The Covid Cult's Attack on Science and Society

BY ROGER KOOPS AUGUST 30, 2021 PHILOSOPHY, POLICY, PUBLIC HEALTH 37 MINUTE READ

My compliments to members of the "Covid Cult." Look at what they have been able to accomplish by instilling such universal panic over a common respiratory virus (that appears to have a comparable overall mortality risk as influenza but with a strong age gradient: severe for older people with health risks and far less dangerous for young people). This was especially amazing since the virus had already been well disseminated throughout the world without revealing anything about which to be panicked before suddenly the Cult seized power.

They were able to tap into the deep well of totalitarian inclinations of "politicians" everywhere and at the same time so clearly demonstrated how they can be led around by the nose. These totalitarians now command the police and armies and they discard and ignore the very laws that founded their countries/states only to introduce personal mandates.

Hence, they were able to create whole prison nations (Australia and New Zealand being the most notable, but there are many others) and semi-tyrannical despotisms (U.K., Ireland, France, Spain, Italy, and many states as well as the Federal Government in the US, Canada, and others) where none existed before.

They were able to enlist, very effectively, most major media in most countries as sources of propaganda and brainwashing, and they have profited from it.

They were able to enlist technology companies as sources of censorship and mind control, and they have profited from it.

They were able to enlist corporations to walk lockstep with you, and they have profited from it.

They were able to enlist "Public Health Agencies" (or maybe they are simply a part of the Cult and needed no enlisting?), and they also have profited from it.

They were able to frighten people into believing that some porous covering on their face could actually stop a virus. Or that by standing that magical distance of six feet would prevent the virus from making it to them. Or that by splashing some alcohol on their hands would protect them. Or by erecting plexiglass between merchant and customer, the virus would be confounded. Or that by staying home and hiding, they would somehow be saved along with the rest of the planet.

Likewise, they were able to convince these people that somehow, suddenly now, everyone that they knew or did not know posed a risk to them and should be avoided at all costs. They were also able to convince them that performing any act of humanity, such as enjoying music, attending meetings, socializing, enjoying specially prepared

foods, going to schools, etc. would lead to the destruction of the human race.

They were well funded from both private foundations as well as government sources.

They were able to pave the way for vaccine companies to really profit. I have never heard of a company making a profit on a clinical trial candidate, yet Pfizer reported over $30 billion earnings from their vaccine even though it was not approved; it was experimental. An approved drug is considered a big success if it earns $1 billion in the first year after approval. Kudos to helping establish a completely new record unmatched in pharmaceutical history.

Of course, their success rate is not 100%; there have been holdouts and escapees; countries like Sweden (and others), and states like South Dakota and Florida (and others). But, like any good Cult, they continue to send minions after them to try and castigate them. I do not think their goal is to bring these renegades back into the fold but it is to serve as a warning to others that may want to try to escape. Try to go against us and we will go after you. That is a typical Cult reaction, so I am not surprised.

But, as clever as they have been, none of it would have been possible if not for a public that was ripe to be had. Like any successful "Con," the audience first has to be conditioned. Here, you may have had some luck because the "conditioning" has been going on for some time. You had it easy.

In 1996, Dr. Sagan bemoaned the ignorance of society in regards to science and technology during an interview with Charlie Rose, just about six months before his death in December. Sagan understood that such ignorance could lead to easy manipulation by the people in power. At about the three and a half minute mark he said, "Sooner or later it will blow up in our faces." Then Sagan predicted an explosion would occur.

He makes another point if you listen on: "Science" is not about what makes us feel good. I will return to this.

The "Technology Paradox"

There exists what I call the "Technology Paradox" (I am not sure if someone has previously stated this in this way so my apologies if so). As technology improves and controls more aspects of human existence, the human being becomes lazier and weakens physically, intellectually, socially, and emotionally. Incidentally, the "Technologists and Technocrats" are not exempt from this de-evolution.

It actually benefits Technocrats if the words "Science" and "Technology" are used together, even interchangeably. Most people do not realize that Science and Technology are not the same things and are not seeking the same goals. Technocrats seem like parasites riding on the back of science. Here is why.

The goal of "Science" is about understanding and a process to seek the truth. In other words,"Science" is a methodology (continually evolving

mostly by trial and error) and as noted by Dr. Sagan, is not intended to make us feel good – it is what it is. It does not give immediate answers. But, it functions best when there is open debate and disagreement.

The goal of "Technology" – what used to be called "the practical arts" –is making human existence easier. So, at least part, if not most, of the goal of "Technology" is to make us "feel good." In this respect, technology is oftentimes at odds with science. But in trying to make life easier and make us feel good, addiction to technology can result, which now makes people more at the mercy of those who control the technology. Yes, technology can become a dependency.

