

# U.S. Pandemic Response

Jane M. Orient, M.D.

In the event of a public health emergency, the U.S. federal government is supposed to work together with state and local authorities to supply needed information and laboratory support, help protect against contagion, and provide needed supplies and personnel. The COVID-19 pandemic has exposed many weaknesses and vulnerabilities.

The four pillars of pandemic response are: (1) contagion control; (2) early treatment; (3) hospitalization; (4) vaccination to assist with herd immunity.<sup>1</sup> As McCullough et al. observe, many countries have operationalized all four pillars, including the second pillar with distributed medication kits of generic medications and nutritional supplements to be used at home. This pillar could be augmented with prophylactic drug treatment. In the U.S., Canada, United Kingdom, Western European Union, Australia, and some South American countries, the other three pillars are relied on almost exclusively.

Intense political controversy has surrounded this discussion, with attempted censorship of “harmful misinformation,” as determined by “trusted” authorities. Some venues insist on prominent display of links to official advice, such as the Centers for Disease Control and Prevention (CDC): [cdc.gov](https://www.cdc.gov). Since many physicians will dismiss without consideration any information from a source tarred with an “anti-vax” label, one must state from the outset that AAPS does not oppose vaccination. AAPS does not endorse or oppose specific measures but favors medical interventions, including drugs, surgery, vaccines, or other modalities that have benefits exceeding risks in an individual patient, to which the patient has given informed consent.

## Contagion Control

Local and state public health agencies always defer to the CDC. It is important to consult CDC and local rules and regulations frequently, as they change frequently, and penalties for noncompliance may be draconian. Physicians may be reported to the health department or licensure board by patients or employees if they deviate from masking or other mandates.

Enforcement is based not on outcomes measures related to actual safety but rather on following rules that may be arbitrary and even counterintuitive. Gatherings may be limited to 10, 30, or 50 persons, with no rationale as to why 10 persons are safe, but not 11. Gyms in Tucson, Ariz., were required to install no-touch water faucets, but recently were required to disable them, under threat of fines or closure, so that clients could not refill their water bottles on site.

## Masks

Mask recommendations have varied greatly. Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Disease (NIAID) since 1984 and effectively the current COVID

information chief, changed his recommendations several times in 11 months. In March 2020 he said that masks were not necessary, but in May 2020 said that they were. They are still needed after vaccination, he said in September 2020, and he recommended double masking in February 2021, when he also said that masks would be necessary until COVID-19 is “not a threat at all.”<sup>2</sup>

At first, it was frequently said that “my mask protects you, and your mask protects me.” This seems to have fallen out of favor, but it helped perpetuate the notion that wearing a mask is a selfless act, and declining to wear one an antisocial act that threatens others. There is no point in masking a person who is not shedding COVID virus, say one who has recovered from COVID-19 or is in an age group that is unlikely to transmit virus, i.e., children. Persons who are incubating or suffering from COVID shed virus from the respiratory tract for a limited period, perhaps 10 days,<sup>3</sup> so very few people are contagious at any given time. Since we don’t know who they are, the policy is to mask everyone, with little to no consideration of adverse effects. If asymptomatic spread is likely, then every breathing person may be seen as a potential threat.

One meta-analysis reported a very low risk of transmission from asymptomatic vs. symptomatic household contacts (0.7% vs. 18%), but the number of cases was small.<sup>4</sup> An editorial in *BMJ* stated that transmission from asymptomatic persons was three to 25 times less than from symptomatic persons, and referenced a study of 10 million people in Wuhan that found no evidence of asymptomatic transmission.<sup>3</sup>

“Searching for people who are asymptomatic yet infectious is like searching for needles that appear and reappear transiently in haystacks, particularly when rates are falling.”<sup>3</sup>

But according to a model developed by CDC researchers, more than half of all COVID-19 cases transmit from people who don’t have any symptoms.<sup>5</sup> This is used as the rationale for universal masking and widespread testing of healthy people.

There is clearly a double standard about “evidence-based medicine” for masks as well as other contagion-control measures as compared with early treatment recommendations. Evidence supporting the effectiveness of masks for controlling respiratory infections is weak and conflicting.<sup>6</sup> It is readily shown that by coughing or speaking or singing or perhaps even breathing people emit a cloud of droplets, and droplets can be stopped by masks. One can certainly observe that one’s mask becomes damp after wearing it for a time. Many viruses are small enough to pass through a mask, but most viruses are attached to droplets. Droplets may be blocked—or they can leak around the edges of a mask.

Persons most in need of respiratory protection are of course those caring for infected patients. The government role in pandemic preparedness should involve stockpiling emergency supplies, but these were woefully lacking early

on. The protective gear depleted in the 2009 H1N1 influenza epidemic, including 100 million masks, was not replaced,<sup>7</sup> and our supply lines were outsourced to China. Then the Food and Drug Administration (FDA) blocked the use of technology for sanitizing N95 masks for reuse.<sup>8</sup> N95 masks alone are not adequate for high-risk, aerosol-generating procedures. Eye protection as well as powered air-purifying respirators (PAPRs) are needed. CDC now posts considerations for optimizing the supply of PAPRs.<sup>9</sup>

### Disinfectants

Handwashing of course must be constantly mentioned. As Ignasz Semmelweis demonstrated in the 19th century, simple handwashing greatly reduced the incidence of childbed fever. But how much is enough? At some point, skin damage makes repeated sanitizing counterproductive. Yet microorganisms are still found on surfaces even with conscientious adherence.

