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Maine's Rise in COVID-19 Cases Linked to Face Masks

Gov. Mills' Face Mask Mandate Not Based on Actual Science



The Data Shows Prolonged Face Mask Use Increases Risk of Catching Respiratory Illness

By: David Deschesne
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EDITOR'S NOTE: FOR SCREEN SHOTS OF THE REFERENCED DOCUMENTS CITED HEREIN, PLEASE SCROLL TO THE BOTTOM OF THIS PAGE IN THE FOOTNOTE SECTION

The recent rise in COVID-19 cases in Maine could be linked to the prolonged use of face masks by the general public. Scientific data collected in randomized controlled trials over the past sixty years has shown consistently that the use of face masks to stop respiratory viruses is not only ineffective, but face masks may actually cause an increase in respiratory illnesses such as influenza and COVID-19.

Maine's governor, Janet "Big Sister" Mills has been mandating face masks among the public since early Spring ostensibly to stop the spread of COVID-19. However, in light of the voluminous amounts of data that were already available at the time, the move by Big Sister seems to be one based more on psychology and brainwashing than on actual, objective, empirical scientific data.

The U.S. CDC reported a meta-analysis of 10 face mask studies in the February, 2020 edition of its medical Journal, [Emerging Infectious Diseases](#)¹ which concluded face masks do not work to prevent transmission of respiratory viruses.

One of the key studies cited in that CDC report was of 1607 hospital workers in Vietnam, published in the journal [BMJ Open](#) on April 22, 2015.² The study concluded that the use of surgical masks to control viral spread (which they are not designed to do, anyway) was negligible and that the prolonged use of the iconic cloth masks, so popular in today's society, actually *increased* the cases of respiratory illness significantly.

Furthermore, a more recent study conducted by the US CDC's COVID-19 Response Team and published in the CDC's [Morbidity and Mortality Weekly Report](#)³ showed that there is a 20 times greater chance of catching COVID-19 with prolonged wearing of a face mask when compared to those who never wore a face mask. In that CDC study, it was found that of the 154 new cases of COVID-19, where patients had both a positive PCR test for the purported virus' RNA particle and real symptoms, around 85% reported they wore a face mask often, or always, up to fourteen days prior to symptom onset. The control group in that study also showed symptoms of some sort of respiratory illness, but had a negative COVID-19 PCR test. In that control group, 88% of the people reported often or always wearing a face mask. Around 4% of both groups reported never wearing a face mask prior to symptom onset.

This data continues to be ignored by Big Sister Mills and an establishment corporate media who simply refuses to report these facts on face masks in order to prop up a fear-based narrative that turns people into fearful slaves of

the governor, rather than empowered masters of their own lives via a strong, healthy and functional immune system.

Dr. Jay Bhattacharya, M.D., professor at Stanford University Medical School, physician, epidemiologist, health economist and public health policy expert focusing on infectious diseases and vulnerable populations, said he thinks face masks should not be mandated. “Masks have a use in certain settings where people use them properly. So, for instance, in hospital settings and places where you can't avoid being in very, very close contact with people that are vulnerable,” said Dr. Bhattacharya. “Mask mandates, like I've heard some politicians propose, are not supported by the scientific data. For instance, there is no randomized evidence to suggest mask mandates would work to slow the spread of the disease. In fact, for influenza the randomized studies that have been done suggest that they don't work to slow the spread of the disease.”

To be clear, Dr. Bhattacharya is admittedly not against face mask use when used properly. “As I said, they have appropriate uses in appropriate places. We should take seriously what the scientific evidence is saying and not adopt policies that are far beyond what the scientific evidence has said.”

Most people today aren't even using face masks correctly. Face masks must be changed out after every hour of use to prevent bacterial growth from building up and being re-breathed. Nearly all people in society wear a mask into a business, then when they leave they'll hang it under their chin, stuff it in their purse or pocket, or throw it on the dashboard of their car. At the next stop, they take that dirty, contaminated mask, put it on and begin breathing through it, thinking they are “stopping the spread” of a virus, unaware of how their handling of the mask has made it more likely they'll catch a respiratory illness than if they had worn no mask at all.