Technology has a basis in science and science makes use of technology so there is an interdependency. Technology can improve efficiency, reduce waste, speed up performance, improve communication, etc. It also can transfer work load, both physical AND mental, from human to machines. Sometimes, these are good things but left unchecked, the result can be disastrous.

The Covid Cult has utilized technology very effectively in attacking, or maybe commandeering, the term "Science". The phrase "Follow the Science" has no relevant meaning in science but it does mean "Follow the Modeling" which is synonymous with "Follow the Technology." Indeed, computer modeling has been confused with "science;" it is not science. Yet, you were able to convince a public that knew no better that somehow science was connected.

When you declared "war" on a "virus," war was also declared on "science."

True science has been banned and labeled "misinformation." True science has been forced into an underground enterprise. This had to be the goal of the Covid Cult because true science has always been an enemy of Cults. Check the history of the despots mentioned above and you will see what people were considered "enemies." "Science" has been hijacked.

The Covid Cult has also been quite successful at following the work of researchers such as Solomon Asch, who in 1951 demonstrated the power of "Group Think" and "Conformity to Delusion."

The Covid Cult has managed to take Dr. Asch's classic experiment, where an experiment was rigged to see if a person would follow Group Think and incorrectly identify a long line as a short line from a set of the two (look it up if you are interested in the details). The Cult has managed to convince many people that the long line is the short line, figuratively, with their narratives.

But, the Covid Cult has had a rather large advantage. Dr. Asch only used local social pressure in a laboratory setting on individuals in his experiment. The Covid Cult has gone far beyond the laboratory and have performed real social inquisitions of people who go against the narrative (usually on the "technology" platforms). This has included threatening jobs and livelihoods; loss of income, education, and social functions; loss of health maintenance and freedom of choice; loss of

friends and family by creating imagined divisions; attempts to lay guilt, and more on those that did not go along with the narrative.

Further, the Asch experiments did not attempt to brainwash via repetition of memes and fear, censorship, or any of the myriad of actions that have emerged in 2020. People in the Asch experiments were not bombarded by signs everywhere saying "Follow the Science" or laced with cute symbols of "masks" and "distancing" and "cleansers," etc.

Clearly, the Covid Cult has successfully used "Group Think" to their advantage through repetitive messaging, censorship, and attacking science, using all of the weapons at their disposal as described above. The Covid Cult has been very effective at making people believe that the "long line" is the "short line."

Dr. Asch would also be amazed. Dr. Asch only exposed the tip of the iceberg; the Covid Cult has exposed all of the subsurface ice.

The Covid Cult has been adept at taking advantage of the dangerous binary thinking that now pervades society. People seem to now think only yes or no, for or against, "In this together" or "selfish," Democrat or Republican, Anti-Trump or deplorable, left or right, etc. Nonsensical options such as wear a mask or make someone die, or take a "jab" or keep everyone in their Gulag have also been at the forefront of the Covid Cult binary mentality.

Binary "thinking" is a trait of computers. Computers are based on "zero" or "one," "gap" or "fill" (the fundamental chemistry of semiconductors), "yes" or "no," etc. It is also the goal of "brainwashing." Abstract thought is not a part of the process and indeed logic and abstract reasoning are enemies of mind control.

The problem is that the world functions 99.99% of the time in the large gray zone. To think that the world functions in a binary mode is delusional. The more you try to force binary thinking into a world that is not binary, the more it is like trying to put a square peg in a round hole. You have to hammer it in with force (with brainwashing). There are many square pegs who are not ready to be pounded into the round hole. If someone wants to call me a "square peg," I consider it a compliment.

Some "Long Lines" that are still "Long Lines"

There are many things that cannot be "canceled," try as you will.

1. Naturally Acquired Immunity (NAI)

Trying to "cancel" NAI by ignoring its existence is like trying to "cancel" ultraviolet (UV) radiation from the sun by ignoring its existence – both are a part of nature and they follow their own rules, not yours, not mine. The human immune system and NAI likely developed because viruses long preceded humans on the evolutionary timeline. In other words, we have been doing an intimate, symbiotic dance with viruses (including coronaviruses) as long as humans and our predecessors have

roamed the planet. If this dance was not mutually beneficial, both would have probably died out long ago, or maybe never even started.

NAI cannot be understood until it is clear what is meant by the term "Immunity." Since part of the Covid Cult tactic is confusion, we need to throw a lifeline into the definition of immunity before it too is morphed into some grotesque concept by the Covid Cult.

Immunity does NOT mean "free of pathogens." Immunity relates to the level of disease that a person may experience due to the presence of a pathogen. Immunity refers to the relative strength of the immune system in response to a pathogen or rather, how much disease one might experience from a pathogen.

There is the pathogen and then there is the disease that results. For example, the Human Immunodeficiency Virus (HIV) can lead to the disease called "AIDS" (after 40 years, still no vaccine). The Epstein-Barr virus can lead to the disease called mononucleosis. The influenza virus(es) can lead to the disease called "the flu."

