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Presenting L.D. 1382, "An Act to Establish the Guiding Public Health Principles of Focused Protection for Pandemics of a Highly Infectious Respiratory Disease"

Before the Health and Human Services Committee

Monday, April 24, 2023

Senator Baldacci, Representative Meyer, and members of the Committee on Health and Human Services: I am Eric Brakey, Androscoggin Senator, representing the people of Auburn, New Gloucester, Poland, and Durham.

Thank you for your time and attention today as I present L.D. 1382, "An Act to Establish the Guiding Public Health Principles of Focused Protection for Pandemics of a Highly Infectious Respiratory Disease."

As some may recall, we recently experienced an unprecedented state of emergency, lasting fifteen months, in which the executive branch was invested with the powers of the legislature. (It is worth noting that, in the Roman Republic, when a single individual was invested with the power to both make and execute laws for a period of emergency, they called this a "dictatorship.")

During this period of dictatorship (which occurred not only in Maine, but also in many states across this country and the world), instead of formal law-making as we are conducting today — in which elected representatives hear from the public and consider all the various interests at stake in a proposed policy — we had law-making by executive mandate with no public input on policies that profoundly impacted the lives of every man, woman, and child in the state of Maine.

In that time of pandemic, the Governor instituted lockdown-focused policies — a deviation from the norm of how we've dealt with viral respiratory pandemics of the past — which sought to prevent the public from breathing in the vicinity of and touching one another. To that end, we experienced the mass quarantine of largely healthy populations through shelter in place orders; businesses closures; school closures; church, synagogue, and mosque closures; and public propaganda campaigns with ever-shifting facts and goal posts, promoting fear of your neighbor as a biohazard, which included the censorship of dissenting voices from both the public at-large and the scientific community.

Now that this aberrant period is largely in our rearview mirror, prudence demands we reflect on what took place, take stock of the benefits and harms these policies created, and apply what lessons we can learn to avoid making the same mistakes in future pandemics.

In November 2020, three epidemiologists from Harvard, Oxford, and Stanford authored a document called "The Great Barrington Declaration," which criticized lockdown policies for:

> "...producing devastating effects on short and long-term public health. The results (to name a few) include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden."

Instead of universal lockdowns, they recommended a public health strategy built around focused protection of the vulnerable and recognition of the gradual development of herd immunity among:

> "We know that vulnerability to death from COVID-19 is more than a thousand-fold higher in the old and infirm than the young. Indeed, for children, COVID-19 is less dangerous than many other harms, including influenza.
>
> "As immunity builds in the population, the risk of infection to all – including the vulnerable – falls. We know that all populations will eventually reach herd immunity – i.e. the point at which the rate of new infections is stable – and that this can be assisted by (but is not dependent upon) a vaccine. Our goal should therefore be to minimize mortality and social harm until we reach herd immunity.
>
> "The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection."

It is also worth noting (and of relevance to other legislation you are hearing today) that these epidemiologists also recommended utilizing healthcare working with natural immunity from a prior infection to care for the most vulnerable in nursing homes:

> "...nursing homes should use staff with acquired immunity and perform frequent testing of other staff and all visitors. Staff rotation should be minimized."

Utilizing healthcare workers with natural immunity (which is the most effective protection against infection and transmission), was the recommendation. Instead, many of these healthcare workers were fired from their jobs.

The Great Barrington Declaration has been co-signed by nearly one million individuals across the world, including 16,067 medical and public health scientists, as well as 47,541 medical practitioners. (For reference, the full text is included with my supporting documents.)

This legislation would enact into statute seven guiding principles, built upon a foundation of focused protection, which should have guided us through this past pandemic, but still can guide us through future such events.

These principles were outlined by Dr. Jay Bhattacharya of Stanford University (one of the three authors of the Great Barrington Declaration) during a November 2022 presentation at the Soho Forum. With the remainder of my testimony, I will share each one and the reasons for them.

A. Public health advice must consider the impact on overall public health rather than be solely concerned with a single disease and consider the benefits and harms of any public health measure, weighing the short-term versus the long-term consequences of the measure;

One of the great flaws of the COVID response was single-minded focus on the spread of the virus, while disregarding the negative consequences on other aspects of public health that resulted from the measures taken.

Among the direct consequences of lockdown policies include:

- Rising rates of depression, suicide, obesity, alcohol and substance abuse, DUI and overdose deaths, domestic violence;
- Short-term and long-term rising poverty rates from economic and educational disruptions;
- Delayed preventative medical care due to the suspension of "elective" procedures.

While the full picture of damage from lockdowns is something we will likely grapple to understand throughout the next generation, we can begin to make sense of it all by examining excess mortality rates — death rates that exceed the baseline based on recent trends.

According to a report of the Maine Policy Institute (included with my supplemental documents), when we examine the excess mortality rates for Maine in 2021, 43% more Mainers aged 30 to 49 died than would be expected in a "normal year." This excess mortality rate is nearly 20% higher than any other age group, which should raise alarm bells because this is an age category not especially vulnerable to COVID-19.

Across all age groups, the report concludes that COVID-19 itself only accounts for about half of the excess mortalities.

Maine Annual Excess Mortality By Age Group, 2020-21				
	2020		2021	
15-29	-1.8	-0.97%	9.2	4.98%
30-49	111.4	16.49%	293.4	43.43%
50-64	153.4	9.30%	405.4	24.58%
65-74	319.4	12.05%	695.4	26.24%
75-84	322.8	9.05%	741.8	20.80%
85+	159	3.25%	281	5.74%
All Ages	1065.2	7.79%	2403.2	17.57%

By focusing on COVID-19 transmission to the exclusion of all other measures for public health, lockdown policies created numerous additional public health crises beyond the pandemic itself.

B. Public health policy must protect the most vulnerable populations of the State, including children, low-income families, individuals with disabilities and the elderly, and may not shift the burden of protecting against the disease from the affluent to the less affluent;

As Bhattacharya describes it, lockdowns are a "trickle-down epidemiology policy where the idea is if we protect the laptop class, everyone else is protected."

But of course, not everyone could afford to shelter in place, work from home, and ensure adequate education for their children. Those on the economic margins — who were often at low risk for severe COVID infection — were among the hardest hit by the effects of lockdown policies.

Further, while Maine experienced lower rates than many states, it is hard to definitively isolate the reasons for this. With data from all 50 states, including control groups like Florida (which adopted focused protection measures instead of lockdowns), there is no clear correlation between lockdown policies and COVID rates.

C. Public health advice must address the needs of each population in the State within the cultural, religious, geographic and other contexts of the population. If a population in the State believes that places of worship are essential, the public health advice should consider places of worship as essential in determining the advice;

Churches, mosques, and synagogues were shut down, while liquor stores stayed open.

The lack of respect for the cultural and religious needs of Maine populations, paired with clearly arbitrary designations for what was essential and what was non-essential, has bred a justifiable lack of trust in public health officials across many communities.

D. **Public health policy must be based on comparative risk evaluations, risk reductions and reducing uncertainties using the best available scientific evidence but recognizing that risk cannot be entirely eliminated;**

As Bhattacharya again notes, the "idea that we have to live with risk — there is no perfect, there are only trade offs — is central to public health and something that the public was misled about during the pandemic."

E. **Public health recommendations must present facts as the basis for guidance and may not employ fear, shame or falsehood to manipulate the public;**

Public health requires public trust.

Throughout the pandemic, however, we found ourselves subject to public health officials promoting so-called "noble lies." This included:

- Shifting timelines for emergency measures, beginning with what was billed to the people as just "two weeks to stop the spread" in order to buy preparatory time for hospitals.

- Changing guidance on the effectiveness of masks — not based on updated scientific understanding, but based upon the availability of masks.