Dr. Bhattacharya is also disturbed at the collateral damage done to society when governments irresponsibly mandate face masks when there is no scientific evidence to support that position. “I think there are also enormous social harms caused by these mask mandates. Masks have become a political issue, a partisan issue; you wear a mask if you are a Democrat, you don't wear a mask if you are a Republican and you look on your fellow citizens and say well, you're being irresponsible or you don't care about freedom. I think public health should unite, not divide. Masks, I think, have become an issue, especially these mandates. When it turns into a political issue like this we have to think, as public health workers, very carefully whether we've actually done the right thing. I think we've done a very, very poor job with the messaging, taking the science seriously, and we've created a disunity in the populace around masks - the distrust for one another that public health is not supposed to create.”

In addition to Dr. Bhattacharya sounding the alarm on face masks, the University of Minnesota's Centers for Infectious Disease Research and Prevention (CIDRAP) also posted a [commentary](#)⁴ co-authored by Dr. Lisa Brosseau ScD, a national expert on respiratory protection and infectious diseases and professor (retired) at the University of Illinois, Chicago (UIC) and Dr. Margaret Sietsema, Ph D, an expert on respiratory protection and an assistant professor at UIC. They noted, “Sweeping mask recommendations - as many have proposed - will not reduce SARS-CoV-2 transmission, as evidenced by the widespread practice of wearing masks in Hubei province, China before and during its mass COVID-19 transmission experience earlier this year. Our review of relevant studies indicates that cloth masks will be ineffective at preventing SARS-CoV-2 transmission, whether worn as source control or PPE.....we continue to conclude that cloth masks and face coverings are likely to have limited impact on lowering COVID-19 transmission...”


Notes - hyperlinks with respective screen shots

1. https://wwwnc.cdc.gov/eid/article/26/5/19-0994_article

transmission remains questionable, and worthy of further research.

Face Masks

In our systematic review, we identified 10 RCTs that reported estimates of the effectiveness of face masks in reducing laboratory-confirmed influenza virus infections in the community from literature published during 1946–July 27, 2018. In pooled analysis, we found no significant reduction in influenza transmission with the use of face masks (RR 0.78, 95% CI 0.51–1.20; $I^2 = 30%$, $p = 0.25$) (Figure 2). One study evaluated the use of masks among pilgrims from Australia during the Hajj pilgrimage and reported no major difference in the risk for laboratory-confirmed influenza virus infection in the control or mask group (33). Two studies in university settings assessed the effectiveness of face masks for primary protection by monitoring the incidence of laboratory-confirmed influenza among student hall residents for 5 months (9,10). The overall reduction in ILI or laboratory-confirmed influenza cases in the face mask group was not significant in either studies (9,10). Study designs in the 7 household studies were slightly different: 1 study provided face masks and P2 respirators for household contacts only (34), another study evaluated face mask use as a source control for infected persons only (35), and the remaining studies provided masks for the infected persons as well as their close contacts (11–13,15,17). None of the household studies reported a significant reduction in secondary laboratory-confirmed influenza virus infections in the face mask group (11–13,15,17,34,35). Most studies were underpowered because of limited sample size, and some studies also reported suboptimal adherence in the face mask group.



Disposable medical masks (also known as surgical masks) are loose-fitting devices that were designed to be worn by medical personnel to protect accidental contamination of patient wounds, and to protect the wearer against splashes or sprays of bodily fluids (36). There is limited evidence for their effectiveness in preventing influenza virus transmission either when worn by the infected person for source control or when worn by uninfected persons to reduce exposure. Our systematic review found no significant effect of face masks on transmission of laboratory-confirmed influenza.

