First Do No Harm

Open letter from health professionals and scientists to the Prime Minister

We the undersigned British health professionals and scientists, wish to express our serious concern about the current situation regarding the outbreak of the SARS-CoV-2 virus. The management of the crisis has become disproportionate and is now causing more harm than good.

We urge policy makers to remember that this pandemic, like all pandemics, will eventually pass but the social and psychological damage that it is causing, risks becoming permanent.

We call for restoration of our normal democratic governance and for politicians to be independently and critically informed in the decision-making process. After the initial justifiable response to Covid-19, the evidence base now shows a different picture. We have the knowledge to enable a policy that protects the elderly and vulnerable without increasing all other health and economic harms and which is not at the expense our whole way of life and particularly that of the nation's children.

'First do no harm' is a basic tenet of medical ethics, understanding that a cure must never be worse than the disease itself. However, there is increasing evidence that the collateral damage now being caused to the population will have a far greater impact in the short and long term, on all sections of the population, than the number of people now being safeguarded from Covid-19. In our opinion, the current measures, and the strict penalties for non-compliance, are contrary to the values formulated by Public Health England, which states, 'We exist to protect and improve the nation's health and wellbeing, and reduce health inequalities' [1].

We have somehow reached a situation where the whole of life in Britain, as in many countries, has focused on a single condition and one which is now endemic. 'Zero' Covid is not a realistic option in a global world. In this letter, we highlight many other areas of health and well-being that are now largely overlooked. We also look at an alternative strategy which we believe can best protect the vulnerable, whilst allowing most people to return to near normal life and provide references to just some of the many scientific papers which explain why we have reached this conclusion.

Our current knowledge about covid-19

At the beginning of the pandemic, the WHO predicted a disease that if uncontained would spread to maybe 50% of the world's population claiming 3.4% victims, in other words millions of deaths by a highly contagious novel virus for which no pre-existing immunity or vaccine was available. Measures were understandable and widely supported, as there was concern that unprecedented pressure would be placed on our hospitals. Thus, the stated purpose of the initial lockdown was to "flatten the curve"

and protect the NHS[2]. Hospitals rose to the occasion, Nightingale Hospitals were built, no one died for lack of intensive care facilities - a huge credit to the staff of the NHS.

Gradually, as our knowledge has accumulated, it has become clear that objective facts show a different reality. The known global infection rate to date stands at less than 1% of the world population [3]. The true mortality rate is also over-estimated as we now know that many people have very mild or no symptoms and were thus not included in the testing regime at the start of the pandemic in the UK or elsewhere. We also know that serious disease and indeed death are linked to older age and pre-existing health conditions [4] , so it is on protecting this group that we should be concentrating.

It has also become clearer that the pandemic has not exhibited truly exponential growth; rather, it has been shown to follow a classic Gompertz curve from the very early stages of each outbreak [5]. The Gompertz curve is used as the classic model of population dynamics in conditions where there is some limiting factor to the rate of growth. In the case of Covid-19 this observation supports the theory that a level of pre-existing immunity was present in the population prior to lockdown, thus limiting the spread of infection. This pre-existing immunity is probably due to immunity to common cold viruses which, in 40-60% of individuals, is thought to give some protection against Sars-CoV-2. In addition, we now know that exposure to the virus, even without symptoms, generates robust cellular immunity that is likely to have a long duration [6] [7]. Consequently, measurements of antibody prevalence in populations almost certainly give a serious underestimate of both exposure and immunity. It is vital we build on this immunity that is developing naturally in the population. Perversely population lockdowns could impede this process. Indeed, new evidence published this week, reports the potential increase in total deaths resulting from school and university closures. [8]. We also know a lot more about effective ways to treat Covid-19, such as early use of anticlotting agents and dexamethasone, plus avoidance of invasive ventilation. Evidence from both Germany and the UK show a significantly lower in-hospital mortality rate in the later stages of the epidemic [9],[10].

Waiting for a vaccine

This would appear to be the government's main exit plan and is a strategy fraught with risk. We do not know when, or even if, an effective vaccine will become available. Any vaccine is unlikely to give complete protection against the virus and any protection may only be of short duration. A vaccine is also unlikely to provide superior protection to immunity that is developing naturally. Thus, a vaccine is only one tool to help limit viral spread and alone will not eliminate the disease. We feel these facts have not been made clear to the general public, many of whom view a vaccine as a simple solution to the pandemic [11].

Widely publicised data is exaggerating the current risk

Widespread population testing using PCR is distorting the current risk. Use of such a test in a clinical situation (as in pillar 1) was very helpful as a rapid screen but the testing strategy now seems to be driving policy. The problem of functional false positive rates has still not been addressed and particularly in the context of low prevalence of disease whereby false positives are likely to exceed true positives

substantially and moreover correlate poorly with the person being infectious [12], [13]. Alongside this we have the issue that it is normal to see an increase in illness and deaths during the winter months. This is well known in the case of pneumonia and influenza. Any increase in positive cases and deaths therefore needs to be presented in the context of the normal seasonal illness/death rate. It is notable that UK death rate is currently sitting around average for this time of year [14]. The use of the term 'second wave' is therefore misleading.

