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First, Do No Harm: If Primary Healthcare Remains Shut Down, Toll on Elderly Will be Worse Than COVID-19

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Theme: Intelligence, Science and Medicine

I'm a doctor 'on the front-line' in the 'war against COVID-19'. Yes, we have a huge problem, but it is not necessarily the virus itself. The real problem is hidden in plain sight. Let's see if we can begin to discern it.

Lockdown Time

This is how doctors, nurses and other medical staff and administrators are handling this crisis.

They have set up "contaminated" respiratory divisions at clinics and hospitals, which are separated from the rest of the outpatients and health staff. *Anybody* coming in with a cough, or who is sneezing, or showing any sign of respiratory distress, is directed to this division and kept separated from those coming in with wounds or any other non-respiratory-related illness. That way, contagion is not propagated to the entire building, but is kept isolated within the respiratory division, which has its own doctors and staff handling cases there. Again, **all incomers with respiratory symptoms – which in reality can be anything from the common cold to the typical seasonal flu, even a cough due to seasonal allergies – are sent to this respiratory division**.

Every time a doctor has to record anything related to a patient's consultation, he or she must type a note in a file (most of which are electronic) under a certain category. Because a pandemic has been declared, and in view of the global lockdown effort, that category is specified by international codes that have been designated for this particular coronavirus. After all, people require sick leave letters or isolation labels from doctors, who determine which to issue to whom depending on their likelihood of being infected or in close contact with infected people.

Here are the international codes that have been designated for this lockdown. The 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) for COVID-19 are as follows:

- B34.2 for both COVID-19 confirmed cases and PROBABLE cases
- Z20.828 for possible cases and contacts of those who were confirmed and/or are probable cases.

Detailed instructions and updates as to how to use these codes in the clinical setting are arriving at medical facilities every day. In my country, a 'definitive' version was sent out in

the last few days. **At the beginning of this, many people were being labelled B34.2 [‘confirmed’/’probable’] when they should really have received the other code [Z20.828 – ‘possible’]**. Additionally, those whose tests were inconclusive (probable cases), were nevertheless grouped together with ‘confirmed’ cases. While these codes of distinction make sense for managing a crisis situation, **they unfortunately also leave much room for subjective interpretation**.

Testing, Testing, 1-2-3?

Tests for the presence of this “novel” coronavirus are done through RT-PCR (real-time reverse transcription polymerase chain reaction) testing, which detects antigens of the virus or proteins or nucleic acids, which is the RNA genetic information of the virus. These genetic tests, even though there are limitations to what they can reveal, are the official and optimal way to test people.

Another way to test is by determining the presence of an immune response against the virus. These have been called “rapid tests” because they take much less time to do than the genetic tests. In this case, IgM antibodies are produced earlier and IgG antibodies later. Both can be detected in the rapid test. However, according to a published study on such tests for COVID-19:

> “The seroconversion sequentially appeared for Ab [antibodies], IgM and then IgG, with a median time of 11, 12 and 14 days, respectively. **The presence of antibodies was < 40% among patients in the first 7 days of illness**.”

Therefore, rapid tests to measure the presence of IgM or IgG antibodies against COVID-19 are not useful for the detection of acute cases.

One problem brought to the fore by the lockdown is that they’re not testing the general population because the entire population is considered suspect anyway. It is, after all, an emergency. **Those being tested are, for the most part, hospitalized patients. This creates numbers from samples that don’t reflect the overall picture of COVID-19 in the general population**. Hospital populations are one thing, but the general population at home is an entirely different thing.

As this paper published on 26 March 2020 in the *New England Journal of Medicine* explains,

> “**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%.** This suggests that the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of approximately 0.1%) or a pandemic influenza (similar to those in 1957 and 1968) rather than a disease similar to SARS or MERS, which have had case fatality rates of 9 to 10% and 36%, respectively.”

How can we know? One country is testing its entire population. According to numbers published by the government of Iceland on 25 March, Iceland has the highest proportion of tests performed by any single country in the entire world. Iceland’s chief epidemiologist, Thorolfur Guðnason, is quoted as saying,

> "Early results from deCode Genetics indicate that a low proportion of the general population has contracted the virus and that about **half of those who tested positive are non-symptomatic**," said Guðnason. "**The other half displays very moderate cold-like symptoms**."

