Heritage
FAMILY HEALTH, PC
at The Doctor's Inn

April 25, 2020

The Honorable Governor Tom Wolf
Office of the Governor
Commonwealth of Pennsylvania
508 Main Capitol Building
Harrisburg, PA 17120

Re: Data from a semi-rural Pennsylvania primary care practice as pertains to Covid-19

Dear Governor Wolf,

My wife and I have been board-certified attending physicians in the Commonwealth of Pennsylvania since 2005 and 2006, respectively. Our clinical teeth were cut by "storming the wards"[1] in the UK-based NHS hospitals, where clinical practice was driven more by good history-taking and exam skills rather than reflexive testing. We returned to our native Pennsylvania and completed our residency training in family and community medicine at Penn State Hershey.

Our current practice was established in 2011 and is located outside Schaefferstown in southern Lebanon County. We care for over 6,000 patients from Lebanon, Lancaster, and Berks Counties. Most are farmers, tradespeople, and small business owners. Many of our patients are from Amish and Mennonite communities, and therefore circulate widely in closely-knit social, school and church communities. Many even have a religious practice known as the "holy kiss,"[2] which is widely used at church gatherings. I acknowledge my perspective as a primary care physician and not an ER physician or intensivist. I have the utmost respect for my colleagues on the front lines of ERs and ICUs. I also acknowledge that our

[1] The term used by a consultant neurologist we worked with in Dundee, Scotland during an internal medicine rotation.
[2] This is generally a greeting "kiss" on or near the mouth practiced between men with men and women with women. Most avoid this practice if they have a common cold, etc. This has of course been avoided during the era of social distancing but was practiced commonly throughout this past winter.

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practice is not representative of the entire Commonwealth. However, any primary care office is a microcosm of the health of the larger community, and our office offers a unique perspective based on the patient population we serve.

During the week between Christmas and New Year, we noticed a significant increase in office sick visits. The next three months (January to March) turned out to be the "worst" winter for sickness that either of us recall in our clinical careers. This week I did a chart review of all the patients we had tested for the flu.[3] These were symptoms that either of us had determined to be very likely influenza and so the rapid test was utilized to help establish the diagnosis.[4] Our chart review findings were interesting:

- January: 18 positives out of 33 flu swabs (55%)
- February: 10 positives out of 16 flu swabs (62.5%)
- March: 3 positives out of 12 flu swabs (25%)

Among the three months, this represents a cumulative positive of 50.8%. In other words, only half the cases that aroused our clinical suspicion for influenza were positive. This either represents poor physician clinical judgment or the possibility that something else was clinically occurring—possibly yet-unnamed Covid-19.[5] In reviewing these charts, I was struck with the number of times we noted in the record something like—*surprised that flu swab was negative, as clinically appears to be flu*. One patient seen by my wife initially on 2/6/20 particularly caught my attention. This patient presented with flu-like symptoms but was negative; patient returned on 2/10/20 for "chest tightness" and again on 2/21/20 for "ongoing cough." I was doing a CDL physical on a young man last week and he told me that he's quite certain his entire family had Covid-19 in mid-February, as "I had the worst cough I've ever had which knocked me out for a week" and his children only had mild symptoms.[6] The above data also indicates that whatever was occurring in our community peaked in January and was waning through February and March; in other words, our curve was already flattening.[7] One school in our community was so affected during January that it was dismissed for a few days while it was fumigated. This decision was made without any government intervention or mandate.

[3] While "the flu" is used very broadly in our community, this is specifically a 15-minute rapid test for influenza A or B. Note that our practice is to test one member in a family. If one member has an illness, it is presumed that family members with similar symptoms have the same. Hence the numbers could likely be multiplied by 2 to 4+, and then extended to family contacts who didn't come to our office. This applies to both positive and negative tests.

[4] The common triad of COVID-19 symptoms (fever, cough, and shortness of breath) is relatively non-specific, as these are features (with some variation) of any upper respiratory infection, viral or bacterial.

