

September 18, 2020

Muntu R. Davis, MD, MPH  
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Dear Dr. Davis,

I am writing to request that you reassess the [September 10 Preliminary Injunction](#) that has been imposed upon Grace Community Church in Sun Valley. Specifically, I request that you modify your County Health Order in order to allow indoor worship services at this Church based on extensive evidence that this congregation of more than 5,000 members is very healthy and is at very low-risk for COVID-19. The congregation has had no reported illnesses or deaths due to COVID-19. Furthermore, there is 50 years of peer-reviewed epidemiologic evidence that regular church attenders have substantially reduced mortality rates and that regular church attendance is an established risk factor associated with reduced death rates. The mortality benefits of regular church attendance are summarized in the attached Abstracts from my [2008 Preventive Medicine article](#) and a [1997 Am J Public Health article](#) and my full 2008 article. Table 2 from my 2008 article shows that in a representative national NHIS cohort those subjects adhering to four simple health practices, one of which is weekly church attendance, had a total age-adjusted death rate that was only **one half** of the death rate among the entire cohort, which was followed for ten years.

Thus, a very strong case can be made that the health benefits of indoor worship services exceed the minimal health risks of COVID-19 for this congregation. Furthermore, my request is entirely consistent with the [Department of Public Health](#) Vision ('Healthy People in Healthy Communities'), Mission ('Advance the conditions that support optimal health and well-being for all'), and Value 3 ('Collaboration'). The purpose of this request is to provide you with public health evidence that supports the Church's legal challenge to the Preliminary Injunction. If you agree to make my requested reassessment, I will submit additional supportive evidence, including evidence from other COVID-19 experts, such as, the attached September 17 Wall Street Journal OpEd by UCLA Associate Professor of Medicine Joseph A. Ladapo, MD, PhD.

Thank you very much for your timely consideration of my important request.

Sincerely yours,

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**ABSTRACT:** Lifestyle and reduced mortality among active California Mormons, 1980-2004

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**Objective:** The objective is to measure the relationship of several healthy characteristics of the Mormon lifestyle to mortality.

**Method:** We examined 9815 religiously active California Mormon adults followed for mortality during 1980-2004 and 15,832 representative U.S. white adults enrolled in the 1987 National Health Interview Survey (NHIS) and followed for mortality during 1988-1997. The standardized mortality ratio (SMR) and 95% confidence interval (CI) was calculated relative to U.S. whites defined to have a SMR of 1.00.

**Results:** Active California Mormons practice a healthy lifestyle advocated by their religion, which emphasizes a strong family life, education and abstention from tobacco and alcohol. Unusually low SMRs occurred among married never smokers who attended church weekly and had at least 12 years of education. For those aged 25-99 years at entry, the SMR for all causes of death was 0.45 (0.42-0.48) for males and 0.55 (0.51-0.59) for females. For those aged 25-64 years at entry, the SMR for all causes of death was 0.36 (0.32-0.41) for males and 0.46 (0.40-0.53) for females. Life expectancy from age 25 was 84 years for males and 86 years for females. **These SMRs were largely replicated among similarly defined persons of all religions within the NHIS cohort.**

**Conclusions:** Several healthy characteristics of the Mormon lifestyle are associated with substantially reduced death rates and increased life expectancy.

**ABSTRACT:** Frequent attendance at religious services and mortality over 28 years

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Am J Public Health 1997 Jun;87(6):957-961. doi: 10.2105/ajph.87.6.957.

**Objectives:** This study analyzed the long-term association between religious attendance and mortality to determine whether the association is explained by improvements in health practices and social connections for frequent attenders.

**Methods:** The association between frequent attendance and mortality over 28 years for 5286 Alameda County Study respondents was examined. Logistic regression models analyzed associations between attendance and subsequent improvements in health practices and social connections.

**Results:** Frequent attenders had lower mortality rates than infrequent attenders (relative hazard [RH] = 0.64; 95% confidence interval [CI] = 0.53, 0.77). Results were stronger for females. Health adjustments had little impact, but adjustments for social connections and health practices reduced the relationship (RH = 0.77; 95% CI = 0.64, 0.93). During follow-up, frequent attenders were more likely to stop smoking, increase exercising, increase social contacts, and stay married.

