# Commentary: COVID-19 pandemic and national lockdown: The cascading effect

Recent COVID-19 pandemic has inflicted India in a dreadful way.[1,2] In order to antagonize the continuously rising cases, a national lockdown was imposed in multiple phases.[1,2] All territories were divided into different zones based on incidence and prevalence of the disease and local human movement was governed by this data. While the lockdown worked tremendously in curtailing an abrupt spike in fatalities, its adverse effects have profoundly vandalized the routine and emergency health care services especially in non-COVID-19 dealing hospitals. The financial, geographical, and conveyance constraints have limited delivery of optimal-quality ophthalmic-care to high-risk as well as non-emergency cases. Video-conferencing and telephonic consultations have served as a stop-gap arrangement, albeit, with their own limitations.

A crippled routine as well as emergency eye upkeep is an ill-consequence of lockdown all over India and similar data can be encountered from various dedicated ophthalmic centers of the country.[3] The patients have suffered to gain attention for a problem as miniscule as refractive error to as major as microbial keratitis and retinal detachment. The impact on ophthalmic health is even worse in super-specialty hospitals providing escorted eye care as most of these are also directly catering to COVID-19 infected individuals and may be especially evaded by ophthalmic patients out of fear of acquiring the SARS CoV-2 virus.[3] At our own center which is a multi-speciality tertiary care institution also concerned with COVID-19 infected patients, ophthalmic care has constantly shrunken. A part of this fear can also be attributed to local and national media and social-networking sites where active discussions and passive knowledge are being rampantly circulated.

Adding fuel to the fire is a demanding and inconducive outcome of the outbreak and the lockdown on health care personnel. While the former has attacked them psychologically, the latter has traumatized them monetarily. In private institutions who lack any kind of financial aid from the government, economic deficits have cascaded to salary cuts and job losses with consequent complete shutdown of multiple small-scale centers. In government hospitals where budget is not a primary limitation, digression of doctors from all fields for collective COVID-19 management has created their deficiency in respective departments and ophthalmology is not immune to this. Fortunately, this reduced availability of care-givers has been currently balanced by a concomitant fall in patient inflow. However, as normalcy is restored, this shortfall needs to be filled aptly to combat an ever-increasing patient influx. This is easier said than done as recruitment of new personnel has been presently halted in most centers and seems far from resumption. Also, with suspended retrieval of donor corneas, industrial shut-down and diversion of raw material for production of essential health-care equipment, scarcity of ophthalmic devices is expected to emerge in the future. All this is anticipated to affect novice ophthalmologists and residents in training profoundly by demotivating them in the beginning of their career. While an extension of tenure may boost the latter, the emotional and psychological after-effects needs to be handled sensitively in the former.

To sum-up, the health care receivers (patients) and providers (doctors) should be considered a single unit for all practical purposes. The adverse effects of COVID-19 pandemic and lockdown are going to be long-standing and may take years to recover. During this period, both the ends of the chain need to function together to place mankind over personal interests lest a second peak occurs.

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