“Deep cleaning” is demanded, and the New York City Metropolitan Transit Authority (MTA) estimates that its annual COVID-related sanitation costs will be close to \$380 million. The MTA asked the federal government for advice on whether to focus solely on aerosols rather than surfaces, but was told to concentrate on fomites. By the end of 2020, global sales of surface disinfectants totaled \$4.5 billion, an increase of more than 30% over the previous year.<sup>10</sup>

Virus can be recovered from surfaces for a long period of time. Researchers swabbing hospital rooms and quarantine facilities found that the virus could be lurking everywhere, for example, on personal items such as reading glasses and water bottles. But what is the evidence that touching surfaces transmits disease? Studies have used conditions that do not apply outside the laboratory; they may have started with huge amounts of virus. And while viral RNA may be detected, this might be the equivalent of finding “the corpse of the virus.” Studies using the common cold rhinovirus suggest that transmission by touching objects is very unlikely to occur.<sup>10</sup>

Thus, a *Nature* editorial opines, “Now that it is agreed that the virus transmits through the air, in both large and small droplets, efforts to prevent spread should focus on improving ventilation or installing rigorously tested air purifiers.”<sup>11</sup> It is, however, easier to clean surfaces than to improve ventilation, and consumers have come to expect disinfection protocols.

A generally disregarded source of infected aerosols is toilet flushes.<sup>12</sup> Viable coronavirus may persist in the gastrointestinal tract much longer than in respiratory secretions.<sup>13</sup>

### Effectiveness

The U.S. has fared badly in this pandemic. According to Theresa Cullen, M.D., M.S., the director of the Pima County (Ariz.) Health Department, the U.S. has just 4% of the world's population, but a quarter of its confirmed COVID-19 cases and deaths. She states that “Americans must get vaccinated to begin to live safely again”—although they must still wear a mask: a tacit acknowledgement that the mask, social distancing, and handwashing requirements have not been successful in controlling the pandemic. Dr. Cullen also acknowledges that the social, emotional, and academic catastrophes from the pandemic have been extreme, but she does not attribute any of these to the public health response to the pandemic.<sup>14</sup>

Statistics on case incidence and deaths from various

jurisdictions with varying regulations on contagion control show little support for the efficacy of mask mandates or lockdowns.<sup>15</sup> The states of New York and California, for example, with very severe control measures are doing worse than Florida or South Dakota—or Sweden and Belarus.<sup>16</sup> Of course, there are many confounding variables, such as age, population density, and unreliability of reporting. Depending on the jurisdiction, mandates may be tightened or liberalized based on the percentage of positive tests in a particular jurisdiction. However, the prevalence of disease in the population tested is not considered, nor is the cycle threshold of the polymerase chain reaction (PCR) test or the sensitivity and specificity of other tests that might be used. The rate of positive tests, and the percentage of those that are false positives, are critically dependent on the prevalence of disease in the population being tested.

Assessing the progress of the pandemic depends critically on reliable diagnosis.

### Diagnosis and Tracking

A key responsibility of the CDC is to provide laboratory support and expertise on diagnoses, and statistics on the distribution and incidence of disease. The U.S. was criticized for lagging behind on testing in the early days, and there are growing questions about the reliability of the reports that have been at the top of the news for months.

On Jan 23, 2020, Germany's equivalent of Dr. Tony Fauci, Dr. Christian Drosten, along with colleagues from the Berlin Virology Institute and the head of a small Berlin biotech company, published a study in the scientific journal *Euro Surveillance* from the EU Center for Disease Prevention and Control, which claimed to have developed the first effective test for detecting infection with the novel coronavirus identified only days before in Wuhan, China. The paper was immediately endorsed by Director General Tedros Adhanom of the World Health Organization (WHO), and was published at warp speed: submitted on Jan 21, 2020, accepted on Jan 22, and published online on Jan 23. WHO had recommended the worldwide test even before the paper was published. On Jan 21, the worldwide total of deaths attributed to the Wuhan virus was six.

Although the standard operational protocol for the Drosten PCR test is 30 cycles as a maximum reasonably reliable cycle threshold (Ct), WHO and Dr. Drosten recommended a Ct of 45 cycles, as did German health officials. Had a maximum Ct of 35 been specified, the number of coronavirus-positive tests would be less than 3% of the number that was given.<sup>17</sup> An external peer review by 23 scientists, including some who have patents related to PCR or DNA isolation and sequencing, and a former Pfizer chief scientist, identified numerous flaws in the article. They concluded that “an analytical result with a Ct value of 45 is scientifically and diagnostically absolutely meaningless.”<sup>18</sup> Nonetheless it is the foundation for the testing that guides draconian public health control measures.

The panic leading to the original lockdown was not guided by actual testing but by epidemiologic computer models that predicted wildly unlikely fatalities from the coronavirus. On Mar 30, the infamous Imperial College London model predicted 2.2 million deaths in the U.S. by Sept 1 without government action. That prediction was absurd, given the dispersal of the U.S. population and the fact that China's coronavirus death

toll had reportedly already leveled off at a few thousand. The authors of the study soon revised it radically downward, but too late, as it had already become the basis for the exercise of unprecedented government power.

