From the President

A Perspective on Our Time with COVID

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I thank our members for this opportunity to serve as the president of the Association of the American Physicians and Surgeons (AAPS).

This past election year superimposed with COVID-19 has delivered significant challenges, well beyond the multiple issues already pressing the medical profession. The COVID crisis has clearly exposed the increasing subjugation of the individual practice of medicine to multiple corporate, media, world, and various government agendas. Social distancing has impaired personal and especially group interactions supporting our mission: For the first time since AAPS's inception in 1943, a virtual annual meeting resulted.

AAPS continues to be the vanguard of medical professional organizations, representing physicians and patients in providing direct and personal access, emphasizing direct patient care in the independent practice of medicine. AAPS represents above all the freedom of choice embodied in the principles of the United States Constitution, under the Hippocratic principles and ethics of medicine, as reflected in the AAPS's motto: ***Omnia pro Aegroto—all for the patient.***

COVID-19 Restrictions to Patient Access and Care

COVID-19 mandates have imposed considerable limitations on medical freedom, including access to personal physician care, specific drugs, and elective surgery availability to patients.[1] In contrast, during our last great American novel viral medical crisis with AIDS in the 1980s, personal responsibility was the primary defensive answer.

The COVID-19 crisis was recognized in China only after the large-scale construction of hospital facilities could no longer be concealed. China recently reported complete control of the virus (if this can be believed), after implementing extreme totalitarian measures, including forcing citizens to stay in their apartments and welding the exits closed, and restricting individual traffic.

COVID-19 is the second novel coronavirus epidemic coming from China, as SARS originated there in 2002.[2] On the rationale that no FDA-approved medical therapies exist for COVID, significant restrictions of basic American freedoms were successively imposed upon the American population to "cap the peaks" of the "surge" of infection and death.

Presidential powers under the Constitution and the National Emergencies Act were invoked, and all 50 U.S. states have declared a "state of emergency" in response to COVID-19. This peak was "capped," and massive deaths did not occur. No patients were forced to share ventilators as was initially feared. Indeed, mechanical ventilation was subsequently felt to contribute to deaths.

How many infections were prevented and lives actually saved? Biased media chose to stress the inflated numbers of lives lost as failure. But it was China that failed to contain its national epidemic and prevent it from becoming a global pandemic. China failed to warn the world in a timely manner, despite its 2002 SARS experience. While the Trump Administration is repeatedly blamed for U.S. COVID-19 deaths, restrictions, and consequences, the blame actually belongs to China and to unprepared U.S. government appointees.

American governmental agencies are run by people appointed, usually decades ago, who clearly failed to act rationally. This was documented by the *60 Minutes* program "A Flight from Hell," showing how infected and dying cruise-ship patients were flown from France to Atlanta and across the nation despite the CDC's being alerted to their impending arrival.[3]

Appointed leaders should have provided definitive information and appropriate protective gear early, obligating and directing individual Americans to protect themselves. But instead of ensuring accurate education, information, guidelines, and the needed personal protective equipment (PPE) to the public, and calling for personal responsibility, media were left to overreach, generalize, and create hysteria.

The vast majority of healthy and non-elderly Americans overcame the infection without death or significant adverse effects, even as asymptomatic cases. Hysterical fear closed the economy and delayed production of needed materials. Worse, because of the outsourcing to China of material production *over decades*, the U.S. is dependent on China for PPE, disinfectants, and nearly all American pharmaceuticals.[4]

Intrusion into Medical Care

COVID-19 is a coronavirus and subject to the widely known biological parameters of transmission, infection, and re-infection of other coronaviruses, which annually cause 20 percent of common colds. The first "novel coronaviruses" were noted when SARS and Middle East Respiratory Syndrome (MERS) occurred decades ago. They were studied at that time, and therapies were proposed.

SARS was first recognized in Guangdong Province, China, in November 2002. MERS-CoV emerged in the fall of 2012 in the Arabian Peninsula, and the mortality rate was estimated to be between 30 and 40 percent.

When I first became aware of COVID-19 in January, I ordered N95 masks for personal use (before they rapidly disappeared from the open market) and protection for family members at high risk. PPE, masks, and toilet paper became rapidly unavailable, while the economy rapidly constricted due to social-distancing impositions and stay-at-home $1,200 government payments, all instead of ramping up production. Our appointed medical experts and leaders first recommended to NOT wear masks, then to wear them, and then to use "coverings," which include almost anything from T-shirts to valved N95 masks (which allow unfiltered expulsion of exhaled breath and circumvent containment of virus). Physicians were restricted, including by medical and pharmacy board sanctions, from providing personalized advice and treatment based on previous outbreaks and available therapy.

