Dr David Unwin can stop people dying of COVID19

3rd November 2020

[By helping them to lose weight]

If you want to avoid dying of COVID19, one of the most important things you can do, if you are overweight, is to shed the pounds

'….in the first meta-analysis of its kind, published on 26 August in Obesity Reviews, an international team of researchers pooled data from scores of peer-reviewed papers capturing 399,000 patients. They found that people with obesity who contracted SARS-CoV-2 were 113% more likely than people of healthy weight to land in the hospital, 74% more likely to be admitted to an ICU, and 48% more likely to die.' [1]

Why? Well, the 'why' centres around the damaging effect of raised blood glucose on endothelial cells and… it gets complicated.

For now, though, the most important thing is not to understand the complex metabolic and physiological pathways involved, it is simply to help people to lose weight, and this is where Dr David Unwin comes in.

For years now he has believed, as I do, that the main driver of weight gain, leading on to type 2 (T2) diabetes, is a high carbohydrate diet.

This, of course, is the exact opposite of what we have been told for decades by the 'experts' who demonise fat and promote carbohydrates. We have the 'eat-well' plate, and the 'food pyramid', and hundreds of thousands of dieticians around the world, all promoting carbohydrates as *the* 'healthy' option.

Dutifully following this advice, the entire population of the western world has become fatter, and fatter… and fatter. By the way, this is not a coincidence; it is cause and effect.

Getting back to Dr Unwin, years ago he despaired of ever getting any of his patients to lose weight. It was so disheartening that he furtively studied his pension plan, and dreamed of retirement, so fed up was he becoming. Then one day a patient came in who had lost a lot of weight and kept it off.

At first this woman was reluctant to say how she had done it, as she feared the inevitable criticism. In the end, she told Dr Unwin that she had lost weight, and kept it off, by eating a low carbohydrate diet. In Dr Unwin's own words:

'A few years ago, I was interested to find out how a patient had improved her diabetic control. She confessed she had ignored my advice and learnt a much better way to look after herself, from the internet. I suppressed my wounded pride and looked at the Low Carb Forum on Diabetes.co.uk There were thousands of type two diabetics on there ignoring their doctors – and getting great results (now that is just not allowed).' [2]

Yes, Dr Unwin did not criticize, instead he was intrigued. Could this possibly be true? It went against everything he had been told about healthy eating, and weight loss, and T2 diabetes. Fat has twice the calories, per gram, as carbohydrates and suchlike. Eating fat, he believed, makes you fat, and then you develop diabetes, and heart disease.

Dr Unwin did more research, then he made the decision to work with patients, mainly those with diabetes, to see if a low carbohydrate diet could be beneficial. Lo and behold, it was … very beneficial. It was like a miracle cure.

In 2014 he published a paper on his results on a small number of patients. *'Low carbohydrate diet to achieve weight loss and improve HbA1c in type 2 diabetes and pre-diabetes: experience from one general practice.'*

'It was observed that a low carbohydrate diet achieved substantial weight loss in all patients and brought about normalisation of blood glucose control in 16 out of 18 patients. At the same time, plasma lipid profiles improved, and BP fell allowing discontinuation of antihypertensive therapy in some individuals…

Conclusions *Based on our work so far, we can understand the reasons for the internet enthusiasm for a low carbohydrate diet; the majority of patients lose weight rapidly and fairly easily; predictably the HbA1c levels are not far behind. Cholesterol levels, liver enzymes and BP levels all improved. This approach is simple to implement and much appreciated by people with diabetes.'* [3]

Now, he has published results of a much larger study, on nearly two hundred patients over a six-year period. It is called. '*Insights from a general practice service evaluation supporting a lower carbohydrate diet in patients with type 2 diabetes mellitus and prediabetes'* Published in BMJ nutrition [4].

Here are the main findings, which I nicked directly from the press release:

- 46% drug-free T2 diabetes remission
- Significant improvements in weight, blood pressure and lipid profiles
- 93% remission of prediabetes
- £50,885 annual saving on the Norwood GP practice NHS diabetes drug budget
- If every GP practice in England spent the same on drugs for diabetes per patient as Norwood the NHS could save £277 million!
- Older patients can do as well as younger ones with a low carb approach.
- The participants who started with the worst blood sugars saw the greatest improvements in diabetic control
- Four individuals came off insulin altogether
- Total weight loss for the 199 participants was 1.6 metric tons!

This paper will be attacked, of course. There are massive financial interests involved here. As stated, if every GP practice in the UK used the low carb approach, the NHS could save £277 million (~$350m) in drug costs. Scaled up to the US, with much higher drugs costs, one could be looking at around $2Bn/year. Around the world, who knows, but vast sums of money.

So, you can imagine the joy that this paper will be met with in pharmaceutical company boardrooms around the world. The words 'lead' and 'balloon', spring to mind. Equally the massive low-fat, high carb food manufacturers will be throwing their hands up in horror – '*my bonus, my bonus…nooooo*.' You can take your low carb yoghurts and….

As for the rest of us. I can assure you that Dr David Unwin has only ever been interested in one thing. Working out how to help people lose weight and control their diabetes. He has achieved this.

Will his research now be taken up by the authorities around the world? Will we move away from promoting a high carbohydrate diet? You have to be joking. There is far too much money to be lost by companies who exert tight control over the world of medical research, and whose lobbyists swarm around the politicians in rich countries.

Which is a damn shame, because more than ever in this endless COVID19 pandemic, obesity represents a health crisis. This paper, and the tireless work by Dr David Unwin, clearly tells us what we need to do, now, urgently. His approach won't work instantly, and it won't work for everyone – nothing ever does. However, it represents hope. It could save hundreds and thousands of lives. Better than any vaccine?

Thank you, once again, Dr Unwin. A man who I think of as a friend. Your research should be shouted from the rooftops. I can only do my bit.

1: https://www.sciencemag.org/news/2020/09/why-covid-19-more-deadly-people-obesity-even-if-theyre-young

2: https://www.rcgp.org.uk/clinical-and-research/resources/bright-ideas/working-on-weight-loss-with-type-ii-diabetic-patients-dr-david-unwin.aspx

3: *https://www.practicaldiabetes.com/wp-content/uploads/sites/29/2016/03/Low-carbohydrate-diet-to-achieve-weight-loss-and-improve-HbA1c-in-type-2-diabetes-and-pre-diabetes-experience-from-one-general-practice.pdf*

4: https://nutrition.bmj.com/content/early/2020/11/02/bmjnph-2020-000072

This entry was posted in COVID-19, Diet & Health on November 3, 2020 [https://drmalcolmkendrick.org/2020/11/03/dr-david-unwin-can-stop-people-dying-of-covid19/] .

How dangerous is COVID19?

26th October 2020

[What is the true Infection Fatality Rate]

This article appeared in Russia Today https://www.rt.com/op-ed/504167-facebook-fact-checkers-censorship/ I have made a couple of small changes to it

Facebook fact checkers censured me, and informed me I was wrong, when I said COVID infection fatality rate was around 0.1%. But what do the latest studies say?

The world's top scientists can't yet be certain how deadly COVID-19 is, so why are Facebook's censorial police consistently flagging stories saying this is 'misinformation' & claiming the rate is NINE times worse than my estimate?

COVID-19 has impacted the world with massive force, a pandemic beyond anything seen in living memory. There has been an unprecedented reaction – some would say an unprecedented over-reaction. But what are the real figures, what is the true risk from the virus?

It is very difficult to know. At the start of any pandemic, no-one can be sure how many people have been infected. As the World Health Organization states:

"Under-detection of cases may be exacerbated during an epidemic, when testing capacity may be limited and restricted to people with severe cases and priority risk groups (such as frontline healthcare workers, elderly people and people with comorbidities)."

As a general rule, the fatality rate starts by being significantly overestimated, and then falls, as more and more people are tested, and those with mild or asymptomatic infections are identified. With swine flu, the lowest estimated infection fatality rate – the total number of people who die after being infected, whether or not they suffered any symptoms – was one in a thousand, ten weeks into the pandemic. It ended up at 2 in 10,000. Five times lower.

A few weeks ago, I suggested the final infection rate from COVID-19 could be as low as 0.1%. By which I mean that out of every thousand people infected, one would die.

This created something of a storm and various self-appointed fact-checking 'authorities' decreed that this figure was completely wrong. Under the heading '*What is the real death rate'* it was stated that:

"By looking at English data, it is clear that the death rate in this country must be much higher than 0.1%. The researchers who conducted the REACT-2 survey produced a more detailed analysis, which estimated an overall death rate that is nine times higher, at about 0.9%."

Of course, this is important to get right. If the infection fatality rate is 0.1%, then the total number of deaths in the UK will top out at around 67,000. If it is 0.9%, the final death toll could be over 500,000, which means we have (potentially) another 450,000 deaths to go. Indeed, it is the fear of the '450,000' figure that is driving the renewed lockdowns.

So, where do we stand now? The figures are still all over the place, with some perhaps more reliable than others. Interestingly, the WHO (perhaps inadvertently) estimated the infection at far lower than 0.9%

Around two weeks ago, Dr Mike Ryan, the executive director of the WHO's health emergencies programme, stated the WHO estimated that 750 million people have been infected worldwide:

'An estimated 750 million, or 10 per cent of the world's population, have been infected by COVID-19, World Health Organisation (WHO) official Dr Mike Ryan has said.'

At the time of his statement, there had been just over one million deaths recorded worldwide (1,034,068 to be fully accurate). Using these two figures, the IFR can be easily calculated. It is 1,034,068/750,000,000 = 0.138%. How accurate is this figure? Well, who knows for certain? It is probably as accurate as most other current estimates.

Yet even using these WHO-endorsed figures is apparently *verboten* in the eyes of the Facebook 'fact checkers'. Another site that reported these numbers also found its story flagged as "misinformation" by Facebook, and has subsequently accused the social media giant of *"selling falsehoods and re-writing history"*.

One wide-ranging piece of work, a review of 61 studies of COVID deaths covering 51 countries, was done recently by John Ioannidis, a professor of epidemiology at Stanford University, and a man described as *"a lion of medical science"*. The article, peer-reviewed and published by the WHO, concluded that the infection fatality rate currently stands at 0.23%, and suggested it would fall further, warning: *"The inferred infection fatality rates tended to be much lower than estimates made earlier in the pandemic."*

Who would one rather believe on this matter? A Harvard-trained infectious disease specialist, author of some of the most cited articles in medical history, and a man who "The Atlantic" has called "one of the most influential scientists alive"? Or some 'fact checkers' who, I'm confidently guessing, don't have quite such a track record or expertise?

It is true the fatality rates currently differ widely from country to country, influenced by other factors such as age and health. In Singapore, there have been nearly 60,000 'cases' recorded, with twenty-eight deaths. This represents a *case* fatality rate of 0.02%.

As for Iceland, which was (proportionately) the most tested population in the world and used as a benchmark in the early days of the pandemic, things have moved on. As of late October, they have had just over 4,000 'cases' of COVID19 and eleven deaths.

This represents a *case* fatality rate of 0.26%. You may have noticed my switch to case fatality rate. Case fatality rate means (or used to mean) those with symptoms of the disease, not just those infected. So, the case fatality rate will always be higher than the infection fatality rate, as the infection fatality rate includes those with no symptoms. Many of whom will be untested and undetected.

Another, more recent paper, by Prof. Ioannidis looking at the global Infection Fatality Rate came to the conclusion that it stood, as of October 7th, at 0.15-0.20%.

Of course, this figure is for the entire population, including the elderly, and those at higher risk because they have other serious medical conditions. His latest estimate of the IFR in the population aged under 70 is 0.04%. Which is 4 in 10,000, and this figure includes people with serious underlying medical conditions.

What would it be for healthy people under 70? Almost certainly a lot less, but I have seen no good figures on this.

As is very clear, the figures have not yet settled down, and different countries have very different estimates. One constant thing though, as with previous pandemics, is the high fatality figures found at the start are steadily falling. The Centre for Evidence Based Medicine in Oxford have been looking at the declining case fatality rates over time, and says:

"Crude estimates of the CFR over time show that for people aged 80 and over the average CFR was 29% up to week 18, fell to 17% in weeks 19 to 27, and for mid-July onwards the CFR was 11% – a decrease of 61%.

"A larger decrease is seen in the ages 60-79 with average CFR ~ 9% in March/April falling to 2% in July August."

Of course, it is up the individual to decide which figures they believe to be the most accurate. This is an area where the science is clearly not yet settled. Different authorities are claiming very different fatality rates. But – despite what Facebook's 'fact checkers' maintain – very few researchers currently appear to believe the infection fatality rate of COVID-19 is anywhere near 0.9%.

What about those who believe that they can determine what the infection fatality rate for COVID19 really is, and will be, and also believe that they can act as judge and jury in determining who is right, and who is wrong, on this issue? Well, at the risk of being damned again, I politely suggest a bit of humility would be appropriate. Attempting to shut down debate in science used to be the role of the Spanish Inquisition. I thought we had moved on. Debate is the lifeblood of science.

This entry was posted in COVID-19 on October 26, 2020 [https://drmalcolmkendrick.org/2020/10/26/how-dangerous-is-covid19/] .

Promoting the Fifth International Public Conference on Vaccination

13th October 2020

'I would rather have questions that cannot be answered, than answers that cannot be questioned' Richard Feynman.

As the impact of COVID19 rampages around the world, there is going to be a massive push to get vaccines launched, and immense pressure applied to people to be vaccinated. Therefore, this seems like a perfect time to have a conference on informed consent in Vaccination.

So, I am helping to publicise the Fifth International Public Conference on Vaccination on-line conference*. Information on this can be found here:

https://app.glueup.com/event/protecting-health-and-autonomy-in-the-21st-century-20563/home.htmlhttps://www.nvic.org/about/conference.aspx

I am acutely aware of the fact that even the mildest caution about vaccines leads to you being instantly labelled as an anti-vaxxer, and thus dismissed as some kind of anti-science lunatic.

However, I think we have an immensely important issue rising to the surface today, with many countries lining up to make any vaccine for COVID19 as close to mandatory as can be achieved, without using force.

This is distinctly worrying. As I pointed out in a previous blog, the Phase III trials for any Sars-Cov2 are not due to report for years. Which means that vaccines are about to be rushed onto the market with very sparse data on safety and efficacy. I think that people have a right to be concerned, and a right to refuse to be vaccinated without massive pressure brought to bear.

I strongly believe that this, and other issues on informed consent, desperately need to be debated – out in the open – and the National Vaccine Information Center is trying to do this. The people involved seem to be as far from being zealots as can be imagined. They just want an open and reasoned discussion.

Here is their statement on the issues of informed consent.

Informed Consent: An Ethical Principle

The National Vaccine Information Center (NVIC) has not advocated for the abolishment of vaccination laws as other groups have proposed. However, we have always endorsed the right to informed consent as an overarching ethical principle in the practice of medicine for which vaccination should be no exception. We maintain this is a responsible and ethically justifiable position to take in light of the fact that vaccination is a medical intervention performed on a healthy person that has the inherent ability to result in the injury or death of that healthy person.

In consideration of:

- *the fact that there can be no guarantee that the deliberate introduction of killed or live microorganisms into the body of a healthy person will not compromise the health or cause the death of that person either immediately or in the future; and*
- *with very few predictors having been identified by medical science to give advance warning that injury or death may occur; and*
- *with no guarantee that the vaccine will indeed protect the person from contracting a disease; and*
- *in the absence of adequate scientific knowledge of the way vaccines singly or in combination act in the human body at the cellular and molecular level*
- *vaccination is a medical procedure that could reasonably be termed as experimental each time it is performed on a healthy individual*

Further, the FDA, CDC and vaccine makers openly state that often the number of human subjects used in pre-licensing studies are too small to detect rarer adverse events, making post-marketing surveillance of new vaccines a de facto scientific experiment. In this regard, the ethical principle of informed consent to vaccination attains even greater importance

I would urge people to have a look at this conference, sign in, and make up their own minds about what is going on.

**Disclosure of interest*: I was asked to give a lecture at this conference for which I will be paid. The title of my talk is '*Manipulating Science to Endorse Policy, and Market Products.*'

This entry was posted in COVID-19, Vaccines on October 13, 2020 [https://drmalcolmkendrick.org/2020/10/13/promoting-the-fifth-international-public-conference-on-vaccination/] .

A Sars-Cov2 vaccine – don't hold your breath

10th October 2020

[But concern may be in order]

I suppose most people believe the trials on vaccines for COVID19 will be looking to demonstrate that they reduce the risk of infection, death, or serious illness – or suchlike.

Also, you may have heard that several vaccines could be ready for use early next year 2021. Maybe even later this year.

As Dilbert may retort: Hahahahahahahahahahahaha! Oh, let me pause and wipe away my tears of mirth.

Really. Think about it. Then think a bit more…

AstraZeneca (AZ) is thought to be leading the pack with their vaccine AZD1222. Their major clinical trial will recruit 30,000 participants – which is good. You can find the trial description on Clinicaltrials.gov. It goes by the snappy title *'Phase III Double-blind, Placebo-controlled Study of AZD1222 for the Prevention of COVID-19 in Adults.'* [1]

You may be interested in the start and end date of this AZ trial:

Estimated Study Start Date: *August 17, 2020*

Estimated Primary Completion Date:* *December 2, 2020*

Estimated Study Completion Date: ***October 5, 2022***

*date when all volunteers have been recruited onto the trial.

As you can see, even if all goes to plan, their study will not be completed until two years from now. Then they will have to analyse the data and suchlike, which will take a couple of months, even as a rush job. Which means they are unlikely to have everything sorted before early 2023.

For those who were claiming, a few months ago, that a vaccine would be ready by September this year i.e. a month ago, this would be stretching the word '*ready*' far beyond its natural boundaries.

As for studying deaths from COVID19, this trial will not be looking at anything as tricky as that. Preventing deaths from COVID19 is not an end-point they are aiming for.

Below I have listed the primary end-points for study NCT04516746. By primary end-points, I mean those outcomes that will be used to determine if the trial has been a success or failure.

Sorry, jargon alert, and boring but also necessary, I feel, just so you know I am not making this stuff up. My comments in brackets [ ].

PRIMARY END-POINTS OF AZ STUDY

1: To estimate the efficacy of 2 IM doses of AZD1222 compared to placebo for the prevention of COVID-19 in adults ≥ 18 years of age [Time Frame: 1 year]

A binary response, whereby a participant is defined as a COVID-19 case if their first case of SARS-CoV-2 RT-PCR-positive symptomatic illness occurs ≥ 15 days post second dose of study intervention. Otherwise, a participant is not defined as a COVID-19 case.

[You may note that a positive SARS-Cov-2 RT-PCR test is not sufficient to define someone as having been infected with the virus – they must also have symptoms.]

2: To assess the safety and tolerability of 2 IM doses of AZD1222 compared to placebo in adults ≥ 18 years of age [Time Frame: a: 28 days post each dose of study Intervention. / b: from Day 1 post-treatment through Day 730.]

a: Incidence of adverse events.

b: Incidence of serious adverse events, medically attended adverse events, and adverse events of special interest.

3: To assess the reactogenicity of 2 IM doses of AZD1222 compared to placebo in adults ≥ 18 years of age (Substudy only) [Time Frame: 7 days post each dose of study intervention.]*

Incidence of local and systemic solicited adverse events.

*In vaccine clinical trials, the term **reactogenicity** refers to the property of a vaccine of being able to produce common, "expected" adverse reactions, especially excessive immunological responses and associated signs and symptoms, including fever and sore arm at injection site.

At this point I feel the need to point out that preventing deaths from COVID19 is not even a secondary end-point for this trial either. So, whatever else we will find out, we are not going to know if AZD1222 saves any lives. Or, to be technical, the trial is not sufficiently 'powered' to reach statistical significance for overall mortality.

Anyway, getting back to the timelines, you may now be thinking, how on earth are they planning to launch a vaccine next year, if they are not going to complete their key clinical trial until October 2022? Do they have a time machine?