“Never before had public officials required millions of lawful businesses to shut their doors, throwing tens of millions of people out of work,” writes Heather MacDonald of the Manhattan Institute. Arbitrary distinctions were made between essential and nonessential businesses. Wine stores and marijuana dispensaries were deemed essential, whereas surgery centers were required to close and hospitals had to cancel “non-essential” operations. Large grocery stores got the green light, but small retail establishments with only a few customers each day were shuttered. Michigan Governor Gretchen Whitmer even used her red pen within megastores to bar the sale of seeds, gardening supplies, and paint.<sup>19</sup>

Nursing home residents represented more than 50% of the coronavirus death count in many counties, and 80% in several states, yet everyone was assumed to be at equal risk. Although the U.S. death toll was demographically circumscribed in this way, whole industries saw their capital wiped out overnight. “Science” supposedly dictated the timetable for reopening, based on rates of hospital bed vacancies and new infections, but the benchmarks seemed to have been drawn out of a hat.<sup>19</sup>

MacDonald states that “the collapse of government legitimacy is complete.... For three months, public officials abdicated the responsibility to balance the cost and benefits of any given policy. They put the future of hundreds of millions of Americans in the hands of a narrow set of experts who lack all awareness of the workings of economic and social systems, and whose internal ‘science’ was built on the ever shifting sand of speculative models and on extreme risk aversion regarding only one kind of risk.”<sup>19</sup>

Now that millions of lives and livelihoods lie in ruins, WHO has changed its COVID testing criteria. In what some have suggested is politicized timing, the protocol for COVID-19 test was changed just one hour after Joe Biden was sworn as President of the United States. This will result in a large decrease in the number of confirmed cases.

WHO warned about the high risk of false positives and that “the cycle threshold (Ct) needed to detect virus is inversely proportional to the patient’s viral load.” Also, “as disease prevalence decreases, the risk of false positive increases,... irrespective of the claimed specificity.” WHO now calls the PCR test “an aid to diagnosis”—not a definitive confirmatory test.<sup>20</sup>

The death rate is of far more serious concern than the total count of cases. But this too depends on accurate diagnosis. One study contends that the CDC inflated the COVID numbers by 1,600%.<sup>21</sup> It states that CDC “illegally enacted new rules for data collection and reporting exclusively for COVID-19”: on Mar 24, 2020, the CDC published an alert instructing medical examiners, coroners, and physicians to deemphasize the underlying causes of death. COVID-19 was to be listed in Part I of death certificates as the definitive cause of death, regardless of confirmatory evidence, rather than in Part II as a contributor to death in the presence of preexisting conditions. Thus, just 6% of the people counted as COVID deaths died of COVID-19 alone.

*The National File* concludes that the CDC “significantly inflated data that has been used by elected officials and public health officials, in conjunction with the unproven projection

models for the Institute for Health Metrics and Evaluation (IHME), to justify extended closures for schools, places of worship, entertainment, and small businesses, leading to unprecedented emotional and economic hardships nationwide.”<sup>22</sup>

Comparisons between countries using different national data with different definitions are extremely problematic. “The fog of pandemic chaos has even engulfed the most basic and best-understood of all outcomes: death.” In the UK, Prof. Carl Heneghan and Dr. Tom Jefferson ask, “Are we looking at deaths by Covid? Deaths with Covid? Or even deaths post-Covid?” They note that one study shows that nearly a third of all COVID-19 deaths recorded in July and August might have actually been the result of other causes—cancer, for example, or road traffic accidents. In September 2020, they state that COVID-19 accounted for an average of 11 of the 1,687 deaths in Britain every day. In comparison, 124 people died from flu and pneumonia; 460 from heart disease; and 450 of cancer. There were on average 15 deaths from suicide every day. Testing data are so poor that they do not include the proportion of positive tests that were done on asymptomatic persons or the date at which the symptoms began.<sup>23</sup>

Not only are the statistics controversial, but “the dreadful daily drumbeat of COVID-19 data” is unprecedented. Before COVID-19, ordinary people would almost never see data in the raw forms that are being promulgated now before they can be carefully reviewed and validated. In July, the CDC was still collecting, cleaning, and revising data on deaths from early May. This is not because of incompetence or malicious intent. Days of panic have resulted from accepting a first draft without skepticism, writes Matt Shapiro, an engineer and data-visualization expert.<sup>24</sup>

### **Neglected Contagion Control Methods**

Notably, most of the mandated measures involve control of human behavior, rather than control of the virus, such as by engineering modifications in the environment, or individual actions to strengthen immunity or reduce infective dose. These interventions could also be of widespread utility against other pathogens, including antibiotic-resistant bacteria.

Engineering solutions, especially clean water and sanitation—not vaccines—have been responsible for stopping most epidemics and for most increases in life expectancy. But “for air-borne viruses, we have created the equivalent of cities with contaminated water and sewage running down the streets,” stated environmental and earth scientist James Conca. Air-purifying technology, including upper-air germicidal ultraviolet light, which was a key strategy in the tuberculosis era, is available.<sup>25</sup>

The CDC’s classroom guidance would keep 90% of schools at least partially closed, according to CNBC journalist Will Feuer.<sup>26</sup> There is no evidence that keeping desks six feet apart will reduce already tiny transmission rates. The policy of having children come to school only two to three days per week so that these distances can be enforced is likely not of much help for parents who need to work full-time. Dr. Leana Wen, former Baltimore Health Commissioner, noted that the CDC’s guidance omitted any ventilation measures. It does advise improving ventilation to the extent possible, as by opening windows and doors. However, there is no guidance on portable air filtration systems or suggestions on overhauling schools’ heating, air

conditioning, and ventilation (HVAC) systems.<sup>26</sup>

Numerous protocols are available for nutritional supplements; c19protocols.com is curated by AAPS. Iodine has been shown to be an effective disinfectant on mucous membranes. In a Bangladeshi randomized controlled trial with 606 subjects, the use of 1% povidone iodine in eye/nose drops and mouth gargle reduced COVID-19 hospitalizations by 84% and mortality by 88%.<sup>27</sup> Other nasal sprays, which use xylitol or carrageenan, also appear to be effective.<sup>28</sup>

### Early At-Home Treatment

COVID-19 can be a devastating disease, with a shockingly high in-hospital mortality. The second pillar of pandemic control is to treat early, which is part of the plans to deal with virtually all diseases—except COVID-19.

