(Photo by Marco Cantile/LightRocket via Getty Images)

The Covid Physician's true coronavirus timeline

"My experience is no one but the government and mainstream media are sharing apocalyptic Covid-19 death experiences with me"

ARTILLERY ROW
By
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Valentine's Friday, 2020. A quarter century practising medicine. Half in hospitals, half in general practice. I'd been treating unseasonal, politely-coughing, relatively-well patients for the previous two and a half weeks.

Extraordinarily, on Saturday at 4am I was abruptly awoken by uncontrollable, whole body, flailing movements. They continued without relent for 5 hours. I'd hypothesised I was having a *grand mal* seizure, but as I lay violently shaking and goose-pimpled I coldly concluded I was conscious, so these were rigors. I'd witnessed two in my career one as a naïve house officer on a medical ward, and now the second in the comfort of my own bed. It wasn't my last hurrah.

Two Paracetamol, two duvets, two days of bad diarrhoea and I returned to work Monday, a few pounds lighter and clinically puzzled. This was no ordinary fever. As it happens, two other GPs in my vicinity later described similar contemporaneous symptoms, and we all tested negative for Roche's Covid-19 antibody assay 4 months later. That, however, is not so meaningful since most people are thought to clear the virus without the need for specific SARS-CoV-2 antibodies. On top of this, in PHE's own studies, Roche's test demonstrated only 83.9 per cent – 86.7 per cent sensitivity, so it was missing 13-17 per cent of true positives.

How many are still dying of perfectly treatable illness?

There are two arms of the cellular immune response. The immediate, innate system (no specific antibodies required), and the delayed, adaptive immune system (B and T-cells, and specific antibodies required which may or may not persist after the infection). So, no antibodies does not necessarily equate to future risk. 10 per cent of us may raise antibodies in response to the acute infection. We could die in the attempt. 90 per cent of us might deal with the infection innately, yet have nothing but our healthy, vigorous lives to show for it. A vaccine may not work, it may not be safe to some, it may raise antibodies but still not work. It may raise antibodies and make matters worse by 'pathogenic priming' and enhancing any future infection. These are all normally valid medical points, but I do not feel our government

likes doctors and scientists making these anymore. The normal medical and scientific truths of our time feel radically heretical to modern day Dr. Galileos.

Something very odd was going around. I don't usually get ill on the job, and I have never had the influenza vaccine. As many doctors might agree, to our families' inconvenience we become ill as soon as we switch off, relax, and take a holiday.

What was even odder to witness was the surreal lock-stepped, global lockdown that began around March 2020. Same language, same procedure, same time, no independent engagement of resource nor intelligence, no bespoke solutions. All but Sweden appeared to fall into a blind panic. The theatrics of lockdown on 26th of March did affect me, I was ejected from my accommodation and struggled to find anyone willing to take on a walking NHS repository of certain viral death. I returned to work in a single-handed practice with a deep dread of the cataclysm that would befall me and my community. No such thing happened.

I recall the fear of the clerical staff. They furtively asked why I wasn't wearing a mask – remember this was the early days of PPE shortage, with no government mandate of general mask-wearing. My attitude was flimsy clinical masks were of no real effect, and besides risk of infection is part of the job description. However, I quickly succumbed to their unease to avoid the inevitable escalating inquisition and workplace disciplinary. I learned quickly, knowledge and experience were now nullities.

I had the easiest 3 months of NHS practice in my life from March to June 2020

Frankly, if it had not been for mainstream media and the government, I would not have even noticed there were a pandemic. I experienced no excessive dying, and no excessive becoming seriously ill. Since January, I have worked in three different general practices across England, in two regions. Accumulatively, they contained over 16,000 patients. Up to my last time of asking in September 2020 there had been many well Covid-19 "swab positives", and only 5 deaths "with" a Covid-19 "swab positive". Those 5 deaths were all white, over 60 years, with other co-morbidities.

