From: Ed Martin <REMreason@outlook.com>
Sent: Monday, April 20, 2020 4:48 PM
To: Council Coments <CouncilComments@jonesboro.org>
Subject: Lift the Curfew and Apologize for Overreach

I like and support Mayor Perrin but in this case he is wrong. I don't know whose advice he is listening to but he is wrong.

I am personally staying at home but that is my choice, not because of a curfew.

As bad as this virus is we have faced a bad or worse without these kinds of draconian measures.

I am very proud of our Governor for refusing to put a statewide SIP order in place despite tremendous pressure to do so. We are one of the few states that took a more sensible and measured approach.

One of the problems is if everyone follows the same plan – even if that plan is flawed – then we don't really know what worked and what did not.

Viruses spread. That is what they do. According to the CDC well before this pandemic struck America the 2019-2020 flu season was going to be a bad one. They were seeing a lot of negative tests for Influenza but "flu-like illness" and deaths were already running ahead of the typical season. It is likely many of these were COVID-19 related since there was no testing at the time. If they were not then it means we have some other similar "novel" virus or viruses that are causing similar symptoms, hospitalizations and deaths.

My biggest problem with the COVID-19 response is everyone is acting as if every infection, every hospitalization and every death is additive to what we experience each year from Influenza, Pneumonia and other Upper Respiratory "flu-like" illnesses. They are not. This isn't opinion it is fact based on CDC numbers. At the same time we are seeing COVID-19 cases (which are being tested and tracked at levels higher than we ever have before for any other pathogen) we are seeing a drop in hospitalizations and deaths from Influenza. In other words this virus is in many cases taking the place of the other infection rather than coming on top of Influenza.

We are not going to see a doubling of hospitalizations or deaths this flu season. It is likely we will end up with something less than 10% increase.

A single death if avoidable is worth Herculean effort to save but the response is outsized with the actual threat and there is always a price to be paid when government sets precedent and concentrates power in too few individuals. That is because government is really inefficient and must apply "one-size-fits-all" approaches that simply do not work well in complex and varied situations.

There is even debate among some infectious disease experts about whether we would reach "herd immunity" faster by allowing the young and healthy to be exposed and spread the virus to those who are less likely to need hospitalization or die. In other words it is within the realm of possibility that our over-reaction to the threat will actually cost lives because while the virus might spread slower it will spread wider since it will be able to find hosts who have not developed immunity for a much longer period of time.

I would ask the council to consider these facts and they are facts direct from the CDC and OSHA. So this isn't my opinion. It is data that is available to anyone willing to look and seek to understand.

It seems like forever ago but on January 2nd 2020, Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, said while it's impossible to predict how the flu will play out, the season so far is on track to be as severe as the 2017-2018 flu season, which was the deadliest in more than four decades, according to the US Centers for Disease Control and Prevention. "The initial indicators indicate this is not going to be a good season -- this is going to be a bad season," Fauci said.

"Flu cases and hospitalizations because of the flu have also risen sharply since the season began in October. CDC estimates there have been at least 6.4 million flu illnesses and 55,000 hospitalizations. The only thing predictable about flu is that it's unpredictable."

Of course back then nobody was paying much attention because we have flu every year. Most people didn't even know who D. Fauci was.