Well, it goes like this.

Clinical trials – before a drug is approved – normally go through three clinical phases.

- **Phase I**: Evaluate safety, determine safe dosage, identify side effects (in a small group of human volunteers, maybe twenty or thirty)
- **Phase II**: Test effectiveness, further evaluate safety (maybe a couple of hundred volunteers).
- **Phase III**: Confirm effectiveness, monitor side-effects, compare to other treatments (up to tens of thousands of volunteers).

Following completion of the Phase III trial, the data are sent to the regulatory authorities, who will then determine if the 'drug' is both safe and effective. Or at least safe and effective enough to recommend approval.

The AZ trial I have been talking about up to now, is a phase III trial, with 30,000 participants.

However, clearly, with SARS-Cov-2 vaccines, they are not going to (and cannot) wait for Phase III trials to complete. Instead, they are planning to launch directly after (what would normally be called phase II trials) to finish.

Regarding this, I was sent an e-mail by a friend regarding these phase II trials, and what they are trying to achieve. The e-mail is summary of an article by William A Haseltine who writes this, of himself.

'For nearly two decades, [William A. Haseltine] was a professor at Harvard Medical School and Harvard School of Public Health where I founded two academic research departments, the Division of Biochemical Pharmacology and the Division of Human Retrovirology. I am perhaps most well-known for my work on cancer, HIV/AIDS, and genomics.'

You can look him up on Wikipedia if you like.[2] Basically, it sounds like he knows what he is talking about, with regard to science, viruses and suchlike. Although when it comes to research on vaccines for COVID19 he seems to have spotted commercial reality for the first time in his life.

Here was the e-mail, sent to me:

Here is an interesting article about the COVID-19 vaccine trials written by William A. Haseltine, who was a professor at Harvard Medical School and Harvard School of Public Health, and who founded two academic research departments, the Division of Biochemical Pharmacology and the Division of Human Retrovirology.

Here are the two most important points he makes, which summarizes what he says in his article, are:

"These [vaccine] protocols do not emphasize the most important ramifications of COVID-19 that people are most interested in preventing: overall infection, hospitalization, and death."

[The COVID-19 vaccine trials are only looking to see if these vaccines reduce symptoms that may be as mild as cough and headache. They are NOT requiring that the vaccines reduce the risk of infection, hospitalization or death.]

"It boggles the mind and defies common sense that the National Institute of Health, the Center for Disease Control, the National Institute of Allergy and Infectious Disease, and the rest would consider the approval of a vaccine that would be distributed to hundreds of millions on such slender threads of success."

He also notes how few people there are in each of these studies for their interim analysis, which he says the companies will probably use to try and get Emergency Use Authorization from the FDA:

- "For Moderna, the interim analysis includes giving the vaccine to only 53 people."
- "For Johnson & Johnson, their interim analysis includes [only] 77 vaccine recipients "
- "For AstraZeneca, their interim analysis includes [only] 50 vaccine recipients"
- "For Pfizer, their interim analysis includes only 32 people getting the vaccine."

"These companies likely intend to apply for an emergency use authorization (EUA)

The full article was published in Forbes magazine, and can be seen there [3] .

In super-short form, the current plan is these vaccines will be launched after giving them to around fifty people – each. At which point we will have no idea if they prevent infection, hospitalisation, or death. In addition, we will not really know if they are safe, as the numbers involved are simply too small – and the timelines too short.

I hope you can now see my scepticism earlier this year, when people were claiming a vaccine could be made available six months after the start of the outbreak. I was aware – as is everyone else who knows how clinical trials are done – that this simply cannot be done. Or to be more accurate, the only way to do it is by cutting some essentially corners. The corners called 'safety', and 'efficacy'.

Yes, I fully accept these are not normal times, and there is certainly a need for speed. Yes, I also accept that we probably should be willing to accept an increased level of risk to tackle the enormous problems caused by COVID19.

However, for the average person, between the ages of twenty and fifty, the upper range estimate of the risk of dying of COVID19, if you get infected, is 0.0003 = 0.03%, which is 3 in 10,000.[4] This figure comes from the CDC in the US, which continues to stick to a higher estimated Infection Fatality Rate (IFR), than almost anyone else.

Their lower level estimated IFR for this age group is around one in 15,000. Either way, these are very low risk levels indeed. Under the age of twenty, the risk is almost incalculably small. So, for the majority of the population, under the age of fifty (realistically under sixty), we really should not be in a mad rush to vaccinate. We need the type evidence for both safety and efficacy that can only be provided by a Phase III trial.

However, I fear that such is the clamour for a vaccine, so desperate the need, we are going to be launching vaccine after vaccine, based on extremely thin evidence indeed. Not only that, it seems that in some countries, whilst reluctantly backing away from suggesting that COVID19 vaccination would be compulsory, are going to make it almost impossible to refuse.

Here is one headline, discussing the ideas being talked about in Australia *'No overseas travel, and no welfare payments: The way the government will force people to get a COVID-19 jab – even as the PM insists the vaccine will NOT be compulsory.'*

- *Australians could face being banned from travelling overseas for refusing jab*
- *Federal Health Minister Greg Hunt said he would 'not rule out' strict measures*
- *Echoed prime minister saying he'd make vaccine 'as mandatory as possible'*
- *Scott Morrison said later on Wednesday he had no power to enforce a vaccine*
- *Mr Hunt said government was not considering making inoculation compulsory*
- *But said authorities would have option of enforcing policies like 'no jab, no pay'*[5]

As mandatory as possible? Sorry, but mandatory is binary. It is, or it isn't. As for the concept of compulsory vaccination. According to the Australian Prime Minister compulsory vaccination would mean pinning people to

the floor and vaccinating them. However, telling people that they cannot travel, or work, or receive welfare payments, is tantamount to compulsion.

In my opinion, if we had fully tested vaccines, that were known to be both safe and effective, contemplating such actions would still be several steps too far. However, compelling people to get vaccinated, when all we have is Phase II studies to go on, ventures into extremely worrying territory.

We will effectively be compelling people to become participants in a massive medical research trial. It is my understanding that actions such as this would lie directly within the Nuremberg Code.

Point one: *The voluntary consent of the human subject is absolutely essential*.

This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of ***force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion****; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.* [6]

The Nuremburg Code was written after the Second World War to ensure that nothing like the unethical human experimentation carried out then on prisoners would *ever* happen again.

If people want to take these vaccines, of their own free will, that is up to them, and they may be right to make that decision.

However, I am deeply concerned that many others will be coerced, one way or another, to be vaccinated against their will.

1: https://clinicaltrials.gov/ct2/show/NCT04516746?term=NCT04516746&draw=2&rank=1

2; https://en.wikipedia.org/wiki/William_A._Haseltine

3: https://www.forbes.com/sites/williamhaseltine/2020/09/23/COVID-19-vaccine-protocols-reveal-that-trials-are-designed-to-succeed/

4: https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

5: https://www.dailymail.co.uk/news/article-8642881/Health-Minister-Greg-Hunt-reveals-tough-rules-people-refuse-COVID-19-jab.html

6: https://www.nejm.org/doi/full/10.1056/nejm199711133372006

This entry was posted in COVID-19 on October 10, 2020 [https://drmalcolmkendrick.org/2020/10/10/a-sars-cov2-vaccine-dont-hold-your-breath/] .

A podcast on Covid

A couple of days ago I had a chat with Dr Zac Cox about all things Covid. Which wandered about a bit, and does last for an hour and a half, we were enjoying ourselves. Sorry for my hungover look. I was a bit hungover.

However, even though it is a bit long, I thought that regular readers of this blog may be interested in having a look. It is on Brandnewtube, because if it were on YouTube it would not last long. The new world censors would have a fit.

It can be seen here https://brandnewtube.com/watch/dr-zac-uncensored-with-dr-malcolm-kendrick-live_W2EGf2HuoMorJVI.html

This entry was posted in COVID-19 on October 6, 2020 [https://drmalcolmkendrick.org/2020/10/06/a-podcast-on-covid/] .

False positive tests

28th September 2020

(This post contains an erratum regarding a technical issue, at the end)

There has been a lot of noise about false positive COVID19 tests in the news. So, I thought I would try to explain what it all means. Or do my best anyway.

There are two measures in most medical screening tests which are usually defined as the ‘sensitivity’ and the ‘specificity’ of a test. In my opinion, these two words are far too close together in sound, so they are very easy to mix up in your brain.

I find it easier to think of the accuracy of test results in this way.

- False negatives
- False positives

A false *negative* is a result which informs someone that they do *not* have a disease, when in fact they do.

A false *positive* is a result which informs someone they *do* have a disease, when they don't.

Ideally a test should never give a false negative (100% sensitivity) nor give a false positive (100% specificity). There is no known test that does this. In general, there is a trade-off going on between these two measures.

By which I mean, if you aim for 100% sensitivity, the specificity often falls away – and vice-versa

For example, in cancer screening the primary objective is you must *never* miss a case. So, the sensitivity rate is set very high. By definition the rate of false negatives is very low.

A shadow on the breast, a few strange cells here, a few strange cells there – *'that might be cancer, better to be safe than sorry. Don't take the risk'*. Positive cancer test.

To put this another way. The fear of missing *any* cases of cancer results in the number of false positives being high. This raises the question with COVID19. Is it better to underdiagnose – many false negatives. Or over diagnose – many false positives?

Note I am talking here primarily about the naso-pharyngeal swab tests (i.e., antigen tests) which are used to see if you have the virus NOW and not the blood (antibody) test done which may be done later to see if you have *ever* had the virus.

This issue does not seem to have been discussed. If you want to prevent spread of COVID19, you would presumably want very few false negatives in these swab tests. Otherwise people will be told they don't have the disease – when they do – and happily go off spreading it around. Equally, you would be relaxed about false positives. People would isolate when they don't need to, but not a great health issue.

Weirdly, however, this does not seem to be the case.

COVID19 false negatives

With COVID19, there are a lot of false negatives, with some studies quoting figures as high as 50%. That is, half of those told they are not infected with COVID19, are probably infected[1]. A systematic review got figures between 2% and 29%. So, we could call that an average of 16%?

As you can see, these figures are clearly all over the place. This is in major part because there is no 'gold-standard' COVID19 test. By which I mean that we do not have a '*test of tests*.' Namely, the expensive and time-consuming test by which we absolutely can know if someone truly is infected. The test against which your 'field tests' can be calibrated/verified.

Indeed, currently, there is no current agreement as to what 'infected' means with COVID19. Does it mean finding viral particles in the nose, sputum, or throat – or all three? Does it mean finding viral particles in these places, and also isolating it in the bloodstream, or lungs? Does it mean finding evidence of antibodies specific to COVID19 two to three weeks following 'infection?' Or what? It would be nice to know.

COVID19 false positives

More troubling, right now, than the very poor sensitivity of COVID19 testing (high number of false negatives) is the knotty question of how many false positive tests there are? This is important, because we are told that cases are rising and rising as we suffer a 'second wave' of COVID19.

However, if we have a high rate of false positives, then the rise in 'cases' could be driven by a rise in testing – and nothing else. And you don't need a high percentage of false positive tests to do this. If the false positive rate is as little as just one per cent (1%) this means the majority of people told they are positive for COVID19, do not have COVID19!

I know that most people find this a difficult one. It goes like this.

First, you have to know the estimated prevalence of the disease in the community. That is, the total number currently infected. Last time I looked it was one in nine hundred. For the sake of this calculation I shall call it one in a thousand. [Or, to put it another way, sixty-seven thousand people in the UK (population 67 million) are currently infected with COVID19].

Using this one in a thousand figure. This means, if you randomly tested ten thousand people, you would expect to find ten COVID19 cases [forgetting the false negatives for now].

On the other side of the coin. If the false positive rate is one per cent, you would have an additional one hundred false positives cases.

10,000 x.01(1%) = 100

Putting this another way. With a prevalence of one in a thousand, and a false positive rate of one per-cent you would have ten true COVID19 positive cases, and ninety false positives. Ergo, the vast majority of people told that they have COVID19, do not. Is this actually happening?

There is heated debate. As in much heat and little light.

In order to shed a little light, I have been communicating with a senior scientist in a COVID19 facility who feels things have gone very wrong. Below is his take on the false positive situation, from a couple of weeks ago. It is highly technical, but for those who can follow it, I think the author makes some critical points. I have not named him for, were I to do so, he would almost certainly land in very hot water. However, the references are verifiable.

1: https://www.bmj.com/content/bmj/369/bmj.m1808.full.pdf

What do positive SARS-CoV-2 RT-PCR tests mean? (Absolutely Nothing!)

The Cepheid Xpert Xpress SARS-CoV-2 RT-PCR test is the "Gold Standard" COVID-19 antigen test used in our laboratory. The specificity of this test from the manufacturer's package insert[1]. [Here referred to as negative percentage agreement or NPA) is 95.6% or 0.956 when expressed as a fraction].

I don't know about other RT-PCR tests, but I imagine the specificity will be similar for all widely used commercially available kits.

The specificity of a test is defined by the equation:

SP = TN / (TN + FP)

Where SP = specificity, TN = number of true negatives, FP = number of false positives. TN + FP = the total number of tests carried out.

Now the latest Government figures from Monday 7th September state that 350,100 tests were carried out and 2,948 people tested positive [2]. So, if we apply the above equation to our PCR test and the Government's figures, we get:

0.956 = TN / 350,100

Therefore, the number of true negatives is:

TN = 350,100 * 0.956 = 334696

Therefore, the number of false positives, FP we would expect from 350,100 tests is:

FP = 350,100 – 334,696 = 15,404

This is more than five times the number of positive tests reported, which means we cannot have any confidence that any one of those positive tests represents a genuine case.

Table 3. Xpert Xpress SARS-CoV-2 Performance Results

		Expected Results		
Xpert Xpress SARS-CoV-2		Positive	Negative	Total
	Positive	44[a]	2[b]	46
	Negative	1	43	44
	Total	45	45	90
PPA		97.8% (95% CI: 88.4% - 99.6%)		
NPA		95.6% (95% CI: 85.2% - 98.8%)		

a. One specimen was reported as "SARS-CoV-2 Presumptive Pos" in initial testing and yielded a "SARS-CoV-2 Positive" test result upon retesting.
b. The two false positive specimens were collected during the COVID-19 pandemic.

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What these figures show is that it is totally inappropriate to use RT-PCR as a screening test for a virus in an asymptomatic population when the prevalence of the infection is very low.

Even if there were a test with 99% specificity, you would still expect to get 3500 false positives from performing 350,000 tests – which is still greater than the number of "cases" reported. When the number of "cases" is lower than your rate of false positives, then a positive result on its own is virtually meaningless.

The PCR test is best utilized as a diagnostic test to confirm the diagnosis of an infection based on clinical signs and symptoms. It certainly should not be used as a screening test when there is low prevalence of disease and should NEVER be used as the sole determinant in the diagnosis of a case.

One source of false positives is the persistence of fragments of viral RNA long after a patient may have recovered and is no longer infective. These fragments will be amplified by PCR and will give a positive result that is indistinguishable from a genuine case. We've had a patient whose swabs have been testing positive in our lab every week for over 3 months!

Non-specific amplification is another possible source of false positives. The nasopharyngeal swab samples are "dirty" samples: they are full of bacterial, fungal, other viral, and host DNA and RNA. Some of these will have high percentage sequence homology [*NB homology basically means a similar sequence of base pairs- my words]* to the gene sequences targeted by the PCR assay and these can also be amplified. The risk that this may have occurred is higher if the positive test has a very high Cycle Threshold (Ct) value – say 35 or above.

Recently, it has come to my attention that one of the primers – an 18-base primer for a region of the RdRP gene – has exact sequence homology with a region on human chromosome 8 [3,4].

So, if any laboratory uses a PCR assay with that particular primer, they're likely to get a lot of false positives!

Politicians and Health Officials are basing their numbers of cases entirely on the results of these tests, which are not fit for this purpose.

They are then using these figures to terrorise the population, and to justify decisions to impose local lockdowns, and increase nonsensical general restrictions which are having a massive impact on people's lives and their health, and also on the economy, particularly hitting small businesses hard.

1. https://www.cepheid.com/Package%20Insert%20Files/Xpress-SARS-CoV-2/Xpert%20Xpress%20SARS-CoV-2%20EUA%20PI%20GX%20System%20rev%20D.pdf
2. https://coronavirus.data.gov.uk/
3. https://pieceofmindful.com/2020/04/06/bombshell-who-coronavirus-pcr-test-primer-sequence-is-found-in-all-human-dna/
4. https://www.ncbi.nlm.nih.gov/nucleotide/NC_000008.11?report=genbank&log%24=nuclalign&from=63648346&to=63648363

ERRATUM

In this blog I included a piece on false positives from a senior laboratory scientist. A number of people wrote in suggesting that the calculation was wrong. I contacted the scientist on this matter, and he has written:

In performing my calculation, I was unable to calculate the number of true positives (TP) because I did not have a figure for the prevalence of COVID-19. Since the prevalence seemed to be close to zero from the results obtained in the laboratory where I work, I assumed that TP would be negligible compared to the total number of tests carried out, and therefore did not include this in the equation I used. I acknowledge that the number of false positives (FP) calculated was thus an approximation.

I have since learned that the prevalence is approximately 0.1% according to the ONS, which means that my value for FP is actually a very good approximation, and this validates my argument that the number of false positives far outnumbers the number of true positives.

I hope that clarifies matters

This entry was posted in COVID-19 on September 28, 2020 [https://drmalcolmkendrick.org/2020/09/28/false-positive-tests/] .

More COVID19 news from Sweden

A few weeks ago, an emergency physician working in Sweden, Dr. Sebastian Rushworth, asked me if I would be willing to replicate an article from his blog on mine. I was more than happy; it was a great article. The only problem being that his writing puts mine to shame – in a second language. Although he did later tell me he had been to boarding school in England for several years. So, I feel a bit better. If not much.

He has now done an update, outlining how things are getting along in Sweden. I thought it would be of great interest for people to get news from the front line, so to speak.

As many of us know Sweden, alone in Western Europe, decided not to impose a tough lockdown. In fact, the only forcible restriction that was imposed was to ban people meeting in groups of more than fifty. Slightly later, a further restriction was placed on nursing home visits.

Apart from this, all other Government recommendations were purely voluntary [Imagine that, a Government treating its citizens as responsible human beings].

When Sebastian wrote to me recently, I sent him back this e-mail.

"Great article. Could you send it in Word format? I will obviously link back to your blog.

Also, would it be possible to put in an additional section – to go at the front of the piece – as to what measures were taken in Sweden, and what the average person in Sweden actually did. The narrative we now have (from the pro-Lockdown lobby) is that the people of Sweden, being so law-abiding and community aware, essentially locked themselves down.

Which meant that the Swedish partial lockdown was more effective than, for example, the UK 'harsh' lockdown. Because the Swedes self-policed themselves, and the Brits did not. This is usually stated with great confidence from people who provide no evidence to back this assertion up. People who have probably never been to Sweden, nor ever talked to anyone from Sweden, and probably couldn't point to Sweden on a map.

I understand schools stayed open, bars and restaurants stayed open. Gatherings of more than five hundred people were prohibited etc. What did Swedes do with masks, and going to work, for example? I think that information directly from the front line in Sweden, on these things, would be useful for people to know."

So, Sebastian added a bit onto the front as follows:

"At the beginning of August I wrote an article about my experiences working as an emergency physician in Stockholm, Sweden during the COVID pandemic. For those who are unaware, Sweden never went into full lockdown. Instead, the country imposed a partial lockdown that was almost entirely voluntary. People with office jobs were recommended to work from home, and people in general were recommended to avoid public transport unless necessary. Those who were over seventy years old, or who had serious underlying conditions, were recommended to limit social contacts.

The only forcible restriction imposed by the government from the start was a requirement that people not gather in groups of more than fifty at a time. After it became clear that COVID was above all dangerous to people in nursing homes, an additional restriction was placed on nursing home visits.