2. <https://bmjopen.bmj.com/content/5/4/e006577>

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Objective The aim of this study was to compare the efficacy of cloth masks to medical masks in hospital healthcare workers (HCWs). The null hypothesis is that there is no difference between medical masks and cloth masks.

Setting 14 secondary-level/tertiary-level hospitals in Hanoi, Vietnam.

Participants 1607 hospital HCWs aged ≥ 18 years working full-time in selected high-risk wards.

Intervention Hospital wards were randomised to: medical masks, cloth masks or a control group (usual practice, which included mask wearing). Participants used the mask on every shift for 4 consecutive weeks.

Main outcome measure Clinical respiratory illness (CRI), influenza-like illness (ILI) and laboratory-confirmed respiratory virus infection.

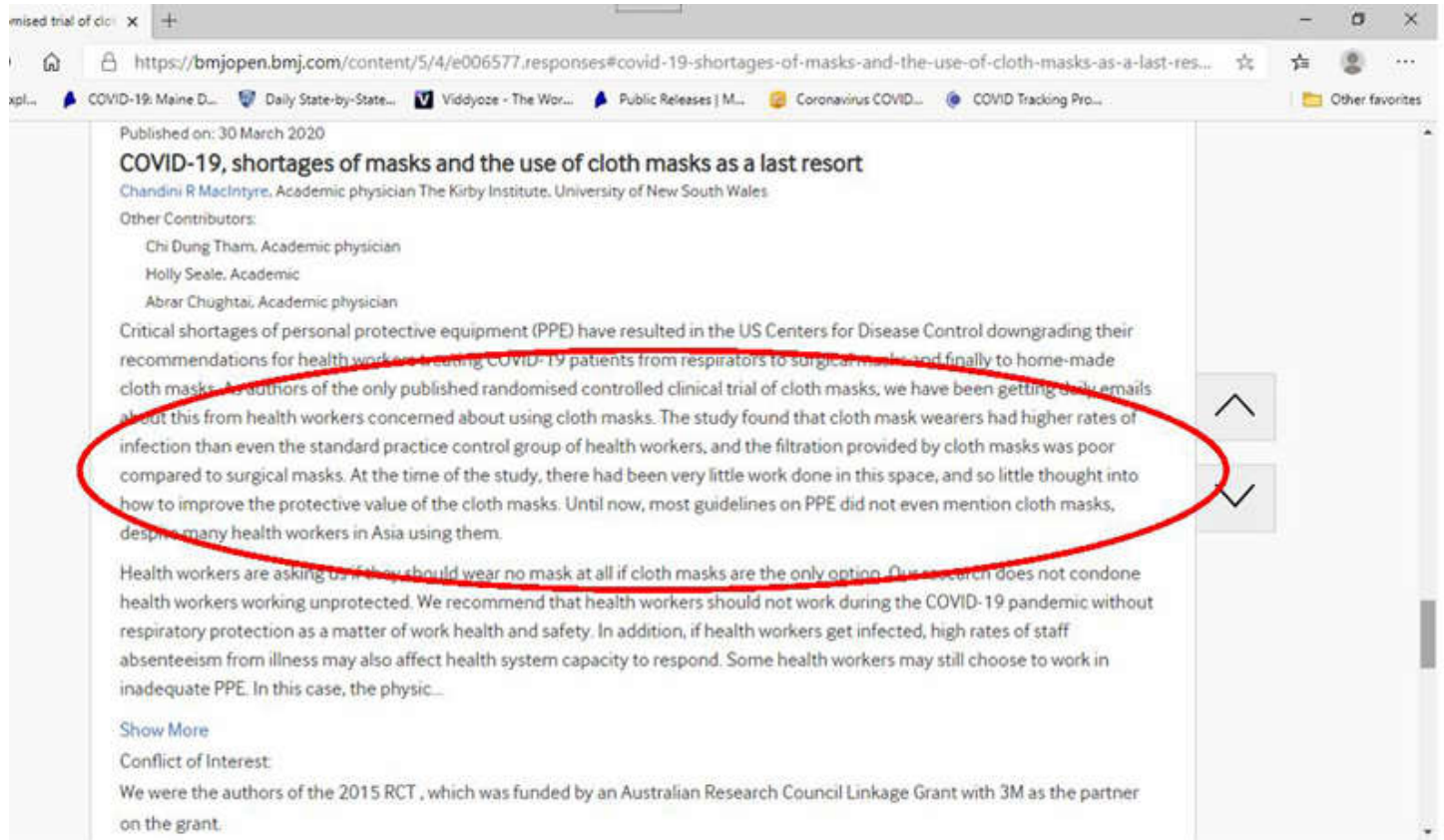
Results The rates of all infection outcomes were highest in the cloth mask arm, with the rate of ILI statistically significantly higher in the cloth mask arm (relative risk (RR)=13.00, 95% CI 1.69 to 100.07) compared with the medical mask arm. Cloth masks also had significantly higher rates of ILI compared with the control arm. An analysis by mask use showed that (RR=6.64, 95% CI 1.45 to 28.65) and laboratory-confirmed virus (RR=1.72, 95% CI 1.01 to 2.94) were significantly higher in the cloth masks group compared with the medical masks group. Penetration of cloth masks by particles was almost 97% and medical masks 44%.

