Mask Confusion: Infringing on INDIVIDUAL RIGHTS

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Not only are cloth masks ineffective at stopping the spread of viruses, but the fear-based mask requirements violate individuals' right to health-risk assessment.

by Cathy A. Spigarelli

"It's sad. I wasted a whole year of my life for this?" This was a text message from my 22-year-old son, who tested positive for COVID. His only symptom? Loss of smell. From the perspective of a healthy 20-something, preventive interventions were far worse than the disease. This illustrates the individual nature of health-risk assessment. Assessing health risk and the measures taken to protect oneself is personal. Yet, protection from COVID-19, in the form of cloth masks, was required for all, even the healthy, low-risk population. Despite an absence of scientific data supporting cloth mask effectiveness, this became the social norm. How could "cloth masks for all" have happened at a time when "follow the science" was touted by every politician, authority figure, and media organization as a worthy battle cry? A retrospective view of the past year provides answers and reveals how individual rights were trampled by masking requirements and baseless mandates emanating from manipulation, fear, confusion, and a lack of information and understanding rather than from actual science. Rather than government making such decisions for people, coercing them to obey with fear, people need to be allowed to make health decisions for themselves. Medical tyranny has no place in the American constitutional republic.

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Behind the Mask

During the early stages of the pandemic, respiratory protection in the form of N95 and surgical masks was in high demand by healthcare workers and the general public. Unfortunately, such masks were in short supply. Public demand for these masks had to be stopped to free up supply for healthcare personnel. On February 29, 2020, then-U.S. Surgeon General Jerome Adams tweeted, "Stop buying masks! They are NOT effective in preventing the general public from catching #Coronavirus, but if healthcare providers can't get them to care for sick patients, it puts them and our communities at risk." This was certainly a confusing statement to anyone without knowledge of respiratory protection. Did the surgeon general really say surgical masks are *not* effective for the public, yet effective for others? And did he suggest that the effectiveness of masks is location-dependent, i.e., hospital versus the grocery store? This was only the beginning of mask confusion. On April 18, 2020, the FDA released its Emergency Use Authorization (EUA) to manufacturers of face masks (cloth and non-FDA surgical-like masks with questionable effective-

The thinking part of the brain shuts down when the "fight or flight" response is triggered by fear. Fear bypasses logic, and we stop asking questions.

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Just a feel-good talisman: When the government gave out patterns for cloth masks, many undoubtedly felt safe wearing such masks. In truth, they do next to nothing to stop viruses, and serve only to make wearers feel safe.

ness), justifying the EUA by concluding that increased availability of face masks was needed for the general population, so FDA-approved surgical masks could be reserved for healthcare workers.

On April 3, 2020, the Centers for Disease Control (CDC) introduced a cloth mask "pattern" and instructed the general population to make their own cloth masks using this template. The public, with little understanding of respiratory protection, bought into this intervention, believing cloth masks to be as protective as the masks being prioritized for healthcare workers. To make matters more confusing, on April 24, 2020, the FDA set labeling requirements for the manufacturers of face masks for the public. The EUA specifically states that cloth and non-FDA surgical-like masks (intended for the public) could not be labeled as "a surgical mask; for use in a clinical setting where infection risk through inhalation is high; for antimicrobial or antiviral protection or uses for infection prevention or reduction; or as a respiratory protection device." So, why would the public be encouraged and eventually required to wear these EUA-sanctioned cloth masks? According to FDA labeling prohibitions, it is most certainly *not* for the prevention of viral infection. When it comes to matters of public health, public trust is critical, and this was not a good place to start.

During this time, the media and pandemic authorities generated a great deal of fear among the general public, especially since many details about the coronavirus were still unknown. A solution to this fear? Cloth masks! Many Americans accepted this masking intervention as valid and effective.

How, with virtually no scientific data supporting the effectiveness of cloth masking, could this intervention have been so easily adopted? Fear can strongly influence a person or group's ability to make accurate risk assessments. In the article "How Does Fear Influence Risk Assessment and Decision-Making?" Dr. Joseph Pierre, M.D., a health sciences clinical professor in the Department of Psychiatry and Biobehavioral Sciences at UCLA, sheds light on how fear impacts risk assessment. According to Dr. Pierre, "When it comes to assessments of risk, there may be no more pertinent emotion than fear." The thinking part of the brain shuts down when the "fight or flight" response is triggered by fear. Fear bypasses logic, and we stop asking questions.