There are people who have HIV but do not experience AIDS. There are people with Epstein-Barr but do not experience "Mono." There are people with influenza but do not experience "the flu."

If I say that I have some immunity to the flu, I am not saying that the virus can never enter my body. I am saying that my immune system works to prevent me from experiencing the disease that we call "the

flu" after I have been infected by the virus that we call influenza. But it is more than a yes or no (binary) answer.

Immunity can be thought of more as a sliding scale. There are some people with weak immune systems who experience diseases more severely, and people with very strong immune systems who have a weak experience with diseases. Most people have normal immune systems and experience most diseases mildly.

Clinically, it is easier to recognize the extremes (left side can include immune deficiency disorders and right side can include autoimmune disorders). However, the middle ground is more difficult and is very much dependent on the individual. Factors such as age, general health, genetics, diet and lifestyle, social habits, mental outlook, and more can all play a role as to where on the scale you fit.

Complicating matters is the fact that each and every pathogen/antigen has its own "immunity scale" for each and every person. For example, one person may rarely suffer from the flu (influenza virus), but may suffer a summer cold (rhinovirus) each year. Another person may rarely get that cold but will get put out of commission every year with the flu. My immunity scales probably are quite different from another person's scales. During my adult life, I have tended to experience the flu about once every seven years.

For six years, my immune system was able to prevent me from experiencing the disease but the virus was everywhere. Each time I did experience the flu, I had significant life stress occurring. Since stress

weakens the immune system, I was more susceptible to disease. Look back at your own life and make your own evaluation. Can you find a link to stressful events in your life and when you became sick? What about timing?

Each immunity scale for each pathogen also has an expiration date (even those with lifetime immunity – we maybe just tend to die before the expiration date is finished) and that expiration date is different for each person. My expiration period seemed to be about 6-7 years for influenza. Another person might go 10 years and another only 3.

Clearly, immunity is not some binary consideration; it is largely gray zoned.

Your immune system has two major components, the first responders (immunoglobulins, interferons, etc.) and the specific antibodies, the heavy guns or "terminators". With mild pathogens, the first responders tend to be enough. With Coronavirus, this seems to be relatively common.

My experience with Covid was mild so it would not surprise me if I did not actually produce specific antibodies to the virus. My first responders may have been sufficient to deal with it. But, another person may have had more disease and did produce antibodies. In the end, how do we compare? It is not really possible to say. If we both were to encounter the virus again, who has the better chance of less disease?

The immune system strengthens, generally, by exposure to pathogens/antigens. That exposure leads to Naturally Acquired Immunity (NAI). NAI is the most common and strongest form of immunity. But, even NAI is not always helpful.

The rabies virus is endemic in many animals in the wild but is deadly when encountered by domesticated animals or humans because our immune system is "naive" to the virus which means that we have little or no capacity to fight the virus. There is no such thing as "seasonal rabies." There are no "rabies" waves in the population. You are fortunate if you can live your whole life without ever encountering the virus. Fortunately, the virus is a slow starter so vaccines are available to assist the immune system before the virus can take hold. This is an example where vaccines are extremely useful.

So, when NAI is not an option, sometimes we have developed vaccines to assist the immune system. But, there are more known pathogens that do not have a vaccine than those that do. So, we cannot always depend on vaccines.

Vaccines are usually made by weakening the natural pathogen in the laboratory (attenuation) or inactivating the pathogen. The idea for the vaccine is that there remains enough of the key parts of the pathogenic virus available in the vaccine to jumpstart the immune system enough for it to go into action if the real pathogen is encountered (infection) but not so much that it creates the full disease. But, since we all react differently when confronted with a pathogen, we will all react

differently when dealing with a vaccine. After all, a vaccine is only a pathogen surrogate.

The past year has presented a new approach to vaccines, the m-RNA vaccine (messenger-RiboNucleicAcid). This vaccine is a laboratory-created virus using the adenovirus base. That is correct; when you take the m-RNA vaccine, you are taking a man-made virus. This is not an attenuated or inactivated version of the natural virus.

A man-made virus can cause an immune response just like a natural virus. If you suffer from inflammation, fever, or worse after getting the vaccine, you are experiencing vaccine disease. We call those "side effects" only to soften the blow but really, you are experiencing a form of disease. So, there is a new disease that we can call CoVaxED (Coronavirus Vaccine Experienced Disease), in keeping with the 2020 nomenclature.

Further, since the vaccine is meant to mimic the virus, it is possible that you can transmit the vaccine/virus to others. This has been known with vaccines. The smallpox vaccine was capable of being spread to others from the open sore that was the result of the inoculation of the skin. It was recommended that until the "scab" disappeared, that a person avoid contact with another person. Is this possible with the m-RNA vaccines? Maybe, but it has never been examined in the clinical trials.

