A Critical Review of CDC USA Data on Covid-19: PCR/Antigen Tests & Cases Reveal Herd Immunity Only, and Do Not Warrant Public Hysteria or Lockdowns

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James DeMeo, PhD *

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"What is the hardest thing of all? That which seems the easiest.
For your eyes to see, that which lies before your eyes."
– Goethe

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Abstract
Basic all-cause US death data for 2020, when reviewed in light of a claimed Covid-19 pandemic, suggest *most annual excess deaths are due to the physical consequences of lockdown-related mandates which create economic ruin and added emotional and somatic-pathological devastation within vulnerable populations.* The CDC's data on Covid-19 lab-confirmed tests, cases and deaths were reviewed as plotted on the same ordinate vertical axis scale, indicating a high correlation between tests and cases, but no correlations or causality between either tests or cases to deaths. Covid-19 deaths among age-groups of high-risk elderly 65+ years and older, were found to be of nearly identical percentages as in all-cause deaths in the same age demographic. Daily death/case ratios failed to affirm any significant global growth or spread of an expected deadly viral pandemic. Claimed Covid-19 deaths followed a dominant seasonal wintertime pattern, peaking within the different winter months of the two hemispheres. *These direct reviews of the official data exposed multiple contradictions to basic causality and logic, revealing observed pathology and deaths are primarily due to extreme lockdown measures undertaken to control a presumed viral pandemic, but not to any viral pandemic itself.* Problems in PCR/Antigen tests and electron-microscopy for specific identification of SARS-CoV-2 were exposed, indicating the claimed Covid-19 lab tests and clinical diagnoses are, at high numbers, inaccurately mis-attributing ordinary end-of-life diseases and conditions to a poorly-demonstrated virus. This is why lab-confirmed cases among asymptomatic people who remain healthy have soared to dramatically high numbers, while lab-confirmed deaths have not. All-cause death data suggest respiratory disorders such as influenza or pneumonia are being inappropriately reclassified as Covid-19. Soaring "case" numbers reflect *herd immunity only*, while increased death numbers are due to comorbidities made worse in vulnerable populations by forced lockdowns and economic ruin.

Introduction

One of the primary missions and responsibilities of the scientific world is to make accurate observations, analyses and predictions, based upon rational logic and causality. When science strays from that mission, and promotes inaccurate theories for social application or government policy, the consequences can be disastrous. Modern medicine is not free from such risks, of promulgating public policy based upon flawed theories. Such has been the case with the claims about a deadly virus SARS-CoV-2 causing Covid-19 disease (SARS = Severe Acute Respiratory Syndrome). Even within the "official" Covid-19 theory or paradigm, there are numerous flaws and inconsistencies. This is seen notably in how laboratory tests identify "cases" among predominantly asymptomatic people, with failed predictions on who will get sick and die, versus those who remain healthy and live. We expect a true pandemic with so many "confirmed by laboratory testing" cases to predict and drive up the "confirmed deaths by Covid-19" in a manner far more substantial than is observed. There has been a general failure among all parties – medicine, science, media and government – to appreciate that fact.

Early in 2020, when horror stories and videos from Wuhan China began to appear in the American and European media, diagnoses of Covid-19 disease were made solely by clinical observations. The Covid-19 diagnostic criterion included difficulty breathing, fever, chills, heavy mucous coatings in the throat and upper windpipe, a "ground glass" opacity on chest x-rays, and other pulmonary symptoms, often accompanied by heart irregularities. Great fear of a deadly super virus escaped from a bio-weapons facility also spread around the world, with reports of massive numbers of people dying in Wuhan, and videos of panicked people overwhelming hospitals, or sometimes dropping dead in the street. Panic and hysteria were created among the general public and front-line nurses and doctors. Hazmat suits, gloves, masks, isolation wards and other protective measures were instituted, to protect hospital staff, and to contain the spread of the presumed new and potentially deadly airborne virus. China began locking down their citizens, the entire city of Wuhan being isolated by military forces, and both they and the World Health Organization (WHO) began advising similar lockdowns as a means to "control the spread" of the virus.

Patients with the above symptoms were rushed into isolation wards, treated as if they had the black plague, and were often placed onto ventilators, which required the administration of paralytic drugs also to keep them immobilized, which in many cases drove up the death numbers. Panic and anxiety added to physical distress, and people with just about any respiratory symptoms typical of influenza or pneumonia, were being given a Covid-19 diagnosis.

Whether or not these steps were justified, deaths increased among elderly populations who sought refuge or treatments in the hospitals, and many more died in nursing homes where isolation and anxiety were widespread. Some states like New York transferred sick elderly people from hospitals into nursing homes, where isolation and containment was impossible, and deaths soared. The issue of whether these people were suffering from a new disease created by a viral bio-weapon, Covid-19, or merely from ordinary pneumonia, influenza and other lung and heart disorders exacerbated by panic and anxiety (which causes sphincter muscles as in the throat and bronchial tubes to contract), thereby creating similar presenting symptoms, remains an open question rarely asked. In early 2020, I also had no reason to seriously question the official narratives about Covid-19, but became increasingly skeptical, for the reasons which follow.

PCR-Confirmed Cases Do Not Support a Claimed "Pandemic"

Around mid-March, new forms of laboratory diagnosis became widely available, such as Polymerase Chain Reaction (PCR) biochemical tests (discussed below). Additional antigen tests were also subsequently developed, and today there are a range of PCR/Antigen testing apparatus. These were claimed to produce more accurate diagnosis of Covid-19 than could be obtained by clinical diagnosis of presenting symptoms only. However, both the PCR and antigen tests were over-hyped, and never so precise or accurate in their determinations. A comparison of the claimed "laboratory confirmed" case and death data are revealing on this matter.

Data on the Covid-19 numbers, such as "confirmed cases" and "confirmed deaths" were firstly tracked on a weekly basis and published in early May of 2020 by the US Center for Disease Control (CDC). I watched those numbers steadily grow, but found a more reliable graphic presentation of the *daily* data reports at the Our World In Data (OWID) website. By July, the graphics clearly indicated a loss of causality and correlation between the two factors, daily confirmed cases and deaths, a problem which continued through the end of the year 2020, and now into 2021. OWID's data came from the CDC through November 30, and afterwards from Johns Hopkins University (JHU). A separate Supplemental Information PDF discusses these differing data sources. https://www.researchgate.net/publication/348894789_Supplementary

Figure 1 below shows the actual OWID graphic of *daily confirmed cases and deaths* placed together upon the same ordinate or vertical scale of numbers. The red line soaring upwards are the *cases*, while the nearly flat, horizontal black-grey line at the bottom are the *deaths*. As one can readily see, the plotted curve

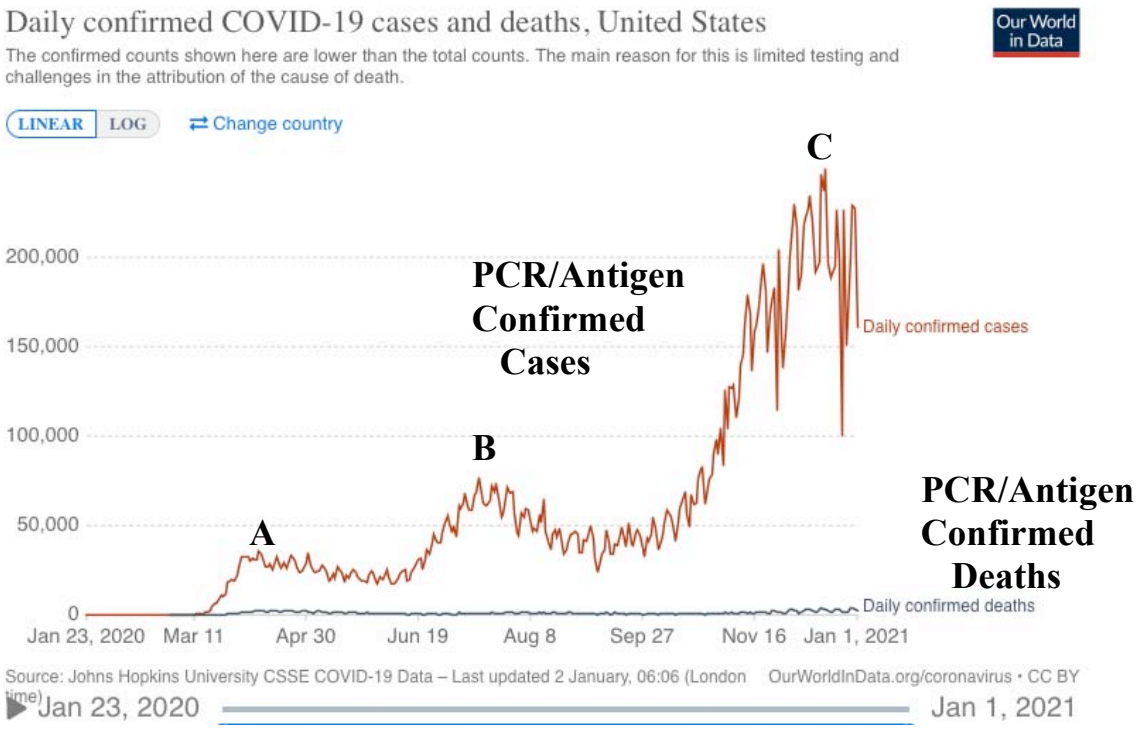


Figure 1: Daily Covid-19 PCR/Antigen Lab-Confirmed Cases & Deaths, USA only, From early March 2020 to Jan, 1, 2021. Our World in Data website. https://ourworldindata.org/grapher/daily-covid-cases-deaths?time=2020-01-01..latest&country=~USA

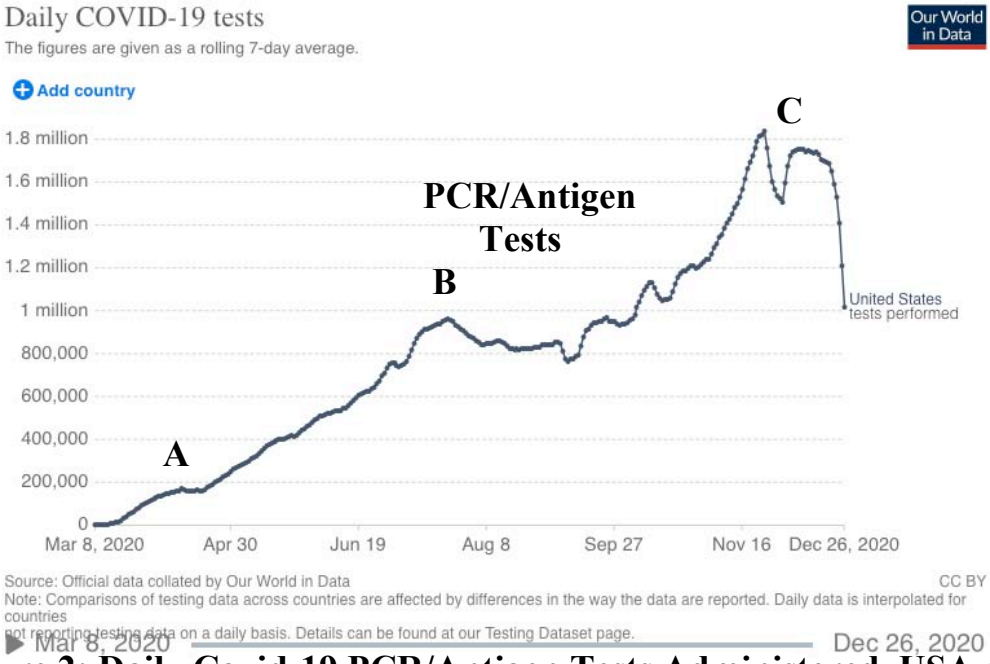


Figure 2: Daily Covid-19 PCR/Antigen Tests Administered, USA only, March 8 to Dec. 26, 2020, with 7-day averaging. Our World in Data website. https://ourworldindata.org/grapher/daily-covid-19-tests-smoothed-7-day?time=earliest..latest&country=~USA

of PCR/Antigen confirmed cases is *not congruent* with the daily confirmed deaths, directly indicating they *are not and cannot be causally linked*. The only way the confirmed case and death data can be made to appear as such is by presenting those same data on a logarithmic scale, which boosts up smaller numbers and suppresses larger numbers. Or the case and death data are separated into two different graphs with the death data being exaggerated in height by several orders of magnitude. Such exaggerations misrepresent the death data as being nearly identical to the case data, when in fact they are not. Figure 1, above, clarifies the actual situation, and sets the record straight:

1. Daily Covid-19 PCR/Antigen confirmed *cases* were firstly recorded in early March, increasing over the months to dramatic numbers approaching 250,000 lab-confirmed cases per day. Three major peaks are observed in those cases: "A" in early to mid-April, "B" over the month of July, and "C" a third peak in confirmed cases starting in October and continuing to increase until late December and into January 2021. Daily lab-confirmed cases surged upwards to above 100,000 on Nov.3rd, and to nearly 250,000 in mid-December.

2. By contrast, *the numbers of daily lab-confirmed deaths have not followed such a dramatic pattern*. Confirmed deaths have instead remained on a fairly steady level, from several hundred to 1500 daily confirmed deaths, with the exception of the initial period from March through April, and again in late November into mid-December. Those are cold winter periods when confirmed deaths went above 2000/day to over 3000/day on some days in December.

3. Overall *there is no significant correlation observed between the strongly surging daily confirmed cases with the relatively steady and dramatically lower numbers of daily confirmed deaths. "PCR/Antigen confirmed cases" do not predict who lives and who dies, much less who gets sick or remains healthy.* Instead, as detailed below, the variations in death numbers for the USA as a whole reveal a seasonal pattern, of increasing deaths in late winter of early 2020, when the Covid-19 crisis began, declining thereafter as the USA weather warmed up. A very slight lesser rise in Covid-19 deaths occurred in mid-summer, as a possible expression of lung-irritating hot-humid and dusty/pollen situations in the southern tier of US states. A third slight rise in confirmed death numbers occurred during November and December, reflecting wintertime cold conditions which swept across the nation. However*, the dramatic increase in confirmed cases peaking in December (point C)* shows *no corresponding dramatic increase in daily confirmed deaths*.

If the daily confirmed cases truly reflected the spread of a living deadly and airborne viral agent able to cause death in patients, then there would be a

predictable and steadily increasing number of daily deaths, recording the spread of such a contagious deadly virus into the population as an increasing phenomenon. Absolute numbers of deaths would then more closely match the soaring curve of daily confirmed cases with a slight lag period. However, that is not what the Figure 1 graph reveals.

Additional answers can be found in Figure 2, presenting a graphic of daily Covid-19 *test* numbers. Figure 2 reveals a generally constant and steady increase in confirmed 7-day averaged Covid-19 PCR/Antigen tests, starting in early March 2020 and continuing until the end of the year. While the correlation between the curves of *test and case* numbers in these first two figures is strong, *the correlation between the curves of both test and case numbers to those of confirmed deaths is weak, nearly absent as they eye can clearly see.*

The test-number curve of Figure 2, in agreement with the case numbers in Figure 1, also shows a subtle bulge or increase in the numbers of tests over late March into mid April (point A), with another peak in daily tests from late June through July (point B). Both of those peaks in daily PCR test numbers match in rise, but not in numbers, with the first and second peak in daily confirmed Covid-19 *cases* (A and B) in Figure 1. There also is a dramatic increase in the PCR/Antigen *test and case* numbers starting in mid-October, which together reach a maximum in December (point C).

The actual number of Covid-19 PCR/Antigen tests have soared to over a million per day since early October, reaching 1.8 million daily tests in late November, without any clear correlation to the daily deaths. The most obvious and real correlation in the Figures 1 and 2 graphs is that between the *daily PCR/Antigen laboratory tests* and *daily confirmed cases*. However*, neither of those two variables shows agreement with daily confirmed deaths, which remain at a relatively low number throughout the "pandemic".* Arguably, if a real pandemic was occurring, the lab tests would accurately predict who got sick and who remained healthy, and who lived or died, in which case, laboratory confirmed cases and death numbers would more closely correlate. *They do not.*

These data, when graphed, reveal a basic problem in claimed causality. At the graphical peaks in late December, at point C, a record of around 1.8 million tests were made, detecting around 250,000 positive test reactions or cases. That is about a 14% positive detection rate. What does that mean, exactly? At the same approximate time, around 3000 daily deaths were claimed. That works out to be one-fifteenth of one percent of tests (0.16%) or 1.2% of cases. The low probability of dying from Covid-19, viewed by such percentages, are not

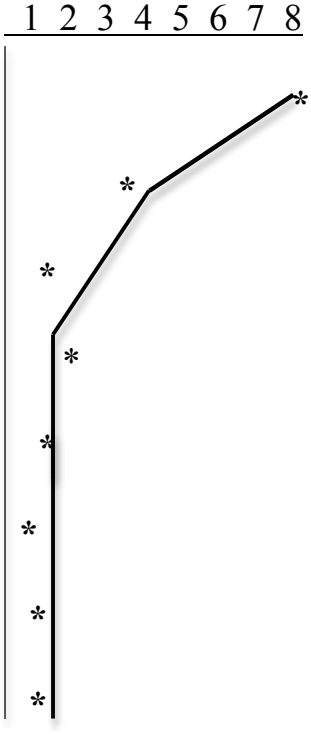
sufficient reason for the panic, hysteria, and loss of constitutional liberties from forced masking, lockdowns, economic destruction, and all the rest. More specifics can be added.