Conclusions This study is the first RCT of cloth masks, and the results caution against the use of cloth masks. This is an important finding to inform occupational health and safety. Moisture retention, reuse of cloth masks and poor filtration may result in increased risk of infection. Further research is needed to inform the widespread use of cloth masks globally. However, as a precautionary measure, cloth masks should not be recommended for HCWs, particularly in high-risk situations, and guidelines need to be updated.

Trial registration Number Australian New Zealand Clinical Trials Registry: ACTRN12610000887077

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The next screen shot is an addendum added by the study's authors in the above link in footnote 2



The image is a screenshot of a web browser displaying a BMJ Open article. The article title is "COVID-19, shortages of masks and the use of cloth masks as a last resort" by Chandini R MacIntyre, an academic physician at The Kirby Institute, University of New South Wales. The article is dated 30 March 2020. A red oval highlights a paragraph of text in the main body of the article. The highlighted text reads: "As authors of the only published randomised controlled clinical trial of cloth masks, we have been getting daily emails about this from health workers concerned about using cloth masks. The study found that cloth mask wearers had higher rates of infection than even the standard practice control group of health workers, and the filtration provided by cloth masks was poor compared to surgical masks. At the time of the study, there had been very little work done in this space, and so little thought into how to improve the protective value of the cloth masks. Until now, most guidelines on PPE did not even mention cloth masks, despite many health workers in Asia using them." The article also lists other contributors: Chi Dung Tham, Holly Seale, and Abrar Chughtai. A "Show More" link is visible below the highlighted text. The browser's address bar shows the URL: https://bmjopen.bmj.com/content/5/4/e006577.responses#ovid-19-shortages-of-masks-and-the-use-of-cloth-masks-as-a-last-res...

3. <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6936a5-H.pdf>

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Morbidity and Mortality Weekly Report

TABLE. (Continued) Characteristics of symptomatic adults ≥18 years who were outpatients in 11 academic health care facilities and who received positive and negative SARS-CoV-2 test results (N = 314)^a — United States, July 1–29, 2020

Characteristic	No. (%)		P-value
	Case-patients (n = 154)	Control participants (n = 160)	
Previous close contact with a person with known COVID-19 (missing = 1)			
No	89 (57.8)	136 (85.5)	<0.01
Yes	65 (42.2)	23 (14.5)	
Relationship to close contact with known COVID-19 (n = 88)			
Family	33 (50.8)	5 (21.7)	<0.01
Friend	9 (13.8)	4 (17.4)	
Work colleague	11 (16.9)	6 (26.1)	
Other**	6 (9.2)	8 (34.8)	
Multiple	6 (9.2)	0 (0.0)	
Reported use of cloth face covering or mask 14 days before illness onset (missing = 2)			
Never	6 (3.9)	5 (3.1)	0.86
Rarely	6 (3.9)	6 (3.8)	
Sometimes	11 (7.2)	7 (4.4)	
Often	22 (14.4)	23 (14.5)	
Always	108 (70.6)	118 (74.2)	