There are additional weapons in the arsenal in absence of a vaccine and/or if NAI is weak. We can use immune boosting agents such as interferon, immunoglobulins, and monoclonal antibodies that will help

fight the pathogen and hopefully limit the disease. In some people, it will and some it won't, all depending on that immunity scale.

We also have therapeutic drugs such as antibiotics, anti-fungal, and antiviral medicines that will go after the offending pathogen or the opportunistic infections that may occur. Other therapeutics may fight the serious effects of disease such as anti-inflammatory drugs (since inflammation is a serious disease response), anti-fever medications, steroidal medications to repair damaged tissues, etc. These may help some sufferers but may not help others.

What is the ace in the hole weapon that each person has? Individual health.

2. Naturally Acquired Immunity (NAI) as a Superior Form of Immunity

NAI has been understood for decades but it has existed as long as there have been humans. It is a basic concept in human immunology. Over time, we have learned a lot about how NAI compares to other forms of immunity producing options, such as vaccines.

The following table examines what is known about NAI and vaccines for various common pathogens. This table outlines some of the more common pathogens.

Pathogen Name	NAI Immunity Period	Vaccine Immunity Period
Variola	Lifetime	12-15+ years

(Smallpox)		
Varicella (Chickenpox)	Lifetime	Unknown
Poliomyelitis (Polio)	Lifetime	1st Dose: 4-5 years 2nd Dose: Unknown
Rubeola (Measles)	Lifetime	Long Lasting (but not lifetime)
Rubella	Lifetime	15+ years
Rabies	Unknown	Unknown
Influenza	>1 year (depending on variant)	<1 year
Rhinovirus	>1 year (maybe)	NA (No Vaccine)

In almost all cases, NAI has been demonstrated to have a much longer immunity expiration period than the vaccine (and these have been the best case scenarios). Rabies is somewhat of an exception since people who experience rabies without a vaccine tend to die. There may have been people who have survived rabies but it is so rare that medical science may have no record of this.

So, we do not know how long immunity might last in a person who survives rabies, if someone were able (I do not want to volunteer for this one). Further, a person who is given the vaccine for rabies because they have been exposed may never be exposed again, so we do not

have much data as to how long the vaccine immunity lasts. In domestic animals, the period is assumed to be about one year for vaccination.

The difference between the pathogens that give lifetime NAI and those that do not is due primarily to the type of pathogen. Human-only pathogens that produce little or no variation will give much longer NAI periods. This is one reason why both NAI and vaccines for respiratory infections (primarily influenza) have much more reduced periods. They tend to be mammalian viruses, i.e. viruses that are shared. They also change quickly as they go through populations (variants).

The fact that a virus is shared with many other mammalian species does not necessarily mean that we become infected directly from some species. Just because Coronavirus can be found in cats, for example, does not mean that your cat will infect you with the virus (but, there is no data that can rule it out either). The fact that the virus can infect your cat, however, does give a breeding ground for the virus that can keep it going. The result is that the virus has a much broader base of survival and opportunity to mutate or vary in order to survive (variants). We share respiratory viruses because all mammals share the same respiratory chemistry. We all breathe air to survive.

The following Table illustrates the variant issue quite clearly with respiratory viruses.

Main URI Viruses and Characteristics

Virus	Size1nm	Family/Type	Morphology
Influenza	80-120	OrthomyxoviridaeNegative Strand RNA	EnvelopedHeli
Coronavirus	50-120	CoronaviridaePositive Strand RNA	EnvelopedHeli
Rhinovirus	30-80	PicornaviridaePositive Strand RNA	NakedIcosahe(

1. nm=nanometer (1000 nm=1 micron). 2. Season of peak occurrence. 3. Human and Mammalian, actual numbers unknown

Although there have been attempts for decades to try and develop vaccines for rhinovirus and Coronavirus, they have not been successful because of the variant issue. We may be witnessing that reality even now with the Coronavirus vaccines.

Influenza vaccines were started in the 1940s. Yet, even today the effectiveness of any influenza vaccine can be predicted as less than 50%.

3. Naturally Acquired Immunity (NAI) may be Dominant on the Planet.

The Covid Cult has been trying to ignore or "cancel" NAI and refusing to recognize a very large swath of the world population that has already experienced Coronavirus and Covid. I am not sure if this is directed at trying to force vaccines on populations, although I suspect that is

maybe the case in part. By "canceling" NAI, the brainwashing propaganda is that the only way to get some immunity is from a vaccine (the WHO even edited its website to that effect).

