Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

European Journal of Internal Medicine 77 (2020) 138

Contents lists available at ScienceDirect

European Journal of Internal Medicine

journal homepage: www.elsevier.com/locate/ejim

Letter to the Editor

Non-SARS CoV2 positive critical patients: Sons of a lesser God?

As the number of confirmed cases of coronavirus in Italy continues to rise, the reorganization of the hospitals outlined by Grasselli et Al. [1] across the country made wards slowly emptied, elective activities interrupted, and intensive care units freed up to create as many beds as possible.

Simultaneously, in many small, non-hub hospitals, because of the chronic shortage of staff, internal medicine teams -doctors and nurses- often without any formal, adequate training, have been moved to the newly, hastily created COVID wards, where, beside caring for patients' general needs, they just implement the therapeutic protocol the hospital chose (if ever) to treat SARS CoV-2 positive patients, hoping that the drugs they're prescribing out of any evidence do more good than harm [2]. All the clinical competence of the teams most of the time has come down to watching out for clinical deterioration, when the patient is not responding to high-flow nasal oxygen or positive end-expiratory pressure (when available), trying not to miss the right moment to call the intensivist [3].

At the same time, what is left of the internal medicine wards has been clumsily staffed with doctors and nurses with different competences, bewildered and anxious about their new tasks when facing patients of all ages with a wide range of diseases and clinical presentations, from severe dyspnea to acute abdominal pain, from apparently accidental fall to general critical conditions, with different workups, differential diagnoses, prognoses and therapies [4].

Once again, in these small, non-hub hospitals, we are facing a floor-ceiling effect in human resources management: high skilled internal medicine nurses and doctors are (mis)used to take care of patients mostly admitted just because SARS CoV-2 positive and whose clinical course is often sadly dichotomous, whereas non-SARS CoV-2 positive critical patients, whose clinical course has yet to be inferred from medical history, clinical presentation and workup, are taken care of by nurses and doctors with competencies ordinarily developed and valuably implemented in quite different settings of care.

Although *"Res nova et regni novitas me talia cogunt moliri"* [5], still the feeling that in these days "ordinary patients" are deemed sons of a lesser God is strong and worrisome. SARS CoV-2 pandemic has drained all medical attention on treating affected patients, jeopardizing the ability to maintain the standard of care we were used to provide for non- SARS CoV-2 related disease. Public messages on social distancing make people refrain from seeking medical care going to the hospital. Moreover, procedures to protect caregivers from infection will impose to rule out SARS CoV-2 infection on any patient admitted, and any urgent procedure the internist would advise will be delayed awaiting for the results. Non-SARS CoV-2 patients might eventually pay a heavy, unexpected toll because of the dramatic change in practicing medicine we have been forced to. We hope, as Grasselli et Al. pointed out [1], that our health care system, not organized in collaborative emergency networks, will work toward one now, without prejudicing any longer and again internal medicine practice, the very heart of many hospital activity.

Declaration of Competing Interest

I have no actual or potential conflict of interest

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https://doi.org/10.1016/j.ejim.2020.04.047
Received 18 April 2020; Accepted 20 April 2020
Available online 29 April 2020