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21.02.2021

Politics & Science: Rahm Emanuel, Mike Pence, Homosexuality, Pandemics, Masks, Vaccines

Photograph by Nathaniel St. Clair

Aside from their icy-mobster visages, Rahm Emanuel and Mike Pence have something else in common. Both, as members of presidential administrations, tried to rewrite Centers for Disease Control (CDC) pandemic guidance for political purposes. The reason why one was successful and the other was not has nothing to do with courageous CDC scientists threatening to resign in protest; instead, the different outcomes had to do with politics.

I'll get back to Rahm Emanuel and Mike Pence, but first, the reality that politics routinely dictates scientific proclamations—this reality embarrassingly obvious to me because I have seen it repeatedly occur in my own mental health profession. When people embrace a war mentality—whether the war is on communism, terrorism, heroin, or schizophrenia—they become terrified of the enemy; they fantasize that authorities are honest and competent in securing victory; and they are highly vulnerable to propaganda. War goes hand in hand with fear, and fearful people don't think critically; and so, as it has often been observed: "In war, truth is the first casualty."

Science, Politics, and Homosexuality

It is not at all controversial among psychiatrists and psychologists to acknowledge that declarations about which human behaviors are deemed mental illnesses are politically influenced. The only controversy among professionals is whether *all* such mental illness declarations are political or whether only *some* of them are political (I'm in the *all* camp). There is no controversy that at least some mental illness declarations are political because it is widely known how homosexuality became a mental illness and how this so-called mental illness was abolished.

The American Psychiatric Association (APA), the guild of American psychiatrists, declares which human behaviors are mental illnesses in their *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), which the APA intermittently revises (the current 2013 revision is called *DSM-5*). Until 1973, the APA had categorized homosexuality as a mental illness—a declaration obviously not based on science. Gay activism by the late 1960s, as exemplified by the 1969 Stonewall uprising, had become a significant political force; and in 1973, following a political uprising against the APA by gay activists and their allies, the APA abolished homosexuality as a mental illness. For a brief moment in time, it was obvious—even to the mainstream media—that science had nothing to do with the creation of at least one mental illness, and it was obvious to everyone that it was successful political activism—not any new scientific research—that caused the abolition of homosexuality as a mental illness.

Homosexuality had been classified as a mental illness because it made most psychiatrists uncomfortable, and the shrinks in charge of the *DSM* were certain that homosexuality upset most of society. Historically, in practice, the criteria for any behavior being declared a mental illness has been: (1) whether the behavior is legal but makes psychiatrists uncomfortable; (2) whether psychiatrists believe that most of society is frightened by the behavior; and (3) whether psychiatrists conclude that those individuals they are pathologizing are not capable of politically retaliating against psychiatry. Thus, the APA is not about to classify 24% of Americans who believe the Bible is the literal word of God as having bizarre delusions symptomatic of schizophrenia. However, in the 1980 *DSM-III*, the APA created oppositional defiant disorder (ODD), the "symptoms" of which include refusing to comply with rules and requests from authorities and often arguing with authorities. The APA, apparently, was

unintimidated by the political organizational skills of anti-authoritarian twelve-year olds, and ODD has become an increasingly common diagnosis.

Rahm Emanuel, Rich Besser, and the CDC

In 2009, during the H1N1 (swine flu) pandemic, Rahm Emanuel was Obama's chief of staff. Thanks to the National Library of Medicine Archives and its H1N1 Oral History Project that contains a 2010 interview with Dr. Rich Besser, acting CDC director in 2009, we have a first-hand look at just how the dance between politics and science plays out at the highest levels—including Besser's encounter with Rahm Emanuel. Scientists and doctors with no aspirations to be at the top of institutional hierarchies may not be all that wowed and intimidated by powerful politicians; however, professionals such as Besser who do achieve prestigious institutional positions tend to be wowed and intimidated by powerful politicians.

Rich Besser has the kind of looks that make for a TV doctor, and in fact he had been a health reporter for a San Diego local TV station in the 1990s, and later joined ABC as chief medical analyst. After Besser became acting CDC director in 2009, he recounts in that 2010 interview how he was awestruck and intimidated by his first encounter with Barack Obama and his staff.