The federal government maintains a Strategic National Stockpile (SNS) to supplement state and local medical supplies and equipment during public health emergencies. The supplies, medicines, and devices for lifesaving care contained in the stockpile can be used as a short-term, stopgap buffer when the immediate supply of these materials may not be available or sufficient.<sup>29</sup> Items that it contains include smallpox vaccine, nerve gas antidotes, Tamiflu™, antibiotics, and other essential drugs. Early in the COVID-19 pandemic, manufacturers donated about 100 million doses of hydroxychloroquine. AAPS sued FDA in a so-far-unsuccessful attempt to get the stockpile released to treat COVID-19 patients.<sup>30</sup>

This second pillar has not only been neglected, but actively suppressed,<sup>31</sup> as discussed in two Senate hearings,<sup>32,33</sup> with the likely consequence of 100,000 or more preventable U.S. deaths.

### Hospitalization

The SNS contains items to augment hospital supplies. A surge capability for hospital beds and recruiting additional personnel is an essential part of a robust pandemic response plan. Despite billions of dollars expended, little has been achieved.<sup>34</sup>

Hospital trains were developed by the British in the late 19th century, and by the outbreak of World War I, state-of-the-art hospital trains were in operation. The Disaster Train<sup>35</sup> would be a rapidly deployable method to respond to pandemics as well as all types of mass casualties. It could include Biosafety Level-4 cars—another idea that lies fallow.

Fortunately, despite much concern about overwhelming hospitals and undoubted severe stresses in some places, the most dire scenarios have not occurred—yet.

Radical changes have occurred in the way hospitals treat patients and their families.<sup>31</sup> Segregation and constant testing, unthinkable for AIDS, are now routine.

### Vaccination

The fourth pillar is the one that is touted by authorities as the one thing that can end the pandemic and restore some sort of normality. This would be the first viral pandemic in history to be ended by a vaccine, save smallpox—and that took about a century. From time immemorial, humanity has faced outbreaks of infectious disease. These threats came, often devastated

populations, and then disappeared when the pathogens ran out of susceptible hosts. Sometimes the epidemic would reemerge months, years, or even centuries later, as smallpox did.

For this one illness, COVID-19, there is an unprecedented massive effort to vaccinate almost the entire population of the world as quickly as possible, and to severely constrain the liberty of the nonvaccinated. Media giants suppress negative information about the COVID-19 vaccines now being rapidly deployed under an Emergency Use Authorization (EUA), none having yet been fully approved (and licensed) by FDA. From the AMA's messaging center, physicians can download talking points and learn the AMA's positions, e.g., on eliminating non-medical exemptions for vaccines.<sup>36</sup>

AMA president Susan Bailey, M.D., sent a mass e-mail stating: "The research is alarming. More than 30 percent of Americans are hesitant to get a COVID-19 vaccine, due to misinformation and distrust. Fortunately, experience has shown us that patients trust their physician's recommendations, so we have a unique opportunity to educate them."

### Conflicts of Interest

One of the most powerful proponents of universal vaccination is Bill Gates, whose qualifications for this role are worth reviewing. With the late Paul Allen, he founded the trillion-dollar software behemoth, Microsoft. At its 18-month-long antitrust trial, which began in May 1998, Microsoft was accused of trying to create a monopoly that led to the collapse of the rival internet browser Netscape by giving its browser software for free. Gates gave hours of videotaped testimony,<sup>37</sup> during which he frequently responded, "I don't recall." To rehabilitate his tarnished public image, he founded the Bill and Melinda Gates Foundation (BMGF), to which he contributed \$20.3 billion dollars. The BMGF is the world's largest private foundation, with more than \$50 billion dollars in assets. It is the second largest donor to WHO next to the U.S. According to the *Washington Times*, WHO did not announce the coronavirus to be a pandemic until the day after Gates made a very large donation to a cause that benefits WHO.<sup>38</sup>

Gates is actively involved in the "solutions," with investments in vaccines and contact-tracing technology. The BMGF pledged \$750 million as the "seed money" to set up the Global Alliance for Vaccines and Immunization (Gavi), whose partners include certain countries, the Bill and Melinda Gates Children's Vaccine Program, International Federation of Pharmaceutical Manufacturers Association, Rockefeller Foundation, United Nations Children's Fund, WHO, and the World Bank. The Gavi board is comprised of representatives from "Big Pharma."<sup>39</sup> Requiring proof of vaccination is envisioned as an opportunity to establish a digital identity program controlled by Microsoft and Gavi.<sup>40</sup>

Another advocate of mass vaccination is German Chancellor Angela Merkel, whose government is advised by Bill Gates.<sup>17</sup> She stated at the G7 Summit that the pandemic is not over until all the people in the world are vaccinated.<sup>41</sup>

### Vaccine Safety and Efficacy

As of Feb 12, more than 35 million Americans have received COVID-19 vaccines, but the FDA's promised monitoring system, known as BEST, is still in its developmental stages. It probably won't be capable of analyzing safety data for weeks or months,

by which time 100 million may have been vaccinated, according to numerous federal health officials.<sup>42</sup>