[5] Note that on February 11, 2020, the International Committee on Taxonomy of Viruses named SARS-CoV-2 as the virus responsible for COVID-19 (the disease), according to this source at the WHO. It was named CoV-2 because of its genetic similarity to the coronavirus responsible for the SARS outbreak of 2003. Note also that "a close study of circulating [SARS-CoV-2] viral genomes suggests that the first infection and human-to-human spread occurred between mid-September and early December 2019," according to the AAPS May 2020 newsletter.

[6] Neither this patient nor his family presented to our office for care; they simply "hunkered down" at home and rode out their symptoms. I suspect there were many families with similar symptoms who didn't present for care, as this is rather typical of our practice.

[7] We of course cannot be certain this was Covid-19, although we have a strong clinical suspicion it was. Now that SARS-CoV-2 IgG antibody testing is available, we will be offering this testing in office to our patients beginning the week of 4/27/20.

It should be noted that we have swabbed no one for the flu in the office in the month of April.[8] We have also had almost no calls in almost three weeks from patients concerned that they had Covid-19 symptoms.[9]

As a matter of timeline, you closed schools throughout the Commonwealth the same afternoon that President Trump declared a national state of emergency (March 13) and declared a state of emergency in Pennsylvania on March 16. Late on March 19, you ordered non-essential businesses closed and issued the initial stay-at-home orders on March 23 for seven counties surrounding Philadelphia. Lancaster and Berks Counties were added on March 27 and Lebanon County on March 31. On March 30, you extended stay-at-home orders throughout the Commonwealth through April 30. You ordered patrons and employees of essential businesses to wear mandatory facemasks on April 19, effective 8 PM. On April 20, you extended those orders through May 8. I am familiar with your phased approach to reopening the Commonwealth and am aware that large gatherings of more than 25 will still be prohibited in the yellow phase of reopening. The Governor's website states that the "phased approach relies on safety and science." In an era of evidence-based medicine, I have been surprised by the lack of evidence and scientific support for many of your recommendations, as outlined below.

Before outlining my concerns, I quote US Attorney General Barr from an interview with Laura Ingraham on April 21: "Our federal constitutional rights don't go away in an emergency. They constrain what the government can do. And in a circumstance like this, they put on the government the burden to make sure that whatever burdens it's putting on our constitutional liberties are strictly necessary to deal with the problem. They have to be targeted. They have to use less intrusive means if they are equally effective in dealing with the problem."[10] I aim to show in the four concerns I outline below that the Commonwealth has not adequately proven that burden.

MORTALITY RATE

Because words are so frequently misconstrued in our highly polarized age, let me be clear. "Unquestionably, SARS-CoV-2 can cause respiratory and multi-organ failure; occasionally strikes down young, healthy individuals with terrifying speed; has overwhelmed intensive care units in some areas; and is highly contagious."[11] I am not disputing that fact. It is also true that "the vast majority of people, especially children, recover uneventfully, as their immune systems defeat the virus."[12]

Department of Health data shows a mortality rate in the Commonwealth of 3.8% on April 23. The same day's *Wall Street Journal* shows a national morality rate of 5.5% and a worldwide rate of 7%.[13] From my frequent calculations, these percentages have remained relatively constant over the past few weeks.

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[8] Patient visits have been cut in our office by 50%, but we are still seeing patients, including "sick" ones, and isolating appropriately.

[9] Shortly after the declared state of emergency, we fielded many calls from patients with either symptoms or concerned that they might have symptoms. We've had two positive COVID-19 cases in our office. One, unfortunately, did not survive.

[10] From the interview, reported here on Fox News.

[11] From the AAPS (Association of American Physicians and Surgeons) May 2020 newsletter, "Virus and Resistance," Vol 76, no 5, available here.

[12] Ibid.

[13] *The Wall Street Journal*, 4/23/20, p. A4, data from Johns Hopkins University.