Legal prescription of available and approved FDA pharmaceuticals (such as hydroxychloroquine with azithromycin or doxycycline) to patients was restricted or forbidden, under threat of licensing "sanctions." The initial SARS

experience described potentially effective drugs, which were also initially prescribed to President Trump by his physician but withheld from the general population. Even very expensive FDA-unapproved and experimental therapies have been authorized for the elite few, while inexpensive, practical, and available therapies were withheld from physicians and their patients. How is this logical? Every reasonable measure should have been allowed as a patient-physician informed decision. Recent U.S. Senate hearings have strongly questioned the role of these appointees in failing to assure and reassure the public by providing positive guidance in the EARLY treatment and prevention of COVID-19 with all currently available drugs including hydroxychloroquine.[5]

"Advice" from various media pundits still abounds, while patients remain frightened to avail themselves of necessary routine care, resulting in "unintended consequences" and deaths. Family members were excluded from participation in the care of their loved ones in hospitals and nursing homes, while "triage" mandates contributed to limitations of care and individual advocacy, which is especially essential for the elderly, sick, and disenfranchised.

COVID-19 diagnoses were encouraged by payments for "up-coding" and liberalized definitions of "cases"—at a time before testing was even available or accuracy was poor.[6] Widespread use of testing was questionable from the beginning, with scattershot-style testing resulting in medical mismanagement due to the testing method itself.

Running healthy individuals through street testing sites, where handwashing was impossible (sinks in parking lots?), may have simply infected instead of detected! These and multiple other factors made any rational assessment of the numbers of COVID cases and deaths a daunting task. Simply assuming that everyone has COVID and practicing universal precautions at all times, testing only to confirm clinical diagnoses, appears to be the only logical approach to epidemiological control.

The working population and schoolchildren were sequestered and robbed of opportunities, in spite of the fact that 80 percent of all deaths were in patients older than 65, a group that represents only 13 percent of the population (see Table 1). We do not know the numbers of actual COVID-19 deaths, or those unintended deaths from lost care, failed advocacy, suicides, and fear, or significant personal detriment from created financial and educational limitations of shutdowns.

Table 1. COVID-19 Mortality

Age group	COVID-19 Deaths	Percentage of COVID Deaths
Under 1 year	8	0.008%
1-4 years	5	0.005%
5-14 years	13	0.013%
15-24 years	125	0.121%
25-34 years	699	0.676%
35-44 years	1,780	1.722%
45-54 years	4,976	4.815%
55-64 years	12,307	11.909%
65-74 years	21,462	20.769%
75-84 years	27,529	26.640%
85 years and over	34,435	33.322%
All Ages	103,339	100.000%

Source: CDC

We have now discovered individuals becoming reinfected *within this first year of COVID*, raising considerable uncertainty about viable immunizations, especially as antibody titers in those infected appear to decline rapidly. These factors are, however, unlikely to stop government mandates forcing immunizations on low-risk schoolchildren and young adults, and thereby creating financial windfalls for corporate executives. Freedom of choice will be usurped. We have noted physicians being sanctioned, fired, and ostracized for speaking out against the questionable doctrines of corporate leaders or government appointees. Fear is curtailing freedom.

Declaring 'War' on COVID-19

Every life matters, and each death is a loss. Still, everyone does die. When soldiers stormed Normandy's beaches on June 6, 1944 (D-Day), we *knew* many would die, and as in any war, the concept of "acceptable risk and losses" justified the means. In any pandemic, deaths will occur. As a 66-year-old anesthesiologist, I go repeatedly into the highest COVID risk location daily: hospitals and patients' airways. Society and my professionalism expect me to work, despite being high-risk "elderly."

Firefighters run to fires. Astronauts go to space. Truck drivers must face the traffic. Life is dangerous, but we minimize personal danger and keep living. I have never had a COVID test, as I have not had frank COVID symptoms. I wear simple surgical masks and practice good hygiene. Everyone should. Masks should be free. Those under 65 are at low (acceptable) risk and should carry on with life and the economy. If you can go shopping, you should go to work, to school, and live.

Perhaps the U.S. death rate is unacceptable because China failed, or because so many Americans are urbanites with extremely unhealthy lifestyles that predispose to death from COVID. As an anesthesiologist, I can clearly emphasize that ventilation of even healthy morbidly obese patients represents an extremely increased risk, technically difficult, and bordering on impossible in such a patient with diseased lungs. COVID-19 may merely be the "wake up call" for America to start taking personal health seriously, because health is indeed a personal responsibility and should never be delegated to government.

AAPS Advocacy

AAPS is a unique organization, advocating for patient and physician rights and freedom of individualized and personal care. I came to AAPS in 2010, when the Federation of State Medical Boards (FSMB) attempted to force the sales of its Maintenance of Licensure upon Ohio physicians and as the American Board of Medical Specialties (ABMS)—both private corporate entities—was similarly forcing its Maintenance of Certification upon all physicians and at great cost.

