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How the Medical Profession Contributes to COVID-19 Vaccine Hesitancy

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Hopefully the pandemic will be over within another year. In the meantime, the medical profession and public health officials continue to denigrate and sanction 'anti-maskers' and 'anti-vaxxers', as discussed in previous papers [1-6]. This behavior inflames the people characterized as anti-vaxxers and anti-maskers, increases polarization, and breeds distrust in the medical profession. These effects of the denigration and sanctions can do nothing but increase vaccine hesitancy. The medical profession should stop putting all blame for vaccine hesitancy on a misinformed public, and instead should examine its own contributions to vaccine hesitancy. I am double vaccinated. There are a number of topics that illustrate the unhelpful attitudes and unscientific statements of doctors and public health officials during the pandemic. These are reviewed below.

Ivermectin

Ivermectin for COVID-19 has been attacked aggressively in the courts, the media and the medical literature as being ineffective. It has been referred to as a 'horse worm drug' even though it has long been approved by the FDA for use in humans. The main study cited to justify the banning of ivermectin from clinical practice randomized 238 patients with mild-moderate COVID-19 to ivermectin and 238 to placebo [7]. The authors reported adverse events occurring in 77% of participants receiving ivermectin and 81.3% of those on placebo, indicating both that ivermectin is safe compared to placebo, and a high nocebo effect rate in both groups. Both groups received a 5-day course of ivermectin or placebo. There was an escalation of care to a higher level in 4 participants receiving ivermectin and 6 receiving placebo. The median time to resolution of symptoms was 10 days on ivermectin and 12 on placebo. There were no statistically significant differences between groups on any outcome measures. However, ivermectin resulted in a 17% reduction in time to symptom resolution. The authors cited four randomized controlled trials of ivermectin that had not yet been published, all with positive results, including one with substantial differences between ivermectin and placebo on a range of clinical measures [8].

Although the reduction in time to symptom resolution was not statistically significant in the JAMA study [7], a 17% reduction in duration of symptoms would result in a very large reduction in personal suffering across a large sample. If ivermectin also reduced hospitalizations and deaths by 17% in a future randomized controlled trial, that would be very helpful. Normally, in medicine, a study like this would not be used to support a ban on using the medication in hospitals or clinics. Rather, there would be a call for further research, and prescribing the medication would be regarded as a legitimate off-label use of the medication in clinical settings, given that it is generic, cheap and safe, especially if there were no more effective medications available. Although there is a posture of science and protecting patients in mainstream medicine, the behavior of the medical profession with regards to ivermectin has been starkly different from standard practice. In standard practice, the existence of a trial showing a reduction in time to symptoms resolution of 17%, plus a set of unpublished trials showing a positive effect, would never result in the aggressive dismissal of that medication. This is disturbing because such deviations from standard medicine could happen regarding any disease or treatment in the future, if politics over-ride standard practice. It doesn't matter if ivermectin proves not to be useful in properly designed future trials. The problem is the unscientific hostility towards a cheap, generic, safe and potentially useful medication. The standard mantra - "there is no evidence that ivermectin works" - is not scientifically true. That is an attitude, not a scientific statement.

Lockdown Mandates

The justifications for lockdowns at the height of a pandemic are clear and valid, but there has been an over-use and over-reaction in government lockdown mandates. For example, as a former resident of the Northwest Territories in Canada, I was interested to read that the level of lockdown there has just been increased by the top public health physician. Why? In a population of 44,991 people [9], throughout the entire pandemic there have been 2 COVID-19 deaths [10] and 918 confirmed infections as of September 24, 2021. This is a death rate of 2/44,991 = 0.00004 and an infection rate of 0.02. As percentages, these are an infection rate of 2% and a death rate of 0.004%. How do those numbers justify an increased lockdown? Similarly, in the Canadian province of New Brunswick, levels of lockdown have been increased recently [11]. The province of 781,315 people has recorded 49 deaths (49/781,315 = 0.0006, or a death rate of 0.06%): the increased lockdown level is justified by one additional recent death. These lockdowns in response to those levels of threat do not make sense. This does not mean that one should be 'anti-lockdown', but it calls into question the judgment of public health officials. Excessive lockdowns will breed distrust in the medical profession and public health officials and fuel vaccine hesitancy.

The Wuhan Lab Leak Theory

It is possible that the COVID-19 pandemic started with a lab leak at the Wuhan Institute of Virology [6]. It is also possible that it did not. A serious problem in the medical profession has been the vitriol and condemnation directed at anyone who supported the Wuhan lab leak theory, at least for the first year of the pandemic. This vitriol was justified by a letter in *The Lancet* on March 7, 2020 [12] in which the authors stated that: "We stand together to strongly condemn conspiracy theories suggesting that COVID-19 does not have a natural origin. . . Conspiracy theories do nothing but create fear, rumours, and prejudice that jeopardise our global collaboration in the fight against this virus. We support the call from the Director-General of WHO to promote scientific evidence and unity over misinformation and conjecture."

The problem with this letter [12] was the major conflicts of interest that the authors did not disclose [13]. Rather, they represented themselves as objective scientists. Of the 27 authors of the letter, 26 had direct connections with the Wuhan Institute of Virology. For example: Peter Daszak and five other authors were affiliated with EcoHealth Alliance, which funded gain of function research on coronaviruses at the Wuhan Institute of Virology; three authors were affiliated with Britain's Welcome Trust which funded research at the Wuhan Institute of Virology; and five were coauthors of Dr. Ralph Baric, who is an author on papers from the Wuhan Institute of Virology. The Lancet letter was designed to shut down any suggestion that the pandemic could have started with a leak from the Wuhan Institute of Virology. This is not objective science. It is using an appearance of science for politics and self-protection. This kind of posturing by leading figures in virology and public health carries the risk of blowback once it is exposed for what it is, which in turn can do nothing but undermine confidence in public health and the medical profession.