Adverse consequences of current measures in adults

Social isolation has led to an increase in depression, anxiety, suicides, intra-family violence and child abuse [15]. Fear and persistent stress have a proven negative influence on psychological and general health [16]. Yet fear seems to be the main strategy for inducing compliance with government measures, whether fear of contagion, fear of prosecution or indeed calling on neighbours to report transgressors to the police, leading to further societal fracturing. The way in which Covid-19 has been portrayed by politicians and the media has done little to promote well-being. Metaphors invoking war and an invisible enemy have been widespread, together with phrases such as 'care heroes in the front line' and 'corona victims', fueling the idea that we are dealing with a global 'killer virus'. Pervasive 'stay safe' messages give the impression that normal life has become perilously dangerous. The relentless daily presentation of the rising death toll was unleashed on the population in March, without interpreting those figures, without comparing them to flu deaths in other years, without comparing them to deaths from other causes. As death rates fell, the media swapped to highlighting rising 'cases'. This coverage has induced unparalleled levels of fear in the population and, in particular, indoctrinates young children with a negative and potentially damaging narrative. Widespread use of masks may well be adding to fear but this is not being considered, despite limited scientific evidence of benefit [17].

The NHS has been all but shut to non-Covid conditions and delays in diagnosis have been highlighted in general practice [18] and this is beginning to be revealed in rising waiting lists for cancer diagnosis and treatment [19] and excess non-Covid deaths [20] Moreover, the huge adverse effect on the economy and people's livelihoods will have its own effect on increasing poverty and the health consequences of that, widening the gap between rich and poor [21], [22], [23].

Adverse effects on children and young people

As a demographic, children are disproportionately affected by the restrictions. Effects on children are particularly concerning especially knowing their extremely low likelihood of serious disease and the small part they play in viral transmission [24]. The Royal College of Paediatrics and Child Health has reported delays in referral for diabetes, cancer and child protection issues [25]. Development and growth are also hampered through reduced social and family interaction, exacerbated by the 'Rule of 6'. Reduced access to learning in schools, educational groups, extra-curricular activities, sport, nurseries and baby classes, all impact on children's physical health and on their mental health [26]. Parents at many primary schools are now being asked to wear masks when collecting their children, so despite spending months explaining that this

virus is not dangerous to kids or young adults, we are graphically showing them the reverse, adding to levels of fear.

Widespread and excessive testing in educational settings is having an additional impact, exacerbating these issues. The parent group UsforThem has evidence of wide variation in how self-isolation rules are applied, with some schools sending home children with minor coughs and colds who are then refused re-entry to school without a negative test. Whole year groups are sometimes being sent home for a single 'positive' test but with no knowledge whether the child in question is truly infectious [27]. The emotional, physical and economic impact of such measures on young people and families is unparalleled [28].

Lack of leadership and varied interpretation of guidance by individual educational settings, has resulted in the adoption of disproportionate Covid measures in large numbers of schools, nurseries and other childcare settings. Many of them raise serious issues of child welfare and safeguarding. The lack of any credible milestones to return to normal, cast-iron, full-time schooling, risks causing irreversible harm to the socio-educational prospects of a generation of children [29].

Another way forward

At present, there appears to be no clear exit strategy, other than waiting for a vaccine. It is clear that this virus has become endemic, yet current 'protective' measures are causing avoidable and likely long-term harm to society as a whole. People's health, quality of life and livelihoods are in peril for a disease with a mortality rate comparable to many other diseases that befall us.

We welcome the proposals by many respected medical professionals in recent open letters [30], [31], [32] in this regard and we ask the government to urgently consider the following strategy:

1. Acceptance that Covid-19 will remain as one of several winter viruses.

2. Public restrictions should be informed by a broad range of independent scientific and medical views, assessed on a benefit to harm ratio and debated in parliament before implementation.

3. Urgently address the unreliability of PCR testing, by adhering to a published cycle threshold cut-off. Discontinue testing of asymptomatic adults and mildly symptomatic children.

4. Produce a balanced long-term sustainable plan for dealing with NHS winter pressures.

5. Consider fully the impact on children, young adults and family life in consultation with those who have the welfare of these groups at heart.

6. Provide factual balanced and contextual advice to the public which allows individuals to manage their own risk.

7. Concentrate efforts on supporting and protecting the most vulnerable. For example, urgently identify health or social care facilities where COVID infected patients can convalesce until no longer infectious, thus avoiding early discharge to care homes.

8. Encourage the return to normal life for the less vulnerable members of society with the understanding that this will help to generate population immunity and thus suppress the spread of the virus in the longer term.

We urge policy makers to remember that this pandemic, like all pandemics, will eventually pass but the social and psychological damage that it is causing, risks becoming permanent.

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