^a Respondents who completed the interview 14–23 days after their test date. Five participants had significant missingness for exposure questions and were removed from the analysis. Patients were randomly sampled from 11 academic health care systems that are part of the Influenza Vaccine Effectiveness in the Critically Ill Network sites (Baystate Medical Center, Springfield, Massachusetts; Beth Israel Deaconess Medical Center, Boston, Massachusetts; University of Colorado School of Medicine, Aurora, Colorado; Hennepin County Medical Center, Minneapolis, Minnesota; Intermountain Healthcare, Salt Lake City, Utah; Ohio State University Wexner Medical Center, Columbus, Ohio; Wake Forest University Baptist Medical Center, Winston-Salem, North Carolina; Vanderbilt University Medical Center, Nashville, Tennessee; John Hopkins Hospital, Baltimore, Maryland; Stanford University Medical Center, Palo Alto, California; University of Washington Medical Center, Seattle, Washington). Participating states include California, Colorado, Maryland, Massachusetts, Minnesota, North Carolina, Ohio, Tennessee, Utah, and Washington.

[†] Other race includes responses of Native American/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, and other; these were combined because of small sample sizes.

[‡] Reported at least one of the following underlying chronic medical conditions: cardiac condition, hypertension, asthma, chronic obstructive pulmonary disease, immunodeficiency, psychiatric condition, diabetes, or obesity.

[§] Community exposure questions asked were “In the 14 days before feeling ill about how often did you:” with options of “shop for items (groceries, prescriptions, home goods, clothing, etc.)” (missing = 1); “have people visit you inside your home or go inside someone else’s home where there were more than 10 people”;

4. <https://www.cidrap.umn.edu/news-perspective/2020/04/commentary-masks-all-covid-19-not-based-sound-data>

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we have reviewed the many modeling studies that purport to demonstrate that cloth masks or face coverings have the potential for flattening the curve or significantly decrease the number of cases. These studies fail to recognize several important facts:

- The filter performance of a cloth material does not directly translate or represent its performance on an individual, because it neglects the understanding of fit.
- Cloth masks or coverings come in a variety of shapes, sizes, and materials and are not made according to any standards.
- Transmission is not simply a function of short random interactions between individuals, but rather a function of particle concentration in the air and the time exposed to that concentration.
- A cloth mask or face covering does very little to prevent the emission or inhalation of small particles. As discussed in an earlier CIDRAP commentary and more recently by Morawska and Milton (2020) in an open letter to WHO signed by 239 scientists, inhalation of small infectious particles is not only biologically plausible, but the epidemiology supports it as an important mode of transmission for SARS-CoV-2, the virus that causes COVID-19.

In summary, though we support mask wearing by the general public, we continue to conclude that cloth masks and face coverings are likely to have limited impact on lowering COVID-19 transmission because they have minimal ability to prevent the emission of small particles, offer limited personal protection with respect to small particle inhalation, and should not be recommended as a replacement for physical distancing or reducing time in enclosed spaces with many potentially infectious people. We are very concerned about messaging that suggests cloth masks or face coverings can replace physical distancing. We also worry that the public doesn't understand the limitations of cloth masks and face coverings when we observe how many people wear their mask under their nose or even under their mouth, remove their masks when talking to someone nearby, or fail to practice physical distancing when wearing a mask.

References
Anfinrud P, Stadnytskyi V, Bax CE, et al. Visualizing speech-generated oral fluid droplets with laser light scattering. *N Engl J Med* 2020 (published online Apr 15)

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