The Death/Case Ratios Do Not Support a Claimed "Pandemic"

The ratio of daily lab-confirmed Covid-19 deaths to the daily lab-confirmed Covid-19 cases, or the *death/case ratio*, further supports the criticism of *no correlation or causality*, as revealed in a separate analysis of selected 15-day periods within the Figure 1 data. The dates I selected align with major maxima and minima inflection points of the Covid death/case data (across point A and beyond B) as well as across four regions of the last major upward surge of cases, from October through December (ending at point C). These are identified with given death/case percentages in Table 1 below. This Table, in association with the Figure 1 CDC/JHU/OWID data (from which they were extracted) reveals an initial possible infectious but short-lived epoch of correlation (point A) lasting over March and April of 2020, when testing was mostly confined to hospitals with sick and suffering people. The death/case ratio for that 15-day period was high, at over 8%, but thereafter it declined dramatically. The confirmed death/ case ratios continued to subside down to lower levels until the end of 2020, when in spite of soaring daily confirmed cases, reflecting major testing of non-hospitalized and generally asymptomatic people, the average daily death/case ratios declined, to 1.38%, 0.88%, 1.1% and 1.3% (point C).

Table 1: USA Data Averages from Figure 1 over Selected 15-Day Periods

15-Day Average Confirmed Deaths/Cases		Ratio
April - First case-peak *maxima* (A)		
April 16-30	2,327 / 28,6920.	**8.11%**
June - Subsequent case-*minima*		
June 3-17	785 / 21,763	**3.61%**
July - Second case-peak *maxima* (B)		
July 16-30	948 / 66,360	**1.43%**
Sept - Subsequent second case-*minima*		
Sept 1-15	764 / 37,117	**2.06**%
Oct - slope of first case-peak *maxima*		
October 9-24	813 / 59,057	**1.38%**
Nov - slope of second case-peak *maxima*		
Nov. 14-28	1,495 / 169,130	**0.88%**
Dec Early - slope of third case-peak *maxima* (C)		
Dec. 1-15	2,373 / 208,428	**1.1%**
Dec Late - slope of fourth case-peak *maxima* (C)		
Dec. 17-31	2,553 / 199,062	**1.3%**



The average of these death/case ratios for all the above periods of 2020 works out to be 2.48%. Looking only at the numbers for the major "PCR/Antigen confirmed cases" peak from early October through December of 2020, the death/case ratios averaged 1.17%, indicating a major decline which was established since late July 2020. Again, this is not the kind of numerical situation one expects in a situation of major deaths from an expanding and raging infectious pandemic. In such a case, the death/case ratios would have started at around 8% and grown ever higher over many months before receding, as the claimed Covid-19 virus spread into the entire population.

How else to interpret these data trends except to say *the "confirmed cases" being detected by laboratory testing have No Correlation to the numbers or percentages of people dying.* Meanwhile, the number of laboratory tests being done shows a good or excellent correlation to the number of "confirmed cases". *This indicates the PCR/Antigen tests are reacting to something in the body fluids of healthy asymptomatic test subjects, but not to a living infectious deadly virus. Most likely they are reacting to DNA/RNA fragments and debris from dead virus, plus suppressed antigens and antibodies associated with prior corona-type viral exposures. Those exposures would include such things as colds, influenza, or contact with dormant coronavirus material which has stimulated the healthy immune systems of large segments of the population.*

The PCR/Antigen tests, then, have little or no predictive value in determining who is or will become sick from Covid-19, or who might die from it, but merely are detecting healthy biochemistry from prior exposures to one or another non-lethal corona-virus. The large numbers of "positive" laboratory tests are therefore primarily indicative of *Herd Immunity Only. Widespread testing results do not signal any kind of persisting or resurgent deadly viral pandemic.*

Figures 3 and 4, below, further confirm this interpretation of *no infectious viral pandemic*. They show the same graphics as in Figures 1 and 2, of daily PCR-confirmed cases, deaths and tests, but this time with regression lines drawn in, showing the general trend of data for all three variables.

This direct visual presentation of the data tells us one primary fact: *The more PCR/Antigen tests being done, the more asymptomatic "cases" are being identified, but with very few sick people with no living virus in them. Such asymptomatic people are also at no risk of infecting other people. They pose no risk to public health and identify a higher level of herd immunity within our populations than anticipated by the "deadly infectious Covid-19" theory.* If the Covid-19 laboratory test kits were truly accurate in detecting "confirmed cases" reflecting a living airborne infectious virus, whereby those "cases" would

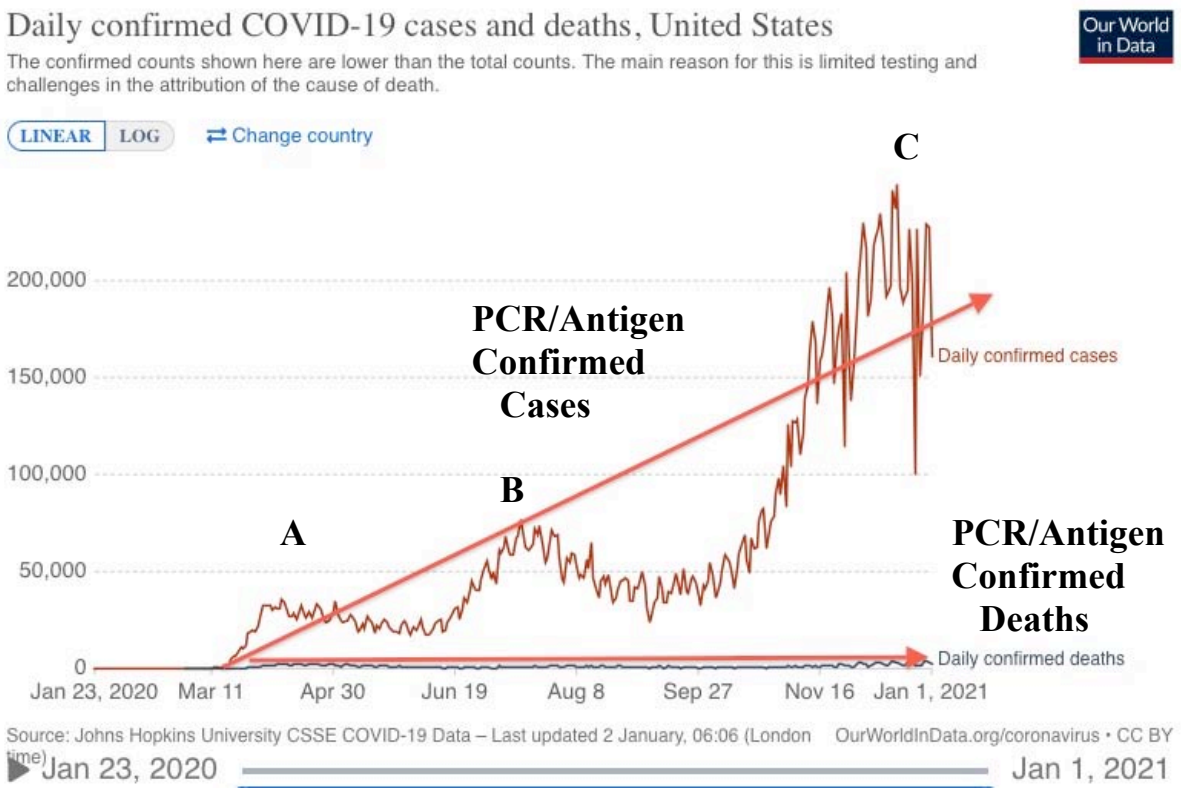
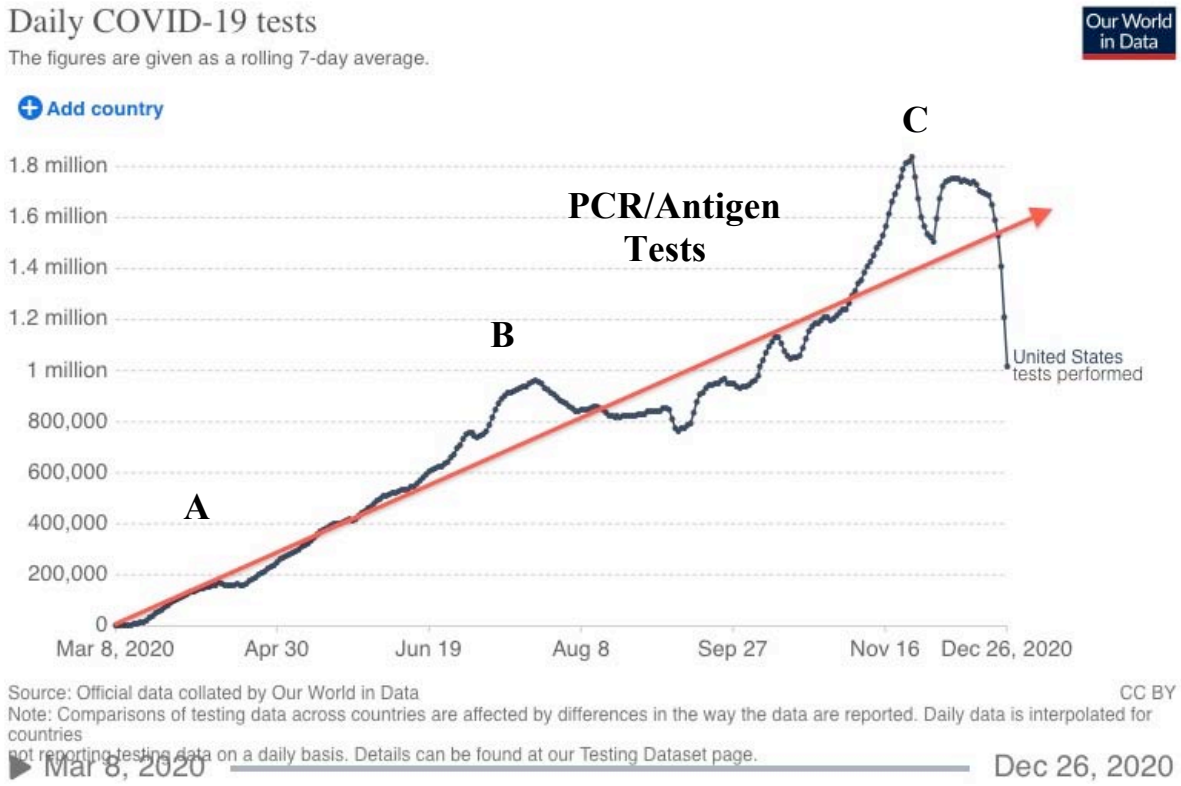


Figure 3 (above): Daily PCR/Antigen Confirmed Covid-19 Cases & Deaths

Figure 4 (below): Daily Covid-19 PCR/Antigen Tests
Same as Figures 1 and 2, but with regression lines added by author



succumb to illness and could infect other people by aerosol exhalations, sneezing, or direct touch-contact, then the confirmed deaths would have accordingly exploded to very high numbers in a manner of weeks, and would today be strongly correlated to both PCR/Antigen tests and cases, and with a similar pattern in their incidence graphs. *But they have not,* except as misreported by medical, media and political hysterics.

Covid-19 Seasonality Does Not Support a Claimed "Pandemic"

The seasonality of Covid-19 data also supports similar conclusions, that Covid-19 diagnoses (by clinical observations or by laboratory tests) are primarily the consequences of re-classifications of other better-known diseases and conditions, notably influenza and pneumonia as occur during wintertime. Northern and Southern Hemisphere nations reveal a general wintertime pattern in Covid deaths, at opposite times of year, as shown in Figures 5 and 6.

These Figures were taken directly from the OWID interactive website, and reveal a component to Covid-19 deaths which is mostly denied or ignored by the CDC, WHO and medical community. Today it is all too obvious. Covid-19 seasonality is nevertheless still being hushed up by websites preaching Covid hysteria, as with the following contradictory comparison from WebMD.com:

> "October 15, 2020 -- Respiratory viruses tend to be seasonal, including the two most common flu viruses, but the coronavirus that causes COVID-19 seems to be a year-round nuisance..."
> https://www.webmd.com/lung/news/20201014/covid-19-doesnt-seem-seasonal-study-says

"Nuisance"!? "Seems to be"? Certainly it is a "year-round" problem if we look at the whole-Earth average. But individual nations and regions show different peaks of claimed Covid-19 at different times of year. The issue of seasonality is a sensitive one, because by standard diagnoses, Covid-19 does indeed afflict populations quite similar to "common flu viruses", primarily, though not exclusively, during the cold-wet winter months. Figure 5 presents Covid-19 daily death data for Germany, Italy, France, Spain, Canada, Sweden, Greece and Japan, all of whom show the conventional Northern Hemisphere winter pattern. Figure 6 presents similar data for South Africa, Argentina, Chile and Australia, the most southerly Southern Hemisphere nations with significant Covid-19 deaths. New Zealand also shows a winter pattern similar to Australia, but with numbers so low they hardly show up on the graphic. Both figures reveal a clear wintertime climate pattern. This issue of seasonality is well-known to epidemiologists, who today mostly have lost their voices.

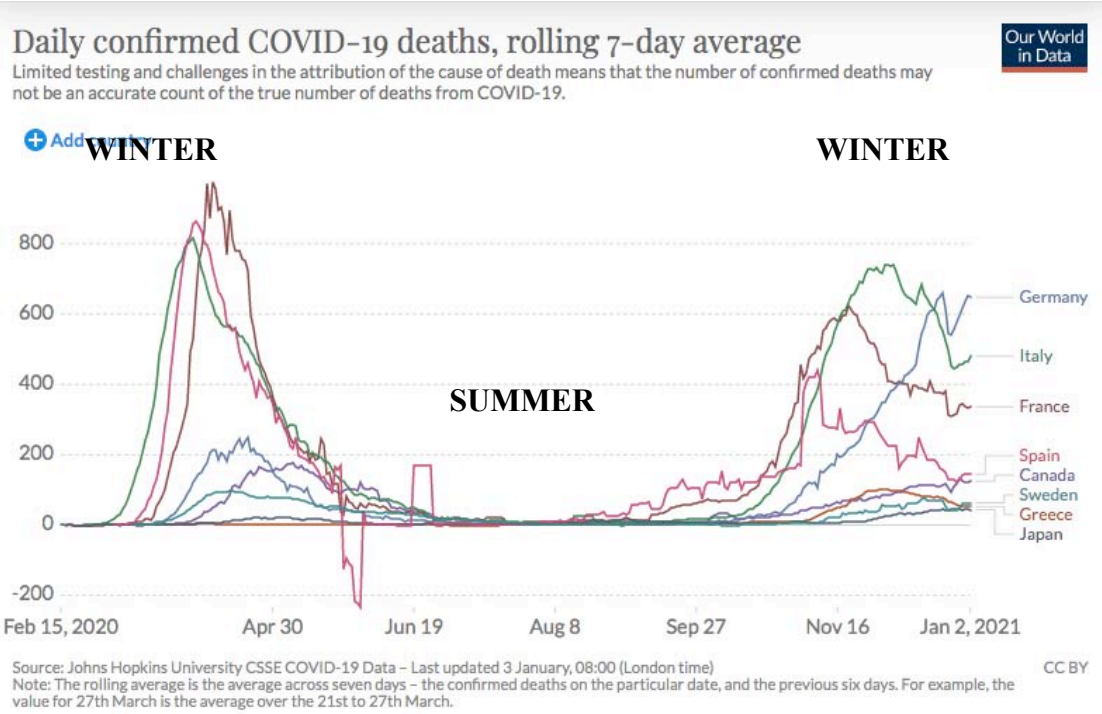


Figure 5: Covid-19 Daily Deaths in Northern Hemisphere Nations
https://ourworldindata.org/covid-deaths?country=CAN~FRA~GUF~DEU~GRC~ITA~JPN~ESP~SWE

