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July 11, 2020 Facebook Article #24

Analysis of COVID 19 and Reopening the Assembly

Greetings Brothers and Sisters,

I apologize for the delay in these postings regarding analyzing the COVID 19 situation as it relates to reopening the assembly. I had a conversation with Matt about the content and objective of this analysis and we seem to have ironed out most of the issues. Because of the delay and the suggestion there is an alternate view, I am going to lay out my conclusions now rather than at the end. There cannot be an alternate view before the first view is expressed. Perhaps this will avoid reading into the analysis something that is not there.

**Note: The next three postings have been combined into one very long one just to get to the end sooner.**

1. This analysis does not address when we will open. That will be left to others to decide.
2. It does address several things:
   a. What information we should use to make our decisions about opening.
   b. What biblical principles apply as we filter through the differing opinions about the matter.
   c. Unity in the body.

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My conclusions are:

1. The Coronavirus is real. No matter how many doubts may exist by personal opinion, internet postings, political diatribe, or even medical views, we have to treat it as a serious threat.
2. We must use the best available information to guide our opening process.
3. A general biblical principle that guides us through the differing opinions is that we should always esteem others more highly than ourselves.
4. Another parallels how the wealthy should look to the needs of the poor. In similar fashion, the healthy should defer to the aged and health compromised as much as possible.
5. Sacrifices will have to be made to accommodate the whole. Probably no one will escape making some concessions to the way they would like things to be.

**To avoid public disputes through Facebook ripostes, if you have a bona fide and verifiable source of information that disputes any facts presented in this assessment, please refer them to me where we can review them together or do additional research. If necessary we can make alterations to these contents in the future.**

If you have additional concerns, advice, or wish to volunteer service to meet the reopening goals, please do **as the elders have asked on several occasions**, contact them.

I continue to maintain what I wrote in the opening message; namely, that the recommendations from the major medical institutions and experts are not in any major disagreement about social distancing practices for public group associations.

What now follows is an attempt to give a logical assessment of a number of claims and opinions about COVID 19.

**Claim:** The number of cases of coronavirus is exaggerated by duplicate reporting. Every time a person gets tested it gets counted as another case. Some people have been tested multiple times and each time is added to the total. Therefore the cases are exaggerated; hence, the threat of the virus is exaggerated.

**Answer:** I have seen that claim also, even from a political action group that I have in the past had some respect for, but I have not been able to confirm this claim. It seems to me that common sense would dictate that medical people would be able to distinguish between a test that was negative and one that was positive. It is hard for me to believe that the medical community across the nation is in a conspiracy to report all negative tests as positive cases of coronavirus. Whatever irregularities may be involved, by in large the case reports should at the least reveal trends. The present trend is a +50% increase in cases of coronavirus over the peak in mid-April. Discounting some duplication of reporting and increased testing, the graph of the trend is still both revealing and dramatic. It is a precipitous upward curve that is hard to translate into an improving situation.

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Another more favorable factor is the death curve, while have increased some, it is in no way as precipitous as the case curve. This could bode well for the future, but it will probably take two or three more weeks to see if the death curve follows the case curve.

**Claim:** The deaths from the coronavirus are exaggerated because many people who die from heart disease, cancer, or some other cause are counted as COVID deaths if they had the disease at the time of death.

**Answer:** This has always been difficult for a clear demarcation with any virus-caused deaths. COVID 19, like influenza and other viruses, rarely, if ever, is said to have killed anyone. I think Matt suggested to me that some cases are attributed to flu or other viruses because they can get a better benefit from insurance or Medicare (I am not certain of this. Perhaps Matt can refine this comment). In any event what viruses can do is make a person so sick that any underlying weakness is exacerbated until the person dies of the underlying weakness. Even if there was no known problem before the viral attack, the patient incurs a complication, usually pneumonia. From that point the patient's organs suffer an abnormal strain and technically die of respiratory failure or some other organ failure. Reports are coming forth that COVID 19, more than other viruses, directly attacks other organs than the lungs.