Thus, FDA is relying on already established tracking systems. Officials claim that “so far, few serious problems have been reported through these channels and no deaths have conclusively been linked to the vaccines. The 30-year-old initiative, known as the Vaccine Adverse Event Reporting System, or VAERS, relies on self-reported cases from patients and health care providers.”<sup>42</sup>

Yet, deaths have occurred. Former *New York Times* reporter Alex Berenson posted his review of VAERS data on Twitter. He stated that there were 21 deaths reported after 180 million influenza vaccinations, or one death in 9 million, which is plausibly coincidental, and one death per 35,000 COVID shots or 19,000 completed vaccinations. That would mean a person is 300 to 900 times more likely to die after receiving a COVID vaccine than a flu vaccine.<sup>43</sup>

Dr. Harvey Risch notes that if all U.S. deaths occurring after vaccination were “ones that would have occurred naturally anyway,” we would expect to see approximately the same numbers of deaths each day after vaccination. However, here is what the VAERS showed around Feb 19: on day 0, there were 138 deaths; day 1, 147; day 2, 76; day 3, 49; day 4, 43; day 5, 35; day 6, 24; day 7, 21; day 8, 16; day 9, 17; days 10-14, 61 or 12.2/day; days 15-30, 66 or 4.1/day. It is apparent that there is a background mortality of no more than about 4 deaths/day in people who have been vaccinated so far, and that in these 693 deaths within 30 days of vaccination, about 120 would be the baseline, leaving 573 deaths caused by the vaccines.

To replicate these results, go to <http://vaers.hhs.gov/data.html>. Click “D” and “open,” then “deaths,” “Covid-19 vaccines,” all locations, and then individually choose days after vaccination. Do it 12 times to get all of the numbers (Risch H, unpublished observations, Feb 20, 2021).

Reports from the British Yellow Card system show that as of Feb 22, there were 77,207 reports on the Pfizer-BioNTech vaccine since Dec 8, including 197 deaths and nine cases of blindness. For the Oxford vaccine, since Jan 4, there have been 114,625 reports, including 205 deaths and 16 cases of blindness. Most reported reactions are minor or transient, but there is a wide variety of serious reactions involving many body systems. Neurological effects include seizures, movement disorders, and paralysis (including, but not limited to Bell palsy). The UK Medicines & Healthcare Products Regulatory Agency concludes:

Generally, these reactions are not associated with more serious illness and likely reflect an expected, normal immune response to the vaccines.... [For] medical conditions reported in temporal association with vaccination, the available evidence does not currently suggest that the vaccine caused the event.... The expected benefits of the vaccines in preventing COVID-19 and serious complications associated with COVID-19 far outweigh any currently known side effects.<sup>44</sup>

It is too early to see potential long-term consequences such as carcinogenesis, mutagenesis, or impairment of fertility.

Pathogenic priming, or antibody-enhanced disease, has been reported with previous coronavirus vaccines. Experimental animals that developed a good antibody response to a vaccine

developed a severe hyperimmune response and died when later exposed to the wild virus. This has not been seen in human trials of the COVID-19 vaccines. The trials of the two mRNA vaccines (Pfizer-BioNTech and Moderna) and the AstraZeneca Oxford vaccine (which uses an adenovirus modified to include SARS-CoV-2 genetic material) appear very large with considerably higher enrollment than most Phase III trials, which typically range between 300 and 3,000 participants. Notably, however, very few participants who received the vaccine developed COVID-19. Dr. Simone Gold and associates write that “while this may (or may not) imply that the vaccine is effective, the much bigger problem is that it tells us almost nothing about how exposure to COVID-19 affects people who receive the vaccine.” In the Pfizer-BioNTech and Moderna trials, only 8 and 11 vaccinated participants, respectively, developed COVID-19.<sup>45</sup>

An additional possible complication might come from the spike protein itself, manufactured by the vaccinee’s own body, without virus. Dr. Wolfgang Wodarg discusses possible uncontrolled cell fusions causing tissue damage, microthrombi, and autoimmune phenomena. A study by the Paul Ehrlich Institut warns that the coronavirus spike could generate these effects, but ignores the vaccination-induced spikes.<sup>46</sup>

All medical interventions involve a risk/benefit analysis, and those rushing to get vaccinated emphasize the more than 400,000 U.S. deaths attributed to COVID-19 and the growing concerns about “long-hauler” syndrome.

With more than half of its citizens vaccinated and the recent release of a vaccine tracking app, the state of Israel is reopening parts of its economy, after a two-month lockdown, to vaccinated persons, who must still wear masks and observe social distancing and limits on gathering.<sup>47</sup>

Early results from Israel’s aggressive mass vaccination campaign with the Pfizer-BioNTech BNT162b2 mRNA vaccine are said to be consistent with the efficacy findings in the trials.<sup>48</sup> The *NEJM* article does not consider adverse effects, and reports only relative risks. The absolute risk reduction is far less impressive, e.g., 2.7% for severe COVID after two doses and 0.5% for death after one dose, versus relative risk reductions of 92% and 72%, respectively.