- Grossly overstating the effectiveness of COVID vaccination at preventing viral infection and transmission (despite a lack of scientific evidence to support those claims) and downplaying any reported negative effects.

- Misleading the public on the nature of alternative treatments being pursued by other medical professionals (for example, a national media campaign mislabeling Ivermectin — an FDA-approved anti-parasitic drug that won the 2015 Nobel Prize in Medicine — as a "horse medicine.")

- Asserting false claims of certainly over viral origins and coordinated efforts to suppress the lab leak theory by the very public health officials who approved taxpayer funding for gain-of-function research at the Wuhan Institute of Virology.

When members of the public, including highly qualified scientific experts, disrupted these claims, public health officials coordinated with media partners (especially social media companies) to engage in widespread censorship instead of public debate.

Lies and censorship, no matter how well-intended, have done lasting damage to the public's trust in our public health institutions.

F. **Medical interventions may not be forced on a population, and a population may not be coerced into medical interventions, and medical interventions must be voluntary and based upon informed consent. A public health official must advise and may not set rules and must provide information and resources for an individual to make an informed decision; and**

This is supposed to be a free country. When it comes to our health decisions, recommendations from public health authorities are welcome, but force and coercion are not. The slew of mandates imposed on the Maine people, most with questionable effectiveness as we look back with hindsight, were never appropriate.

G. **Public health authorities must be honest and transparent with what is both known and unknown, advice given must be evidence-based and explained by data and the authorities must acknowledge errors or changes in evidence as soon as the authorities are aware of the changes.**

A dangerous degree of arrogance has crept into our public health institutions. As Bhattacharya notes, "we should not have people in charge of public health who believe they are science itself."

Mistakes are inevitable. They will happen. But public health official should be upfront with the public on the degree of certainty they have with their recommendations and the evidence that supports them. When their critics (whom they censored) turn out to be right, they should not defer accountability with a slight of hand claiming "the science has changed." If the science has changed, why were so many blacklisted scientists accurate in pointing out the lack of scientific basis for those recommendations?

Now that the public health emergency is over, there must be some degree of reflection on the extra-constitutional measures that were implemented with no public legislative process, and reconciliation for the unnecessary harms those policies imposed on the Maine people.

I've brought this legislation forward with hope of encouraging that process and putting into statute some of the lessons learned from our recent experiences.

Thank you for your time and consideration. I will gladly take any questions.

The Great Barrington Declaration

As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection.

Coming from both the left and right, and around the world, we have devoted our careers to protecting people. Current lockdown policies are producing devastating effects on short and long-term public health. The results (to name a few) include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden. Keeping students out of school is a grave injustice.

Keeping these measures in place until a vaccine is available will cause irreparable damage, with the underprivileged disproportionately harmed.

Fortunately, our understanding of the virus is growing. We know that vulnerability to death from COVID-19 is more than a thousand-fold higher in the old and infirm than the young. Indeed, for children, COVID-19 is less dangerous than many other harms, including influenza.

As immunity builds in the population, the risk of infection to all – including the vulnerable – falls. We know that all populations will eventually reach herd immunity – i.e. the point at which the rate of new infections is stable – and that this can be assisted by (but is not dependent upon) a vaccine. Our goal should therefore be to minimize mortality and social harm until we reach herd immunity.

The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection.

Adopting measures to protect the vulnerable should be the central aim of public health responses to COVID-19. By way of example, nursing homes should use staff with acquired immunity and perform frequent testing of other staff and all visitors. Staff rotation should be minimized. Retired people living at home should have groceries and other essentials delivered to their

home. When possible, they should meet family members outside rather than inside. A comprehensive and detailed list of measures, including approaches to multi-generational households, can be implemented, and is well within the scope and capability of public health professionals.

Those who are not vulnerable should immediately be allowed to resume life as normal. Simple hygiene measures, such as hand washing and staying home when sick should be practiced by everyone to reduce the herd immunity threshold. Schools and universities should be open for in-person teaching. Extracurricular activities, such as sports, should be resumed. Young low-risk adults should work normally, rather than from home. Restaurants and other businesses should open. Arts, music, sport and other cultural activities should resume. People who are more at risk may participate if they wish, while society as a whole enjoys the protection conferred upon the vulnerable by those who have built up herd immunity.

On October 4, 2020, this declaration was authored and signed in Great Barrington, United States, by:

Dr. Martin Kulldorff, professor of medicine at Harvard University, a biostatistician, and epidemiologist with expertise in detecting and monitoring infectious disease outbreaks and vaccine safety evaluations.

Dr. Sunetra Gupta, professor at Oxford University, an epidemiologist with expertise in immunology, vaccine development, and mathematical modeling of infectious diseases.

Dr. Jay Bhattacharya, professor at Stanford University Medical School, a physician, epidemiologist, health economist, and public health policy expert focusing on infectious diseases and vulnerable populations.

Total Signatures	**937,355**
Concerned Citizens	**873,747**
Medical & Public Health Scientists	**16,067**
Medical practitioners	**47,541**

FATAL CONCEIT

MORTALITY IN MAINE DURING THE COVID-19 ERA

MAINE POLICY INSTITUTE

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FATAL CONCEIT

MORTALITY IN MAINE DURING THE COVID-19 ERA

OCTOBER 2022

NICK MURRAY
DIRECTOR OF POLICY

Key Findings

- Mortality attributed to COVID-19 only explains about half of the excess in 2020 and 2021.
- In 2021, 43% more Mainers aged 30 to 49 died than would be expected in a normal year.
- In nearly all age groups, excess mortality was greatest in the last quarter of 2021.
- Maine recorded 58% more drug overdose deaths in 2020 and 2021 compared to the 2015-2019 quarterly average.
- Mainers under age 40 had more than 17-times-greater risk of dying from a drug overdose than from COVID-19 over 2020 and 2021.

2021: AMERICA'S DEADLIEST YEAR EVER

There is no denying it. Over the last two-and-a-half years, the United States has seen a sustained increase in mortality. US Centers for Disease Control and Prevention (CDC) data show that from 2019 to 2021, average life expectancy at birth in the United States declined by 2.7 years, the largest two-year decline since the early 1920s.[1] Every state saw a decline; from New York, which saw the average lifetime shrink by three years, to Hawaii, which had a 0.2 year drop.[2]

The CDC dubbed 2021, the second year of the COVID-19 pandemic, the nation's "deadliest year ever."[3] This is determined by measuring "excess mortality," establishing a historical baseline rate of overall deaths, or a way to compare to an average year, and measuring deviation from that level over time. Americans aged 15-64 who died in 2021 was a staggering 40% greater than what would be expected based on historical trends.[4] While 2020 deaths were also above the historical average, it was nothing like 2021.

These staggering and sobering statistics caught the attention of life insurers in early 2022. Scott Davison, CEO of Indiana-based life insurer, OneAmerica, reported during a Chamber of Commerce virtual event that his company saw death rates increase by 40% compared to the pre-pandemic period, and that was seen across the industry.[5] Some in the business are wondering if this is indicative of undercounted COVID-related deaths. Jonathan Porter, global chief risk officer with Reinsurance Group of America Inc. (RGA) explained their thought process on a conference call: "One of the things that makes us believe that these really are direct or indirect COVID is the causes of death tend to be comorbid with COVID. Alzheimer's, diabetes, things like that, but in addition they tend to move with the COVID deaths."[6]

While some may attribute the mortality spike to the pandemic, an April 2022 paper published in the *Journal of the American Medical Association (JAMA)* studied 21 peer nations in addition to the US, but found that none experienced decreases in life expectancy as large as the US. These nations, which included Canada, Denmark, France, Germany, Israel, Netherlands, Norway, Portugal, South Korea, Spain, Sweden, Switzerland, and the United Kingdom (UK), also faced significant infection rates of SARS-CoV-2, the virus which causes COVID-19.[7] Many confounding factors make finding a direct correlation to the pandemic difficult, but the difference between American mortality to similar nations begs for an explanation.

