

COVID-19: Reflections on the Disease and the Response

David A. Westbrook, M.D.

Many Americans today, as we are interned in our homes, are thinking about the price of freedom and the trade-offs between freedom and security. One example of this is Texas lieutenant governor Dan Patrick stating that he would gladly risk his demise to protect the future freedom of his children and grandchildren. This is not a martyr acting to throw himself in front of gunfire, but a rational leader questioning the wisdom of shutting down the economic behemoth that is the United States, and willing to risk disease in order to save the future of his descendants.

This is the dilemma we face today. Do we give up our natural, God-given freedoms and sacrifice the next generation's economic well-being as well as family, social, and religious connections based on statistical prognostications? Might other strategies be more effective?

Who is in charge? Is the federal government determining a national strategy and mobilizing a national effort? Do we turn over the leadership entirely to statisticians and epidemiologists to guide us? In a war, major strategic decisions are made by presidents, not generals or statistical modelers.

The larger vision must be the future health of a country and not the short-term strategic good. What if Gen. Douglas MacArthur had made the decision to drop the atomic bomb on North Korea and China during the Korean conflict? The wisdom of the Founding Fathers deemed the President to be the military commander-in-chief for good reason.

The Extent and Impact of Disease

As of Apr 16, there were 7,616 U.S. deaths out of more than 304,824 cases reported due to SARS-CoV-2.¹ About the same time, the Centers for Disease Control and Prevention (CDC) reported 120,000 hospitalizations and 6,600 deaths from influenza, including the most prominent Victoria B strain.² With regard to the latter, CDC's recommendations³ are to avoid contact with others if you are sick, avoid touching your face, cover coughs and sneezes, and wash hands often. There were no recommendations to self-quarantine for those not infected or to generally avoid groups, as there were with COVID-19. Businesses were not shut down for influenza.

As of early April, CDC reported⁴ that 80 percent of all COVID-19 deaths in the U.S. were among those older than 65. The high case fatality rate in Italy (1,625 deaths out of 22,512, or 7.2 percent) as of Mar 17 is partly explained by Italy's relatively older population (23 percent are 65 years and older). Further, of 355 fatalities analyzed by the Italian institute of Health, 50 percent had more than one co-morbidity.⁵

A reasonable approach would be self-quarantine of older persons, particularly those with one or more co-morbidities. Instead, we are quarantining everybody, based on modeling, even though Dr. Anthony Fauci, the primary spokesman for White House policy using disease modeling recently stated, "I've looked at models....they don't tell you anything. You can't rely upon models."⁶

In March, Dr. Fauci prophesied that COVID-19 deaths could reach 10 times the deaths from influenza. A 2 percent incidence would mean 2–4 million deaths in the U.S. Yet, he also stated that "if one assumes that the number of asymptomatic or minimally symptomatic cases is several times as high as the number of reported cases, the case fatality rate may be considerably less than 1%."⁷ That is, he admits that he really doesn't know the denominator, that is the total number of people who were actively infected plus the number who had been infected yet had survived after a brief flu-like illness or had remained asymptomatic. So, which is it, Dr. Fauci? What has happened in less than one month to change an overwhelming plague that will kill more people than any past epidemics to one akin to the seasonal influenza? Data on prevalence "could make a difference in an epidemic that kills 20,000 and one that kills two million."⁸ But only suspect cases had been tested.

The first testing used the polymerase chain reaction (PCR), which identifies active cases. Widespread antibody testing to find recovered cases is the only way to determine the infection fatality rate.

We also have difficulties with influenza statistics. Only symptomatic persons are tested. Moreover, influenza deaths are conflated with pneumonia deaths, and influenza cases with influenza-like illness (ILI). Meaningful comparisons must use comparably derived statistics.

Who Is Determining Response Strategy?

Relying solely on statistically minded epidemiologists and public health authorities rather than on treating physicians to determine strategy invites a society of forced universal testing, vaccinations, quarantines, and limited treatments that could extend beyond the controversial mandates we see today.

