

On August 20, 2020, I admitted my first COVID patient – Joseph, a 97 y/o Italian linguistics professor from a living facility where he contracted COVID. His daughter begged the ALF to give him hydroxychloroquine but they refused. On admission, he was clearly too far along to recover. In violation of hospital policy (and thanks to compassionate nursing staff), I was at least able to ensure that his daughter was at his side for the final days of his life.

On October 18, 2021, I discharged my last COVID patient – 60 y/o Steve, who had spent 40 days struggling with COVID pneumonia. If not for his loving, bulldog of a wife who fought hospital policy to stay by his side 24/7 (and give him ivermectin!) he most certainly would not have survived.

When the much-loved pastor of a local church lay in the ICU on a ventilator dying, his family was denied visitation (!!). When I brought his immediate family to the bedside so they could pray with him before he died, the hospital imposed a \$500 fine and a two-week suspension of my hospital privileges.

A young mother gave birth in August 2021 while sick with COVID. As she deteriorated, her OB consulted me. I confirmed bilateral pneumonia and an oxygen saturation of 85% and falling. I gave her ivermectin and transferred her to the medical floor, where I continued treatment with ivermectin, enoxaparin and a multidrug regimen. She went home with her baby after three days. The hospital disciplined me for dispensing ivermectin and removed me as Department Chair of Family Medicine, citing its expectation that medical staff remain “lockstep” with hospital policy.

On New Year’s Day 2021, a young car salesman and single father of two was admitted with COVID. Unable to provide ivermectin or hydroxychloroquine, I treated him with high-dose steroids and anticoagulants and visited him daily while he remained isolated on high-flow oxygen and BiPAP. After returning home, he told me, “You saved my life,” and that without my daily visits, encouragement and prayers, “I would have just given up.”

On that same COVID unit, I overheard a young hospitalist berating a patient who was begging to be treated with HQ or IVM. Walking up to him in the hallway, I let him know that his patient, isolated and with only his cell phone, likely knew more about the treatment of COVID than he did.

One Sunday afternoon while making rounds in that same hospital, I encountered one of the critical care physicians in the doctors’ lounge. I asked him why he would not consider using anticoagulants to prevent microthrombosis in COVID patients. He responded “There is no evidence for that”. I pounded my fist on the table and yelled “The only f***ing evidence you need is that your patients are dying!” Yes, I was again disciplined by the hospital for being a disruptive physician.

In the 14 months between Joseph and Steve, I made 450 visits to patients in 5 hospitals, cared for patients Monday to Friday in my medical office, took calls 24/7 with @ 3000 telehealth visits from COVID patients all over the country, and made house calls to hypoxic COVID patients to get them treatments which would keep them OUT of the hospital.

In retrospect, I hold no resentment against these hospital physicians who were following protocols. They were “lockstep” with the current medical literature, established “experts” and their hospital employers.

Yes, I was a disruptive physician. But my only motivation was to find a way to bring at least one small ray of hope into the lives of those patients who were otherwise abandoned by our health care system. And if I have learned nothing else in my 36 years as a family physician, it is that there is no healing without hope.

One of Orlando’s largest hospital systems emailed its 2,000 medical staff urging them not to prescribe medications including ivermectin, hydroxychloroquine, azithromycin and prednisone to COVID patients. Hospitals were also paid approximately \$15,000 for each COVID patient admitted.