**Conclusions:** Lower mortality rates for frequent religious attenders are partly explained by improved health practices, increased social contacts, and more stable marriages occurring in conjunction with attendance. The mechanisms by which these changes occur have broad intervention implications.

**Simplified Table 2 (Enstrom and Breslow 2008)**

Standardized Mortality Ratios (SMRs) and 95% Confidence Interval (95% CI) for all causes of death during 1988-1997 among the U.S. white subjects aged 25-99 years at entry in the 1987 National Health Interview Survey (NHIS) cohort for selected subgroups based on four basic lifestyle characteristics

	White males	White females
NHIS Cohort Characteristics	SMR (95% CI)	SMR (95% CI)
Entire cohort: Deaths/subjects SMR (95% CI)	982/6664 0.90 (0.85–0.96)	1195/9168 0.83 (0.79–0.88)
One characteristic (as of study entry):		
Never (never smoked cigarettes)	0.72 (0.63–0.83)	0.70 (0.63–0.79)
12+ years (12+ years of education)	0.82 (0.75–0.91)	0.77 (0.70–0.85)
Married	0.82 (0.74–0.90)	0.75 (0.66–0.85)
Weekly (attend church at least weekly)	0.78 (0.68–0.88)	0.70 (0.62–0.79)
Two characteristics:		
Never & 12+ years	0.67 (0.56–0.79)	0.65 (0.57–0.74)
Never & Married	0.63 (0.53–0.74)	0.63 (0.53–0.74)
Never & Weekly	0.60 (0.48–0.74)	0.63 (0.55–0.72)
Married & Weekly	0.67 (0.58–0.77)	0.61 (0.51–0.74)
Three characteristics:		
Never & 12+ years & Married	0.58 (0.47–0.71)	0.46 (0.37–0.58)
Never & 12+ years & Weekly	0.54 (0.41–0.71)	0.59 (0.50–0.70)
Never & Married & Weekly	0.51 (0.40–0.66)	0.52 (0.42–0.66)
12+ years & Married & Weekly	0.65 (0.55–0.78)	0.46 (0.37–0.59)
Four characteristics (“optimum”):		
Never & 12+ years & Married & Weekly Deaths/subjects SMR (95% CI)	36/557 0.47 (0.33–0.64)	41/1169 0.38 (0.28–0.52)

## Lifestyle and reduced mortality among active California Mormons, 1980–2004

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### Abstract

**Objective.** The objective is to measure the relationship of several healthy characteristics of the Mormon lifestyle to mortality.

**Method.** We examined 9815 religiously active California Mormon adults followed for mortality during 1980–2004 and 15,832 representative U.S. white adults enrolled in the 1987 National Health Interview Survey (NHIS) and followed for mortality during 1988–1997. The standardized mortality ratio (SMR) and 95% confidence interval (CI) was calculated relative to U.S. whites defined to have a SMR of 1.00.

**Results.** Active California Mormons practice a healthy lifestyle advocated by their religion, which emphasizes a strong family life, education and abstention from tobacco and alcohol. Unusually low SMRs occurred among married never smokers who attended church weekly and had at least 12 years of education. For those aged 25–99 years at entry, the SMR for all causes of death was 0.45 (0.42–0.48) for males and 0.55 (0.51–0.59) for females. For those aged 25–64 years at entry, the SMR for all causes of death was 0.36 (0.32–0.41) for males and 0.46 (0.40–0.53) for females. Life expectancy from age 25 was 84 years for males and 86 years for females. These SMRs were largely replicated among similarly defined persons of all religions within the NHIS cohort.

**Conclusions.** Several healthy characteristics of the Mormon lifestyle are associated with substantially reduced death rates and increased life expectancy.