Besser tells us that after he had heard from the White House that the president wanted him to provide an overview of the H1N1 pandemic, he anxiously asked others in the administration if they had "any advice on how do you brief the President and the Cabinet." When Besser arrived in the Cabinet room, he tells us that "there was the whole Cabinet milling around waiting for the President to arrive." When Obama finally arrived, he announced that all of the decisions made had to be based on the best science available, and he then asked Besser to give him an update. In his update, Besser discussed school closings and that the CDC "had just issued guidance recommending closure for two weeks." Afterwards, Obama told him, "Dr. Besser, that was a perfect briefing," which provided such a buzz for Besser that he admits, "after that, I don't remember anything he said . . . I know he asked me a few questions, and they were good questions, but I was kind of blown away by the experience, and I don't remember what those two questions were."

After the meeting ended, John Brennan, then Deputy National Security Advisor for Homeland Security and Counterterrorism, told Besser, "Rich, I need you right away in Rahm Emanuel's office to discuss the school closure." As Besser headed to this next meeting, a playful Obama told him, "Rich, you're a lot taller than you look on TV. . . Do you play basketball?" Besser sheepishly responded, "I am the most pathetic basketball player ever . . . . Mr. President, I can't shoot." Besser tells us that Obama then told him, "That's okay. You can crowd the link. You're big. Put your arms up and you can crowd the link." Then Obama turned to his basketball-playing pal Arne Duncan and said, "Hey, what do you think about this guy for a basketball team?" Poor Rich Besser—Obama tried to make him "one of the

guys," but Besser knew so little about basketball that he recounts that Obama said "crowd the link" when Obama no doubt said "crowd the *lane*."

Next, Obama exited, and at the table was Arne Duncan, the Secretary of Education; Janet Napolitano, the Secretary of Homeland Security; and Kathleen Sebelius, the Secretary of Health and Human Services; along with David Axelrod and Rahm Emanuel. Besser reports, "They said, 'Okay, Rich, we need to talk about the guidance you all just put up about school closure. It's not gonna fly'" (Besser doesn't clarify who exactly *they* included). Besser reports this unsettled him, recounting that he "just came out of this meeting where they said that science was going to drive guidance, and I'm looking around the table and I'm thinking, I'm the only scientist at this table."

Then Rahm Emanuel said, "Let me take a stab at rewriting it." And Besser reports that Emanuel "has a pad and he starts writing some guidance." Besser tells us that he told Sebelius, "Madam Secretary, I'm not real comfortable with this," but she responded, "It's okay, just wait." Then Emanuel writes some guidance and says, "Okay, how about this?" and he starts to read it.

Besser, dutifully complying with Sebelius, kept his mouth shut, but to his relief, there is a "white knight" in his story. It is David Axelrod who says, "You know, Rahm, I don't think it's a good idea for you to be writing scientific guidance." After which, Besser tells us, "So Rahm balls up this piece of paper and throws it into the corner, says a few words that he's been known to say."

However, Besser next has to deal with Obama's basketball buddy, Arne Duncan, the Secretary of Education, who it turns out feels slighted by the fact that he hasn't been consulted about the CDC's school guidance. Besser tells us that he learned that "guidance that says children should be out of school for two weeks has major implications." Duncan proceeded to talk about children needing to learn as much as possible and that schools provide meals for some children, but he neglected mentioning a political issue involved in all school closings: the childcare provided by schools allows millions of parents to go to work and keep the economic machine going.

Shortly after this meeting, the Deputy Communications Director handed Besser guidance with some changes on it and told him, "Rich, I want you to look at this and see if it's consistent with the science." Among the changes, Besser tells us, "one was that, instead of saying schools will be closed for two weeks, it said they would be closed for one week at which time there would be a reassessment." Besser was asked, "Can you live with that?" and Besser responded, "Yeah."

While this rewrite of CDC guidance about school closing was, from my point of view, relatively benign, the bottom line is that politicians had a say over CDC guidance.

Mike Pence and the CDC

Not benign at all was the 2020 CDC guidance rewrite by Mike Pence that I previously detailed in *CounterPunch* ("COVID-19 Slaughter, CDC Tragedy, and One U.S. Authority without Blood on His Hands").