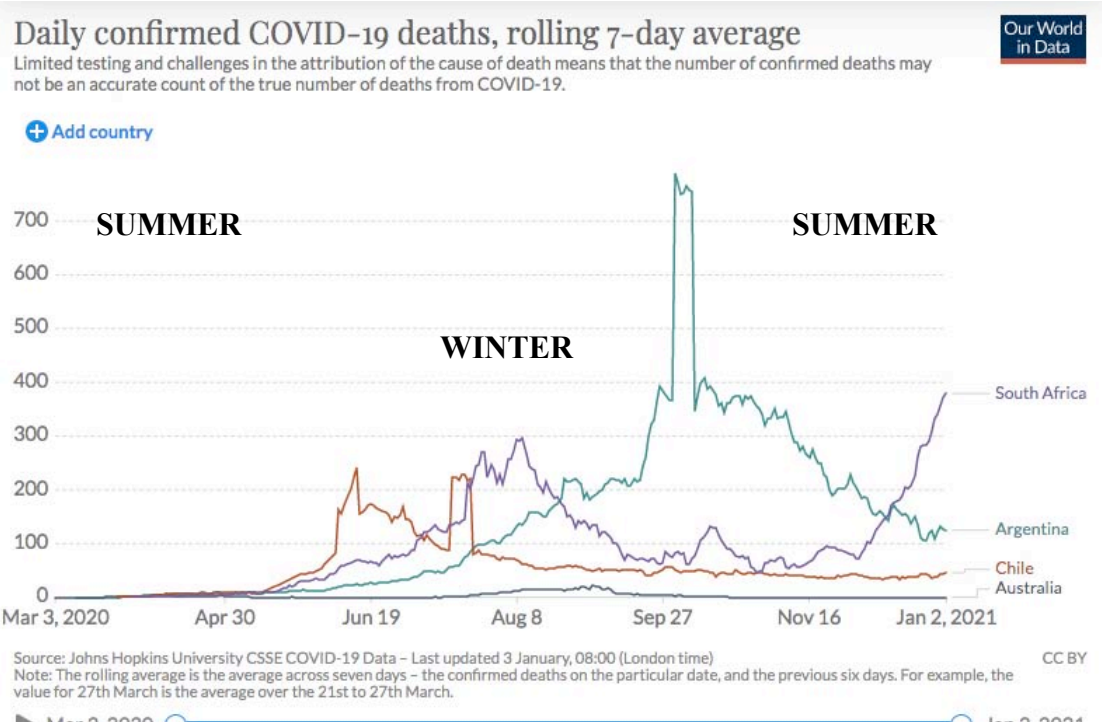


Figure 6: Covid-19 Daily Deaths in Southern Hemisphere Nations
https://ourworldindata.org/covid-deaths?country=ARG-AUS-CHL-ZAF

The Death Toll from Lockdowns, Forced Masking & "Deaths by Despair"

In spite of political, medical and media misrepresentations, there is no clear evidence that shows locking down entire societies, disrupting economies or forcing everyone under oxygen-depriving masks does anything of benefit towards mitigation against claimed Covid-19. The best review of this was presented in a video by Ivor Cummins, who also expanded upon the issue of seasonality: https://www.youtube.com/watch?v=3cjgicrA504

Cummins' video presented various data graphics showing how daily Covid-19 deaths were already on a clear downward trend at the time when many of the nation-wide or USA state-wide lockdowns were instituted. Data was also presented where lockdowns were instituted and Covid-19 deaths increased thereafter, or had no changes at all, indicating lockdowns had no benefits. Likewise, ending of lockdowns had no significant effect upon national or state populations, either positive or negative. However, all states and nations showed the above-noted trends increasing Covid-19 deaths as the weather turned damp and cold, and decreasing deaths as it turned dry and warm. States which locked down most ferociously often had the most intensive spikes in death afterwards, perhaps due to the secondary health issues created by lockdowns and masking.

In example, the state of Florida, whose Governor DeSantis basically ended all lockdowns and banned forced-masking laws in late September, experienced a gradual lowering Covid-19 death rates, as shown in Figure 7 below.

Additionally, as seen in Figure 8, Florida (red bar at bottom) compared more favorably than strong lockdown states such as OR, MA, CA, KY, IL, MI, OH, NM and MN. Florida had lower rates of cases, hospitalization and deaths. This list is selective and incomplete, but the reader will understand the point, that critical complaints to end lockdowns and masking have significant facts to back them up, indicating there is little or no benefit to public health by lockdowns and forced masking policies. This figure was reproduced by Cummins from a NY Times web resource which has since removed the comparative information. https://nytimes.com/interactive/2020/us/states-reopen-map-coronavirus.html

A similar situation is found in the state of South Dakota, where Governor Kristi Noem refused to order any lockdowns. Same with Idaho, Montana and Georgia, all with minimal government edicts on lockdowns, masking or social distancing. Retail stores, restaurants, salons, barber shops, churches, gyms and outdoor recreation proceeded there as normal. They did not suffer any increase in deaths because of it, their death-case ratios ranged between 1.1% and 1.7%. By contrast, in the most heavy lockdown states such as New York,

Pennsylvania, New Jersey, Massachusetts or New York City in isolation, death-case ratios ranged between 2.6% to 4.4%, *more than double the no-lockdown states*. The numbers on this are shown in Table 2 below.

This is an incomplete analysis. There are no additional no- or mild-lockdown states I could list, and admittedly I selected some of the worst of the lockdown states for comparisons. Some states with severe lockdowns, such as Oregon or Washington also have death/case ratios similar to the no-lockdown states. But I could not find a no-lockdown state with higher death/case ratios. This analysis proves the point that locking down entire states in an extreme manner has no benefits, creating even worse conditions for their citizens, with *more* deaths, not fewer. The absence of lockdowns suggests the most life-protective approach.

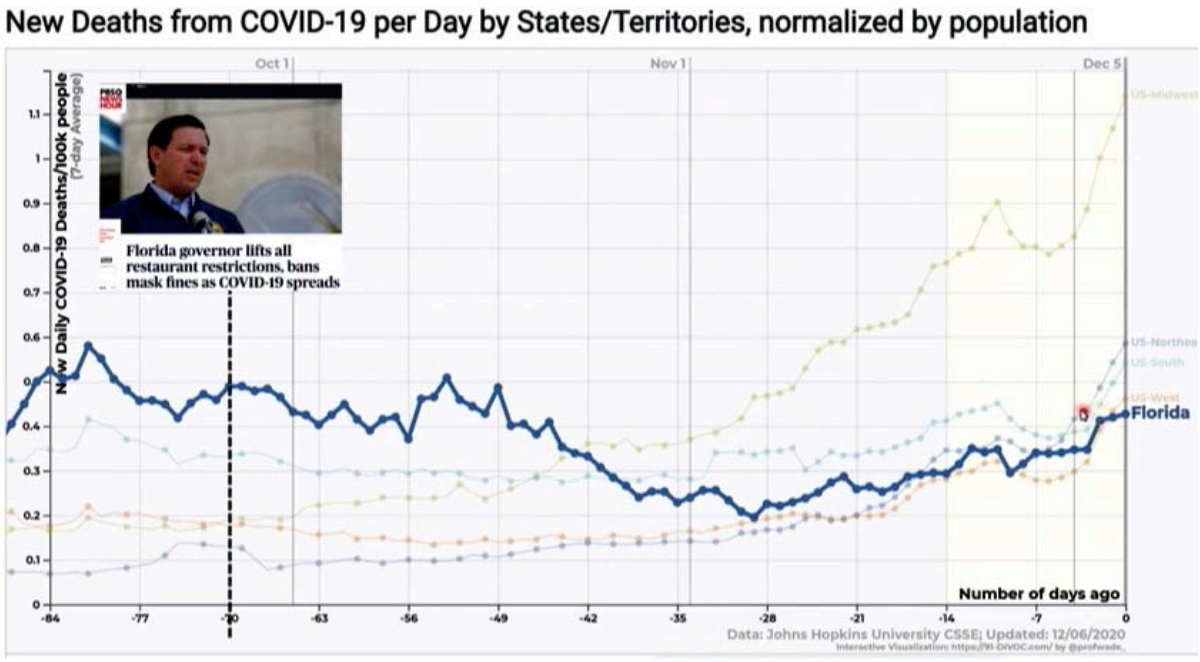


Figure 7: Lack of Increase in Florida Deaths After End of Lockdowns
https://www.youtube.com/watch?v=3cjgicrA504

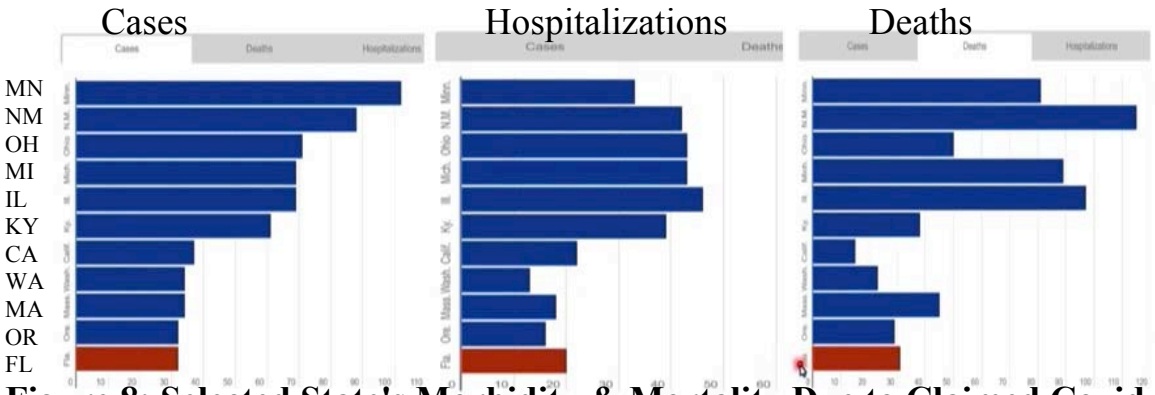


Figure 8: Selected State's Morbidity & Mortality Due to Claimed Covid-19
https://www.youtube.com/watch?v=3cjgicrA504

Table 2: Death/Case Ratios in Selected Locked Versus Unlock States

As of 5 Feb.2021	Total Cases	Total Deaths	Death/Case Ratio
NO OR MILD LOCKDOWN STATES			
Florida	1,700,000	27,456	1.6%
Georgia	909,170	14,,413	1.6%
Idaho	165,058	1,760	1.1%
Montana	95,539	1,312	1.4%
South Dakota	109,132	1,804	1.7%
Texas	2,400,000	39,320	1.6%
SEVERE LOCKDOWN STATES			
Massachusetts	537,208	14,859	2.8%
Michigan	619,150	15,739	2.5%
New Jersey	713,324	21,886	3.1%
New York	1,400,000	44,210	3.2%
New York City	632,306	27,609	4.4%
Pennsylvania	871,435	22,422	2.6%

Data from: https://www.nytimes.com/interactive/2020/us/states-reopen-map-coronavirus.html

Greater determining variables, more powerful than claimed SARS-CoV-2 – such as cold winter weather, the percentage of older people in a given state, and an abundance of comorbidities in older age groups being mistaken as Covid-19 by inaccurate diagnoses and flawed PCR/Antigen tests – produce these different death numbers. Florida for example has more older folk than many other states, but also milder winters, and people spend a lot more time out in the Sun getting good exposure for Vitamin D synthesis. A healthy diet and vitamin intake, especially C and D, are great preventives for all kinds of respiratory illness. Other states such as New York engaged in brutal measures against their older age groups, moving elderly with multiple comorbidities from hospitals into nursing homes, promoting with fanfare the use of deadly ventilators. Today a scandal is just emerging, where NY State has been undercounting their death numbers, to boost up the sagging popularity of their Governor Cuomo.

Whatever else may be at work, graphical confirmed case data for most states as given at the above cited NY Times website, nearly all show the wintertime seasonal pattern of incidence, as discussed above. Several entire webpages identify and provide links to different published studies in science or medical journals that refute benefits of lockdowns as well as exposing the deadly consequences of lockdowns: https://thefatemperor.com/published-papers-and-data-on-lockdown-weak-efficacy-and-lockdown-huge-harms/ https://www.researchgate.net/publication/348894789 https://collateralglobal.org

Tables 3 and 4, below, are taken from a UK website organized by four university professors, working privately outside of government. They provide a summary of the depressing horrors created by lockdowns and forced masking.

Table 3: Mental & Social Health: Categories of Increased Collateral Damage from Covid-19 due to Hysteria, Lockdowns, Forced Masking.
Reports are from peer-reviewed research in the UK unless otherwise noted

Addiction & Substance Abuse - 39% relapse of recovered addicts, 1 million affected; 34% increase in anti-anxiety meds in USA; 33% to 38% increase in alcohol consumption with increased alcohol-related liver injury. 4% increase in on-line gambling.

Alzheimer's & Dementia - 32% living with dementia report increased symptoms, apathy, resignation or "giving up"; ~60% show increase in behavioral & psychological symptoms; ~66% increase in stress-related symptoms in caregivers

Eating Disorders - Overall increase in PTSDs, reduced access to support services

Pregnancy & Parenthood - Reduction in personal human-contact support at all levels, leading to distress among mothers and infants. Reduction in confidence by expectant mothers and parents of newborns. Increased post-partum depression.

Sleep Disorders - 60% of people reporting worse sleep since lockdowns began, especially among young children.

Suicidal Behavior - Social isolation, anxiety, fear of contagion, uncertainty, chronic stress and economic difficulties are at work to increase depressive, anxious emotion, as well as substance abuse and psychiatric medications. Heightened suicidal risk among those with pre-existing conditions. Increased self-abuse and suicidal/self-harm thoughts, notably among women, low-income, unemployed and those with physical illness, mental disorders or Covid-19 diagnosis.

Mental Health Trends - Lockdown pains are similar to those experienced by prisoners, no less than those sentenced by judges against criminals. Mental health care has largely deteriorated across the board. Nearly 20% of adults experience depression, double the pre-Covid-19 situation.

Domestic Violence/Child Abuse - 60% increase in battered women (Global). Schools and social services basically shut down along with primary & secondary health care, closures of daycare. Calls to UK hotlines reporting physical child abuse up by 32%. Increases in child sexual exploitation.

https://collateralglobal.org/

Table 4: Physical Health: Diseases and Conditions Made Worse by Covid-19 Hysteria, Lockdowns and Forced Masking:

Reports are from peer-reviewed research in the UK unless otherwise noted

Cancers - Diagnostic declines from 19% to 72% in UK, 18,500 added deaths estimated within the 68 million UK population. Extrapolated to USA population of 330 million (4.85 times more people), USA cancer deaths may have increased by ~90,000 additional over 2020.

Cardiovascular disease - Excess deaths at home (+35%) and nursing homes/hospices (+32%) unrelated to claimed Covid-19 infection. UK 56% increase in Out-of-Hospital Cardiac Arrest. USA has 635,000 cardio-deaths per year, so an increase of 56% extrapolated is ~356,000 additional USA heart disease deaths for 2020.

Children's health - Isolation misery, despair, malnutrition all on the rise. Globally ~30% reduction of essential nutrition in poverty nations. Closures of schools, loss of school sports exercise, lack of contact with peer-group friends, loss of romantic contacts, emotional trauma, increases in obesity, sleep, eating disorders.

Infectious diseases (other than Covid-19) - Globally: up to 400,000 extra TB deaths. Singapore: 37% increase is dengue fever cases.

Stroke - delays in treatment have exacerbated all aspects of recovery.

Surgery - delays have exacerbated all aspects of the original problems as well as the prospects of recovery.

https://collateralglobal.org/

To the above pathology we may add problems associated with increased poverty and homelessness due to lockdown economic disruptions. A 1982 study "Corporate Flight: The Causes and Consequences of Economic Dislocation" by B Bluestone, B Harrison and L Baker, cited in W. Thomas' book *Economic Issues today: Alternative Approaches* (2005) stated that "According to one study [by Bluestone et al.] a 1 percent increase in the unemployment rate will be associated with 37,000 deaths." Today, by that death toll per 1%, and with a 40% increase in USA population from 1982 (232 mil.) to 2020 (330 mil.), and with a 6.7% unemployment rate which increased by 3.2% from the pre-Covid era of 3.5%, that would compute to an estimated 165,760 additional "deaths by despair" in the USA for 2020, working its damage through all the paths and avenues mentioned above and below. See the discussion here: https://nypost.com/2020/04/20/explaining-the-link-between-unemployment-deaths-amid-coronavirus/

From the UK comes the following report, which would most surely reflect conditions in the USA, Canada and other Western democracies:

"...alcohol-related deaths climbed to the highest in recorded history in the UK, with 5,460 deaths being logged between January and September alone... ... a dramatic increase in calls to the London Ambulance Service for suicide-related or attempted suicide reasons. Between March and November of last year, some 15,541 suicidal calls were logged by the service, up from 11,703 during the same time period the previous year. Lockdowns have severely impacted the mental health of children as well, with increasing numbers of children arriving at A&E hospitals after self-harming or overdosing on drugs... 'Children are a lost tribe in the pandemic. While they remain (for the most part) perplexingly immune to the health consequences of Covid-19, their lives and daily routines have been turned upside down.' ...children are increasingly suffering from anxiety, isolation, and boredom. 'Children in mental health crisis used to be brought to A&E about twice a week. Since the summer it's been more like once or twice a day. Some as young as 10 have cut themselves, taken overdoses, or tried to asphyxiate themselves'... " https://www.breitbart.com/europe/2021/02/04/amid-rise-in-child-self-harm-alcohol-deaths-suicidality-boris-johnson-appoints-mental-health-ambassador

It takes years for actual data to be recorded and reported on such factors, but the anecdotal reports are indicative of a gigantic unreported and ignored problem.

