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LETTER TO THE EDITOR

COVID-19—Conspiracy or Not? Some Thoughts on Bauer and Bobrow

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PLATINUM OPEN ACCESS

I am pleased about the discussion which my review of Kennedy's book *The Real Anthony Fauci* has stimulated. It is a signature of the COVID-19 crisis that scientific discourse has broken down. There seem to be only two camps: those who "believe" in the mainstream narrative that COVID-19 is a deadly killer virus with far above average Case Fatality Rates that could only be halted by drastic non-pharmaceutical interventions such as complete lockdowns, stay-at-home orders, and mask mandates; for which no treatment existed; which had to be spotted early by broad coverage of PCR tests even of asymptomatic people; and for which the emergency use admission of rapidly developed, badly tested vaccinations was the only and thus legally warranted action.

And on the other side the "conspirationists:" those who think that the whole story was overblown, that the virus was manufactured, either by China or some other secret service, to trigger a crisis that either served the pharmaceutical industry in developing and marketing a completely new brand of preventive pharmaceuticals, mRNA, and vector vaccines; and/or to issue vaccine passports that serve the larger purpose of having complete control of the population in a China-style system of social compliance points that allow access to privileges such as travel, holidays, etc.; or even a coup d'état serving to abolish our democratic system.

This thinking in camps is obvious in the public discourse in the mainstream media, TV, and print. It is obvious in the scientific discourse, where critical voices are sidelined into small outlets or penalized by retractions. It is obvious in the discussion between Bobrow, myself, and Bauer, with Bauer holding a middle ground by admitting to human incompetency as the most likely factor of the crisis (which I sympathize with, but won't discuss further). I will by no means be able to address all these points in a short commentary. Especially, I will not get into the HIV/AIDS-debate, as this is probably even more complicated than the COVID-19 debate. But let me pick out a few obvious points.

The Seemingly High Case Fatality Rate

Bobrow's reply to Bauer noted the enormous death toll of COVID-19 documented on dashboards all over the world, especially in and for the US. At the face of it, it is true: Many fatalities are attributed to SARS-CoV2 as the causative agent, many more than are usually registered for flu. However, there are a few points to be considered.

In no country has there been a clear definition what counts as a "COVID-19 death." In Germany, doctors and pathologists were explicitly forbidden by public health authorities to do autopsies in the first phase of the pandemic to ascertain causes of deaths, and I believe the same was true in many other countries. Some pathologists did so nevertheless and published findings that at most 30% to 40% of those COVID-19 deaths are directly attributable to the virus as a cause. The rest died of underlying diseases. This is a common pattern in old people: Their system is weak, and a respiratory virus kills off the patient. Now, interestingly, these data never saw the light of peer-reviewed day, be-

cause in one case the pathologist received an express order not to publish by his university. And I have it on trustworthy evidence that this order was underwritten by a threat to personal consequences. Why would that happen if we were talking about a purely scientific dispute?

So, we can take it that those numbers are completely unreliable, because they are not validated. Had our, and for that matter the US, public health authorities been interested in true causal attribution, they would have ordered well-taken samples of autopsies to determine causality and approximate percentage of deaths of people in whom PCR-tests for SARS-CoV2 was positively and truly attributable to the virus. The fact that this was not only not done, but actively sabotaged by authorities is a far cry from incompetence in my eyes, and if incompetence it would be a type that is punishable.

And in fact, as referenced by me in my original review: Meta-analyses of infection-fatality rate—this is quite different from case-fatality rates—revealed that there is no difference from influenza (Ioannidis, 2021). The overblown case-fatality rate is manufactured or an artefact, depending on your view, produced by counting every fatality with a positive COVID-19 PCR test as a COVID-19 death.

The PCR Test

Bobrow also pointed out that the PCR test allows us to diagnose viruses and determine the viral load. Both statements are only partially correct. For the question of what is being found and diagnosed is highly dependent on the primer samples and on the cycle-threshold used. The cycle-threshold, i.e., the number of amplifications that are being conducted, were originally 45 with the test published by Drosten and his team that became the blueprint and standard used by the WHO and other institutions (Corman et al., 2020). I have been and still am conducting expert interviews. I have spoken to academic experts who have been working with PCR tests all their careers. They confirm: Such a high amplification threshold is never used if one wants to detect live virus or infectious agents. And indeed, meta-analyses of studies show that beyond a cycle-threshold of 22 no infectious agent is discoverable, only RNA-fragments (Jefferson et al., 2020; Stang et al., 2021). These fragments can stem from a previous infection, they can be signs of contamination, but they do not constitute proof of infection, let alone infectiousness. Yet such PCR results have been used to determine "COVID-19 cases" and "COVID-19 fatalities." This is, again, a far cry from good laboratory and scientific practice.