Dr. Pierre explains how fear is often disproportionate to actual risk. This is essentially what my son expressed upon experiencing COVID-19 for himself. What he had imagined through the lens of fear created by the news media, social media, health experts, and politicians, in addition to the concerning and onerous restrictions placed on his daily life, was greatly disproportionate to his actual experience of the disease. After all, the risk assessment for a healthy 22-year-old is far different than it is for an 80-year-old with underlying conditions. Yet, a collective risk assessment was made that severely and negatively harmed much of the population. Individuals were not allowed to make health-risk assessments for themselves, and this drastically and improperly — if not criminally — interfered with their natural and constitutionally protected rights. Through the constant bombardment of harrowing news reports, many people were led to believe that masks and quarantines were correct for them, even though they were young, healthy, and had no underlying conditions. People living in fear will accept solutions such as cloth masks even if there is no evidence supporting their effectiveness. Seeing masked people all around us served as a constant reminder that there is danger, reinforcing fear and encouraging a continuation of mask-wearing.

Risk assessment is the process of identifying hazards and evaluating any associated risks, and is generally followed by risk mitigation — implementing *reasonable* control measures to remove or reduce such risks. The presence of fear, of course, means control measures might not be reasonable. Dr. Pierre states, "Fear is often associated not only with high and potentially

overestimated perceptions of risk, but also overestimates of the benefits of protective measures." An example of this type of overestimation, cited by Dr. Pierre and attributed to Harvard Law professor Cass Sunstein, is the creation and implementation of the largely ineffectual Transportation Safety Administration (TSA) after 9/11. Not surprisingly, two decades after the 9/11 tragedy, the TSA is still in place. Wearing a cloth mask in public during a pandemic could be seen as the equivalent of removing your belt and shoes for inspection before boarding an airplane. Are these actions protective, or is fear driving you to overestimate their effectiveness? Is doing *something*, albeit ineffective, better than doing *nothing at all*?

It could be argued that interventions that decrease fear but do little to reduce actual risk are not justified. Cloth-masking is an example of this. "The mask is almost like a talisman," remarked Margaret Harris, part of the World Health Organization's coronavirus response team. "People feel more secure and protected." This strategy also keeps more effective masks/respirators, designed to American Society for Testing and Materials (ASTM) standards, in the hands of healthcare workers. This is a double win for those managing the population — more effective masks for healthcare and a talisman for the public. But it also comes at a cost — public distrust, infringement on an individual's rights, and the potential for increased risk of infection.

Peer pressure and mask-shaming lead to compliance with "mask mandates." The CDC's guidance was that cloth masking was voluntary, preserving individual health-risk assessment. Nevertheless, personal choice was quickly pulled off the table and morphed into not just masks for all, but masks all the time and everywhere at the state and local levels, and among many large retail chains. On July 20, 2020, Walmart, one of the first to take such action, stated on their website, "Currently about 65 percent of our more than 5,000 stores and clubs are located in areas where there is some form of government mandate on face coverings. To help bring consistency across stores and clubs, we will require all shoppers to wear a face covering starting Monday, July 20." Need toilet paper? Put a mask on to get it.

Other retailers, businesses, and employers quickly followed suit. In this litigious society, who can blame them? The bandwagon effect took hold. As more people and businesses adopted masking, groupthink, the desire for conformity and harmony in the group, dominated. To minimize conflict, people even began wearing masks while alone in a car or when hiking outside on a remote trail. Indeed, people had to contend with peer pressure and the threat of violence against them for not masking, and the media got exceedingly good at mask-shaming. As Sunstein noted in the 2014 *Harvard Business Review* article "Making Dumb Groups Smarter," people often fall prey to "reputational pressure, which leads people to silence themselves or change their views in order to avoid some penalty — often, merely the disapproval of others." Sunstein, it is worth noting, is a star left-wing "intellectual." A former Obama administration official, he is a proponent of using the peer-pressure tactics he describes to make people conform. "An individual will focus on his own tastes — what he likes and what he doesn't," Sunstein wrote in his article for *Harvard Business Review*. "If he consults with others, he is likely to learn that his tastes are idiosyncratic. In such cases, group deliberation supplies an important corrective."