Beyond all the above, there are the deleterious effects of forced masking upon respiration, and how they reduce oxygenation of the blood, and make one more susceptible to accidents and infections due to constantly breathing in one's own contaminated exhalations. *The effects of lockdowns and forced masking have been like a wrecking ball upon the health and well-being of society, with a real and serious death count that appears to be even greater than the 400,000 deaths claimed as due to Covid-19 alone.* In fact, these increases due to lockdowns may be, in the final analysis, exactly what is being recorded and inaccurately blamed on Covid-19.

In sum, we may expect as a by-product of all the lockdowns, forced masking and economic disruption related to Covid-19, the following incomplete and generalized death-counts:

Table 5: Rough Estimated USA Deaths Created by Covid-19 Lockdowns, Masking and Destroyed Economy

Added Cancer Deaths	90,000
Added Heart Disease Deaths	356,000
Added Unemployment "Deaths by Despair"	165,760
Totals:	**611,760**

Of course, each of these three categories overlaps the others to some unknown degree, so the actual net number might be "only" half, or 2/3rds of the total – which would be a 2020 **"Death by Despair" of around 306,000 to 408,000 persons**. And it must be stated, this is only a short-list of available data on the question. I have not been able to find actual data about increased suicides and drug overdoses, but assume those would fall into the "added unemployment" category. The actual real numbers of dead due to lockdowns may be twice as high as what's given here. That suggests the "unthinkable", of course, that Covid-19 is merely a substitute diagnosis for most of these deaths, being mis-classified in accordance with the dominant Covid-19 theoretical framework.

There are four additional research studies worth mentioning, all with quantitative approaches but none undertaken towards the end of 2020, and none attempting to calculate excess deaths. They nevertheless point to the same conclusions presented herein.

* A study by John Pospichal: "Questions for Lockdown Apologists", published in late May 2020. He reviewed mortality figures for different states and nations during the early period of the Covid-19 crisis, showing lockdowns did not help to reduce deaths, but generally increased them. "...why did the virus...wait until lockdowns were imposed to suddenly start killing at levels which exceeded normal deaths?" https://medium.com/@JohnPospichal/questions-for-lockdown-apologists-32a9bbf2e247

* A study by Joel Smalley: "Dems COVID19 Lockdown Measures Causing Most Deaths", published on 27 June 2020 in *Principia Scientific International.* States governed by Democrats had a higher number of excess deaths than those governed by Republicans, which he attributed to the Democrats stronger push for draconian lockdowns than the Republicans. "... the results of analysis of empirical data on mortality and counter-measure severity of all 50 US states, actually shows a statistically significant INCREASE in mortality associated with HIGHER degrees of counter-measure severity." https://principia-scientific.org/study-covid19-lockdown-measures-causing-most-deaths/

* A study by T Engelbrecht & C Kohnlein: "COVID-19 (excess) mortalities: viral cause impossible—drugs with key role in about 200,000 extra deaths in Europe and the US alone" https://realnewsaustralia.com/2020/10/01/covid-19-excess-mortalities-viral-cause-impossible-drugs-with-key-role-in-about-200000-extra-deaths-in-europe-and-the-us-alone/

* A study by D.G. Rancourt et al. "Evaluation of the virulence of SARS-CoV-2 in France, from all-cause mortality 1946-2020". The authors concluded: "We

are certain that this 'COVID-peak' is artificial... We suggest that: • the unprecedented strict mass quarantine and isolation of both sick and healthy elderly people, together and separately, killed many of them, • that this quarantine and isolation is the cause of the "COVID-peak" event that we have quantified, • and that the medical mechanism is mainly via psychological stress and social isolation of individuals with health vulnerabilities. According to our calculations, this caused some 30.2 K deaths in France in March and April 2020."https://www.researchgate.net/publication/343775235_Evaluation_of_the_virulence_of_SARS-CoV-2_in_France_from_all-cause_mortality_1946-2020

Interesting also, in 2019 (pre-Covid-19) the WHO issued pandemic guidelines that explicitly forbade – "Not recommended in any circumstances" – the use of "Contact tracing, Quarantine of exposed individuals, Entry and exit screening, Internal travel restrictions, Border Closures". This statement, reproduced below in Figure 9, was for both epidemic and pandemic circumstances.

Table 1. Recommendations on the use of NPIs by severity level

SEVERITY	PANDEMIC[a]	EPIDEMIC
Any	Hand hygiene Respiratory etiquette Face masks for symptomatic individuals Surface and object cleaning Increased ventilation Isolation of sick individuals Travel advice	Hand hygiene Respiratory etiquette Face masks for symptomatic individuals Surface and object cleaning Increased ventilation Isolation of sick individuals Travel advice
Moderate	*As above, plus* Avoiding crowding	*As above, plus* Avoiding crowding
High	*As above, plus* Face masks for public School measures and closures	*As above, plus* Face masks for public School measures and closures
Extraordinary	*As above, plus* Workplace measures and closures Internal travel restrictions	*As above, plus* Workplace measures and closures
Not recommended in any circumstances	UV light Modifying humidity Contact tracing Quarantine of exposed individuals Entry and exit screening Border closure	UV light Modifying humidity Contact tracing Quarantine of exposed individuals Entry and exit screening Internal travel restrictions Border closure

NPI: non-pharmaceutical intervention; UV: ultraviolet.

Figure 9: WHO's 2019 Recommendations for Pandemic Reduction
https://thefatemperor.com/wp-content/uploads/2020/11/WHO-Pandemic-Guidelines-2019.pdf (see page 3)

Why did the WHO change their views, less than a year later for Covid-19? And why did the world's leaders and freedom-oriented populations so sheepishly or enthusiastically go along with it?

From all the above, I must conclude: *It is very possible that all these massive deaths are due to the public hysteria and panic over a claimed super-virus. The high mortalities are resultant more directly due to economic disruption, unemployment, government-sanctioned poverty, isolated elderly succumbing to multiple comorbidities, and added suicides, drug overdoses, homicides and other factors. The deaths are the product of the failed Covid-19 virus theory, which has resulted in the lockdowns and all the physical and emotional trauma which came as a consequence.*

Overlap & Possible Dual-Classification or Re-Classification of 2020's Influenza, Pneumonia, and Other Diseases into the Covid-19 Category

Another factor requiring further discussion is how Covid-19 death numbers appear to reflect a large proportion of elderly who died of similar-symptom influenza and pneumonia, or other respiratory or heart-related diseases. Deaths from those long-known maladies appear to be re-classified by some CDC reports into the Covid-19 category, or they receive a dual-classification, of a single death which alarmingly might be counted in both categories.

Pneumonia and influenza combined claimed from 3.34% of the USA population in 1999 to 2.47% in 2016, on a slow declining slope, reducing by 0.87% over that long period of 18 years, or a reduction of about 0.05% per year. https://ourworldindata.org/search?q=Influenza+USA

Assuming that trend would continue, and extrapolating those data, the 2020 death rate from pneumonia and influenza combined would have claimed around 2.3% of USA deaths. That percentage is *higher* than the average Covid-19 confirmed death/case ratios in the latter part of 2020, of 1.17%, as summarized in Table 1 above. However, the same source for these pneumonia/influenza data, cited above, also has a segregated classification of "Lower Respiratory Disease" which constituted around 7% of USA deaths averaged over the 1999 to 2016 period. And that group includes pneumonia, adding to the potential numbers of deeper-lung diseases and disorders that could be misdiagnosed as Covid-19, and which due to their similarities also may react positively on PCR/Antigen tests (more on that below). It is admitted by physicians that diagnoses of Covid-19 versus other major lung disorders can be difficult, the symptoms overlap to a considerable degree, as stated on the following University of California at San Francisco Covid-19 website:

Is it possible to tell the difference between flu symptoms and COVID-19 symptoms?

> "I think it's tough because both the flu and COVID-19 can have a variety of overlapping symptoms... fever, chills and body aches, upper respiratory symptoms like runny nose and sore throat, lower respiratory symptoms like cough and pneumonia, and some gastrointestinal symptoms like nausea, vomiting and diarrhea. While you could say certain symptoms are slightly more associated with one virus than the other, there's enough overlap that there's uncertainty... we wouldn't use the presence or absence of those symptoms to rule in or out either illness." [Jahan Fahimi]
>
> "The typical symptoms of flu are relatively consistent – fever, cough and muscle aches. These are also common in COVID-19, but it's become clear as the pandemic has progressed that COVID-19 symptoms vary more wildly than those of the flu – from no symptoms at all in some 45 percent of cases to deadly pneumonia and myriad cardiovascular and neurological issues..." [Chin-Hong]
> https://www.ucsf.edu/news/2020/09/418606/can-you-tell-if-its-flu-or-covid-19-doctors-say-its-not-so-clear

It is also noteworthy that, in late January 2020, the CDC was observing a dramatic increase in influenza, which had "risen for 2 consecutive weeks" and "caused at least 19 million illnesses, 180,000 hospitalizations, and 10,000 deaths so far" over the 2019-2020 winter season. There were only 11 Covid-19 cases in the whole USA at that time, apparently as determined by clinical diagnoses. So, what happened to that surge in influenza of January 2020? Did it decline or just disappear, at the same time that Covid-19 cases began to rise? And if so, is this yet another indication of Covid-19 misdiagnoses, either by clinical or PCR/Antigen confusions with influenza or other respiratory illness? https://www.medscape.com/viewarticle/924728 (See CDC Jan.2020 archive)

This understanding appears correct, given how in late 2020, cases of influenza reportedly declined to nearly zero. Consider the following January 1st 2021 interview with epidemiologist Knut Wittkowski, former head of Biostatistics, Epidemiology and Research Design at Rockefeller University:

> "Influenza has been renamed COVID in large part ...There may be quite a number of influenza cases included in the 'presumed COVID' category of people who have COVID symptoms which Influenza symptoms can be mistaken for, but are not tested for SARS RNA ... [Those patients] also may have some SARS RNA sitting in their nose while being infected with Influenza, in which case the influenza would be 'confirmed' to

be COVID." https://justthenews.com/politics-policy/coronavirus/influenza-levels-continue-cratering-some-cite-covid-measures-even-covid Also see the Supplementary Information for this research paper: https://www.researchgate.net/publication/348894789

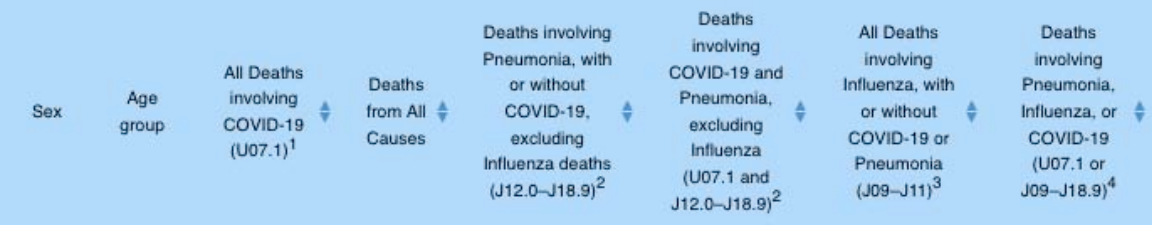
The CDC's Flu-View website indicated the winter rates of positive tests for influenza, as of 26 Dec. 2020, was 0.2%, very low by any comparable prior year, which range from around 5% to 20% for the same month.
https://www.cdc.gov/flu/weekly/index.htm

CDC websites also reveal a common lumping of pneumonia and influenza with Covid-19, in the same categories. For example, on one website presenting the incidence of pneumonia and influenza by week, produced by the National Center for Health Statistics Mortality Surveillance, they speak about the "Percent P&I" (pneumonia and influenza) in text and on the ordinate (vertical) scale of a dominant graphic.
https://gis.cdc.gov/grasp/fluview/mortality.html

However, another website from the CDC presenting similar text and nearly identical graphics has reclassified "P&I" into "Percent due to PIC", lumping together pneumonia, influenza and Covid-19. The ordinate or vertical scale is rebranded also, from the above earlier "% of All Deaths Due to P&I" to "% of All Deaths Due to PIC". Other irregularities are present.
https://www.cdc.gov/flu/weekly/index.htm

These overlaps and mixing of influenza, pneumonia and Covid-19 are quite apparent on the CDC's weekly reports, as seen in the Figure 10 banner identifying variant group definitions. While the banner reveals all deaths involving Covid-19 (defined by code U07.1), it also lists several categories that mix Covid-19 with influenza and/or pneumonia, either individually or together. However, it does not show the isolated figures for influenza, pneumonia or Covid-19 independently, without mixing them up, which would be the proper method for an authentic scientific review of the different maladies.

Figure 10: Multiple Accountings for Influenza, Pneumonia and Covid-19



https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm

Those CDC data did not reveal the centrally important question of how many people died of a strictly Covid-19 diagnosis, as per PCR/Antigen testing, without pneumonia, influenza or other comorbidities. That question becomes doubly important given how in a "Comorbidities, Table 3" section of the same weblink above, they make a very long list of exactly what other diseases and disorders people with a positive PCR/Antigen "confirmed case" or "confirmed death" were suffering from. They list six categories under the heading of "Respiratory diseases", seven categories under "Circulatory diseases", plus separate listings for Sepsis, Malignant neoplasms, Diabetes, Obesity, Alzheimers, Vascular and unspecified dementia, Intentional and unintentional injury, poisoning and other adverse events, conditions and causes.

Those categories were further broken down into age groups, as will be discussed in a following section, from which it was observed that the overwhelming number of deaths in all those comorbidity categories occurred in elderly groups of 65 years and older. *But nowhere on any of the Covid-19 tracking websites could I find a discussion or number of people who died of Covid-19 without those comorbidities.* The comorbidity data does inform us, however, that most of the Covid-19 deaths must be afflicted by more than one or two comorbidities, given how two or three of those individual categories, when added together, exceed the "total Covid-19 deaths".

What is going on in these different presentations of the same data, if not a re-definition and shifting of pneumonia, influenza and other broad categories of significant deaths into a Covid-19 classification, either in whole or in part? At best, it reveals diagnostic difficulties and confusions. At worst it is *Very Bad Science, with possible implications of fraud!*

To find out how many people died of Covid-19 only, without comorbidities, one has to turn to sources outside of the CDC, or which quote from CDC pages which have since been deleted. For example, in the Abstract of a paper by Ealy, et al. dated to October 2020, they wrote:

> "According to the Centers for Disease Control and Prevention (CDC) on August 23, 2020, 'For 6% of the deaths, COVID-19 was the only cause mentioned. For deaths with conditions or causes in addition to COVID-19 , on average, there were 2.6 additional conditions or causes per death.'[1] For a nation tormented by restrictive public health policies mandated for healthy individuals and small businesses, this is the most important statistical revelation of this crisis. This revelation significantly impacts the published fatalities count due to COVID-19." https://jdfor2020.com/wp-content/uploads/2020/11/adf864_165a103206974fdbb14ada6bf8af1541.pdf

Ealy et al. also produced a time-line of CDC methods for acquiring and reporting of epidemic deaths, revealing how in February 2020, CDC changed its method of data collection and counting – as in the *Medical Examiners' and Coroners' Handbook on Death Registration* and the *Physician's Handbook on Medical Certification of Death* – thereby abandoning a methodology they had successfully employed nationwide since 2003. From February 2020 onward, the CDCs data reports on Covid-19 became increasingly confused and obscure, and by Ealy, et al., "violated data quality, objectivity, utility and integrity requirements". By using the 2003 methods of computing Covid-19 fatalities, the conclusions given in the above Abstract, of 6% of deaths being due only to Covid-19, without comorbidities, were founded. The 2020 year end total USA Covid-19 deaths including comorbidities, was 313,671, which by the 6% calculation suddenly drops to **18,820 deaths for the full year**, which works out to be 52 deaths per day, for all 50 US states. About 1 death, per state, per day. That is a dramatically different picture of this "pandemic". My own method of calculating "excess deaths" due to Covid-19 are similarly low, as on page 34.

Electron Microscope Image Errors?

