PROBLEMS WITH CURRENT UK GOVERNMENT LOCKDOWN POLICY

1. There might be a real increase in cases but there is form of categorization occurring in the NHS where deaths with the non-specific symptoms of SARS-CoV-2 (the presumed viral agent)(Covid19 is the disease) are being attributed to SARS-CoV-2 without serological or laboratory (tissue culture) confirmation. Are autopsies being undertaken on all of the deceased? SARS-CoV-2/Covid19 is not like Ebola or the Hantavirus, and has not been categorized by the Government as a 'Highly Contagious Infectious Disease' (HCID)). This peculiar categorization of non-specific cases being due to SARS-CoV-2 will act to confound the epidemiological picture by inflating the actual numbers of illness due to SARS-CoV-2.

2. This picture of people with a 'new' condition might seem on its own a 'large' number but it is relatively smaller in the historical context of annual winter deaths from flu and pneumonia. For example, see the Government's statistics from the flu epidemic 2018/19 (attached). In 2018/19 there were 1,692 deaths attributed to flu and many more for pneumoniae. By comparison, what is being described by the Government and all of the media as an 'epidemic' or a 'pandemic' fails to reach the proportions of last year's flu epidemic where 1,692 people died (according to the Government) with many more deaths attributed to pneumoniae. For example in 2012 the British Lung Association said there were 28.952 in the same period from pneumonia. There was a 12% decline in deaths from 2008, but the population has increased 5% from 2012, so it is probably not an unreasonable estimate to say 25,000 pneumonia deaths in 2018/19 https://statistics.blf.org.uk/pneumonia. Therefore in 2018/19 just under 27,000 deaths from flu/pneumonia without the same 'pandemic' label. This lack of any relative comparison with 2018/19 by either the government or the media isolates the current events from those which occurred in 2018/19, and thereby solidifies in the public psyche the frightening idea that a huge epidemic is now happening.

3. The tests for Covid19 are not yet calibrated to different populations like those without symptoms. 'Died after testing positive for Covid19' (what we hear daily in the media) is not the same as 'died due to Covid19' which is an evidence-based statement of disease causation. Tests are giving false positive and false negative readings, where people's symptoms are being falsely attributed to Covid19 and where those without any symptoms are being falsely told they have Covid19. Test manufacturer data sheets warn about this fact of medical test technology and public health authorities in different jurisdictions are charged with advising on the calibration of these tests for the different populations in which they are to be used. This explains why only hospital patients are being tested and why there is a delay in rolling out tests (e.g. antibody tests) to the wider population which has understandably become extremely worried about Covid19 through Government messages. The lack of calibration of these tests will add to the number of Covid19 positives, further bolstering a perception of a disease out of control.

4. The NHS has consistently and continually been telling sick people via NHS 111 - as well as in high profile advertising in billboards, TV and radio etc. - to self-isolate and not to attend their usual health services when they have a set of generic non-Covid19 specific symptoms. This list of symptoms can apply to literally hundreds of different diseases and illnesses. Who doesn't have a cough or runny nose living in our heavily polluted capital? This reduction and now virtual closure of primary care GP services in London has been gaining momentum since February. This may have been effective in causing people to let their chest (and other) symptoms advance and thus when they finally show up at A&E they are in a much worse fulminating condition. The Government advice therefore may be helping to create some of the dire clinical status that is being experienced in A&E departments with patients presenting in acute respiratory distress syndrome (ARDS).

5. Healthcare practice in hospital to lessen the perceived risk of Covid19 transmission via aerosolized contaminants discounts treating hypoxia in patients presenting with cough and fever with non-invasive ventilation (NIV) based on evidence, in favour of intubation and ventilation (possibly irrespective of clinical need), which may also help to explain the reported increased use of the existing critical care capacity. This situation is further exacerbated by the lack of personal protective equipment (PPE) and the necessary hardware, like ventilators and suitably trained critical care nurses and doctors, all of which have been negatively impacted in the last 12 years by Government austerity policies.

6. The current lockdown picture can be clouded by the 'fog of war' (meaning: the uncertainty in our current situation of lockdown due to a perceived threat to the public health). Healthcare staff will see cases as more serious through the 'lens' of a positive SARS-CoV-2 test and given the widespread awareness that there is something 'out there' that is officially perceived as 'dangerous' to everyone. Every presenting clinical picture in a patient will be attributed to the agency of SARS-CoV-2 when a test result is returned as positive. This will act to further inflate the statistics on Covid19 deaths and further bolster the perception of an epidemic which is getting out of control.

7. Many patients are being enrolled in clinical trials of antiviral, rheumatoid arthritis and malaria drugs around the world, although no drugs have been tested on more than a handful of SARS-CoV-2 patients, if any. This may be encouraged by doctors who are desperate to find a 'silver bullet', and obviously by pharmaceutical companies who are racing to get drugs approved for Covid19. However, it is not clear that it is possible to obtain informed consent from elderly patients with pre-existing health conditions, particularly those on ventilators, who may not realize that the probability of benefits is unknown, and the probability of side effects is very real. Furthermore, the trials will almost certainly not be double-blinded, randomized, placebo-controlled trials, so the data will be of limited use.

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