At no time has there been any requirement on people to wear face masks in public. Restaurants, cafés, hairdressers, and shops have stayed open throughout the pandemic. Pre-schools and schools for children up to the age of sixteen have stayed open, while schools for children ages sixteen to nineteen switched to distance learning.

My personal experience is that people followed the voluntary restrictions pretty well at the beginning, but that they have become increasingly lax as time has gone on. As a personal example, my mother and my parents-in-law stayed locked up in their homes for the first six weeks or so of the pandemic. After that they couldn't bear to be away from their grandchildren any longer.

In my earlier article in August, I mentioned that after an initial peak that lasted for a month or so, from March to April, visits to the Emergency Room due to COVID had been declining continuously, and deaths in Sweden had dropped from over one hundred a day at the peak in April, to around five per day in August.

At the point in August when I wrote that article, I hadn't seen a single COVID patient in over a month. I speculated that Sweden had developed herd immunity, since the huge and continuous drop was happening in spite of the fact that Sweden wasn't really taking any serious measures to prevent spread of the infection.

So, how have things developed in the six weeks since that first article?

Well, as things stand now, I haven't seen a single COVID patient in the Emergency Room in over two and a half months. People have continued to become ever more relaxed in their behaviour, which is noticeable in increasing volumes in the Emergency Room. At the peak of the pandemic in April, I was seeing about half as many patients per shift as usual, probably because lots of people were afraid to go the ER for fear of catching COVID. Now volumes are back to normal.

When I sit in the tube on the way to and from work, it is packed with people. Maybe one in a hundred people is choosing to wear a face mask in public. In Stockholm, life is largely back to normal. If you look at the front pages of the tabloids, on many days there isn't a single mention of COVID anywhere. As I write this (19th September 2020) the front pages of the two main tabloids have big spreads about arthritis and pensions. Apparently, arthritis and pensions are currently more exciting than COVID-19 in Sweden.

In spite of this relaxed attitude, the death rate has continued to drop. When I wrote the first article, I wrote that COVID had killed under 6,000 people. How many people have died now, six weeks later? Actually, we're still at under 6,000 deaths. On average, one to two people per day are dying of COVID in Sweden at present, and that number continues to drop.

In the hospital where I work, there isn't a single person currently being treated for COVID. In fact, in the whole of Stockholm, a county with very nearly two and half million inhabitants, there are currently only twenty-eight

people being treated for COVID in all the hospitals combined. At the peak, in April, that number was over a thousand. If twenty-eight people are currently in hospital, out of two and a half million who live in Stockholm. Which means the odds of having a case of COVID so severe that it requires in-hospital treatment are, at the moment, about one in eighty-six thousand.

Since March, the Emergency Room where I work has been divided in to a "COVID" section and a "non-COVID" section. Anyone with a fever, cough, or sore throat has ended up in the COVID section, and we've been required to wear full personal protective equipment when interacting with patients in that section. Last Wednesday the hospital shut down the COVID section. So, few true cases of COVID are coming through the Emergency Room that it no longer makes sense to have a separate section for COVID.

What about the few formal restrictions that were imposed early in the pandemic?

The restriction on visits to nursing homes is going to be lifted from October 1st. The older children, ages sixteen to nineteen, who were engaging in distance learning during part of the spring, are now back in school, seeing each other and their teachers face to face. The Swedish public health authority has recommended that the government lift the restriction on gatherings from fifty people to five hundred people.

When I wrote my first article, I engaged in speculation that the reason Sweden seemed to be developing herd immunity, in spite of the fact that only a minority had antibodies, was due to T-cells. Since I wrote that article, studies have appeared which support that argument.

This is good, because T-cells tend to last longer than antibodies. In fact, studies of people who were infected with SARS-CoV-1 back in 2003 have found that they still have T-cells seventeen years after being infected. This suggests that immunity is long lasting, and probably explains why there have only been a handful of reported cases of re-infection with COVID, even though the virus has spent the last nine months bouncing around the planet infecting many millions of people.

As to the handful of people who have been reported to have been re-infected. Almost all those cases have been completely asymptomatic. That is not a sign of waning immunity, as some claim. In fact, it is the opposite. It shows that people develop a functioning immunity after the first infection, which allows them to fight off the second infection without ever developing any symptoms.

So, if Sweden already has herd immunity, what about other countries? How close are they to herd immunity? The places that have experienced a lot of COVID infections, like England and Italy, have mortality curves that are very similar to Sweden's, in spite of the fact that they went into lockdown. My interpretation is that they went into lockdown too late for it to have any noticeable impact on the spread of the disease. If that is the case, then they have likely also developed herd immunity by now. Which would make the ongoing lockdowns in those countries bizarre.

What about the vaccine? Will it arrive in time to make a difference? As I mentioned in my first article, lockdown only makes sense if you are willing to stay in lockdown until there is an effective vaccine. Otherwise you are

merely postponing the inevitable. At the earliest, a vaccine will be widely available at some point in the middle of next year.

How many governments are willing to keep their populations in lockdown until then? And what if the vaccine is only thirty per-cent effective? Or fifty per-cent? Will governments decide that is good enough for them to end lockdown? Or will they want to stay in lockdown until there is a vaccine that is at least ninety per-cent effective? How many years will that take?

So, to conclude: COVID is over in Sweden. We have herd immunity. Most likely, many other parts of the world do too, including England, Italy, and parts of the US, like New York. And the countries that have successfully contained the spread of the disease, like Germany, Denmark, New Zealand, and Australia, are going to have to stay in lockdown for at least another year, and possibly several years, if they don't want to develop herd immunity the natural way.

This entry was posted in COVID-19 on September 21, 2020 [https://drmalcolmkendrick.org/2020/09/21/more-covid19-news-from-sweden/] .

Growing concern about Lockdown from doctors in Belgium

19th September 2020

In order to make you aware that there are a growing number of doctors in Europe who feel that Lockdown has been an unmitigated disaster, I have downloaded an open Letter from doctors in Belgium. It can be seen here. https://docs4opendebate.be/en/open-letter/

Doctors in other countries e.g. Germany have done much the same thing. I am putting this on my blog so that as many people as possible read it.

Open letter from medical doctors and health professionals to all Belgian authorities and all Belgian media.

We, Belgian doctors and health professionals, wish to express our serious concern about the evolution of the situation in the recent months surrounding the outbreak of the SARS-CoV-2 virus. We call on politicians to be independently and critically informed in the decision-making process and in the compulsory implementation of corona-measures. We ask for an open debate, where all experts are represented without any form of censorship. After the initial panic surrounding covid-19, the objective facts now show a completely different picture – there is no medical justification for any emergency policy anymore.

The current crisis management has become totally disproportionate and causes more damage than it does any good.

We call for an end to all measures and ask for an immediate restoration of our normal democratic governance and legal structures and of all our civil liberties.

'A cure must not be worse than the problem' is a thesis that is more relevant than ever in the current situation. We note, however, that the collateral damage now being caused to the population will have a greater impact in the short and long term on all sections of the population than the number of people now being safeguarded from corona.

In our opinion, the current corona measures and the strict penalties for non-compliance with them are contrary to the values formulated by the Belgian Supreme Health Council, which, until recently, as the health authority, has always ensured quality medicine in our country: "Science – Expertise – Quality – Impartiality – Independence – Transparency". [1]

We believe that the policy has introduced mandatory measures that are not sufficiently scientifically based, unilaterally directed, and that there is not enough space in the media for an open debate in which different views and opinions are heard. In addition, each municipality and province now has the authorisation to add its own measures, whether well-founded or not.

Moreover, the strict repressive policy on corona strongly contrasts with the government's minimal policy when it comes to disease prevention, strengthening our own immune system through a healthy lifestyle, optimal care with attention for the individual and investment in care personnel.[2]

The concept of health

In 1948, the WHO defined health as follows: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or other physical impairment'.[3]

Health, therefore, is a broad concept that goes beyond the physical and also relates to the emotional and social well-being of the individual. Belgium also has a duty, from the point of view of subscribing to fundamental human rights, to include these human rights in its decision-making when it comes to measures taken in the context of public health. [4]

The current global measures taken to combat SARS-CoV-2 violate to a large extent this view of health and human rights. Measures include compulsory wearing of a mask (also in open air and during sporting activities, and in some municipalities even when there are no other people in the vicinity), physical distancing, social isolation, compulsory quarantine for some groups and hygiene measures.

The predicted pandemic with millions of deaths

At the beginning of the pandemic, the measures were understandable and widely supported, even if there were differences in implementation in the countries around us. The WHO originally predicted a pandemic that would claim 3.4% victims, in other words millions of deaths, and a highly contagious virus for which no treatment or vaccine was available. This would put unprecedented pressure on the intensive care units (ICUs) of our hospitals.

This led to a global alarm situation, never seen in the history of mankind: "flatten the curve" was represented by a lockdown that shut down the entire society and economy and quarantined healthy people. Social distancing became the new normal in anticipation of a rescue vaccine.

The facts about covid-19

Gradually, the alarm bell was sounded from many sources: the objective facts showed a completely different reality. [5] [6]

The course of covid-19 followed the course of a normal wave of infection similar to a flu season. As every year, we see a mix of flu viruses following the curve: first the rhinoviruses, then the influenza A and B viruses, followed by the coronaviruses. There is nothing different from what we normally see.

The use of the non-specific PCR test, which produces many false positives, showed an exponential picture. This test was rushed through with an emergency procedure and was never seriously self-tested. The creator expressly warned that this test was intended for research and not for diagnostics.[7]

The PCR test works with cycles of amplification of genetic material – a piece of genome is amplified each time. Any contamination (e.g. other viruses, debris from old virus genomes) can possibly result in false positives.[8]

The test does not measure how many viruses are present in the sample. A real viral infection means a massive presence of viruses, the so-called virus load. If someone tests positive, this does not mean that that person is actually clinically infected, is ill or is going to become ill. Koch's postulate was not fulfilled ("The pure agent found in a patient with complaints can provoke the same complaints in a healthy person").

Since a positive PCR test does not automatically indicate active infection or infectivity, this does not justify the social measures taken, which are based solely on these tests. [9] [10]

Lockdown.

If we compare the waves of infection in countries with strict lockdown policies to countries that did not impose lockdowns (Sweden, Iceland ...), we see similar curves. So there is no link between the imposed lockdown and the course of the infection. Lockdown has not led to a lower mortality rate.

If we look at the date of application of the imposed lockdowns we see that the lockdowns were set after the peak was already over and the number of cases decreasing. The drop was therefore not the result of the taken measures. [11]

As every year, it seems that climatic conditions (weather, temperature and humidity) and growing immunity are more likely to reduce the wave of infection.

Our immune system

For thousands of years, the human body has been exposed daily to moisture and droplets containing infectious microorganisms (viruses, bacteria and fungi).

The penetration of these microorganisms is prevented by an advanced defence mechanism – the immune system. A strong immune system relies on normal daily exposure to these microbial influences. Overly hygienic measures have a detrimental effect on our immunity. [12] [13] Only people with a weak or faulty immune system should be protected by extensive hygiene or social distancing.

Influenza will re-emerge in the autumn (in combination with covid-19) and a possible decrease in natural resilience may lead to further casualties.

Our immune system consists of two parts: a congenital, non-specific immune system and an adaptive immune system.

The non-specific immune system forms a first barrier: skin, saliva, gastric juice, intestinal mucus, vibratory hair cells, commensal flora, ... and prevents the attachment of micro-organisms to tissue.

If they do attach, macrophages can cause the microorganisms to be encapsulated and destroyed.

The adaptive immune system consists of mucosal immunity (IgA antibodies, mainly produced by cells in the intestines and lung epithelium), cellular immunity (T-cell activation), which can be generated in contact with foreign substances or microorganisms, and humoral immunity (IgM and IgG antibodies produced by the B cells).

Recent research shows that both systems are highly entangled.

It appears that most people already have a congenital or general immunity to e.g. influenza and other viruses. This is confirmed by the findings on the cruise ship Diamond Princess, which was quarantined because of a few passengers who died of Covid-19. Most of the passengers were elderly and were in an ideal situation of transmission on the ship. However, 75% did not appear to be infected. So even in this high-risk group, the majority are resistant to the virus.

A study in the journal Cell shows that most people neutralise the coronavirus by mucosal (IgA) and cellular immunity (T-cells), while experiencing few or no symptoms [14].

Researchers found up to 60% SARS-Cov-2 reactivity with CD4+T cells in a non-infected population, suggesting cross-reactivity with other cold (corona) viruses.15 Most people therefore already have a congenital or cross-immunity because they were already in contact with variants of the same virus.

The antibody formation (IgM and IgG) by B-cells only occupies a relatively small part of our immune system. This may explain why, with an antibody percentage of 5-10%, there may be a group immunity anyway. The efficacy of vaccines is assessed precisely on the basis of whether or not we have these antibodies. This is a misrepresentation.

Most people who test positive (PCR) have no complaints. Their immune system is strong enough. Strengthening natural immunity is a much more logical approach. Prevention is an important, insufficiently highlighted pillar: healthy, full-fledged nutrition, exercise in fresh air, without a mask, stress reduction and nourishing emotional and social contacts.

Consequences of social isolation on physical and mental health

Social isolation and economic damage led to an increase in depression, anxiety, suicides, intra-family violence and child abuse.[16]

Studies have shown that the more social and emotional commitments people have, the more resistant they are to viruses. It is much more likely that isolation and quarantine have fatal consequences. [17]

The isolation measures have also led to physical inactivity in many older people due to their being forced to stay indoors. However, sufficient exercise has a positive effect on cognitive functioning, reducing depressive complaints and anxiety and improving physical health, energy levels, well-being and, in general, quality of life.[18]

Fear, persistent stress and loneliness induced by social distancing have a proven negative influence on psychological and general health. [19]

A highly contagious virus with millions of deaths without any treatment?

Mortality turned out to be many times lower than expected and close to that of a normal seasonal flu (0.2%). [20]

The number of registered corona deaths therefore still seems to be overestimated.

There is a difference between death by corona and death with corona. Humans are often carriers of multiple viruses and potentially pathogenic bacteria at the same time. Taking into account the fact that most people who developed serious symptoms suffered from additional pathology, one cannot simply conclude that the corona-infection was the cause of death. This was mostly not taken into account in the statistics.

The most vulnerable groups can be clearly identified. The vast majority of deceased patients were 80 years of age or older. The majority (70%) of the deceased, younger than 70 years, had an underlying disorder, such as cardiovascular suffering, diabetes mellitus, chronic lung disease or obesity. The vast majority of infected persons (>98%) did not or hardly became ill or recovered spontaneously.

Meanwhile, there is an affordable, safe and efficient therapy available for those who do show severe symptoms of disease in the form of HCQ (hydroxychloroquine), zinc and AZT (azithromycin). Rapidly applied this therapy

leads to recovery and often prevents hospitalisation. Hardly anyone has to die now.

This effective therapy has been confirmed by the clinical experience of colleagues in the field with impressive results. This contrasts sharply with the theoretical criticism (insufficient substantiation by double-blind studies) which in some countries (e.g. the Netherlands) has even led to a ban on this therapy. A meta-analysis in The Lancet, which could not demonstrate an effect of HCQ, was withdrawn. The primary data sources used proved to be unreliable and 2 out of 3 authors were in conflict of interest. However, most of the guidelines based on this study remained unchanged ... [48] [49]

We have serious questions about this state of affairs.

In the US, a group of doctors in the field, who see patients on a daily basis, united in "America's Frontline Doctors" and gave a press conference which has been watched millions of times.[21] [51]

French Prof Didier Raoult of the Institut d'Infectiologie de Marseille (IHU) also presented this promising combination therapy as early as April. Dutch GP Rob Elens, who cured many patients in his practice with HCQ and zinc, called on colleagues in a petition for freedom of therapy.[22]

The definitive evidence comes from the epidemiological follow-up in Switzerland: mortality rates compared with and without this therapy.[23]

From the distressing media images of ARDS (acute respiratory distress syndrome) where people were suffocating and given artificial respiration in agony, we now know that this was caused by an exaggerated immune response with intravascular coagulation in the pulmonary blood vessels. The administration of blood thinners and dexamethasone and the avoidance of artificial ventilation, which was found to cause additional damage to lung tissue, means that this dreaded complication, too, is virtually not fatal anymore. [47]

It is therefore not a killer virus, but a well-treatable condition.

Propagation

Spreading occurs by drip infection (only for patients who cough or sneeze) and aerosols in closed, unventilated rooms. Contamination is therefore not possible in the open air. Contact tracing and epidemiological studies show that healthy people (or positively tested asymptomatic carriers) are virtually unable to transmit the virus. Healthy people therefore do not put each other at risk. [24] [25]

Transfer via objects (e.g. money, shopping or shopping trolleys) has not been scientifically proven.[26] [27] [28]

All this seriously calls into question the whole policy of social distancing and compulsory mouth masks for healthy people – there is no scientific basis for this.

Masks

Oral masks belong in contexts where contacts with proven at-risk groups or people with upper respiratory complaints take place, and in a medical context/hospital-retirement home setting. They reduce the risk of droplet infection by sneezing or coughing. Oral masks in healthy individuals are ineffective against the spread of viral infections. [29] [30] [31]

Wearing a mask is not without side effects. [32] [33] Oxygen deficiency (headache, nausea, fatigue, loss of concentration) occurs fairly quickly, an effect similar to altitude sickness. Every day we now see patients complaining of headaches, sinus problems, respiratory problems and hyperventilation due to wearing masks. In addition, the accumulated CO2 leads to a toxic acidification of the organism which affects our immunity. Some experts even warn of an increased transmission of the virus in case of inappropriate use of the mask.[34]

Our Labour Code (Codex 6) refers to a CO2 content (ventilation in workplaces) of 900 ppm, maximum 1200 ppm in special circumstances. After wearing a mask for one minute, this toxic limit is considerably exceeded to values that are three to four times higher than these maximum values. Anyone who wears a mask is therefore in an extreme poorly ventilated room. [35]

Inappropriate use of masks without a comprehensive medical cardio-pulmonary test file is therefore not recommended by recognised safety specialists for workers.

Hospitals have a sterile environment in their operating rooms where staff wear masks and there is precise regulation of humidity / temperature with appropriately monitored oxygen flow to compensate for this, thus meeting strict safety standards. [36]

A second corona wave?

A second wave is now being discussed in Belgium, with a further tightening of the measures as a result. However, closer examination of Sciensano's figures (latest report of 3 September 2020)37 shows that, although there has been an increase in the number of infections since mid-July, there was no increase in hospital admissions or deaths at that time. It is therefore not a second wave of corona, but a so-called "case chemistry" due to an increased number of tests. [50]

The number of hospital admissions or deaths showed a shortlasting minimal increase in recent weeks, but in interpreting it, we must take into account the recent heatwave. In addition, the vast majority of the victims are still in the population group >75 years.

This indicates that the proportion of the measures taken in relation to the working population and young people is disproportionate to the intended objectives.

The vast majority of the positively tested "infected" persons are in the age group of the active population, which does not develop any or merely limited symptoms, due to a well-functioning immune system.

So nothing has changed – the peak is over.

Strengthening a prevention policy

The corona measures form a striking contrast to the minimal policy pursued by the government until now, when it comes to well-founded measures with proven health benefits such as the sugar tax, the ban on (e-)cigarettes and making healthy food, exercise and social support networks financially attractive and widely accessible. It is a missed opportunity for a better prevention policy that could have brought about a change in mentality in all sections of the population with clear results in terms of public health. At present, only 3% of the health care budget goes to prevention. 2

The Hippocratic Oath

As a doctor, we took the Hippocratic Oath:

“I will above all care for my patients, promote their health and alleviate their suffering”.

“I will inform my patients correctly.”

“Even under pressure, I will not use my medical knowledge for practices that are against humanity.”

The current measures force us to act against this oath.

Other health professionals have a similar code.

The ‘primum non nocere’, which every doctor and health professional assumes, is also undermined by the current measures and by the prospect of the possible introduction of a generalised vaccine, which is not subject to extensive prior testing.