Visual identifications of SARS-CoV-2 in the electron microscope also reveal variations which, to my eye as a skilled microscopist (youtu.be/-PVnS72IIY8) and probably to many others, suggest different viral entities. Electron

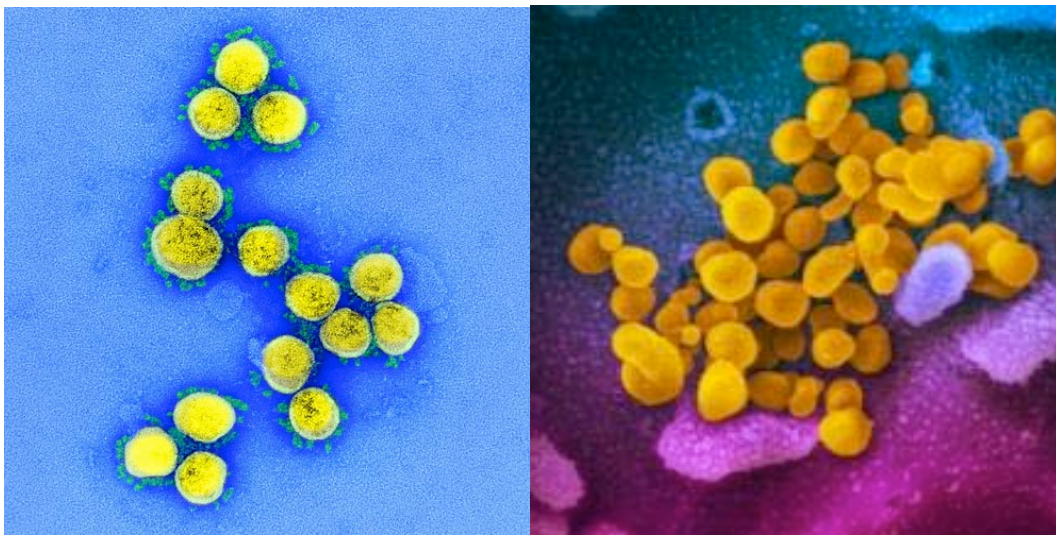


Figure 11: Two Dissimilar Images of Claimed SARS-CoV-2. (NIH/NIAID)
https://www.niaid.nih.gov/news-events/novel-coronavirus-sarscov2-images
For reference, similar viral images appear on the NIAID's MERS-CoV page:
https://www.flickr.com/photos/niaid/albums/72157634229836113
The following website also shows many different electron micrograph images of claimed SARS-CoV-2, only some of which appear identical to others.
https://www.flickr.com/photos/niaid/albums/72157712914621487

micrograph images of claimed SARS-CoV-2 are not so clearly distinguishable from other corona viruses typical of influenza, pneumonia or other respiratory disease. Figure 11 shows two dissimilar images of claimed SARS-CoV-2 virus, as obtained from NIH/NIAID. Aside from the false-color variations added to enhance their contrasts, without clarifications they do not appear to be the same viral entities. A caption with the above images revealed the difficulty in making assessments of what is SARS-CoV-2, and what is something else:

> "... the images do not look much different from MERS-CoV (Middle East respiratory syndrome coronavirus, which emerged in 2012) or the original SARS-CoV (Severe Acute Respiratory Syndrome coronavirus, which emerged in 2002). That is not surprising: The spikes on the surface of corona viruses give this virus family its name – corona, which is Latin for "crown," and most any coronavirus will have a crown-like appearance."
> https://www.niaid.nih.gov/news-events/novel-coronavirus-sarscov2-images

The Fallacy of PCR/Antigen Testing "Accuracy"

The PCR, or Polymerase Chain Reaction testing method, is a biochemical process whereby millions of copies of a specific DNA/RNA molecule in a test sample can be replicated. The process employs a chemical solution of polymerase mixed with a person's body fluids, and then subjected to repeated cycles of thermal heating and cooling, periodically adding extra small amounts of polymerase reactant that binds to DNA/RNA strands and replicates them as the temperatures cycle up and down. By doing so, tiny and otherwise undetectable traces of DNA/RNA can be magnified millions of times over, in quantities sufficient for study. Once this process is completed, the amplified and replicated genetic material from body fluids is analyzed via gel electrophoresis or similar methods. Originally undertaken as a lengthy hands-on, one-at-a-time procedure in test tubes, the PCR magnification process is today automated, undertaken in specialized laboratory machinery. The process can then yield electrophoretic "markers" by which the test-amplified DNA/RNA can be compared to another presumably "known" sample, as taken from someone who died of Covid-19. That is the theory. When used for clinical diagnoses, however, all kinds of serious questions arise. Primarily it is this:

If you only have such a tiny quantity of a virus in your system which requires PCR methods to magnify it so it can be detected and identified, then how can it have any biochemical significance or effect upon your physiology? And doesn't that indicate, the presumed virus is not replicating itself?

Those questions have been systematically ignored by "PCR Testing Kit" advocates and profit-seeking pharmaceutical companies, starting in the AIDS years when PCR tests were yielding false positives on "HIV" in abundance. But there are other major scientific reasons why *SARS-CoV-2 PCR testing is specifically flawed, and has no objective value for clinical diagnoses.*
https://uncoverdc.com/2020/12/03/ten-fatal-errors-scientists-attack-paper-that-established-global-pcr-driven-lockdown/ (web references continue)
https://uncoverdc.com/2020/04/07/was-the-covid-19-test-meant-to-detect-a-virus/ https://articles.mercola.com/sites/articles/archive/2020/12/18/pcr-test-reliability.aspx https://cormandrostenreview.com/report/

1. PCR tests cannot distinguish between a living infectious virus and a dead virus of the same type. It will also yield a positive indication when detecting DNA or RNA fragments from the break-down products of a multitude of viral entities similar to the one the test is supposed to be looking for. This is why vast numbers of asymptomatic people with zero living SARS-CoV-2 in their systems are getting false-positive results from these tests.

2. SARS-CoV-2 virus is very similar in appearance and symptoms to other corona viruses as associated with influenza, pneumonia and other respiratory disorders. Specific virus identification is not possible. How can one know if the PCR "detection" is living virus or remnant dead viral matter from immune-system destruction of it? We cannot know. PCR does not give such answers.

3. The outcome of a "Covid-19 test" is dependent upon the number of thermal heating and cooling cycles a sample is put through. If this *cycle threshold* is exceeded, the magnified DNA and RNA begins to distort in a way that it becomes more reactive to many different things, and thereby may yield higher rates of false positive reactions. More than 17 cycles starts producing false results. More than 30 cycles is considered scientifically bogus, with very high percentages of false positives. However, the FDA and CDC recommend PCR test machinery be set to 40 cycles or higher. The WHO recommends 35 cycles.

Kary Mullis, who invented the PCR method of DNA/RNA amplification and won a Nobel Prize in Chemistry in 1993 for doing so, did not accept the HIV theory of AIDS due to its heavy reliance upon PCR magnification to prove its existence. HIV was also criticized by top virologist Peter Duesberg as being a harmless "passenger retrovirus", while other AIDS critics considered it to be a non-existing creation of haphazard PCR magnifications. No pure culture isolation has been made of either HIV or SARS-CoV-2, nor of other corona viruses. Mullis, who died in 2019, was basically excommunicated from the world of science for his public criticisms of PCR methods and the HIV theory

of AIDS, even as myriad biotech and pharmacy companies, but not Mullis, raked in billions from his discovery. Today, the same big problems and inaccurate claims that emerged during the bogus "HIV epidemic" (which was supposed to depopulate Africa and kill tens of millions of people by now), have come back once again under the umbrella of Covid-19. https://www.nobelprize.org/prizes/chemistry/1993/mullis/lecture/

Such problems as these are why many PCR testing labs around the country have reported 100% positive for entire populations they tested. This created a major scandal in Florida, where several labs were consistently reporting 100% Covid-19 results, alerting Governor DeSantis to their bogus nature, and to end the massive lockdowns the "experts" had been advising. https://www.clickorlando.com/news/local/2020/07/15/high-coronavirus-positive-case-rate-reveals-flaws-in-florida-department-of-health-report/

Most interesting on PCR is how, in early January 2021, the WHO issued an Information Notice exposing its lack of accuracy, stating: "WHO reminds [lab workers] that disease prevalence alters the predictive value of test results; as disease prevalence decreases, the risk of false positive increases...This means that the probability that a person who has a positive result (SARS-CoV-2 detected) is truly infected with SARS-CoV-2 decreases as prevalence decreases, *irrespective of the claimed specificity*." https://www.who.int/news/item/20-01-2021-who-information-notice-for-ivd-users-2020-05

Antigen test kits similarly rely upon biochemical reactions, but more directly react to viral membrane components. They are quicker in their analysis, but considered less reliable due to high levels of "false negatives" which are blamed upon "hiding virus" in a patient considered by other approximations to have a Covid-19 infection. This reasoning is sophistry, however, as it excludes the possibility that there isn't any "hiding virus" at all! It is simply an inconvenient truth that antigen test kits show far fewer "positives" than the doctors anticipate. Additionally, antigens and antibodies can reside in the same host, indicating a healthy and successful immune-system termination of that toxic element. The antigen tests are no better than PCR in "confirming" living infectious virus.

There are unfortunately other factors that can lead to a positive Covid-19 diagnosis, testing or not. Statements made by many physicians on internet and in video interviews, and eventually by Senator Scott Jensen of Minnesota (also a physician) have identified at least one motivation for doing so: large sums of money are given to hospitals by Medicare and other Federal agencies when they take on a new Covid-19 patient who is placed on a ventilator, around $39,000 in total. A video of Jensen's statement has since been censored by YouTube, but

the *USA Today* newspaper and FactCheck.org launched separate investigations of the subject, concluding his statement was true.

> "Hospital administrators might well want to see COVID-19 attached to a discharge summary or a death certificate. Why? Because if it's a straightforward, garden-variety pneumonia that a person is admitted to the hospital for – if they're Medicare – typically, the diagnosis-related group lump sum payment would be $5,000. But if it's COVID-19 pneumonia, then it's $13,000, and if that COVID-19 pneumonia patient ends up on a ventilator, it goes up to $39,000."
> https://www.usatoday.com/story/news/factcheck/2020/04/24/fact-check-medicare-hospitals-paid-more-covid-19-patients-coronavirus/3000638001/
> https://www.factcheck.org/2020/04/hospital-payments-and-the-covid-19-death-count/

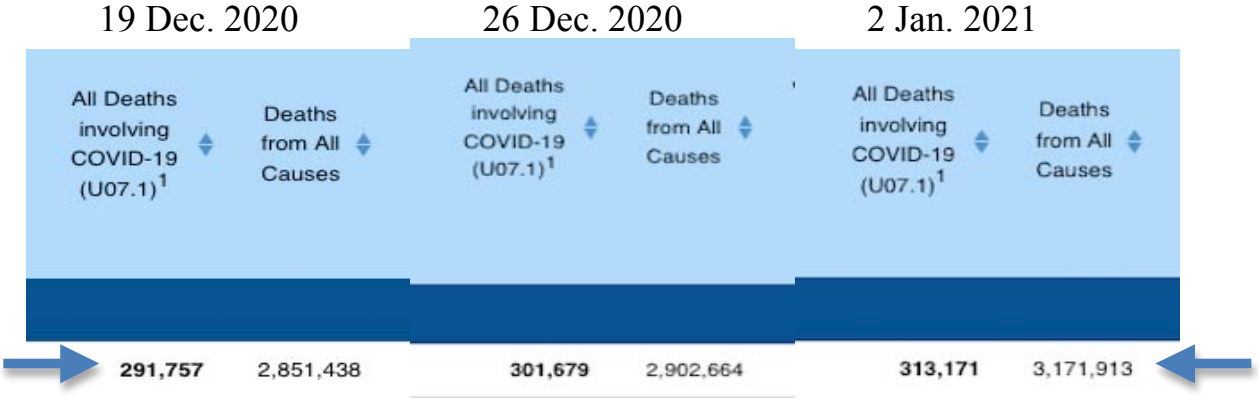
These revelations further suggest that many Covid-19 deaths may be classified twice, firstly by the real cause of their deaths (influenza, pneumonia, lung cancer, diabetes, etc.) and later as Covid-19, by the determinations of hospital staff and administrators, or by the CDC itself. Below in the next section, I present CDC confirmed-death data in Tables 7 and 8, casting further doubt upon the exclusive and singular claim of a deadly viral pandemic destroying the lives of people in the USA at high numbers. Many lives are being destroyed, but we must ask if this is more due to questionable diagnoses, and the added deaths due to severe anxiety, panic, hysteria, forced lockdowns, economic ruin and attending social chaos and poverty, than by a claimed SARS-CoV-2 viral pandemic. There is significant documentation to support this interpretation. https://www.nber.org/system/files/working_papers/w28304/w28304.pdf

Basic Data on USA Annual Human Mortality

Assuming a deadly virus SARS-CoV-2 causing Covid-19 disease, and arguing from within that "official" paradigm, we should expect a pandemic to drive up the annual increase in all-cause deaths far more than the average annual increase in lives lost each year as from other causes, and thereby reduce overall life-expectancy for 2020. Using my own estimate of the 2020 year-end death tolls from all causes and extrapolating from provisional CDC data released on 26 December 2020, I could not believe the numbers made public by the CDC in early January 2021. There were two major "data dumps" contained within them, both of which appeared quite suspicious.

In addition to updating its Covid-19 death totals, the CDC and its subsidiary National Center for Health Statistics (NCHS) added several hundred thousand all-cause deaths into their 2020 year-end calculations. Here in Figure 12 are three screen shots from the CDC websites, for their Dec.19, Dec.26, 2020, and Jan.2, 2021 calculations. A summary of the numbers is given in Table 6.

Figure 12: Year-End Changes in CDC All-Cause and Covid-19 Data



https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm

Notice the increase in Covid-19 and all-cause deaths over this two week period:

Table 6:	**Rise in**	**Rise in**
Week of	**Covid-19 Deaths**	**All-Cause Deaths**
19 to 26 Dec.	9,922	51,226
26 Dec.20 to 2 Jan.21	11,492	**269,249**

The rise in all-cause deaths in the last week of 2020 was a giant number – **269,249 –** five times what might be expected by the usual prior weeks of more gradual increases. Another factor is how around the same time, the Covid-19 death numbers rose by **89,000** – from the reported 313,171 to a media-announced 400,000 – two astonishing data-dumps within a few days.

This becomes all the more acute when reviewed over the prior decade. Table 7 below provides the all-cause death and annual increase death numbers going back to 2010. There is a trend of increasing annual all-cause death numbers with an annual increase in each subsequent year reflecting earlier decades of increasing population growth. Life Expectancy remains about the same for the decade, at around 78.5 to 78.9 years, the number for 2020 being estimated without Covid-19. The *annual increases* in all-cause deaths are also variable over the decade with an unexpected minima of 15,633 in 2019, a maxima of 86,212 in 2015, and of course 269,249 in 2020 – with an overall average annual increase from 2010 to 2019 of 44,806. The numbers presented here for 2020 are

provisional through the end of the year, using CDC and other data sources as referenced.

Table 7: Number of People Dying Each Year in the USA, All Causes, with Annual Increases From the Prior Year

Year	All-Cause Deaths[1]	Annual Increase	Covid-19 Deaths	Life Expectancy[2]
2010:	2,468,435			78.49y
2011:	2,515,458	47,023		78.64y
2012:	2,543,279	27,821		78.79y
2013:	2,596,993	53,714		78.94y
2014:	2,626,418	29,425		78.91y
2015:	2,712,630	86,212		78.89y
2016:	2,774,248	61,618		78.86y
2017:	2,813,503	39,255		78.84y
2018:	2,839,205	25,702		78.81y
2019:	2,854,838	15,633		78.87y
2020:[3]	**3,171,913[3]**	**317,075[3]**	**313,171[4]**	**78.93y[2]**

1. https://www.cdc.gov/nchs/products/nvsr.htm "Deaths: Leading Causes for (year)"
2. Life Expectancy & Other Data. *For 2020*, estimated without Covid-19: https://www.macrotrends.net/countries/USA/united-states/life-expectancy
3. Provisional 2020 data from 1 Jan 2020 to 2 Jan.2021. 4. or 400,000 ?? https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm

At first, I could not accept the CDC's two year end "data dump" numbers, of either the 317,075 annual increase in all-cause deaths, or the 313,171 increase to 400,000 Covid-19 deaths, which required an adding of 89,000 nearly overnight.

Provisionally, today, I view both numbers as due to two separate major errors:

Error 1: The Covid-19 death numbers are a misinterpetation (or misrepresentation) of deaths by multiple comorbidities, for the simple reason of their showing up as "positive results" on highy inaccurate PCR and Antigen tests, or by equally inaccurate clinical diagnoses in hospitals.

Error 2: The high number of increased deaths in the "All Causes" category appear as the consequences of lockdowns, forced masking, economic ruin and "deaths by despair" – all being deliberately imposed upon a panicked and frightened population, at the point of the policeman's gun.

Covid-19 death counts appear in reality to be an artificial diagnostic category for those who die of those other-cause diseases and disorders. We have all heard the stories of someone dying in a traffic accident, or being shot in a robbery, with the death certificate reading "Covid-19". Less frequently do we hear about the massive inaccuracies of the "laboratory testing" methods, or the

massive deaths which are due solely to economic ruin and isolation despair, where lockdowns, masking and economic disintegration has its own "comorbidities", driving people over their limits into an early grave.

