11 August 2021

Open Letter from the UK Medical Freedom Alliance to:

- Prof Chris Whitty – UK Government Chief Medical Adviser
- Rt Hon Sajid Javid – Secretary of State for Health and Social Care
- Dr Gregor Smith – Scottish Chief Medical Officer
- Jeane Freeman MSP – Scottish Government Health Secretary
- Dr Frank Atherton – Welsh Chief Medical Officer
- Vaughan Gething – Welsh Assembly Minister of Health and Social Services
- Dr Michael McBride – Northern Ireland Chief Medical Officer
- Robin Swann – Northern Ireland Assembly Minister of Health

Re: Face Covering Mandates & Governmental Restrictions – Call for the Exit Strategy

The UK Medical Freedom Alliance are an alliance of medical professionals, scientists and lawyers who are campaigning for Informed Consent, Medical Freedom and Bodily Autonomy to be protected and preserved.

In our previous Open letter, dated 18 February 2021[i], we called upon the UK governments to immediately suspend *"all regulations and related guidance that mandate the wearing of face coverings in any setting"* and to publish *"detailed impact assessments, as stipulated by the WHO, regarding the effects recorded to date, since the introduction of face covering mandates"*.
In that letter, the reasons for our request were clearly laid out and fully referenced. We detailed the evidence showing that face masks can cause significant physical, psychological and societal harm. We asked the government to provide evidence that benefits of face mask wearing outweighed the many risks.

We regret to find that our appeal has not been acknowledged, and our concerns have not been addressed since then. Instead, despite Covid-19 restrictions being lifted, the intentions appear to be for face covering mandates to largely remain in place in Scotland[ii], and specifically in the healthcare setting across the whole UK[iii].

Therefore, we now renew our request for transparency regarding scientific evidence informing this policy and relevant impact assessments. **We further request that the governments lay out their exit strategy**, specifying and justifying the conditions deemed to be required to lift these mandates. Below, we would also like to raise specific concerns regarding communications from the UK governments, relating to benefits and risks of wearing face coverings.

1. The UK Government's Guidance on Face coverings was updated on 20 July 2021 but contains no references supporting face coverings for asymptomatic people[iv]. Guidance from the Scottish Government[v] contains a link to *"scientific evidence that face coverings are effective"*. This document mentions only two studies, in a footnote, that have investigated face coverings. Instead, at least one third of the references listed are outlining how to harness behavioural science in order to increase adherence to any interventions for the purpose of infection control.

2. The UK Government's Guidance links to a document issued by Public Health England "Covid-19: Guidance for maintaining services within health and care settings – Infection prevention and control recommendations"[vi], which does not provide references to peer-reviewed literature regarding universal masking. It refers to a document from April 2021 entitled "Masks for health workers to mitigate airborne transmission of SARS-CoV-2"[vii]. This document states *"there is a*

distinct paucity of rigorous research regarding the risk of SARS-CoV-2 infection amongst HCW [healthcare workers] in the UK". It recommends that face coverings are *"routinely worn by all staff and patients as far as possible to provide source control"* but does not provide any evidence for the effectiveness of this measure. It does refer to the *"risk of noncompliance events with respiratory PPE"* which *"could lead to self-contamination"*. It further relates that *it "may interfere with communication and vision"* and *"can give a sense of false protection"*.

