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Review Article

Politics and Medicine (In the Fight against Pneumonia, it is not the Politicians who are Losing, but the Doctors)

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Abstract

This article describes a case in which an attempt was made to portray the failures of medical professionals as a consequence of the incompetence of government leaders. Time and new data have shown that politics is not an influential factor in medical matters. Medical problems are not determined by the color of national flags and remain the exclusive prerogative of medical professionals.

Keywords: *Antibiotics; Acute Pneumonia; Side Effects of Antibiotic Therapy; Transformation of the Etiology of the Pneumonia; Viral Pneumonia; Coronavirus Disease; Coronavirus Pandemic; US Healthcare; Politics; Distortion of Ideas about the Nature of Acute Pneumonia*

Abbreviations

AP: Acute Pneumonia; ARDS: Acute Respiratory Distress Syndrome; CAP: Community-Acquired Pneumonia; COVID-19: Coronavirus Pneumonia; ICU: Intensive Care Unit; MERS: Middle East Respiratory Syndrome; NEJM: The New England Journal of Medicine; SARS: Severe Acute Respiratory Syndrome; SARS-CoV-2: Coronavirus Pandemic 2; WHO: World Health Organization

Introduction

Five years ago, a publication in a prestigious and widely read American medical journal with a high international reputation *The New England Journal of Medicine* (*NEJM*) caught my attention [1]. This sudden interest was sparked by an editorial on the important influence of policy on the quality of medical outcomes. This topic arose, not coincidentally, at a time when the world was gripped by the SARS-CoV-2 pandemic, for which medicine was unprepared. A huge number of patients with coronavirus pneumonia emerged, for whom traditional antibiotic therapy proved ineffective. A chaotic search for a suitable etiotropic alternative to treat these patients followed, accompanied by an equally chaotic search for reasons that could explain the seemingly sudden collapse of medicine. It was this particular issue of the journal that caught my attention. But to write a reasonably competent commentary on this matter, I wanted to wait a little while and observe the medical community's reaction to this announcement, and also to see whether any significant changes, if any, would occur in the strategy and tactics for addressing this pneumonia problem.

The essence of the aforementioned article was that the journal's editorial board placed the blame for the failure of official medical care at the onset of the SARS-CoV-2 pandemic squarely on the federal government, openly believing that its decisions had a decisive influence (!?) on the effectiveness of treatment. It was in this context that the article was presented, characterized by such traits as "the impossibility

of predicting the number of American lives lost due to weak and inadequate public policy" (!?) and a verdict of "the dangerous incompetence of political leaders" [1]. To ensure the full credibility of the commentary and to ensure that it did not continue a political debate but rather reflected, first and foremost, a medical perspective on the issue, it was necessary to await and evaluate not only the critical remarks but also the specific proposals and actions that the leading experts on the editorial board are obliged to propose.

Discussion

Five years have passed since the publication of this article. During this time, it has become clear that the United States has suffered the greatest tragedy of the pandemic: more than a million people have died from COVID-19 pneumonia, far exceeding the death toll in other countries [2]. This occurred despite the undisputed leadership of the American healthcare system in innovation and funding [3,4]. At the onset of the coronavirus pandemic, Global Health Security Index was compiled, ranking the United States first among 195 countries [5]. However, the results of realizing this powerful potential have proven completely contrary to expectations, and a compelling scientific explanation for this massive failure has yet to be presented. To understand the reasons for this phenomenon, it is necessary to trace the dynamics of transformations in this field of medicine over the past century and the perception of these changes within the professional community, simultaneously assessing the role of politics.

Early microbiological studies of the etiology of AP established that this disease did not have a single responsible pathogen [6] and that host commensal microorganisms [7] were common among the many microbes. However, the microbiological composition of AP remained stable for several decades, with pneumococcus being the predominant pathogen, consistently accounting for 95 percent or more of cases [8-12]. This situation began to change dramatically after the widespread introduction of antibiotics in the early 1940s. By the late 1940s, an increase in the proportion of staphylococcus [13] was noted, and over the next decade, it became the new leading pathogen of AP, especially in children [14]. This evolution of the etiologic composition of the disease was not characterized by long-term stability. This process was observed throughout the antibiotic era.

Along with the constant change in the leading pathogens causing AP, the development of microbial resistance to antibiotics is also observed. However, these two side effects of antimicrobials remained virtually unnoticed throughout their use. As early as the 1930s, the so-called microbial concept of AP emerged, becoming the "gold standard" after the initial results of antibiotic use [15]. Therefore, the primary goal, which has occupied researchers and clinicians for decades, has been the earliest possible introduction of targeted etiotropic drugs. The long-term search for a specific pathogen remains an unresolved problem for practical use. The same applies to resistant microflora, the emergence of which was known from the early years of antibiotic use, but no specific measures were taken.