In addition to mask-shaming, the media did its part to influence the public to wear masks by leveraging "authority bias." They effectively used the opinions of authority figures (who were not experts in respiratory protection) to promote "cloth masks for all." A national Internet survey showed that 75 percent of Americans adopted cloth face coverings after being advised to do so by the CDC and the White House Coronavirus Task Force. It was a sad turn of events when the CDC noted that "cloth face coverings fashioned from household items or made at home from common materials at low cost can be used as an additional, voluntary public health measure." This guidance does not align with the science that underpins respiratory protection and protective-mask design. In a June 2020 podcast, Dr. Michael Osterholm of the Centers for Infectious Disease Research and Policy (CIDRAP) stated, "Frankly, I believe that this issue of CDC recommending the use of cloth masks without any substantial scientific evidence that they provide such protection, and in conflict with their own expertise in NIOSH [National Institute for Occupational Safety and Health, part of

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Do as I say, not as I do: Dr. Anthony Fauci not only admitted that masks are ineffective, but has violated his own "official" recommendation to wear one or more masks in public.

History repeating itself: Cloth masks were shown to be ineffective during the 1918 Spanish Flu pandemic. Why have governments and businesses insisted people wear them for COVID-19?

the CDC], has helped create the immense confusion that exists around this issue. In short, I believe the CDC has failed the public by creating this confusion."

Another sad day came when Dr. Anthony Fauci encouraged the public to wear two or three cloth masks, effectively an admission that wearing one mask is not effective. But it is important to note that before Fauci became America's most widely known and influential voice in support of mask-wearing, he did not support the practice so far as the uninfected were concerned. For instance, on February 22, 2020, in one of Fauci's e-mails recently made public through a Freedom of Information Act request, he said in response to a question from an administration official about wearing a mask, "masks are really for infected people to prevent them from spreading infection to people who are not infected rather than protecting uninfected people from acquiring infection." He added, "The typical mask you buy in the drug store is not really effective in keeping out virus, which is small enough to pass through the material. It might, however, provide some slight benefit in keep[ing] out gross droplets if someone coughs or sneezes on you."

Publicly, Fauci echoed this same sentiment on March 8 in a *60 Minutes* interview: "The masks are important for someone who's infected to prevent them from infecting someone else…. There's no reason to be walking around with a mask. When you're in the middle of an outbreak, wearing a mask might make people feel a little bit better and it might even block a droplet, but it's not providing the perfect protection that people think that it is. And, often, there are unintended consequences — people keep fiddling with the mask and they keep touching their face."

Understanding the Science

Cloth masking is not a novel idea. There is a history of cloth masking that we could have learned from. During the 1918 Spanish Flu, gauze masks were used by both healthcare workers and the public. What impact on disease did cloth masking have then? Masks were voluntary across the nation, except for San Francisco, where they were mandated (people were fined or jailed for non-compliance). Interestingly, this had no impact on the infection and death rates when comparing San Francisco to other similarly sized cities. This lack of impact was analyzed by W. H. Kellogg, the secretary of the California State Board of Health. He attributed it to the poor quality of homemade masks, wearing masks improperly, wearing masks at the wrong time, ineffective fabric, and a false sense of the effectiveness of masking. All five of these issues persist today among users of cloth masks, and no doubt explain why wearing cloth masks has had little to no effect on the spread of the virus.

Masking has also been studied in recent, pre-COVID times. Most studies have been conducted on N95 respirators and surgical masks used by healthcare workers. Generally, what can be ascertained from these studies is that N95 respirators are the most protective mask type, yet also the most uncomfortable for extended wear. Surgical masks have some effectiveness, but are less effective than N95s for respiratory protection due to looser fit. The few studies that have focused on cloth masks suggest that they are not particularly useful.