Vaccine

Survey studies on influenza vaccinations show that in 10 years we have only succeeded three times in developing a vaccine with an efficiency rate of more than 50%. Vaccinating our elderly appears to be inefficient. Over 75 years of age, the efficacy is almost non-existent.[38]

Due to the continuous natural mutation of viruses, as we also see every year in the case of the influenza virus, a vaccine is at most a temporary solution, which requires new vaccines each time afterwards. An untested vaccine, which is implemented by emergency procedure and for which the manufacturers have already obtained legal immunity from possible harm, raises serious questions. [39] [40] We do not wish to use our patients as guinea pigs.

On a global scale, 700 000 cases of damage or death are expected as a result of the vaccine.[41] If 95% of people experience Covid-19 virtually symptom-free, the risk of exposure to an untested vaccine is irresponsible.

The role of the media and the official communication plan

Over the past few months, newspaper, radio and TV makers seemed to stand almost uncritically behind the panel of experts and the government, there, where it is precisely the press that should be critical and prevent one-sided governmental communication. This has led to a public communication in our news media, that was more like propaganda than objective reporting.

In our opinion, it is the task of journalism to bring news as objectively and neutrally as possible, aimed at finding the truth and critically controlling power, with dissenting experts also being given a forum in which to express themselves.

This view is supported by the journalistic codes of ethics.[42]

The official story that a lockdown was necessary, that this was the only possible solution, and that everyone stood behind this lockdown, made it difficult for people with a different view, as well as experts, to express a different opinion.

Alternative opinions were ignored or ridiculed. We have not seen open debates in the media, where different views could be expressed.

We were also surprised by the many videos and articles by many scientific experts and authorities, which were and are still being removed from social media. We feel that this does not fit in with a free, democratic constitutional state, all the more so as it leads to tunnel vision. This policy also has a paralysing effect and feeds fear and concern in society. In this context, we reject the intention of censorship of dissidents in the European Union! [43]

The way in which Covid-19 has been portrayed by politicians and the media has not done the situation any good either. War terms were popular and warlike language was not lacking. There has often been mention of a ‘war’ with an ‘invisible enemy’ who has to be ‘defeated’. The use in the media of phrases such as ‘care heroes in the front line’ and ‘corona victims’ has further fuelled fear, as has the idea that we are globally dealing with a ‘killer virus’.

The relentless bombardment with figures, that were unleashed on the population day after day, hour after hour, without interpreting those figures, without comparing them to flu deaths in other years, without comparing them to deaths from other causes, has induced a real psychosis of fear in the population. This is not information, this is manipulation.

We deplore the role of the WHO in this, which has called for the infodemic (i.e. all divergent opinions from the official discourse, including by experts with different views) to be silenced by an unprecedented media censorship.[43] [44]

We urgently call on the media to take their responsibilities here!

We demand an open debate in which all experts are heard.

Emergency law versus Human Rights

The general principle of good governance calls for the proportionality of government decisions to be weighed up in the light of the Higher Legal Standards: any interference by government must comply with the fundamental rights as protected in the European Convention on Human Rights (ECHR). Interference by public authorities is only permitted in crisis situations. In other words, discretionary decisions must be proportionate to an absolute necessity.

The measures currently taken concern interference in the exercise of, among other things, the right to respect of private and family life, freedom of thought, conscience and religion, freedom of expression and freedom of assembly and association, the right to education, etc., and must therefore comply with fundamental rights as protected by the European Convention on Human Rights (ECHR).

For example, in accordance with Article 8(2) of the ECHR, interference with the right to private and family life is permissible only if the measures are necessary in the interests of national security, public safety, the economic well-being of the country, the protection of public order and the prevention of criminal offences, the protection of health or the protection of the rights and freedoms of others, the regulatory text on which the interference is based must be sufficiently clear, foreseeable and proportionate to the objectives pursued.[45]

The predicted pandemic of millions of deaths seemed to respond to these crisis conditions, leading to the establishment of an emergency government. Now that the objective facts show something completely different, the condition of inability to act otherwise (no time to evaluate thoroughly if there is an emergency) is no longer in place. Covid-19 is not a cold virus, but a well treatable condition with a mortality rate comparable to the seasonal flu. In other words, there is no longer an insurmountable obstacle to public health.

There is no state of emergency.

Immense damage caused by the current policies

An open discussion on corona measures means that, in addition to the years of life gained by corona patients, we must also take into account other factors affecting the health of the entire population. These include damage in the psychosocial domain (increase in depression, anxiety, suicides, intra-family violence and child abuse)[16] and economic damage.

If we take this collateral damage into account, the current policy is out of all proportion, the proverbial use of a sledgehammer to crack a nut.We find it shocking that the government is invoking health as a reason for the emergency law.

As doctors and health professionals, in the face of a virus which, in terms of its harmfulness, mortality and transmissibility, approaches the seasonal influenza, we can only reject these extremely disproportionate measures.

We therefore demand an immediate end to all measures.

We are questioning the legitimacy of the current advisory experts, who meet behind closed doors.

Following on from ACU 2020 46 https://acu2020.org/nederlandse-versie/ we call for an in-depth examination of the role of the WHO and the possible influence of conflicts of interest in this organisation. It was also at the heart of the fight against the "infodemic", i.e. the systematic censorship of all dissenting opinions in the media. This is unacceptable for a democratic state governed by the rule of law.[43]

Distribution of this letter

We would like to make a public appeal to our professional associations and fellow carers to give their opinion on the current measures.We draw attention to and call for an open discussion in which carers can and dare to speak out.

With this open letter, we send out the signal that progress on the same footing does more harm than good, and call on politicians to inform themselves independently and critically about the available evidence – including that from experts with different views, as long as it is based on sound science – when rolling out a policy, with the aim of promoting optimum health.

With concern, hope and in a personal capacity.

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17: Conn, Hafdahl en Brown, 2009; Martinsen 2008; Yau, 2008

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24: http://www.emro.who.int/health-topics/corona-virus/transmission-of-covid-19-by-asymptomatic-cases.html

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49 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31324-6/fulltext

There is no revival of the pandemic, but a so-called casedemic due to more testing.

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COVID-19 and Foxy-Loxy

17th September 2020

In the last few weeks in various podcasts and interviews people have been trying their best to get me to say that the entire COVID-19 panic is a conspiracy. I understand what they are trying to do, but I was not born yesterday! The moment you say, or even imply, something is a conspiracy you step on a landmine that blows you, and your reputation, to smithereens.

Because you immediately become a conspiracy theorist. *'You are David Icke and I claim my million pounds'.* For those who have never heard of him, look him up. According to Wikipedia:

"Icke believes that the universe is made up of "vibrational" energy and consists of an infinite number of dimensions that share the same space. He claims that an inter-dimensional race of reptilian beings called the Archons (or Anunnaki) have hijacked the earth, and that a genetically modified human–Archon hybrid race of shape-shifting reptilians known as the Babylonian Brotherhood, the Illuminati, or the "elite", manipulate global events to help keep humans in constant fear. The Archons feed off the "negative energy" this creates [1]. "

Now, he may not believe that anymore, maybe he never did. Maybe it was a joke, and his words got twisted. But he has managed to gather the kind of reputation that tends to make people suspect he may not be entirely

tightly sane. '*Beware the Archons*.'

In truth, I have thought long and hard about what a COVID19 conspiracy might actually be or look like. A shadowy Dr. No sitting in an underground layer, stroking a spoiled, fluffy white cat, and cackling. *'Yes, Mr Bond, soon the entire world will be under my control as my vaccine is released, turning everyone into mindless zombies. Mwahahahahahaha!'*

I would just say to Dr. No. Sorry, it's too late, the Kardashians already did the '*turning the entire world into mindless zombies'* thing. Now their work here is done. They will soon be heading back to their home-world of Kardashia to plot the destruction of entire inter-galactic civilisations using their inanitron device, powered entirely by trivium crystals.

However, I do not believe in worldwide conspiracies… humans are too incompetent to get a proper worldwide conspiracy organised for one thing. However I do believe in Foxy-Loxy.

If you remember the children's tale of 'the sky is falling', Chicken Little manages to scare all the other animals, Ducky Lucky et al. into believing the sky is falling, and they rush in blind panic to tell the king. They then run into Foxy-Loxy:

"Well, well, and good day," said Foxy Loxy. *"Where are you rushing on such a fine day, my delicious little friends?"*

"Help us! Help us!" cried Chicken Little, Henny Penny, Ducky Lucky, Goosey Loosey, and Turkey Lurkey. *"It's not a fine day at all. The sky is falling, and we're rushing to tell the king!"*

"And how do you know the sky is falling?" asked Foxy Loxy.

"I saw it with my own eyes, and heard it with my own ears, and part of it fell on my head," Chicken Little said. "I see," said Foxy Loxy. *"Well then, follow me, and I'll show you the way to the king."*

So Foxy Loxy led Chicken Little, Henny Penny, Ducky Lucky, Goosey Loosey, and Turkey Lurkey across a field and through the woods. He led them straight to his den, and they never saw the king, or anyone else, ever again…

In other versions of the story, Foxy-Loxy deliberately throws the acorn that hits Chicken Little on the head, in order to start the panic in the first place. He then waits to take advantage of the ensuing events. *'Now please, you must all to follow me, for I will keep you safe.'*

In other words, there is no worldwide cabal, no great shadowy conspiracy. Instead what we have is – what I call – a conspiracy of the willing. When fear strikes, the vast bulk of the public really, really, want to be protected, and will do almost anything to feel safe. The medical profession wishes to protect people and will do almost anything they are told, to help their patients.

Politicians very much wish to be seen as great statesmen, protecting the public and bringing in laws to do so. Standing at podiums looking terribly serious and important and pretending to be Winston Churchill.

So, if Sciensey-Wyensey can convince Experty-Wexperty that the sky is falling, then it is easy to get Publicky-Wublickey, Doctory-Woctory and Nursey Wursey, and Politiciany-Opportunity-Wunity to join in. There is no conspiracy here, but there is a massive drive for them all to rush to the king for protection.

At which point, Foxy Loxy has them all perfectly under control. A little nudge here, a little nudge there, and the entire mob will head off in whatever direction you wish. A shepherd with two perfectly controlled sheepdogs. The dread sheepdogs of fear and empty promises.

1: https://en.wikipedia.org/wiki/David_Icke

This entry was posted in COVID-19 on September 17, 2020 [https://drmalcolmkendrick.org/2020/09/17/covid-19-and-foxy-loxy/] .

A way to control COVID-19 (for now)

13th September 2020

[Winter is coming]

In the flu pandemic at the end of World War One, the average age of death was twenty-eight [1]. In the UK, the average age of death from COVID19 is eighty-one for men, and eighty-four for women. Which is older than the average life expectancy in parts of the UK. These data are from the Office of National Statistics (ONS), as analysed and reported in the Daily Mail [2].

[I do not usually reference newspapers for scientific data, but this article is very clear and understandable for the lay reader].

The risk of dying if you get infected and have serious symptoms, requiring some medical actions – the case fatality rate (CFR*) – also rises exponentially as you get older. In Italy, in the early stages of the pandemic, the CFR for those under twenty-nine was zero per cent. Rising to twenty per cent in those over eighty [3].

[*this figure changes over time. It always falls as more and more people are tested. See previous blogs also about mixing up CFR with Infection Fatality Rate (IFR)]

I am not getting into an unwinnable argument as to the value of human life at different ages. I am simply making the point that COVID19 is, for reasons not well established, vastly more serious in the elderly population. This is very different from previous epidemics.

COVID19 also targets those with significant underlying medical conditions. A recent report from the Centers for Disease Control and Prevention (CDC) in the US, found that ninety-four per cent of patients who died from COVID19 had other '*health conditions and contributing causes*.' [4]

In essence, we know that COVID19 is a disease that is both significant and deadly in the elderly population. Particularly the elderly population with underlying medical conditions. For those of working age – who are otherwise healthy – COVID19 is far less serious. The risk appears to be lower than for influenza. In children, and those under forty, the risk is almost non-existent.

Therefore, it is relatively straightforward to identify pretty accurately those who we need to help protect from COVID19, and those who we do not.

On this basis I am going to recommend that the best way to protect the vulnerable elderly is to build up immunity in the younger population, in order to stop the spread throughout the whole community. If eighty per cent of the population under seventy were to get infected, this would stop transmission in its tracks, and COVID19 would be gone.

However, what we are doing currently is to lockdown ever more tightly to stop the spread. Whether or not this is working is unclear. However, let us assume that it is doing so. Then, I would argue that we are doing precisely the wrong thing at precisely the wrong time.

It is true that in recent weeks, positive infection tests have risen rapidly. However, deaths have not nor have hospital admissions. In the month of August (which is as far as the Office for National Statistics figures go), in the under thirty age group, there was one death [5].

Of course, if more and more people get infected, and more elderly vulnerable people get infected, there will eventually be an increase in deaths. Therefore, what we need to do right now – before winter comes – is to encourage everyone who is fit and well and under the age of seventy (slightly arbitrary figure) to take the masks off, get together and spread this virus far and wide.

At the same time, all of those who are older and/or vulnerable should self-isolate, and this should be rigorously encouraged, and supported. How long would it take to infect the rest of the population?

Using widely accepted figures. If the R number is three (average number of people an infected person will go on to infect), and the serial interval is four days (time from becoming infected to infecting others) [6], then we can do a little thought experiment.

We start with the number of people currently infected. Today, Sept 11th there were 3,539 positive tests in the UK. Assuming people are infectious for a week, then the minimum number of people who have COVID19,

currently, who could spread it is 3,539 x 7 = 24,773.

This assumes we have detected every single infected person in the UK, which is not possible, so my 24,773 figure is a major underestimate of the true starting point.

If the R number is three, and the serial interval is four, we would treble the number of cases every four days. We start on day one with 24,773 infective people.

Day one = 24,773

Day five = 74,319

Day nine = 222,957

Day thirteen = 668,871

Day seventeen = 2,006,613

Day twenty = 6,019,839

Day twenty-four = 18,059,517

Day twenty-eight = 54,178,551

That's it. Done in a month. Of course, it doesn't quite work like that. As more and more people get infected, there are less people left to infect so the R number drops. We also know that a number of people have already been infected. How many? Who knows.

However, the general principle stands. We could protect the vulnerable elderly by creating sufficient immunity in the rest of the population, ensuring that the elderly are shielded at the same time, and it could be done rapidly.

Matt Hancock (UK health secretary, for those reading this blog in other countries), made the utterly insensitive comment urging people not to kill their granny:

'Young people have been urged by the health secretary not to "kill your gran" by spreading coronavirus after an increase in cases led to calls for mass testing of students.'[7]

Has this man been on a course on how to really and truly insult and upset your electorate? If not, then he is clearly just a natural.

Leaving that to one side, Matt Hancock should be urging young people to get infected and '*protect your granny*' – and also your grandpa. Because grandpas are people too.

Yes, I know, some people, many people… most people? Will be upset by what I have written. How can you possibly encourage people to go out and get infected? Do you want people to die?

No, I want the least possible number of people to die of this awful disease, and its terrible consequences. I also want to stop lockdown as soon as possible because I know that lockdown kills people. Currently it is killing far more than COVID19. Forgetting the economy, forgetting the social destruction and loss of jobs and livelihoods, there are terrible things happening to lives.

Here is what the UK Parliament was told, early on in the lockdown:

'A global surge in domestic abuse has been reported during the coronavirus pandemic, as those living with domestic violence face greater risks at home during lockdowns, and support services are harder to reach and to provide.

The UK has followed the global pattern of rising domestic abuse risks during the crisis: calls and contacts to helplines have increased markedly and evidence suggests incidents are becoming more complex and serious, with higher levels of physical violence and coercive control.

Counting Dead Women has calculated that there were at least sixteen domestic abuse killings of women and children between 23 March and 12 April.' [8]

Young children are far more likely to die at the hands of their parents than they are to die of COVID19, and young women are far more likely to die at the hands of their abusive partners. Vulnerable children are far safer at school than at home. Yet, we are locking them in their houses.

So, I would turn the whole argument around. Why are we killing children with Lockdown? Get rid of the virus, now, get rid of lockdown now, and allow them to live. Allow the rest of us to have a job, and a future.

As for our elderly people, trapped in houses and Care Homes, unable to see their families. Get rid of this virus now, get rid of lockdown now, and allow them to live. To those who believe they occupy the moral high ground by demanding more lockdowns, more protection etc. I believe that you are failing to protect anyone.

The fact is that we know who to protect, and the best way to do it is to create population-wide immunity as fast as possible. In doing so, we will not overwhelm the hospitals. We will not destroy the NHS – or any other health service around the world. So long as this disease does not rampage through the elderly population again.

For those who say, we must wait for a vaccine. I would say that you could be right to do so, one may appear. However, if you are not right, if problems emerge in development or rollout, what do we do. Lockdown forever? Keep the elderly apart from the rest of society, forever?

I would also say that we cannot plan on the basis that this 'vaccine' saviour of humanity may appear. We can only plan on the basis of what we know, what we have got right now. What we have got is a virus that is, for the vast majority of the population is, relatively benign. The majority of people who test positive are not even aware they have been infected.

Yes, of course, if we let COVID19 fly free in those under seventy, there will be deaths. How many? That is very difficult to say. John Ioannidis, a professor and researcher that I rate very highly, attempted to calculate the Infection Fatality Rate in the under seventy population. In July he put it at 0.04%. So, I will go with his figure [9].

0.04% is four in ten thousand. Which may not sound a lot to some. However, in the UK, we have sixty-seven million people, of whom fifty-six million are under age seventy. So, four in ten thousand fatalities would result in twenty-two thousand four hundred deaths. I agree that is a lot, but this figure comes in far too high, for a number of reasons.

First, it is estimated that we would need 80% of population to be infected, to create population wide immunity. So, we can immediately reduce twenty-two thousand four hundred to eighteen thousand. Still too many? Well we would, of course, shield people with underlying diseases such as type II diabetes and cancer and heart disease.

If the Centers for Disease Control and Prevention (CDC) figures are correct, ninety-four per cent of those who die of COVID19 have other serious underlying conditions. So, if we also protect those under seventy, who have serious underlying condition, the eighteen thousand figure reduces to one thousand and eighty.

Which means that it may be possible to achieve population wide immunity at a (maximum) cost of just over one thousand deaths, from COVID19, Probably not even that, as we do now know far better how to treat it than we did at the start. We could also do this by the end of the year – by the latest. You still think one thousand deaths is too many. Well, consider the alternative.

Let us look at just one condition, cancer. Due to the actions taken to reduce deaths from COVID19, there has been a serious delay in cancer diagnosis. Here from the Lancet:

'Substantial increases in the number of avoidable cancer deaths in England are to be expected as a result of diagnostic delays due to the COVID-19 pandemic in the UK. Urgent policy interventions are necessary, particularly the need to manage the backlog within routine diagnostic services to mitigate the expected impact of the COVID-19 pandemic on patients with cancer.'[10]

The authors estimated the years of life lost from delayed cancer diagnosis and treatment will be in the region of 59,204 – 63,229. A year of life lost is not the same outcome as a life lost dying from COVID. However, sixty thousand years of life lost is significantly greater than one thousand COVID19 deaths, and the longer we go on, the greater this number becomes.

This, remember, is just one condition. The ONS estimated that lockdown has, so far, caused sixteen thousand excess deaths due to such things as people not attending hospital with heart attacks and strokes, and suchlike. I want to emphasize this is not my figure, it comes from SAGE [11].

I don't think I can make the point forcefully enough that we are not playing a zero-sum game here, whereby every COVID life saved is a life saved, that would otherwise be lost. Lockdown itself, kills people, in their

thousands and thousands. Their tens of thousands. More than COVID19 itself, in total? Some people think so, including me.