Based upon seroprevalence studies conducted mainly by John Ioannidis, between 30-40% of the Earth's population has likely experienced the Coronavirus (by early 2021) labeled SARS-CoV-2 and had some form of Covid-19 based upon their position on that scale of immunity. Many of those people did not notice much in the way of symptoms or the symptoms were so weak that they were dismissed as nothing special. Some people experienced noticeable symptoms, maybe more like a moderate "cold" (my experience) lasting a few days. Some people experienced more profound symptoms more like a "flu." Some people became sick enough that they went to see a doctor.

Some people experienced enough serious disease where they had to go to a hospital and maybe some of those were admitted, but later recovered and were released. Some people eventually died (approximately 0.1%).

That means that a significant portion of the people on the planet already have had an experience with the virus and probably have a form of NAI that is likely superior to any vaccine. This is news that the Covid Cult does not want people to know.

We do not know when this virus began but it was long before December 2019, as has been assumed based upon the announcement from China. It was probably at least as early as September 2019 or even

earlier. The earlier the timing starts, the greater the NAI in populations around the world. The result of this is clear. There has been less serious disease and attempts to create a vaccine response.

4. The True Coronavirus Vaccine Efficacy Cannot Be Ascertained from the Clinical Trials.

Note: As I write this, I have learned that the regulatory arm of the Covid Cult, the FDA, has approved the Pfizer vaccine. This is disappointing but not surprising because it essentially was already "approved." What would have happened had the FDA said "no" after this long of forcing the vaccine on people around the world? The FDA painted itself into a corner very early by granting EUA. I do not think anyone is surprised by this approval; it was inevitable. Even if the adverse events deaths were in the millions, the FDA would have approved the vaccine.

The number that is being thrown around by the Covid Cult is 90-94% efficacy for the m-RNA vaccines (although that number is now diminishing over time to as low as 60%). These numbers are very misleading and are calculated by simple computer algorithms that assume a homogeneous population and ignore NAI. The actual efficacy cannot be determined and, at best, may not be determined for several years.

My reasoning for this is as follows.

A vaccine is considered a "prophylactic" or something that is given in advance of disease; it hopefully will assist the immune system and either prevent or minimize disease. A vaccine is intended to be given before exposure to the pathogen in order to allow the immune system time to develop some form of immunity.

This is different from a normal drug therapeutic (DT), which is intended to work after you have the disease.

In a clinical trial for a DT, you have a clearly identified group of patients with known levels of disease in both active and placebo groups. You then monitor, with administration of the DT, clearly identified markers of disease between the two groups to see if there is a significant impact, i.e. disease reduction, from the DT as compared to a placebo. For example, in a particular cancer therapy you might measure reduction in tumor size, or reduced timing of spread (metastasis). This is a "positively" controlled study. That is, you can actually measure a response.

A clinical study for a vaccine is completely different. With a vaccine, both active and placebo groups are not sick or infected but are healthy (presumably). The goal of the study is to demonstrate that the healthy remain healthy. It is trying to prove a spurious negative; that is, that no disease or less disease are indicators of vaccine effectiveness. This has typically been why vaccine trials focus more on safety. Efficacy is very, very difficult (maybe impossible) to prove in human trials.

There are several inherent flaws in vaccine trials that limit any interpretation of the data. These flaws have been quite pronounced but completely ignored with the Covid vaccine trials. I have reviewed the trial summaries (full data has not been made available) directed at the m-RNA vaccines. To summarize, approximately 30,000 (plus or minus) participants were chosen with about half in the active arm and half in the placebo arm. The study was conducted over a series of 99 sites. The mean time to evaluate was 2 months; that is, the participants were examined for signs of Covid up to an average of two months after the second dose (based upon either symptoms and/or PCR).

The actual number of "positives" in both active and placebo groups was pretty low, less than 1% of the participants in each arm. The "active" group had fewer positives than the placebo group. But, does this indicate efficacy?

Flaw 1: The most significant flaw in these vaccine trials is the lack of homogeneous participants. If the goal is a measure of whether a person experiences Covid within the mean 2-month time frame, there can be no relevance between any of the participants. The reason is that you would need to maintain a homogeneous risk of exposure for all participants in both active and placebo groups in order to draw any conclusion. That is, all participants have to have exactly the same risk exposure to the pathogen. That can never be assured.

For example, suppose that the active group participants had fewer "positives." But, what if more of the active participants lived in areas where the virus was minimal or nonexistent? What if more of the active

participants had lifestyles that reduced their risk to exposure naturally? Conversely, what if more of the placebo group participants lived in areas where there was more active virus and the exposure risks increased?

It is true that the study was double-blind randomized meaning that at the time, no one knows who gets what (volunteers and medical administrators do not know). But, with 30,000 participants over 99 sites, there is a real possibility that the exposure risks could be heavily skewed. Of course, it is also possible that the skewing made the efficacy look weaker than it would be. In other words, without a truly controlled exposure risk profile, we cannot interpret any data that was obtained. Thus, the data could actually show a much lower efficacy or it could show a higher efficacy. My opinion is lower based upon previous experience with these viruses but that could be a wrong assumption.