The *NEJM* article and one published on Ynet, the best known Israeli website, hide the most important data, which show the Pfizer vaccine’s adverse effects, according to a re-analysis posted on the Hebrew language website Yakim.org. Engineer Haim Yativ and Dr. Hervé Seligmann, of the Aix-Marseille University Faculty of Medicine, Emerging Infections, and Tropical Diseases Unit in Marseille, France, write that “The table provided by the Ministry of Health on February 10 states [there were] 660 COVID-19 deaths among the vaccinated, 51.9% of the deaths for that period. Only 1.3 million Israeli, among 8 million (about 1 in 8, 12.5%), were vaccinated during that period. Accordingly, vaccination promotes deaths because 51.9% of deaths during that period are for the 12.5% vaccinated in that period.” They conclude that during a 5-week vaccination period the vaccines killed 40 times more elderly people and 260 times more younger people than the disease itself would have killed. This toll does not include cardiac and other events resulting from inflammatory reactions.<sup>49</sup>

Israel’s program has been described as a massive human experiment that violates the Nuremberg Code.<sup>50</sup>

## "Influenza"

Over the centuries the course of respiratory viruses has been so erratic that in the Middle Ages they were attributed to the influence of planets. They were known as "influenza degli astir," from which we get the term influenza, write Heneghan and Jefferson. Although today's political and public health authorities claim to be able to predict "trajectories" and "waves," these authors opine that "our bewildered prime minister [of the UK] and his platoon of inept advisors might as well be using the planets to guide us through this pandemic, so catastrophic and wildly over-the-top are their decisions."<sup>23</sup>

## Conclusions

The disastrous global response to COVID-19 has been plagued by lack of preparedness, conflicts of interest, highly politicized "science," suppression of open discussion, disregard of the bedrock principle of informed consent, and willful neglect of what is likely the most important pillar of response: early treatment. Risk/benefit assessment is fatally compromised by inaccurate, distorted, or absent data concerning the incidence and mortality of disease and the safety and efficacy of countermeasures.

**Jane M. Orient, M.D.**, is a general internist practicing in Tucson, Ariz., and the managing editor of the *Journal of American Physicians and Surgeons*.

## REFERENCES

1. McCullough PA, Alexander PE, Armstrong R, et al. Multifaceted highly targeted sequential multidrug treatment of early ambulatory high-risk SARS-CoV-2 infection (COVID-19). *Rev Cardiovasc Med* 2020;21(4):517-530. doi: 10.31083/j.rcm.2020.04.264. Available at: <https://rcm.impress.com/article/2020/2153-8174/RCM2020264.shtml>. Accessed Feb 24, 2021.
2. Zeisloft B. The V different mask policies held by Dr. Fauci in eleven months. *Daily Wire*; Feb 11, 2021.
3. Pollock AM, Lancaster J. Asymptomatic transmission of covid-19: what we know, and what we don't. *BMJ* 2020;371:m4851. Available at: <http://dx.doi.org/10.1136/bmj.m4851>. Accessed Feb 25, 2021.
4. Madewell ZJ, Yang Y, Longini IM Jr, Halloran E, Dean NE. Household transmission of SARS-CoV-2: a systematic review and meta-analysis. *JAMA Netw Open* 2020;3(12):e2031756. doi:10.1001/jamanetworkopen.2020.31756.
5. Crist C. 59% of COVID cases stem from asymptomatic spread. *WebMD*; Jan 11, 2021. Available at: <https://www.webmd.com/lung/news/20210110/59-percent-of-covid-cases-stem-from-asymptomatic-spread>. Accessed Feb 2, 2021.
6. Singleton MM. Mask facts; Sep 26, 2020. Available at: <https://aapsonline.org/mask-facts/>. Accessed Feb 24, 2021.
7. Colton E. *Los Angeles Times* and *Bloomberg News*: Federal stockpile of N95 masks was depleted under Obama and never restocked. *Wash Examiner*, Mar 23, 2020.
8. Bolyard P. UNREAL: FDA sat on critical mask-sanitizing technology, leaving the job up to grandmas with sewing machines. *PJ Media*; Mar 29, 2020.
9. CDC. Considerations for optimizing the supply of powered air-purifying respirators (PAPRs): For healthcare practitioners (HCP); Nov 3, 2020. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppr-strategy/powered-air-purifying-respirators-strategy.html>. Accessed Feb 24, 2021.
10. Lewis D. COVID-19 rarely infects through surfaces. So why are we still deep cleaning? *Nature* 2021; 590:26-28. Available at: <https://media.nature.com/original/magazine-assets/d41586-021-00251-4/d41586-021-00251-4.pdf>. Accessed Feb 25, 2021.
11. Editors. Update guidance on how coronavirus spreads. *Nature* 2021;590:7. Available at: <https://www.nature.com/articles/d41586-021-00277-8>. Accessed Feb 25, 2021.