Following the acknowledgement of the spike in death over 2021, public health experts have offered several theories as to why it might be happening. Some say that it is latent effects from the pandemic; more people caught COVID-19 than we could count, and we know that some patients have some lingering effects from the illness, so these deaths could be lagging effects of so-called "Long-COVID."

Since COVID-19 affects younger and healthier populations less than older, less healthy individuals, some question whether the spikes in deaths of Americans under 65 are due to the somewhat-novel respiratory illness. Official statistics from the World Health Organization (WHO),[8] UK,[9] and US CDC[10] show the vast majority of excess mortality occurring in 2021 and 2022 cannot be attributed to COVID-19. Instead, it is more likely these are the effects of delayed preventative medical care due to suspension of "elective" procedures during 2020, in addition to the immense social effects of lockdowns[11] that drove sustained depression and economic malaise, which can also cut lives short.[12]

Casey Mulligan and Robert Arnott wrote of this "historic, yet largely unacknowledged, health emergency" of dramatically increasing excess deaths among young and middle-aged American adults in a working paper published by the National Bureau of Economic Research (NBER) in June 2022:

> *"The age pattern of excess non-COVID deaths reveals something about the types of factors driving poor health during the pandemic. With the young experiencing so many excess deaths, even though their average personal risk from Covid is minimal, many of the pandemic's effects on health seem to be working through market channels."*

They assert that lockdown policies, "such as closing workplaces or changing law enforcement practices, may have made it more expensive to maintain health or made unhealthy lifestyles less expensive."[13] Consequences of isolation fell predominantly on younger Americans, though the elderly were not spared. Lockdowns pursued in their name meant that those in long-term care homes and hospitals who were not allowed visitation by family or friends, critical lifelines to the outside world. State policy emphasized isolation and disconnection among the population, young and old.

Lockdowns, tried in spring 2020 for the first time in history, continued far beyond that initial panic of an unknown coronavirus emerging from the central Chinese city of Wuhan. These prohibitions and restrictions receded, then swelled again and again over the course of the last two-and-a-half years, continuing to cast a shadow over Americans' daily lives.

How many lives did we actually save in the pursuit of suppressing the coronavirus? Studying changes in all-cause mortality, or the overall death rate among the population, compared to the pre-pandemic period, will allow for a more unobstructed view of the effects of these novel policies. It will highlight which age groups and causes of death warrant further examination. Comparing those with historical cause of death data will help parse out a truer picture of the impact on life over the last two years.

This analysis necessitates the use of federal CDC data because Maine CDC has not been fully transparent with data related to COVID-19, as well as other issues.[14] Limited data offered by health care systems and by state officials like Dr. Nirav Shah, director of Maine CDC and Governor Janet Mills made determining which fatalities and hospitalizations were caused by COVID-19 difficult.

While some hospital systems report how many patients were admitted "for COVID" versus "with COVID," they don't all count it the same way. That question had not even been addressed in the public sphere until late 2021, so for the first 18 months of the pandemic, the public heard "COVID-19 deaths" reported not realizing that those could have been anyone who passed away after having received a relatively recent

positive PCR test result. Because of this policy, deaths attributed to COVID likely overcount the number of true deaths "from COVID," rather than undercount.

Hospitals in Maine rarely distinguished between incidental and primary admissions for COVID hospitalization or deaths ("*with* COVID" vs "*from* COVID," respectively) in its public data reports. Maine CDC's estimates on incidental hospitalizations were only released upon specific request from legislators. Some estimates, offered by representatives of large hospital systems like MaineHealth, ranged from 20% to 30% of patients being admitted for something other than COVID-19, but testing positive during their stay.[15] Every patient admitted to Maine hospitals were being tested for the virus, sometimes daily, but certainly upon admission. Thus, figures of "COVID-related" deaths are likely inflated from continuing this practice for more than two years.

Additional mischaracterization was more likely to occur during the prevalence of the Omicron subvariants of SARS-CoV-2. For instance, by June 2022, the weekly UK-based news and culture magazine, *The Spectator*, noted that 65% of COVID-positive National Health Service (NHS) patients were not primarily being treated for the virus.[16] A preprint paper first appearing in early June 2022 supported by the Keck School of Medicine of the University of Southern California found that "67.5% of SARS-CoV-2 PCR positive hospital admissions were not for COVID-19 but with COVID-19."[17]

In a paper recently published in *Lancet*, a prestigious UK medical journal, researchers attempted to measure excess mortality "due to the pandemic" and found that their estimate is more than triple the number of reported COVID-19 deaths worldwide:

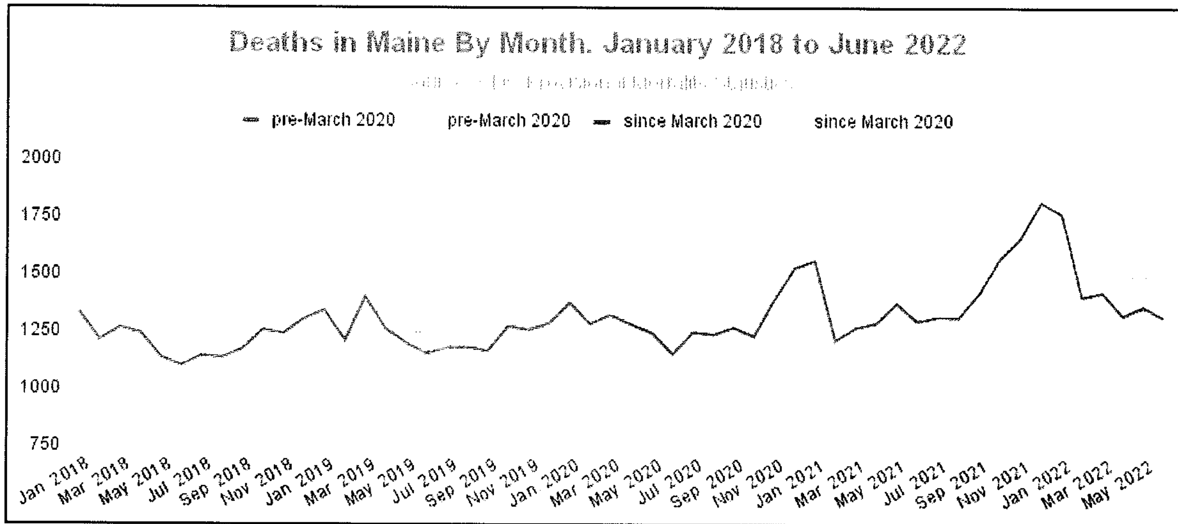
> *"In addition to deaths from SARS-CoV-2 infection, social distancing mandates and other pandemic restrictions might have decreased deaths from some diseases and injuries, such as road accidents, and increased others, such as deaths from chronic and acute conditions affected by deferred care-seeking in overstretched health-care systems, relative to expected or baseline conditions... The magnitude of disease burden might have changed for many causes of death during the pandemic period due to both direct effects of lockdowns and the resulting economic turmoil. To correctly divide excess deaths into those directly due to SARS-CoV-2 infection and those associated with changes in other diseases and injuries, multiple drivers of change in mortality since the onset of the pandemic need to be considered."*

These researchers concede that within their definition of deaths "due to the pandemic," they include the effects of lockdown policies which caused the loss of millions of livelihoods and separated people from their communities. In this way, the paper regards the "effects of the pandemic" to be much greater than what has been attributed to the virus itself, even with the liberal application COVID as cause of death. As they mentioned, multiple potential drivers for mortality must be discussed.[18]