Nevertheless, private practices everywhere have been shut down, leaving many people who were relying on them to manage their health having to wait until further notice. Anything non-essential to the coronavirus emergency is postponed. **This means that the very important role of primary healthcare carried out by family doctors and general practitioners (GPs) has effectively shut down. And I'm decidedly more worried about patients whose scheduled consultations were cancelled**, for reasons I explain below.

From the Health Trenches

One of my correspondents is a medical doctor who works in one of Italy's most afflicted hospitals. At first glance, his testimony supported what has been repeatedly highlighted: 'above-normal' numbers of people, including young people, in respiratory distress or with extensive pneumonias, etc.

However, something else he said caught my attention: **he reported seeing many patients – both hospitalized and non-hospitalized – who present with mild clinical symptoms, and he further clarified that they comprised "most" of his patients**.

This bears repeating: **MOST hospitalized and non-hospitalized patients present with mild clinical symptoms**. No matter how much of a 'warzone' doctors in certain hotspots may subjectively *feel* they are currently in, the numbers they are dealing with are nevertheless going to – with hindsight or contextual data – prove consistent with such data as that coming from Iceland.

People lying on the floor somewhere in a Spanish hospital because there aren't enough beds. Believe it or not, this happens from time to time…

Photos and videos circulating online from one hospital show people lying on the floor. As a colleague related in one of the multiple WhatsApp groups created for medics of late:

> "I think that this video is very sensationalist… [It's my hospital] where, unfortunately, the patients in the ER could not sleep on a sofa, and they asked to lay down in the floor, so they could sleep. It was lamentable, but with 120 people pending hospitalization, it was impossible to give them all beds. Nevertheless, the situation got better, and we have doubled the number of beds available, and even though we don't an excess of material, we aren't short-staffed…"

What seems to be compounding this largely administrative crisis is that a lot of people who would otherwise be at home with primary healthcare follow-ups are unnecessarily remaining in the hospital. That is a luxury you simply cannot take in countries with a very elderly population, who can go into respiratory failure even with a banal bug. There are also a *lot* of comorbidities in the general population today.

It's true that the COVID-19 virus is playing a role in atypical pneumonias seen in younger people who can go into respiratory distress. But according to a paper published in *JAMA* on 17 March, almost **87 per cent of deaths in Italy have been in patients over 70 years old – as happens during ANY flu season**. The chief of Italy's Superior Institute of Health reported midway through this month that:

> "From the medical records examined so far (not much more than 100), the majority of deaths from Covid-19 in Italy have been among the very old. **The average age is 80.3 years**. **The majority of deaths had 3 or more associated serious health issues**. Two patients who died did not have any of the most common serious health issues, although other issues may become apparent as further investigation takes place. Just two people under 40 years old have died, both 39 years old – **one had cancer and the other one had diabetes, obesity and other health problems prior to the infection**."

The panic combined with the administrative and medical directives are sending ALL emotionally and physically distressed patients to the hospitals. The fact remains, however, that MOST people in the general population will not go into respiratory distress. Perspective should be kept so as to not break the hospital system.

To get an idea of the characteristic issues facing elderly patients, let's review a fictional but typical case:

Say an 86-year-old patient has a fever. He has been coughing for days previously. A doctor might find he's approaching respiratory failure. In his medical history you find that he has chronic kidney failure (as most elderly do), heart failure, chronic obstructive pulmonary disease (COPD), diabetes, high blood pressure, atrial fibrillation and hypothyroidism. Such a cluster is not unusual in someone his age, which is why a patient like this could be taking up to 12 medications, including potent blood thinners. A person like this might be labelled 'COPD – exacerbation'. If he's hospitalized, they will test for microbes including bacteria and viruses. If he's not making progress, his organs might start to fail. Or the patient might get better. Some don't, and – brace yourselves… *they die*.

European hospitals and clinics are overburdened with such cases because there are many elderly patients with comorbidities. Nevertheless, assistance and pretty good health care is *always* provided – until the very end. In the past, I was often pleasantly surprised by just how much Europeans care about their elderly. Now I have gotten used to it. In other countries, they just don't bother.

Intensive Care Units (ICU) might consider running a 'common sense filter'. An old patient with an infection, with multiple diseases, and with multiple organ failure might signal to them that it's time for this person to pass away peacefully, with care taken to minimize their suffering. It is often the case that an elderly patient has expressed officially that when the time comes, he or she will just want to pass away and *not* be reanimated. It can happen that health staff get so fixated on treating older patients, that a younger person doesn't have an ICU bed when it's needed, i.e. in cases of respiratory distress.