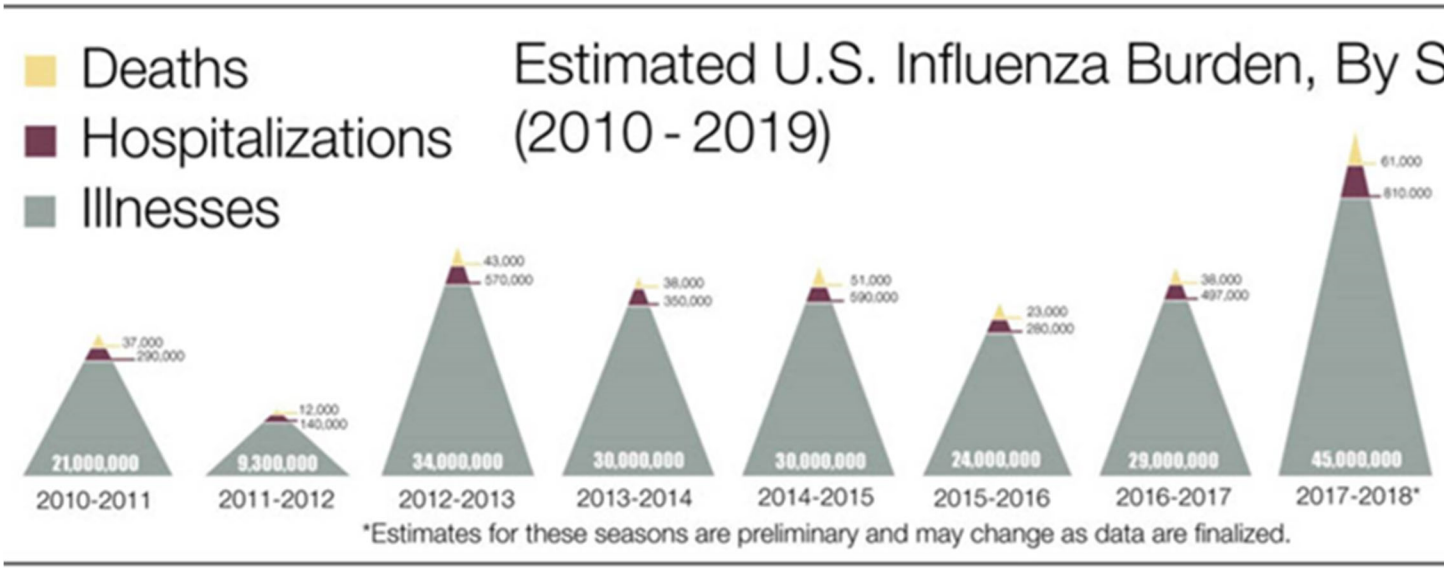
Flu deaths in children are reported to CDC, flu deaths in adults are not nationally notifiable. In order to monitor influenza related deaths in all age groups, CDC tracks pneumonia and influenza (P&I)-attributed deaths through the National Center for Health Statistics (NCHS) Mortality Reporting System. This system tracks the proportion of death certificates processed that list pneumonia or influenza as the underlying or contributing cause of death. This system provides an overall indication of whether flu-associated deaths are elevated, but does not provide an exact number of how many people died from flu.

During the 2017-2018 season, the percentage of deaths attributed to pneumonia and influenza (P&I) was at or above the epidemic threshold for 16 consecutive weeks. During the past five seasons, the average number of weeks this indicator was above threshold was 11 (range of 7 to 15 weeks). Nationally, mortality attributed to P&I exceeded 10.0% for four consecutive weeks, peaking at 10.8% during the week ending January 20, 2018.

As it does for the numbers of flu cases, doctor's visits and hospitalizations, CDC also estimates deaths in the United States using mathematical modeling. CDC estimates that from 2010-2011 to 2013-2014, influenza-associated deaths in the United States ranged from a low of 12,000 (during 2011-2012) to a high of 56,000 (during 2012-2013).

From October 1, 2017 through April 28, 2018, 30,453 laboratory-confirmed influenza-related hospitalizations were reported through the Influenza Hospitalization Surveillance Network (FluSurv-NET), which covers approximately 9% of the U.S. population. People 65 years and older accounted for approximately 58% of reported influenza-associated hospitalizations. Overall hospitalization rates (all ages) during 2017-2018 were the highest ever recorded in this surveillance system, breaking the previously recorded high recorded during 2014-2015; a high severity H3N2-predominant season when CDC estimates that hospitalizations captured through FluSurv-NET translated into a total of 710,000 flu hospitalizations that seasons.

Here is a chart that shows 2010 to 2018. The worst year had 61,000 estimated deaths.



Of course because the reporting system only covers slightly less than 9% of US Citizens and misses almost all illegal aliens so it isn't complete. But they are good at estimating based on the data the do have.

This SARS-2 / COVID-19 virus has a name and tests have been developed. We are testing more than ever. So the data regarding it is probably better than usual.

In the past un-named and strains that no test exists for were called "flue-like illness" and lumped together. Chances are there have been many viruses like this one in the past but they were never named or tested or tracked as effectively.