EXPLORING MAINE MORTALITY DATA

All deaths recorded in Maine from 2018 to 2021 are displayed in the graph below, one can see a dramatically-increasing trendline (red) since early 2020, compared to mortality from 2018 until March 2020 (blue). The pandemic-era trajectory is distinctly higher than pre-pandemic. Noticeable spikes

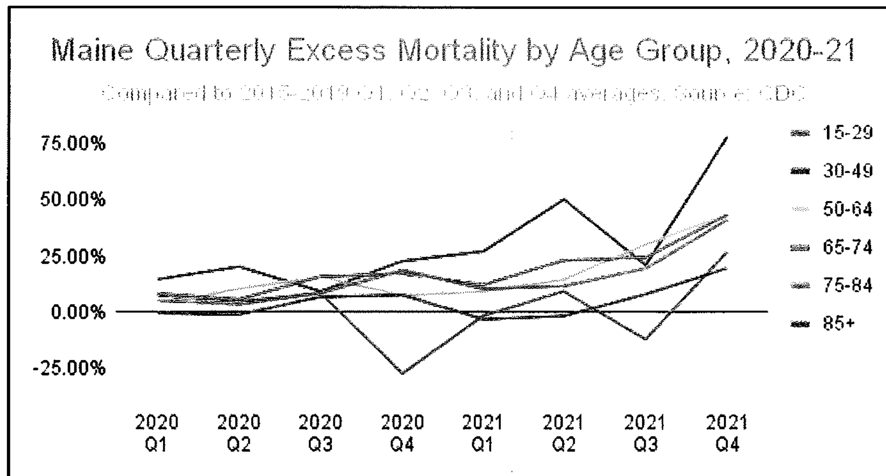
occurred in the winter surge of late 2020 as well as in the latter half of 2021, exceeding any which had occurred since 2018.



In order to better understand which groups were most affected by this spike in mortality, we looked at two datasets from the CDC using slightly different age groupings. Deriving a historical baseline of mortality from weekly data across 2015 to 2019, we find considerable annual excess mortality in 2020 of more than 10%—but that paled in comparison to 2021, when the state saw an excess of more than 20% on average. In raw numbers, about 1,065 more Mainers than expected passed away in 2020, but more than 2,400 more died in 2021. Most staggering, 43% more Mainers aged 30 to 49 died in 2021 than would be expected in a "normal" year.[19]

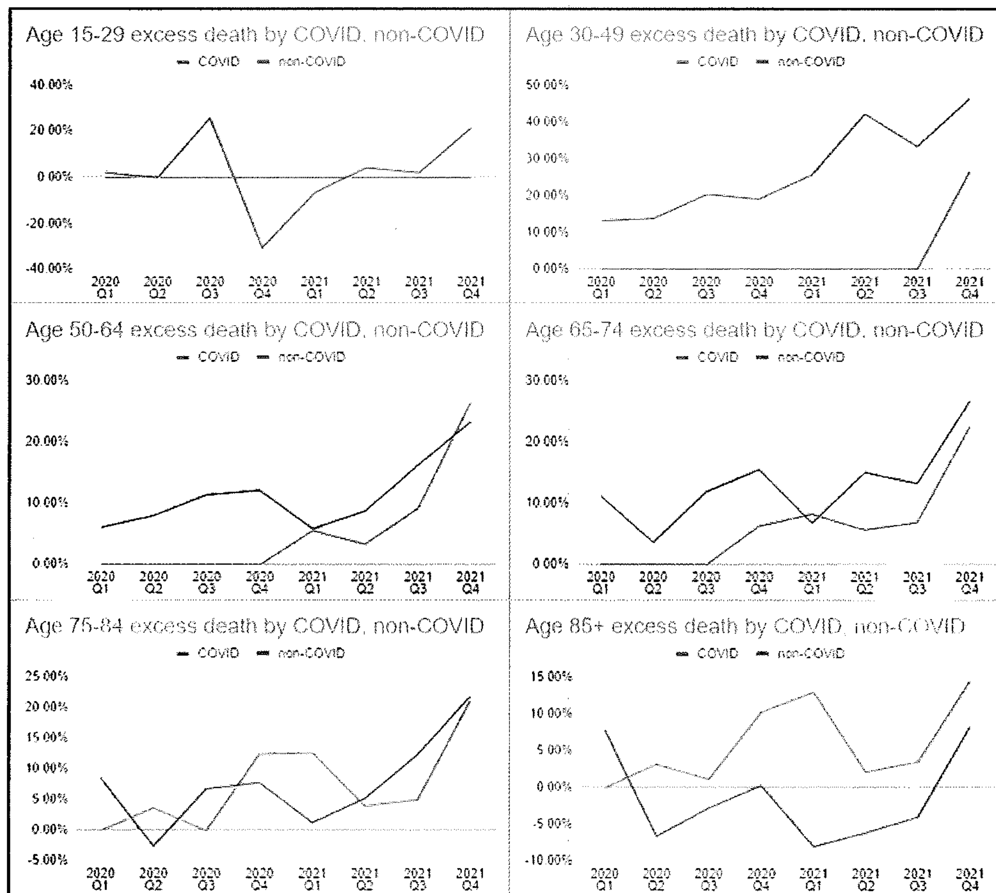
Maine Annual Excess Mortality By Age Group, 2020-21				
	2020		2021	
15-29	-1.8	-0.97%	9.2	4.98%
30-49	111.4	16.49%	293.4	43.43%
50-64	153.4	9.30%	405.4	24.58%
65-74	319.4	12.05%	695.4	26.24%
75-84	322.8	9.05%	741.8	20.80%
85+	159	3.25%	281	5.74%
All Ages	1065.2	7.79%	2403.2	17.57%

Data from CDC Quarterly Provisional Mortality estimates show a substantial spike in mortality across all age groups in the final quarter of 2021, with the worst befalling Mainers between age 30 and 49. While excess mortality among those between 50 and 64 trended generally within the bounds of the population-wide average, excess death in that age group jumped to become significantly higher than the average by the last half of 2021.[20]



Looking at deaths attributed to "COVID" versus those which are not (referred herein as "non-COVID" deaths), we find greater non-COVID excess mortality in Maine among younger age groups in 2020, which seemed to have caught up to older groups in 2021. Middle-age groups experienced this phenomenon in both years, though also much worse in 2021. The graphs below demonstrate the extent to which deaths attributed to COVID and non-COVID causes made up that age group's overall excess mortality each quarter.[21]

Maine excess mortality by age group, attributed to COVID-19 and non-COVID causes



Source: CDC

While older age groups experienced significant COVID-related mortality during 2020 and into the winter surge of early 2021, data show that the virus can explain only about half of the excess. Excess mortality skyrocketed in the last half of 2021, with COVID-related deaths rising as well as non-COVID causes, even though COVID-19 vaccination was widely accepted. Perhaps most striking is that, while Mainers aged 30 to 49 experienced few COVID-related deaths for most of the pandemic, those jumped in the last quarter of 2021 to drive 26% excess deaths, while non-COVID causes also spiked to contribute another 46% excess. Overall, 73% more Mainers aged 30-49 died during the last three months of 2021 than would be expected.

USMortality.com shows that even during the winter COVID surge of late 2020 and early 2021, Maine's excess mortality percentage exceeded the normal range for only a short time. But, in the latter half of 2021, the state saw between 18% and 42% more deaths than expected each week during this time, greater than at any time in 2020.[22] It is difficult to overstate how rare a mortality event like this is in human history. Life insurers like OneAmerica and RGA quoted above regard a 10% increase in excess mortality as a three-standard-deviation occurrence, or a once-in-200-year event. Frankly, 30-40% excess is astronomical.

