

Peter Doshi speech for MedChi talk

Nov 6, 2021

Hello. I'm Peter Doshi. I am on the faculty at the University of Maryland and an editor at The BMJ. I have no relevant conflicts of interest and my comments today are my own.

In my brief talk this morning, I'm going to present four distinct reasons why I think covid vaccine mandates cannot stand. I want to be clear up front that this is not about being for or against the vaccine, I'm focused here squarely on the question of mandates and coercion. And I believe each of these four reasons, on its own, is sufficient reason to reject mandates.

First, we have been assuming performance characteristics that these products simply do not have. When we use the word "vaccine," we think of a product that blocks infection and transmission, and is thus able to bring about herd immunity, like what we have with polio. But the products from Pfizer, Moderna, and J&J don't stop infection and transmission.

Given this, they might be better thought of as drugs, not vaccines. DRUGS, able to ameliorate disease in those infected. In fact, until January this year, the current mRNA products would not have even met the dictionary definition of vaccine. And it's hard to imagine we would ever have accepted mandating a drug. But the definition was altered and now they are vaccines. But just because the dictionary changed its definition of vaccine shouldn't mean somehow that now it's acceptable to mandate. They still remain products that are not stopping infections and transmission.

[NEXT SLIDE] My next argument is that mandates can only stand if they can be applied to populations in which we can predict a net benefit, and we are able to exempt from the mandate those populations in which we can predict a net harm.

Well, with covid vaccines, the problem is that we cannot exempt a population in which we can reasonably predict the harms outweigh the risks – and that is those with past SARS-CoV-2 infections. Because natural immunity has proven very protective against reinfection, it does not matter that vaccination may improve that protection. The problem is that protection afforded by natural immunity is so high that one cannot improve that protection by much. On the flip side, however, adverse events are common, and there are multiple surveys now that indicate that the adverse event profile in those with past infections is worse than those who are SARS-CoV-2 naïve. So in those with past SARS-CoV-2 infection, the harms are common, and therefore definitely outweigh the benefits (which are small, and uncommon).

And this population for which the net harms predictably will outweigh the net benefits, is large.

The CDC estimated somewhere between 32 and 43% of Americans were infected by May this year, before Delta. Today it may be well above half.

A rational mandate, then, would have to exempt all these people from the mandate. But even if you wanted to exclude this population, practically speaking, we lack sensitive tests of immunity capable of knowing who all these people are. So we have no means of excluding them from the mandate, and thus the mandate can't stand.

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[NEXT SLIDE] My third argument is that mandates are socially unacceptable in American society. We tend to focus on mandate performance in terms of what it will do to vaccination rates and covid metrics like cases, hospitalizations, or deaths. However a mandate may affect those parameters, mandates, as we have seen, also have effects on the social fabric of our society—and I would argue that mandates are helping tear up that social fabric.

Surely these things are unintended consequences, but these are profoundly negative unintended consequences. People who feel coerced will naturally feel angry, resentful, and not trust in the system. Mandates will enable vax-or-mask type policies which will segregate and stratify people into vaccinated vs. unvaccinated. They are socially divisive, and should not be part of any society that values civility, inclusivity, diversity, and social justice.

[NEXT SLIDE] My final argument is about data and transparency. So this argument is aimed at the science people. If you are interested in analyzing the data for, say, Pfizer's trial, you will have to wait until May 2025 before you can even request it from the company. For Moderna, they recently said that data - quote - "may be available ... with publication of the final study results in 2022." And since the trial is not officially to end until October 2022, we are probably talking late 2022. For J&J, try next July.

If you weren't aware that the data were inaccessible, I suspect this is because so few healthcare practitioners and researchers are accustomed to conducting an independent review of the raw data--so there is little outcry when those data are inaccessible.

So while we are told to keep "following the science," what we are following is not a scientific process based on open data.

I'll just reiterate something I wrote last August, before we had results from any of the pivotal covid vaccine trials: clinicians and professional societies need to declare that they will not endorse treatments or vaccines unless there is complete data transparency.

In such a situation, mandating a vaccine without access to the data should be a total non-starter.

So I'll just leave it there – my four arguments against mandates. Thank you for listening and I look forward to the discussion.