

## Commentary

# Commentary: Suggested Questions for Reporters Concerning COVID-19

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A great deal of inconsistent and misleading information about COVID-19 has been provided by the CDC and leading medical authorities in the United States [1-3]. For example, in February, 2020 the Surgeon General stated that there was no need to wear facemasks in public. Within a few months, the CDC, governments and leading medical authorities were strongly recommending wearing facemasks in public or instituting mandates. This change in policy was framed as being based on science, data and intervening new research. In fact, there was no new research. Medical authorities claim that their recommendations are based on science when, in fact, the evidence they cite often provides no data on facemasks at all, and ignores the existing meta-analyses of randomized controlled trials, all of which show no difference in viral transmission and infection rates with and without facemasks being worn in public [4-7]. Statements about COVID-19 made by medical authorities should not be accepted at face value and should be questioned critically. Such questioning is a standard procedure in science. What follows is a list of questions that reporters or members of the public could ask their governments, doctors and medical authorities:

1. Do you know that there are four meta-analyses of randomized controlled trials of facemasks for reducing viral infection rates in public? Have you read those papers? Do you know that all randomized controlled trials of facemasks in public demonstrated that they do not reduce infection rates?
2. Have you looked at the references on the CDC website that support the recommendation that people wear facemasks in public? Do you know that none of those references provide any evidence that facemasks actually work in public? Do you know that none of those references are to the published meta-analyses?
3. Do you know that in February, 2020 the Surgeon General of the United States said very emphatically that there is no need to wear facemasks in public? This policy was changed based on the claim that new research and data had been gathered since. Do you know that there was in fact no such research or data? Can you provide any references for new research on facemasks in public published between February and May, 2020?
4. Can you provide any data on how much of the increase in COVID-19 cases in any given time frame is due to increased

testing and how much is due to an actual increase in infection rates?

5. Can you explain why the official death rate from COVID-19 was initially cited as being as high as 13% when it is actually under 1%?
6. Can you explain the pore sizes of facemasks (50-100 microns) compared to the size of viruses (0.1 microns) and respiratory aerosols (2-3 microns)? Why would you expect face masks to have any effect on transmission by asymptomatic carriers who are not coughing or sneezing and not emitting droplets?
7. What would you say if a farmer was worried about mice coming onto his property: to protect himself he puts a post in the ground every 40 feet? He sees on the Department of Agriculture website that a post every 40 feet can protect you from mice. He feels safe and reassured. Surely you would agree that a post every 40 feet cannot block out mice. True? This is exactly the same as a face mask pore of 50-100 microns blocking out virus particles and aerosols. What is the difference between facemasks and the mice example? Why do you believe that facemasks can work?
8. It has been said many times by medical authorities that the purpose of facemasks is to protect other people from you if you are an asymptomatic carrier, not to protect you from others? How is that possible? Why would facemasks protect person A from person B but not person B from person A? Do you agree that this statement by medical authorities makes no sense?
9. Since serious COVID-19 disease and death are rare in healthy people under 50, why is it necessary to lock down the entire population? Why couldn't we just have a voluntary lockdown of at-risk populations who are old, infirm or have serious medical problems?
10. Why is it often not allowed to compare COVID-19 to the flu? This is a logical comparison since both are viral illnesses. COVID-19 killed far more people than the flu in 2020 but far less than the flu killed in 1918-1919. How many deaths would you guess there have been in people under 50 in 2020 due to COVID-19 and how many deaths from the flu? Do you think

that fear of COVID-19 in healthy people under 50 is increased out of proportion to the risk? Do you think this is true of their fear of the flu but in the opposite direction?

11. How many people have been infected with the coronavirus in the United States in 2020? Why don't we know this number exactly? Do you agree that randomized testing in selected areas of the country could give us an accurate number? Why hasn't this been done? Would you agree that the number may be around 5%? 5% of 330,000,000 million = 16.5 million. Let's say there have been 220,000 deaths. That would mean a death rate of about 1.3% in infected people – correct? If 20% of people have been infected then the death rate is about 0.3% - correct? If 70% of deaths are in people over 70, then the death rate under 70 is at most about 0.4%, and possibly under 0.1% - correct? This is about the same as the annual death rate from the flu – correct?
12. According to the CDC, flu vaccines average about a 40% effectiveness and some years are as low as 9%. Correct? Authorities agree that to get herd immunity from vaccines you need an effectiveness of at least 70%. Isn't it therefore true that the odds of vaccines providing herd immunity for COVID-19 are pretty much zero? Do you agree that there has never been a successful coronavirus vaccine so far, despite many efforts?

13. Wouldn't the correct science and data-based policy be that there is no need to wear facemasks in public? If you disagree, what is the science and what are the data supporting your viewpoint?

## References

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