It appears, however, that a more accurate approach to mortality is as Dr. Fauci et al. wrote in an editorial in *The New England Journal of Medicine (NEJM)*:

> On the basis of a case definition requiring a diagnosis of pneumonia, the currently reported case fatality rate is approximately 2%. In another article in the *Journal*, Guan et al. report mortality of 1.4% among 1099 patients with laboratory-confirmed Covid-19; these patients had a wide spectrum of disease severity. 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 suggest 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.[14]

It has been widely reported that Dr. Fauci has said that US Covid-19 deaths will likely be closer 60,000, the upper limit of an annual flu.[15] A preliminary seroprevalence Stanford study of a population in Santa Clara County, California released on April 17 suggests rates 50 to 85 times higher than known cases, thereby yielding a Covid-19 fatality rate of "0.12% to 0.2%--far close to the seasonal influenza than to the original, case-based estimates."[16]

The huge unknown is whether this has been drastically reduced due to aggressive social distancing and quarantine (i.e. "flattening the curve"), or if this is the natural course of the disease, as would be suggested by our patient population and other emerging data.

SOCIAL DISTANCING: QUARANTINE

It is fair to say that the term "social distancing" was probably unheard of to most Americans just a few months ago. It certainly was new to me. Americans are now either voluntarily or compulsively isolating themselves, wearing facemasks, avoiding physical contact, maintaining 6-foot distances, not meeting in groups over 10, etc. In this and the following section, I focus on the first two.

"Flattening the curve" is now household language. We've all heard of the initial predictions from Imperial College London and the IHME (Institute for Health Metric and Evaluation) from the University of Washington. These mathematical and epidemiological models have been widely debated and criticized. Threats of quarantine led to the world's first toilet paper shortage and awareness that SARS-CoV-2 could live on hard surfaces for hours to days as well as be transmitted by airborne droplets for up to 6 (some suggested 27[17]) feet led to the sanitizer shortage.[18]

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[14] *NEJM* 2020; 382:1268-1269; March 26, 2020 print edition.
[15] The CDC estimates annual flu deaths in the USA to be around 30 to 60,000. Their "preliminary estimates" were 61,000 in 2017-18; 34,157 in 2018-2019; and 24 to 62,000 in 2019-2020.
[16] As reported on 4/17/20 in *The Wall Street Journal*, available here.
[17] From JAMA, March 26, 2020, available here.
[18] Our office policy has *always been* to wipe down rooms with medical-grade germicidal wipes between every patient; we have simply continued that practice with increased diligence.

Quarantine is not new as a public health strategy. It was certainly practiced in biblical times for lepers.[19] "Organized institutional responses to disease control began during the plague epidemic of 1347-1352"[20] in Europe. Tognotti further writes, "Quarantine…strategies have always been much debated, perceived as intrusive, and accompanied in every age and under all political regimes by an undercurrent of suspicion, distrust, and riots. These strategic measures have raised (and continue to raise) a variety of political, economic, social, and ethical issues. In the face of dramatic health crisis, individual rights have often been trampled in the name of public good. The use of segregation or isolation to separate persons *suspected of being infected* [emphasis mine] has frequently violated the liberty of outwardly healthy persons…"

And that is the key—"suspected of being infected." Because under current Commonwealth restrictions, we are all suspected of being infected. That is certainly how it's portrayed by the media. But is that true? I went to the medical literature to find out.

Some of the first returning travelers from Wuhan, China were thought to be asymptomatic transmitters of Covid-19. Bill Gates wrote in the February 28, 2020 *NEJM*, "There is also strong evidence that it can be transmitted by people who are just mildly ill or even presymptomatic."[21] His reference was a correspondence piece signed by 20 physician-scientists and published online by *NEJM* on February 18 and later in the print edition of March 26, 2020. Their language was far less certain:

- "…epidemiologic *uncertainty* regarding *possible* transmission of the virus by asymptomatically or subclinically symptomatic infected persons. It is *unclear* whether persons who show no signs or symptoms of respiratory infection shed SARS-CoV-2."
- "We discovered that shedding of potentially infectious virus *may* occur in persons who have no fever and no signs or only minor signs of infection [all emphases mine]." [22]