I say this because ONS further estimated that, in England alone, the economic recession itself will lead to around 17,000 excess deaths per year, for several years. Add that to the sixteen thousand this year, add that to the cancer lives lost…

'This (estimated recession) *produces an increase in deaths of between 1.2% and 6.8% in England as a result of the negative economic impact from COVID-19 and associated NPIs* (actions that are taken to prevent the disease i.e. lockdown)*, with a central estimate of 3.1%. This is between 6,800 and 38,300 additional deaths per year, with a central estimate of 17,400 per year* [11]*.'*

The other point to bear in mind is that, if we shield the elderly and vulnerable, and create population immunity, we are also protecting millions of people who would have a far greater risk of dying if they became infected.

Using an infection fatality rate of one per cent in the over seventies [it is probably higher than that] we have twelve million people over seventy in the UK. If eighty per cent got infected, this could result in nine hundred and sixty thousand deaths. That would certainly overwhelm the health service.

So, I would ask people to turn their thinking around on COVID19. We have it within our power, right now, to get rid of COVID19 by the end of the year. Will this get rid of it forever – who knows – it may return in the winter. If not this winter, next winter?

If we open up society there will be a cost, there will be deaths, that is inarguable. However, I believe that we will save far more lives by letting this disease spread in the younger, healthy population. We will save both children and adults, and we can return to normal life.

Therefore, the proposal is simple. Work out who is most at risk, work out how to keep them shielded, then encourage everyone else to get out there and live their lives as before. [General Practitioners have already been asked to create lists of their patients who are most vulnerable, so most of this work has been done]. Once we have the infection rates sufficiently high to block viral spread, the entire population, including the elderly and vulnerable, can be released to live their lives as before.

The alternative is to wait, in hope, for a vaccine. One that is almost certainly not going to get here before winter arrives in the Northern Hemisphere. By which time further irreparable harm will have been done, and thousands more lives will have been lost, unnecessarily.

1; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3734171/

2: https://www.dailymail.co.uk/news/article-8470843/The-average-COVID-19-victim-OLDER-age-people-usually-die-Scotland.html

3: https://ourworldindata.org/mortality-risk-COVID#the-case-fatality-rate

4: https://www.jems.com/2020/08/31/cdc-report-underlying-conditions-94-percent-COVID-19-deaths/

5: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales

6: https://www.sciencedaily.com/releases/2020/03/200316143313.htm

7: https://www.thetimes.co.uk/article/affluent-youth-are-catching-coronavirus-most-says-matt-hancock-qvbpxw2nk

8: https://publications.parliament.uk/pa/cm5801/cmselect/cmhaff/321/321.pdf

9: https://www.medrxiv.org/content/10.1101/2020.05.13.20101253v3

10: https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(20)30388-0/fulltext

11: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907616/s0650-direct-indirect-impacts-COVID-19-excess-deaths-morbidity-sage-48.pdf

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COVID – why terminology really, really matters

4th September 2020

COVID – why terminology really, really matters

[And the consequences of getting it horribly wrong]

When is a case not a case?

Since the start of the COVID pandemic I have watched almost everyone get mission critical things wrong. In some ways this is not surprising. Medical terminology is horribly imprecise, and often poorly understood. In calmer times such things are only of interest to research geeks like me. Were they talking about CVD, or CHD?

However, right now, it really, really, matters. Specifically, with regards to the term COVID 'cases.'

Every day we are informed of a worrying rise in COVID cases in country after country, region after region, city after city. Portugal, France, Leicester, Bolton. Panic, lockdown, quarantine. In France the number of reported cases is now as high as it was at the peak of the epidemic. Over 5,000, on the first of September.

But what does this actually mean? Just to keep the focus on France for a moment. On March 26th, just before their deaths peaked, there were 3,900 'cases'. Fourteen days later, there were 1,400 deaths. So, using a widely accepted figure, which is a delay of around two weeks between diagnoses and death, 36% of cases died.

In stark contrast, on August 16th, there were 3,000 cases. Fourteen days later there were 26 deaths. Which means that, in March, 36% of 'cases' died. In August 0.8% of 'cases' died. This, in turn, means that COVID was 45 times as deadly in March, as it was in August?

This seems extremely unlikely. In fact, it is so unlikely that it is, in fact, complete rubbish. What we have is a combination of nonsense figures which, added together, create nonsense squared. Or nonsense to the power ten.

To start with, we have the mangling of the concept of a 'case'.

Previously, in the world of infectious diseases, it has been accepted that a 'case' represents someone with symptoms, usually severe symptoms, usually severe enough to be admitted to hospital. Here, from Wikipedia.... yes, I know, but on this sort of stuff they are a good resource.

*'In epidemiology, a **case** fatality rate (CFR) — sometimes called **case** fatality risk or disease lethality — is the proportion of deaths from a certain disease compared to the total number of **symptomatic** people diagnosed with the disease.'* [1]

Note the word symptomatic i.e. someone with symptoms.

However, now we stick a swab up someone's nose, who feels completely well, or very mildly ill. We find that they have some COVID particles lodged up there, and we call them a case of COVID. Sigh, thud!

A symptomless, or even mildly symptomatic positive swab is *not* a case. Never, in recorded history, has this been true. However, now we have an almost unquestioned acceptance that a positive swab represents a *case* of COVID. This is then parroted on all the news channels as if it were gospel.

I note that, at last, some people are beginning to question how it can be that, whilst cases are going up and up, deaths are going down, and down.

This is even the case in Sweden, which seems to be the final bastion of people with functioning brains. However, even they seem surprised by this dichotomy. In the first two weeks of August they had 4,152 positive swabs. Yet, in the last two weeks of August, they had a mere 14 deaths (one a day, on average).

That represents 1 death for every 300 positive swabs or, as the mainstream media insists on calling them, positive 'cases'. Which, currently, represent a **case** fatality rate of 0.33%. Just to compare that with something similar, the case fatality rate of swine flu (HIN1), was 0.5%. [2]

Thus, lo and behold, COVID is a less severe infection than swine flu – the pandemic that never was. That's what these figures appear to tell us. They tell us almost exactly the same in France where they 'appear' to have a current case fatality rate of 0.4%.

On the other hand, if you look at the figures from around the world, they are very different. As I write this there have been, according to the WHO, 25 million cases and 850,000 deaths. That is a **case** fatality rate of more than 3%. Ten times as high.

Why are these figures so all over the place? It is because we are using horribly inaccurate terminology. We are comparing apples with pomegranates to tell us how many bananas we have. Our experts are, essentially, talking gibberish, and the mainstream media is lapping it up. They are defining asymptomatic swabs as cases, and no-one is calling them out on it. Why?

Because… because they are frightened of looking stupid? Primarily, I believe, because they also have no idea what a case might actually be So, it all sounds quite reasonable to them.

The good news

However, moving on from that nonsense, there is some extremely good news buried in here. Which I am going to try and explain. It goes as follows.

At the start of the epidemic, the only people being tested were those who were being admitted to hospital, who were seriously ill. Many of them died. Which is why, in France, there was this very sharp, initial **case** fatality rate of 35%. In the UK the initial case fatality rate was I think 14%. Last time I looked at the UK figures, the case fatality was 5%, and falling fast.

This fall has occurred, and will occur everywhere in the World, because as you increase your testing, you pick up more and more people with less severe symptoms. People who are far less likely to die. The more you test, the more the case fatality rate falls.

It falls even more dramatically when you start to test people who have no symptoms at all. In fact, as you broaden your testing net, something else very important happens. You gradually move from looking at the **case** fatality rate to the **infection** fatality rate.

The **infection** fatality rate is the measure of how many people who are infected [even those without symptoms, or very mild symptoms] who then die. This is *the* critical figure to know because it gives you an accurate assessment of the total number of deaths you are likely to see.

IFR x population of a country x % of population infected = total number of deaths (total mortality)

So, where have we got to. Well, although the case fatality rate in the UK still currently stands at 5%, because it is dragged up by the 14% rate we had at the start. If we look at the more recent figures things have changed very dramatically.

In the first two weeks of August there were 13,996 positive swabs in the UK. In the second two weeks of August there were 129 deaths. If you consider every positive swab to be a case, this represents a **case** fatality rate of 0.9%. Around one fifteenth of that seen at the start.

I think you can clearly see a direction of travel here.

- At the start on the pandemic we had a, brief, 35% fatality rate in France
- It was 14% in the UK at the start
- It now sits at 5% in the UK – over the whole pandemic
- In August, in the UK, it was down to 0.9%
- It is currently 0.47% in Germany
- It is currently 0.4% in France
- It is currently 0.33% in Sweden

It is falling, falling, everywhere. Where does it end up, this hybrid case/infection fatality rate? Remember, we are still only testing a fraction of the population, so we are missing the majority of people who have been infected, mainly those who do not have symptoms. Which means that these rates must fall further, as they always do in any pandemic.

To quote the Centre for Evidence Base Medicine on the matter:

'In Swine flu, the IFR (infection fatality rate) *ended up as 0.02%, fivefold less than the lowest estimate during the outbreak (the lowest estimate was 0.1% in the 1st ten weeks of the outbreak).'* [3]

The best place to estimate where we may finally end up with COVID, is with the country that has tested the most people, per head of population. This is Iceland. To quote the Centre for Evidence Based Medicine once more:

'In Iceland, where the most testing per capita has occurred, the IFR lies somewhere between 0.03% and 0.28%.' [3]

Sitting in the middle of 0.03% and 0.28% is 0.16%. As you can see, Iceland, having tested more people than anywhere else, has the lowest IFR of all. This is not a coincidence. This is an inevitable result of testing more people.

I am going to make a prediction that, in the end, we will end up with an IFR of somewhere around 0.1%. Which is about the same as severe flu pandemics we have had in the past. Remember that figure. It is one in a thousand.

It may surprise you to know that I am not the only person to have made this exact same prediction. On the 28th February, yes that far back, the New England Journal of Medicine published a report by the National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, MD (A.S.F., H.C.L.); and the Centers for Disease Control and Prevention, Atlanta. [4]

In this paper '*Covid-19 — Navigating the Uncharted*' they stated the following:

'On the basis of a case definition requiring a diagnosis of pneumonia, the currently reported case fatality rate is approximately 2%. In another article in the Journal, Guan et al. report mortality of 1.4% among 1099 patients with laboratory-confirmed Covid-19; these patients had a wide spectrum of disease severity. If one assumes that the number of asymptomatic or minimally symptomatic cases is several times as high as the number of reported cases, ***the case fatality rate*** *(my underline)* ***may be considerably less than 1%.*** *This suggests that* ***the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza****.'*

A **case** fatality rate considerably less than 1%. Their words, not mine. As they also added, *'the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza.'*

At this point, you may well be asking. Why the hell did we lockdown if COVID was believed to be no more serious than influenza? Right from the start by the most influential infectious disease organisations in the World.

It is because of the mad mathematical modellers. The academic epidemiologists. Neil Ferguson, and others of his ilk. When they were guessing (sorry estimating, sorry modelling) the impact of COVID they used a figure of approximately one per cent as the *infection* fatality rate. Not the case fatality rate. In so doing, they overestimated the likely impact of COVID by, at the very least, ten-fold.

How could this possibly have happened?

When they put their carefully constructed model together on the 16th of March, if they had been reading the research, they must have been aware that they were looking at a maximum **case** fatality rate of just over 1% in China, right at the start, where the figures are always at their highest.

Which means that, unless COVID was going to turn out nearly 100% fatal, we could never get anywhere near 1%, for the infection fatality rate. Even Ebola only kills 50%.

But they went with it, they went with 1%. Actually, Imperial College reduced it slightly to 0.9%, for reasons that are opaque.

From this, all else flowed.

If the INFECTION fatality rate truly were 0.9%, and 80% of the population of the UK became infected, there would have been/could have been, around 500,000 deaths.

0.9% x 80% x 67million = 482,000

LOCKDOWN

However, if the **case** fatality rate is around 1%, then the **infection** fatality rate will be about one tenth of this, maybe less. So, we would see around 50,000 deaths, about the same as was seen in previous bad flu pandemics.

DO NOT LOCKDOWN

What Imperial College London did was to use a model that overestimated the infection fatality rate by a factor of ten.

We now know, as the IFR rates of various countries falls and falls, that the Imperial College estimated IFR was completely wrong. The UK, for example, has seen 42,000 deaths so far, which is 0.074% of population. The US *has* seen about 200,000 deaths 0.053%. Sweden, which did not lockdown down, has seen about 6,000 deaths, which is an infection fatality rate of 0.06%. All three countries are opening up and opening up. Whilst the 'cases' are rising and rising, the deaths continue to fall. They are, to all intents and purposes, flatlining.

In Iceland it is around 0.16% and falling. In other words…

Stop panicking – it's over

Whilst everyone is panicking about the ever-increasing number of cases, we should be celebrating them. They are demonstrating, very clearly, that COVID is far, far, less deadly then was feared. The Infection Fatality Rate is most likely going to end up around 0.1%, not 1%.

So yes, it does seem that '***the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza.'***

Wise words, wise words indeed. Words that were written by one Anthony S Fauci on the 28th of February 2020. If you haven't heard of him, look him up.

Critically though, eleven days after this, he rather blotted his copybook, because he went on to say this *"The flu has a* ***mortality*** *rate of 0.1 percent. This* (COVID) *has a* ***mortality*** *rate of 10 times that. That's the reason I want to emphasize we have to stay ahead of the game in preventing this."* [5]

The *mortality* rate Dr Fauci? Could it possibly be that he failed to understand that there is *no* such thing as a mortality rate? Did he mean the case fatality rate, or the infection fatality rate? If he meant the Infection mortality rate of influenza, he was pretty much bang on. If he meant the case fatality rate, he was wrong by a factor of ten.

The reality is that, no matter what Fauci went on to say, severe influenza has a **case** fatality rate of 1%, and so does COVID. They also have approximately the same **infection** fatality fate of 0.1%.

It seems that Dr Fauci just got mixed up with the terminology. Because in his Journal article eleven days earlier, he did state… *'This suggests that the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza…* [and here is the kicker at the end] *(which has a* ***case fatality rate of approximately 0.1%).****'*

You see, he did say the case fatality rate of influenza was approximately 0.1%. Wrong, wrong, wrong, wrong… wrong.

Oh dear, oh dear, oh dear. With influenza, Dr Fauci, the CDC, his co-authors, the National Institute of Allergy and Infectious Diseases and the National Institutes of Health *and* the New England Journal of Medicine got **case** fatality rate and **infection** fatality rate mixed up with influenza. Easy mistake to make. Could have done it myself. But didn't.

You want to know where Imperial College London really got their 1% infection fatality rate figure from? It seems clear that they got it from Anthony S Fauci and the New England Journal of Medicine. The highest impact journal in the world – which should have the highest impact proof-readers in the world. But clearly does not.

Imperial College then used this *wrong* NEJM influenza case fatality rate 0.1%. It seems that they then compared this 0.1% figure to the reported COVID case fatality rate, estimated to be 1% and multiplied the impact of COVID by ten – as you would. As you probably should.

So, we got Lockdown. The US used the Fauci figure and got locked down. The world used that figure and got locked down.

That figure just happens to be ten times too high.

I know it is going to be virtually impossible to walk the world back from having made such a ridiculous, stupid, mistake. There are so many reputations at stake. The entire egg production of the world will be required to supply enough yolk to cover appropriate faces.

Of course, it will be denied, absolutely, vehemently, angrily, that anyone got anything wrong. It will be denied that a simple error, a mix up between case fatality and infection fatality led to this. It will even more forcefully stated that COVID remains a deadly killer disease and that all Governments around the world have done exactly the right thing. The actions were right, the models were correct. We all did the RIGHT thing. Only those who are stupid, or incompetent cannot see it.

When wrong, shout louder, get angry, double-down, attack your critics in any way possible. Accuse them of being anti-vaxx, or something of the sort. Dig for the dirt. '*How to succeed in politics 101, page one, paragraph one*.'

However, just have a look, at the figures. Tell me where they are wrong – if you can. The truth is that this particular Emperor has no clothes on and is, currently, standing bollock naked, right in front of you. Hard to believe, but true.

I would like to thank Ronald B Brown for pointing out this catastrophic error, in his article *'Public health lessons learned from biases in coronavirus mortality overestimation.'* [6]

I had not spotted it. He did. All credit is his. I am simply drawing your attention to what has simply been – probably the biggest single mistake that has ever been made in the history of the world.

1: https://en.wikipedia.org/wiki/Case_fatality_rate

2: https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(10)70120-1/fulltext#:~:text=Methods%20for%20estimating%20the%20case,a%20novel%2C%20emerging%20infectious%20disease.&text=To%20avoid%20similar%20underestimations%2C%20accounting,be%20about%200%C2%B75%25.

3: https://www.cebm.net/covid-19/global-covid-19-case-fatality-rates/

4: https://www.nejm.org/doi/full/10.1056/nejme2002387

5: https://reason.com/2020/03/11/covid-19-mortality-rate-ten-times-worse-than-seasonal-flu-says-dr-anthony-fauci/

6: https://www.cambridge.org/core/journals/disaster-medicine-and-public-health-preparedness/article/public-health-lessons-learned-from-biases-in-coronavirus-mortality-overestimation/7ACD87D8FD2237285EB667BB28DCC6E9

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COVID – What have we learned?

25th August 2020

We have learned that people who are asymptomatic can, cannot, can, cannot, can, cannot, can... spread the virus.

That the accuracy of PCR antigen testing is brilliant, useless, brilliant, useless, brilliant, useless.

That false positive tests are impossible, common, impossible, common, impossible, common.

That facemasks are useless, necessary, useless, necessary, useless… absolutely necessary.

We also know that some people are, are not, are, are not are, naturally immune. In addition, we know that having had COVID means that you can, cannot, can, cannot, can cannot – maybe you can, frankly who knows, get it again. I think Kurt Vonnegut Junior put it best:

"We do, doodley do, doodley do, doodely do,
What we must, muddily must, muddily must, muddily must;
Muddily do, muddily do, muddily do, muddily do,
Until we bust, bodily bust, bodily bust, bodily bust."

I like to think I have some expertise in reading medical research papers, then trying to work out what they really mean, rather than what they say they mean. I even gritted my teeth and wrote the book "*Doctoring Data*" in order to help people understand the endless games and manipulations that are played with research studies.

I analysed the power of money to distort research findings, in ways such that black can be magically turned into white.

Of course, distortion is not just driven by money. This is only one of the factors that lays its heavy hand upon research. There are many others. The immense power of an idea to set thoughts in concrete, previous public statements made and fearing loss of authority if you change your mind. Status, power, political games, etc.

Just to look at an example of actions not (obviously) driven by money. On the back of COVID, Bill Gates seems determined to be remembered as the man who vaccinated the world. It will be his enduring legacy. He probably knows that his Microsoft empire will simply be a sub-paragraph in an MBA hypothesis in a hundred years. On the other hand, worldwide vaccination will secure him a place in history.

Although I understand many of the forces at work to distort research, and how the manipulates are carried out, when it comes to COVID I have almost given up. Almost everyone seems to have an agenda, twisting and turning meaning this way and that.

In many cases, the end result seems to be a determined effort to inflate the mortality figures, or paint COVID as the evillest virus ever. I suspect the vaccine manufacturers have a major role to play in this.

Just to give one reasonably well-known example of this. In England, if you ever had a positive test for COVID, and then died, you were added to the COVID death statistics. Whatever killed you, however long after you had a positive test you died of COVID.

This has recently been changed. Primarily because it was so patently ridiculous that even Matt Hancock (UK health secretary) was no longer able to confirm that this was absolutely the correct thing to do. Although it seems he had no idea it was happening in the first place.

Despite this change, we still have the situation in the UK, where you can never, officially recover from COVID – which is equally mad. Once you've got it, you've got it. I suspect this will be quietly changed at some point – maybe it has been, and I didn't notice.

On the other hand, other very strange things took place, in the opposite direction. Right at the start of the pandemic, the UK Govt changed COVID to an infection no longer considered of high consequence

As of 19 March 2020, COVID-19 is no longer considered to be a high consequence infectious disease (HCID) in the UK.[1]

Yes, the 19th of March. The UK went into lockdown on the 16th of March *[Error, this should be the 23rd march*], and three days later COVID was no longer a high consequence disease. The only disease in history which has required lockdown, including the obliteration of many basic human rights, and the trashing of the entire economy. Yet it is not a disease of high consequence?

