A Few Rhetorical Questions about the COVID19 Pandemic:

If we can prevent probability of early pulmonary involvement of COVID-19 infections from progressing to respiratory distress by a factor of 10-100, would the problem not then change from "global crisis" to only "challenging epidemic"?

What if the solution involved the artful unproven use of commonly available commercial Rx?

What if that treatment could be identified prospectively by community evaluation in real time at clinics currently triaging patients and sending them home in isolation to ride out the disease?

What if the process of evaluating such interventions carried some degree of medical risk?

What if our society's institutional procedures for systematic clinical research is decentralized and therefore unable to mobilize rapidly on short notice across institutional boundaries?

I have confidence that "a white knight" with a new medicine will emerge and that convalescent serum from recovered patients will probably improve resistance for healthcare workers on the front line, **but** it is the large numbers of severe respiratory cases that is overwhelming regional healthcare capacity *today*.

My institutionally grounded colleagues are eager to queue up bright ideas, and the process of review is competitive and slow even when expedited and the science is complex and difficult to arrange. Our research institutions have their hands full. This mornings newsfeed tells us that 170 health care workers on the front line at my alma mater Brigham and Women's Hospital in Boston have contracted active disease. Talking with some, they are feeling shell shocked. A senior colleague of mine in Brescia Italy reports that several of his colleagues at their institution have recently died. Our tertiary care teaching hospitals traditionally lead the way in innovative medical research as they will also in "next stage" of solutions to the current pandemic. B*ut to identify a simple intervention that simply reduces the severity of the pulmonary complications, a* community based systematic intervention-based approach to evaluate options needs to be implemented *as soon as possible* (i.e. within weeks).

In this time of national emergency, rigorous but simple outcomes data and monitoring of possible complications of specified approaches can be obtained in the community with simple training and data collection techniques. A single central institutional review (central IRB) and a central data oversight committee of qualified experts can provide needed patient protection and guidance to participating clinics. The burden imposed on the clinics would be as simple as obtaining initial informed consent, registering enrollment of qualifying newly ill patients and providing to take home their protocol designated "actionable intervention", a diary to collect critical data, and arrangements for follow up using best available technology.

The critical outcome are (1) preventing progression to serious respiratory progression requiring hospitalization/ intensive care and (2) reducing the volume of patients inundating our hospitals. Envisioned is a treatment method that heals our communities and spares vital resources, even if it does not help with duration of active disease. To conduct such a coordinated prospective effort can only happen with facilitated guidance from regional/ national leadership or within large provider networks. Community triage clinics are not research institutions with dedicated research staff and do not have the infrastructure to coordinate this without simple central administrative help and community volunteers. It can be done simply. It is time to mobilize to find the first answer and mobilize our communities to help. If this fails, then we have lost nothing, and we can await that white knight's hoof beats knowing that we have tried.