3. The "Scientific Evidence" linked to in the Guidance from the Scottish Government "Mitigation to Reduce Transmission of the new variant SARS-CoV-2 virus SAGE-EMG, SPI-B, Transmission Group, 23 Dec 2020"[viii] refers to two studies. The study by Mitze et al[ix] claiming that reduction in transmission could be a high as 45%, applied poor methodology, and the limitations of the study are even pointed out by the authors with *"no use of a strict group control approach"*. The other article by Cowling and Leung[x] also states that Mitze et al *"might have overestimated the impact of masks"*. The main reference in the overview by Cowling and Leung is the rapid scoping review by Brainard et al "Community use of face masks and similar barriers to prevent respiratory illness such as Covid-19"[xi], which assessed 12 randomized controlled trials and 21 observational studies, concluding that *"specific accurate estimates of the degree of protectiveness of face masks from the currently available evidence base are unreliable"*. Cowling and Leung summarize the findings of this review saying that *"face mask interventions could probably reduce transmission by a small margin but not a large margin in the community".*

4. National Services Scotland have issued a "Rapid review of the literature: Assessing the infection prevention and control measures for the prevention and management of Covid-19 in health and care settings"[xii] last updated 16 July 2021. It states *that "face masks do not provide protection against airborne particles"* and then examines the evidence regarding face masks for source control and for protection.

    a. The evidence for source control is entirely unconvincing as it is largely based on an *"experimental study using simulated SARS-CoV-2 virus expulsions and mannequin heads"*, whilst also referring to a small study with healthy volunteers showing that *"air escape does limit the overall efficiency of surgical masks"*.

    b. Examining the evidence for face masks as a protective measure, it is repeatedly described as *"weak"* and *"sparse"* in this review. Reference is made to the review by the Australian National Covid-19 Clinical Evidence Taskforce, which was *"unable to produce evidence-based graded recommendations due to the limited evidence base".*

    Despite the paucity of evidence, this rapid review concludes that face masks should be worn by health care workers and patients at all times. **These recommendations are in complete incongruence with the analysis of the evidence presented and are therefore scientifically unjustifiable**.

5. Recommendations made by the WHO are frequently cited to justify universal masking policies. However, the WHO guidance on "Mask use in the context of Covid-19"[xiii], as referred to in our previous Open Letter, points out the ***"limited and inconsistent scientific evidence to support the effectiveness of masking of healthy people in the community"***. Regarding a universal masking policy in hospital systems, the guidance refers to two studies, which however are said to have *"had serious limitations"*. Further guidance is therefore based on *"expert opinion"* and includes reference to *"potential harms and risks",* including *"potential of self-contamination"*, *discomfort, facial temperature changes and headaches"* as well as *"false sense of security".* Carrying out

impact assessments of implemented mask policies *"through good quality research"* is also an integral part of the WHO guidance, which has not been translated into current UK policies.

6. We refer to our previous Open Letter[i] for references to scientific studies that have examined the effectiveness of face masks in preventing viral transmission. We specifically refer to a Policy Review by the US Centers for Disease Control and Prevention (CDC) dated May 2020[xiv], which found that evidence from 14 randomized controlled trials of hand hygiene or face masks *"did not support a substantial effect on transmission of laboratory-confirmed influenza"*.

7. A comprehensive literature review by Swiss Policy Research, updated in August 2021[xv], concluded that *"**Face masks in the general population might be effective, at least in some circumstances, but there is currently little to no evidence supporting this proposition. If the coronavirus is indeed transmitted via indoor aerosols, face masks are unlikely to be protective. Health authorities should therefore not assume or suggest that face masks will reduce the rate or risk of infection**."*

8. Face covering mandates do not usually specify whether they are meant to protect the mask wearer (personal protection) or their environment (source control), although the general message is often conveyed as an appeal to protect others, especially in relation to masks for children. In any case, the evidence for both purposes is weak, as outlined above.