In the BAME-dominated practice of nearly 6000 where I work with the most deprived, the poor, the homeless, addicts, and migrants, no one was known to have died in association "with" a Covid-19 swab-positive test.

In the practice of 1800 where I worked through the inception and peak of the pandemic, only two people died of anything between January and July. These two were expected deaths of metastatic terminal cancer.

Enough has been said on statistics and science to convince the current government response is disproportionate. Yet most governments dismiss it all with incredible contempt. Clinical experience is as equally relevant as the statistical manipulation and science. My experience is no one but the government and mainstream media are sharing apocalyptic Covid-19 death experiences with me. I don't see it in my clinical practice as a simple GP.

My attitude to the government pandemic advice hardened significantly when I received the CCG (Clinical Commissioning Group) advice on pyrexical over-70-year olds in the community: do not admit them. If they get very ill, call the Macmillan nurse and palliative care team. This was my first sniff of the new-normal clinical lunacy. It was redolent of the

swine flu panic where in 2009 we were negligently told to prescribe novel anti-viral medication to anyone on the basis of the slightest raised temperature, regardless of better alternative diagnoses. A reasonable body of doctors would never do this under sane conditions.

I did research. Given my older patients were to be left at home to sink or swim, I concluded that the very safe hydroxychloroquine, zinc and azithromycin combination was worth trying in the best interests of those marooned patients. I was blessed to have my own NHS dispensary and quickly ordered the medications. That was when the second whiff of madness was caught: the gas-lighting mainstream media was repeatedly telling me it was very dangerous, they were lambasting my brave and learned international medical colleagues for daring to say anything but a vaccine was effective in mitigating Covid-19. Our CCG pharmacist emailed all GPs to ask us to not prescribe hydroxychloroquine in suspected Covid-19 cases as this would diminish stock for the usual rheumatoid and lupus users.

My older patients were to be left at home to sink or swim

As it happens, such was the lack of community cases of clinically unwell Covid-19, I never had to use the triple therapy. The closest I got was when a very feverish lady in her 80s was being left to probably die of a severe sepsis. She was refused hospital admission. At that time, I was not allowed to see her, as we had a dedicated coronavirus "red hub" to remotely triage queried coronavirus cases to. Its guidelines had concluded temperature equated to coronavirus, which in turn equated to no hospital access allowed for over-70s. This was my third experience of what was now a reeking stench. Fortunately, her home-help called me to notify me of the ensuing danger. I assessed the situation remotely and concluded that the clinical logic of the red hub was wrong. The most likely cause was line sepsis (she had an in-dwelling feeding line in a major blood vessel). I spoke to the red hub and the hospital to explain that the guidelines were fatally negligent. They took her in, and line sepsis it was. This simply required a new line and intravenous antibiotics. She survived to re-join her husband, but how many are still dying of perfectly treatable, potentially fatal illness?

The fourth time, I was called by a Macmillan nurse. She had been delegated the responsibility of persuading me to prescribe a cancer drug without due normal clinical process by the Consultant breast surgeon, who presumably was instructed to avoid doing his job at all costs. The nurse explained to me the lady who had a very large breast lump diagnosed in hospital just before lockdown was somehow neglected to be assessed for 5 weeks, presumably because of lockdown. Here's where it got more distressing. She said the consultant would not be able to see her for at least 3 months. Would I see her and confirm there really was a lump and prescribe a speculative breast cancer treatment? Normal protocol would be a two-week maximum wait for a cancer specialist and biopsy. Then a treatment plan, usually some combination of a biopsy-determined hormonal medication, radiotherapy, surgery and chemotherapy.

In her case, they wanted me to provide speculative hormonal medication without any real prospect of review, confirmatory biopsy nor other intervention for at least 3 months.

Moreover, I was told by the nurse that the poor dear did not even sound all there over the phone. Inference: doesn't really matter what she thinks, she's old and it's a hopeless case.