Reported October 15, 2020 by *ProPublica* ("Inside the Fall of the CDC"), the CDC had, in mid-May 2020, published an investigation of a COVID-19 outbreak at a church that had resulted in four deaths, and it also detailed a superspreader event in which 52 of the 61 singers at a 2½-hour choir practice developed COVID-19, with two people dying from it. Jay Butler, the CDC Deputy Director for Infectious Diseases charged with directing the CDC's COVID-19 response, was tasked with crafting CDC guidance for religious organizations' activities. Trump announced that the CDC would "very soon" release safety guidelines for places of worship, and so Butler's team rushed to finalize this guidance, which urged congregations to consider suspending or at least decreasing the use of choirs. However, the Trump White House then removed this choir guidance, to which Butler's team initially resisted. Then, Mike Pence, chair of the President's Coronavirus Task Force, intimidated the CDC into compliance; *Propublica* recounts: "The next day, a furious call came from the office of the vice president: The White House suggestions were not optional. The CDC's failure to use them was insubordinate, according to emails at the time."

The Trump White House forced the CDC to make changes that were in no way benign. The original CDC guidance was replaced with the White House version, and the choir dangers went unmentioned. Later that weekend, *Propublica* reports, "Butler, a churchgoer himself, poured his anguish and anger into an email to a few colleagues," his email reading: "I am very troubled on this Sunday morning that there will be people who will get sick and perhaps die because of what we were forced to do."

When investigating the CDC in 2020, *Propublica* describes a state of terror within the CDC: "People interviewed for this story asked to remain anonymous because they feared retaliation against themselves or their agency." With the departure of Trump and his appointed CDC director, Robert Redfield, perhaps we will learn more about other successful political intimidations by the Trump White House.

The CDC Mask Flip Flop

One area with a putrid political smell is the CDC's April 3, 2020 mask guidance flip flop, which the CDC justified by its claim of "new evidence"—this despite the fact that no such "new evidence" had been discovered, a fact painfully reported by Michael Osteholm, director of the Center for Infectious Disease Research and Policy (CIDRAP) and now a member of Biden's 13-member COVID-19 Advisory Board. Perhaps one day we will learn more from the bullied CDC staff as to what was involved in this CDC reversal and its false claim of "new evidence."

The untrue "new evidence" claim is deeply troubling because (1) even if the longstanding conclusions of mask ineffectiveness by respected scientific authorities—such as the CDC's

own National Institute for Occupational Safety and Health (NIOSH) and CIDRAP—proves down the road to be wrong, when the CDC claimed "new evidence" on April 3, 2020, this was a false claim, and that damages CDC credibility; and (2) in the event that NIOSH and CIDRAP's conclusions about mask's unreliability and ineffectiveness are scientifically valid, the CDC flip flop created a false sense of security that may well have cost many lives.

Prior to the cloth mask guidance flip flop, the U.S. Surgeon General Jerome Adams had tweeted on February 29, 2020: "Seriously people—STOP BUYING MASKS! They are NOT effective in preventing general public from catching #Coronavirus." The U.S. Surgeon General, like many other public health authorities, follows the CDC lead, and so on April 4, 2020, Adams famously flip flopped, demonstrating how to make cloth masks from scarfs, bandanas, and t-shirts.

Only two weeks prior to the CDC's April 3 cloth mask recommendation, as I previously reported in *CounterPunch,* Jay Butler, directing the CDC's COVID-19 response, stated on March 18, 2020 (CDC video, 52:12 mark): "CDC does not recommend use of masks in the general community, and that's not a new recommendation. That's been a standing recommendation for some time, primarily because there's not a lot of evidence that there is benefit."

Butler knew that NIOSH, which is a part of the CDC, had for many years been studying respiratory protection from small airborne particles; and NIOSH had concluded that even surgical masks—no less cloth masks—were not reliably protective. Osterholm quoted NIOSH's website after the CDC flip flop: "A surgical mask does not provide the wearer with a reliable level of protection from inhaling smaller airborne particles and is not considered respiratory protection." (Unlike cloth and surgical masks, N95 respirators, if fitted correctly, are protective for its wearer, but N95s routinely have valves that release unfiltered air when the wearer breathes out, thus N95s don't prevent the wearer from spreading the virus.)

