EXECUTIVE SUMMARY

COVID-19: Restoring Public Trust During A Global Health Crisis

March 23, 2021

An Evidence-Based Position Paper to Ensure Ethical Conduct

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COVID-19: Restoring Public Trust During A Global Health Crisis

During our investigation into the variety of topics this manuscript covers, a theme began to stand out as a consistent concern. Safe and effective treatments for COVID-19 are inexplicably being withheld. As you read the full position paper, you will encounter many similar examples of what appears to be willful misconduct across several topics. These areas, and pertinent takeaways, are outlined below.

Topic area 1 - Asymptomatic transmission is the basis for public health policies regarding masking and social distancing.

- Wuhan Participant Study - **9,898,828 enrolled participants** were tested using qualitative COVID RT-qPCR testing. Only 300 possible asymptomatic carrier candidates were identified. Of the 300 possible asymptomatic carriers, all were tested using live cell culture to determine if their PCR samples could produce replication-competent virus. All 300 live cell cultures were negative for being able to produce replication-competent virus, indicating that none of the 300 people identified as potential asymptomatic carriers from the 9,898,828 people tested were infectious. **Therefore 0.00% of COVID transmissions were asymptomatic**.
- Asymptomatic transmission is widely assumed globally but has never been definitively proven based upon the five medical gold-standards of empirical evidence for the evaluation of infectious disease discussed in the position paper.

Topic area 2 - PCR testing is the major basis for the diagnosis of COVID.

- RT-qPCR tests are quantitative tests. However, it appears that PCR testing is intentionally being used qualitatively, and cycle threshold values are being manipulated to increase or decrease case counts.
- **Qualitative COVID RT-PCR tests are being used to do exactly what they are not calibrated to do**, while confirmatory serologic viral load and antibody testing has been deemphasized.
- Qualitative COVID RT-PCR cannot determine whether a person is infectious and therefore should not be used to establish a diagnosis without the assistance of additional confirmatory lab testing.

Topic area 3 - Effective treatments for COVID exist and are inexplicably being withheld by the FDA and CDC.

- **Comprehensive nutritional study** - Used vitamin A (100,000 IU/day), vitamin C (1,000mg/hour during waking), vitamin D (50,000 IU/day), and Lugol's Iodine (25mg). **One hundred seven out of 107 patients fully recovered within seven days of treatment.**
- **Vitamin D study** - 191,779 participants **across all "latitudes, races/ethnicities, both sexes, and age ranges"** demonstrated that participants with deficient serologic vitamin D (<20 ng/mL) were more than twice as likely to be infected by the SARS-COV-2 virus (12.5% vs 5.9%) when compared against participants with a healthy amount of serologic vitamin D (≥ 55 ng/mL).
- **Ivermectin study –** "Viral clearance was treatment dose- and duration-dependent. In six randomized trials of moderate or severe infection, there was a 75% reduction in mortality (Relative Risk=0.25 [95%CI 0.12-0.52]; p=0.0002); 14/650 (2.1%) deaths on ivermectin; 57/597 (9.5%) deaths in controls) with favorable clinical recovery and reduced hospitalization."

- **Hydroxychloroquine (HCQ) study** – A meta-analysis of 192 studies concluded that HCQ is effective when used early. Early treatment is most successful, with 100% of studies reporting a positive effect and an estimated reduction of 67% in the effect measured (e.g., death, hospitalization, etc.) using a random effects meta-analysis (RR 0.33 [0.25-0.43]).

- **National Health and Nutrition Examination Survey studies** – The CDC has known for at least two decades that Americans are deficient in the following key immunological nutrients: **Vitamin A** (35-45% of the population is deficient), **Vitamin C** (37-46%), **Vitamin D** (65-95%), **Vitamin E** (60-84%), and **Zinc** (11-15%).

Topic area 4 - Violations of federal law appear to have been perpetuated by the CDC with respect to death certificates, irrevocably altering COVID-19 mortality metrics and causing unnecessary harm to the American public.

- Data quality was irreparably compromised by the CDC's implementation of the NVSS COVID Alert No. 2 document on March 24, 2020, **which significantly altered death certificate reporting**, as well as the CDC's adoption of the Council of State and Territorial Epidemiologists' position paper on April 15, 2020 **that defined the criteria for COVID cases without safeguards in place to ensure that the same person could not be counted multiple times.** Both practices have significantly affected data aggregation and interpretation, and both adoptions appear to be in violation of the Administrative Procedures Act, the Paperwork Reduction Act, and the Information Quality Act at minimum.

