September 24, 2021

To: The Wabash Community

From: President Scott Feller

Re: Articulating Goals

Thanks to all who read and commented on my last message about how we use data in our decision-making. I realize it was long and it required careful reading. I will keep this shorter, but can't promise the topic is any less challenging. As I wrote previously, the questions we are facing now are tougher to answer than those we addressed earlier in the pandemic. For example, whether or not we all should get vaccines is a much easier question to answer than whether or not we should all get boosters.

I think that one of the barriers we face in answering these tough questions is that we often don't have a shared understanding of what our goals are for COVID-19 mitigation. This is at the center of the recent conversation at the FDA and CDC around booster shots.

While I haven't read the entire application packet, I have seen some of the key papers and summaries of the data making the case for boosters. Pfizer and many independent scientists point to laboratory data on waning antibody levels that can be effectively raised with a third shot. Their position is supported by both randomized studies showing a gradual decline in vaccine efficacy and observational studies showing that a booster dose reduced infections and hospitalizations for those age 60 and over.

There is also significant resistance to the booster plan – or at least to any plan that includes low-risk individuals – from many public health scientists, including top FDA officials. There are concerns about equity, specifically that Americans would be receiving a third dose while much of the world has no access to vaccines, and differing interpretations of the sometimes-conflicting studies on vaccine efficacy over time. But beyond the ethical and scientific considerations, I believe that much of the disagreement revolves around different views of the *goal* of COVID-19 vaccination.

If the goal of the vaccination program is to eliminate infections, then the argument for boosters is much stronger. While eliminating infections sounds like a sensible goal, most epidemiologists now consider it unrealistic and argue that the goal should be to *reduce severe disease* that could lead to hospitalization or death. They often point out that antibody levels do not equate to immunity against severe disease, and that while waning antibody levels may be associated with more frequent breakthrough infections, these are typically mild or asymptomatic.

I am not sure what our goal is as a nation and I am glad I don't have to decide the questions about how resources are allocated toward one goal or the other. I suspect the FDA and CDC will land on boosters for only the older population based on the age dependence of vaccine effectiveness that I described in my last message, i.e., they will weigh the disease goal heavily. But perhaps the desire to reduce infections and reduce anxiety will lead them toward an infection reduction goal and widespread boosters. And maybe this will stimulate discussion on what our goal should be as a country.

I have heard from some people that on campus “the goalposts keep moving.” To continue the football analogy, I would argue that it is the first down markers that keep moving as we make progress toward our goal, which always has been to **provide a full residential college experience**. But I acknowledge that I haven’t commented as much on the top-level goal; instead, I have focused on getting us to “another Wabash College first down!” It is probably also worth noting that zero COVID cases never has been and likely never will be part of our institutional goal (though it sure felt great to not have any positive tests the last two weeks).

We should remember that in the earliest days of the pandemic we could NOT achieve the goal of residential education. In the spring of 2020, little was known about the virus. The risk that students, faculty, and staff would fall ill in large numbers, potentially burdening our local health care systems, was such that we had to pivot to virtual classrooms. By that fall, with what we knew about the relatively low risk of severe disease for the majority of our campus, and with numerous tools to further mitigate transmission, it was reasonable to attempt residential education. And with a universally vaccinated campus this fall, risk is reduced for most to a point comparable to seasonal flu or the activities we engage in daily such as traveling by automobile.

What needs to happen for us to continue to achieve our residential education goal? For one, we must keep case numbers low enough on campus that we don’t exceed our capacity to provide isolation housing. A second element is for the community to feel sufficiently safe to effectively teach, learn, and live together. This is challenging to address because personal risk assessment varies dramatically among the vaccinated. We should all be sensitive to these differing levels of comfort, for example by wearing a mask when someone asks you to do so (or by taking their wearing of a mask as a signal that it would be appreciated if you would do the same).

I want to conclude by sharing a thought-provoking essay from the *New York Times* written by a pair of public health scientists from Harvard and Boston universities. The essay raises tough questions, in particular, how do we make decisions on when and how to roll back mitigations that have been helping us meet our COVID goal? I know it is a question we must work to address as some of these practices have an impact on our core activities here at the College.

Scott Feller