In the March 12, 2020 edition of *Eurosurveillance*, I discovered:

- "Currently, *there is no clear evidence that COVID-19 asymptomatic persons can transmit SARS-CoV-2*, but there is accumulating evidence indicating that a substantial fraction of SARS-CoV-2 infected individuals are asymptomatic [emphasis mine]."[23]

In the April 10, 2020 edition of the CDC's *MMWR*, I discovered this language:

- "…the existence of presymptomatic or asymptomatic transmission would present difficult challenges to contact tracing. Such transmission modes *have not been definitely documented for*

[19] It wasn't until the twentieth century that leprosy was discovered to not be a contagious disease, thanks to the heroic work of Dr. Paul Brand and others.
[20] Eugenia Tognotti, "Lessons from the History of Quarantine, from Plague to Influenza A," *Emerg Infect Dis*. 2013 Feb; 19(2): 254–259.
[21] Bill Gates, "Responding to Covid-19—A Once-in-a-Century Pandemic?" *NEJM*, February 28, 2020.
[22] Hoehl et al. "Evidence of SARS-CoV-2 Infection in Returning Travelers from Wuhan, China," *NEJM* 2020; 382:1278-1280.
[23] Mizumoto et al. "Estimating the asymptomatic proportion of coronavirus disease 2019 (COVID-19) cases on board the Diamond Princess cruise ship, Yokohama, Japan, 2020," Euro Surveill. 2020 Mar 12; 25(10): 2000180. (This journal is "Europe's journal on infectious disease epidemiology, prevention and control since 1996.")

COVID-19, although cases of presymptomatic and asymptomatic transmissions *have been reported* in China and *possibly occurred* in a nursing facility in King County, Washington."[24]

- "The *possibility* of presymptomatic transmission of SARS-CoV-2 increases the challenges of COVID-19 containment measures, which are predicated on early detection and isolation of symptomatic persons. The magnitude of this impact is dependent upon the extent and duration of transmissibility while a patient is presymptomatic, *which, to date, have not been clearly established* [all emphases mine]."[25]
- Scattered throughout the rest of the report were words such a *likely*, *suggest*, *suggested*, *could have occurred*, *might occur*, etc.

Hence, the quarantining of *all* Commonwealth citizens—regardless of symptoms or exposure—is being mandated in the face of uncertain scientific evidence, on the undocumented assumption that we are *all* "suspected of being infected." There is simply not scientific evidence to support that mandate.

Parmet and Sinha write in the April 9, 2020 *NEJM*, "In public health practice, 'quarantine' refers to the separation of persons (or communities) who have been exposed to an infectious disease. 'Isolation,' in contrast, applies to the separation of persons who are known to be infected. In U.S. law, however, 'quarantine' often refers to both types of interventions…"[26] They state a common-sense obvious, "Patients with mild symptoms should stay home when possible." They further write, "…many low-wage and gig workers cannot afford to stay home. Nor can they handle the economic impact of other social distancing measures…" I would argue that the Commonwealth is acting outside the traditional and legal understanding of both quarantine and isolation.

Indeed, as Attorney General Barr stated in the previously mentioned interview, "…the idea that you have to stay in your house is disturbingly close to house arrest. I'm not saying it wasn't justified. I'm not saying in some places it might still be justified. But it's very onerous, as is shutting down your livelihood. So these are very, very burdensome impingements on liberty…"

A report in *The BMJ* published on April 2, 2020 notes that four fifths of Covid-19 cases are asymptomatic. Tom Jefferson, epidemiologist and honorary research fellow at University of Oxford's Centre for Evidence-Based Medicine (CEBM), called this "very, very important. The sample is small, and more data will become available…let's just say [the results] are generalisable…then this suggests the virus is everywhere. If—and I stress, if—the results are representative, then we have to ask, 'what the hell are we locking down for?'"[27]