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**Keywords:** Epidemiology; Mormons; Lifestyle; Health practices; Mortality; Longevity

### Introduction

Previous research has shown that members of The Church of Jesus Christ of Latter-day Saints, more popularly known as Mormons, are a well-defined U.S. population with low risk to mortality (Enstrom, 1975, 1989, Merrill, 2004). There are currently about 12 million Mormons worldwide, including about 6 million in the United States and about 0.8 million in California. They are interesting from a disease prevention standpoint because of Section 89 of the Church “Doctrine and Covenants,” known as the “Word of Wisdom” (The Church of Jesus Christ of Latter-day Saints, 1833). This doctrine advises against the use of tobacco, alcohol, coffee, tea, and illegal drugs, and recommends a well-balanced diet. Also, the Mormon religion emphasizes a strong family life and morality and advocates education and good health practices. Religiously active Mormons, specifically

those Church members known as High Priests, are of particular interest because they adhere strictly to the Mormon lifestyle and have done so for most or all of their lives. High Priests retain this designation for the rest of their lives.

Other health-conscious religious groups, like Seventh-Day Adventists, and frequent church attenders in general also have substantially reduced mortality rates (Hummer et al., 1999; McCullough et al., 2000). Frequent church attenders were more likely to abstain from smoking, to have good health practices, and to stay married, factors associated with lower death rates. This paper examines active California Mormons and a general population sample in order to obtain new evidence on the relationship of mortality to religious involvement in combination with several basic health practices.

### Methods

The characteristics of active Mormons were assessed by a one-time mailing of a four-page UCLA lifestyle questionnaire to each of about 12,000 California

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Table 1  
SMRs for all causes of death for entire 1979 active California Mormon cohort and “optimum” subgroup (married never smokers who attended church weekly and had at least 12 years of education), along with subgroups adhering to three additional health practices

Selected subgroups	1980–2004 deaths			
	Males		Females	
	Deaths/subjects	SMR (95% CI)	Deaths/subjects	SMR (95% CI)
<i>Ages 25–99 at entry</i>				
Entire cohort	1897/5223	0.54 (0.51–0.57)	1123/4592	0.61 (0.57–0.65)
“Optimum” subgroup	872/3340	0.45 (0.42–0.48)	777/3811	0.55 (0.51–0.59)
“Optimum” subgroup with Moderate BMI	756/2969	0.43 (0.39–0.47)	602/2988	0.52 (0.47–0.57)
“Optimum” subgroup with Moderate BMI & Reg Phys Act & Proper Sleep	558/2337	0.40 (0.36–0.44)	402/2187	0.47 (0.42–0.53)
<i>Ages 25–64 at entry</i>				
Entire cohort	885/4106	0.40 (0.36–0.44)	601/3950	0.52 (0.46–0.58)
“Optimum” subgroup	543/2951	0.36 (0.32–0.41)	456/3407	0.46 (0.40–0.53)
“Optimum” subgroup with Moderate BMI	460/2613	0.34 (0.30–0.39)	352/2665	0.44 (0.38–0.51)
“Optimum” subgroup with Moderate BMI & Reg Phys Act & Proper Sleep	341/2070	0.32 (0.28–0.37)	243/1974	0.41 (0.34–0.49)

Four lifestyle characteristics defining the “optimum” subgroup: “Never”=never smoked cigarettes; “12+ years”=12+ years of education; “Married”=married; “Weekly”=attend church at least weekly.

Definitions for additional health practices: “Moderate BMI”=moderate body mass index ( $20 \leq \text{BMI} < 30 \text{ kg/m}^2$ ); “Reg Phys Act”=regular physical activity (often or sometime engage in active sports, swim, or take long walks or often garden or do physical exercises); and “Proper Sleep”=proper sleep (usually 7–8 h per day) (2).

High Priest households with valid addresses on the Church’s computerized membership file as of about December 1, 1979. Responses were received at UCLA in late 1979 from 9815 persons aged 25–99 years (5223 High Priests and 4592 wives) (Enstrom, 1989). The address of subjects was followed by linkage with the California Department of Motor Vehicles driver license records and Internet address databases, such as, [PeopleFinders.com](http://www.PeopleFinders.com).