In 2021, more Mainers' deaths were attributed to COVID than in 2020, growing concurrently with non-COVID deaths over the year. An August 2022 report by the Society of Actuaries (SOA) found that Americans younger than 45 were at higher risk of death for non-COVID causes over the pandemic.[23] Indications that COVID-19 is not the primary driver of higher-than-expected mortality prompt further investigation to other possible explanations.

In most-to-all age groups, excess mortality was the highest in the fourth quarter of 2021. Why was this the case? Shouldn't we have seen lower mortality—at least from COVID-19 itself, to say nothing of overall mortality—from widely deploying several new public health strategies like COVID-19 vaccination and treatments like Pfizer's Paxlovid? Shouldn't the state and the nation have been able to save more lives, not fewer, as the pandemic progressed and science and government officials learned more?

DELAYED MEDICAL CARE

In mid-March, just before Governor Janet Mills declared the state of emergency, the U.S. Surgeon General called on states to delay "elective" medical procedures to attempt to conserve personal protective equipment (PPE) and hospital capacity in the event of exponential growth in serious coronavirus cases.[24] A more specific, tiered framework was distributed by the Centers for Medicare and Medicaid Services in April 2020 to help medical professionals and hospitals develop a standard of care within the new paradigm.[25]

The list of so-called "non-essential" procedures include regular check-ups, cancer screenings like mammograms, joint surgeries, as well as some preventative care visits such as pediatric vaccinations.[26]

Patients who had to postpone their biopsy or cancer screening delayed a potentially earlier diagnosis crucial to ensuring recovery. The Maine CDC's *Shared Community Health Needs Assessment Report 2022* recognized that pandemic-era "challenges in accessing care have impacted chronic disease management and caused delays in nonemergency procedures."[27]

In August 2020, Maine Policy warned about the effects of canceling or postponing important medical procedures like these,[28] referencing a report published in the National Institutes of Health (NIH) Public Health Emergency COVID-19 Initiative that noted the "consequences of surgical delays will likely manifest in increased costs to the health care system...often requiring more intense and more costly treatment."[29]

Given NIH's 2020 warning, public health officials should be looking into how delayed medical care played into the overall need for health care services, as well as disease progression among patients who could not see their provider. Are these effects evident in the provisional mortality data, or is it too early to tell?

CDC WONDER data on cause-of-death by ICD-10 coding[30] show that excess deaths among Mainers attributed to circulatory system failure (I00-I99) rose 3.5% in 2020, but doubled proportionally over the next year to 7%.[31] *The Wall Street Journal* reported similar data nationally: "Mortality rates from heart disease and stroke rose 4.3% and 6.4% respectively in 2020."[32] Heart disease, the number one cause of death for Americans,[33] driven by the nation's concurrent epidemics of obesity and diabetes, is rampant even in "good" years.

Deaths attributed to diseases of the endocrine system (E00-E88) in Maine were 6.7% higher than expected in 2020, a proportion which nearly-tripled to 17.9% excess in 2021.[34] Despite many delayed or skipped cancer screenings and treatments over 2020,[35] deemed "elective procedures," neither Maine nor US mortality data show significantly higher excess deaths attributed to cancers. It is possible that the effects will not be seen in mortality data for many years.

These examples of delayed and withheld medical care pertain to non-COVID causes, but some suggest that top-down approach to developing care protocols for COVID-19 also led to greater mortality attributed to the virus.

Several doctors found success experimenting with multi-drug protocols to treat COVID-19 illness in the first months of the pandemic, but were ultimately ignored by leading public health officials. Dr. Pierre Kory of the Frontline COVID-19 Critical Care Alliance (FLCCC) testified to a Senate committee in May 2020 that lack of recommending methylprednisolone, a steroid which he noted was used with success in prior coronavirus outbreaks like SARS and MERS, is "causing needless death."[36] The National Institutes of Health (NIH) never included it in its directives, even recommending against several other commonly-used drugs and supplements mentioned in FLCCC protocols,[37] like vitamin D, vitamin C, Zinc,[38] and Ivermectin.[39]

DEATHS OF DESPAIR

The recent spike in youth mental illness[40] and suicidal ideation[41] alone should be a wake-up call to anyone still clamoring for more COVID-inspired mandates on the youth, but many other unintended consequences of locking down younger populations have also reared their ugly heads. Often called "deaths of despair," these are those who have succumbed to alcohol abuse, drug addiction, or depression leading to suicide. Over 2020 and 2021 the United States saw significantly more of these cases, the vast majority of whom were under age 60.

Both the US and Maine CDC recorded significant jumps in emergency department (ED) visits for suicide attempts during the pandemic years 2020 and 2021. Overdoses involving fentanyl, a powerful synthetic opioid, are now the leading cause of death among Americans between the ages of 18 and 45.[42] More Americans aged 16 to 64 died from alcohol-related causes than from COVID-19 over 2020 and the first half of 2021.[43]

There were clear warning signs for state and federal health officials over 2020 and 2021, showing how their pandemic policies contributed to a more sedentary and depressed youth population.[44] Yet, it took the CDC until August of 2022 to advise school children not to miss class because of an exposure to someone who tested positive for the coronavirus, nor to be tested themselves if they are not symptomatic. Data has shown for nearly two years that school-aged children face a vanishingly low risk of severe outcomes from a case of COVID-19.

Officials seemingly ignored the unintended consequences of lockdown policies and delayed issuing sensible guidance based on real-world evidence for many more months than necessary.

SUICIDE AND DEPRESSION

In June 2021, the CDC reported that, from mid-Feburary to mid-March 2021, "suspected suicide attempt ED visits were 50.6% higher among girls aged 12 to 17 years than during the same period in 2019."[45] By March, the agency reported survey results showing that, over the prior year, among American high schoolers, "44.2% experienced persistent feelings of sadness or hopelessness, 19.9% had seriously considered attempting suicide, and 9.0% had attempted suicide."[46]

Researchers affiliated with the Children's Hospital of Philadelphia wrote in the September 2021 issue of the journal *Pediatrics* that, while primary care visits for depression screening fell slightly among 12 to 21 year-old adolescents between the last half of 2019 and the first half of 2020, screeners recorded significantly more patients with suicidal thoughts. Perhaps a sad harbinger of the future, the study noted that "positive suicide risk screens increased" around 16%, showing "a 34% relative increase in reporting recent suicidal thoughts among female adolescents."[47]

Sadly, Maine CDC data mirror this trend. Emergency department visits "involving suicidal intent" were 24% higher in 2020 and 17% higher in 2021, compared to the 2017-19 quarterly average. Over all of 2020 and 2021, deaths by suicide were about 4% lower than the 2018-19 average, but tragically, spring and summer of 2021 saw 10% more than expected.[48]

The late-2021 spike in suicide in Maine is a likely signal of growing anxiety and depression within the population. A tragic, but sadly predictable outcome of the massive disruptions to daily life and mandated social isolation brought on by lockdown policies pursued by the Mills administration for many months, the repercussions of which are still being felt in 2022.