Although it is a legal requirement to indicate the number of cycles used for testing, the official documents issued in Germany have, as a rule, not given this information. I know from talking to people working in such labs and from informal information that the standard practice was and still is to use 35 to 37 cycles of amplification, far beyond the 22 cycles known to be the threshold for identifying a viral load that is associated with potential infectivity.

Perhaps a clarification is in order here: PCR tests cannot, in principle, determine viral loads or infectivity because they have to break down all material, denaturalize it to test for DNA or RNA sequences. The conclusion that someone is infected or infectious, or to deduce the viral load associated with it, is entirely indirect and crucially dependent on the number of amplification cycles.

Now, given that all persons in relevant positions to make decisions about cycle thresholds and associated practices actually know this: Why would one want to gear the whole system of diagnostics towards oversensitivity? Does anyone have a natural and innocent explanation? I have so far not found one, and therefore can only conclude that our institutions are either incompetent (Bauer) or malicious (Kennedy and "conspirationists"), and most likely both.

The Novel Vaccines with Mandates, Vaccine Passports, and Aggressive Campaigns

The Public Health Emergency of International Concern (PHEIC) was declared by the WHO after a short deliberation period advised by a panel of experts—a fact that was even criticized by one of the recent pandemic preparedness exercises on a monkeypox emergency (Yassif et al., 2021). It is obvious: There would never have been a chance of having emergency-use admission to market these new vaccines without such a PHEIC. A second concern is the fact that there are no medications that can be used for treatment. I will deal with this latter point in the next paragraph.

These novel vaccines introduce a completely new pharmaceutical principle, and it is well worth remembering: This principle has so far failed to work in cancer, for which these techniques have been originally developed, and it has failed as an HIV vaccine, which is well-documented by Kennedy (2021). The company that developed those vaccines in Germany, BioNTech, had developed the technique as a cancer remedy. It did not work and the company was actually insolvent before Bill Gates came in and bought huge shares in it, a fact I have on good evidence from my interviews. Another of my interview partners was working on mRNA-based medications against cancer for the German government 10 years ago. They abandoned this research track because the substances violate one basic principle of pharmacology: The dose, or amount of stuff they produce, cannot be controlled. In other words: No one

knows how much of the end-product is being produced by the cells—and by which cells—the mRNA happens to be hosted in. This problem has not been solved. Thus, we are working with vaccines that violate one basic principle of pharmacology: to know with what dose of the end product we are treating an organism.

The second problem is that the lipid-nano particles that are used to package the mRNA are themselves toxic because they are highly inflammatory (Ndeupen et al., 2021) and do not have a human use clearance, to my knowledge in any country, certainly not in Germany and the EU. But they received indirect clearance with the emergency use of the vaccines. The risk–benefit ratio of these vaccines is terribly bad. We were the first to point this out (Walach et al., 2021a). That paper was retracted after protests and shortly afterwards republished (Walach et al., 2021b). One of the protests came from the head of pharmacovigilance in the Netherlands, whose data we had used. At the time, the pharmacovigilance data in Holland showed four suspected deaths per 100,000 vaccinations (now it is two). We used data from the then largest observational study to calculate that we are saving at the most six lives per 100,000 vaccinations.

Meanwhile, the six-month Pfizer study became available, which allowed us to calculate that in fact we are maximally saving five lives per 100,000 vaccinations (Walach, et al., 2022). The German pharmacovigilance data show that there were 1,802 deaths associated with COVID-19 vaccines as of September 30, 2021, which is more suspected deaths than that of all other vaccines together since inception of the database beginning of 2000 by a factor of 28, or by a factor of 560 more per year. One should consider that such passive monitoring systems like adverse reaction databases are underestimating effects by more than 80%, as direct comparisons and a meta-analysis of such comparisons in other cases show (Alatawi & Hansen, 2017; Hazell & Shakri, 2006). It is for future systematic cohort studies actively documenting benefits and risks that do not exist so far (Wu et al., 2021) to cast the final word. This is difficult, because all ongoing long-term studies have been unblinded so that no long-term control groups exist (Tanveer et al., 2021).

But perhaps one glance at the US all-cause mortality data gleaned from the CDC website says it all (Figure 1). Figure 1 presents the all-cause mortality dashboard data of the US Centers for Disease Control and Prevention website. The blue bars represent the weekly mortality data for the US. The orange and red lines represent the expected number of deaths and the upper boundary beyond which excess mortality occurs.