- For the previous 17 years, pre-existing/comorbid conditions were reported in Part I, not Part II, of death certificates—without incident. **By reporting in Part II rather than Part I, the role of comorbidities as cause of death has been deemphasized.** This change significantly impacts statistical aggregation, according to Certified Death Reporting Clerks we interviewed. A point of contention with the 2020 change is that it was made without official notification in the Federal Register to initiate federal oversight and invite mandatory public comment.

Topic area 5 - Inaccurate projection models have been widely used to justify public health policies.

- All computer projection models make assumptions and require inputs. Unfortunately, vast uncertainty surrounds most inputs, especially at the start of a public health crisis.

- Many models assume everyone is equally susceptible to infection. However, susceptibility depends upon variables such as available nutrient status, pre-existing conditions, age, genetic predispositions, socioeconomics, individual mental outlook, stress exposure, restorative sleep, bioaccumulation of chemical pollution, environmental exposure, place of residence, and multiple other factors unique to the individual.

- Many COVID-19 projection models presume the frequency of asymptomatic transmission. The underlying assumption is that such infection *is possible.* However, a 2018 modeling study noted, ***"In practice, incorporating asymptomatic carriers into models is challenging due to the sparsity of direct evidence."***

Topic area 6 - Violations of medical ethics appear to have been perpetuated by the CDC and FDA.

- Withholding evidence-based treatment from 399 American men during the Tuskegee Experiment was evidence of willful misconduct and the impetus for our current medical ethics laws. From 1943 to 1972, evidence-based treatment for syphilis was willfully withheld from 399 participants enrolled in the Tuskegee Experiment. **With this understanding, would the withholding of evidence-based treatments from 332 MILLION Americans during COVID-19 also be considered willful misconduct?**

- Since the **Moderna/NIH clinical trial does not end until October 27, 2022**, and the **Pfizer/BioNTech clinical trial does not end until January 31, 2023**, the experimental COVID biologics (vaccines) are considered to be under investigation for safety and efficacy until the trials conclude.

- **With this in mind, every person has the legal right to decline the use of an experimental product still in clinical trial.** On this point, we must stand resolute in protecting the individual civil rights each person has over their own bodily sovereignty that are protected by existing informed consent laws. This is especially important since **very limited short-term safety data exists, and no long-term safety data exists.**

Topic area 7 - Clinical trials continue while adverse events are increasing each week that experimental COVID biologics are distributed.

- According to the federal Vaccine Adverse Events Reporting System (VAERS), **1,739 people have died** and **38,444 people have experienced adverse events** after receiving experimental COVID biologics for records reported from December 13, 2020, to March 12, 2021.

- The Pfizer/BioNTech clinical trial design measured serologic antibody production post-vaccine administration in Phase 1 only and in fewer than **25 enrolled participants total**. Establishing serologic antibody production is the key to determining the efficacy of the experimental COVID biologic. Considering **this was not done in Phase 2/3 constitutes** a major design flaw of the clinical trial because **the trials cannot demonstrate that the biologic actually provides immunity**.

- Only 40,137 of 43,998 enrolled participants were included in final efficacy analysis. A reason for **3,861 enrolled participants not being included in final efficacy analysis** was unable to be located within the New England Journal of Medicine (NEJM) peer-reviewed publication.

- Only 37,706 of 43,998 enrolled participants were included in final safety analysis. A reason for **6,292 enrolled participants not being included in final safety analyses** was unable to be located within the New NEJM publication.

Conclusion:

The collection of this growing body of evidence demonstrates that an independent grand jury investigation and congressional investigation into the research discussed in our position paper is a reasonable and necessary action on behalf of all Americans.

For a copy of the full position paper, visit: **https://www.greenmedinfo.com/slide/covid-19-restoring-public-trust-during-global-health-crisis.**

You can learn more about the call for an investigation into the CDC's conduct during COVID-19 at **https://standforhealthfreedom.com/action/investigate-the-cdc**.

For questions or inquires, please email **COVIDResearchTeam@protonmail.com**.