ALCOHOL

Another symptom of growing despair among the American population, *The New York Times* reported on a September 2020 study in JAMA which found that, "Americans increased the frequency of their alcohol

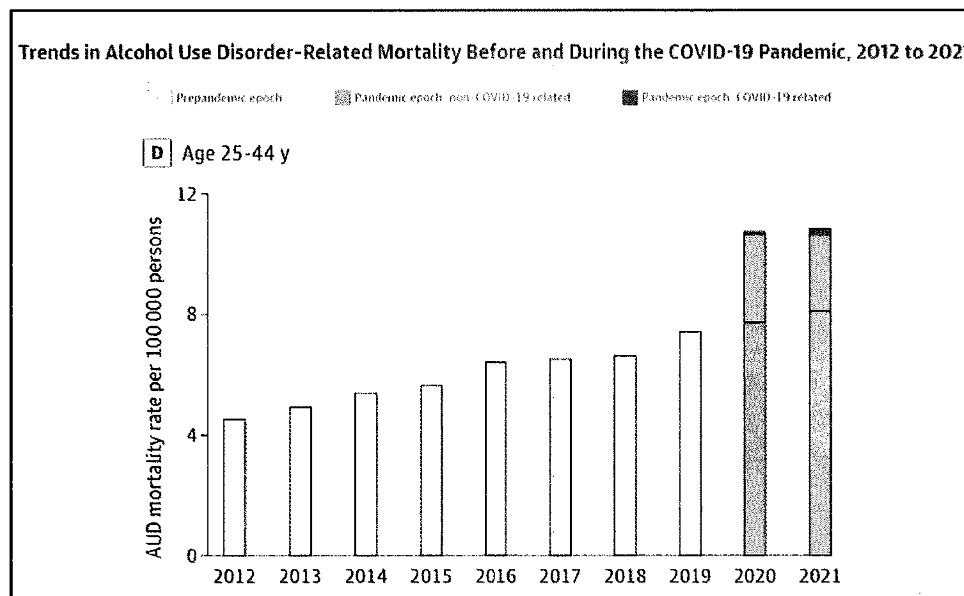
consumption by 14 percent compared to a year earlier." This was an early signal that Americans were turning to alcohol to cope with non-stop pandemic- and lockdown-induced stress. The JAMA study also found "a 41 percent increase in the number of days on which women drank heavily, defined as having four or more drinks in a couple of hours."[49]

In February 2021, the American Psychological Association (APA) published a national survey finding that 23% of adults reported drinking more in the year preceding to manage stress, but among parents, rates were even higher; 29% of mothers and 48% of fathers reported drinking more to cope. "Nearly half of mothers who still have children home for remote learning (47%) reported their mental health has worsened."[50]

It's no surprise that increased alcohol use brings myriad other detrimental social and health outcomes. *The Times* reporting continued:

> *"psychological damage from the past year has caused sharp declines in physical health, including widespread weight gain and disruptions in sleep. Hospitals around the country have reported an increase in admissions for hepatitis, cirrhosis, liver failure and other forms of alcohol-related diseases."*

Before the pandemic, CDC reported that alcohol-related causes were responsible for the deaths of 380 Americans per day, or more than 138,000 every year.[51] By May 2022, a review of mortality in the US due to alcohol-use disorder (AUD) found a staggering surge compared to previous years. In 2020, AUD-related deaths were 25% higher than history would suggest; in 2021, researchers saw 22% more. Perhaps most tragically, "the youngest age group (25-44 years) demonstrated the largest increase in AUD mortality (40.47% in 2020 vs 33.95% in 2021) across all age groups."[52]

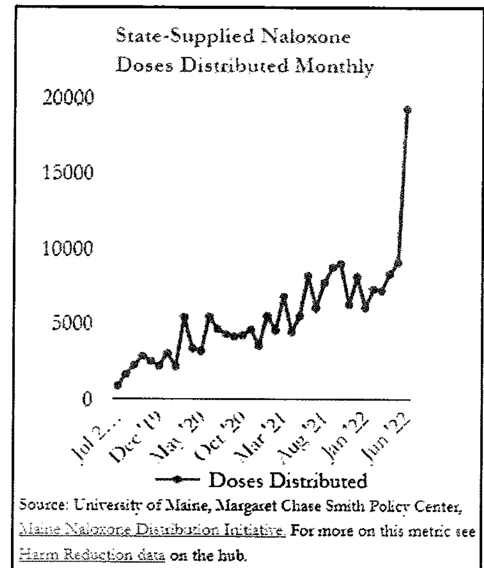


The increase in drinking and alcohol-related fatalities extended to the roadways as well. Deaths attributed to driving under the influence (DUI) rose nearly 15% nationwide from 2019 to 2020, according to the DUI Report from Zutobi, an online drivers' education resource website. The report called 2020 "the worst year

since 2005." Maine was ranked 6th-worst in Zutobi's "DUI Severity Score," with 28% more DUI-related deaths in 2020 year-over-year which made up nearly 40% of all road fatalities.[53] Authors noted that this spike in drunk driving "could be because of the increased loneliness that came with COVID 19 and the shutdowns,[54] leading to increased consumption in the home."

This led the *Bangor Daily News* to declare that "Maine has an OUI problem," noting that CDC data show "Maine had the highest rate of alcoholic liver disease deaths in the Northeast – including New England – in 2020…the 11th-highest rate of such deaths in the country."[55]

DRUG OVERDOSE



Source: University of Maine, Margaret Chase Smith Policy Center, Maine Naloxone Distribution Initiative. For more on this metric see Harm Reduction data on the hub.

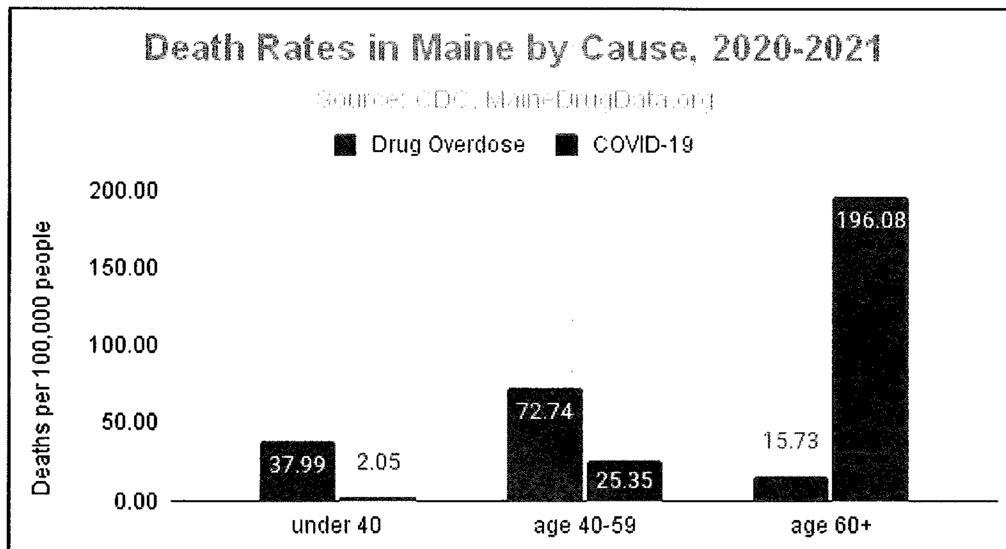
Maine, and the nation at large, has seen a dramatic uptick in drug overdoses during the pandemic era as well. In 2021, fatal overdoses surpassed a staggering 100,000 in the United States.[56] In Maine, all drug-related emergencies have become more common. Statewide distribution of the overdose-reversal drug Naloxone, also known as Narcan, doubled in the first half of 2022, after steadily increasing over the previous two years.[57]

Over 2020 and 2021, Maine recorded 1,136 total drug overdose deaths, 58% greater than the 2015-19 quarterly baseline. Though the opioid crisis is not a new public health issue—the last decade saw a tripling of yearly drug deaths—it has reached unfathomable levels in the last two years.[58] Among all 50 states, Maine has the 9th-highest rate of death by drug overdose.[59]

Maine Drug Overdose Deaths, 2014-2021

	Quarterly average	Change from previous year's average
2014	52	21.6%
2015	68	30.7%
2016	94	38.2%
2017	104.25	10.9%
2018	88.5	-15.1%
2019	95	7.3%
2020	126	32.6%
2021	157.75	25.2%

To put this in perspective, over 2020 and 2021, Mainers under age 40 had more than 17-times-greater risk of dying from a drug overdose than from COVID-19.[60] Those aged 40 to 59 had nearly-triple the risk of death from an overdose. Only for those at least 60 years of age and older did COVID-19 pose a greater risk. If one looks critically at how COVID deaths were counted, it is possible that the risk for younger Mainers from COVID is even less.