But looking at 2017-2018 there were an estimated 45 million cases, with 810,000 hospitalizations and 61,000 deaths for what we typically call flu. Those are just estimates but probably fairly close.

Yet we never shut down economies, issued shelter-in-place orders or curfews despite millions being at risk of infections, hundreds of thousands hospitalized and tens of thousands of deaths.

The CDC is showing that laboratory-confirmed flu activity is low at this time but elevated "influenza-like-illness" is likely related to COVID-19. It is probably true that any year when there are people testing negative for Influenza A or B but have flu-like symptoms those are probably due to unidentified viral strains.

What is most interesting about this flu season and why I have been saying for months that the COVID-19 deaths are not all "additive" is the CDC data is estimating 56 million flu illnesses which includes COVID-19. That is 11 million more than 2017-2018 and likely due to far more testing and reporting than we have ever had before. More people going to get tested due to fear. More organizations reporting test results. More focus brings more awareness and better data.

They are estimating deaths for all flu-like illness including COVID-19 and Influenza as well as unknowns are at 62,000 for this season. **That is only 1,000 more than 2017-2018.**

The CDC itself says, **"Influenza testing across the United States may be higher than normal at this time of year because of the COVID-19 pandemic. These estimates may partly reflect increases in testing in recent weeks and may be adjusted downward once the season is complete and final data for the 2019/20 season are available."**

So it is likely that actual increased cases are maybe 10% higher than 2017-2018 but likely less.

Now just a single additional death is tragic for that individual and their family. But the reality is the entire world has responded to this in a way that is illogical when looked at just on the facts. Maybe they know something they are not telling us. Possibly that this is a strain that was developed as a weapon and it has more long-lasting effects. But the reality is it isn't as lethal as some strains, it doesn't impact children or young people as severely as Influenza, it is taking the place of typical flu-like illnesses this season rather than increasing the burden on top of those typical cases, so the net increase will statistically look like a bad flu season but we won't see a doubling of illnesses or deaths.

Take this statement from CDC specific to Influenza. Keep in mind that we have tests for Influenza A and Influenza B. Keep in mind that Influenza A and B are included in the "Flu-like Illness" statistics making up part of them.

The number of hospitalizations estimated so far <u>this season is lower</u> than end-of-season total hospitalization estimates for <u>any season since CDC began making these estimates</u>.

That means that something (COVID-19) is taking the place of what would normally be Influenza infections.

So as I have been saying since looking at data back in January this COVID-19 virus that we have named and developed tests for and are reporting on at record rates is not in large part additive to illnesses and hospitalizations and deaths of flu-like illnesses. It is part of the total and to a large degree replacing the other flu-like illnesses rather than increasing the burden.

The COVID-19 pandemic has resulted in a lot of illnesses, hospitalizations and deaths. However at the same time the hospitalizations for influenza are lower than any on record since we started keeping records. So **while one is increasing the other is decreasing. The net result is some increase but you can't look at COVID-19 data as all new cases that would not otherwise have occurred.**

If you listen to the news media you would believe that this is somebody's fault and people are dying as a result of failures etc. What is really happening is there is far more awareness of every hospitalization, every test result, every death. But you can't look at the COVID-19 statistics alone without also looking at the Influenza and other flu-like illness statistics. When looking at the data this year you also have to realize that we have tested far more people than ever before and reported to a higher degree than ever before. What that means is the numbers for this year will be higher simply due to the increased effort

and focus on testing and reporting. If prior years had this much focus then the numbers for those years would also be higher.

All things being equal we will probably see a 5% increase in hospitalizations and deaths give or take a few percentage points. Horrible because you are talking about big numbers but not anywhere near what one would assume based on the worldwide response.

Historically flu-like illnesses impacting healthcare workers has always been a problem so this too is not new as one would be led to believe by news reports.

From CDC 2018 statistics:

"Most of the United States is experiencing widespread and intense influenza activity. Indicators used to track influenza-like-activity are higher than what was seen during the peak of the 2014-2015 season, the most recent season characterized as being of "high" severity. A NIOSH study recently published in the American Journal of Infection Control found that more than 40 percent of health care personnel with influenza-like-illness (ie, fever and cough or sore throat) continued to work while sick during the 2014-2015 influenza season.