Jefferson and colleague Carl Heneghan, professor of evidence-based medicine and Centre director, write: "[There can be] little doubt that the price of lockdown to society and economic paralysis is likely to be paid for generations to come. In the short term economic devastation seems certain, imposing a heavy penalty on us and probably successive generations…Lockdown is going to bankrupt all of us and

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[24] Wei et al. "Presymptomatic Transmission of SARS-CoV-2—Singapore, January 23-March 16, 2020," *MMWR*, April 10, 2020; Vol 69, No 14, p. 411.
[25] Ibid, pp. 414-15.
[26] Parmet & Sinha, "Covid-19—The Law and Limits of Quarantine," *NEJM* 2020; 382:e28.
[27] Michael Day, "Covid-19: four fifths of cases are asymptomatic, China figures indicate," *BMJ* 2020;369:m1375.

our descendants and is unlikely at this point to slow or halt viral circulation as the genie is out of the bottle. What the current situation boils down to is this: is the economic meltdown a price worth paying to halt or delay what is already amongst us?"[28]

Professor Yitzhak Ben Israel of Tel Aviv University has plotted the rates of new coronavirus infections in the USA, UK, Sweden, Italy, Israel, Switzerland, France, Germany, and Spain. "The numbers told a shocking story: irrespective of whether the country quarantined like Israel, or went about business as usual like Sweden, coronavirus peaked and subsided in the exact same way…His graphs show that all countries experienced seemingly identical coronavirus infection patterns, with the number of infected peaking in the sixth week and rapidly subsiding by the eighth week."[29]

SOCIAL DISTANCING: FACE MASKS

The Commonwealth's mandate for wearing facial coverings in public "essential" space is again predicated on the unfounded assumption that *all* are "suspected of being infected." Up until a month or two ago, the common medical recommendation for facial masks was in obvious healthcare settings such as ORs or possible exposures or to *possibly* limit spread from infected to non-infected people. As recent as March 4, 2020, recommendations on a *JAMA* patient page stated: "Face makes should not be worn by healthy individuals to protect themselves from acquiring respiratory infection because *there is no evidence that face masks worn by healthy individuals are effective in preventing people from becoming ill* [emphasis mine]."[30]

The universal mandate for facial coverings is a somewhat subversive twist of the above statement; we are now being asked to believe that wearing a mask will somehow prevent us from making other people ill (i.e. the inconclusive asymptomatic transmitter described above). But if "there is no evidence" that a face mask prevents a well person from becoming ill, how can there now be evidence in a few short weeks that a face mask prevents a well person from making another well person ill?!

Jefferson and Heneghan recently revised some of their original work on how effective barriers are to transmitting infections. They note, "Evidence from 14 trials on the use of masks vs. no masks was disappointing: it showed no effect in either healthcare workers or in community settings. We could also find no evidence of a difference between the N95 and other types of masks…"[31] In all fairness to them, they state that "our findings cannot be the final word." They also state that "there is no evidence of effectiveness" of cloth masks.

However, the Commonwealth's citizens have always been industrious, and the making of cloth masks has become quite a cottage industry locally, some selling for over $10! The Commonwealth is of course following the recommendation of the CDC. But as recently as March 17, 2020, the CDC "does not recom-

[28] Jefferson & Heneghan, "COVID-19—The Tipping Point," April 8, 2020, on CEBM website.
[29] As reported by Marina Medvin, April 15, 2020, in Townhall. I looked at the Professor's original paper, but it was in Hebrew. This was also reported on April 23, 2020 in the UK's *The Telegraph*, under the title "Coronavirus dies out within 70 days no matter how we tackle it, claims professor."
[30] Desai & Mehrotra, "Medical Masks," *JAMA*. 2020;323(15):1517-1518. doi:10.1001/jama.2020.2331, published March 4, 2020.
[31] Jefferson & Heneghan, "COVID-19—Masks on or off?" April 17, 2020, on CEBM website.

