

# COVID-19 revolution: a new challenge for the internist

## The next future of COVID-19 epidemic in Italy

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### ABSTRACT

As the main title 'COVID-19 revolution: a new challenge for the internist' states, the global coronavirus infection disease 2019 (COVID-19) pandemic represented a new challenge for the internists. This paper is part of a series of articles written during the difficult period of the ongoing global pandemic and published all together in this fourth issue of the *Italian Journal of Medicine*, with the aim of sharing the direct experiences of those who were the first to face this severe emergency, expressing each point of view in the management of COVID-19 in relation to other diseases. Each article is therefore the result of many efforts and a joint collaboration between many colleagues from the Departments of Internal Medicine or Emergency Medicine of several Italian hospitals, engaged in the front line during the pandemic. These preliminary studies therefore cover diagnostic tools available to health care personnel, epidemiological reflections, possible new therapeutic approaches, discharge and reintegration procedures to daily life, the involvement of the disease not only in the lung, aspects related to various comorbidities, such as: coagulopathies, vasculitis, vitamin D deficiency, gender differences, *etc.*. The goal is to offer a perspective, as broad as possible, of everything that has been done to initially face the pandemic in its first phase and provide the tools for an increasingly better approach, in the hope of not arriving unprepared to a possible second wave.

This paper in particular deals with possible future perspectives in Italy.

Given that the epidemic outbreak we are experiencing represents an unprecedented situation for our time, hypothesizing what will happen next autumn is extremely important for those involved in risk management and clinical risk management in particular.

The coronavirus infection disease 2019 (COVID-19) pandemic represents the event model that brings healthcare closer to aeronautics. In aviation pilots and passengers risk together, the same happens for patients and healthcare workers during pandemics.

Our country, which was one of the first to be hit hard by the epidemic, after China,<sup>1</sup> is currently experiencing a phase in which the infection is fairly well under control: small scattered outbreaks, minor cases and almost empty intensive care.<sup>2</sup> This situation is undoubtedly favored by the public health measures applied so far and by the good weather that allows us to live outdoors. But what will happen when we resume living indoors (school, work, ...) for many hours a day? The much-debated weakening of the virus has not yet been demonstrated and the most accepted hypothesis to explain the reduced virulence is the reduction of the viral load due to physical distancing and the use of masks that reduce the risk of contracting the infection by more than 80%.<sup>3</sup>

It is very probable, however, that we will find ourselves *returning indoors* with a number of infections not equal to zero and without the parachute of the vaccine. Therefore, as in the case of endemic infections - infection constantly maintained at a baseline level in a geographic area independently from external inputs - the balance will be done by individual behaviors, guided by situational awareness. The greater the situational awareness that our country has matured, the less dangerous the future will be.

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Situational awareness, which is the correct perception of environmental elements and events with respect to time or space, the understanding of their meaning and the projection of their status into the future, should not be confused with catastrophism, and its strength is already making a difference in countries such as Japan, where the outbreak was controlled without resorting to lockdown,<sup>4</sup> the long-term consequences of which are still far from manifesting fully.

However, situational awareness cannot be improvised, and it is built with a joint effort between the scientific world, information, politics and society, learning from experience and above all not forgetting. The first rule of risk management is *building memory for organizations*.

Therefore:

- let us limit regionalization in the management of events that affect the whole country;
- let us leave public health out of the political debate, clinical governance should be independent from political and administrative governance;
- let us give priority to skills, while implementing team work;
- let us penalize ambiguous, non-transparent and univocal communication;
- let us continuously monitor the results to gradually adjust the *course*;
- let us protect our healthcare professionals;
- let us intensify tests and better track contacts;
- let us avoid blocking elective health care with all the inevitable consequences of delayed diagnosis and therapy;
- let us reduce the level bureaucracy the system through an *evidence-based administration* that produces documents that are clear readable to all and not incomprehensible decrees and ordinances, the citizens are not jurists;
- let us apply a systemic approach and avoid adopting partial solutions, according to a sequential/hierarchical logic.

The more than anticipated events of phase 1 have been painstakingly chased: masks, intensive care, Health Care Residence (*Residenza Sanitaria Assistenziale*, RSA), swabs, serological tests, management of acquisitions, implementation of the second phase. The answer to be adequate is a set of simultaneous actions; the success achieved in other countries in the management of the epidemic, but also in some regions of our country, depended precisely on a variety of measures introduced simultaneously. In some contexts, the transition from a patient centered care to a community centered care was faster, aware that the epidemic should have been managed in the area.

But above all, let's behave and demand responsible social behavior from everyone: our Health System and economy cannot bear a second wave and a new lockdown.

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