The study used a national opt-in Internet panel survey of 1,914 healthcare personnel during the 2014-15 influenza season. The study found that 414 (22%) respondents had self-reported influenza-like illness. These healthcare workers missed a median of 2 days of work, 57% visited a medical provider for symptoms relief, and 25% were told they had influenza.

Of the 414 healthcare personnel with self-reported influenza-like illness, 183 (41%) reported working during their illness for a median of 3 days. Pharmacists (67%) and physicians (63%) had the highest frequency of working with influenza-like illness. Compared with physicians, a lower proportion of assistants and aides (41%), nonclinical healthcare providers (40%), nurse practitioners/physician assistants (38%), and other clinical healthcare providers (32%) reported working with influenza-like illness."

Not sure if you caught the significance but this was just a survey to determine statistics that were likely across the board. It found that **22% had self-reported influenza-like illness. That is basically 1-in-4 healthcare workers**. Just over half visited a medical provider due to symptoms (so roughly 13%) and of those 25% tested positive for one of the two strains of Influenza – or basically 3% of all healthcare workers tested positive for Influenza. The rest (19%) had flu-like symptoms but either were not tested or their Influenza test was negative but they had flu-like symptoms. In other word they had a virus that had not been named or a test developed.

Had we not discovered, named and developed tests for COVID-19 we would be lumping the cases in with "flu-like illness of unknown origin" as we do every year with a high percentage of hospitalizations and deaths.

Exact data is hard to come by on healthcare worker mortality due to infectious diseases caught at work (because they are people too and can become infected the same way non-healthcare workers can).

However, “With available information from federal sources and calculating the additional number of deaths from infection by using data on prevalence and natural history, we estimate the death rate for healthcare workers from occupational events, including infection, is 17–57 per 1 million workers.”

The CDC says there are roughly 6 million healthcare workers with potential patient contact so that would equate to deaths as high as 342 as a direct result of infections from caring from sick patients.

OSHA estimates there are 9 million workers so that would increase the numbers by 50% to over 500. OSHA also believes the number of infected is higher stating that during 2009 H1N1 virus that 50% of the cases in healthcare workers were the result of exposure at work.

OSHA stated, “OSHA does not have data on the exact number of occupationally-acquired infectious diseases in the United States and other developed countries because there are no centralized surveillance systems that specifically document all occupationally-acquired infectious diseases. This type of data also suffers from underreporting.”

So any numbers are suspect. There are probably far more cases of healthcare worker deaths related to infections acquired treating others than the numbers suggest.

However with COVID-19 each and every one will be tracked and counted. So it will appear worse than it is when compared to year where the information is underreported according to both CDC and OSHA. Again not that every single death is tragic but the numbers are not as bad as it would seem on the surface when compared to a “normal” year when you really dig into historical information that is known to be under-reported.

The 158 page OSHA report basically showed what we know to be true – we are not prepared to protect healthcare workers and even years before this a third of healthcare workers were not provided with adequate PPE. So this isn’t anything new. We should have been better prepared because they knew it was an issue. They recommended guidelines that evidently were not followed.

https://www.osha.gov/dsg/id/OSHA-2010-0003-0239.pdf

Maybe one reason they didn’t prepare better is the mortality rate for healthcare workers is estimated to be considerably less than truck drivers, pilots, firemen, fishermen, etc.

Thus far there have been over 400 deaths world-wide for healthcare workers. Last count I saw was around 50 in the United states. So around 10% of the average annual deaths of healthcare workers due to infections acquired trying to help others.

So again it is very bad, tragic, unacceptable – but not all that unusual from a statistical standpoint than a “normal” year prior to COVID-19.

The CDC maintains a long list of infectious diseases that healthcare workers acquire while working and many of them are deadly. It is a dangerous thing to do. We should have been better prepared to protect them not only with PPE but with procedures and disinfection etc.

Probably the most lacking thing that would make the greatest difference is forced airflow with filtration to reduce the pathogens parts per million or dilute what they are exposed to. Shorter hours allowing

them to get out of the concentrated pathogen environment, make fewer mistakes, and have more rest so their immune systems are not ran down. Simple things that could be done but are not due to cost.