This happened virtually unremarked. Very quietly, you could almost say sneakily. What on earth went on here? My guess is this was done to stop healthcare workers suing the NHS if they contracted COVID at work – as almost no medical staff had adequate PPE. There may be other reasons, but I struggle to think what they may be.

Wherever you looked there was confusion, and statistical manipulation, and then we moved onto the hydroxychloroquine saga. At the very start of the pandemic I wrote a blog suggesting hydroxychloroquine could be helpful. This was based on earlier research demonstrating this drug could hamper viral entry into cells and, once within the cell, could impede viral entry into the nucleus. I even tried to get my trust to stockpile some of the drug – no chance there. Hydroxy-what?

Little did I know the massive storm that would erupt around this drug. A drug that has been around for decades. It is available over the counter in many countries and is, I think, the most widely used drug in India. It is primarily an anti-malarial drug – as it helps to prevent entry of the malaria parasite into cells and can hamper it breaking down haemoglobin, thus destroying red blood cells.

It is also used as an anti-inflammatory in diseases such as rheumatoid arthritis and systemic lupus erythematosus (SLE), where it is extraordinarily safe (in the correct doses). It has been looked at as a possible anti-viral for many years. Earlier this year, I was reading various papers about it. Such as this one *'Effects of chloroquine on viral infections: an old drug against today's diseases.'*

Chloroquine is a 9-aminoquinoline known since 1934. Apart from its well-known antimalarial effects, the drug has interesting biochemical properties that might be applied against some viral infections. Chloroquine exerts direct antiviral effects, inhibiting pH-dependent steps of the replication of several viruses including members of the flaviviruses, retroviruses, and coronaviruses. Its best-studied effects are those against HIV replication, which are being tested in clinical trials. Moreover, chloroquine has immunomodulatory effects, suppressing the production/release of tumour necrosis factor α and interleukin 6, which mediate the inflammatory complications of several viral diseases'.[2]

[Chloroquine and hydroxychloroquine are essentially the same drug, when it comes to efficacy/activity, but hydroxychloroquine has less side-effects. 'Hydroxy' means an OH group has been added to the basic compound]

I have to say I didn't bother to read anything from 2020. It was clear that commercial interests were already heavily contaminating this area.

Which meant that, in order to get a handle on untainted data, I went back to calmer research papers from another era. Anyway, having read around the area, it seemed that hydroxychloroquine might do some good. It was certainly pretty safe, and we had nothing else at the time. Thus, I recommended that it might be used.

Then, the distorting engine was switched to full power. Driven by two main fuel types. Type one was money. Companies with anti-viral agents, such as remdesivir, did not want a 'cheap as chips' drug being used. No sirree, they wanted massively expensive (and almost entirely useless) anti-virals to be used instead.

This resulted in a study published in the Lancet, no less, slamming hydroxychloroquine through the floor. It turns out the study was almost entirely fabricated, by researchers strongly associated with various companies who, surprise, surprise, make anti-virals.

The other fuel type was the hybrid money/vaccine. If hydroxychloroquine (plus zinc and azithromycin) works, then there was great concern this would lower uptake of any vaccine that was developed. In addition, it would not be possible to impose emergency vaccine laws, which would make the manufacture of any vaccine far quicker and easier.

Such laws, in the US, are known as Emergency Use Authorisation (EUA). If enacted, these laws mean that a vaccine does not have to be tested for safety and efficacy before use. Just whack it out there, untested. Also, there is no possibility of suing a vaccine manufacturer if it turns out the vaccine caused serious problems.

In the US, UK, and several other countries, complete legal protection against vaccine damage is already enshrined in the law, so nothing changes here.

However, there is still a requirement to carry out at least some research on efficacy and safety. The EUA would remove this barrier. Just get it out there, no questions asked, none possible.

Depending on your view of the ethical standards of those companies manufacturing such vaccines, you would either welcome this move, or feel deeply disturbed. I would be in the latter camp. No way I am taking an active medication that has not been tested for either safety or efficacy.

Whatever camp you are in, there are vast fortunes to be made from developing the first vaccine for COVID-19. If all barriers to immediate uptake are removed, we have a goldrush on our hands. No need to prove your vaccine works, no need to demonstrate it is safe, no chance of being sued. Billions of dollars to be made. What could possibly go wrong?

Which takes us back to that pesky drug, hydroxychloroquine. Does it work, does it not? It seems we will never be allowed to know. Recently the Food and Drug Administration in the US, removed authorisation for its use. Even in a hospital, such as he Henry Ford in Detroit, that appeared to be getting impressive results:

'"The U.S. Food and Drug Administration informed us that it would not grant our request for an emergency use authorization for hydroxychloroquine for a segment of COVID-19 patients meeting very specific criteria," said Dr. Adnan Munkarah, Henry Ford's executive vice president and chief clinical officer, in a statement' [3]

All other trials around the world have also being stopped by the National Institutes of Health, the World Health Orhanisation and the UK health authorities.

This, remember, is a drug that has been taken by, literally, billions of people. It is considered safe enough to buy over the counter, yet now it is so dangerous that it cannot even be used for research purposes. Of course, you can still take it if you have rheumatoid arthritis, SLE, malaria – or suchlike – where it remains perfectly safe and is also known to reduce inflammation (a major problem with COVID).

At a stroke discussion, or research, has become virtually impossible, as noted by the Henry Ford hospital in Detroit.

'Last week, Henry Ford issued an open letter about its study, saying, "the political climate that has persisted has made any objective discussion about this drug impossible."

The health system said in the letter that it will no longer comment outside the medical community on the use of hydroxychloroquine to treat novel coronavirus.'

So, what have we learned? We have learned that medical science is not a pure thing – not in the slightest. We have also learned that the world of research has not come together to conquer COVID, it has split apart.

Those wanting to make money, have distorted and damaged research for their own ends. Those who want to vaccinate the world, forever, have seen a door open to the promised land. Those who wanted lockdown, are inflating the numbers of those killed. Democrats in the US are using COVID as a stick to beat Donald Trump. It is all a bloody horrible mess.

It is said that the first casualty of war is the truth. Never has this been more certain that with COVID. In this case, first we killed the truth, then we killed science, then we beat inconvenient facts to death with a club. It is all extraordinarily depressing.

1: https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid#status-of-covid-19

2: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7128816/

3: https://eu.freep.com/story/news/health/2020/08/13/henry-ford-health-hydroxychloroquine-covid-fda/3360940001/

This entry was posted in Conflicts of Interest, COVID-19 on August 25, 2020 [https://drmalcolmkendrick.org/2020/08/25/covid-what-have-we-learned/] .

How bad is COVID really? (A Swedish doctor's perspective)

7th August 2020

A doctor working in Sweden as an emergency care physician contacted me to discuss all things COVID-19. He has also written a blog, which can be seen here.

I asked if I could reproduce it on my blog as I felt it was a fascinating persepctive on what was happening in Sweden. It is also incredibly well written, in English, for someone who is Swedish. Most humbled. I hope you enjoy it.

Ok, I want to preface this article by stating that it is entirely anecdotal and based on my experience working as a doctor in the emergency room of one of the big hospitals in Stockholm, Sweden, and of living as a citizen in Sweden.

As many people know, Sweden is perhaps the country that has taken the most relaxed attitude of any towards the COVID pandemic. Unlike other countries, Sweden never went in to complete lockdown. Non-essential businesses have remained open, people have continues to go to cafés and restaurants, children have remained in school, and very few people have bothered with face masks in public.

COVID hit Stockholm like a storm in mid-March. One day I was seeing people with appendicitis and kidney stones, the usual things you see in the emergency room. The next day all those patients were gone and the only thing coming in to the hospital was COVID. Practically everyone who was tested had COVID, regardless of what the presenting symptom was. People came in with a nose bleed and they had COVID. They came in with stomach pain and they had COVID.

Then, after a few months, all the COVID patients disappeared. It is now four months since the start of the pandemic, and I haven't seen a single COVID patient in over a month. When I do test someone because they have a cough or a fever, the test invariably comes back negative.

At the peak three months back, a hundred people were dying a day of COVID in Sweden, a country with a population of ten million. We are now down to around five people dying per day in the whole country, and that number continues to drop. Since people generally die around three weeks after infection, that means virtually no-one is getting infected any more.

If we assume around 0.5 percent of those infected die (which I think is very generous, more on that later), then that means that three weeks back 1,000 people were getting infected per day in the whole country, which works out to a daily risk per person of getting infected of 1 in 10,000, which is miniscule. And remember, the risk of dying is at the very most 1 in 200 if you actually do get infected. And that was three weeks ago. Basically,COVID is in all practical senses over and done with in Sweden.

After four months. In total COVID has killed under 6,000 people in a country of ten million. A country with an annual death rate of around 100,000 people. Considering that 70% of those who have died of COVID are over 80 years old, quite a few of those 6,000 would have died this year anyway. That makes covid a mere blip in terms of its effect on mortality.

That is why it is nonsensical to compare covid to other major pandemics, like the 1918 pandemic that killed tens of millions of people. COVID will never even come close to those numbers. And yet many countries have shut down their entire economies, stopped children going to school, and made large portions of their population unemployed in order to deal with this disease.

The media have been proclaiming that only a small percentage of the population have antibodies, and therefore it is impossible that herd immunity has developed. Well, if herd immunity hasn't developed, where are all the sick people? Why has the rate of infection dropped so precipitously? Considering that most people in Sweden are leading their lives normally now, not socially distancing, not wearing masks, there should still be high rates of infection.

The reason we test for antibodies is because it is easy and cheap. Antibodies are in fact not the body's main defence against virus infections. T-cells are. But T-cells are harder to measure than antibodies, so we don't really do it clinically. It is quite possible to have T-cells that are specific for covid and thereby make you immune to the disease, without having any antibodies.

Personally, I think this is what has happened. Everybody who works in the emergency room where I work has had the antibody test. Very few actually have antibodies. This is in spite of being exposed to huge numbers of infected people, including at the beginning of the pandemic, before we realized how widespread COVID was, when no-one was wearing protective equipment.

I am not denying that COVID is awful for the people who do get really sick or for the families of the people who die, just as it is awful for the families of people who die of cancer, or influenza, or an opioid overdose. But the size of the response in most of the world (not including Sweden) has been totally disproportionate to the size of the threat.

Sweden ripped the metaphorical band-aid off quickly and got the epidemic over and done with in a short amount of time, while the rest of the world has chosen to try to peel the band-aid off slowly. At present that means Sweden has one of the highest total death rates in the world. But COVID is over in Sweden. People have gone back to their normal lives and barely anyone is getting infected any more.

I am willing to bet that the countries that have shut down completely will see rates spike when they open up. If that is the case, then there won't have been any point in shutting down in the first place, because all those countries are going to end up with the same number of dead at the end of the day anyway. Shutting down completely in order to decrease the total number of deaths only makes sense if you are willing to stay shut down until a vaccine is available. That could take years. No country is willing to wait that long.

COVID has at present killed less than 6000 in Sweden. It is very unlikely that the number of dead will go above 7,000. An average influenza year in Sweden, 700 people die of influenza. Does that mean COVID is ten times worse than influenza? No, because influenza has been around for centuries while COVID is completely new.

In an average influenza year most people already have some level of immunity because they've been infected with a similar strain previously, or because they're vaccinated. So it is quite possible, in fact likely, that the case fatality rate for COVID is the same as for influenza, or only slightly higher, and the entire difference we have seen is due to the complete lack of any immunity in the population at the start of this pandemic.

This conclusion makes sense of the Swedish fatality numbers – if we've reached a point where there is hardly any active infection going on any more in Sweden, in spite of the fact that there is barely any social distancing happening, then that means at least 50% of the population has been infected already and have developed immunity, which is five million people.

This number is perfectly reasonable if we assume a reproductive number for the virus of two: If each person infects two new, with a five day period between being infected and infecting others, and you start out with just one infected person in the country, then you will reach a point where several million are infected in just four months. If only 6000 are dead out of five million infected, that works out to a case fatality rate of 0.12 percent, roughly the same as regular old influenza, which no-one is the least bit frightened of, and which we don't shut down our societies for.

This entry was posted in COVID-19 on August 7, 2020 [https://drmalcolmkendrick.org/2020/08/07/how-bad-is-covid-really-a-swedish-doctors-perspective/] .

Cholesterol lowering has no impact

5th August 2020

This article was first published on RT.com on the 4th of August, and it can be seen here

In the midst of the COVID-19 epidemic almost every other medical condition has been shoved onto the side-lines. However, in the UK last year, heart attacks and strokes (CVD) killed well over one hundred thousand people – at least twice as many as have died from COVID-19.

CVD will kill just as many this year. Which makes it significantly more important than COVID-19, even if no-one is paying much attention to it right now. So, it is good to see that research goes on, and papers are still being published.

One of the most significant, and of great interest to me personally, was a critical examination of the benefits of lowering cholesterol. This was published on the fourth of August. The paper was called '*Hit or miss: the new cholesterol targets,*' and it came out in Evidence Based Medicine, one of the key titles that sits under the umbrella of British Medical Journal publishing

It was carefully worded, as all clinical papers are, but a key section of the press release was as follows: *"Setting targets for 'bad' (LDL) cholesterol levels to ward off heart disease and death in those at risk might seem intuitive, but decades of research have failed to show any consistent benefit for this approach, reveals an analysis of the available data, published online in BMJ Evidence Based Medicine."*

What is being said here is the following. Everyone thinks that lowering LDL, a.k.a. 'bad cholesterol is considered the single most important way to reduce the risk of heart disease and strokes. However, "*decades of research have failed to show any consistent benefit for this approach.*"

Surely this flies in the face of almost all the advice we have been bombarded with for the last fifty years, or so? Cholesterol – by which we really mean low density lipoprotein (LDL) – is a killer and must be lowered. This is the whole point of statins, *the* single most widely prescribed type of drug in the history of medicine. Drugs that have racked up sales of nearly one trillion dollars since their launch.

Now, newer, and far more expensive LDL lowering medications are available, riding on the success of statins. They are injectable, rather than a tablet, and the cost is far higher. In the US, you are looking at around $5,000 per year. In the UK, one of these drugs Repatha, costs the NHS just over £4,000 per year. These drugs are known as PCSK9-inhibitors.

These are eye-watering costs. It is estimated that around seven million people in the UK take statins currently. If everyone converted to a PCSK9-inhibitor, this would cost the NHS twenty-eight billion pounds a year. Not far off the entire defence budget.

But do these drugs work, does lowering LDL work? Surely it does, surely it must. The answer is, not necessarily. Yes, statins have been found to reduce the risk of cardiovascular disease, not by a massive amount, but the effect exists. At least in some studies, if not all.

However, many other drugs also reduce the risk of cardiovascular disease without having any effect on LDL levels, e.g. aspirin. A number of researchers have long argued that the benefits of statins are mainly due to "off-target" effects. By which they mean that, yes, statins lower LDL, but they also have effects on many other things and it is the "other things" that provide the benefit.

For example, statins have been found to have quite strong anti-coagulant (anti blood clotting) effects. Same as aspirin, as highlighted in the 2013 paper, '*Anticoagulant effects of statins and their clinical implications.*' It states:

"There is evidence indicating that statins… may produce several cholesterol-independent antithrombotic [anti-coagulant] *effects."*

So, it has always remained possible that the main benefit of statins was NOT due to their impact on lowering LDL BUT because of something else that they do.

In this recent study, the authors decided to examine this possibility. So they gathered together all the LDL lowering trials – at least those big enough, and long enough to count – and try to establish whether the amount that the LDL was lowered, matched the reduction, if any, in cardiovascular disease. The technical term for this is "dose-response".

Or, to put this another way, if the LDL hypothesis is correct, the greater the LDL lowering, the greater the benefit on CVD should be. What did they find? Here are the key findings – from the press release:

"Their analysis showed that over three quarters of all the trials reported no positive impact on the risk of death and nearly half reported no positive impact on risk of future cardiovascular disease.

And the amount of LDL cholesterol reduction achieved didn't correspond to the size of the resulting benefits, with even very small changes in LDL cholesterol sometimes associated with larger reductions in risk of death or cardiovascular 'events,' and vice versa.

"Thirteen of the clinical trials met the LDL cholesterol reduction target, but only one reported a positive impact on risk of death…

"Considering that dozens of [randomised controlled trials] of LDL-cholesterol reduction have failed to demonstrate a consistent benefit, we should question the validity of this theory."

And they conclude: *"In most fields of science the existence of contradictory evidence usually leads to a paradigm shift or modification of the theory in question, but in this case the contradictory evidence has been largely ignored, simply because it doesn't fit the prevailing paradigm."*

In short, what they found was that there was absolutely no correlation between the amount that LDL was lowered and the resulting benefit on CVD. In fact, the benefit was inverse i.e. the less the LDL was lowered, the greater the benefit.

This is a hugely important finding that really ought to be shouted from the rooftops. I admit I have a horse in the race, having long argued that LDL has nothing to do with heart disease (and being roundly condemned for doing so). So, it is nice to have my thoughts so powerfully supported in a peer-reviewed, high impact journal.

For the average person on this street, what this research means is that you should stop worrying about your LDL levels, and obsessively trying to get them down with drugs or diet. Tucked away in the paper was this significant finding:

*"Moreover, consider that the Minnesota Coronary Experiment, a 4-year long RCT [randomised controlled trial] of a low-fat diet involving 9423 subjects, actually reported an **increase** in mortality and cardiovascular events despite a **13% reduction in total cholesterol**."*

Cholesterol (LDL) went down, CVD went up. We really are wasting a colossal amount of money. And causing avoidable death?

This entry was posted in Cardiovascular Disease, Cholesterol & Statins on August 5, 2020 [https://drmalcolmkendrick.org/2020/08/05/cholesterol-lowering-has-no-impact/] .

COVID fear

25th July 2020

This was first published on RT.com https://www.rt.com/op-ed/495421-inflated-covid-19-fatality-rates/

Why the scaremongering about COVID?

This week we were told that, in the UK at least, anyone who had a positive COVID test who then died – of anything – would be recorded as dying of COVID. No matter when they die.

Which means that someone could have been tested positive in March, with no symptoms of COVID at all, who then died in July. They would be recorded, in the official figures, as dying of COVID. Even if the were hit by a bus.

Even more weird is the fact that there does not seem to be any time limit to this. So, you could test positive in March 2020, then die in March 2040, and still be recorded as dying of COVID. I doubt this will happen, but it could.

To be honest I have known something very strange has been going on with the UK data for some time. In that, the UK has not provided any figures on how many people have recovered from COVID. In almost all countries, figures are provided on the total number of cased, the total number of deaths, the number of active cases and the number who have recovered.

In the US for example, there have been just over three and a half million cases, a hundred and forty thousand deaths and one point seven million people have officially recovered. In the UK, there have been nearly three hundred thousand cases, forty-five thousand deaths – and no recorded recoveries.

In short, in the UK, you cannot ever recover from COVID. Once you've got it, that's it, you've got it. This anomaly has been reported on before. Here for instance, from the Guardian in June.

'Britain is an outlier internationally in not reporting the number of people who have recovered from Covid-19 alongside statistics on deaths and numbers of identified cases.' [1]

Why would anyone want to do this? You would think the Government would be pulling out all the stops to decrease the number of recorded COVID deaths. Especially as the UK is sitting in a pretty dismal place on the international comparison charts. Why deliberately inflate your figures.