Trump's lies about the nature of the COVID-19 outbreak, its seriousness, testing, and treatment have been well-documented, making it clear that Trump's only agenda with regard to COVID-19 was to keep it from derailing the economy so as not to derail his re-election. The problem for Trump was that polls showed that most Americans were unconvinced that COVID-19 was no big deal. To keep the economy and the stock market from collapsing, many more Americans than Trump's true believers needed to feel they could responsibly work, shop, and travel—and most Americans did trust the CDC.

I don't know if the CDC got the message from politicians to reverse their mask guidance. What is known is that on April 3, 2020, the CDC flip flopped on the mask issue without any "new evidence" to justify doing so, and masking up certainly did make Americans feel they were being responsible in their working, shopping, and traveling—evidenced by

holiday airport scenes of throngs of people awaiting boarding all of whom were masked up but inches from one another.

In the Netherlands, unlike the United States, public health authorities have been candid about the political nature of their flip flop on mask guidance. Jaap van Dissel, termed by the U.S. press as the "Dutch Dr. Fauci," is the Director of the Dutch National Institute for Public Health and the Environment Center for Infectious Disease Control, and he has served as chairperson of his nation's Outbreak Management Team (OMT). Van Dissel and the OMT—based on the research findings of limited value of masks to prevent infection, along with their concern that masks would result in a false sense of security and less physical distancing and the above airport scenes, along with their apprehension that incorrect use of masks could increase disease transmission—concluded it was unwise to recommend masks, reported *Newsweek* on August 5, 2020. At that time, the Dutch Minister for Medical Care, Tamara van Ark, reaffirmed Van Dissel and OMT's position: "From a medical point of view, there is no evidence of a medical effect of wearing face masks, so we decided not to impose a national obligation." However, in October 2020, the *Dutch News* reported that though "Jaap van Dissel has stood by his view that non-medical face masks have a 'very limited' effect" and that the rest of the OMT has "the same opinion" as Van Dissel, the *Dutch News* stated, "Nevertheless, he said, the OMT will follow where the politicians lead."

The false assertion by the CDC that there was "new evidence" to justify its mask recommendation reversal was upsetting for CIDRAP director Osterholm, who reviewed the facts on June 2, 2020 (click here for transcript). Osterholm tells us that the CDC's mask recommendation flip flop "was published without a single scientific paper or other information provided to support that cloth masks actually provide any respiratory protection." He explains that the CDC's so-called "new evidence" had nothing at all do with mask effectiveness, but that it consisted of seven reports or papers listed as 'Recent Studies' that detailed the risk of presymptomatic or asymptomatic transmission. Osterholm tells us, "There was nothing about how well such masks protect against virus transmission, particularly from aerosol-related transmission. Never before in my 45 year career have I seen such a far-reaching public recommendation issued by any governmental agency without a single source of data or information to support it."

Osterholm tells us that he talked to close friends and colleagues who work at the CDC and, "They universally disagreed with the publication of this recommendation based on the lack of information supporting that cloth masks actually reduced the risk of virus transmission to or from someone wearing a cloth mask."

The mask recommendation flip flop is, of course, not the only highly visible flip flop in U.S. history. One of the most well-known reversals was Woodrow Wilson's flip flop with respect to U.S. entrance into World War I. Wilson had boasted in his 1916 presidential campaign about having kept Americans out of the war, but then after his re-election, created a

Committee of Public Information (CPI) with a network of 75,000 lecturers to spread pro-war propaganda in movie theaters, churches, lodges, and colleges. Those involved with CPI included not only Edward Bernays, author of *Progaganda*, but novelist Booth Tarkington, muckraker Ida Tarbell, newspaper editor William Allen White, and other influential Americans. In PBS's American Experience "Master of American Propaganda," about CPI's chair George Creel, it is noted that, "Propaganda became, and remains, one of the dirty words of American politics. Even so, subsequent emergencies — World War II, the Cold War and the War on Terror—have necessitated similar international campaigns to engage domestic and foreign publics."

