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Playing in the Sandbox of Medical/ Scientific Publishing

I appreciate the many papers the AAPS Journal has published about COVID-19 and vaccines, including mine.[1] Most medical journals rejected such articles on vaccine adverse reactions, at a time when stopping the vaccine rollout could have made a huge difference. Why? Possibly relevant is the observation that during World War II, the world's largest scientific publishing house (Butterworth) was owned by British intelligence (MI6), and the intelligence services have continued to control/ influence publishing since that time.

So, what information is allowed to be published? We are far from the days of the seasoned physician scientist making organized observations at the bedside. We give no credence to bedside acumen, decades of clinical practice, or even to clinical case research. "Case Reports and Review of the Literature," with direct, real-life observations, are gone. They are considered "poor quality evidence." No number crunchers were employed, and the papers were too easy to read.

I was asked to peer review a paper providing a long and highly technical critique of the Pfizer vaccine research. The authors rigorously rebutted Pfizer's claims, for example of 95% efficacy. I recommended publication, but couldn't help noting that Pfizer's gruelingly detailed statistical analysis might bamboozle even doctors into thinking that vaccine usefulness has been proven by such means. As a renegade professor of Orthopaedics once said, "If it takes 10 statisticians to prove something works—it probably doesn't." Economic pundit Max Keiser describes financial sleight of hand as "complexification and crapification"—terms that apply aptly to most medical articles today.

A doctor from 1890 might point out that the real question is: "Did the vaccinated population survive more than the unvaccinated? Or not?" Neither the paper I reviewed nor the paper they were rebutting answered that simple question.

The FDA's summary of the Pfizer study—the emergency use authorization document (EUA)—claimed that the vaccine was 95% effective in preventing COVID-19 disease among clinical trial participants, with eight COVID-19 cases in the vaccine group and 162 in the placebo group. That may sound effective, but these are very few of the more than 40,000 participants in the EUA study. And, they chose a 19 day window of observation beginning after the first week (when they considered the vaccine to be ineffective). Of course, we now know that deaths and other side effects began immediately, and are occurring more than a year later. From the irreverent novel *The House of God*: "If you don't want to find a fever, don't take a patient's temperature." Or, "WNL = We Never Looked."

This insular, statistical approach to assessing medical effectiveness is like playing war in a sandbox: "don't go outside the box," "no sand in each other's eyes," "six people in the box at a time," etc. It's a great game, but it bears no relationship to real warfare.

In the real world of medicine, does anyone care about 19 days? We want to know whether treatments will prolong life or decrease suffering. Outside the sandbox in 2023, all-cause mortality, which usually varies 0.1% year to year, is up 40-82% in working age groups and 3% in infants. An insurance company board member told me that actuaries are literally not reporting death data to the insurance companies who pay them. In New Zealand, with the worst batches of Pfizer vaccine, death rates ranged from 4.52% to 21.38%.[2]

You will not see this in peer-reviewed medical publications, official websites, or mainstream news. Late cancers, infertility, miscarriages, neurological impairments, and the loss of the equivalent of 10 professional soccer teams to unexplained "Sudden Adult Death Syndrome" are not reportable in the sandbox rules.

As Nikola Tesla said, "The scientists of today think deeply instead of clearly. One must be sane to think clearly, but one can think deeply and be quite insane."

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