In our current approach of trying to mitigate the spread of infection, little government energy has been devoted to improving treatment, but only to the supply of ventilators and hospital beds. Attempts to innovate are hamstrung by devotion to the randomized controlled trial (RCT). In our age of "best practices," physician experience and patient-based decision-making are viewed as ineffective or harmful in the absence of RCTs.

Traditional medical ethics and the Oath of Hippocrates require physicians to treat patients, one at a time, not statistical metrics or populations. Every doctor I know has prescribed FDA-approved drugs "off label," with awareness of the risks, based on medical literature and physicians' experience.

In an initial study involving 80 patients, French physician Didier Raoult⁹ showed significant reduction of respiratory viral load when patients were treated with hydroxychloroquine (HCQ), azithromycin (AZT), and zinc. Further, Dr. Vladimir Zelenko¹⁰ from Upstate New York has reported successful treatment of 700 patients with COVID-19 using a similar regimen. Mainstream media has derided such reports, and social media giants try to suppress mention of them, referring everyone to the CDC,

the World Health Organization (WHO), or other government-approved sites. Such thinking harkens back to the treatment suffered by Ignaz Semmelweis or Joseph Lister when they demonstrated lifesaving practices to a skeptical academy.

Clinical trials are underway, but a community at risk cannot wait months or years for results when patients are dying. Experience suggests that these drugs need to be used early, at the onset of fever and dyspnea and before the onset of “cytokine storm,” the severe inflammatory response leading to fulminant respiratory distress syndrome and death.

Following an encouraging comment by President Trump on *ABC News* on Mar 16, the Food and Drug Administration (FDA) issued an emergency use authorization (EUA)¹¹ for use of HCQ and chloroquine from the National Strategic Stockpile, but only for hospitalized patients.

Congress passed “Right to Try” legislation on May 22, 2018. This, however, applies to cancer patients without access to investigational drugs in the latter stages of illness, not to early or prophylactic use of long-established drugs.

Economic impacts of the response to COVID-19 include an estimated 40 percent drop in the gross domestic product in the second quarter.¹² As many businesses close, the unemployment rate may come close to the 25 percent that occurred in the Great Depression,¹³ or even exceed it.

Congress quickly passed legislation for \$2 trillion in unemployment relief and small business loans—but what will be done next if there is no economic revival?

White House advisers have suggested that lockdown orders remain in place until no new cases and no deaths have resulted. Such policy might indeed bankrupt the country, resulting in far greater national security concerns. As stated in a *Wall Street Journal* editorial, “No society can safeguard public health for long at the cost of its overall economic health.”¹⁴

The response is being driven by political forces and media coverage, not data. The media emphasizes worst-case scenarios and focuses on a few prominent scientists, even those who contradict themselves. Some treatments, such as the use of plasma from recovered patients or the not-yet-approved remdesivir, are highlighted, while the HCQ/azithromycin/zinc regimen and others are ignored or claimed to be dangerous or fraudulent. The media appears to accept that a central authority should make treatment decisions rather than individual, independent physicians.

Many security questions have been raised, especially related to our relations with China, which failed to notify the world of a potential pandemic when cases were first noticed. There is the potential effect, allegedly intended by some, of furthering the establishment of a global totalitarian regime. Surely there have been unprecedented intrusions into the liberty to associate, to travel, and to work.

President Trump has suggested a rolling return “normal” activity in relatively unaffected regions, such as the Midwest states, to soften the economic hardship for most of the country and forestall economic collapse. But is he in charge—and should he be? Who is making the decisions about priorities, what information to communicate, and the criteria for action? Are statistical models, based on unknown variables and often wildly incorrect, dictating edicts with profound effects on the economy and everyday life? Are bureaucracies at every level imposing their will without oversight or accountability?

The FDA appears to be trying to vastly expand its authority over physicians’ treatment decisions, ignoring the importance

of physicians’ experience. FDA guidelines are not the only appropriate source for medical decisions. For thousands of years physicians have been deciding what treatment or what drug is necessary. This includes the assessment of side effects as well as efficacy of any given treatment. Physicians are also trained to evaluate evidence. Yet one White House adviser presumes to declare that a large body of the best available clinical evidence on HCQ treatment is merely “anecdotal.”