In the March 18, 2020 CDC video in which Butler states that "CDC does not recommend use of masks," Butler actually hints at a recommendation *against* cloth masks: "We are also concerned about the exposure of hands to the face. . . . Just [an] anecdotal observation—not true scientific data—I've watched people in public who are wearing the mask and how often they put their hand to their face to adjust the mask . . . . It really makes me wonder if it actually might have a negative benefit on the risk of infection. . ."

While most public health authorities were not recommending *against* cloth masks, they were averse to recommending *for* masks because they feared that this would devolve into a "false sense of security," or as CIDRAP put it, "Their use may result in those wearing the masks to relax other distancing efforts because they have a sense of protection." This issue for Osterholm is hugely important: "If these cloth masks do little to reduce virus transmission due in large part to their lack of protection against aerosol inhalation or exhalation, do we not have an obligation to tell the public of this potential limitation? How many cases of COVID-19 will occur when people using cloth masks and not understanding the limitations of their effectiveness participate in activities with others where virus transmission does occur?"

In some cultures—for example, some Asian ones—there is greater compliance with *all* directives from authorities, and so when people comply with something of little value, this will not deter them from complying with what is known to be scientifically effective. However, American culture is different, and so what worried CIDRAP was that if Americans have a sense of security from mask wearing, they would become more careless about what may be more difficult to practice but is unequivocally effective, such as physical distancing and avoiding crowds.

CIDRAP continues to be one of the few public health authorities attempting to re-prioritize physical distancing. In CIDRAP's current "STOP SWAPPING AIR" campaign, it conspicuously de-prioritizes cloth masks, stating: "Special forms of breathing protection, such as N95 respirators, can protect you from breathing in aerosols. But cloth face coverings are not designed to filter out such small particles, and they also may enter through the gaps around the cloth."

To be clear, I wear a mask in public for a couple of reasons. Nowadays, not wearing a mask in a supermarket is as rude as not wearing a yarmulke in an orthodox synagogue or not taking off one's shoes in a mosque; and so as to not agitate others, wherever yarmulkes, shoelessness, or masks are required, I obediently comply. In addition to politeness, I also wear a mask for a perversely selfish reason—call me ungenerous, but I'm not about to provide satisfaction to those people who derive sadistic pleasure when a mask eschewer contracts COVID-19. Perversities aside, for protecting others and myself, I am biased to science and CIDRAP's recommendations.

While Dutch public health authorities' mask guidance annoyed U.S. authorities, as of February 14, 2021, the Dutch COVID-19 death rate is 85 per 100,000, which is 57% of the U.S. death rate of 148 per 100,000. This is not to say that the Dutch approach has been the best—New Zealand has had 25 deaths for its entire population of five million people—but at the Dutch COVID-19 death rate, approximately 206,000 fewer Americans would be dead as of February 14, 2021.

Freethinking about Failure and Vaccines

On February 2, 2021, PBS's "Frontline" broadcast "China's COVID Secrets" about the Chinese government's failures regarding COVID-19, especially its early cover up of human-to-human transmission. Given that the United States has, by far, more COVID-19 deaths than any other nation, with over 485,000 dead by February 14, 2021, there shouldn't be much debate as to whether or not U.S. authorities also horribly mishandled the pandemic. We do not know the most important way that U.S. authorities failed. We do not know how important the mask flip flop will turn out to be, or whether the CDC testing fiasco (detailed by *Propublica*) or another wrongdoing emerges as a bigger deal. What we do know is that while it is politically safe for Americans to spell out Chinese transgressions, it is not yet politically safe for American to engage in fearless freethinking about why the U.S. has, by far, more COVID-19 deaths than any other nation.

Since April 2020, Americans have increasingly masked up. A July 31, 2020 *Newsweek* headline announced, "95 Percent of Americans Now Wear Face Masks after State Mandates and Trump's 'Patriotic' Endorsement" (on July 21, Trump tweeted a picture of himself wearing a mask, stating "There is nobody more Patriotic than me, your favorite President!"). However, in the 2020-2021 winter, the United States has seen record daily COVID-19 death totals. Since April 2020, both residents and staff in US nursing homes and assisted living facilities have stringently masked up, yet residents have been dying in droves; by December 2020, residents and staff accounted for 39.3% of all U.S. COVID-19 deaths (the CDC reports that 81% of all COVID-19 deaths have occurred in individuals 65 years and older: 32.5% among those 85 and older; 27.6% among those 75-84; and 21% among those 65-74).