9. **Universal masking of healthy people for the purpose of source control may only be considered based on evidence for asymptomatic transmission**.

    a. The assumption of clinical significance of asymptomatic individuals for transmission of disease was made early on in 2020 and has never been re-evaluated. **Good evidence of asymptomatic spread of SARS-CoV-2 has not been demonstrated in the published literature**. Effective transmission is directly correlated to viral load, which is known to be low in the absence of symptoms.

    b. Data from a large Chinese population study suggest there is **no requirement for measures of source control in asymptomatic people, even after a positive test**[xvi]. In this study, over 10 million residents in Wuhan, China, were screened in May 2020, finding no new symptomatic and only 300 asymptomatic cases. There were no positive tests amongst 1,174 close contacts of asymptomatic cases. Similar findings were published in a study of nearly 80,000 close household contacts[xvii].

    c. A detailed analysis of the literature by consultant pathologist Dr Clare Craig FRCPath, highlighted the paucity of persuasive evidence that asymptomatic transmission is of any clinical significance[xviii]. On close examination of the raw data from meta-analyses, it was revealed that any conclusions about the relevance of asymptomatic transmission are *"based on a surprisingly small number of cases (six in total globally)"* adding a caution that *"the possibility that they are all coincidental contacts with false positive results cannot be ruled out"*[xix]. Therefore, **pre-symptomatic and asymptomatic transmission appear to be rare, posing a negligible risk to the population**.

    d. The document from National Services Scotland quoted above[xii], states that *"there has been limited evidence of transmission from positive-asymptomatic cases"*.

10. If face masks are advocated as personal protective equipment, it is not evident how this justifies a mandate. In no other circumstances are any measures for protection or preservation of health made mandatory without a robust evidence base, especially when safety has not been established or even assessed. If it was government policy to enforce measures to protect respiratory health,

one may argue that a law against smoking should be considered. However, until recently, decisions regarding health and lifestyle were the responsibility of each individual. **Suggestions that people who do not comply with governmental health policies may be criminals[xx] or may be declared ineligible to receive health care services in the UK[xxi], are not compatible with the principles of a free society and the principles of medical freedom and bodily autonomy**.

11. Whilst in the initial stages, there may have been considerable uncertainty how best to advise and protect the population, there is now data from countries (such as Sweden) and states in the US, who have implemented very different policies, showing clearly that **mask mandates and other restrictive measures have had no impact on the rates of Covid-19 cases**[xv].

12. Comparing numbers of Covid-19 deaths per million people between the UK and Sweden, where mask mandates and other lockdown measures were never implemented, also indicates that **governmental restrictions are not effective in reducing Covid-19 deaths** (Fig 1). Data from the US states of Florida, where restrictions were lifted before October 2020, and California, where strict mandates remain in place, suggest the same conclusion (Fig 2).

13. Figure 1, showing potential routes of transmission for all SARS-CoV-2 variants in the Evidence Summary referred to by the Scottish Government[viii], demonstrates three entities of the "Infected person", the "Environment" and the "Susceptible person". Whilst all emphasis has been on separating those entities for the purpose of mitigation, it has been completely ignored that susceptibility is variable and amenable to intervention. **It is most unfortunate that there has been no communication from governments or any other official advisory groups with recommendations how to improve general health, strengthen immunity and reduce susceptibility to viral infections**, when there is a significant body of evidence supporting a number of options[xxii]. Likewise, there have been no initiatives or funding for research into this approach.

14. Recommendations to reduce transmission referred to by the Scottish Government[viii], state that *"Fear inducing messages should be avoided".* We argue that face masks worn by the public serve as a **visual signal of continued danger** and hence contribute to an inappropriate message of fear.

15. Over 18 months after Covid-19 was declared a pandemic, the paucity of evidence regarding all the implemented restrictions, including mask mandates, is deeply disappointing. **Continued enforcement of any such measures is contradicting the principles of evidence-based medicine, previously highly regarded by all medical practitioners in the UK, as they are based on governmental and institutional edicts rather than peer-reviewed science**.

    a. The **evidence for the effectiveness of face coverings is not robust**, specifically regarding universal masking. There is no clear communication whether masks are supposed to provide source control or personal protection in healthy people, nor is there transparency regarding the effectiveness of different face mask types and materials and regarding the effectiveness in different environments.

    b. There has been **no communication regarding any potential harms and risks associated with prolonged mask wearing**, as outlined in our previous Open Letter[i], nor have there been individual risk assessments. Although included in the WHO guidance, no impact assessments have been published, even after many months of face covering mandates. This is particularly regrettable regarding mandates affecting schoolchildren.

    c. Instead of efforts to consolidate evidence for the role of face masks and to carry out impact assessments, a significant amount of research has been carried out into behavioural modification techniques used to achieve increased adherence to the mandated restrictions. We suggest that **no additional initiatives for behavioural modification would be necessary if there was robust and transparent scientific evidence for the proposed intervention**.