Deaths from January 1, 1980 through December 31, 2004 were ascertained by repeatedly matching the identifying information of cohort members with the California Statistical Death File and the nationwide Social Security Death File. A total of 1897 male and 1123 female deaths were identified by both sources. Subjects with a known address who were not identified as deceased were assumed to be alive. Based on this follow-up process, only about 2% of the subjects were lost as of January 1, 2005.

To examine persons of all religions within the general U.S. population, use was made of the Cancer Risk Factor Supplement, Epidemiology Study of the 1987 National Health Interview Survey (NHIS) (Hummer et al., 1999). The National Center for Health Statistics (NCHS) provided us with health and lifestyle data collected in 1987 on 22,080 NHIS respondents (NCHS, 1992) and with information about 2617 deaths through December 31, 1997 identified by matching these respondents with the National Death Index (NCHS, 2004). Analysis of mortality from January 1, 1988 through December 31, 1997 was conducted among the 15,872 white subjects initially aged 25–99 years.

Analyses focused on four “optimum” characteristics associated with the active Mormon lifestyle and mortality: married, never smoked cigarettes, attend church at least weekly, at least 12 years of education. These characteristics were also assessed in the NHIS cohort. Additional analyses were done

Table 2  
SMRs for all causes of death among the U.S. white subjects in the 1987 NHIS cohort for selected subgroups based on five basic lifestyle characteristics defined in Table 1

Selected subgroups	1988–1997 deaths			
	White males		White females	
	Deaths/subjects	SMR (95% CI)	Deaths/subjects	SMR (95% CI)
<i>Ages 25–99 at entry</i>				
Entire cohort	982/6664	0.90 (0.85–0.96)	1195/9168	0.83 (0.79–0.88)
One characteristic:				
Never (never smoked cigarettes)	255/2280	0.72 (0.63–0.83)	686/4815	0.70 (0.63–0.79)
12+ years (12+ years of education)	560/5226	0.82 (0.75–0.91)	645/6995	0.77 (0.70–0.85)
Married	626/4618	0.82 (0.74–0.90)	350/5114	0.75 (0.66–0.85)
Weekly (attend church at least weekly)	315/1989	0.78 (0.68–0.88)	517/3788	0.70 (0.62–0.79)
Two characteristics:				
Never & 12+ years	154/1959	0.67 (0.56–0.79)	333/3557	0.65 (0.57–0.74)
Never & Married	152/1519	0.63 (0.53–0.74)	180/2725	0.63 (0.53–0.74)
Never & Weekly	93/838	0.60 (0.48–0.74)	344/2425	0.63 (0.55–0.72)
Married & Weekly	215/1587	0.67 (0.58–0.77)	139/2196	0.61 (0.51–0.74)
Three characteristics:				
Never & 12+ years & Married	96/1306	0.58 (0.47–0.71)	88/2223	0.46 (0.37–0.58)
Never & 12+ years & Weekly	52/709	0.54 (0.41–0.71)	173/1775	0.59 (0.50–0.70)
Never & Married & Weekly	61/654	0.51 (0.40–0.66)	84/1419	0.52 (0.42–0.66)
12+ years & Married & Weekly	135/1280	0.65 (0.55–0.78)	76/1840	0.46 (0.37–0.59)
Four characteristics (“optimum”):				
Never & 12+ years & Married & Weekly	36/557	0.47 (0.33–0.64)	41/1169	0.38 (0.28–0.52)
Five characteristics:				
Never & 12+ years & Married & Weekly & Moderate BMI	30/475	0.43 (0.30–0.61)	29/875	0.35 (0.24–0.50)

involving three health practices known to have a substantial relationship to total mortality: moderate body mass index, regular physical activity, and proper sleep (Enstrom, 1989).

The standardized mortality ratio (SMR) and 95% confidence interval (CI) for all causes was calculated for the “optimum” subgroup of active Mormons. Also, SMRs for all causes have been calculated for the full active Mormon and NHIS cohorts, as well as various subcohorts defined by specific lifestyle characteristics and health practices. Calculation of each SMR (observed deaths divided by expected deaths) was done using a survival program developed by Monson (Monson, 1974; Enstrom, 1989). Expected deaths were based on concurrent death rates among U.S. whites.