Treating the Unvaccinated as Untouchables

There is nothing wrong with trying to motivate people to get vaccinated for COVID-19. It seems clear that the risk for severe illness, hospitalization and death all drop substantially with vaccination. However, it is less clear that vaccination by itself reduces the rate of viral transmission in public when social distancing is in place. We know that vaccinated individuals can have break-through infections. Regardless, unvaccinated people are now being shunned, denigrated, and financially punished: they are becoming untouchables. For example, the New York Metropolitan Transportation Authority recently changed its policy to continue a $500,000.00 death benefit for the families of employees who die of COVID-19, but canceled the benefit for families of unvaccinated employees [14]. Similarly, Southwest Airlines withheld an award of an extra 16 hours of pay from unvaccinated workers while also cutting sick pay for unvaccinated workers [15]. In New York, the Governor is considering bringing in out-of-state health care workers and declaring a state of emergency due to the number of health care workers refusing to get vaccinated [16]; recent legislation prevents them from coming to work. Bringing in out-of-state health care workers would compound staff shortages and burnout in other states. In addition, the New York state labor department issued guidance that people who lose their jobs due to vaccine refusal will not be eligible for unemployment benefits. These government actions will cause 'anti-vaxxers' to regard their own actions as morally justified civil unrest, which will in turn reinforce their behavior and increase the dividedness and hostility in the United States.

The motive of encouraging people to get vaccinated is fine, but these methods are not. They create two classes of citizens and punish one class financially for exercising what, up till now, has been a right. Why do we not punish smokers and the morbidly obese for occupying hospital beds and imposing costs on society, including increased insurance premiums? Such punishment would be widely regarded as a human rights violation. The difference is that unvaccinated people increase the risk of infection for others. However, smoking can increase the health risks for other people due to second-hand exposure, yet no one punishes smokers or their families financially. No-smoking areas are designed to protect people, not to punish smokers, who experience only a minor inconvenience from not being able to smoke indoors. The problem here is not the fact that vaccination rates are lower than is desirable. The problem is that public health and medicine are becoming tools for punitive social control. If unchecked, this could escalate in a dangerous direction. The medical profession has been contributing to the creation of a class of untouchables, the unvaccinated. This has been done through nasty condemnation, threats to withhold medical services, and government financial penalties. More people have died from drug overdoses in the twenty-first century than from coronaviruses. There are negative attitudes towards 'addicts' in both the general public and the medical profession, but the pandemic ramps such attitudes up because of the fear it generates. These negative attitudes push people away from the medical profession. There are two forces at work: doctors driving anti-maskers and anti-vaxxers further away into isolation and extremism, and extremists pulling them in that direction. Rather than attacking the attractive force, the medical profession should reduce the repulsive force.

Face Masks

There are no randomized controlled trials that demonstrate a reduction in viral transmission in public from wearing face masks, and there are multiple trials demonstrating no effect [2,4]. A year and a half into the pandemic, the negative trials are still not referenced by doctors, the CDC, public health officials and governments who strongly recommend or mandate face masks. This is an example of politics over-riding science. Two recent studies reported by the CDC [16,17] that are characterized as providing strong evidence in favor of face masks do not actually do so. In one study [16], the authors surveyed 3142 counties but included only 16.5% of them in their final analysis, which rules out the results being representative or valid. In the other study [17], the authors surveyed 999 schools and divided them into 210 schools that adopted masking early in the study time period, 309 that adopted masks late, and 480 that never adopted a mask mandate. They reported the percentage of schools experiencing a COVID-19 outbreak during the study period, but they never defined an 'outbreak'. Whether an outbreak could be one case, or required some minimum number of cases was not stated. Thus, the no-mask

schools, in principle, could have had fewer total cases than the masked schools because they had a smaller number of cases per outbreak. The authors concluded that, "this was an ecologic study, and causation cannot be inferred." In their text [17,18], the percentages of schools with outbreaks were: early mask 8.4%; late mask 32.5%; and no mask 59.2%. However, in their table the percentages were: early mask 8.0%; late mask 20.0%; and no mask 24%. The numbers in the table suggest that there was no difference between late masking and no masks – the lower percentage in the early mask schools could have been due to the virus not being as widespread in the early part of the study period, rather than a mask effect. Why doctors, public health authorities and governments recommend mask mandates remains a mystery. Mask mandates are a risky strategy because once the public catches on that face masks do not work for reducing viral transmission in public, the medical profession could experience blowback and there could be increased vaccine hesitancy.

Concluding Thoughts

The problem outlined here is not with ivermectin, face masks, the Wuhan lab leak, or mandates as such. The problem is the misinformation being provided by doctors, governments and public health authorities during the pandemic. This misinformation can do nothing but increase distrust in the medical profession and vaccine hesitancy. Physicians have contributed to the creation of a social class of untouchables – the 'anti-maskers' and 'anti-vaxxers' – who are denigrated and accused of spreading misinformation, which they often do. But the social ostracism of this class, which includes a significant number of medical workers, is compounding the problem of vaccine hesitancy, not solving it. The medical profession should take a look at its own misinformation rather than attacking members of the public. Attacking is different from educating. This does not mean that vaccine hesitancy is entirely the medical profession's fault – but medicine should examine its own role in vaccine hesitancy and any unintended consequences of its attitudes, behavior and recommendations.

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