But as bad as COVID-19 is the facts are it is having a serious impact but a large percentage of the impact is not additive but rather replacing other pathogens which would have had similar outcomes for many.

That is what the actual facts show. Statistically speaking 2019-2020 season will see an increase – part of which will be do to drastically increased testing and reporting – but the increase will not be nearly as much as you would think based on the response and reporting.

I just wish someone would report the actual facts without sensationalizing it and making people fearful of everyone. It is bad. But it isn't end-of-all-things-as-we-have-known-them bad. It is worse than normal but not so bad that a reasonable person would expect the kind of reaction we have seen whether government over-reaction or people hording.

The most "novel" or unprecedented thing about this crisis is our response worldwide and even in small communities like Jonesboro.

When the data is all in and normalized to account for increased testing and reporting I suspect if we look at Influenza, Pneumonia, Flu-like Illness and COVID-19 hospitalizations and deaths we will see less than 20% increase worldwide vs. totals averaged across the last decade for Influenza, Pneumonia and Flu-like Illness.

One thing is for sure – the reaction was very different this time around and it does not appear to be proportionate with the risk.

Hopefully you realize we have had more than 3 times as many deaths from auto accidents in Arkansas in 2020 than we have for COVID-19. https://asp.arkansas.gov/fatal/index.php?do=reportsLinks&year=2020

If the justification for this curfew is saving lives does that mean Mayor Perrin is going to outlaw vehicles in Jonesboro city limits where he has jurisdiction as well? There have been more hospitalizations and deaths due to auto accidents than COVID-19 in Jonesboro, in Craighead County and in the State of Arkansas. So if the reasoning is to keep us safe why don't they just outlaw vehicles and driving? I mean someone causes ever crash fatal or not. It is somebody's fault. If nobody were driving then we would all be safe from hospitalization or death by vehicle accident.

The point being that this pandemic does not rise to the level of risk that should be required for the government at any level – national, state, county or city – to trample on the rights of a free people and dictate what they can or cannot do and the "keeping citizens safe" argument does not hold water because it is not applied to all of the other (and greater) risks to the health and safety of Jonesboro's citizens.

This kind of action is always too broad in scope and to narrow in thinking.

What if this curfew is in place and a tornado is bearing down on Jonesboro during curfew hours? Citizens don't have the right to leave their homes to go to a shelter?

What if a person is suicidal and the only thing that keeps them from killing themselves is meeting in person with their sponsor or group members? Would that be considered medical reasons and who gets to decide?

What if a parent is concerned about an adult child or a pastor concerned about a member of their church? Those are not in the list of exceptions.

What about a neighbor who is concerned about another neighbor? Also not in the list of exceptions.

Even pets. Who hasn't gone looking for a pet that is missing at night? Also not in the exceptions.

Who gets to decide what is "essential" and what isn't? Mayor Perrin? Police Chief Rick Elliott? City Medical Director Dr. Shane Speights?

Where is the proof that driving or walking between 10 PM and 6 AM is going to endanger anyone?

I won't even get into the disagreement over whether social distancing works and the so-called experts who told us that 6' was safe but now other experts are saying more like 21 feet or more.

Or the experts who claim facemasks help and the other experts who say they make things worse for both the patient and the caregiver? They work for some pathogens but when the pore size is .3 microns and 95% effective filtering (5% ineffective) which is 300 nanometer size and the virus is 80 to 120 nanometers they might reduce some spread but they don't stop them. Not to mention secondary infections from where the masks are touched, set or disposed of. Not to mention they are not worn properly. That they don't fit the face properly. Worse that after as little as 5 minutes of breathing the humidity is so high they are ineffective. That is why studies done since SARS have disagreed on whether to even require PPE for healthcare workers and some studies have even shown that infection rates for both caregiver and patient are actually higher when mask are worn.

All this says is we don't really know what works and what doesn't. We don't know that the actions taken have not extended the life of the virus and threatened even more people. Yet despite actual hard evidence from studies and disagreement among scientists and medical professionals from 3M, OSHA, CDC, WHO and others we implement mandatory and restrictive orders that impact the lives of millions negatively on top of the threat from the virus.