12. Orient JM. Reemerging diseases. *Doctors for Disaster Preparedness Newsletter*, May 2018. Available at: <https://www.ddponline.org/2018/07/24/re-emerging-diseases/>. Accessed Feb 25, 2021.
13. Jefferson T, Spencer EA, Brasse J, Heneghan C. SARS-CoV-2 and the role of orofecal transmission: evidence brief. In: *Analysis of the Transmission Dynamics of COVID-19: An Open Evidence Review*. Published Online Jul 17, 2020. Available at: <http://www.cebm.net/evidence-synthesis/transmission-dynamics-of-covid-19/>. Accessed Feb 25, 2021.
14. Cullen T, Garcia JE. The COVID-19 pandemic—a multi-faceted health, social and economic catastrophe. *Pima County Medical Society*; Feb 2, 2021. Available at: <https://pimamedicalsociety.org/the-covid-19-pandemic-a-multi-faceted-health-social-and-economic-catastrophe/>. Accessed Feb 25, 2021.
15. Orient JM. A perspective on SARS-CoV-2, the most dangerous virus in history. *J Am Phys Surg* 2020;25:38-46.
16. Stockman D. Why the virus patrol has it ass-backwards, part 3. *David Stockman's Contra Corner*; undated. Available at: [https://www.davidstockmanscontracorner.com/why-the-virus-patrol-has-it-ass-backwards-part-3/?mc\\_cid=3983667055&mc\\_eid=2946779cce](https://www.davidstockmanscontracorner.com/why-the-virus-patrol-has-it-ass-backwards-part-3/?mc_cid=3983667055&mc_eid=2946779cce). Accessed Feb 25, 2021.
17. Engdahl FW. Coronavirus scandal breaking in Merkel's Germany. *New Eastern Outlook*; Oct 12, 2020. Available at: <https://journal-neo.org/2020/12/10/coronavirus-scandal-breaking-in-merkel-s-germany-2/>. Accessed Feb 25, 2021.
18. Borger P, Malhotra BR, Yeadon M, et al. External peer review of the RTPCR test to detect SARS-CoV-2 reveals 10 major scientific flaws at the molecular and methodological level: consequences for false positive results. *Corman-Drosten Review Report*; Nov 27, 2020. Available at: <https://cormandrostenreview.com/report/>. Accessed Feb 25, 2021.
19. MacDonald H. Four months of unprecedented government malfeasance. *Imprimis*, Jun 18, 2020. Available at: <https://imprimis.hillsdale.edu/four-months-unprecedented-government-malfeasance/>. Accessed Feb 25, 2021.
20. Haynes M. One hour after Biden inaugurated, WHO changes COVID testing criteria: the change is expected to lead to a reduction in COVID case tallies. *LifeSite News*; Jan 22, 2021. Available at: <https://www.lifesitenews.com/news/one-hour-after-biden-inaugurated-who-changes-covid-testing-criteria>. Accessed Feb 25, 2021.
21. Ealy H, McEvoy M, Chong D, et al. COVID-19 data collection, comorbidity and federal law: a historical retrospective. *Science, Public Health Policy, Law* 2020;2:4-22. Available at: <https://www.ratical.org/PandemicParallaxView/C19dataCollection-C+FL-HistPerspec.pdf>. Accessed Feb 25, 2021.
22. McMurray P. CDC exposed: inflated Covid deaths by 1600% throughout the election, 'violated multiple federal laws' peer-reviewed study finds... state, local governments must act. *Gateway Pundit*; Feb 9, 2021.
23. Heneghan C, Jefferson T. The only 'circuit break' in the pandemic we need now is from the government's doom-mongering scientific advisers who specialise in causing panic and little else, say Prof Carl Heneghan and Dr Tom Jefferson. *Daily Mail*; Sep 20, 2020. Available at: <https://www.dailymail.co.uk/debate/article-8751389/Oxford-scientists-circuit-break-need-cycle-bad-data-bad-science.html?eType=EmailBlastContent&cid=461bce9c-18b9-4f6b-823a-0dec33cf26e>. Accessed Feb 26, 2021.
24. Shapiro M. The horrible misreporting of COVID data: a cautionary tale. *Commentary*, September 2020:30-33.
25. Orient JM. Following the (fake) science. *Civil Defense Perspectives* 2020;35(4). Available at: <https://www.physiciansforcivildefense.org/2021/01/14/following-the-fake-science/#more-505>. Accessed Feb 25, 2021.
26. Feuer W. CDC's classroom guidance would keep 90% of schools at least partially closed. *CNBC*; Feb 18, 2021. Available at: <https://www.cnb.com/2021/02/18/cdcs-classroom-guidance-would-keep-90percent-of-schools-at-least-partially-closed.html>. Accessed Feb 25, 2021.
27. Choudhury IM, Shabnam N, Ahsan T, et al. Effect of 1% povidone iodine mouthwash/gargle, nasal and eye drop in COVID-19 patient. *Bioresearch Communications* 2021;7(1):919-923. Available at: <http://www.bioresearchcommunications.com/index.php/brc/article/view/176>. Accessed Feb 25, 2021.
28. Orient JM. D.I.Y. COVID medicine. *Doctors for Disaster Preparedness Newsletter* 2020;36(5). Available at: <https://www.ddponline.org/2021/02/04/d-i-y-covid-medicine/#more-810>. Accessed Feb 25, 2021.