Conclusions

The appropriate role of government is to protect its citizens. But what authority can it legitimately assert on the pretext that its “protection” does more good than harm? The COVID-19 pandemic is putting the meaning of our constitutionally protected rights in the spotlight. Can they be obliterated by a statistically based declaration of emergency? Can physicians’ authority be overruled by unprecedented constraints on their ability to prescribe an approved drug for a newly arisen indication?

David A. Westbrook, M.D., is an endocrinologist practicing in Dayton, Ohio. Contact: d.westbrook@gmail.com.

REFERENCES

1. Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Available at: <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>. Accessed Apr 5, 2020.
2. Fleming M. CDC reports 13 million flu cases thus far in 2019-20 season. Available at: <https://www.contagionlive.com/news/cdc-reports-13-million-flu-cases-thus-far-in-201920-season>. Accessed Apr 6, 2020.
3. Centers for Disease Control and Prevention. Influenza (Flu). Take three actions to fight flu infographic. Available at: www.cdc.gov/flu/resource-center/freeresources/graphics/infographic-fight-flu.htm. Accessed Apr 5, 2020.
4. Oke J, Heneghan C. Global COVID-19 case fatality rates. *Oxford COVID-19 Evidence Service*; Mar 17, 2020, updated Apr 7, 2020. Available at: www.cebm.net/covid-19/global-covid-19-case-fatality-rates/. Accessed Apr 7, 2020.
5. Van Beusekom M. Italian doctors note high COVID-19 death rate, urge action. *CIDRAP*, University of Minnesota; Mar 24, 2020. Available at: <https://www.cidrap.umn.edu/news-perspective/2020/03/italian-doctors-note-high-covid-19-death-rate-urge-action>. Accessed Apr 5, 2020.
6. Wan W, Dawsey J, Parker A, Achenbach J. Experts and Trump advisers doubt White House’s 240,000 coronavirus deaths estimate. *Wash Post*, Apr 2, 2020. Available at: <https://www.washingtonpost.com/health/2020/04/02/experts-trumps-advisers-doubt-white-houses-240000-coronavirus-deaths-estimate/>. Accessed Apr 5, 2020.
7. Fauci AS, Lane C, Redfield RR. COVID-19—navigating the uncharted. *N Engl J Med* 2020; 382:1268-1269. Available at: <https://www.nejm.org/doi/full/10.1056/NEJMe2002387>. Accessed Apr 5, 2020.
8. Bendavid E, Bhattacharya J. Is the coronavirus as deadly as they say? *Wall St J*, Mar 24, 2020.
9. Bartlett T. A French scientist says he can cure COVID-19. Other researchers have their doubts. *Chronicle Higher Education*, Apr 1, 2020. Available at: <https://www.chronicle.com/article/A-French-Scientist-Says-He-Can/248405>. Accessed Apr 5, 2020.
10. Smilovitz T, Dox E. U.S. mulls treatment of Jewish doctor who claims to have cured coronavirus. *Jewish World*, Mar 31, 2020. Available at: <https://www.ynetnews.com/article/HyAoSnePl>. Accessed Apr 5, 2020.
11. FDA. Emergency Use Authorization. Available at: www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#covidtherapeutics. Accessed May 3, 2020.
12. U.S. Chamber Staff. Quick take: Coronavirus’ economic impact. *U.S. Chamber of Commerce*; Mar 16, 2020. Available at: <https://www.uschamber.com/series/above-the-fold/quick-take-coronavirus-economic-impact>. Accessed Apr 5, 2020.
13. Bartash J. Millions of lost jobs may push unemployment rate to highest since Great Depression. *MarketWatch*, May 2, 2020. Available at: <https://www.marketwatch.com/story/millions-of-lost-jobs-may-push-unemployment-rate-to-highest-since-great-depression-2020-05-02>. Accessed May 3, 2020.
14. Editorial Board. Rethinking the coronavirus shutdown. *Wall St J*, Mar 18, 2020. Available at: <https://www.wsj.com/articles/rethinking-the-coronavirus-shutdown-11584659154>. Accessed May 3, 2020.