

COVID-19: Up Close and Personal

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We have lived through an amazing few months dealing with the coronavirus. Earlier this year, when we began hearing about this infection, I was concerned about how it would affect the community in which I live. Covington, Georgia, is a small town that is growing with the influx of new citizens moving here from metropolitan Atlanta. My wife and I moved here from Columbus, Georgia, in 1982 after I completed my family medicine residency. It was an exciting time in our lives to begin a dream we had been working toward for many years. We have raised our four children in this part of our state and have experienced many blessings over the years.

To have a pandemic occur this year was the remotest thing from our minds, and especially to have it affect our practice, our patients, our friends, and our family. COVID-19 is evil. When I experienced it, I felt as though I was dying.

The Association of American Physicians and Surgeons has been at the forefront in assisting me with decisions regarding therapy for my coronavirus patients. I have read a lot in the lay press as well as our various medical journals. AAPS has done a wonderful job of distilling the information into a format for the practicing physician to utilize.

Earlier this year, a physician in Texas who had a large number of nursing home patients who were successfully treated with hydroxychloroquine (HCQ) caught my attention. At the beginning of the pandemic, I was an attending physician for about 95 patients total at three nursing homes. Since HCQ had worked in Texas and there was a prophylactic dose recommendation, I began covering my patients with this medicine, hoping to protect them from the viral wave that would eventually reach our local facilities. Along with HCQ, I also learned vitamins C and D3 and zinc would help defend against the virus. There was also news regarding Dr. Zelenko's success in New York with HCQ.

I have had numerous patients travel to countries where they needed to have malarial prophylaxis and have treated these patients with HCQ without any problems over the past 38 years. I also discussed HCQ with two older local physicians, a cardiologist and an ophthalmologist, who said that in their careers they had not seen any significant number of adverse effects from HCQ.

It was not long into the pandemic when difficulties in HCQ availability for my patients started to arise in Georgia. I initially started them on 400 mg weekly with milk or food, as well as daily vitamin C 2,000 mg, vitamin D3 2,000 IU and zinc 50 mg. I took this prophylactic regimen myself and recommended it to my family, friends, neighbors, and office patients.

I began to hear that our local pharmacies were refusing to fill prescriptions for HCQ unless the patient had lupus or rheumatoid arthritis, and the diagnosis code would have to be on the prescription. This was something that had never occurred in my experience. I called the local pharmacists involved who told me it was their company policies forcing them to reject the prescriptions.

Then I began to hear from the nurses at the nursing homes that they were having trouble getting the HCQ for my patients there. I called the facility pharmacist, who stated his company policy had been adjusted to reject prophylactic HCQ. The state pharmacy board had notified the nursing home pharmacies that they could possibly lose their license if HCQ prescriptions were filled without a diagnosis of SLE, RA, or a positive COVID test. The irony regarding this position was that the testing in Covington for coronavirus was essentially unavailable to the nursing home patients unless they were admitted to the hospital in respiratory distress. I found this to be very disconcerting.

I have been politically active over the years and knew to call my state representative and senator when I have any problems with state issues. I notified them of the difficulty I was having. Neither of them is a medical professional. I was assured they would appeal to Gov. Brian Kemp, who has a staff member from Covington. I notified him as well but only received an email soliciting a financial contribution—was this coincidental?

As the concern for local COVID infections continued to rise, I grew increasingly irritated by the government's ineptitude for enabling primary care physicians to treat our patients early in their illness. We have all been encouraged to treat our influenza patients with oseltamivir (Tamiflu®) as early as possible. Likewise, we want to decrease the possibility of complications from *Herpes zoster* infections, so we encourage patients to begin their acyclovir as soon as possible. It only makes sense to treat COVID illnesses as soon as possible to prevent the deterioration that so many of our high-risk patients have experienced.

In March, I saw my first COVID-like illness. I have to call the illnesses "COVID-like" because testing has been mostly unavailable throughout most of this year, so that positive confirmation has been lacking. In any event, I have been treating patients and not tests.

For example, my first patient who wanted a laboratory confirmation of her illness saw me on Tuesday, Mar 24. I started her on HCQ, azithromycin, vitamins C and D3, and zinc. She was much better by that Friday, but her children insisted that she get a COVID test. They had found an outpatient facility in a community about 45 minutes from my practice and took her there with a note from my office. On Sunday, Apr 5, nine days later, the out-of-town lab called me to report that my patient's COVID test was positive. Thank goodness my patient was willing to take the antibiotics empirically!