This flaw is the same flaw from the original computer models as to disease risk. The original computer models assumed the same disease risk in everyone, even though that was obviously not the case.

Flaw 2: Study Timing. This was another critical flaw with the Covid vaccine trials. The studies were performed during the summer of 2020, well after the pandemic had been going for several months, maybe almost one year. They were performed when viral infections/transmissions were definitely on the wane. The vaccines were also based upon the original genome (presumably), which may

have no longer applied (due to variants). That means that you are dealing with a shrinking population that was truly "naive."

Flaw 3: The studies excluded people who had been confirmed with prior Covid-19 (reliability?), but they did not exclude prior experience with other Coronavirus variants, such as the original SARS. We know that there is cross-immunity protection from the other variants of Coronavirus. Did this skew results?

Flaw 4: The Binary Nature of the Endpoint. The trials were looking for disease/no disease as an indicator. The fact is that vaccines and the immune system work on the sliding scale. The initial trials did nothing to try and examine if the vaccines reduced disease severity (at least I have never seen any data released to support that claim). So, severity of disease is just as important but was never a part of the trials because that would complicate the efficacy claims. For example, suppose that the placebo group was confirmed to have the virus at a rate 2x (double) more than the active group. But, what if the severity of disease (more hospitalizations and medical interventions) in the active group was greater than the placebo group? What conclusions could be drawn about the vaccine? That sort of data MIGHT indicate no effectiveness, or if the data were vice versa, might indicate better effectiveness. But this evaluation was never part of the trial.

Flaw 5: Dosing. As far as I have seen, there has been no data to support the "dosing" regimen of the vaccines. Surely, you would want to compare a single dose group as well to see if a single dose has an effect. This was never performed. The study only included double dosed with

single dosed individuals dropped from the study if they could not continue to a second dose for whatever reason. That is a cardinal sin in clinical trials; you always want to have data related to dosing.

Flaw 6: Discontinuation of the study. After "unblinding," placebo volunteers were offered the vaccine. This is oftentimes done with DT as a therapy option but I have never seen this with a vaccine trial. What that means is that the placebo group has been either diminished or lost so further insight into the possible immunity period that is offered by the vaccines, long-term health and safety effects that may arise, etc. are not possible. In other words, those trials offered no data beyond the 2-months, double dose scenario. There is no other data to support this limit on the vaccines.

All of these flaws should have been of major concern during the FDA review in 2020 but apparently were not considered or considered and ignored. Clearly, the FDA is not interested in examining these flaws. Could that be because the former head of the FDA now serves on Pfizer's Board? Was that a "reward" for a job well done for Pfizer?

Vaccines tend to have something called a "challenge study" where you give a "test subject" (one who is immune naive to the pathogen) the vaccine, in a controlled environment and protocol, and wait for the appropriate immune response time. Then you expose the subject to the pathogen and see if they develop disease, or you measure the factors of immune response.

The "test subjects" that are used are animals because medical ethics prohibits the use of a "challenge" on humans. It is considered unethical to expose a healthy person to a pathogen with no assurance that harm would not be done. I have not seen the challenge study data so I cannot comment on those results. I have read accounts that these challenge studies were not performed at the time of EUA, but I cannot confirm that as the case. If that is true, that is another huge error in how vaccine trials should be performed.

But, there is a final efficacy problem and we are seeing that result now. That is, the URI viruses rapidly change (variants). This is a major reason why the influenza vaccines have poor efficacy and why there have never been vaccines before 2020 for coronavirus and why there remains no vaccine for rhinovirus.

There is also the "X" factor. The m-RNA vaccines are a new technology. They are laboratory created viruses using a virus substrate base (adenovirus). The complete failure by the FDA to do its job means that we may never get clear data as to whether these "vaccines" are safe (and the data is dubious on safety) and effective (no data). As mentioned above, we do not even know if they can be "transmitted" to others like any other virus.

5 . The Coronavirus may be already endemic

This version (2020) of the Coronavirus may already have become endemic; that is, it has become a normal part of our living environment, just like rhinovirus and influenza. It means that you may sometimes

experience it and sometimes maybe not. There may be stronger seasons and weaker seasons, just like influenza. Learning to live with it is natural just like we live with influenza and rhinovirus. The best thing an individual can do is maintain their own health.

It also means that the same group of people will be at risk for severe disease. Age plus serious health conditions is always the recipe for more severity with any pathogen, including respiratory viruses. Year after year this will always be the case.

Elderly people in rest homes are and always will be vulnerable because the immune system naturally weakens as we age. We start the inevitable slide to the left side of the immunity scale as we age; that slide quickens if we have other health issues (see below). But, it goes beyond aging because they also tend to be isolated. Isolation also weakens the immune system.