However, it is not just the UK that is hyping up COVID deaths. A reader of my blog sent me an analysis of the WHO advice on death certification, which seems accurate. In his analysis:

1. If you die of anything and they suspect you might have it, with no tests and perhaps just because everyone else is assumed to have it, then COVID-19 goes on the death certificate as primary cause of death. Broadly speaking… unless the patient dies of something that is sudden and cannot be a long-term comorbidity.
2. If you have the same symptoms as flu or pneumonia you must be put down as COVID19 and not due to an influenza type illness.
3. Any certificates that are in any way erroneous with regard to the above must be recoded to conform.
4. Any COVID-19 codes that are wrong should not be fixed in any circumstances

To me looks like a recipe for systematic over inflation of death counts, designed to disallow or circumvent clinical judgement [2].

In the US Dr Scott Jensen, who is a physician, and a member of the Minnesota senate, has been notified by the board of medical practice in Minnesota that he is being investigated for public statements he has made.

Essentially, he is being accused of spreading misinformation about the completion of death certificates, and the overestimation of deaths from COVID-19. Also, that he has been comparing COVID-19 to influenza, in terms of how serious it is. This is considered 'reckless advice'.

For pointing out the over-reporting of COVID-19 deaths and daring to claim that COVID-19 is no worse than a bad flu season, he could be struck off the medical register. You can see Dr Jensen discussing this YouTube [3].

So, it seems that, around the world the same things are being seen. A seemingly coordinated attempt to vastly over-inflate the number of deaths caused by COVID-19, and to drive home how deadly it is.

For example, a few days ago, a new story hit the headlines in the UK, warning of hundreds of thousands of deaths this winter.

'The UK could see about 120,000 new coronavirus deaths in a second wave of infections this winter, scientists say.

Asked to model a "reasonable" worst-case scenario, they suggest a range between 24,500 and 251,000 of virus-related deaths in hospitals alone, peaking in January and February.' [4]

Where did this come from? It was a model, using exactly the same assumptions as that created by Prof Neil Ferguson from Imperial College London in March. The one that warned of five hundred thousand deaths in the UK. Only out by a factor of ten. Probably far more, because many of the deaths recorded as due to COVID have been, simply, wrong.

How certain was their prediction of 120,000 deaths? Professor Stephen Holgate, who chaired the report then said. '*This is not a prediction – but it is a possibility*.' A possibility… Perhaps it should be published in the *Journal of possibility-based medicine*. A journal where you simply make up facts, then see how many people run around in sheer terror.

What is now happening is extremely disturbing. COVID has certainly been a serious disease, but the flu epidemics of 1957 and 1967 were just as bad, if not worse, with regard to total fatalities. They were both over a million, and COVID has a long way to go to match that [5]

In addition, in those epidemics far more younger people died. With COVID, if you are under fifteen, the chance of dying of COVID is around one in two million, which is three times less than the chance of being struck by lightning [6].

Across Europe, the excess in deaths has simply disappeared [7]. There is no increased mortality anywhere to be seen. Whilst we are told about outbreaks of COVID deaths in various cities, the rate of new infection in these 'outbreaks' is less than one in a thousand. Which is not really an outbreak at all.

Despite this, mask wearing is to be mandatory. When COVID-19 took off, no-one was wearing a mask in my unit, unless they were helping a patient, and there was no social distancing between staff. Now the trust has decreed masks must be worn at all time, and social distancing is being ruthlessly enforced. A bell now rings, and we must wipe of all surfaces in front of us…

The reality is that COVID-19 has all but gone in the UK and Europe. The slow, but inexorable rise in deaths in the UK is being driven by the fact that anyone who has ever had a positive COVID-19 test, who dies, is recorded as dying of COVID.

Yet, as COVID-19 disappears, mask wearing and social distancing is being enforced as never before, and the prospect of a deadly second wave is being waved like a black shroud, with warnings of hundreds of thousands of deaths to come.

A biomedical scientist in the UK sent me an e-mail two days ago, about the testing they had done.

'In the week 9th – 16th July we carried out 2800 PCR tests (across three different platforms: mainly on the Hologic Panther, but some on the Cepheid GeneXpert and Biomerieux BioFire) and had only 4 positives. These 4 positives were all patients who had previously tested positive. We had NO new cases, and after checking back a few weeks, the only

positives we have had have been from repeat swabs from these same 4 patients – they were almost acting like QC samples to ensure that our tests were actually working properly!'

Two thousand eight hundred tests and none positive. This scientist contacted other laboratories, and they were seeing the same things. *'I have contacted a couple of nearby NHS Pathology Labs and they reported the same findings as us: zero or near zero new cases for several weeks.'*

What on earth is going on?

1: https://www.theguardian.com/world/2020/jun/18/health-experts-criticise-uk-failure-track-recovered-covid-19-cases

2: https://www.who.int/classifications/icd/Guidelines_Cause_of_Death_COVID-19.pdf

3: https://www.youtube.com/watch?v=KpGeRFK0tao

4: https://www.bbc.co.uk/news/health-53392148

5: https://www.webmd.com/cold-and-flu/what-are-epidemics-pandemics-outbreaks#3.

6: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19englandandwales/deathsoccurringinjune2020

7: https://www.euromomo.eu/graphs-and-maps#z-scores-by-country

This entry was posted in COVID-19 on July 25, 2020 [https://drmalcolmkendrick.org/2020/07/25/covid-fear/] .

Replies to the vitamin D article by the guest contributor

11th July 2020

Having published the guest article by 'Bob' there have been a lot of comments. I have not replied, as it was not my article. However, Bob has put together a kind of generic reply to people's posts which I think may be useful and informative.

Hello Everybody – I wrote the article and have read your comments. First, I want to thank Dr. Kendrick for publishing my thoughts in his esteemed blog. I started following Dr. Kendrick's blog around 2015 and am a devoted reader. My favorite single post is the one titled "Salt Is Good for You."

I was introduced to the wonderful world of Vitamin D in 2010 when a physician directed me to the Vitamin D Council website, now defunct. John Cannell's articles on influenza, and on autism, were compelling for me. I started taking 5000 IU per day in December 2010 (at age 60) and I noticed that I no longer got colds or influenza in the winter. Before 2010 I would get one or two colds every winter, with the usual sore-throat – head cold – chest congestion sequence. Since then I have had exactly 5 colds, all very mild. I now take a higher dose but I think people should look at the advice provided in the Grassrootshealth article and make up their own minds as to appropriate dose.

My article sketches out a theory that yields a series of hypotheses which can be tested. Thus, one notes a general pattern, and scratches one's head over exceptions. Hence my discussion of Ecuador and South America.

I propose that an underlying difference in susceptibility to coronavirus arises from the fact that the New World was epidemiologically isolated from the rest of the world until about 500 years ago. Before then the indigenous populations of the New World and the Old World were exposed to and therefore developed adaptive mechanisms to ward off different groups of pathogens.

This is illustrated by the well-known susceptibility of New World populations to Old World pathogens like measles and smallpox. The higher death rates in many South American countries suggests that the indigenous New World genome has not yet fully adapted to Old World coronaviruses. Thanks, Terry Wright, for the Guayaquil reference.

Thank you, John Stone, for the reference to the Stadler article observing that there is a significant level of immunity to Covid19 already present in the population. We had another clue to this fact early in the pandemic with outbreaks on two ships, the cruise ship Diamond Princess, and the US aircraft carrier Theodore Roosevelt. Both occurred before people took protective measures, and it can be argued that the close quarters of shipboard life are ideal for the transmission of the disease. On both ships, everybody was tested for Covid19. Results were remarkably similar. On both ships, 17 percent of the people tested positive for the virus, and of those, 50 percent were asymptomatic. It looks like 83 percent of the shipboard populations were immune to the virus. Why?

Several of you have pointed out that death rates from various countries are inconsistent with the sunshine theory. First, do not confuse cases with deaths. Case totals are the creatures of testing programs, which vary from place to place. Deaths are a much harder statistic.

That said, country-specific factors come into play. In comments, Andrew Larwood and Simon C pointed out Finland's vitamin D supplementation program would reduce deaths. Their death rate per million is 59, which seems very low for a country in the winter at such a high latitude. Now I know why. Another factor may be fatty

fish, a dietary source of Vitamin D, which is consumed in quantity in Scandinavia. Håkan, your comment about Sweden is relevant.

Many people attribute the higher rate of Covid19 deaths to the lack of a lockdown. However, an equally good case can be made that the dark-skinned immigrant population in Sweden is more deficient in vitamin D and thus more susceptible to the illness. See this article by Dr. David Grimes where he notes that 1 percent of the Swedish population may be responsible for 40 percent of deaths: http://www.drdavidgrimes.com/2020/04/vitamin-d-and-immunity-important.html and this one: https://www.bmj.com/content/368/bmj.m1101/rr-10 If you have read Dr. Kendrick's last blog post, "Distorting science in the COVID pandemic," you would know that the very low death rate (7 per million) in Morocco may be due to their use of hydroxychloroquine to treat sick patients.

Does implementation of hydroxychloroquine treatment explain the abrupt decline of coronavirus deaths in the UAE on May 12? https://www.palmerfoundation.com.au/preliminary-injunction-sought-to-release-hydroxychloroquine-to-the-us-public-studies-show-benefits/ If you look at the death rate graphs for a number of Muslim countries, there is a distinct uptick in cases at the end of May. Does this have something to do with Ramadan, which was April 23 to May 23 this year?

David Bailey, your comment is spot-on. Look at the seasonality of acute myocardial infarction. In the higher latitudes one gets daily doses of sunshine in the summer, but not in the winter, and it is the dailiness of the dose that is key to protection of the endothelium. This is also why randomized clinical trials of vitamin D tend not to show a strong protective effect against CVD, because most do not use a daily dose, rather, dose intervals are weekly or longer (and the dose is usually too small and the duration of the trial too short).

Thank you all for your comments.

This entry was posted in Dr Malcolm Kendrick on July 11, 2020 [https://drmalcolmkendrick.org/2020/07/11/replies-to-the-vitamin-d-article-by-the-guest-contributor/] .

Here is a Coronavirus puzzle for you to ponder – A guest article

9th July 2020

A guest article

I was sent this piece on Vitamin D and COVID by a reader of this blog. I thought it was very good and asked them if they minded me posting it. They said fine, but they wish to remain anonymous. Not everyone likes the glare of publicity – with all the attending Trolling and insults that inevitably follow [you should read my in-box sometime].

Season, Latitude, and COVID-19 Severity

Here is a coronavirus puzzle for you to ponder. For context, let's look at how many people have died of COVID-19 in the USA (as of mid-June). Websites give different totals, but it's around 120,000, or about 360 per million of population. So how many died in Australia? 102. How many died in New Zealand? 22. In both countries, the death rate is 4 per million. That is an extraordinary contrast!

Wouldn't public health officials like to know the cause of this difference? Are the Antipodeans that much better at hand-washing and social distancing than the people of New York, Italy or Great Britain? Do they share a highly-effective cure kept secret from the rest of the world? Or is there another reason for the disparity?

Unlike the USA and other countries where the disease has taken a huge toll, the coronavirus arrived in Australia and New Zealand in mid-summer. Most of the inhabitants of these two countries are descendants of pale-skinned British settlers (and convicts in the case of Australia). Yet at the same time the death rate in Great Britain, the homeland of their ancestors, is over 600 per million.

This suggests that sunshine, and, specifically, the sunshine vitamin, are responsible for the difference. If you look at the death rates throughout the world, it becomes apparent that countries in the southern hemisphere fared much better than countries north of the equator.

Actually, the division between countries with high death rates and low death rates is about the 37th parallel north. According to Wikipedia, the 37th parallel is the dividing line between greater than average and less than average sun exposure.

So it appears that people living south of the equator, and south of the 37th parallel north, experienced, in general, higher levels of sun exposure and lower death rates from the coronavirus than those in the northern hemisphere north of the of the 37th parallel.

This explains the very low death rates observed in Africa. Many experts have forecast that the coronavirus would take a heavy toll in Africa because of poor healthcare infrastructure in much of the continent. Yet this has not happened. For example, death rates in Ghana, Nigeria, Kenya, Ivory Coast, Togo, South Sudan, Niger and Burkina Faso are between 2 and 3 per million.

Virtually all of the continent is south of the 37th parallel north and sub-Saharan Africa is close to the Equator. It could be argued that the low death rate is an artifact of poor record keeping, but reasonably good data about another virus, Ebola, reached world attention, so high death rates from coronavirus would likely be evident.

The same is true in the Far East. Indonesia, Malaysia, Singapore and Sri Lanka are near the equator and have coronavirus death rates per million of 8, 4, 4, and 0.5. But this pattern breaks down when one looks at that most equatorial of nations, Ecuador.

Here the reported coronavirus death rate is about 223 per million. Other major countries of the South American continent, Brazil, Peru, Chile and Bolivia, have per million death rates of 208, 208, 176, and 54, which is quite a contrast to those seen in Africa and Southeast Asia. The disparity may arise from a greater susceptibility to the coronavirus among people with indigenous ancestry.

Support for this idea comes from the death rates in Argentina and Uruguay, which are 19 and 7, per million, respectively. Unlike the rest of South America, the populations of these two countries are very largely of European ancestry, mostly Spanish and Italian. Remember that while it was summer in Argentina and Uruguay, at the same time it was winter in Spain and Italy, where COVID-19 death tolls per million were 580 and 571, respectively.

This analysis supports the idea that the virulence of the coronavirus, as measured by death rate, varies inversely with sun exposure. Where the coronavirus struck during the summertime, in the southern hemisphere, death rates were very low, in very marked contrast to countries in the higher latitudes of the Northern Hemisphere, where the coronavirus struck in mid-winter. The cause proposed to explain this disparity is Vitamin D levels in the respective populations. How does that work?

Vitamin D3 is created in the skin by the ultraviolet light in sunlight. Before the advent of dietary supplements, sunlight was the only significant source of Vitamin D3. Fatty fish is a natural dietary source. Vitamin D3 is transformed inside the body to calcidiol, 25(OH)D3, which is not a vitamin, but a hormone.

Calcidiol has a half-life in the body of 2 to 3 weeks, so serum levels decline if they are not continually replenished by sun exposure or dietary supplements. Winters in the higher latitudes diminish sun exposure due to shorter days, lower sun angle (if the sun is lower than 45 degrees in the sky, little UV light makes it through the atmosphere), and the need to bundle up or stay indoors in cold weather.

About 15 years ago it was discovered that Vitamin D is critical to the proper function of the innate immune system. Broadly, there are two kinds of immunity – innate and acquired. The body acquires immunity when it creates antibodies in response to infection by a specific pathogen. This is the principal behind vaccines – to trigger the creation of antibodies.

However, the body also has an innate immune system that responds to the wide range of pathogens to which it is exposed every day. Recently it has been demonstrated that the innate immune system is the body's principal defense against another viral disease – influenza. The annual wintertime outbreaks of influenza are triggered by declining levels of serum vitamin D in the host population. That is why influenza doesn't occur in the summer and is very uncommon in the tropics.

For in-depth discussion of innate immunity, Vitamin D3 and influenza, read the paper in Virology Journal titled "On the Epidemiology of Influenza" by John Cannell, et. al., and his earlier paper "Epidemic Influenza and

Vitamin D" published in the journal Epidemiology and Infection. Open access full text of both articles can be found on the internet on PubMed.

However, the COVID-19 coronavirus is not influenza, so the role of innate immunity and Vitamin D in the incidence and virulence of this disease must be established. Given the very recent emergence of COVID-19, it is understandable that not very much research on the role of Vitamin D has been published.

However, one key paper has come out, which has been summarized in the website Grassroothealth.net/blog/first-data-published-covid-19-severity-vitamin-d-levels/. The data are observational and the population of patients was 212, but the results are statistically significant. People with adequate levels of serum Vitamin D in their blood experienced mild bouts of COVID-19, while those with inadequate levels suffered ordinary, severe or critical cases. The chart in the article illustrates these data.

The results of this study are exactly consistent with the idea that sun exposure is inversely correlated with the virulence of COVID-19. When serum levels of Vitamin D are high, the disease is mild. When they are low, the disease is severe. Which then leads one to ask what are the specific effects of Vitamin D that reduce the severity of COVID-19 infection?

There are at least two. Severe cases can be complicated by what is called a "cytokine storm." This is a severe over-reaction of the immune system that can be fatal. Vitamin D is known to prevent this condition (see the above-referenced articles by John Cannell). A second effect is related to the recent discovery that COVID-19 attacks blood vessels, in particular, the endothelium, which is the internal lining of vessels, causing widespread clotting[1].

Research published in 2015 showed that Vitamin D3, in the form that is created in the skin by UV light or taken as a dietary supplement, has a direct, protective effect on the endothelium [2] Because Vitamin D3 lasts in the body only a day or so before it is processed into calcidiol, one needs a daily dose of sunshine or supplement to maintain the protective effect on blood vessels. It should be underscored that sunscreen blocks UV rays from reaching the skin and therefore diminishes the formation of Vitamin D. The skin pigment melanin is a natural sun screen and has a similar effect.

What does this mean for people who want to protect themselves from the malign effects of COVID-19? Vitamin D3 is not some untested off-label prescription drug or sketchy supplement: it is an essential hormone naturally produced in the human body by sunlight on the skin.

With enough sun, one's body makes all that is necessary to counteract the virus. But modern lifestyles can make it impossible for many people to get sufficient daily sun exposure in the summer, and during Minnesota winters it is physically impossible because the sun is too low in the sky, not to mention that it is too cold to take off your clothes.

Therefore, one needs a program of supplementation with Vitamin D3, which is readily available over the counter. The question, of course, is how much. Grassrootshealth has devoted considerable study to finding the answer, a good discussion of which can be found here [3] The coronavirus statistics I used are from the site Worldometers [4]

1: https://www.sciencetimes.com/articles/25872/20200529/coronavirus-respiratory-disease-change-everything.ht.

2: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0140370.

3: https://www.grassrootshealth.net/blog/current-recommendations-low/

3:: www.worldometers.info/coronavirus/#countries.

This entry was posted in COVID-19 on July 9, 2020 [https://drmalcolmkendrick.org/2020/07/09/here-is-a-coronavirus-puzzle-for-you-to-ponder-a-guest-article/] .

Distorting science in the COVID pandemic

5th July 2020

This blog has been published in RT.com https://www.rt.com/search?q=malcolm+kendrick

I've lost all trust in medical research – the financial muscle of Big Pharma has been busy distorting science during the pandemic

Evidence that a cheap, over-the-counter anti-malarial drug costing £7 combats COVID-19 gets trashed. Why? Because the pharmaceutical giants want to sell you a treatment costing nearly £2,000. It's criminal.

A few years ago, I wrote a book called Doctoring Data. This was an attempt to help people understand the background to the tidal wave of medical information that crashes over us each and every day. Information that is often completely contradictory '*Coffee is good for you… no, wait it's bad for you… no, wait, it's good for you again,'* rpt. ad nauseam.

I also pointed out some of the tricks, games and manipulations that are used to make medications seem far more effective than they truly are, or vice-versa. This, I have to say, can be a very dispiriting world to enter. When I give talks on this subject, I often start with a few quotes.

For example, here is Dr Marcia Angell, who edited the New England Journal of Medicine for over twenty years, writing in 2009:

"It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgement of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as editor of the New England Journal of Medicine."

Have things got better? No, I believe that they have got worse – if that were, indeed, possible. I was sent the following e-mail recently, about a closed door, no recording discussion, under no-disclosure Chatham House rules, in May of this year:

"A secretly recorded meeting between the editors-in-chief of The Lancet and the New England Journal of Medicine reveal both men bemoaning the 'criminal' influence big pharma has on scientific research.

"According to Philippe Douste-Blazy, France's former Health Minister and 2017 candidate for WHO Director, the leaked 2020 Chatham House closed-door discussion between the [editor-in-chiefs] – whose publications both retracted papers favorable to big pharma over fraudulent data.

"Now we are not going to be able to, basically, if this continues, publish any more clinical research data because the pharmaceutical companies are so financially powerful today, and are able to use such methodologies, as to have us accept papers which are apparently methodologically perfect, but which, in reality, manage to conclude what they want them to conclude," said Lancet [editor-in-chief] Richard Horton."

A YouTube video where this issue is discussed can be found here. It is in French, but there are English subtitles.