In a viral related death, the medical community generally assumes that the patient would probably not have died at that time had it not been for the viral infection. In the midst of a great increase in ICU treatments, deaths, and an overworked medical staff, certainly some deaths could be automatically dismissed as a COVID death when, in fact, it may not have been. It is a challenge to identify irrefutably that each death attributed to influenza or COVID is truly viral caused. But, the medical community is unequivocal in its understanding that viral illnesses are dangerous health threats. COVID is multiple times more dangerous because it appears to have very debilitating effects on many different organs in many different people without being able to predict who they are or what will be affected. What we should be following are the graph lines over time. The specifics may be understated or overstated, but the trends will still emerge.

**Question:** If we wait until later instead of sooner to open and still someone contracts the virus and dies, is that any worse than if we open sooner and someone dies? Will we not feel bad in either case?

**Answer:** Of course we will feel bad in either case. We will feel bad whenever a brother or sister dies. But there is a difference between opening when the best available information reveals that the threat level is very high than when it has been shown to be greatly reduced. Opening in the midst of a 50% increase in cases does not provide either the sound reason or comfort level as, for example, opening with 50% decrease in cases and deaths. Certainly we will still feel bad in the latter instance, but we will feel much worse in the former. The latter was based upon what was thought by the evidence to be a low risk decision; the former was known to be a much greater risk. How much risk do we want to take with each other's lives? In my opinion we should observe the trends closely and use them to make our decision; not anecdotal blurbs on the internet or political posturing. In any event we will open at some

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time and the circumstances at the time should determine the degree with which we implement safety procedures and the intensity by which we will enforce or encourage them.

**Claim:** The coronavirus is no more dangerous than the ordinary influenza.

**Answer:**

1. The worst year in recent decades for influenza was, I believe, the 2017 – 2018 season in which upwards of 80,000 deaths were attributed to influenza. Generally the range is between 12,000 and 60,000. This number, again, is not precise for the same reasons given above. It is a judgment call that the influenza contributed to another underlying weakness that resulted in death. By comparison the coronavirus is responsible, again mainly indirectly, to 136,000 deaths since the end of January.
2. The 80,000 deaths to influenza in the 2017 – 2018 season was with zero mitigation efforts. We have experienced the 136,000 deaths with the most extreme mitigation efforts in the history of the world. We can only imagine how much worse it could have been without isolation. It should be noted the Spanish flu epidemic which killed 625,000 people in a population of 103,000,000 ultimately resisted the epidemic with masks and public closures, including churches. It also met with resistance from anti-mask groups. Things don't change much.
3. Generally, the common flu kills less than 1% (I've seen several reports at approx. .5%) of reported cases. Worldwide reporting reveals that the coronavirus is killing about 3.4% of reported cases. On this basis alone, the coronavirus is between 3.4 and 7.8 times more deadly than the ordinary flu.
4. Italy reports 11,500,000 confirmed cases of coronavirus with 535,000 deaths. This equates to a 4.65% death rate. On Italy's experience, the coronavirus is between 4.65 and 9.3 times more deadly than influenza.
5. New York City reports 221,637 confirmed case with 22,661 deaths which equates to a 10.2% death rate. Compare this death rate to influenza and we would calculate coronavirus to 10 – 20 times more deadly.
6. Just a few days ago from the National Geographic website article, *How Scientists Know*, scientists who have been studying this disease since its beginning concluded "the latest best estimates show the COVID-19 is around 50 – 100 times more lethal than the seasonal flu, on average." (I have seen similar such reports but do not remember where at this time.) I have no idea how they arrived at this number, but if it does nothing else it suggests that the coronavirus is a much greater threat to our lives than influenza.

**Proposition:** Some want to open the assembly without or largely without protective measures, not wanting to maintain social distancing or wear a mask. Some information is floating about the internet that claims no more precautions are necessary beyond what we do when it's the typical flu season. Sneezing or coughing into one's sleeve suffices in place of masks. Some suggest that if anyone feels uncomfortable with these unrestrictive social distancing guidelines, perhaps they should continue with isolation.

