Spain indicate that the pandemic is forcing such measures.

**Table 1** Distribution of Crude Death Rates and COVID-19 related mortality

<table>
<thead>
<tr>
<th>Country</th>
<th>CDR 2019</th>
<th>% Elderly Death</th>
<th>Population 2020</th>
<th>Estimated deaths</th>
<th>Expected deaths per day (all causes)</th>
<th>Deaths due to COVID-19 from 28-Mar-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>11-3</td>
<td>85%</td>
<td>83,783,942</td>
<td>806,739</td>
<td>2,594</td>
<td>64 (2%)</td>
</tr>
<tr>
<td>Italy</td>
<td>10-6</td>
<td>89%</td>
<td>60,461,826</td>
<td>640,895</td>
<td>1,756</td>
<td>887 (51%)</td>
</tr>
<tr>
<td>UK</td>
<td>9-4</td>
<td>85%</td>
<td>67,886,011</td>
<td>638,129</td>
<td>1,748</td>
<td>260 (15%)</td>
</tr>
<tr>
<td>France</td>
<td>9-4</td>
<td>85%</td>
<td>65,273,511</td>
<td>613,571</td>
<td>1,681</td>
<td>319 (19%)</td>
</tr>
<tr>
<td>Spain</td>
<td>9-2</td>
<td>86%</td>
<td>46,754,778</td>
<td>430,144</td>
<td>1,178</td>
<td>832 (71%)</td>
</tr>
<tr>
<td>USA</td>
<td>8-8</td>
<td>74%</td>
<td>331,002,651</td>
<td>2,012,823</td>
<td>7,990</td>
<td>425 (5%)</td>
</tr>
<tr>
<td>Canada</td>
<td>7-8</td>
<td>82%</td>
<td>37,742,154</td>
<td>294,389</td>
<td>807</td>
<td>16 (2%)</td>
</tr>
<tr>
<td>China</td>
<td>7-3</td>
<td>72%</td>
<td>1,459,323,776</td>
<td>10,507,063</td>
<td>28,786</td>
<td>5 (&lt;1%)</td>
</tr>
<tr>
<td>India</td>
<td>7-3</td>
<td>49%</td>
<td>1,380,004,385</td>
<td>10,074,032</td>
<td>27,600</td>
<td>8 (&lt;1%)</td>
</tr>
<tr>
<td>Iran</td>
<td>4-8</td>
<td>70%</td>
<td>83,992,949</td>
<td>403,166</td>
<td>1,105</td>
<td>139 (13%)</td>
</tr>
</tbody>
</table>

**Figure 1** Proportional Mortality Rate due to COVID-19 on the reference dates

**Figure 2** Proportional Mortality Rate due to COVID-19 during 90 days preceding the reference dates

*PMR for Hubei was calculated until 15-03-2020

Authors Contributions: TSR initiated the concept, helped interpret the data, wrote as well as corrected the draft and generally guided the process. RA enlarged the concept, collected secondary data, interpreted the same and involved in writing the draft. LJ aided in literature search and discussion of the findings and enriched the script in quality. DC provided improvements to the concept, helped fetch secondary data in addition to relevant literature and aided in the statistics part.

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References


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