The New England Journal of Medicine, and the Lancet are the two most influential, most highly resourced journals in the world. If they no longer have the ability to detect what is essentially fraudulent research, then… Then what? Then what indeed?

In fact, things have generally taken a sharp turn for the worse since the COVID pandemic struck. New studies, new data, new information is arriving at breakneck speed, often with little or no effective review. What can you believe, who can you believe? Almost nothing would be the safest course of action.

One issue that has played out over the last few months, has stripped away any remaining vestiges of my trust in medical research. It concerns the anti-malarial drug hydroxychloroquine. You may well be aware that Donald Trump endorsed it – which presents a whole series of problems for many people.

However, before the pandemic hit, I was recommending to my local NHS trust that we should look to stock up on hydroxychloroquine. There had been a great deal of research over the years, strongly suggesting it could inhibit the entry of viruses into cells, and that it also interfered with viral replication once inside the cell.

This mechanism of action explains why it can help stop the malaria parasite from gaining entry into red blood cells. The science is complex, but many researchers felt there was good reason for thinking hydroxychloroquine may have some real, if not earth-shattering benefits, in COVID-19.

This idea was further reinforced by the knowledge that it has some effects on reducing the "cytokine storm" that is considered deadly with COVID. It is prescribed in rheumatoid arthritis to reduce the immune attack on joints.

The other reason for recommending hydroxychloroquine is that it is extremely safe. It is, for example, the most widely prescribed drug in India. Billions upon billions of doses have been prescribed. It is available over the counter in most countries. So I felt pretty comfortable in recommending that it could be tried. At worst, no harm would be done.

Then hydroxychloroquine became the centre of a worldwide storm. On one side, wearing the white hats, were the researchers who had used it early on, where it seemed to show some significant benefits. For example, Professor Didier Raoult in France:

"A renowned research professor in France has reported successful results from a new treatment for COVID-19, with early tests suggesting it can stop the virus from being contagious in just six days."

Then research from Morocco:

"Jaouad Zemmouri, a Moroccan scientist, believes that 78% of Europe's COVID-19 deaths could have been prevented if Europe had used hydroxychloroquine… "Morocco, with a population of 36 million, [roughly one-tenth that of the U.S.] has only 10,079 confirmed cases of Covid-19 and only 214 deaths.

"Professor Zemmourit believes that Morocco's use of hydroxychloroquine has resulted in an 82.5% recovery rate from COVID-19 and only a 2.1% fatality rate – in those admitted to hospital."

Just prior to this, a study was published in the Lancet, on May 22nd stating that hydroxychloroquine actually increased deaths. It then turned out that the data used could not be verified and was most likely made up. The authors had major conflicts of interest with pharmaceutical companies making anti-viral drugs. In early June, the entire article was retracted by Richard Horton, the Editor.

Then a UK study came out suggesting that hydroxychloroquine did not work at all. Discussing the results, Professor Martin Landray stated:

"This is not a treatment for COVID-19. It doesn't work," Martin Landray, an Oxford University professor who is co-leading the RECOVERY trial, told reporters. "This result should change medical practice worldwide. We can now stop using a drug that is useless."

This study has since been heavily criticised by other researchers who state that the dose of hydroxychloroquine used was, potentially, toxic. It was also given far too late to have any positive effect. Many of the patients were already on ventilators.

Then, yesterday, I was sent a pre-proof copy of an article about to be published in the International Journal of Infectious Diseases which has found that hydroxychloroquine…

.."significantly" decreased the death rate of patients involved in the analysis. The study analyzed 2,541 patients hospitalized among the system's six hospitals between March 10 and May 2 and found

- *13% of those treated with hydroxychloroquine died while*
- *26% of those who did not receive the drug died.(ref)*

When things get this messed up, I tend to look for the potential conflicts of interest. By which I mean, who stands to make money from slamming the use of hydroxychloroquine (which is a generic drug that has been around since 1934 and costs about £7 for a bottle of 60 tablets)?

In this case it is those companies who make the hugely expensive antiviral drugs such as Gilead Sciences' Remdesvir – which costs $2,340 (£1877) for a typical five-day course in the US. Second, the companies that are striving to get a vaccine to market. There are billions and billions of dollars at stake here.

In this world, cheap drugs e.g., hydroxychloroquine, don't stand much chance. Neither do cheap vitamins, such as vitamin C and vitamin D. Do they have benefits for COVID-19 sufferers? I am sure that they do. Will such benefits be dismissed in studies that have been carefully manipulated to ensure that they do not work? Of course. Remember these words:

'...pharmaceutical companies are so financially powerful today, and are able to use such methodologies, as to have us accept papers which are apparently methodologically perfect, but which, in reality, manage to conclude what they want them to conclude," said Lancet [editor-in-chief] Richard Horton.'

Unless and until governments and medical bodies act decisively to permanently sever the financial ties between researchers and Big Pharma, these distortions and manipulation in the pursuit of Big Profit will continue.

Just please don't hold your breath in anticipation.

(ref) https://edition.cnn.com/2020/07/02/health/hydroxychloroquine-coronavirus-detroit-study/index.html?utm_content=2020-07-03T08%3A10%3A01&utm_source=twCNN&utm_term=link&utm_medium=social

This entry was posted in Conflicts of Interest, COVID-19 on July 5, 2020 [https://drmalcolmkendrick.org/2020/07/05/distorting-science-in-the-covid-pandemic/] .

COVID the strange the inexplicable and the weird

26th June 2020

This article was first published on RT.com

This is so weird and inexplicable I can't fathom it: why did deaths in people aged 15-44 spike during lockdown, & only in England?

As a doctor, I occasionally get confronted with difficult, unexplainable things, but this is a mystery I cannot solve. What lies behind this unusual rise in deaths in an age group that isn't vulnerable to COVID-19?

It has been almost impossible to make any sense of the figures on COVID -19 deaths from around the world. They do say that the first casualty of war is truth. However, the enemy, in this case, does not much care what anyone says, so there is no point in lying to it.

All it wants to do is move from one host to another and propagate itself. Why does it wish to do this? We don't really know, it just does. COVID -19 doesn't do interviews, but we can guess that its mission is to completely

dominate the world.

Faced with the same implacable enemy, you would expect that every country would see similar patterns of infection, and death. Or, you might expect to see the same figures from countries that carried out the same actions. Essentially, did a country lock down, or not.

However, if you do try to compare lock down vs. no lock down, the COVID mortality figures appear incomprehensible. Belgium, for example, entered lockdown on the 18th of March, whilst Belarus did not lock down at all. Belgium has a population of 11.5 million, while Belarus has 9.5 million.

Belgium, as of the 22nd of June, had suffered 9,696 COVID related deaths.

Belarus, as of the 22nd of June, had suffered 346 COVID related deaths.

The death rate in Belgium, per million of population, is 847.

The death rate in Belarus, per million of population, is 36.

Which means that the death rate in Belgium is over twenty-three times as high as in Belarus. Yes, two European countries sitting at approximately the same latitude, both starting with the letter 'B', and they have a vastly different rate of death. What can we make of such statistics? The simple answer would be to say that I don't believe the figures from Belarus.

Alternatively, you could say that you don't believe the figures from Belgium either, because they have the highest death rate from COVID, per million, in the entire world. Why? Who knows? However, I would caution against dismissing figures that you don't like, or don't feel make sense.

After all, there are other countries that did not lock down to any extent, such as Japan, where there has been a death rate of seven per million, or one fifth that of Belarus. I think it would take someone very bold to simply dismiss the Japanese figures.

In fact, the death rate in Japan is very nearly the same rate as the rate in New Zealand, which has had only twenty-two deaths, and has been lauded for its aggressive lockdown policy and low rate of deaths. The NZ death rate is 4.9 per million.

In short, if you look around the world, there are no patterns to be seen, and the death rates between countries vary by more than hundred-fold. However, nowhere in the world have they been weirder, or more difficult to interpret, than in England, and – even more curiously – in younger people.

Around ten days ago, someone pointed out to me an anomaly so strange, so unexpected, that I have since spent a considerable amount of time speaking to other doctors, and statisticians, to find an explanation. With no luck so far.

First, to provide some context. The most accurate figures to use, in studying the COVID epidemic, are excess deaths. That is deaths from all causes, over and above the average from the last few years. If, say, 10,000 people normally die in the first week in April, a figure of 15,000 deaths, in the same week this year, would represent 5,000 “excess” deaths.

This figure is of crucial importance. Mainly because it can be fully relied on. From personal experience, I know that what is written on a death certificate is often no more than an educated guess. I also know that there have also been huge differences across countries in the way that doctors have been instructed to record COVID related deaths.

If an elderly person goes downhill rapidly and dies in a care home, and they did not have a test, did they die of COVID, yes or no? Probably, possibly? Doctors in the UK have been advised to write yes, while in other countries they are more likely to write no. On the other hand, there are tales of doctors in the US being coached to write COVID on almost all death certificates, because the hospital is paid more money if they do so.

Which means that relying purely on the statistics for COVID recorded deaths may be highly misleading. However, you can absolutely rely on the diagnosis of death. It is a tricky clinical condition to miss.

So, if you want the outcome that is the most reliable indicator that something truly significant is going on, you need to look at excess mortality rates. If they stay the same, you can be reassured nothing serious is happening. This is true however much the diagnosis of a single condition rises.

To provide this data, as close to real-time as possible, EuroMOMO (European mortality monitoring activity) was established. Currently, it monitors changes in overall mortality in 24 different European countries. England, Wales, Scotland and Northern Ireland are treated as separate countries. This becomes important.

EuroMOMO showed absolutely no change in mortality across all 25 countries until week eleven, the second week in March. It then rose rapidly, topping-out in week fourteen. By the end of May, everything had fallen back to normal. Which means the COVID mortality spike lasted ten weeks, from start to finish. Overall mortality rates are now lower than normal

It is fascinating that some countries showed a sharp rise in mortality, and some showed nothing. For example, Austria, Denmark, Finland and Germany – nothing. France, Belgium, Spain, the Netherlands, England – major spikes. Thirteen countries spiked, twelve did not.

Then, and here we get to the really weird part, is the data that was tucked away in a sub-section. A massive rise in mortality that was seen in only one country out of the twenty-five, and nowhere else. And a spike in the age group 15 to 44… one of age groups least vulnerable to COVID -19… and in England alone. Not in Scotland, Northern Ireland or Wales. It lasted five weeks and then disappeared.

Frustratingly, the figures on causes of death are not available – some types of death can take a long time to be recorded e.g. deaths from accidents, or suicides. So, were all the excess deaths from COVID, it seems unlikely

as the total number of recorded deaths in this age group has been less than five hundred since the start of the epidemic and that is not going to create such a spike.

Might lockdown have, in some way, have caused it? Might the loneliness of it have caused a rise in suicides? Or a surge in drug overdoses? Or other reckless behaviour?

I don't know… but if we are to truly understand what happened during the pandemic, we need to find out.

This entry was posted in COVID-19 on June 26, 2020 [https://drmalcolmkendrick.org/2020/06/26/covid-the-strange-the-inexplicable-and-the-weird/] .

COVID – will lockdown lead to a major health disaster

11th June 2020

[This article was published in Russia Today I feel I should mention that I have taken some criticism for writing articles for Russia Today, I have remained silent on the matter up to now.

However, I would like to point out that I tried to contact the BBC with regard to many of the issues I have been highlighting e.g. the COVID care home disaster in the UK – no interest. I tried to contact UK newspapers – no interest. And I have a good relationship with a lot of journalists.

In addition to this lack of interest in matters that I felt were extremely important, it concerns me that YouTube has a current policy of censoring content critical of COVID orthodoxy. Toby Young, who can be a divisive figure, wrote about this in the Spectator magazine, pointing out that Google and YouTube are using a form of censorship knowns as 'shadow banning', which makes content they disapprove of extremely difficult to find.

As Toby Young made clear, they shadow banned an interview with Peter Hitchens entitled '*Lockdown is a catastrophe*.' They also removed an interview with Nobel laureate Michael Levitt called '*the case against lockdown*.'

When I criticised the modelling of Imperial College, a huge number of replies came flooding in. They attacked me, but were highly supportive of the modelling, and the Government actions. These posts were from people who have never posted before, or since. Hired guns? I watched an interview where a representative of Facebook explained that they were shutting down any posts on Vitamin C and COVID-19. Calling it fake news. As if they had any idea of the science behind it.

Currently, if people wish to point an accusatory finger at news outlets for manipulating and censoring the news, the facts, the information flow, they need to turn their attention a little closer to home. The mainstream media seem to have become what they should never, ever, be. Cheerleaders for their Governments.

And no, no-one has paid a single rouble to write this little rant. I have never written *anything* that I do not believe to be true. More fool me, probably. So, I would like to say thank you to Russia Today for being willing to publish my, completely unedited, thoughts.]

COVID – will lockdown lead to a major health disaster

I fear we may be heading for a post-lockdown health catastrophe that could mirror the disaster of the post-Soviet era.

The self-inflicted damage we've done to our economies in the name of combating COVID-19 may end up killing far more people than the virus itself. The economic collapse that followed the communist bloc's break-up caused millions of deaths.

There has never been a situation to compare with what we have been living through these past weeks and months. Never in the history of the world have entire countries been locked down. Never have entire countries inflicted such enormous damage to their own economies and distorted their health systems away from all other activities, to deal with a virus.

I felt, right from the start, that the potential harms from lockdown could well exceed any – speculative – reduction in COVID deaths. I began by arguing against lockdown from an economic perspective, which many people hated. They felt it was impossible to put a value on a human life, even to attempt to balance money versus health.

Perhaps they were unaware that we do this all the time. It is why NICE – the UK's National Institute for Health and Care Excellence – was established in 2000. It is what all healthcare systems are forced to do. No country can afford to throw unlimited resources at healthcare. We all must decide what we can, and cannot, afford to do. Tough decisions to make, but essential.

Perhaps I came at the lockdown from a different viewpoint from most other people. When the pandemic took off, I was analysing the impact of economic and social upheaval on mortality. I was looking specifically at the breakup of the Soviet Union, as I knew that there had been a massive health impact from the rapid and uncontrolled "transformation" from a socialist to a market-based system.

An exhaustive study by three Austrian academics of the fallout from the dissolution of the communist bloc demonstrates the economic devastation it wrought:

"The immediate economic consequences of transformation were significant falls in gross national product. For example, between 1990 and 1993, real ***GDP had declined in Lithuania -18 per cent,*** *Ukraine -10 per cent,* ***Russia -10.1 per cent*** *and Tajikistan -12.2 per cent. The first ten years of transformation was a period of* ***great social disruption and chaos****. The introduction of a market system of exchange led to a severe decline in gross domestic product, contraction of the labour market, and* ***unemployment leading to social malaise including a rising death and suicide rate****."*

What was the true impact on health? My main research interest is in cardiovascular medicine, and I was focussed on deaths from coronary heart disease (CHD). In lay terms, this means deaths from heart attacks. I had just put together the graph below, using Lithuania data.

As you can see, there was a dramatic increase in CHD deaths in 1989, the year that the Berlin wall fell. Lithuanians commenced their singing revolution, and there were mass demonstrations for independence, along with significant social upheaval.

The Soviet tanks rolled in, stayed for a bit, then rolled back out again, without doing much. Meanwhile, the Lithuanian GDP fell through the floor, and the rate of CHD virtually doubled over the next three years. A great mountain of increased mortality which makes anything from COVID look like a speed bump.

Of course, there were things over and above economic woes going on in Lithuania. However, I know that economic worries, by themselves, can be deadly. Perhaps the single deadliest thing of all. For instance, a study in South Africa found that people with significant financial worries were thirteen times more likely to have a heart attack:

*"People who reported significant **financial stress were 13 times more likely to have a heart attack** than those who had minimal or no stress. Among those who experienced moderate work-related stress levels, the chances of having a heart attack were 5.6 times higher."*

Lithuania was not the only ex-Soviet country to see a massive increase in death. Not just from CHD, but in all-cause mortality. Here is a section of a report on the break-up:

"The transition to market economies in many post-communist societies of the former Soviet Union and other former eastern bloc countries in Europe has produced a 'demographic collapse,' Among the most serious findings is a four-year drop in life expectancy among Russian men since 1980, from 62 years to 58.

"There were also significant drops in life expectancy in Armenia, Belarus, Bulgaria, Latvia, Lithuania, and Romania. The immediate cause of the rising mortality is the 'rise in self-destructive behaviour, especially among men.' Old

problems such as alcoholism have increased; drug misuse, a relatively new problem in the former communist bloc, has risen dramatically in recent years." The report, Transition 1999, stated that suicide rates climbed steeply too, by 60% in Russia, 80% in Lithuania, and 95% in Latvia since 1989.

Behind the self-destructive behaviour, the authors say, were economic factors, including rising poverty rates, unemployment, financial insecurity, and corruption. Whereas only 4% of the population in the region had incomes equivalent to $4 (£2.50) a day or less in 1988, that figure had climbed to 32% by 1994.

"What we are arguing," said Omar Noman, an economist for the development fund and one of the report's contributors*, **"is that the transition to market economies [in the region] is the biggest … killer we have seen in the 20th century**, if you take out famines and wars. **The sudden shock and what it did to the system … has effectively meant that five million [Russian men's] lives have been lost in the 1990s."***

Five million lives lost in Russia… alone. As I write this, we have reached a worldwide figure of slightly under four hundred thousand deaths from COVID, in total. COVID now seems to be on the way out, and we may never reach half a million deaths in total. The economic impact, however, is only just beginning.

Moving back to CHD again, what were the Russian figures for CHD deaths following transition? As with Lithuania, they are quite fascinating, and highly disturbing.

You may ask why there was a two-year time lag between CHD deaths between Lithuania and Russia. I think the answer is that when the Berlin wall came down in 1989, it triggered an immediate crisis in Lithuania. On the other hand, the rest of the Soviet Union limped on for a couple of years. In 1991 there was an attempted coup, which failed. However, this did signal the end, and the Soviet Union then rapidly broke up.

In late 1991, Russia became a separate country, under the leadership of Boris Yeltsin, and it quickly moved to a market-based economy. Some people became eye-wateringly rich – far more became extremely poor. This, the delayed break up, is almost certainly why the Russian death rate lags Lithuania by two years.

There is another important difference. Russia did not just have one CHD peak, but two. After rising, then rapidly falling, it changed direction and climbed back up again. Why the double peak?

I think this can be explained by the fact that, in August 1998, there was a massive banking collapse. It virtually wiped out the stock market and destroyed the value of the rouble. At the same time, unemployment skyrocketed and the savings of the common man were further obliterated. The recovery took years, as this report makes clear:

"The enormity of Russia's financial collapse on Aug. 17, 1998 only really hit home with me the next day. "We are so f-cked," George Kogan, one of Moscow's most famous and longest serving equity salesmen, explained to me standing in the apartment of Simon Dunlop, one of Moscow's most famous entrepreneurs. "The whole system has just crashed. It will take years for Russia to recover." [5]

Having seen the health impact of economic crashes, I hope you can now see why I was deeply concerned about lockdown. It was clear to me that this could mean massive financial hardship, and I feared that the deaths that followed could be catastrophic.

When our pandemic "experts" were putting together their models on death rate, did they take any of this into consideration? They did not. But what is the point of any model that does not even bother to consider the potential negative impact of what they are recommending?

As a doctor, if I were advising any form of medical treatment, I would be considered negligent if all I did was talk about the benefits. I need to inform the patient about potential downsides. The procedure may not work; you may get worse – and suchlike.

We were persuaded into lockdown with the promise that hundreds of thousands of lives could be saved in the UK – and millions worldwide. We were never warned about the many millions of lives that could – and, I fear, will – be lost as a consequence of lockdown. I consider that to be negligent. Especially as, in this case, the patient in question was the entire population of the Earth.

This entry was posted in COVID-19 on June 11, 2020 [https://drmalcolmkendrick.org/2020/06/11/covid-will-lockdown-lead-to-a-major-health-disaster/] .

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