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**Answer:**

1. My assumption is that anyone who rejects social distancing guidelines, including masks, for an assembly of people in close proximity is not practicing social distancing as they interact in the community. Every time one goes into the public, they incur a certain risk of exposure. If you isolate but go out once a week to the grocery store with masks and sanitizer, and try to exercise social distancing, you engage in a certain, albeit minimal, level of exposure. When you go out a second time, you double your exposure. When you go our without protections, your exposure increases substantially. When you go out more frequently for shopping, dining, and recreation, the exposure increases exponentially. You increase not only your chances of becoming infected, but, regarding the assembly, also of becoming an unknown carrier. As an individual you have the freedom to deal with as much exposure as you choose, but when you come into the assembly, you are no longer an individual. You are a member of the family of God. Responsibility dictates, the more freedom you exercise for yourself outside the assembly, the greater need you have to protect others when you come into the assembly.
2. Until we have information that suggests we can reasonably expect to be safe from the virus without protective measures, we should enact recommended measures and maintain them faithfully in group assembly.
3. As Christians we are to esteem others more highly than ourselves and love the brethren more than our lives. Putting up with protective measures to maximize the safeguards for the most vulnerable is a very small sacrifice for "others."
4. Whether the elderly or the health compromised will choose to come to the assembly or not even with the strictest safeguards is not the question. The question is when we do reopen, is this to be for the convenience of the healthiest or for the protection of the most vulnerable? If we say we want to open the assembly so that we can fellowship as a body, then let's try to make it as available to as much of the body as we can. Doesn't this make sense?

   Let's not divide the body into two groups: One that is young and healthy and another that is old or otherwise health compromised and exclude them. Often the aged and alone need the body experience more than any others. If, indeed, you think you are so healthy you do not need protection yourself, you are the ideal people to labor to make the assembly as safe as possible for everyone. Ask yourself, "What am I doing to help develop and implement the process that will get us open the safest and fastest?"

   The biblical principle is that those who have should be considerate of those who have not. Those with wealth should attend to the needs of the poor. It's not a great spiritual leap to see the parallel that the healthy should be considerate of the unhealthy.

   The best choice, seems to me to make the best choice for the most. After all, this will one day all change and things will one day return to normal. The question is, "Will

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we be the same unified body we were before COVID 19, a more unified body, or a splintered body?"

**Claim:** Masks do not do any good and I oppose them or will not wear them.

**Answer:** Why? I have heard more rhetoric about masks and rights and freedom and whatever over wearing the simple mask than I like to think about. I don't like them, but really what is it with wearing a mask? For those who do not believe in them, what is your reliable, rational source that declares we should not or do not need to wear them? I've given you the most reliable sources I can find. What are yours?

Somehow it has become something of a political or philosophical issue. There is nothing political or philosophical about either a virus or a mask. The former attacks and kills all alike without regard for political or philosophical views. Similarly, the mask protects with the same lack of regard for politics and philosophy.

Furthermore, the mask is more for others than for the wearer. Certainly, the mask can protect the individual from inhaling a virus, but it is more effective in preventing the wearer from spewing out viral laden moisture particles from the wearer as he or she sings, sneezes, coughs, or talks. And don't suggest that using your sleeve is as effective as a mask. That is simply an assumption not based in facts. Besides, many people don't even wear sleeved clothing in the summer time. If wearing masks protects others, is that not a more Christ-like thing to do than not wearing a mask.

It has been proposed that we cannot keep masks on children and they are going to be germ-laden carriers anyway. First, it has not been recommended that children 2 and under should wear them. Older children can be trained to wear them, perhaps as a game. Second, does some exposure argue for more exposure? Consider an assembly of 100 adults and 20 children. Out of those 20 children all of them get loose and spread germs about the building. Does that now suggest that all the adults should remove their masks and now have 120 people spreading germs about? That is not logical.

Doctors and nurses often wear masks all day long. They may not like them, but they get used to them. For those of you who do not wear them in public, you are asked only to wear them for approximately 1 ½ hours on Sunday, less on Wednesday. If medical workers can wear them for 8-12 hour shifts, surely for the sake of your brothers and sisters you can wear one for an hour and a half once or twice a week. How much suffering does that entail?