As can be easily seen on the left side, there is the last hint of excess mortality from the flu season of 2017/2018, which is more visible on older dashboards that go farther back. Then there is a small dip which signals less than expected mortality between January 2019 and the beginning of 2020. Then we see the sharp rise at the beginning of 2020, which is attributed to the first wave of COVID-19, and a smaller peak signaling the second SARS-CoV2 wave in summer 2020. That was when the vaccines were sent through regulation and the vaccination campaign began in the last weeks of 2020 and the beginning of 2021. This coincides with the largest excess mortality peak in the data

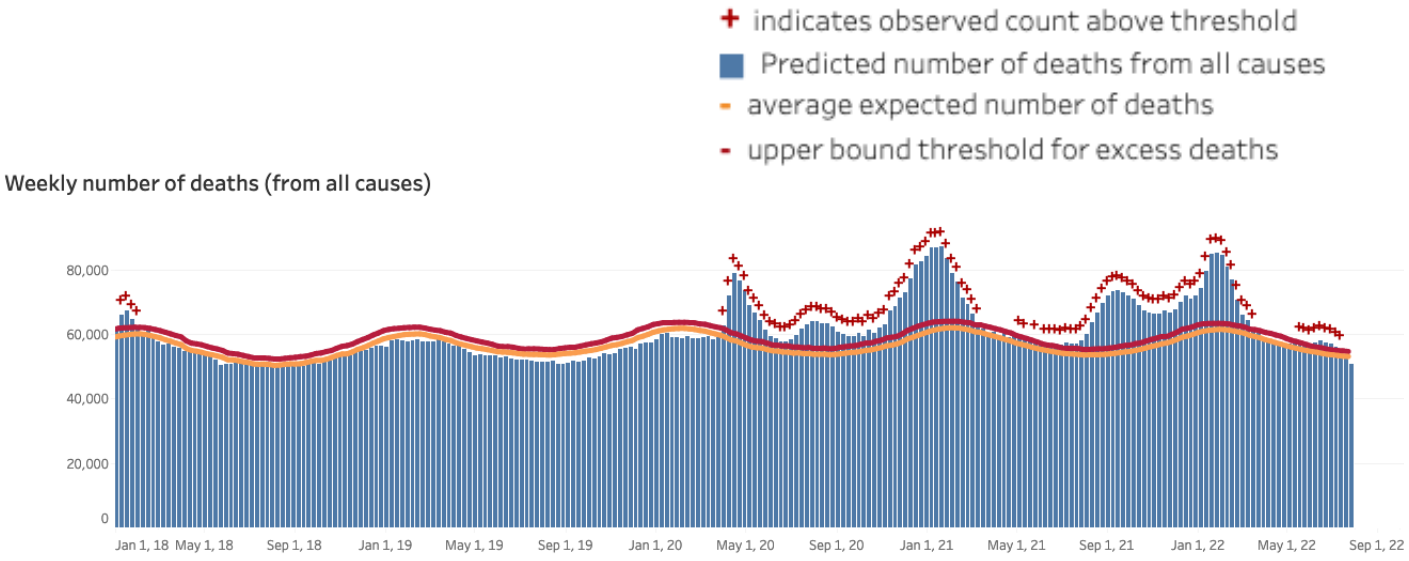

Figure 1. All Cause Mortality United States–Excess Death Rates CDC Data. https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm#dashboard

series so far. The vaccine did not seem to do what it was meant to do. It did not lower mortality rates. If it was causal for anything, then it was causal for increasing mortality.

A case can be made that vaccinating into a rising epidemic curve of any epidemic is a clinical stupidity. So, this might explain the peak at the start of 2021. But then, surely, one would have expected that the vaccinations did their job and prevented further deaths, at least of and with SARS-CoV2. And since this was supposed to be the major health hazard since the Spanish flu of 1918, there should have been a reduction of mortality later on, or even a below-average mortality. But what we see is the contrary: large peaks at the end of 2021 and beginning of 2022, which taken together outrun the supposed COVID-19 peak at the beginning of 2020 easily by an order of magnitude. Where, I would dare to ask, is the signature of a preventative effect of the COVID-19 vaccines? And let us remember: These vaccines were developed and sped through regulation to counter a fatal threat, a killer virus, which would be indomitable without a vaccine that should supposedly reduce mortality. After it became clear that the vaccines would not do what they were said to do, the claims were toned down to "reduce infection rates," then "reduce severity of the disease," "reduce the burden on the health system," none of which was actually proven to be true but was only claimed to be the case based on occasional and anecdotal evidence. Where are the hard data proving that these vaccines prevent deaths and prevent serious illness? I am sorry, Dr. Bobrow, but they do not exist, and I do not find the data in the references you mention.