Mask advocates may contend that U.S. death totals would be even higher without the masking, but isn't it at least possible that the false sense of security of masking makes it easier to (1) not physically distance and (2) not initiate other policies that truly would save lives?

What if we had stringently followed CIDRAP's "STOP SWAPPING AIR" recommendations (for example, "Skip any indoor activities that are not absolutely essential. . . . This means not participating in or watching a choir concert, school dance, or indoor sports"). What if every hospital employee, EMT, and other worker in contact with patients had a large supply of properly fitted N-95 respirators which—unlike cloth and surgical masks—do in fact offer significant protection for wearers? What if we had done everything possible to free people—including nonviolent prisoners, students, and teachers—from their superspreader daily existences? What if, when not possible to free some people from their institutional existence—such as nursing homes—that $12 per hour aids were paid double to communicate to them that they are valuable and cared about, and they were told the pre-flip flop facts about cloth masks' ineffectiveness, and they were guaranteed pay if they did not come to work due to concerns of contact with someone with COVID-19? And what if there had been stringent testing of all nursing home staff and residents?

At the Gold Crest Retirement Center in Nebraska, an April 2020 outbreak resulted in 20 COVID-19 cases, 12 in its assisted living unit and eight in its nursing home, and three residents died. However, after that outbreak, Gold Crest began weekly testing using rapid testing kits; and since the testing began, as reported on December 2, 2020, Gold Crest hasn't had a coronavirus case for any resident. The center's director, Jeff Fritzen concluded: "I think the testing has been a game changer. We're able to identify staff members that have it and get them out of the building." The Gold Crest data is not "scientific evidence" but "anecdotal evidence"; however, in a sane society, this evidence would lead to a scientific investigation; and if validated, this would result in policies that might have saved many thousands of lives.

Instead of stringent testing and physical distancing, throughout 2020, U.S. society has rallied around stringent masking—and vaccine hope.

Even if vaccinations are made compulsory for all staff in nursing homes, neither the CDC nor vaccine makers claim that a vaccinated staff member cannot spread the virus. Specifically, the CDC's COVID-19 vaccine FAQ site acknowledges, "We also don't yet know whether getting a COVID-19 vaccine will prevent you from spreading the virus that causes COVID-19 to other people, even if you don't get sick yourself." This in part is because, as the Pfizer vaccine study states, that among the limitations of their results, "These data do not address whether vaccination prevents asymptomatic infection." The CDC FAQ site also states, "We won't know how long immunity lasts after vaccination until we have more data on how well COVID-19 vaccines work in real-world conditions." With respect to making COVID-19 vaccinations compulsory, it's difficult to imagine how that would not be a violation of one's

civil rights—especially given the fact that both the Pfizer and Moderna vaccines with their new mRNA technology are FDA "unapproved products"—receiving instead FDA "Emergency Use Authorization" (and, as the December 17, 2020 CNBC lengthy headline states: "You Can't Sue Pfizer or Moderna If You Have Severe Covid Vaccine Side Effects. The Government Likely Won't Compensate You for Damages Either").

In terms of the vaccines stopping the slaughter of old and immunocompromised individuals, *BMJ* (formerly the *British Medical Journal*) reported on November 26, 2020 that in the Pfizer and Moderna vaccine trials, effectiveness "endpoint" was "importantly not the vaccine's ability to save lives, nor the ability to prevent infection [as noted, Pfizer acknowledges that their data does not address whether vaccination prevents asymptomatic infection], nor the efficacy in important subgroups (e.g. frail elderly). Those still remain unknown. . . . children, adolescents, and immunocompromised individuals were largely excluded from the trials, so we still lack any data on these important populations." Furthermore, on June 22, 2020, when freethinking about COVID-19 vaccines among scientists was not so taboo, William Haseltine (a former Harvard Medical School professor and founder of the university's cancer and HIV/AIDS research departments) stated in the *Scientific American*: "Some vaccines worsen the consequences of infection rather than protect, a phenomenon called antibody-dependent enhancement (ADE) . . . . The older we get the poorer our ability to respond to vaccines. Resistance to vaccination begins early at age 30 and becomes progressively more profound with time. That is especially troubling as those over 60 are the population most at risk. Vaccination of the elderly may sometimes succeed by administering repeated doses and by increasing the potency of the vaccine with powerful adjuvants. But these adjuvants can be especially risky for the very old." Whether Haseltine's concerns are relevant to mRNA vaccines is something science has yet to answer.