Sadly, this trend has not slowed down in the first half of 2022. January through June 2022 saw 9.7% more fatal overdoses than the same time period a year in 2021, according to the "Maine Monthly Overdose Report" put together by the Margaret Chase Smith Policy Center and funded by the state Attorney General and Office of Behavioral Health.[61]

Since the age groups in Maine drug overdose data do not overlap exactly with CDC provisional mortality data, this analysis assumes that 80% of the drug overdoses reported by those over 60 were under 65, likely a conservative estimate since those who succumb to a drug overdose are more likely to be younger. Drug overdoses accounted for about half of the excess mortality experienced by Mainers aged 15-64 through 2020. Even though overdoses shot up even higher over 2021, so did overall mortality, so it accounted for much fewer of those prime-aged Mainers' early deaths in 2021.

EFFECT OF EMERGENCY USE COVID-19 VACCINATION

The distribution of COVID-19 vaccine doses in early 2021, the vast majority of which used messenger RNA (mRNA) technology, was a public health intervention of unprecedented scale. The vaccination program was implemented nationwide in the first half of 2021, but not during the initial waves of the COVID-19 pandemic in 2020.

Per-capita COVID-related deaths among Mainers over the age of 60 in 2021 were double that of 2020. Why did Maine and the nation see the highest mortality rates ever recorded after the vaccines were available? The broad uptake of vaccines over 2021 should have contributed to lower death rates overall, or at least from COVID itself.

The concept of "survivorship bias"[62] tells us that those most likely to succumb to the pandemic would have done so in the earlier waves, especially as the average severity of successive strains of the virus diminished, consistent with evolutionary tendency toward viral attenuation.[63]

There are two different ways of judging the vaccines' effectiveness against mortality, either specifically deaths related to COVID-19, or overall population mortality. One review of all-cause mortality within a small Mediterranean island nation between 2016 and 2021 found "a substantial increase of 9.7% in all-cause mortality in Cyprus in 2021 compared to 2020, with an overall mortality increase of 16.5% in 2021 compared to the mean mortality of the previous five years." Specifically, they noted a "sharp increase" over the last half of 2021. In the conclusion of their analysis, authors ominous note that,

> *"The substantial increase in mortality in Cyprus in 2021 is not entirely explained by COVID-19 deaths and is parallel to the concurrent vaccination campaign. This concerning observation should be comprehensively investigated by the National and European public health authorities to identify and address the underlying causes."*[64]

A preprint meta analysis in the journal *Lancet*, consisting of multiple randomized, placebo-controlled trials showed an overall mortality benefit from adenovirus-based vaccines like the products from J&J, AstraZeneca, and Sputnik, but not from mRNA vaccines such as those made by Pfizer and Moderna. *Lancet* researchers looked at studies of more than 122,000 adenoviral vector vaccine recipients and more than 74,000 mRNA vaccine recipients total (each including a placebo/control group), and found that those who took an adenoviral vaccine saw an overall decrease in both Covid and cardiovascular death, with an overall average reduction of more than 60%. On the other hand, mRNA recipients did not show any statistically significant benefit in overall, cardiovascular, or COVID-related mortality.[65] These findings are supported by data from the UK Office of National Statistics (ONS) as well.[66]

To "throw light on the potential differences in nonspecific effects between vaccine types," *Lancet* researchers urged public health officials to conduct randomized-controlled trials "comparing the mRNA vaccines and adenovirus-vector vaccines for their effect on overall COVID-19 mortality as well as non-COVID-19 mortality." As of this writing, public health authorities in the US or UK have published no such study.

The vaccines were recommended by state, national, and global public health authorities for nearly everyone, regardless of age or individual risk profile. In some jurisdictions, including Maine, officials achieved widespread adoption through coercion and state mandates.[67] Even though many aspects of the COVID-19 vaccines were new, and even though the Emergency Use Authorization (EUA) gave the manufacturers near-total legal immunity for any adverse reaction deemed to be caused by their products, state and public health officials cajoled millions to accept it.

As of September 2022, more than two-thirds of the US population, and three-in-four Maine residents are considered "fully vaccinated,"[68] meaning having received at least two injections of an mRNA product, or one dose of the Johnson & Johnson adenovirus-based product. Including boosters, mRNA accounts for more than 95% of all doses administered in the state.[69]

The initial claim from government and public health officials that vaccination would protect against COVID-19 infection have been false for many months, following extensive analysis of patients in Israel[70] and Qatar[71] in late 2021. Successive analysis of the period of Omicron variant prevalence published in *The New England Journal of Medicine (NEJM)* provided further confirmation that the COVID-19 vaccines cannot be relied on to prevent infection.[72]

The Maine CDC repeatedly refused to grant exemptions for COVID-19 vaccination requirements based on immunity from previous infection, even though science has clearly shown that the vaccines are less durable and less protective than "natural immunity." In one study published in NEJM by Goldberg et al. showed at four to six months, and at six to eight months from last dose, the patients who had been previously infected and unvaccinated had 80% fewer cases than the uninfected and vaccinated cohort. Those who had been previously infected and had one dose had about the same case rates as the unvaccinated cohort.[73]

If the vaccines are not effective against infection, as the public was told, is it reasonable to critique effectiveness against severe outcomes like hospitalization and death? The limited, real-world dataset provided by Maine CDC regarding "breakthrough" COVID-19 infections, hospitalizations, and deaths show that, between March 2022 and September 2022, "fully vaccinated" Mainers—those who received an initial series of COVID-19 vaccine products—made up about 73% of COVID-related hospitalizations and deaths.[74] This is not far off from the 76% of the population who is fully vaccinated. Given the prevailing narrative around COVID-19 vaccination, one would expect to see this data favor the vaccinated. Instead, it shows a negligible difference.

It is important to note certain caveats when interpreting this data. For instance, it is more likely that hospitalized patients with COVID-19 are elderly, who are also more likely to be vaccinated. But, it is also more likely that vaccinated people engage in fewer risk behaviors, and thus may be healthier in general, despite other risk factors such as age.[75] More comprehensive analysis of breakthrough data to account for confounding demographic factors is not possible given the limits Maine CDC has imposed on its own public data releases.

Excess mortality increased from 2020 to 2021, not only in Maine, but nationally as well. A preliminary review of the evidence indicates that the administration of the COVID-19 vaccines in 2021 failed as a strategy to stem premature death as a result of the pandemic. If the vaccines work, why didn't they?

Regrettably, US government regulatory and scientific agencies have repeatedly given the public cause to doubt their honesty and integrity. In February 2022, *The New York Times* reported that the CDC had been withholding and obfuscating critical information on the effectiveness of COVID-19 vaccine "booster" doses for middle-age and younger Americans related to COVID-19 hospitalizations.[76]

Following this revelation, Dr. Marty Makary raised an alarm in an April 2022 *Wall Street Journal* op-ed, accusing the FDA of cutting corners in order to recommend a second COVID-19 vaccine booster dose to all American adults age 50 or older, a fourth mRNA dose for many Americans.[77] Makary noted that this led to the resignation of Marion Gruber, former director of the Office of Vaccine Research and Review, along with her deputy, Philip Krause, who both sat on the FDA advisory committee regarding vaccines and other related products.[78] They were concerned with undue influence from political forces, expressing their skepticism for the recommendation in an article in *The Lanc*et, that "If unnecessary boosting causes significant adverse reactions, there could be implications for vaccine acceptance that go beyond COVID-19 vaccines. Thus, widespread boosting should be undertaken only if there is clear evidence that it is appropriate."[79]

Perhaps the near-universal recommendation of multiple doses of COVID-19 vaccine deserves more scrutiny from independent scientists. Dr. Makary and researcher Dr. Tracy Beth Hoeg wrote in July 2022 that the authorization of these products for children as young as six months old was "based on extremely weak, inconclusive data."[80] They note that, "Pfizer reported a range of vaccine efficacy so wide that no conclusion could be inferred. No reputable medical journal would accept such sloppy and incomplete results with such a small sample size."[81] Especially for an age group facing such low risks from SARS-CoV-2 infection, public health officials must have very high confidence in the safety of such products, confidence which cannot be reasonably derived from currently available data.