Is Mayor Perrin serious when he says, "right now, nothing was off the table."? Seriously?

The city council needs to reign this in. I have no doubt it is well-intentioned but it is short-sighted. All you need to do is read your history and it is painfully obvious that nothing "mandatory" applied to all citizens has the desired effect regardless of how well-intentioned. There are always unintended (and negative) consequences.

It is probably why the medical profession swears an oath to "first do no harm" meaning if you don't have a reasonably high degree of assurance that something (a) can be done and (b) will have a positive outcome if done – you do nothing. It is better to do nothing than to take action that increases the damage.

Most of us don't need a law telling us not to drink poison. Most of us don't need a law telling us not to take someone else's life. For those who do the law has no power to stop them from drinking the poison or killing someone. So in general fewer laws are better than more. All you do with mandatory orders impacting everyone is turn people who would not otherwise be law breakers into criminals. Most of us are going to act in a way that protects ourselves and others. I am sure for the others there are already law on the books that can be utilized to reign them in.

Personally I have no interest in living in a nanny state or a place where any one individual thinks they know what is best for not only me but everyone else in their jurisdiction and uses power to force compliance with whatever they choose to believe.

The virus is present. If you could see it the virus is all over the place. It can live for days on some surfaces under some conditions. But it can't live forever outside a host. There is some pretty good evidence that if you let it spread among the young and healthy age groups who are being hospitalized at very low rates and dying at low rates then the virus can't find new hosts to infect. So it is likely that asking senior citizens and people who are at-risk groups to avoid being in public but letting everyone else go about their business is the best approach to "flatten the curve" because the vast majority of those infected would not need medical care.

In a perfect world a real quarantine of 6 weeks would eliminate the virus. Nobody that didn't already have it would get it. The people who have already been exposed it would run it's course in. Then the virus that is shed would die on surfaces after a week or less. If nobody was going anywhere or being around anyone else the virus would die out.

But this is not a perfect world. Some people have to be out – the so-called "essential" workers. People have to eat. People on medication or receiving treatments that keep them alive still have to be cared for. The supply chain has to be kept working or even food and medicine become unavailable. Utilities have to be kept working or people die from no water or freezing or heat depending on the climate where they live and time of year. Once you have any significant percentage out moving around the virus will continue to spread and people will continue to be at risk. It is unavoidable in our modern interdependent world.

Who is to say that New York or any other area would not have had a better outcome with a different approach? We will never know because they did what they did. Some will claim it saved lives and others will argue it cost lives or at least did no good while inflicting tremendous and long-lasting economic damage – likely multi-generational damage.

Effective or not some percentage of people will always defy orders. Actions like the curfew actually results in people coming out to protest – and rightly so because it is an overreach of authority, unreasonable and ineffective.

I hope members vote to end this curfew. I hope there are some left who have some sense and err on the side of liberty and individual rights. When governments back people into a corner and they feel trapped nothing good comes from it. That is why wise leaders do their best to avoid backing people into a corner and forcing them to comply against their will.

I for one have not been out past 10 PM in months. So it doesn't really impact me. But living in a community torn apart by people who feel very strongly one way or the other does impact me. It wasn't

necessary. It probably isn't effective. There is far more potential downside than upside. First do no harm.

End the curfew and apologize for implementing it in the first place. Admit it was probably not wise or effective.

Then ask people to do the right thing. Do whatever they can to reduce the risk to others. You might be surprised to find that more people will align with your wishes when they have the choice than when they are told what they must do or else. Americans kind of have an aversion to that sort of thing. It is part of our national DNA.

It always is a good idea for political leaders to keep in mind that forced compliance didn't work out so well for the king of England. Had he been more reasonable and asked rather than trying to force his will on others – maybe even with the council of advisors – we might still be part of great Brittan. Government leader always have a tendency to keep pushing, keep taking, keep demanding until they take it too far and nothing good ever results for either the leaders or the citizens. Reign it in a bit. Ask. Make forced compliance the last resort.

In this instance we were nowhere near the point that it was justified.

Sincerely,

Ed Martin