Scaring Ourselves to Death

As a child, I was hospitalized for a month with the "Hong Kong Flu." The doctors couldn't cure me; I was discharged but still sick. They were surprised I recovered. From my early brush with illness, I developed a longstanding interest in why some people with possibly fatal illnesses die and others recover.

As an academic who's studied the history of medicine, I've come to realize that my survival stemmed, in part, from the fact that I wasn't afraid of dying. An early case of the 1968 flu, mine preceded the hysteria that came later, with a full-blown epidemic. I didn't know anyone who'd died. Also, quarantine hadn't yet begun: my mother could stay with me in the hospital; her company cushioned me from the terror patients often experience when isolated in unfamiliar surroundings.

There is progress on Covid-19 vaccines, but, meanwhile, cases soar. Until we distribute vaccines, our best defenses against serious Covid-related illness and death are infection avoidance and, if we are infected, our disease-fighting immune systems. Public policy has focused on the former (masks, social distancing, lockdowns), and relatively little attention has been paid to natural immunities and what we can do to keep ours in fighting trim. Worse still, policy may well have worked, recklessly, to undermine immune health, and this has had lethal consequences, especially for African-Americans.

Doctors know that many Covid-related fatalities are not caused by the virus itself, but by immune system overreaction, in which virus-fighting cells mistakenly attack healthy organs. This is especially common in mortality cases of healthy, younger patients. Doctors do not know what causes such overreactions.

Sixty years of testing has, however, established a connection

between stress and immune-system dysfunction, including overreaction. Close reading of comparative medical data suggests we should explore this connection more fully.

Much has been made of the fact that African-Americans have died from Covid-19 at nearly twice the rate of whites. (Were the rates comparable, a staggering number of additional white Americans—105,000—would now be dead.) General health and access to quality health care may not explain the disparity. No one would argue that black Americans were generally healthier or had greater access during the 1910s at the height of the Jim Crow Era (and, indeed, from 1911-17, black mortality rates from influenza were higher than white ones). Yet the black fatality rate during the 1918-19 Spanish Flu epidemic was *less* than that of whites.

Perhaps this is because segregation—which kept black patients from white hospitals or their state-of-the-art units—also spared them the unintended consequences stemming from an overtaxed medical culture whose practitioners were battling a frightening new virus they did not fully understand.

African-Americans sick with Spanish Flu received substandard treatment in segregated hospitals—housed in close quarters—or in black-only hospitals with limited space. Jim Crow, that is, blocked black Americans from hospitals where isolation in quarantine and anxious medical workers may well have wreaked havoc on patients' nervous—and immune—systems.

A variety of 19th century doctors observed that panic could be a disease accelerant. Some cancer surgeons observed that patients' tumors enlarged in a matter of hours upon learning of cancer diagnoses in the area—and panicking about their own cases. At least one Spanish Flu-era doctor observed that pandemics prompt fear and that panic in an ill person can have physiological— sometimes lethal—effects:

> *Patients died who were not very sick. Vigorous… young fellows*

> *of nineteen and twenty turned over and died because they had lost their courage, because other people were dying…. It was always so in an epidemic; patients died who, had they been isolated cases, would have recovered.*

The passage, from Willa Cather, is based on observations by a US Army doctor.

This sounds incredible to us, but it may clear up the greatest mystery about the Spanish Flu: the death rate was highest for people in the prime of life. Adults 18-40 were psycho-neurologically vulnerable because of war and mobilization: already haunted by casualties in their age group, they often found themselves getting influenza during an outbreak in groups of their peers, in army camps and on transport ships. Nursing home residence during Covid, which is a greater risk factor for death than age, is comparable.

Finally, as Clifford Adams, a Jim Crow-Era black Philadelphian who lived through the epidemic, reflected, "There wasn't a lot of comforts in those days." Many African-Americans lived in extreme poverty, some in fear of lynching, and all experienced discrimination. Occupied with ongoing threats, black people could not afford to focus on being sick with a novel flu. In this respect, they were like today's slum dwellers of Mumbai whose hand-to-mouth existence is menaced by lockdowns—and whose Covid death rate is unexpectedly low (the infection fatality rate in New York City is 6 times Mumbai's): the more immediate terrors trump the fear of illness.

With Covid, black patients have the worst of both worlds: many expect to—and often do—receive second-class treatment in first-rate hospitals, where they are also exposed to pandemic-related panic that's seized American medical facilities. The news is filled with reports from doctors who have limited ways to combat a new virus that, despite its structural similarity to other coronaviruses, has inexplicably powerful and variable

effects.

Remove sanctioned panic from the experience of Covid, and, as statistical and anecdotal evidence from other pandemics and around the world suggests, we have deprived the virus of a potency it simply doesn't have on its own, even when it comes to the old and immune-compromised. As virologist Angela Rasmussen writes in *The Guardian*, "Our immune systems are mostly responding to this virus the way we'd expect." "Our search for functional immunity to Sars-Cov-2 is less a biological quandary than a psychological one." The CDC's Covid-19 age-specific survival rates (the percent of the infected that survive) substantiate that our immune systems are working and our fears are overblown:

- Age 0-19 – 99.997%
- Age 20-49 – 99.98%
- Age 50-69 – 99.5%
- Age 70+ – 94.6%.

We are in a vicious cycle. People thinking that, regardless of age, they are liable to die if they get Covid, leads to panic if they become ill or get a positive test. In turn, panic likely leads to some unnecessary Covid deaths among all age groups, accelerates the death rate in socioeconomically disadvantaged communities, and fuels chronic or "long-haul" coronavirus illness. We need to turn down the fear.

This article was republished from the American Institute for Economic Research.

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