AAPS was first to begin this battle, including the legal challenge. AAPS is the *only* physician organization providing legal advice and assistance to members attacked by corporate and regulatory entities, for example, by exposing sham peer review techniques. AAPS advocates for comprehensive and individual patient-physician care—direct patient care—without intrusion of insurance, government, or corporate limitations. In patient-physician interactions, decisions should remain between patient and physician. AAPS is the single

leading source for information about practice models, opting out of Medicare, and private contracting.

Employee Physician Practices

Physician employment contracts are problematic because "no man can serve two masters" (Matthew 6:24).

In the U.S., over decades physicians first became contractors with insurance companies and government. Now they have overwhelmingly become employees, and thus are subservient to non-medically-trained, business-oriented hospital CEOs and to dictates from government and insurance contracts. Medical freedom, authority, and patient care are thus increasingly usurped, while physician liability is expanded, and collective bargaining is circumvented by employer-generated contracts impacting patient care.

Over decades, insurance forms, compliance, electronic data, and payment mandates/impositions have overwhelmed medical practices, exploding costs and consuming more than half of physicians' time, which is now spent on non-medical-care-related data collection. This has created the false narrative that there is a physician shortage, because if the bureaucracy were removed, clinical presence could be immediately doubled.

Instead, we see the burgeoning introduction of nurse practitioners and physician assistants, and new positions for scribes and helpers. They, NPs in particular, are now being afforded practice and prescription authority equal to that of physicians, when they do not have the education or training of physicians. Sometimes they have no state medical board oversight.

The Flexner Report of 1910 led to standardization and excellence in physician medical education and treatment. The report also facilitated the specialist certification industry. Excellence is now being rapidly undermined by introduction of non-physician primary care personnel without adequate clinical training, with solely online education and minimal two-week clinical periods leading to "NP specialist designations."

Because ALL physicians matter, it is essential to welcome as AAPS members and engage this growing number of *employee MDs*, who are increasingly subject to, and often unaware of, the impositions of corporate medicine on them, their patients, and the practice of medicine.

Goals for the Future of Medicine

As a European- and American-trained consultant anesthesiologist with 40 years of experience, I have seen the changes in medical care firsthand and on several continents. I have come to practice "primary care" anesthesiology as a matter of necessity in America in 2020, as corporate medicine has shifted care to deal with only "one presenting complaint" per encounter, using typically the "doc-in-a-box""cost-effective" model of MedExpress and other urgent-care and walk-in centers, eliminating continuity and comprehensive care.

The "'doc' in the box" is also increasingly ***not*** a doctor, but patients are unaware of any difference. Nurse "providers" have not had the extensive medical education that is needed to render the holistic evaluation or comprehensive and effective treatment that physicians offer. All physicians are leaders and teachers, and must engage and advocate for *their* patients at every encounter.

Additionally, many patients lack continuity of care because of costs and decreasing physician availability. Insurance directives promote contracted non-physician office care and facilitate nurses' data collection, guidelines for treatment, and documentation designed to increase profits.

Patients do not *belong* to hospitals, Medicare, or insurance companies, yet these entities dictate bottom-line care along their profit margins. ABMS certification has further robbed patients of *comprehensive* physician analysis, as care is increasingly balkanized into narrow specialties. Modern "corporate care" fractionates treatment and encourages denials, reversing the holistic yet failed approach of the Health Maintenance Organizations of the past decade. Care is now overseen and directed by insurance programs to low-level providers who dutifully follow profit incentives directed by computerized data collection and billing systems.

Call to Action

We cannot let patients or physicians become mere cogs in the corporate medicine machine. Freedom requires that everyone participate. After the November election, our active participation becomes even more important to either stay or get back on track.

Freedom is not free. Terms and conditions apply. Professionalism requires individual participation in society and professional organizations. Every physician must engage at the national and local level, politically and personally. Numbers and dues do matter.

AAPS represents all physicians, and our goals must include them at the state, national, and interpersonal levels. Engage everyone around you, especially employed physicians. I encourage everyone to join AAPS. Please contact me directly as president with your issues and ideas. Inform yourselves regularly and participate.

Visit AAPSonline.org. Welcome others into this organization and participate in medical organizations at state and local levels as appropriate. Together we can, we must, and we do make a difference.

"Health care"—including the financing and management of medical care—is 18 percent of our GDP, of which physicians account for only 7.9 percent of the dollars captured in the 18 percent. Those capturing the other 92 percent are using those dollars to their own advantage.

Money talks. Those not at the table are on the menu, and now more than ever, so is the practice of medicine!

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