These last minute data dumps amplified my own alarm after nearly a year of growing suspicion, given how nearly every source from government and mass media had been steadily blaring horns and beating loud drums, as if to deliberately drive a herd of elk over a cliff – to push people into evermore panic and hysteria, so as to meekly accept the lockdowns and forced masking as some kind of "scientific-medical" necessity, or experiment. To "save lives"! And they do so without any mention of, or concern for the consequences of their actions!

Also suspicious is how the CDC graphics on its "Covid Weekly" websites, and others, confine their weekly data analyses to the years 2017 through 2020, thereby avoiding comparisons to the high mortality years of 2015 to 2016, as shown in Table 7. Is this because 2020 "P&I" and/or "PIC", comorbidities redefined into the Covid-19 category, are not so different from 2015-2016? Too many in the medical profession, and in government bureaucracies and mainstream media apparently believe "death by despair" is a fantasy, and not a solid and real thing that is killing people – and so they simply never mention it.

A graphic seen in Figure 13 recently came to my attention from the Euromomo website, exposing yet additional suspicious factors. Firstly, the graphic correctly shows relatively accurately the wintertime aspect, with the major increases in deaths for all years shown as marked with a "W". Euromomo did not mention this obvious fact which drives higher death rates all by itself.

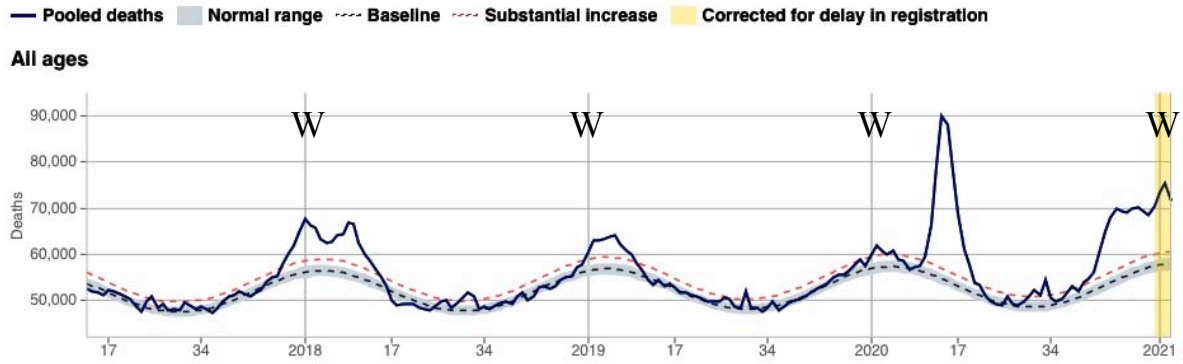
Secondly, the Figure 13 is *inaccurate* in how the area under the curve and above the baseline should reflect the annual increases, from one year to the next. And they do not appear to do so. For example, the area under the peaks, above the baseline for 2020 appear as only 10 times that of 2019, and 5 times that of 2018. The peaks for 2020 should in fact be far greater in size, around double of what is shown.

Third, the years going back to 2015 had incrementally higher all-cause and annual increase deaths as shown in the numerical insert for Figure 13, but the graph only starts sometime in the 12th week of 2017, not showing the early winter months of 2017. Had the graph been extended back to 2014, it might have reveal the peaks of 2020 were not so unusual. To therefore attribute the 2020 peaks as "excess deaths" which include the giant numbers as previously given, can not be true, or if so, in this graphic, Covid19 would be no worse than

an ordinary year with a lot of lung and breathing disorders, influenza and pneumonia.

Figure 13: Euromomo Graphic

Year	Total Deaths All Causes	Annual Increase from Prior Year
2015:	2,712,630	86,212
2016:	2,774,248	61,618
2017:	2,813,503	39,255
2018:	2,839,205	25,702
2019:	2,854,838	15,633
2020:	3,171,913	317,075 or 400,000 ??



https://www.euromomo.eu/graphs-and-maps

Fourth, this graphic is supposed to inform the viewer how 2020 death numbers were so much higher than prior years, to validate the Covid-19 pandemic theory. But to show only three years of prior data is insufficient. And fifth, note the ordinate vertical scale of the graph does not start at zero, but rather around 40,000. If it had started at zero, the graph would either have to be twice as tall, or then compressed down wherein the peaks for all years would be greatly diminished and not look so "scary".

There is a wonderful small book *How to Lie With Statistics* by Darrel Huff. It was required reading in the university when I was younger. Nevertheless, everyone reading this should get it, as such truncated data selection and exaggeration of the data curves are primary methods of deceiving people, without "outright lying". Perhaps this is all simple coincidence and not planned deception, but the Euromomo web graphic is inaccurate, and who knows?

USA Covid-19 and All-Cause Death Counts by Age Group

Table 8A adds to our concerns about the CDC data and Covid-19 pandemic in a more quantitative manner, revealing how the Covid-19 and all-cause death

numbers by age group, transformed into percentages of the totals of those two groups, show nearly identical distributions of deaths in the elderly 65 years and older groups. This makes no sense if there is truly a serious pandemic of a new infectious virus that preferentially attacks the respiratory systems of the elderly, killing them.

For example, Covid-19 disease does not affect young children to any extent, given their natural immunity. That aspect is affirmed in the Table 8A data, presented below with nearly a full year of 2020 data (Feb.1 to Dec.26) directly from a CDC/NCHS website. Covid-19 is also supposed to be killing

Table 8A: USA 2020 Deaths by Covid-19 & All Causes, by Age

From Feb.1	Covid-19		US Deaths			Excess
to Dec. 26	Number	%Cov[1]	All Causes	%All[2]	%Diff.[3]	Deaths
All Ages =>	301,679	10.39%	2,902,664			
Under 1 year	32	0.01%	16,076	0.55%	-0.54%	0
1–4 years	19	0.006%	2,969	0.10%	-0.96%	0
5–14 years	51	0.017%	4,810	0.17%	-0.15%	0
15–24 years	483	0.16%	30,975	1.07%	-0.91%	-4
25–34 years	2,087	0.69%	63,554	2.19%	-1.5%	-31
35–44 years	5,398	1.79%	89,922	3.1%	-1.3%	-71
45–54 years	14,469	4.79%	163,931	5.65%	-0.85%	-123
55–64 years	35,981	11.9%	377,179	13.1%	-1.1%	-384
65–74 years	64,355	21.3%	576,792	19.9%	+1.4%	+940
75–84 years	82,646	27.4%	704,456	24.27%	+3.1%	+2,584
85 years +	96,131	31.86%	872,000	30%	+1.9%	+1,753
			Total Covid-19 Excess Deaths Above All Causes:			**4,663**

https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm
Dec.26 update, remained posted through 6 Jan.2021. 1. Percent of deaths in each Covid-19 age group relative to Covid-19 "All Ages" total deaths; numerical age and all-age total data copied directly from 26 Dec. CDC update. 2. Percent of deaths in each All Causes age group relative to All Causes "All Ages" total deaths. 3. Percent difference, %Cov minus %All. 4. Excess Death Number Extrapolation from %Diff by Age, of claimed Covid-19 deaths.

significantly higher percentages of the elderly than other causes might kill them. However the Table 8A data does not affirm that to any significance. While the 301,679 Covid-19 deaths (smaller in this narrower sample than the

sum in Table 7 above) constitutes 10.39% of the all-cause deaths for 2020, from Feb.1 to Dec.26, this increase is not reflected in the three main Covid-19 death categories, of 65-74 years, 75-84 years and 85+ years. Instead, the percent distributions of deaths in each age group of the Covid-19 column are similar to the percent distributions of deaths in each age group of the All Causes column.

After reducing each age-group death number into a percentage of its column total, then extracting the difference in those percentages (%Cov minus %All = %Diff.) across each age group, and then converting the differences in those percentages into a proportion of the age-group Covid death numbers (Covid-19 Number times %Diff), the numbers of excess deaths for each category were extracted. *Given how the Covid-19 and all-cause deaths in the vulnerable elderly groups are nearly identical, it undermines the claim of a new and deadly Covid-19 viral pandemic.*

In some cases, fewer people died in a given age-specific Covid-19 category than would be expected by comparison to the all-cause death numbers. In other cases, notably the elderly groups, a slightly higher number of death numbers occurred – but not by much. The total number of excess deaths in the Covid-19 category, above the baseline percentages created by all other causes was calculated to be 4,663, an astonishing low number given all the panic, hysteria, lockdowns, economic destruction, etc. that government and media claim are "necessary".

That number of 4,663 excess deaths works out to be around 13 extra deaths per day, for the entire USA. *Thirteen*. I also ran those numbers a second and third time, using slightly different CDC data sets, just to be certain of my methodology and numbers. Those re-calculations are shown in Figures 8B and 8C, below.

The recalculation on Table 8B used the full data set for 2020 hardly changed the excess-deaths calculation. The percent of total Covid-19 deaths as a portion of the all-cause death dropped a bit, from 10.95% to 9.87%, while the comparative calculation of excess Covid-19 deaths went up by 223 persons, from 4,663 to 4,866. However, even with these larger numbers of total 2020 all-cause deaths, claiming over 3.17 million persons, the age-distributions did not significantly change before or after the large increase of 269,249 deaths were added in the last week of 2020.

Table 8B: USA 2020 Deaths by Covid-19 & All Causes, by Age

1 Jan.20 to 2 Jan.21	Covid-19 Number	%Cov[1]	US Deaths All Causes	%All[2]	%Diff.[3]	Excess Deaths[4]
All Ages =>	313,171	9.87%	3,171,913			
Under 1 year	32	0.01%	17,750	0.56%	-0.55%	0
1–4 years	19	0.006%	3,276	0.10%	-0.097%	0
5–14 years	54	0.017%	5,247	0.17%	-0.148%	0
15–24 years	494	0.16%	33,598	1.06%	-0.9%	-4
25–34 years	2,129	0.68%	68,807	2.17%	-1.49%	-32
35–44 years	5,559	1.78%	97,549	3.1%	-1.3%	-72
45–54 years	14,963	4.8%	178,444	5.63%	-0.85%	-127
55–64 years	37,235	11.9%	412,045	13%	-1.1%	-410
65–74 years	66,745	21.3%	630,360	19.9%	+1.44%	+961
75–84 years	85,925	27.4%	770,041	24.3%	+3.16%	+2,715
85 years +	100,016	31.9%	954,796	30.1%	+1.83%	+1,835
			Total Covid-19 Excess Deaths Above All Causes:			**4,866**

https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm
Jan.2, 2021 update, remained posted on CDC webpage through 7 Jan.
Table 8B calculations and notes were the same as Table 8A, page 34.

One clarification for my calculations in Table 8C, on the next page, is that, the figure of 3.17 million all-cause deaths, in Table 8B (above), includes within it the total Covid-19 death counts, and so any proportional calculations must remove the Covid-19 counts from the all-cause counts. Consequently, I made a third re-calculation shown in Table 8C, where the Covid-19 death numbers for each age-group were subtracted from the same age categories of all-causes deaths. That revised Table 8C is presented below, providing the most robust calculation to date, *assuming that the original CDC data is itself robust, which is an open question*.

Table 8C: USA 2020 Deaths by Covid-19 & All Causes, by Age

1 Jan.20 to 2 Jan.21	Covid-19 Number	%Cov[1]	All Causes Minus Cov	%All[2]	%Diff.[3]	US Excess Deaths[4]
All Ages =>	313,171	10.9%	2,858,742			
Under 1 year	32	0.01%	17,718	0.62%	-0.61%	0
1–4 years	19	0.006%	3,257	0.11%	-0.1%	0
5–14 years	54	0.017%	5,193	0.18%	-0.16%	0
15–24 years	494	0.16%	33,104	1.16%	-1%	-5
25–34 years	2,129	0.7%	66,678	2.3%	-1.6%	-35
35–44 years	5,559	1.8%	91,990	3.2%	-1.4%	-80
45–54 years	14,963	4.8%	163,481	5.7%	-0.94%	-141
55–64 years	37,235	12%	374,810	13%	-1.2%	-455
65–74 years	66,745	21.3%	563,615	19.7%	+1.6%	+1,066
75–84 years	85,925	27.4%	684,116	23.9%	+3.5%	+3,013
85 years +	100,016	31.9%	854,780	29.9%	+2%	+2,036
			Total Covid-19 Excess Deaths Above All Causes:			**5,399**

https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm
All Causes deaths are minus the Covid-19 number for each age-group.

Three different calculations have been provided, using different iterations of the publicly-announced CDC Covid-19 and all-cause death numbers for the whole of 2020. No matter how these numbers have been reviewed or calculated, in either Table 8A, 8B or 8C, the final annual excess deaths are low by standard expectations of a raging pandemic requiring massive lockdowns, and justifying state-enforced totalitarian measures. No amount of nit-picking to change the numbers by even hundreds of quanta changes the outcome.

Below is a final Table 9, which summarizes the conclusions from the above three Tables 8A, 8B and 8C.

Table 9: Excess Deaths		**Covid-19 Deaths (?)**		**Covid-19 (?)**
Total Deaths:	**All Causes**	**Num**	**%**	**Excess Deaths**
Table 8A (page 34)	2,902,664	301,679	10.39%	4,663
Table 8B (page 36)	3,171,913	313,171	9.87%	4,866
	All Causes in 8B *minus* Covid-19			
Table 8C (page 37)	2,858,742	313,171	10.9%	5,399
	Averages:		**10.4%**	**4,983**

The last two Tables 8B and 8C included the CDC's corrective data dump of early January 2021, of 317,075 all-cause deaths, but not the additional necessary data increase of approximately 89,000 deaths, to justify the media-reported 400,000 number for Covid-19 deaths. However, neither of those data-dumps, nor other variations in data or calculations mattered at all, in terms of providing a significantly different outcome in computed excess deaths due to Covid-19.

The official CDC data on total Covid-19 and all-cause deaths, segregated into different age-groups, shows approximately the same percentage of deaths, with a total Covid-19 excess deaths averaging 4,983 for 2020. Or one can choose to use the higher number of around 5400 excess deaths. It does not matter. That higher number works out to be around 15 deaths per day, for the whole USA, for all of 2020. These figures for the excess deaths due to Covid-19 are extremely low, even lower than Ealy, et al's above-mentioned 6% of Covid-19 deaths without comorbidities, which computed to 18,930 deaths for the year, which works out to be 52 deaths per day, over all 50 states. One death per state per day.

None of these computations provide justifications for such massive governmental and medical panic-peddling, with lockdowns and other very deadly totalitarian interferences in the health, income and lives of ordinary people.

One must keep in mind how respiratory illness has always been a major factor in the deaths of elderly people. Those over 65 years of age constitute about 88% of all cases of pneumonia and influenza. And they are also a vulnerable group to be heavily hit with "death by despair", and then succumb to whatever comorbidity factors they are afflicted with. "Death by Despair" and comorbidity factors overshadow all what is claimed for the SARS-CoV-2 killer super-virus.

Given the questionable accuracy of Covid-19 PCR/Antigen test kits, the re-definitions pneumonia, influenza and other comorbidities as "Covid-19" (eg, "PIC" confusions, discussed above), and the fact that the majority of claimed Covid-19 cases and deaths occur during wintertime cold-damp conditions, we

can expect the mis-diagnosed and inflated Covid-19 category to be biased towards inclusion of more people in the older age groups, whether or not they were truly infected with a new and deadly virus. This is aside from the financial or virus-ideology motivations for hospital administrators to place Covid-19 on death certificates rather than the comorbidities which actually killed them. Such factors all trend for *a biased and unscientific selection of deceased elderly patients into the Covid-19 category.*

These data as used in my Tables 8A, 8B and 8C, obtained from official CDC sources but reviewed in a different manner than usual, coupled with evidence of Covid-19's non-exclusive symptomology overlapping with many other diseases and disorders, demolish the claims of a severe Covid-19 pandemic demanding "emergency-panic-lockdown" reactions.