29. U.S. Department of Health & Human Services. Strategic National Stockpile. Available at: <https://www.phe.gov/about/sns/Pages/default.aspx>. Accessed Feb 25, 2021.
30. Schlafly AL. AAPS challenges the Food and Drug Administration. *J Am Phys Surg* 2020; 25:112-116.
31. Orient JM. COVID v. the Oath of Hippocrates. *J Am Phys Surg* 2020;25:105-108.
32. Senate Committee on Homeland Security & Government Affairs. Early outpatient treatment: an essential part of a COVID-19 solution. Hearing; Nov 19, 2020. Available at: <https://www.hsgac.senate.gov/hearings/early-outpatient-treatment-an-essential-part-of-a-covid-19-solution>. Accessed Feb 25, 2021.
33. Senate Committee on Homeland Security & Government Affairs. Early outpatient treatment: an essential part of a COVID-19 solution, part II. Hearing; Dec 8, 2020. Available at: <https://www.hsgac.senate.gov/early-outpatient-treatment-an-essential-part-of-a-covid-19-solution-part-ii>. Accessed Feb 25, 2021.
34. Hatfill SJ. The developing threat of new pandemic influenza strains. *J Am Phys Surg* 2018;23:8-14.
35. Orient JM. Pandemic preparedness. *Doctors for Disaster Preparedness Newsletter* 2019;35(5). Available at: <https://www.ddponline.org/2020/01/04/pandemic-preparedness/>. Accessed Feb 25, 2021.
36. AMA. COVID-19 vaccines guide for physicians. Undated. Available at: [https://www.ama-assn.org/delivering-care/public-health/covid-19-vaccines-guide-physicians?utm\\_source=Selligent&utm\\_medium=email&utm\\_term=%25m%25d%25y&utm\\_content=PE\\_BC\\_2021\\_Vaccine\\_20210223&utm\\_campaign=PE\\_BC\\_2021\\_Vaccine\\_20210223&utm\\_uid=2256120&utm\\_effort=FAE03&utm\\_h=](https://www.ama-assn.org/delivering-care/public-health/covid-19-vaccines-guide-physicians?utm_source=Selligent&utm_medium=email&utm_term=%25m%25d%25y&utm_content=PE_BC_2021_Vaccine_20210223&utm_campaign=PE_BC_2021_Vaccine_20210223&utm_uid=2256120&utm_effort=FAE03&utm_h=). Accessed Feb 26, 2021.
37. Gates B. Trial testimony; Aug 27, 1998. Available at: <https://www.youtube.com/watch?v=GmeGPudmSjs&feature=youtu.be>. Accessed Feb 26, 2021.
38. Chumley CK. Bill Gates and his coronavirus conflicts of interest. *Wash Times*, Apr 2, 2020. Available at: <https://m.washingtontimes.com/news/2020/apr/2/bill-gates-and-his-coronavirus-conflicts-of-intere/>. Accessed Feb 26, 2021.
39. Bollinger T. Bill Gates—philanthropist or eugenicist? TTAC Publishing; Feb 29, 2021. Available at: <https://thetruthaboutcancer.com/bill-gates-eugenicist-philanthropist/>. Accessed Feb 26, 2021.
40. Burr C. ID2020 and partners launch program to provide digital ID with vaccines. *Biometric Update.com*; Sep 20, 2019. Available at: <https://www.biometricupdate.com/201909/id2020-and-partners-launch-program-to-provide-digital-id-with-vaccines>. Accessed Feb 26, 2021.
41. Reuters. Pandemic will not end until world is vaccinated, Merkel says. *US News*, Feb 19, 2021. Available at: <https://www.usnews.com/news/world/articles/2021-02-19/pandemic-will-not-end-until-world-is-vaccinated-merkel-says>. Accessed Feb 26, 2021.
42. Kaplan S. As millions get shots, F.D.A. struggles to get safety monitoring system running. *NY Times*, Feb 12, 2021. Available at: <https://www.nytimes.com/2021/02/12/health/covid-vaccine-how-safe.html?>. Accessed Feb 26, 2021.
43. Berenson A. Twitter post. Available at: <https://twitter.com/AlexBerenson/status/1361181090506039300>. Accessed Feb 26, 2021.
44. Medicines & Healthcare Products Regulatory Agency. Coronavirus vaccine—weekly summary of Yellow Card reporting; updated Feb 25, 2021. Available at: <https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting>. Accessed Feb 26, 2021.
45. Gold S, Todaro J, Merritt L, et al. America's Frontline Doctors White Paper on Experimental Vaccines for COVID-19. Undated. Available at: <https://img1.wsimg.com/blobby/go/99d35b02-a5cb-41e6-ad80-a070f8a5ee17/SMDwhitepaper.pdf>. Accessed Feb 28, 2021.
46. Wodarg W. Wurde vom Paul-Ehrlich-Institut eine gefährliche Nebenwirkung der Impfung ausgeblendet? [Has the Paul Ehrlich Institute ignored a dangerous vaccine side effect?] *Multipolar*; Feb 20, 2021. Available at: <https://multipolar-magazin.de/artikel/paul-ehrlich-institut-nebenwirkung>. Accessed Feb 26, 2021.
47. McLoone D. Israel begins reopening economy with 'green pass' for the vaccinated. *LifeSite News*; Feb 22, 2021. Available at: <https://www.lifesitenews.com/news/israel-begins-reopening-economy-with-green-pass-for-the-vaccinated>. Accessed Feb 26, 2021.
48. Dagan N, Barda N, Kepten E, et al. BNT162b2 mRNA Covid-19 vaccine in a nationwide mass vaccination setting [published online ahead of print Feb 24, 2021]. *N Engl J Med*. doi: 10.1056/NEJMoa2101765.
49. Yativ H. The uncovering of the vaccination data in Israel reveals a frightening picture. *Nakim.org*; Feb 15, 2021. Available at: <http://www.nakim.org/israel-forums/viewtopic.php?t=270811>. Accessed Mar 1, 2021.
50. Alliance for Human Research Protection. Government consigned Israeli population to be human subjects in a massive experiment. *AHRP*; Feb 1, 2021. Available at: <https://ahrp.org/government-consigned-israeli-population-to-be-human-subjects-in-a-massive-experiment/>. Accessed Feb 26, 2021.

**Subscribe now!**

# *Journal of American Physicians and Surgeons*

Please enter my subscription to the *Journal of American Physicians and Surgeons*.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Degree: \_\_\_\_\_ Specialty: \_\_\_\_\_

I wish to join AAPS.

M.D., D.O. (\$375)

Associate (\$95)

Subscription only:

Individual (\$75)

Sponsored (\$75)

Institution (\$125)

Send a Subscription with my compliments to: \_\_\_\_\_

Check enclosed  Please charge \$ \_\_\_\_\_ to my Visa, MasterCard, AmEx # \_\_\_\_\_ Exp. \_\_\_\_\_

Signature: \_\_\_\_\_

Mail to: AAPS, 1601 N. Tucson Blvd. Suite 9, Tucson, AZ 85716  
or FAX to 520-325-4230.