Government officials had early knowledge that safety and efficacy could be an issue with these new vaccines, yet they pressed ahead. They refused to take deep dive into reported adverse event signals, and refused to incorporate evidence of significantly waning vaccine efficacy into their guidance until August 2022. Instead, the White House and CDC continued to push and authorize additional doses for younger and younger age groups throughout 2021 and most of 2022, while state officials doubled-down on their own vaccine mandates.

In August, the US CDC updated its guidance on the coronavirus to recommend against testing people without symptoms, eliminate the "test-to-stay" strategy which kept children out of school for many days longer than necessary, and to declare that vaccinated and unvaccinated individuals should be treated the same. In this update, CDC recognized both the efficacy of naturally-acquired immunity against infection, as well as the COVID-19 vaccines' inability to prevent infection or transmission. This update was significant, but issued much too late. The ill effects of persistent isolation, sustained public anxiety, and keeping children out of school for a virus for which very few face serious risk have already been wrought.

All in all, a review of data, official reports, and the medical literature shows that the COVID-19 vaccines were not as effective as the public was told they would be. Health officials had no way of knowing real-world effectiveness, whether they would stop transmission in the way traditional vaccines do, or whether they would actually save lives, yet pressed on with various mandates to ensure adherence to this story. The spike in excess mortality over the course of 2021, while the circulating strains of SARS-CoV-2 were presumably becoming less severe, leaves many questions unanswered, but ultimately casts doubt on the veracity of the narrative from state leaders like Dr. Shah and Gov. Mills.

STATE POLICY RECOMMENDATIONS

After reviewing the data available, several jurisdictions currently are not recommending COVID-19 vaccination for certain populations. For instance, the state of Florida recommends against healthy children receiving it,[82] a UK scientific advisory panel did not recommend the shots for healthy children aged 15 or younger,[83] and the authorities in the European nations of Denmark[84] and Norway[85] do not recommend COVID-19 vaccination for their citizens under age 50 and 65, respectively. Given these developments, Maine state officials should consider rescinding the recommendation of COVID-19 vaccination for children and healthy adults as well.

The Maine CDC should immediately rescind its rule requiring healthcare workers to be "fully vaccinated" for COVID-19 in order to work in "designated health care facilities."[86] By issuing this rule, Gov. Mills forced hundreds of health, medical, and emergency workers out of their jobs, at a time when Mainers spend nearly $1,000 more on health care than the average American.[87] Much peer-reviewed science has shown mandatory COVID-19 vaccination carries no benefit to overall public health precisely because it does not confer sterilizing immunity, that which is protective against infection or transmission. Despite this fact, Dr. Shah repeatedly compared the COVID-19 vaccines to other sterilizing vaccines like those for polio and smallpox, but both the smallpox[88] and polio[89] viruses do not have any animal reservoirs. Unlike SARS-CoV-2, they are only carried by humans.[90]

Contrary to the latest CDC guidance, the Maine CDC rule treats vaccinated workers differently than unvaccinated workers. Despite this, a spokesperson for Maine DHHS responded to an inquiry from WMTW reporter Chris Costa that "the new [CDC] guidance is consistent" with its vaccine requirement for healthcare workers.[91] Without providing any reasoning behind this assertion, DHHS lied to Maine people in order for the administration to avoid responsibility for its failed vaccine mandate.

The Mills administration and Maine Department of Education must also make clear to the University of Maine System[92] and the Maine Community College System[93] that they must rescind COVID-19 vaccine mandates for students to pursue higher education in the state. Many in that age group likely carry some immunity from previous infection, which additionally protects them and others against severe outcomes from COVID-19. As a recent preprint paper outlined, the risk-benefit analysis for young, healthy people shows that vaccination is unnecessary at best and potentially harmful at worst.[94]

On October 20, the CDC's Advisory Committee on Immunization Practices, of which Maine CDC Director Nirav Shah is a member, unanimously voted to add COVID-19 vaccines to the recommended schedule of childhood immunizations.[95] Many states look to this list as a benchmark for their own schedule of vaccinations mandated for public school students. Despite Shah's support for it, DHHS, DOE, and state legislators should resist attempts to add these investigational products to Maine's immunization schedule.[96]

Finally, the Maine Legislature should pass a bill amending the powers of the governor in a state of emergency by requiring an affirmative vote of a majority of legislators every 14 days, and allow for legislative revision and scrutiny of the governor's emergency orders. Emergencies do not last for 15 months. Rules like this could have softened the blow of single-person rule, which led to months of harmful restrictions and lockdowns pushed by the governor.

CONCLUSION

Media, public health officials, politicians, and most Americans have been consumed by the specter of death from/with COVID-19 for more than two years. This led to a singular-focused response, blind to the reality of unintended consequences. Leaders pushed never-before-tried policies and experimental products on their citizens pursuant to the myopic obsession of a new respiratory disease, even years after its discovery. During this time, America experienced its deadliest two-year period in 100 years, including its "deadliest year ever" in 2021.

Sadly, provisional data show heightened all-cause mortality persisted during the first half of 2022. Although statewide mortality was down about 25%, a jaw-dropping 60% more Mainers between ages 25 and 44 died compared to the pre-pandemic average.

Little doubt remains that lockdowns had their own contribution to all-cause mortality, either through delayed health screenings leading to prolonged illness, or increased isolation leading to greater deaths of despair—as evidenced by an inflamed drug overdose crisis which is worse than it's ever been. Assuming that all drug overdose-related fatalities in Maine occurred among those between ages 15 and 64, drug deaths accounted for more than 90% of the excess deaths among that group in 2020, and more than 50% in 2021.

In late March 2020, Gov. Mills was warned by some close advisors of some potential detrimental effects of her stay-at-home order. As reported in a *Bangor Daily News* article, emails uncovered from a Freedom of Access Act (FOAA) request show Peter Mills, Executive Director of the Maine Turnpike Authority—and the governor's brother—expressed skepticism to the type of shutdowns many governors were enacting around the country, including in Maine. "Shelter in place is an unenforceable meat axe remedy best reserved for active shooter situations," he wrote to the governor on March 24, 2020.[97] In hindsight, this advice was among the best Gov. Mills received from her inner circle. It was grounded in reality and human nature, not twisted, fearful pandemic thinking. Too bad that she did not take it seriously.

While the initial effects of the shutdowns would have been devastating on their own, continuing the ethos of social distancing and constant fear of others will likely prove to be the most destructive. The data bear this out. This analysis shows that excess deaths from drug and alcohol abuse, suicide, and failure of the circulatory system and endrocrine system accounted for more than one-third of Maine's overall excess mortality over 2020 and 2021. While these deaths may be seen by some as a "result of the pandemic," they were not a result of viral infection, but more likely the unintended costs of lockdown policies. Maine Policy warned against the potential costs of the governor's response, but she didn't listen.[98]

In an era of marked by historic levels of public mismanagement and incompetence contributing to "America's deadliest year ever," the public must demand scrutiny from all levels of government. Public health officials must allow for independent review of their agencies' actions, processes, incentives, and culture if they wish to regain the public's trust, which they so carelessly lost over the last two-and-a-half years.

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