A deeply ingrained belief in the exceptional properties of antibiotics and the shortsightedness of professional opinion prevented an adequate assessment of the rise in viral pneumonia that began in the late 20th century. By the beginning of this century, viral pneumonias accounted for almost half of all cases worldwide [16,17]. What changed in treatment strategies and tactics as a result of these statistics? No fundamental changes occurred. Antibiotics continued to play a role as the primary, and often the only, treatment option.

At the beginning of this century, two coronavirus epidemics (SARS and MERS) occurred, each accompanied by severe pneumonia and high mortality [18,19]. Moreover, it was known that the coronavirus had not disappeared, and pneumonias of this etiology continued to be reported at a frequency of up to 5% [20,21]. Perhaps this information influenced the perception of the nature of pneumonia? After all, the differential diagnosis based on the pathogen turned out to be an unfulfilled myth [22-24], while the main clinical manifestations of the disease remained unchanged in all observations, regardless of the etiology.

These data indicate that the classic clinical features of AP are determined not by the type of suspected pathogen, but by the pathogenic mechanisms of the process that impair the function of the affected organ. To further confirm that the severity of the condition of patients with AP is in no way related to the pathogenic properties of the pathogen, and to halt our intensive antimicrobial aggression, nature was

forced to respond not only with an increase in the number of viral diseases and their epidemics, but also with the development of the coronavirus pandemic. Now, a single strain of the pathogen has caused the infection of a huge number of people. However, the response to this previously unknown variant of the infectious agent turned out to be extremely diverse - from latent carriage to extremely severe forms of COVID-19 pneumonia [25-27]. In the latter case, the traditional explanation for treatment failure in such patients, based on the supervirulence of the pathogen, could no longer be applied. Analyzing the variability of the body's response to contact with an equivalent irritant, some specialists were forced to return to the long-known characteristic of the development of inflammatory processes, the body's response [28,29].

Recently, research results have begun to emerge defining criteria for various phenotypes of the body's response to inflammatory processes [30-32]. Unfortunately, such data are currently used to predict the development of various complications of AP, such as sepsis, ARDS, and multiple organ failure. Prevention of such conditions is not a priority, despite the fact that treatment of such complications in the intensive care unit (ICU) leads to patient mortality in 40% or more cases [33]. Currently, there is no discussion of setting a goal for early pathogenetic treatment of AP, and there are no signs that such a goal will emerge in the near future. The reason for this confidence is that the aforementioned microbial concept of AP continues to dominate professional understanding of the nature of the disease and the primary method of treatment.

Current pneumonia statistics show that positive microbiological tests do not exceed 30 - 40% [34]. Although most observations remain without an identified pathogen, even among positive results, viruses are beginning to outnumber bacteria [35,36]. Despite these statistics, intensive research into diagnostic panels for bacterial detection and the search for optimal antibiotic prescriptions [37-39] continues in this field. All this occurs as if uncertainty and hopelessness did not permeate medical circles during the recent pandemic [40-43]. This research and the continued leading role of antibiotics in the treatment of pneumonia continue not only amid influenza outbreaks and epidemics of other viral infections, which have intensified in recent years, but also amid the ongoing powerful trail of coronavirus pneumonias [44].

At first glance, it's difficult to understand why pulmonologists are currently unable to critically evaluate and analyze the changes that have occurred to find the optimal solution. However, this is not the only misconception stemming from an unwavering yet overly inflated belief in the therapeutic potential of antibiotics, which hinders an adequate assessment of the dynamic changes that have occurred and are occurring in the problem under consideration. For example, the number of patients with severe forms of so-called community-acquired pneumonia (CAP) is growing every year. This category of patients requires hospitalization and supportive care in addition to etiotropic treatment. In such situations, it turns out that the severity of functional impairment in patients with CAP is assessed using the same parameters as changes in all other inflammatory processes [45,46]. This ignores such an important fact as the differences in the localization of processes in the pulmonary and systemic circulations and the fundamental differences in blood flow parameters in the two halves of the circulatory system [47,48].

As a result, focusing attention and diagnostic efforts on the etiology of CAP and the selection of optimal antibiotics has become a common practice in the management of such patients. However, the decreased effectiveness of such therapy, primarily due to the increase in viral forms of inflammation, has in many cases required additional supportive therapy. Consequently, ignoring the specific pathogenesis of CAP has led, for example, to a misunderstanding of the causes of peripheral circulatory disorders. Systemic changes in blood flow in this disease are compensatory and adaptive, and attempts to normalize these parameters have the opposite effect compared to peripheral inflammatory processes [49,50].

The above list of facts is not classified information and is freely available for review. This information reflects errors and misconceptions that have accumulated over many years regarding CAP and remain widespread without serious and radical attempts to correct them. The US healthcare system is no exception to this rule. Nevertheless, the experts who wrote the aforementioned article, who occupy

such key positions in the medical community, influence public opinion, and whose conclusions are heeded, are obliged to be familiar with the overall situation in this field of medicine and should have provided at least a general overview of the problem under discussion. Even if the authors did not propose specific solutions to the problems discussed, a critical analysis of events and their consequences in the antibiotic era points to the ineffectiveness of treatment for the most seriously ill patients with CAP.