## Results

Basic lifestyle characteristics of the 1979 California active Mormon cohort and the 1987 NHIS cohort are presented in Supplementary file, i.e., Appendix Table 1 for white males and Appendix Table 2 for white females. These tables are limited to persons aged 25–64 years at time of entry and included an “optimum” subgroup within each cohort, defined to be married never smokers who attend church at least weekly and have at least 12 years of education. Given the nature of the active Mormon cohort, these “optimum” characteristics have remained essentially unchanged over time.

Table 1 shows the 1980–2004 SMR for all causes of death by age at entry for the entire active Mormon cohort, the “optimum” subgroup, and the portions of the “optimum” subgroup that adhere to one and three additional health practices. The SMR for the “optimum” subgroup was 0.45 (0.42–0.48) for males and 0.55 (0.51–0.59) for females. The SMRs for those in the “optimum” subgroup with three health practices and aged 25–64 at entry were only 0.32 (0.28–0.37) for males and 0.41 (0.34–0.49) for females.

Table 2 shows the 1988–1997 SMRs for all causes of death for U.S. whites of all religions in the 1987 NHIS Cancer Epidemiology cohort. Results are shown for subgroups with one, two, three, four, and five of the following characteristics: married, never smoked cigarettes, attend church at least weekly, at least 12 years of education, and moderate body mass index. Subjects with the first four characteristics were defined to be the “optimum” subgroup. The SMRs were progressively lower for the subgroups which possessed more of the five characteristics. For the “optimum” subgroup, the SMR was 0.47 (0.33–0.64) for males and 0.38 (0.28–0.52) for females.

To translate these SMR results into life expectancy, the Supplementary file Appendix Table 3 shows abridged life tables for the “optimum” subgroup of active Mormons from age 25 (Anderson, 1999). Males had a life expectancy of 84.1 years, which was 9.8 years greater than that of 1989–1991 U.S. white males. Females had a life expectancy of 86.1 years, which was 5.6 years greater than that of 1989–1991 U.S. white females.

## Discussion

The active California Mormons examined in this study, particularly those in the “optimum” subgroup with four basic lifestyle characteristics, had total death rates that are among the lowest ever reported for a cohort followed 25 years. Also, they

had among the longest life expectancies yet reported in a well-defined U.S. cohort.

We assessed three factors that could have affected the validity of these low death rates. Ascertainment of deaths was essentially complete based on repeated matches with the California and Social Security death files and the location of almost all of those not known dead. The low death rates were not due to healthy respondent bias because the rates observed during the first 8 years have persisted for 25 years. The death rates were not unique to the active California Mormon cohort because they were largely replicated among all religions in the NHIS cohort in this paper and in an Alameda County, California cohort in an earlier paper (Enstrom, 1989).

The death rates observed among these active California Mormons were largely explained by four basic lifestyle characteristics associated with long-term “regularity of life.” These findings suggest a model for substantial disease prevention in the general population. Further examination of the specific impact of individual lifestyle characteristics and health practices is warranted given the magnitude of the mortality effects observed in this study.

## Acknowledgments

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## Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at [10.1016/j.ypmed.2007.07.030](http://dx.doi.org/10.1016/j.ypmed.2007.07.030).

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# How to Live With Covid, Not for It

By Joseph A. Ladapo

The battle against Covid-19 is entering a new phase, and the choice for society is whether to live with the virus or to live for it. This new phase has been marked by four developments: Many states have weathered post-shutdown outbreaks and case counts are falling; the percentage of Americans saying the pandemic is worsening peaked in July and is trending down, according to Gallup polling; the culture wars over lockdowns and distancing mandates are cooling; and inexpensive rapid testing and a vaccine will soon

**If reason finally prevails over panic, policy makers will reopen schools and focus on the vulnerable.**

be available widely. These developments create an atmosphere of possibility—and an opportunity to pivot away from the fear-fueled policy-making that has characterized the pandemic.