Personal Protective Equipment (PPE) should be the last line of defense for controlling a biohazard, and cloth masks are the last resort when it comes to masks. The fundamentals of respiratory protection illustrate why cloth masks fail to protect against COVID. Critical to the effectiveness of any mask is a proper fit, which prevents air leakage, and filter efficiency, which is the ability of the fabric to stop unwanted particles while allowing air through. Both are needed for a quality mask. The filtration efficiency of a common cloth mask is less than one percent of that of an N95 respirator. Unlike N95 respirators and surgical masks, cloth masks do not have any ASTM standard — they are essentially the Wild West of masks. With lack of proper fit, poor filtration efficiency, and no design standard, it should come as no surprise that cloth masks are ineffective. Science predicts that these will fail to perform just like the gauze masks of the 1918 pandemic.

Scientific information on cloth masks was not reaching the public as a result of an orchestrated campaign of censorship, and this was another factor contributing to widespread inappropriate mask use and compliance with mask mandates. The media added to the problem by consulting authority figures who answered questions outside of their expertise. The public needed guidance from experts in aerosol science (CIDRAP); in respiratory protection (OSHA, NIOSH, indus-

trial hygienists, and environmental health and safety professionals); on respirator/mask design standards (ASTM); and on mask design limitations (mask manufacturers). Lack of scientific information led to masking rules and practices that were not science-based. Clear guidance about masks, such as their limitations, when to use one, how to use one, and where masking fits in with other protective measures, was desperately needed. But guidance from respiratory-protection experts was limited, and possibly even restricted. Respiratory-protection experts faced pressure in the form of retracted journal articles, requests to remove articles from their websites, and threatening e-mails if they did not align with "cloth masks for all." Any criticism of masking policy was met with backlash from those who believed cloth masking was the only way to manage COVID.

The CDC's website lists the studies it relies upon in giving cloth-masking guidance. Perhaps not surprisingly, none of the studies listed by the CDC conclude that cloth masks are ineffective, yet there are plenty of such studies out there. One-sided data reliance does not allow for scientific truth to be known. Instead, this adds further to mask confusion and distrust.

Scientific debate over valid and proper study design, data analysis, and final conclusions has also hampered understanding. As an illustration, one of the most notable studies to date, DANMASK 19, a community-based, randomized controlled trial, followed the COVID infection rate in masked versus unmasked groups of 4,862 Danish participants. The masked group had a 1.8-percent infection rate versus the un-masked control group of 2.1 percent. The difference was not statistically significant. The DANMASK study, published in the journal *Annals of Internal Medicine*, concluded: "In this community-based, randomized controlled trial conducted in a setting where mask wearing was uncommon and was not among other recommended public health measures related to COVID-19, a recommendation to wear a surgical mask when outside the home among others did not reduce, at conventional levels of statistical significance, incident SARS-CoV-2 infection compared with no mask recommendation." Yet, the CDC said the study results are inconclusive because the sample size was too small to assess whether masks could decrease transmission of COVID from wearers to others.

It should now be clear that cloth masking during the COVID pandemic did not occur because we "followed the science." In fact, it was a *lack of science* that drove us toward the masking of millions. Indeed, the decision to mask the population was based on fear, manipulation, lack of information, and "better safe than sorry" reasoning. Fear and the need to "do something" resulted in ineffective cloth-mask solutions. Imposing upon individuals' right to decide to mask or not should not have happened without overwhelming scientific data proving masks' unquestionable ability to mitigate disease transmission. This was not the case, and it resulted in distrust and confusion. This divided our country and our scientific community.

How can we put this mask confusion in the past and learn from it for the future? First, the federal government should have nothing to do whatsoever with health advice or mandates. States or local communities should adhere to *voluntary* cloth-masking guidance for the public, lifting state mask mandates and mask requirements in stores, restaurants, and businesses. The public should have the choice to mask or not to mask. Given access to good information and allowed to exercise their natural rights, Americans are perfectly capable of making good and proper health and other choices for themselves.

We did not apply the lessons of the 1918 Spanish Flu pandemic to the 2020 COVID-19 pandemic. And, just as in San Francisco in 1918, the public was mandated to wear ineffective cloth masks that, for the same reasons, failed to protect them. We must take the opportunity now to do better, and to arm with sound information on public masking, policy, and best practices those who will manage the next pandemic. In this way, we can improve pandemic readiness for ourselves and future generations, without trampling on individual risk-assessment rights. ■

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Overkill? Many people would likely say that this individual is taking PPE a bit too far. However, this is closer to the level of PPE everyone would have to wear to truly protect against the coronavirus. Simple cloth masks won't do the job.