16. We have grave concerns regarding proposals for the continuation of universal masking, with no stated endpoint for the mandates particularly in healthcare settings, that is not based on scientific evidence for the following reasons:

    a. Face masks are a medical intervention whose mandate constitutes an **unnecessary restriction on individual bodily autonomy and medical freedom**.

    b. Face masks **potentially cause physical and psychological harms to the wearer**, especially when worn incorrectly or for prolonged periods.

    c. Face masks provide **false reassurance**, as they do not actually prevent viral transmission.

    d. Face masks **promote societal fear and division, and impair healthy communication between people, including between healthcare workers and patients.**

Conclusion

In conclusion, we call for:

- **increased transparency regarding scientific evidence informing government policies and publication of this evidence for independent and public scrutiny; and**
- **an immediate announcement to end ALL mandates of universal masking in ALL settings, including in the healthcare sector.**

We thank for you reading this letter and considering its content.

UK Medical Freedom Alliance

https://www.ukmedfreedom.org

Appendix:

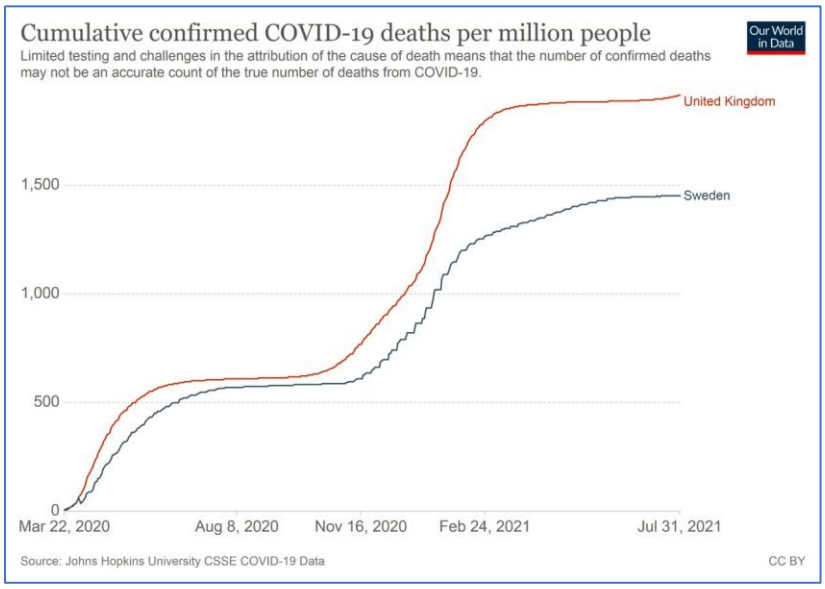

Fig 1 Covid-19 deaths per million people in the UK and Sweden[xxiii]