I placed a sign on my office door asking patients to return to their car and call my office to let us know their situation if they have a fever, cough, chills, sore throat, runny nose, diarrhea, or achiness. I would then see them in their car to prevent exposure to my office staff and patients in the waiting room. It's inexplicable that an infectious disease physician in our area refused to see patients with COVID symptoms.

With a COVID-positive patient in my practice, I had to recognize that the virus had definitely arrived. I began to aggressively educate patients regarding prophylactic COVID

medicines in the hope of preventing further infections. Many of them were grateful for the opportunity to do something for themselves.

In April, I decided to write a letter to the editor of my local newspaper in the hopes of rallying our local citizenry to assist in the effort to free up the HCQ for my patients. I sent a copy to the *Wall Street Journal* and to *The Blade*, my hometown newspaper in Swainsboro, Ga. My oldest brother offered to call his contact at *The Blade*, which was the only newspaper that printed my letter. It is reproduced below.

To the Editor:

I'm having trouble and hope your readers might help the most vulnerable in our community. I am referring to the nursing home patients in our town. After the tragedy at the Kirkland Nursing Home in Washington State, where approximately 47 of the 125 patients died of coronavirus, I have been researching for what I might do to help prevent such an occurrence locally. Last week, I learned a physician in Texas treated the patients in a nursing home with hydroxychloroquine. There are 135 patients in that facility, and only one died of the coronavirus.

I have heard that Dr. Fauci of the National Institutes of Health does not support use of hydroxychloroquine because there has only been "anecdotal" evidence that it might help. Anecdotal refers to what has been "only observed" to occur, similarly to what Sir Isaac Newton observed when he saw the apple drop from the tree, and by anecdotal evidence, determined that something must have caused the apple to drop to the ground.

A French study as well as reports from India have supported the benefits of using hydroxychloroquine in patients with coronavirus infections.

The real difficulty for me to understand is although we all have agreed to stay inside our homes as much as possible these past few weeks, and we have tried to wear gloves and masks when we think about it, as well as we are trying to maintain social distancing as encouraged, none of these activities have been proven by a randomized, double blind controlled trial to actually be effective against coronavirus transmission.

Please don't get me wrong: I have been recommending social distancing, hand washing, gloves/masks where appropriate and will continue to do so. BUT, we also need to provide our vulnerable nursing home patients with the preventive doses of hydroxychloroquine although the evidence for the medicine's effectiveness is only anecdotal. What else do I have? Why not do this? Who can wait for test results when a patient can deteriorate so quickly? The medicine is not expensive. The medicine reportedly has few drug-drug interactions. Please call or write your state and national political office holders as well as Governor Kemp. Ask them to allow physicians to write the medicines they believe are in the best interest of their patients and allow our pharmacists to fill those prescriptions without legal threat of losing our licenses.

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After writing this letter, I did not have any more direct contact with my political leaders. I can just say that eventually, pharmacies in Georgia began to fill my patient's prescriptions.

COVID-19 infections began to rise in Covington this past June. By the July 4th weekend, I received calls about five different residents with COVID-like symptoms at one of the facilities where I was attending patients. I have been taking care of nursing home patients at this facility since around 1985. I was the medical director of the facility as well as of its sister nursing home in Conyers, Ga., about 12 miles away. In 2018, I was asked to hire nurse practitioners to staff these two homes. I chose not to continue as medical director due to the existing patient load for which I was responsible. A younger physician was hired who has built his practice with allied professionals.

On Saturday, July 4, I treated the five patients I was called about for COVID-like illnesses with the previously mentioned regimen. They all did well, except one had to go to the hospital for pneumonia, from which he recovered in the next week. On Thursday, July 9, I read in the local paper that the state health department had tested the nursing home patients for COVID-19 on Monday, July 6, and found 60 COVID-positive patients. I had not been notified of this, but immediately sought to find out whether any of my patients were ill. I was notified by the new medical director that he would not allow any patients in "his" facility to be given HCQ and that it was quackery to do so. We had a rather heated exchange, something that I had never experienced with another physician.