Some may not think it is manly to wear a mask. The mask is not to protect you from us, but to protect us from you. If you could be an unknown carrier, how is it unmanly to wear a mask to protect the body as it assembles? Are medical workers any less brave for wearing masks?

This section details some of the ancillary effects of the coronavirus that do not get major news coverage. The focus has been and continues to be on cases and deaths. For the sake of responding to the epidemic, that is probably sufficient. But for those who think they cannot get

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the virus or, if they do, they are young and strong enough to survive it like influenza with no ill effects, perhaps you should consider this report we found from Reuter's News Service linked to a Fox News site. It is pasted below:

CHICAGO - Scientists are only starting to grasp the vast array of health problems caused by the novel coronavirus, some of which may have lingering effects on patients and health systems for years to come, according to doctors and infectious disease experts. Besides the respiratory issues that leave patients gasping for breath, the virus that causes COVID-19 attacks many organ systems, in some cases causing catastrophic damage. "We thought this was only a respiratory virus. Turns out, it goes after the pancreas. It goes after the heart. It goes after the liver, the brain, the kidney, and other organs. We didn't appreciate that in the beginning," said Dr. Eric Topol, a cardiologist and director of the Scripps Research Translational Institute in La Jolla, California. In addition to respiratory distress, patients with COVID-19 can experience blood clotting disorders that can lead to strokes, and extreme inflammation that attacks multiple organ systems. The virus can also cause neurological complications that range from headache, dizziness, and loss of taste or smell to seizures and confusion. And recovery can be slow, incomplete, and costly with a huge impact on quality of life.

The broad and diverse manifestations of COVID-19 are somewhat unique, said Dr. Sadiya Khan, a cardiologist at Northwestern Medicine in Chicago. With influenza, people with underlying heart conditions are also at higher risk of complications, Khan said. What is surprising about this virus is the extent of the complications occurring outside the lungs. Khan believes there will be a huge healthcare expenditure and burden for individuals who have survived COVID-19. Patients who were in the intensive care unit or on a ventilator for weeks will need to spend extensive time in rehab to regain mobility and strength. "It can take up to seven days for every one day that you're hospitalized to recover that type of strength," Khan said. "It's harder the older you are, and you may never get back to the same level of function."

While much of the focus has been on the minority of patients who experience severe disease, doctors increasingly are looking to the needs of patients who were not sick enough to require hospitalization, but are still suffering months after first becoming infected.

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Studies are just getting underway to understand the long-term effects of infection, Jay Butler, deputy director of infectious diseases at the U.S. Centers for Disease Control and Prevention, told reporters in a telephone briefing on Thursday. "We hear anecdotal reports of people who have persistent fatigue, shortness of breath," Butler said. "How long that will last is hard to say." While coronavirus symptoms typically resolve in two or three weeks, an estimated 1 in 10 experience prolonged symptoms, Dr. Helen Salisbury of the University of Oxford wrote in the British Medical Journal on Tuesday. Salisbury said many of her patients have normal chest X-rays and no sign of inflammation, but they are still not back to normal. "If you previously ran 5k three times a week and now feel breathless after a single flight of stairs, or if you cough incessantly and are too exhausted to return to work, then the fear that you may never regain your previous health is very real," she wrote.

Dr. Igor Koralnik, chief of neuro-infectious diseases at Northwestern Medicine, reviewed current scientific literature and found about **half** of patients hospitalized with COVID-19 had neurological complications, such as dizziness, decreased alertness, difficulty concentrating, disorders of smell and taste, seizures, strokes, weakness and muscle pain. Koralnik, whose findings were published in the Annals of Neurology, has started an outpatient clinic for COVID-19 patients to study whether these neurological problems are temporary or permanent. Khan sees parallels with HIV, the virus that causes AIDS. Much of the early focus was on deaths. "In recent years, we've been very focused on the cardiovascular complications of HIV survivorship," Khan said.

This story from COVID 19 has not been widely reported. Perhaps as time passes and more research is conducted, these concerns will not materialize, but for the moment the prospects from COVID 19 continue on a disturbing trajectory. There is hope for a vaccine sometime this fall or by the end of the year. But, even among the medical industry it is only a hope. I saw one positive and hopeful report, courtesy of Andrea, that there could be an effective treatment forthcoming. Yet, that is one doctor reporting. We can hope and pray.