What you can find, though, in the CDC data (though I won't go into the details here), following the link in Figure 1 and choosing different US States: The mortality peaks, numbers, and patterns for neighbor states, even counties, are so different that the pattern is incompatible with a unified cause such as an epidemically spreading virus that does not stop at state borders. Take Maine and Massachusetts as an example. In Maine you do not see any relevant peak until the end of 2021, while in Massachusetts you see a steep peak at the beginning of 2020 and then a smaller one at the end of 2021, exactly the opposite. The same is true in Europe: Belgium had some of the highest excess mortality data in Europe, while Germany, which borders Belgium, had the lowest before the introduction of the vaccines. Why would an infectious agent that is invariably deadly stop at the border? True, these are all-cause mortality data, and this is what is most interesting, because they are the most robust data. Perhaps they also tell us a different story? Not only that the vaccines were not effective, but that they were even dangerous? This is difficult to prove in the absence of control groups. We are currently trying to disentangle this with a modeling study.

But what is clear from the data is that the vaccine mandates, which are currently crumbling, were unwarranted where they have been introduced. Were they only introduced to enforce vaccine passports, including electronic monitoring systems, piggybacking on the mandates as "necessary" control procedures? We don't know. But I think it is obvious that the argument is not so far off the mark as some would like it to be. At least in Europe, I observed a vicious campaign against persons who refused the vaccine, with political arguments from the political Middle Ages based on "scientific" claims that were neither true nor scientific, as every new study that was published showed. What are we to make of such campaigns, supported by the most powerful TV and mainstream print media around? Had they spoken the truth, no one would have objected. The fact that a loud and vocal minority protested in numbers unseen and unheard of since the time of nuclear armaments in Europe back in the '70s and '80s is a hint that it was not the truth that was promulgated by politicians and media, but a political agenda.

The Myth of a Lack of Early Treatment for COVID-19

I am not a physician. So, I refer to secondary data. One of the prerequisites of Emergency Use Approval of the COVID-19 vaccines was, apart from PHEIC, the lack of potential early treatments. The CDC, NIH, FDA, and other guidelines said so and stipulated: Do not treat these patients unless deterioration sets in, and then start emergency treatment in a hospital. Early on critical care physicians published early treatment protocols (McCullough et al., 2021), and reportedly treated many hundreds of patients successfully with it without hospital admissions. Some of the agents, ivermectin for instance, were attacked by the CDC in broad campaigns. An independent group of high-profile US researchers at academic centers started a website, which I recommend all readers peruse: https://ivmmeta.com/ and https://c19early.com/#fpall. The first is a meta-analysis of all ivermectin studies for COVID-19 and the second compares different treatments for COVID-19. The first meta-analysis shows a huge benefit for ivermectin-treated patients. The second analysis shows the full range of treatments. Again, ivermectin ranges high, and other treatments, including vitamin D, are far more effective than the only one advocated by official sources in the US, remdesivir. Why, one might ask, is it that such a meta-analysis was not put together by official sources but by a crew of highly competent, yet anonymous academics in the US?

The simple fact that these data exist, that you will have trouble finding the website by a simple search, and that the

content of this website is actively and powerfully battled against by the most important public health authority in the US tells you that Bauer is right: Trust into institutions has eroded, to put it mildly. The question of whether the COVID-19 associated deaths were due to the virus, or perhaps due to the various NPIs and their distal consequences we have not even touched upon.

Conclusion

So, the facts are: The preconditions for the new vaccines did not exist from the beginning. The pandemic, although surely associated with a high number of fatalities, was not the killer pandemic it was said to be. The disease was treatable and severe consequences preventable in many cases. This was exactly what was prevented by official propagations and policy. At the same time, these preconditions, a dangerous epidemic with no treatment available, were necessary for a positive regulation for novel vaccines. These vaccines do not do what they were meant to do, yet the discourse about this fact is non-existent and is combatted at all levels. Exactly what should a rational agent conclude, who is neither in bed with Republicans nor Democrats, as I, as a European, am?

No, this is not political either, or a conflict between conservative or progressive, green-liberal or brown-revanchist, as so many columnists want it to be. There is a third position here, i.e. looking at the facts without preconceptions and then thinking about the consequences. And one can easily see: It's the economy, stupid. There is a famous wager by the 17th-century philosopher Blaise Pascal. He used it as an argument for the belief in God. I would like to slightly tweak it. We do not know the truth. But if the "conspirationists" are right and this whole issue is a big mistake on the part of our authorities to try to hide the disaster, or if there is some even more sinister goal behind it, then it is safer to follow this line of reasoning than to ignore this option and keep on trusting. I feel that the burden of proof has already shifted to those who believe that the mainstream narrative is correct and who stipulate that the vaccines are ultimately safe.

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