mend that people who are well wear a face mask…to protect themselves from respiratory diseases, including COVID-19," according to a review in *The Lancet*.[32] Now, that language has been replaced to recommend (but not mandate) wearing face coverings of some sort in public settings, "**especially** [CDC's emphasis] in areas of significant community-based transmission."[33] But *The Lancet* review states, "Universal face mask use in the community has also been discouraged with the argument that face masks provide no effective protection against coronavirus infection." It begs the question what in our medical understanding has changed so dramatically in the space of a few short weeks to have an entirely opposite recommendation? This highlights the arbitrary and non-scientific basis of some of these recommendations—particularly when a one-size-fits-all approach is forced upon all communities across the country.[34]

In an era of evidence-based medicine, I cannot find such evidence to recommend to my patients for the universal wearing of masks. I believe they foster a paranoia (when masked people see unmasked people, for example) as well as an illusion of control.

OVERALL HEALTH

I certainly do not deny the grief of those affected by Covid-19. Family physicians are trained to look at the entire person. The first line to the preamble of the Constitution of the WHO remains apropos: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[35]

While we certainly are in the midst of a pandemic, we have been in pandemics before. Even in far severer cases as referenced by Dr. Fauci et al. above, such draconian measures have not been taken at the expense of an entire society.

Further, focus on Covid-19 seems to have over-run the health system. Routine MRSA precautions seem to have been abandoned at one local hospital.[36] Reports of staff, including physicians, being furloughed abound. A letter to the editor in *The Wall Street Journal* on April 12, 2020 by Dr. Timothy Jackson from Pasadena, California notes:

> "A part of the financial strain in medicine arises from canceling all elective surgery. I am an orthopedic surgeon who performs elective hip replacements. Since mid-March we haven't performed surgery. The rational was to save resources such as masks in anticipation for the rush of Covid-19 patients…The financial struggle that is occurring and will continue for years to come is because my colleagues and I aren't performing important elective surgery.

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[32] Feng et al. "Rational use of face masks in the COVID-19 pandemic," *The Lancet*, March 20, 2020.
[33] Available here on the CDC website.
[34] I found an interesting 2013 literature review that showed that the use of surgical masks in the operating room had no effect on prevention of surgical site infections (SSI). Some of the literature suggested that surgical face masks increased the likelihood of infection, while "all other trials included in the systematic reviews did not demonstrate any statistically significant differences in SSI frequency between the masked and unmasked group." I realize this is not directly applicable to Covid-19, a respiratory infection. But it does show that masks often don't do what we would expect them to do.
[35] This is the classic 1948 definition, available here.
[36] This was reported to me by a staff member at a major local hospital.

> "We cannot continue to deny medical care to the masses…We shut down a large portion of health care prematurely; let us not wait too long to resume this vital function of a healthy society."[37]

Writing in the *NEJM*, Dr. Lisa Rosenbaum recounts multiple stories of cancer and cardiac care not being given in deference to Covid-19. She quotes an interventional cardiologist at Jamaica Hospital Medical Center and Lenox Hill Hospital in New York who said, "I think the toll on non-Covid patients will be much greater than Covid deaths." Michael Grossbard, chief of hematology at New York University's Langone Hospital stated, "Our practice of medicine has changed more in 1 week than in my previous 28 years combined." She recounts the story of a 70s-year old woman with cardiac risk factors presenting to an ED with chest pressure and shortness of breath. She required urgent intubation. Chest x-ray revealed bilateral interstitial pneumonia, so she was transferred to ICU as a "Covid rule-out." While waiting for her Covid results, her troponins continue to rise. When Covid results came back negative, she underwent angiography, but by then she had developed cardiogenic shock due to coronary occlusion and died.[38]