Covid-19 Death Data Inconsistencies Identified by Genevieve Briand

In early December, I learned of a study comparing age-specific Covid-19 and all-cause US deaths, mirroring what I had already summarized in my Table 8A data. This study, "Covid-19 Deaths: A Look at U.S. Data" was presented in an early November webinar by Dr. Genevieve Briand, Assistant Director of the Applied Economics Program at Johns Hopkins University.
https://www.youtube.com/watch?v=3TKJN61aflI

Briand's findings, as presented in the webinar, reviewed all-cause and Covid-19 US deaths up to that early November date, and were summarized in an article by Yanni Gu, posted on Nov. 22 to *The Johns Hopkins News-Letter* (JHNL) as "Published by the Students of Johns Hopkins since 1896". The Briand/Gu *News-Letter* article reviewed the webinar findings, where Briand concluded there was an over-counting of 2020 Covid-19 deaths which could not be reconciled with the available all-cause deaths, probably due to confusions of Covid-19 with other diseases, as I have also concluded independently. The Briand/Gu article stimulated a controversy, and was then "retracted" and censored from the JHNL four days later by its editors, for the reason it *"has been used to support dangerous inaccuracies that minimize the impact of the pandemic."*

The reactions of the editors at JHNL was a clear case of *"Don't confuse us with the facts, our minds are already made up!"*

In fact, after reviewing the CDC data, Briand's analysis and conclusions were anything but inaccurate: As CDC-confirmed Covid-19 deaths increased during the April 2020 peak, most all other causes of death *declined, indicating a*

shifting of other diseases into the Covid-19 category, as I concluded above. Her closing webinar statement was *apropos*:

> "We don't know if a death is from Covid first, or a [different] condition. How are we to best address it? If someone has a heart condition and is over 50, what is the best way to prevent death by Covid-19 or heart attack? Is it to isolate myself, or to exercise? When I see the poster of the CDC of physically inactive people sitting on a bench, with the self-distancing... should you exercise, is that going to be a better way to engage and interact? If you are depressed your immune system goes down... the question is, what is the best way to fight [disease]? To isolate yourself? Or to be happy and meet people, and get out and exercise. And live." (https://www.youtube.com/watch?v=3TKJN61aflI Genevieve Briand, starting around 1:04:45)

The original webpage for the Briand/Gu article was quickly replaced by a statement by the JHNL editors, rationalizing their censorship. https://www.jhunewsletter.com/article/2020/11/a-closer-look-at-u-s-deaths-due-to-covid-19 A PDF of the original article was provided, however, with the obscuring banner "Retracted by The News-Letter" contemptuously plastered across every page. https://drive.google.com/file/d/1Tnb1a8TXHj_jJCM2BDfGSriUgdn-2gec/view

My Tables 8A,B,C above extend the analysis as was independently undertaken by Briand into the end of 2020, wherein I observed similar data inconsistencies, and came to similar conclusions.

Alarmist Reporting on Death Counts

On December 22, just before Christmas, the Associated Press (AP) released an alarmist report that 2020 would end with from 3 to 3.2 million all-cause deaths, *a figure indirectly blamed on Covid-19, but so alarming it would require an additional, as-yet unreported batch of around 300,000 deaths to justify it*. This hysterical report, attributed to the CDC but without any confirming reference, was quickly picked up by nearly every major newspaper and media outlet in the USA, and some overseas, blasting those alarming numbers as a top headline. Grim-faced media stars also seized upon those numbers, driving up the panic and hysteria. https://apnews.com/article/us-coronavirus-deaths-top-3-million-e2bc856b6ec45563b84ee2e87ae8d5e7

Within a week, around the end of 2020, the sum of 400,000 USA Covid-19 deaths was being circulated in the national and international media. Deliberate fear and panic was also being promoted by medical and government health bureaucrats, with support from power-drunk politicians. For example, the CDC Covid Tracker website screamed out misleading full-year cumulative numbers for the USA in a manner conflating "cases" with deaths. On Dec.19, they posted in large text "OVER 17 MILLION TOTAL CASES", "1.6 MILLION CASES IN LAST 7 DAYS" and "312,636 TOTAL DEATHS". By early January 2021, it was "20.5 MILLION CASES" and "350,644 DEATHS". https://covid.cdc.gov/covid-data-tracker/ - cases_casesper100klast7days

A NY Times website, mentioned above regarding death/case ratios in the different states (Table 2) continues promoting hysteria, with numerous state data graphs composed of "cases" that are 7-10 times higher in different states than actual deaths, which are not shown on their graphics. The intention is to deliberately misinform people that the cases are the primary important thing, as they ponder just what the risk of death might be for themselves and family.

Even if those media numbers were accurate, the way they are reported creates the false impression among ordinary people that 17 or 20 million Americans were dying or would soon be dead from Covid-19. The Johns Hopkins University Covid-19 tracker webpage is similar, with big fonts... 85+ million... 20 million... all that's missing are multiple exclamation points. https://coronavirus.jhu.edu/

The WHO Covid-19 website does the same with global numbers: "85 Million Confirmed Cases of Covid-19, Including 1.8 million deaths" https://Covid-19.who.int/

The above statements are announced as the top item on their websites, without qualifications to explain how these are totals since the beginning of the year, or to distinguish that the overwhelming number of "cases" are asymptomatic people, who aren't sick or infectious. Or that the dying and dead are very old and fragile, suffering over years from multiple other diseases and conditions, and are generally at the end of their lives. Or that many died at home or in the emergency room, and are hence PCR tested *post-mortem*, and where the real cause of death is ignored in favor of a "Covid-19" death, to drive up the numbers. They also do not present the much lower trends of the data, or clarify that the "millions" figures do NOT represent the number of people dying in their local towns, counties or states. By such methods they are deliberately fanning the flames of panic and hysteria. Similarly, if searching on Google for "Corona viruses", you are automatically directed to page after page of hysterical

blaring Covid panic. Everything is organized to increase panic and anxiety, not to calm people down for rational considerations.

How can the average person *not* be deeply frightened by these irrational and unnecessary displays of total numbers since January 2020, rather than the actual lower trends, as I've presented them here. In 2021 they continue with adding new Covid-19 numbers into those of 2020. How can ordinary people not believe that their very lives and those of their children are in severe danger, unless they lock down and shelter at home, with forced masking, etc., especially if that's all they hear or see? And that brings us to the alarming phenomenon of how mainstream news, media and internet have conspired to censor and personally destroy by slander, the voices of independent scientists and doctors who oppose the lockdowns and forced masking. The massive censorship exerted today by mainstream media, and by the internet billionaires running Google, Facebook, Twitter, YouTube and the like, suggests a deliberate cover-up of all the facts that run counter to such panic-stricken official pronouncements. The true goal appears to be, *to erase any publicly-uttered opinion contrary to the WHO or CDC fear-porn, so that ordinary people won't hear much of anything beyond what the new Medical Police State, or Pharmaceutical Big Brother, is telling them.*

Such alarmist reporting also parallels a trend where the all-cause case numbers for 2020 are being reported, again and again by grim-faced media stars, as "higher than any prior year!!" as if they are already dead, or will soon be dead because of Covid-19. "Cases! Cases!! Cases!!!"

As noted above, such hysteria causes additional deaths due to the lockdowns and economic devastation that follows, as by the many factors already listed above in a depressing litany. These factors alone may be the cause of the high 2020 death numbers. And how many of them are mis-identified as "deaths due to Covid-19"? Indirectly they all are, due to *Covid hysteria*.

Many professionals have stepped forward to challenge the claims of the Covid-19 "pandemic" – as in the tens of thousands of brave physicians and other public health scientists who signed the *Great Barrington Declaration*, https://gbdeclaration.org, or the members of the *America's Front-Line Doctors* group. https://www.americasfrontlinedoctors.com Another group challenging the massive lockdown terrorism, and the bogus claim that "only a vaccine will save us" is led by Robert F. Kennedy Jr., the *Children's Health Defense*. http://childrenshealthdefense.org ALL of these groups, and many others, are restricted or erased from Facebook, Twitter, YouTube, etc., their voices generally muzzled as in a totalitarian state.

These dissenting physicians, scientists and others take a great risk of being publicly slandered, or to lose their medical licenses, with websites censored, even as the majority of professionals have been threatened to accept the status quo over the health and well-being of their patients. And most of the health professionals and scientists at the top levels of universities, institutionalized medicine and government are doubly complicit. They have remained tone-deaf or silent, even while their wrong-headed conclusions give license and ammunition to socially destructive politicians, who bark out anti-constitutional "dictates" for never-ending lockdowns, towards formation of a literal Medical Police State.

Where does it end?

The data incongruities presented in this paper suggest a quite logical explanation, however unsettling: *The medical profession, hospitals and the WHO and CDC have been inappropriately shifting or duplicating deaths from other causes into the Covid-19 category. These shifted death numbers appear to include those dying of better-known respiratory disorders – COPD, influenza, pneumonia, asthma, emphysema, lung-cancers, congestive heart failure and other diseases and disorders.* And all these diseases and disorders are driven up by annual cycles of frigid and moist wintertime weather, which are clearly seen in the Covid-19 data, further indicating the duplication and overlap. Economic ruin, panic, hysteria and despair have further driven up the death numbers in all categories.

Problems in Medical Diagnosis, and Suppression of Dissent

The medical profession has a long history of violently suppressing members of its own profession when they stray from consensus ideas. This becomes deadly when concealment of medical blunders has taken place. In the mid 1800s, Ignatz Semmelweiss discovered the cause of childbed fever in the doctor's own dirty hands, as they went from disease-ridden wards or the autopsy room, directly to giving pelvic exams to pregnant and laboring women. Thousands of women and infants perished. Semmelweiss observed this happening, and demanded the physicians under his direction wash their hands with chloride of lime, to prevent infectious germs from being carried into the pregnant women's wards. By this simple step, childbed fever, or puerperal fever, was eventually ended. For his discovery, Semmelweiss was viciously attacked and slandered, fired from one hospital post to another, and eventually was locked up in an asylum by a conspiracy of his peers. In that case, it was the medical profession's denial of the germ theory of disease, and of deadly errors, which led to massive deaths of women.

Today, modern medicine accepts the existence of infectious microbes, but additional medical disasters have taken place by stretching the germ theory beyond all rational limits. So-called "hiding" or "slow viruses" are a case in point. These were proposed as disease mechanisms starting in the 1980s, with the Acquired Immune Deficiency Syndrome (AIDS), when physicians ignored the original "Acquired" component and embraced a viral causation even when it could not be definitively isolated. The "infectious HIV" theory spread panic, claiming that while you got infected today, symptoms for AIDS would not appear for 10 years or more. And when you did get sick, the symptoms imitated over 60 different "indicator diseases". PCR tests were developed for HIV, which were no more accurate than the modern PCR tests are for Covid-19. Critics of the slow-hiding virus theory, such as top virologist Peter Duesberg, were attacked and isolated. Duesberg was subjected to censorship of his articles in scientific publications, and punished by his Department of Cell Biology at the University of California at Berkeley. Many others became critical of speculative "infectious HIV" theory, all of whom were attacked and censored, and vilified in the mainstream media as "AIDS deniers". Today, due to massive censorship and cover-up of medical errors and toxic pharmaceuticals such as azidothymidine (AZT), that killed unknown thousands of people, major open questions persist about the legitimacy of the infectious HIV theory. Few today even know about the HIV controversies due to persisting censorship.

Beyond the bogus methods of excessive cycling of PCR methods yielding many false positives, as discussed above, it appears certain that diagnoses of Covid-19 have the same problems of lack of documentation, isolation proofs and clear causality as occurred previously with respect to AIDS.

Covid-19 cases and deaths are conventionally attributed to an infectious virus SARS-CoV-2, but are more easily understood as due to diagnoses which are *confused by the symptoms of influenza, pneumonia, congestive heart disease, and other maladies that are worsened during wintertime epochs of cold temperatures and moisture.* Beyond winter chills, other climate factors are at work driving up influenza and pneumonia, as in India or Brazil, hot-humid regions where incessant rain and flooding during summertime monsoons affects large tropical populations. Or dry dusty or pollen-rich atmospheres, triggering additional respiratory distress. Under all those conditions, lung and heart functions of elderly people with other existing diseases and disorders, are exacerbated. *Such respiratory conditions were, prior to Covid-19, diagnosed according to presenting symptoms.* Today, however, biochemical PCR and antigen tests are generally the diagnostic procedure of choice.

Even before PCR tests, medical errors developed when certain diseases were prematurely attributed to infectious microbes. One example was the pellagra epidemic in the USA, and another, the SMON epidemic primarily in Japan. Physicians assumed these were infectious disorders given how they occurred among groups of people in close proximity, as in families or other population groups, but without questioning the unproven, dogmatically-believed basic assumptions about those diseases.

Pellagra is characterized by fatigue, diarrhea, dermatitis, open sores and dementia, culminating in death. It afflicted families and populations in the rural US Southern states. Starting in the early 1900s and running into the 1940s, some 3 million people were afflicted, with over 100,000 deaths. For reasons of close proximity it was assumed to be an infectious disorder, caused by an as-yet undefined microbe. "Pellagrites" were frequently shunned, and due to dementia were placed in long-term mental hospitals. Pellagra was eventually found to be caused by poor diets lacking in Vitamin B3 (niacin) and tryptophan, as is typical of corn-based diets in poverty regions with low dietary milk, fresh fruits and vegetables. Physician Joseph Goldberger made that discovery in 1915, after bringing pellagra patients back to health by dietary changes and supplementation. He also proved pellagra could not be infectiously transmitted by deliberate injection experiments. Many years passed, with additional deaths, before his findings were widely accepted.

SMON disease (Subacute Myelo-Optico-Neuropathy) had a similar but shorter epoch, appearing as a tourist disorder primarily in Japan from 1955 through 1970. It was characterized by increasing diarrhea, weight loss, disabling paralysis, blindness and death. Around 100,000 SMON deaths occurred in Japan, with more around the world, being attributed to an unknown infectious virus. SMON was later identified as the side-effects of the abundantly-prescribed anti-diarrhea medicine *clioquinol*. Once clioquinol was banned and its manufacturer Ciba-Geigy abandoned its production in 1985, SMON disease disappeared globally. SMON was first identified as an iatrogenic disorder by physician Olle Hansson of Norway, who campaigned against clioquinol, meeting stiff opposition from conventional medicine. The case of SMON not only duplicated the problem of a too-quick attribution of a deadly disease to a microbe, but also ignored more obvious signs of toxic reactions to the physician's favored "medicine".

The skepticism against Goldberger's and Hansson's findings, and the personal opposition they were greeted with, is repeated today in a far worse manner by highly organized pharmaceutically-oriented medicine, in the vilification, censoring and silencing of physicians and scientists who dare challenge the

government-backed "official truth" about Covid-19. Some political totalitarians are today already advocating detention camps for Covid-19 lockdown dissenters, for those who refuse to be vaccinated, or who are "disobedient" to medical authority. Similar demands to lock people up were heard during the AIDS years, to silence critics of the conventional "infectious HIV" theory of AIDS. They were called "AIDS Deniers", just as today the term "Covid Deniers" has become a popular curse, to demonize rational critics as being equal to neo-Nazi Holocaust deniers.

Today the virologists' blundering errors are compounded, to both prescribe generally ineffective but toxic and expensive medicines against Covid-19, or the influenza and pneumonia which defines it, while at the same time working to deny and make illegal effective and inexpensive out-of-patent medicines.

Banned and Slandered, but Effective Remedies

Examples of the banned medicines include hydroxychloroquine, an anti-malaria and anti-lupus drug widely available in many parts of the world, notably in Africa, where it can be purchased over the counter. It is an effective remedy for Covid-19 symptoms as well. https://aapsonline.org/hcq-90-percent-chance/ https://drive.google.com/file/d/1w6p_HqRXCrW0_wYNK7m_zpQLbBVYcvVU/view Another remedy is high-dose vitamin C therapy, firstly advocated by Nobel-Prize winner Linus Pauling in the 1980s, but severely attacked by American medicine given its better efficacy against colds, influenza, and cancer than conventional pharmaceuticals. Many physicians use it today for lung-distressed patients, as an IV-drip of 20 to 40 grams per day. Usually only a few days of such therapy are necessary for significant recovery. One can also home-treat with high-dose vitamin C (powdered calcium ascorbate is best), dissolved in water. http://orthomolecular.org/resources/omns/v16n12.shtml

Similarly, high-dose vitamin D therapy is very beneficial against lung-heart problems, something which modern medicine deprives people of by promoting lockdown madness that keeps people away from sunlight. https://www.academia.edu/44719317/COVID_19_Vulnerability_and_Vitamin_D_Deficiency Ivermectin or azitheromycin are other out-of-patent economical medicines proving help against breathing disorders, also showing benefits to those with a Covid-19 diagnosis who are truly ill, whether it is factually influenza, pneumonia or something else. https://dominicantoday.com/dr/covid-19/2020/09/29/doctors-cure-6000-patients-with-covid-19-with-ivermectin/ Also the use of zinc or silver-ion supplements or lozenges, in various mixtures with the other things mentioned above, can be a natural remedy approach for home treatment, and alternative to questionable hospitalization.

Mainstream media and medicine denies or avoids mention of these home-based treatments due to their ideological and financial alliances with Big Pharma/ BioTech, who advertise heavily in science and medical journals. The mainstream media generally supports only the most orthodox and conventional of treatments, mis-reporting on all what I write above. In-depth discussion on specific treatments for Covid-19 is nevertheless beyond the scope of this article, and so are limited to the above recommended resources.