In the example I outlined above, each disease and infection found in the patient will have its own international code for labelling purposes. As explained earlier, the coronavirus label has its own codes for statistical purposes. **It does NOT mean COVID-19 killed the person**. Some people have so many diseases that any banal bug could take them out. The difference between dying WITH coronavirus or DUE to coronavirus is a subtle but important one.

The Shutdown of Regular Medical Visits

Those with diabetes, heart failure, COPD, etc. have to wait out at home, isolated, until they get the green light to recommence their regular medical visits and follow-ups. Too bad if they catch a cold or anything else from the stress this pandemic is engendering. If they end up in the hospital, they will be tested for coronavirus. In the meantime, they are waiting patiently at home and are very understanding of the system that told them to wait at home because it 'has to deal with more important issues right now'.

I know of a number of hospitalized COVID-19 confirmed cases that could be at home. Most people at home with respiratory symptoms these days have no breathing problems. Nevertheless, as per protocol, and because COVID-19 patients are recovering and then, a week later, it can strike them again, follow-ups are being done after one week.

Before all of this began, **up to 60 patients with either the flu or the common cold were showing up at my health center in just ONE morning. It was one patient after the other with respiratory symptoms**. But due to the lockdown directives, these patients are either staying at home or they're all going to the ER and/or to the hospital. For the most, it's just phone calls to see how they're doing. Primary healthcare has effectively been shut down. This worries me because GPs do a very important job in avoiding decompensations in people with multiple comorbidities who would otherwise end up in the hospital. Patients with issues like heart failure, cancer, COPD, diabetes, high blood pressure, anxiety, severe depression, etc. need constant follow-ups and reassurance.

If hospitals don't let go of the MILD cases, they will soon be in very big trouble. I can easily think of 100-300 people in any single doctor's post covering around 1,500 patients (or 1,900 in some regions, if you count those in elderly residencies) who are at risk of going into respiratory failure or some other emergency if their check-ups are withheld for longer and/or if they catch a cold. Yes, this COVID-19 is highly contagious and it has its peculiarities. **But the fact remains that people have multiple comorbidities and life has to continue. COVID-19 is not the only healthcare issue in the world right now**:

And, again, MOST people, especially those without comorbidities, will only experience a mild form of it. The rest, which is a large majority of the population, will remain without symptoms.

Most of the medical workforce is located in Primary Healthcare, not in hospitals. Now, anything that happens to anybody has to be dealt with by the emergency services in the hospitals because they can't come to primary healthcare doctors, nor can they continue with their regular specialized visits at the hospital. People have complex medical histories and tragic lives. **Other than medical work, primary healthcare workers are often the substitute for what in the past was the counseling work of the local priests and parishioners**. Surely someone should have thought about this? Some hospital doctors often look down on Primary Healthcare providers with disdain, and that is because they don't have the patience to do that kind of job, in which it's important to get to know entire families and their tragic suffering.

Media Heroes Now And Then

The work of Primary Healthcare is always important, but you don't ever see that in the news. The media currently needs hospital heroes and stories of how ER staff don't have time to eat and how an ICU nurse committed suicide after testing positive for COVID-19. But primary healthcare workers are appreciated by their regular patients, especially now that consultations are limited to phone calls because patient-doctor meetings are discouraged. Unlike before, when they didn't have time to eat or take bathroom breaks, or were spending up to four consecutive days working non-stop with very little sleep and dealing with four significant emergencies at the same time, few cared much for healthcare providers because they never heard about their hectic 'wars' against diseases in the news. Such is life.

I leave you with the considered perspective of Dr. John Ioannidis, professor of medicine, of epidemiology and population health, of biomedical data science, and of statistics at Stanford University. He is perhaps THE most "evidence-based" medical scientist in the world today, and he says of this emergency:

> "The current coronavirus disease, Covid-19, has been called a once-in-a-century pandemic. **But it may also be a once-in-a-century evidence FIASCO**."

He later added in a separate publication:

> "If COVID-19 is not as grave as it is depicted, high evidence standards are equally relevant. **Exaggeration and over-reaction may seriously damage the reputation of science, public health, media, and policy-makers. It may foster disbelief that will jeopardize the prospects of an appropriately strong response if and when a more major pandemic strikes in the future**."

Or, as the prime directive of medical ethics goes:

First, Do No Harm.

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Our thanks to Dr. Gary G. Kohls for bringing this to our attention.

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email lists. Crosspost on your blog site, internet forums. etc.

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