Policies forged in fear and panic have wrought tremendous damage in exchange for benefits that were attainable at a much lower cost. Over the past six months, we have managed to sow vicious conflict over health mandates among people who would otherwise be cordial; erode age-old social customs, like visible smiles and human touch, which are critical to social cohesion and personal well-being; and condemn millions of Americans to financial instability, depression and even domestic violence.

The collective goal of this new phase should be to avoid repeating the mistakes of the past. When faced in March with the choice between imposing limited shutdowns to buy hospitals time and increase capacity, and enormous, indefinite shutdowns that ignored societal and economic costs, most political leaders chose the latter. When faced in May and

June with the choice between embracing policies that balanced Covid-19 prevention with the activities that give life meaning and policies that sowed distrust and stirred fierce passions over civil liberties, most political leaders chose the latter. We have the opportunity to choose differently this time.

Some signs point toward institutions shifting away from fear-fueled decision making. The Centers for Disease Control and Prevention issued guidance last month that contacts of persons with Covid-19 “do not necessarily” need testing if they are asymptomatic. Early testing among those infected with the virus may yield false negatives, and testing vulnerable adults and their contacts is far more valuable than testing healthy young adults. The CDC now recommends focusing tests where they are likely to yield the greatest public-health benefits.

The good sense of this recommendation is so plain, it is almost stupefying. Where is the controversy in placing disproportionate energy and attention on populations that are disproportionately at risk for harm from Covid-19? Residents of nursing homes and other long-term care facilities—who represent less than 1% of the U.S. population—have comprised nearly half of deaths from Covid-19. A recent study in *Annals of Internal Medicine* reported that the infection fatality rate in noninstitutionalized persons under 40 was 0.01%, compared with 1.7% among people older than 60—a nearly 200-fold difference. Sensible policies focus special attention on populations facing the greatest harm.

The criticism the CDC has received underscores the determination of too many leaders and health officials to continue choosing fear-fueled policy-making. Consider the facts: The average Covid-19 transmission rate to close contacts is roughly 10% or 15%. The actual number of infections may be six to 24 times the number of reported cases, according to a July study in *JAMA Internal Medicine*. It would be impossible to close the wide gap be-

tween detected and undetected cases without resort to authoritarianism. It's clear that testing low-risk contacts is a low-value activity.

But critics of the CDC's new recommendation subscribe to the belief—knowingly or not—that all attempts to stop Covid-19 transmission are worthwhile, no matter how small the benefit or how high the cost. Increased public recognition of—and scientific support for—sensible policies will steer us away from destructive decisions fueled by fear.

There is also an opportunity to revisit decisions about schooling made by educational institutions at every level. College administrators in Ohio are expending substantial energy trying to stop young people from socializing; high schools in Georgia are being pushed toward closure due to mass quarantining; and intricate plans are being drafted for young children—for whom the virus is less harmful than seasonal influenza—in districts such as Los Angeles.

Placing disproportionate focus on Covid-19 transmission in low-risk populations leads to unwise decisions that do more harm than good. A wiser investment would focus on protecting vulnerable populations, including older teachers, family members and essential employees, by directing testing and personal

protective equipment to them and their close contacts. Early outpatient therapies for Covid-19 may also prevent serious illness in these populations, as described in a recent *American Journal of Medicine* article.

The CDC's quarantine guidelines for healthy, low-risk students should be revisited in light of the outsize effect quarantines have on their educational experience—and the possibility of perpetual quarantining for exposed students if testing is performed frequently. University policies for Covid-19 prevention also have an edge of cruelty: Many of these administrators suspending students “caught” socializing would have been doing the same 30 or 40 years ago.

The point of life is living, and everyone is better off with policies that focus on protecting the most vulnerable populations. That doesn't take universal rapid testing or never-ending mandates. It requires only abandoning fear, being sensible about who is targeted for testing and protections, expanding treatment capacity and therapies—and choosing to live with the virus, rather than to live for it.

*Dr. Ladapo is an associate professor at UCLA's David Geffen School of Medicine.*

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