The general public mostly hears about COVID-19 vaccine's 95% effective rate. Pfizer's vaccine study results report that from a total of 43,448 subjects, 21,720 received the vaccine and 21,728 received a placebo. Among those vaccinated, Pfizer reports 8 COVID-19 cases (0.037% of subjects); and among the placebo group, 162 cases (0.745% of subjects). Thus, there was a "relative risk reduction" of 95% (placebo incidence of 0.745% minus vaccine incidence of 0.037% equals 0.708% which was divided by placebo incidence of 0.745%); but an "absolute risk reduction" of only 0.708% (0.745 placebo incidence minus 0.037 for vaccine incidence). In sum, according to the Pfizer results: among vaccine users, there is a 95% relative risk reduction but a less than 1% absolute risk reduction; it is unknown how long vaccine immunity lasts; and it is unknown whether being vaccinated prevents one from spreading the virus.

Vaccination receptivity has certainly been enhanced by the idea that they are 95% effective. What caught my attention about the 95% rate is how much more effective the claim for COVID-19 vaccines is compared to the influenza vaccine, which as Osterholm recalls, "It

wasn't 70% to 90%, as it had been promoted over and over again by public health and the medical community; but rather in a good year it might be 50%, and many other years it was far below that."

However, to be clear, Osterholm supports both the influenza and COVID-19 vaccines. This presents a dilemma for those who respect Osterholm but don't trust pharmaceutical corporations including Pfizer, whose "Corporate Rap Sheet," according to the Corporate Research Project, is an especially long one. Beyond the typical Big Pharma offences of dangerous products (Pfizer's include its arthritis drug Feldene, painkiller Bextra, and its defective heart valves), illegal marketing, and false advertising, Pfizer has committed offenses that go beyond the standard egregious pale. Pfizer actually tested its antibiotic Trovan on children in Nigeria without receiving consent from their parents who sued Pfizer for using their children as human guinea pigs; and then, the Corporate Research Project notes, "Classified U.S. State Department cables made public in 2010 by Wikileaks indicated that Pfizer had hired investigators to dig up dirt on Nigeria's former attorney general as a way to get leverage in one of the remaining cases." Also unsettling for observers of revolving doors in industrial complexes, in June 2019, Scott Gottlieb, two months after stepping down as the FDA director, joined the Pfizer board of directors.

Most Americans are unaware that COVID-19 vaccines are being developed around the world. The Cuban vaccines, which I don't know enough about to vouch for, are being developed without Big Pharma's financial exigencies—making greater safety claims at least intriguing.

It is quite human to be fearful of COVID-19, and recent history also makes it reasonable for Americans to be fearful of being lied to by self-serving politicians, by scientists intimidated by politicians, and by powerful pharmaceutical corporations that are not intimidated by anyone. However, being consumed by fears, even legitimate ones, can make human beings stupid and sadistic. An antidote to being so consumed is not to deny our fears but to acknowledge them and, through humor or otherwise, release our shame about having them; this doesn't eliminate fear but prevents fear from so dominating our minds that we have no room for critical thought.

Bruce E. Levine, a practicing clinical psychologist often at odds with the mainstream of his profession, writes and speaks about how society, culture, politics and psychology intersect. His most recent book is Resisting Illegitimate Authority: A Thinking Person's Guide to Being an Anti-Authoritarian—Strategies, Tools, and Models (AK Press, September, 2018). His Web site is brucelevine.net

FEBRUARY 19, 2021