As a primary care physician, I am of course interested in my patient's physical health. But I am equally interested in their mental, social, and spiritual health. At his request, Dr. Chris Walker and I had a phone conversation earlier this week regarding coronavirus, return to church, etc.[39] Dr. Walker is the senior pastor at Westminster Presbyterian Church in Lancaster, Pennsylvania, where my wife and I are members. Like most if not all churches throughout the Commonwealth, Westminster has not physically met since an abbreviated morning service on March 15—tomorrow will mark six weeks that we have not physically met as a congregation. During this quarantine, the elders and deacons have reached out by phone to every member and regular attender—over 1200 people. Not one of those 1200 reported having coronavirus. However, many reported significant struggles with job loss, lack of finances, general uncertainty, isolation, loneliness, etc. I am confident this is representative across the Commonwealth.

The Commonwealth must understand that its citizens have largely respected government mandates. All have attempted to be responsible citizens. But all—from Amish deacons to Mennonite bishops to Presbyterian pastors—are asking the same question: *how long can we continue this?* As Dr. Walker said, "This is much more than a job to us [pastors]. We are responsible for the soul care of our congregation, and we cannot do that effectively from a distance." Continuing to limit groups of people to 25 or less throughout the next number of weeks is simply untenable.

The economic and emotional fallout from the quarantine will extend far beyond the effects of coronavirus. These are stories I've dealt with in my office over the past few weeks:

- Farmers pouring thousands of gallons of milk down the drain, sometimes being pumped into the manure pit. *Will the co-op pay? They say so, but I'll believe it when I see it.*
- Chicken farmers needing to gas flocks of chickens.
- Hog famers slaughtering hogs.
- A suicide.
- A cancelled chicken flock which will take 6 to 9 months to recover from.
- Low beef prices.

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[37] *The Wall Street Journal*, April 12, 2020.
[38] All recounted in Rosenbaum, "The Untold Toll—The Pandemic's Effects on Patients without Covid-19," *NEJM*, April 17, 2020.
[39] I am using his name and our conversation with Dr. Walker's permission.

- A young boy with an obvious growth on his eye can't see an ophthalmologist because it's not a medical emergency.
- A fleet of 50 trucks sitting idle, with tens of thousands of dollars of lost revenue.
- Healthy older people "scared to death" that they're going to die from "this virus."
- Patient has a painful toe, but "elective procedures" are prohibited, so I treat with an oral medication. Presents two weeks later with worsening symptoms and I do the procedure.
- Construction crews on hold.
- *Numbness and tingling in both of my arms when I lay down at night. Not sure if it's my asthma or my anxiety*.
- Trichotillomania in a previously stable patient, now with bald patches to prove the anxiety.
- *Things were finally looking up after 5 years of bad milk prices. Now, I don't know what to think.*
- *I need to take the temperature on all my employees when they do come back to work.*

This list goes on. These are the human faces I see in our practice in the midst of the Covid-19 pandemic. It will take a long time to recover from this economic and emotional fallout.

I can certainly appreciate the complexity of making appropriate decisions for the good of the Commonwealth. However, I submit that your mandated restrictions across the Commonwealth are dramatically harming the *overall health* of its citizens. Government does not grant its citizens their "unalienable rights." They are rather "endowed by their Creator" as so eloquently stated in the Declaration of Independence. It is time for the Commonwealth to return to its citizens the respect that its citizens afforded the Commonwealth. It is time that policy be driven by science and not ideology. It is time for healthy citizens to be returned to normal life.

On May 18, 2002, we stood in The Guildhall on Market Square in Cambridge, England and declared: "The health and life of my patient will be my first consideration." The urgency of that oath could not be more apparent.

Respectfully yours,

Joel E. Yeager, MD

CC: Dr. Rachel Levine, Pennsylvania Secretary of Health
Pennsylvania Senator David J. Arnold, Jr.
Pennsylvania Representative Russ Diamond
US Congressman Dan Meuser (PA-09)
US Senator Pat Toomey
US Senator Bob Casey
Dr. Chris Walker, Westminster Presbyterian Church
Heritage Family Health, PC patients and other interested persons