Undoubtedly, treatment outcomes depend entirely on the quality of medical care. The ancient adage that if a treatment is ineffective in a given case, it is not suitable for the given disease remains relevant today. To what extent and in what ways have political incompetence and culpability manifested themselves if the mortality rate from COVID-19 pneumonia in the United States significantly exceeds that of other countries [51]? Responsibility for the strategy and tactics of treating such patients lies entirely with medical professionals in their respective fields, right? In my view, professional incompetence manifested itself precisely in the search for someone to blame for one's own failures. Moreover, the flood of accusations overlooked the fact that American medicine occupies the most privileged position in the world in terms of funding and support [3-5].

Incorrect assessments and conclusions are entirely possible during analytical work. Such a result is permissible, and no one is immune from it. But in this case, the situation has taken a rather unusual turn: it turns out that medical workers are blaming non-professionals for their own unpreparedness to provide effective care to a large number of patients with COVID-19 pneumonia. After all, pandemic statistics have shown from the very beginning that the weakest link is care for hospitalized patients who truly need it, and such patients are few in number compared to all those infected. Professionalism in such situations is determined by impartiality and candor in conclusions and decisions, and not by searching for the guilty. This approach is especially important when it comes to specialists holding high positions in the medical community.

The circumstances leading to the outbreak of the pandemic, which many perceive as a sudden catastrophe, did not arise suddenly or out of nowhere. This event had been brewing and building for at least a couple of decades, and the facts cited above support this assessment. A dramatic mutation of the coronavirus was already noted during the pandemic: 82 (!) new variants of the [52] strain were registered in three months. However, since the turn of the century, inattention to the rise of viral pneumonia and the lack of any conceptual or therapeutic innovations left medicine unprepared for the changing conditions. Therefore, when a new strain of a familiar coronavirus began to spread across the planet faster and more aggressively than previous variants, it caught medicine off guard.

Shortly after the publication of the critical comments [1], elections took place and changes in the country's political leadership occurred. These changes did not affect the incidence and mortality of COVID-19 pneumonia [44], but they did contribute to the emergence of a "conspiracy theory" and initiated a thorough investigation into the supposed sources of infection, involving the intelligence services [53]. The results of this investigation yielded no leads regarding the sought-after sources, but the very fact of a serious intention to assign blame for the catastrophe has become part of the annals of this phenomenon. The most significant aspect of this entire story is the lack of radical changes in the principles of treating community-acquired pneumonia, while the results remained the same. As a result, the world has witnessed a sad paradox: the most optimal healthcare system on Earth has become the record-holder for the number of deaths during a pandemic [2,51].

If criticism of someone isn't quickly confirmed, then in such cases, within the bounds of acceptable scientific discourse, the authors typically issue apologies and retractions. However, in this case, the initial publication was clearly aimed at lobbying for certain political interests while simultaneously maintaining corporate esprit de corps. A second publication on this topic appeared in the same journal only after the official end of the pandemic, in the form of an editorial assessment of the disaster's results, which is also surprising in its content [54]. It turns out that the American healthcare system handled the coronavirus outbreak brilliantly thanks to rapid and timely vaccination of the population. Such a statement, without analysis and explanation of the reasons for the failure of medical care at the hospital level, appears biased and not entirely professional.

Firstly, the quality and effectiveness of coronavirus vaccination raise serious doubts compared to the prevention of other diseases. For example, the effectiveness of coronavirus vaccines lasted only a few months, after which booster doses were required. Secondly, vaccination is purely preventative, not therapeutic. Thirdly, by the time the second commentary was published, preliminary results of the so-called Swedish experiment were already known, in which Swedish government leaders supported the initiative of healthcare workers not to impose strict restrictive measures, bluntly speaking, with the goal of building general immunity among the population. Despite the failure to adhere to the anti-epidemic principles discussed in the first article, the results of this experiment turned out to be among the best in the European Union [55-57]. Finally, the weakest and most crucial link in the healthcare system -the hospital stage, which determines the final results-remained underestimated.

Conclusion

Thus, this story is a clear example of how politics cannot influence the resolution of medical problems. Specific problems facing healthcare and requiring solutions remain the exclusive prerogative and responsibility of professionals. Attempts to portray medical failures and omissions as the result of the political climate in society are of no practical use. The authors of such initiatives, seeking to lobby for their political interests and maintain their "corporate esprit de corps," not only call into question their competence in the matter under discussion and their reputation as high-ranking officials, but also create uncertainty regarding the impartiality and objectivity of the information presented in the journal's pages.

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Conflict of Interest

The author states that he has no conflict of interest.

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