I will close with a personal account relating to respiratory ailments and possibly death therefrom. I will try to make a long story as short as possible. As many of you know Sharon carries a life-long respiratory weakness which apart from age puts her in a high risk category for the coronavirus. She has had many bouts with bronchitis which would keep her from sleeping which would make her more tired and weak which, in turn, would make sleeping more difficult and so the cycle would go. I have often sat up in bed with her so she could lean against me in an effort to be able to breathe enough to get some rest. About ten years ago she had another severe bout of bronchitis and while I should have been able to read the signs better, I did not. She was

having a very difficult time breathing in the night. Her asthma was very bad. We tried to wait until morning to call the doctor when we should have gone in the night to the emergency room. When we finally got there the next morning the emergency room staff put her on respiratory inhalation treatments. She did not respond well to the first treatment. She made no improvement with the second treatment. I was concerned enough to call Jenny who proposed to come home. I told her she could not get here soon enough. Either the treatments would work or… She was given a third treatment with no visible improvement. Finally on the fourth treatment the asthma began to ease and her breathing became a little more relaxed. She was literally weeks upon weeks recovering from that event.

I do not know to this day how serious her condition was. On the one hand the attending physician listed it as respiratory failure while the staff seemed to me very casual about it. The pulmonary doctor she was referred to afterwards said it was not respiratory failure or she would not be seeing him. I don't know what it was, but visually to me it was more than unnerving to see your loved one gasping for air hours on end. I was wondering if we waited too long and she could possibly die slowly by not being able to get air. Perhaps a ventilator was the next step if the breathing treatments would not work, if they had one at that time, but no one told us what the options were. All I could see is Sharon weak, tired, choking, and gasping for air. It was not a pleasant sight.

For those who do not take coronavirus seriously you probably have not seen anyone really ill from a respiratory attack. Evidently, the virus can so strain the system that it causes certain organs to shut-down. With the communicability of the virus the patient cannot have family around. I know indirectly of at least one person, I don't think terribly old, who has died from the virus… alone… because the family was not permitted to be at the bedside.

When we open again, whenever it is, remember many of your brothers and sisters, including some young folks, have underlying issues. Just being 60 or more is an underlying issue. These folks want to come back sometime too. It is not sufficient to consign them to home if the assembly can be made safe enough to accommodate them.

I can see us one day opening again. When I don't know. Probably in the not too distant future. But when we do how can anyone suggest that social distancing, including masks, should not be part of the process? Do these social distancing standards represent an unconscionable distress to you? Are they too much of an infringement on your rights? If you voluntarily cooperate, they represent no loss of rights at all. Is the value of a maskless face greater than the protection of your brothers and sisters?

We are faced once again with a unity issue. It has been suggested to me that we don't have to be united in our opinions about the virus. I would agree. But we have to be united on how we will deal with it. The virus has laid upon us a physical threat, but how we respond to it as a body is a spiritual issue. My opinion is that unity demands that we devise the best system that will serve the needs of the most people. It will inevitably result in some people not getting completely what they want. Perhaps no one will achieve that. In all likelihood we will all have to give up on something that we thought was better. We must not allow a physical challenge rife with differing opinions on how to deal with turn into a spiritual problem.

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For the present do not merely lobby for your favorite scenario, but if you have ideas, propose them to your shepherds. That is what your shepherds asked you to do weeks ago. But at the same time be aware there are complicated and comprehensive issues to deal with that you may not have thought about or are equipped to deal with. If you propose also be prepared to be one of the participants to enact whatever decision comes down. Perhaps the most important thing we can all do, more than propose, is pray. Pray that our shepherds will devise the best plan for the right time according to God's timetable. If, indeed, they are doing that, which I am certain they are, we should have faith that for this congregation it will be the best plan at the right time.

As we open we have an opportunity to put into practice an important Christian principle; namely, we esteem others more highly than ourselves (Rom 12:10; Phil. 2:3).