Changing Definitions of a Disease Case

Another important factor is how the older medical determinations of a "disease case" have been far more loosely defined today, to the point of serious and deadly error. For example, a sick person once was said to have a *case* of a disease, such as tuberculosis, when they had the actual and clearly identifiable symptoms of that disease. For TB it is persisting cough often with blood, chest pain, loss of appetite and weight, fatigue, fever, chills, night sweats, and also with the TB bacterium present at high levels in their body fluids. That is the "old fashioned" fact-driven case-diagnosis and epidemiology. By contrast, today a "case" of Covid-19 is "diagnosed" merely by use of error-prone PCR or antigen biochemical testing methods. One does not need to have symptoms of Covid-19 to be identified as a "confirmed case" where it is *assumed, without scientific evidence or justification,* that by a positive biochemical test, you have living infectious Covid-19 virus within your system and thereby are at risk of Covid-19 sickness, and of infecting other people. "Official" science, medicine and politics then pushes for ever-longer lockdowns and forced masking, in a never-ending spiral of authoritarian demands and unconstitutional "edicts".

"Evidence-Based Medicine" Often Ignores the Evidence

Finally I should mention the general abandonment by modern virology of Koch's Postulates for identification of a pathogen causing a specific disease. Those postulates are similar to rules of evidence used by police when trying to solve a murder - such as fingerprinting, ballistics testing, and eye witness reports. For microbial diseases, they include:

1) The bacteria must be present in every case of the disease.
2) The bacteria must be isolated from the host with the disease and grown in pure culture.
3) The specific disease must be reproduced when a pure culture of the bacteria is inoculated into a healthy susceptible host.
4) The bacteria must be recoverable from the experimentally infected host.

Item number 2 above is a sticking point for claimed viral disorders, such as HIV or the Hepatitis C virus, for which environmental or lifestyle factors within narrow high-risk groups play the major role in immune-system stress and sickness. Space does not permit a full discussion of Koch's Postulates and its growing abandonment, but it seems necessary to point out how the corona viruses have not been isolated in pure cultures by which their pathogenicity on lab animals could be identified in conditions free of other factors. And that weakens the large claims of the new "warp speed" vaccines supposedly based upon such viruses. Even experimental inoculations of volunteers with mucous from influenza patients do not necessarily create influenza symptoms in volunteers. Such are the kinds of evidence that often places modern medicine at loggerheads with epidemiology, biology and other science disciplines, in determining the true causes of diseases, and their most effective treatments.

Modern medicine has also become increasingly centralized and government regulated, rarely to the betterment of the public heath. Growing governmental "command and control" measures, as found in the UK National Health Service, the USA Medicare, and later "Obama-care", increasingly obliterated the independent physician and small clinic. Also the new methods of "test-kit" medicine transferred much of traditional diagnosis from the physician to the laboratory technician, whose presumed skills and laboratory machinery conceal an abundance of unstated and frequently wrong assumptions. It is not merely how AIDS and Covid-19 were/are "diagnosed" by faulty PCR tests. False diagnoses can be deadly when a white-coated authority-figure basically points a "finger of doom" at sick or healthy people, potentially sending them into an emotional death-spiral. The claimed "viral causation" of both AIDS and Covid-19 have never been proven out, and as this paper shows, there is much which weighs against any clear or unchallenged viral cause for Covid-19.

This "testing mania" is also a big problem in the widely used but inaccurate PSA test for prostate cancer, which results in a lot of unnecessary surgery, sometimes leaving older men incontinent and in a worse condition than before the surgery. Genetic tests for female breast cancer susceptibility are similarly questionable, rooted in unproven genetic calculus, and also leading to unnecessary surgical mutilations – in the worst cases, the so-called "preventive mastectomies" where no symptoms of cancer are present, but both breasts are amputated, as a barbaric "preventive", "just to be safe".

Entire books have been written on these subjects, on the over-reach and deadly nature of certain branches of modern medicine. Too often the claims of viral- and genetic-causation of diseases today become the abandoned theories of

tomorrow, for what are later proven to be environmental, dietary or emotion-driven maladies. Genetics and biochemistry have their place, and successes, but far too many failures.

I will end this section by sharing a Covid-19 anecdote of a "death by hospital" which happened to a local friend's father. The elderly man, about 80 years old, developed a cough and fever, typical of influenza. In a panic about Covid-19, his wife rushed him by car to the hospital emergency room. Upon arrival, the medical staff came out in full haz-mat gear, and put him on a stretcher and took him inside, while the wife went and parked the car. A few minutes later, after returning to the emergency room, her husband was not to be seen. She asked around, and the attending young physician told her the man had been moved to an isolation ward. She was told she could not see him anymore, even though he was alert and lucid just a few minutes earlier, and how she had been in intimate contact with her husband over decades, including immediately before his cough and fever developed. Confused, she went home and called her relatives, who came with her to the hospital the next day. They confronted the head doctor, demanding to see the old man, but were again refused. "He has Covid-19 and is now on a ventilator, and cannot be visited or moved anymore." They were not allowed to even see him through a window-glass, and the old man was given a nearly hopeless diagnosis. The family asked the doctor to try high-dose vitamin C therapy, which elicited only a nasty curled-lip denunciation of that idea by the ignorant doctor. The family was cowed and beaten-down by the arrogant, authoritarian doctor, and in my opinion they should have contacted a lawyer with the disposition of a junk-yard dog, to threaten the hospital and doctor with a lawsuit unless their concerns were addressed. In any case, the old man died a few days later, not given any kind of helpful medicine. He was instead left to die alone, drugged into semi-conscious paralysis by the hospital staff to keep him from trying to disconnect from the ventilator. What a Hellish way to die!

Now, this is not an isolated example, I've heard similar accounts from other people, along with more positive accounts where elderly people with serious influenza symptoms did not go to the hospital and cured themselves with the remedies I mention above. This is why I advise people to NOT go to hospitals if they have symptoms mirroring an ordinary cold or flu. Grandma's chicken soup with plenty of garlic, vitamins C and D, zinc supplements and other natural remedies provide a much better chance of recovery. And of course, a healthy lifestyle, good nutrition, vitamins, minerals and preventive health care before you get sick is the best solution of all.

Conclusions and Recommendations

Beyond my conclusions as given in the prior sections, I continue to feel suspicious about the last-minute data-dump of 269,249 new all-cause deaths in the last week of 2020, and the added boost of 89,000 into the Covid-19 death numbers, to build the too-neat round number of 400,000 which is exploding all over the media as I write this paragraph. There may be innocence to some of the number-boosts, as with updated death counts over January 2020 and the last week of December 2020. However, *the way in which it was done exposed a deliberate effort to spread more panic and fear*, as well as a clear element of sadistic political and media power-drunkenness that accompanies everything the CDC, WHO and top "virus experts" are doing and claiming. There is the stench of "official truth" Orwellian deception in every facet of the Covid-19 pandemic. *The manner in which so many dissenting voices of both professionals and laypeople, challenging the "official truth" of Covid-19, have been rudely or brutally censored and erased from mainstream media reports, and from internet social media is exactly what one anticipates during a widespread political/medical cover-up.* It makes understandable the outrage seen within the general public, to speak about "Covid Terrorism", or a "Medical Police State".

The various issues raised above – incongruent case-death data, seasonal variations, similarities and overlaps in clinical diagnoses between what is influenza or pneumonia versus what is Covid-19 disease, electron micrograph puzzles, PCR/Antigen testing inaccuracies, trends in population and deaths, lockdowns and "Death by Despair" – lead us to staggering new open questions, and to a completely different set of critical conclusions about Covid-19. The abundant evidence points to a Covid-19 *epidemic of error and hysteria*.

Is this current "pandemic" one large error of misdiagnoses, an error of categories, of book-keeping, of inaccurate PCR and antigen tests, where seasonal wintertime influenza, pneumonia, colds and various upper and lower respiratory disorders are being misidentified as Covid-19 by inaccurate clinical diagnoses and even less accurate laboratory testing? Are numerous additional deaths the consequence of totalitarian lockdowns, exasperating pre-existing comorbidities, and repeatingly inflaming the citizenry towards hysteria and panic, driving "death by despair" to ever higher numbers? Or towards open social rebellion? And once so wrongly "diagnosed", those who rush to hospitals for help are not given inexpensive, proven remedies for those "lesser conditions and diseases". No, they are instead generally given expensive toxic meds with demands to take experimental vaccines, often putting people through a hellish set of abusive treatments in profiteering hospitals staffed by nurses and physicians with a "warrior" mentality. What does that mean exactly? It

means they are so busy fighting in the trenches against what they conceive to be a deadly enemy plague, and don't have time or patience for anyone who dares to question their Covid Religion. Even when so much of their own advocacy and ministrations – in hospital treatments and laws crushing down ordinary human behavior – wreak havoc upon human society and biology, worsening every kind of symptom and making despair and death more probable.

I regrettably conclude that this is, indeed, what has happened over our *Lost Year* of 2020.

The following summary points can be made:

* Covid-19 cases have soared only due to millions of unnecessary and faulty PCR/Antigen tests being made on the generally healthy and asymptomatic population, primarily revealing *herd immunity*.

* While Covid-19 tests and cases have soared, neither are correlated to, or predict the much smaller number of Covid-19 deaths. Covid-19 death/case ratios were at a high level initially, when PCR/Antigen tests were isolated to those in hospitals, but those ratios declined rapidly when laboratory tests were applied to asymptomatic people. Covid-19 PCR/Antigen tests are since shown to have *No Predictive Value*, which is *the hallmark of a bad scientific theory*.

* Covid-19 laboratory tests, but not any living infectious deadly virus SARS-CoV-2, *create* Covid-19 *cases*, and that is as far as it goes. From such test results, one cannot say who will or will not get sick, or who will or will not die, aside from possible induced psychosomatic alarm and upset due to an hysterically presumed "Covid-19 Death Sentence". *As such, the entire theoretical basis of a new and unique "Covid-19 pandemic" appears as only an artificial diagnostic and theoretical construct.* People who are dying should be diagnosed and treated according to pre-Covid-19 symptomology.

* The numbers of all-cause deaths in the USA over the period from 2010 through the end of 2019, show the same approximate annual increases, of around 46,000 average added deaths per year, due to population growth alone. The largest numbers of deaths in 2020 are concentrated among high-risk elderly in their end-of-life years, in roughly equal proportions between those in the non-Covid "all cause deaths" group and the "deaths by Covid-19" group. As noted above, this further undermines the claims of an infectious deadly viral pandemic. The increased number of deaths in 2020 are not due to any Covid-19 disorder, but from social behavior modifications which have arrived with it.

* The medical symptoms of Covid-19 considerably overlap with those of ordinary upper and lower respiratory problems, such as influenza and pneumonia, further suggesting significantly high percentages of claimed Covid-19 infections are those of other known respiratory diseases and disorders.

* Winter seasonality of Covid-19 deaths affirms a relationship to standard influenza and pneumonia, as well as other maladies that are exacerbated by cold wet weather. Possible mis-diagnosis of those conditions and diseases as Covid-19 is thereby strongly indicated by this one factor alone.

* Deaths by pneumonia, influenza and other comorbidities are being deliberately mixed up with Covid-19 deaths in government health agencies, indicating inaccuracies in Covid-19 diagnoses, which magnify the numbers of Covid-19 deaths, while causing a "disappearance" of deaths in the comorbidity categories.

* The disruptions of normal life due to the Covid-19 hysteria, lockdowns and forced masking has its own deadly pathology, probably equal to or greater than the claimed number of deaths by Covid-19. A large number of people are dying due to pre-existing comorbidities exacerbated by the lockdowns and forced masking, to include heart disease and cancers, suicides, drug overdoses, alcoholism, with increases in depression, addictions, family violence, economic ruin and other horrors. *Those factors are being almost totally ignored by the "experts in power" during this claimed viral pandemic*.

* PCR testing for Covid-19 is highly error-prone due to the intrinsic high sensitivity of that method, especially when the numbers of cycles on PCR-testing machinery are set too high. PCR test methods react to many things, including dead virus, non-living viral DNA/RNA fragments, and antibodies created by healthy people who are no longer at risk of the disease, or of spreading it. *If one needs to use PCR to detect a virus, then there is not much of it in the body by which biochemical significance could be achieved, and it also indicates that such a virus is not replicating itself.*

* Electron microscopy does not reveal any clearly specific image of SARS-CoV-2, the virus blamed for Covid-19, and cannot be easily distinguished from other corona viruses.

* From all the above factors, the high positive PCR/Antigen test rates indicate *Herd Immunity Only*, and not any growing infectious pandemic, be it one of a new malady Covid-19, or older diseases and disorders gathered inappropriately into a new and artificial "Covid-19" category.

Recommendations:

1. Given the abundant evidence against the generalized "Covid-19 pandemic", *there must be a total end to forced lockdowns and masking immediately, with efforts to save the economic basis of normal healthy human life! The economic and social devastation from Covid-19 hysteria and lockdowns has its own seriously harmful and deadly effects upon the public health.*

2. Intelligent protections of the elderly and those at high risk from all sorts of infectious diseases should continue, but without the strictly punitive, sadistic and cruel "protections" such as isolation, forced masking and removal from families. Outdoor exposure to natural sunlight and fresh air, with friends and family, is a life-enhancing and curative remedy all by itself.

3. Proven but suppressed remedies for all kinds of respiratory diseases, such as high-dose Vitamin C, Vitamin D, zinc supplements, hydroxychloroquine and other inexpensive, out-of-patent medicines must be fully legalized and made legally secure for over-the-counter purchase and use. Or at minimum, without prosecution or slander of physicians who choose to use them for treatment of their patients. There should also be a decisive end to medical-pharmaceutical media advertisements as was the case in prior decades. Those who have promoted this pandemic to the public, from the high perch of government offices, should also be fired, and prosecuted if it is proven they stood to profit from the lockdowns or risky vaccines being peddled as a "cure".

4. With such inexpensive and proven remedies as listed above, there is no need for expensive pharmaceuticals or risky untested vaccines, which should remain optional and voluntary only.

5. We must quickly return to the "old normal" not merely for reasons of public health, but also to protect and restore our Constitutional Republic and the liberties and freedoms which are being systematically stolen from everyone by power-drunk politicians, pharmaceutical robbers, and medical bureaucrats.

6. The critical data analysis in this paper has predominantly addressed the situation in the USA. However, by rational extension, the critical points and conclusions presented here are applicable for all world regions, as they go to the basic question of *scientifically-defendable causality*, or the lack thereof.

7. The public must be alerted to this serious situation of emotionally-plagued medical, media and academic misreporting. The public is misled and driven into unnecessary panic and self-destructive actions, to include lockdowns, masking,

anti-social distancing, economic collapse and bankruptcy, treating friends and relatives like lepers, keeping children away from school, or placing them into plastic cages as if they were laboratory rats, and many similar alarmingly Medieval and fractious conducts. Meanwhile, rational voices critical of the Covid-19 "pandemic" are being censored. None of it is rational, or necessary. It is irrational societal suicide, wherein "top" levels of arrogant, sadistic and power-drunk politicians, bureaucrats and medical officials are leading entire nations over a cliff.

8. *The issues surrounding Covid-19 and the related public health are not the exclusive province or domain of medical "experts".* The entire population is being put at high risk by ineffective and unscientific claims, the advocates of which formulate never-ending new laws demanding obedience from the general public – to accept orders from the Big State, to lock down, to wear masks, to anti-socially distance, to keep children out of school, to allow their businesses to shutter down into bankruptcy, and a hundred other things with *very deadly consequences*. Governors and police forces have been unconstitutionally empowered to enforce public health measures of a highly unscientific and totalitarian nature.

THIS MUST END NOW!

Postscript

Since this item was posted for public viewing in early February, some of the citation weblinks have been censored, as with the Ivor Cummins video. The larger article also needs some updating, to include some materials already posted to the Supplementary Information file, the weblink for which is found on pages 1 and 2. There is more pertinent information on the "vanishing Influenza" of 2020, as mislabeled "Covid19". A new section on the toxic nature of "masking" will be added, which appears to be the major cause among frightened post-Covid19 patients now suffering from so-called "long-term" covid. It appears mostly to be a "long-term masking and bad medicine disease". Also the toxic and experimental nature of the vaccines, now being irresponsibly given even to already C19-immune children (!), is far beyond anything reported in the MSM. That also appears as a cause for the uptick of new "cases" since the vaccine introductions in early 2021. I will try and undertake that task in April, and the repost and announce the updated version.

My thanks to Thomas DiFerdinando and Ira Bauer for their helpful reviews and suggestions.

Article originally completed and circulated on 3 January 2021.
Revision with additions and re-organization on 9 February 2021.
Postscript and prior Supplement info integrated into text.
New information and calculations added.
Additional update forthcoming, by mid-April 2021.

The PDF version of this publication may be downloaded from these weblinks:
https://www.researchgate.net/publication/348550612
http://www.jamesdemeo.com/DeMeoCDCdataReviewSM.pdf

Also see the "Supplemental Information" update page accompanying this article, posted at the two weblinks above, most easily from here:
https://www.researchgate.net/publication/348894789
This Supplement page now includes a list of additional research papers on the health hazards and high death counts from lockdowns, forced masking and anti-social distancing, beyond what is presented in this paper.

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