It will happen to me and I guarantee that it will happen to all.

The FDA has the authority to grant the use of a drug candidate that has not been approved but is in clinical trials. This is called "Emergency Use Authorization" (EUA) and is also referred to as "Compassionate Use." The term "Compassionate Use" actually describes the reason for this exemption from normal approval procedures.

In cases of severe disease, often a terminal disease such as cancer, a patient and/or their physician can petition the FDA for an investigational drug. There are restrictions on this usage such as:

- The condition is life-threatening or severely impairing/life altering. [Covid has a survival rate of about 99.9% overall with even greater rate in younger people]
- There are no alternative treatments available or all alternative treatments have been tried with no success. [Most people do not even seek medical help with Covid. For those that do, there are treatments available. Most people die from pneumonia or another bacterial superinfection, all of which have several treatment options.]
- The patient is facing the worst case outcome (that is, their condition is not stable and they are deteriorating). [Patients in this condition will not benefit from a vaccine].
- The patient must be provided with and approve an "Informed Consent" having been informed of all of the known risks of taking a clinical candidate [How many people were given "Informed Consent" with Covid vaccines?].
- The manufacturer or Sponsor of the drug candidate is not held responsible for any serious event. That is, the patient assumes the risk when accepting "Informed Consent" (true with Covid vaccines).
- The patient can always refuse without prejudice (does this really happen with Covid vaccines?). The physician can make the request but if the patient says "no;" that is the end of the story (unless the patient has been declared unable to make their decisions and an appointed guardian makes the decision).

The EUA program is a good program when applied appropriately, which it traditionally has been – except 2020.

Compare the intent of this program to what has been done with the 2020 Covid vaccines. Do you think that the EUA was supported? One could maybe make an argument for the most at risk; elderly in institutionalized care. But, even that could be a stretch since the majority of the at risk people still survive.

Infection with Coronavirus does not equate to death. It does not even equate to hospitalization. It does not even equate to medical intervention. It does not even equate to serious disease experience.

Vaccine Mandates and Passports

The idea of a vaccine "passport" (of sorts) is not new. In very specific cases, people have not been allowed to travel due to the possibility of being exposed to a pathogen that they may have not encountered or by exposing others to a virus that they have not encountered (such as going to remote areas for research of primitive peoples). In those very well defined cases, sometimes people were required to be vaccinated. Sometimes it is a recommendation rather than a requirement.

But even if required, the person had the option to vaccinate or not. Not vaccinating meant not being able to travel to a susceptible population or not putting your own health at risk. It had no other effect on your life. You could still go to movies, restaurants, etc. and live a normal life. You could still travel to almost any other place in the world.

For example, when I came to Japan many years ago I was aware that Japanese Encephalitis was common. It is a Flaviviridae virus that is spread by mosquitoes. Mosquitoes love me. There is a vaccine available

for this virus. But, I was not required to get the vaccine before coming to Japan. Encephalitis is a more serious condition than a respiratory infection.

The rationales that were used for previous vaccine passports do not apply to "Covid." Here are some of the most important reasons, again:

1. All of the world, essentially, has been exposed to the Coronavirus responsible for Covid. So, the concept of introducing something new and dangerous does not exist. The "Delta variant" seems to be the next evolutionary stage and is everywhere where Covid-19 has been so you are not preventing anything (have you wondered why seemingly every place has a "Delta variant" with all of the travel restrictions?).
2. NAI is prevalent in all societies around the world and is superior to the vaccine which is proving to be more and more ineffective. It is not the unvaccinated who are a "risk." The same risk resides with everyone but NAI has a better success rate than vaccines. The data favors NAI people as less risk. NAI people do not benefit from a vaccine.
3. The most at risk segments of society are going nowhere. That is, the elderly people in institutionalized care settings are not going to be going to restaurants, concerts, theaters, sporting events, etc. They will not be flying on commercial international flights around the world. If there is such a thing as a "vaccine passport" for Covid, that is the segment of society that it should be meant for (assuming the vaccines are even effective). But, it has no

meaning because it is like issuing a driving license to a person in a coma.

There are several certainties that we can say about any "vaccine passport:"

1. It DISCRIMINATES totally against healthy people and people who have already had the virus. People with NAI do not need a vaccine and as we have learned, NAI is almost always superior to vaccines. In fact, it is the people with NAI that you should WANT out in society since they are best equipped to protect others because of their strong immune systems.
2. Since vaccines, even under the best of circumstances, have no influence on the pathogen, the "vaccine passport" will have no effect on virus mitigation (zero virus is a delusion) or transmission. The vaccine may only have some effect on how the individual responds to the virus. Maybe they will be less sick than if they did not get the vaccine but since that was never examined in the clinical trials, we have no data to support it.
3. There are many other pathogens that have been ignored due to the obsession with Coronavirus and with the crazy "mitigation" ideas that do not mitigate. Here in Japan, Respiratory Syncytial Virus (RSV), a lower respiratory infection, is on the rise as is tuberculosis (mycobacterium) and believe it or not, hand-foot-mouth disease. These are becoming serious situations in both adults and children, as well as more common ailments such as pneumonia, sinus infections, eye infections, gingivitis, staph infections of the face, mouth, and nose. These all may be linked

to excessive mask wearing. What does a "vaccine passport" do to actually deal with the serious risks? Nothing.