At this point, I decided to resign from the two sister nursing homes since my patients' medical care had been taken from me. I remain the medical director at the third facility where I do allow use of vitamins, azithromycin, and HCQ in the care for COVID-19 patients. It has 65 beds and currently an average 57 patients. We have lost two to three patients to COVID-19. In the other facilities, where the medical director does not use the above medical regimen, 34 patients have died from COVID-19 in the Covington skilled nursing facility, which has about 162 beds and an average of 94 patients. There have been no deaths in the Conyers facility, which has about 105 beds, with a current occupancy as of this writing of 87 patients. I am thankful I was able to discuss my resignation from the two sister facilities with almost every patient family on Saturday, July 11.

In my practice in Covington, coronavirus peaked in August despite my being out of the office from July 31 until Thursday, Aug 20. I contracted the virus on Friday, July 31, and went home. I have no idea how I got it.

I am thankful that my wife and I had started on the prophylactic COVID regimen. Neither one of us had to go to the hospital. The headache, nausea, cough, and achiness were horrendous. I had gotten much better by Wednesday, Aug 5, and decided to stop the HCQ that I was taking three times a day. This was a big mistake. Do not stop your HCQ! Take it for 10 days. I was at my worst on Thursday, Aug 6, and told my wife on Aug 10, "This must be what it feels like to die."

I re-started HCQ 200 mg t.i.d., azithromycin (a Z-Pak®, 500 mg on day 1 then 250 mg for four days), zinc 50 mg q.d., vitamin C 2,000 mg q.d., and vitamin D3 2,000 IU q.d. I eventually added Zofran® (ondansetron) 4 mg s.l. q 4 hr while awake, and alternating ibuprofen 200 mg and acetaminophen q 4h to get some relief from the overwhelming nausea and headache. I lost 20 lbs before awakening symptom-free on Aug 16. I repeated the Z-Pak at day 10 when the cough recurred on Aug 10.

At that time, the Centers for Disease Control and Prevention

(CDC) was recommending 24 hours of being symptom free without the use of antipyretics before returning to work. I waited 4 days just to be sure that I was ready to start seeing patients again.

Since returning to my practice, my wife and I have done well. We did start back on the prophylactic dose of HCQ in the middle of November, because we do not know how long we are immune. We do not want to risk another COVID illness.

I have only seen two patients with COVID-like illnesses this month (November). Since the beginning of the pandemic in Covington, of the approximately 100 office patients I have treated for COVID-like illnesses, about five or six have had to go to the hospital, usually at 7–14 days after symptom onset. NONE have been placed on a ventilator and NONE of them have died. This is not quackery! Early treatment of COVID-19 infections with HCQ, azithromycin, and vitamins has helped numerous patients. Call it anecdotal if you wish, but when you get this infection, I hope you take advantage of the benefit from the medical history of so many patients around our country who have taken these medicines and survived.

I would advise you to not wait for test results if you develop COVID-like symptoms. If you have symptoms, take the

medicines even if your test result is negative! Do not treat the test! Treat the patient!

It will be interesting to follow the discussion regarding the chronic COVID-19 patients, the so called “long haulers.” I wonder whether they are the patients who were not given HCQ or the other recommended medications early on in their illnesses. Also, I hope we will soon have a better understanding about the acquired immunity from the infection and how long it lasts.

Physicians are personally using other prophylactic regimens as well, for example 5,000–10,000 mg of vitamin C daily.

I highly recommend the excellent Webinar on COVID-19 by Dr. Peter McCullough¹, and watch aapsonline.org for updates.

Always remember our motto: *Omnia pro Aegrotis!*

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REFERENCES

1. McCullough P. Early home treatment for COVID-19: a rational response to the global pandemic. AAPS Webinar; Oct 29, 2020. Available at: <https://www.youtube.com/watch?v=C5u5GuErjA&t=7s>. Accessed Dec 3, 2020.

AAPS PRINCIPLES OF MEDICAL POLICY

Medical care is a professional service, not a right. Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

Physicians are professionals. Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government “guidelines,” which soon become mandates. Physicians’ decisions and procedures cannot be dictated by overseers without destroying their professionalism.

Third-party payment introduces conflicts of interest. Physicians are best paid directly by the recipients of their services. The insurer’s contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

Government regulations reduce access to care. Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians’ judgment, etc.

Honest, publicly accessible pricing and accounting (“transparency”) is essential to controlling costs and optimizing access. Government and other third-party payment or price-

fixing obscures the true value of a service, which can only be determined by a buyer’s willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

Confidentiality is essential to good medical care. Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

Physicians should be treated fairly in licensure, peer review, and other proceedings. Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors’ malice, hospitals’ attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

Medical insurance should be voluntary. While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

Coverage is not care. Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.