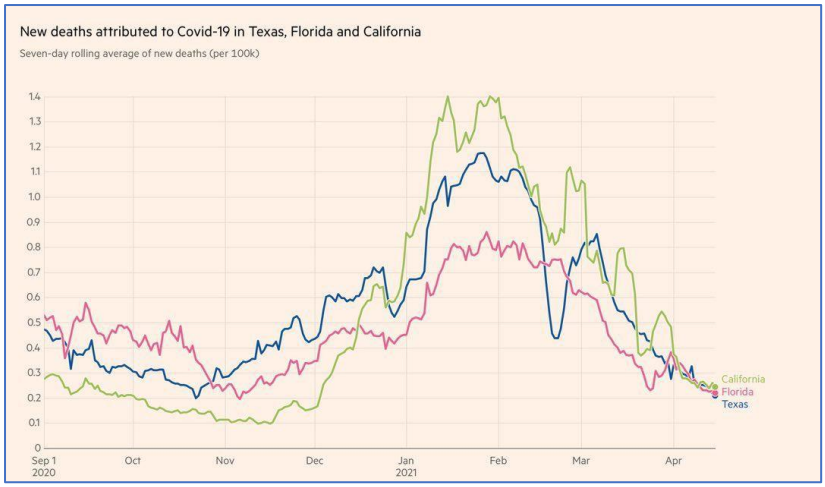

Fig 2 Covid-19 deaths in the US states of California, Texas and Florida[xxiv]

[i] https://uploads-ssl.webflow.com/5fa5866942937a4d73918723/602e6afd2d5e00dbe4cfd228_UKMFA_Open_Letter_Face_Mask_Mandates.pdf

[ii] https://www.bbc.co.uk/news/uk-scotland-57820417

[iii] https://www.england.nhs.uk/2021/07/nhs-patients-staff-and-visitors-must-continue-to-wear-face-coverings-in-healthcare-settings/

[iv] https://www.gov.uk/government/publications/face-coverings-when-to-wear-one-and-how-to-make-your-own/face-coverings-when-to-wear-one-and-how-to-make-your-own#the-reason-for-using-face-coverings

[v] https://www.gov.scot/publications/coronavirus-covid-19-public-use-of-face-coverings/

[vi] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990923/20210602_Infection_Prevention_and_Control_Guidance_for_maintaining_services_with_H_and_C_settings__1_.pdf

[vii] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990923/20210602_Infection_Prevention_and_Control_Guidance_for_maintaining_services_with_H_and_C_settings__1_.pdf

[viii] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/948607/s0995-mitigations-to-reduce-transmission-of-the-new-variant.pdf

[ix] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7768737/

[x] https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.49.2001998

[xi] https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.49.2000725

[xii] https://publichealthscotland.scot/media/8455/2021-07-16-covid-19-rapid-review-ipc-for-covid-19-v16.pdf

[xiii] https://apps.who.int/iris/bitstream/handle/10665/337199/WHO-2019-nCov-IPC_Masks-2020.5-eng.pdf?sequence=1&isAllowed=y

[xiv] https://wwwnc.cdc.gov/eid/article/26/5/19-0994_article

[xv] https://swprs.org/face-masks-evidence/

[xvi] https://pubmed.ncbi.nlm.nih.gov/33219229/

[xvii] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774102

[xviii] https://dryburgh.com/wp-content/uploads/2020/12/Clare_Crag_Evidence-of-Asymptomatic-Spread-of-COVID-19-been-Significantly-Overstated.pdf

[xix] https://lockdownsceptics.org/has-the-evidence-of-asymptomatic-spread-of-covid-19-been-significantly-overstated-2/

[xx] https://www.dailymail.co.uk/news/article-9864341/amp/Not-wearing-face-mask-Tube-CRIMINAL-offence-says-Sadiq-Khan.html

[xxi] https://blogs.bmj.com/bmj/2021/08/04/should-treatments-for-covid-19-be-denied-to-people-who-have-refused-to-be-vaccinated/?utm_source=twitter&utm_medium=social&utm_term=hootsuite&utm_content=sme&utm_campaign=usage

[xxii] https://www.ukmedfreedom.org/open-letters/ukmfa-open-letter-to-royal-college-of-gps-rcgp-re-prevention-and-treatment-of-covid-19

[xxiii] https://ourworldindata.org/coronavirus-data-explorer

[xxiv] https://covid19.healthdata.org/united-states-of-america/florida?view=daily-deaths&tab=compare