4. It is completely totalitarian in concept and purpose.
5. It is unconstitutional to the core.

The Children

The children around the world have been harmed beyond description by the Covid Cult. I would describe it as mass child abuse and I do not understand how anyone can accept this situation.

Actions such as:

Microbiological Accumulating Symbolic Kerchiefs (MASKS): Weakens the developing immune system; exposes the wearer to more intense pathogen risk (viruses penetrate but can accumulate; bacteria and fungi can multiply-see above); exposes others to the same pathogen risks as the wearer; stunts social and communication growth; increases carbon dioxide reinspiration leading to hypoxia which can damage brain cells; social isolation and depression; etc.

School Closures: Stunted educational development; lack of social interaction; increased domestic abuse; reduction in nutrition especially in minority and low income areas, to name a few.

Stress: Social and emotional stresses are evident in many children and young people. What weakens the immune system? Stress. This will make the children more susceptible to disease than they normally would have been.

Children have a lower risk of adverse outcomes than even from influenza. Yet, children today are being condemned to a future of a lower life expectancy than their parents and grandparents. Everything that is being done by the Covid Cult will weaken the youth of today and make them more susceptible to pathogens, mental illness, and hosts of other diseases. For this, the Covid Cult should not only be shamed but "cancelled." This really is child abuse on a worldwide scale.

But, it is even worse than just lowering life expectancy because the quality of life will also be reduced. So, they will have fewer years with less enjoyment, but maybe they will be addicted to their technology giving them some warm and fuzzies.

That is what Cults do, isn't it?

The Covid Cult's obsession with Coronavirus is really the sign of both a group mental aberration and a Cult. But it has "cancelled" sensible health education only to drive the cult narrative.

Obesity (BMI >30) is the number one contributing comorbidity to virtually any disease process, not only pathogens, and certainly that has been the case with Covid. The world's obesity leaders (countries with significant populations) are the U.S. with about 40% adult obesity and the U.K. with about 30% adult obesity. The low ranking countries are in Asia; Japan with about 5%, China about 10%, and the other Asian countries hovering between 5-10%. Western European countries rank between about 15-25%.

Even with many of the policy issues that muddy the waters concerning cases and mortality, it does not take a rocket scientist to see that in societies that do better on the obesity scale (lower obesity), Covid has had less of a disease and mortality impact.

Forcing people to sit in their homes is only going to increase their risk of severe outcomes when they encounter a disease of any type. Closing gymnasiums, stopping recreational activities, and giving them only technological devices as their alternate sources of "diversion" will only make their fat asses fatter. Creating social and personal stresses and fear will only make people seek "comfort foods" and alcohol, which will only make their even fatter asses fatter still.

The one credit that I am willing to give to the CDC is that they have tried to give warning to the prevalence of obesity in not only the US society but around the world.

If a person chooses the obesity pathway, that is their choice. But, they must be prepared to accept the consequences. The responsibility lies with them, no one else. There is enough information available to everyone to understand the dangers of obesity.

For the record, my BMI is between 25-26 (borderline overweight for my height and age) and is slightly inflated since I am a weightlifter so I have a little higher muscle mass than someone my age (60s). My waist size is 33 inches and I can see my toes. I have tried to maintain as much exercise as normal during the past year and a half but I also have to deal with gym closures at whims of officials. I have made extra attempts to

compensate for these actions. My weight has not fluctuated in over 10 years but during the last one and a half years, my weight has been about 1 kg higher than normal despite all of my efforts.

I know that the impact is real and it is more challenging to deal with your own personal health with all of the craziness; but do it. But, do not listen to the Covid Cult because they are not interested in your health.

If the "Public Health" gurus really were interested in "Public Health," they would actually be encouraging "Public Health" rather than the long litany of things that are actually "Anti-Health."

Now is each person's time to decide. There will always be a new variant, there will always be a new mandate, and there will always be the new carrot dangling on the stick in front of your face (like the booster jab) only to be pulled away again. You can acquiesce to this conditioning and reorganize your entire life around the principle of avoiding this one pathogen while giving up all expectations of freedom. Or you can resist the propaganda, get informed, and join with those who are working to rebuild after the disaster of the last year and a half.

Author

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