We all are being policed into wearing any old ineffective rags over our muzzles

I did see her. The old dear was *compos mentis*, and she agreed that she did not want a speculative treatment for which I had no qualification nor experience of initiating. I informed the palliative care nurse I would not do her delegated task. Eventually, without confirming they had back tracked the cancer team saw her for themselves a few weeks later; but both I, the patient, and her daughter had to dig our heels in deeply. How many patients are still languishing with advancing cancer due to a litany of permissive state diktats? Look at section 11 of the unbelievably quickly drafted *Coronavirus Act 2020* on medical indemnity during coronavirus. Does it mean extra indemnity or extra protection for medics, the NHS and the government against the most unforgivable clinical gross negligence during the state-determined pandemic measures?

At this time the shock and awe of the terror and OCD-inducing state mind-programming triad, of *don't touch your face, wash your hands and stay away from other humans* was wearing off. I'd had my fill of hospital NHS TikTok videos and being needlessly back-slapped and clapped for.

In fact, for once in my career I had nothing to do, except keep patients away from the practice, fob them off on the phone, and see the odd one at my own choosing. They were all very understanding, and even thanked me for it. Everything was, in a sense, either coronavirus or not an absolute NHS problem. I now reach into my bag first for a headset, and rarely touch my stethoscope. I am losing my hands-on clinical skills.

Our mission: save the NHS by neglecting ourselves and the NHS. I received numerous CCG advice and flow-charts on the coronavirus-centric mass processing of patients. Most of it was about whom not to see, and who could pass the pearly gates of the hospitals. Then there was the advice on the parallel IT and video-consultation medical industrial revolution: our new NHS normal.

Then there was the circular from the British Medical Association (BMA) received on 22 April 2020 reminding us that we did not have to be that sure to write Covid-19 on a death certificate, simply to the standard of the best of our knowledge and belief. The BMA went on to advise:

In those cases where the doctor is confident on medical grounds that a particular cause of death is likely then that should be entered on the MCCD (Medical Certificates of Cause of Death). Covid-19 is an acceptable direct or underlying cause of death for the purposes of completing the MCCD, even without the results of a positive test, and it is important that likely Covid-19 deaths are reported as such via the registrar.

That was highly irregular, what's to say without testing it wasn't equally likely to be 'flu, or pneumonia like most winters? We now know even a positive test doesn't help diagnose with any confidence.

My trust started to erode in March 2020

Unless you are one of my maximum, lucky two given the golden ticket each morning or afternoon, if you wish to actually be seen and be examined by me these days, go private. For the right price they'll see all of us and pass us on the extra coronavirus-related costs, while we all protect the NHS. To see Sir Simon Stevens CEO of NHSE be tweeted saying, to paraphrase – "*you thought Covid-19 was bad but wait until we ram climate change down*

your throat" simply beggars belief. Isn't this over-ambitious and a slight over-reach of his remit? Surely, he should concentrate on concluding his five-year NHS plan: stealthily privatising the NHS under the helpful cover of the pandemic, *before* joining Greta Thunberg fear-pushing the global green agenda?

I had the easiest 3 months of NHS practice in my life from March to June 2020, no wonder all those apart from in ICU were smiling, laughing, and apotheosising the NHS on social media. This was their first real break in 70 years. They genuinely felt they deserved it. Then, a strange thing happened in an already strange time in June 2020. Bad stink five. I received an email from the CCG. Cascaded presumably by the BMA to every CCG and GP in the country, simultaneously. I was fed their pro-BLM message, and invited to click on a link where I could donate to the neo-Marxist trained BLM leaders via a US Democrat party central-funding company, ActBlue.

How very odd. I had not yet received one email on the pathophysiology of Covid-19, not one email on life-saving potential early community interventions and treatments (maybe more on these another time). Nothing. Yet here was priority number one in the pandemic apart from systematically neglecting my patients: dip into your pockets, doctor. Donate to the statue-toppling, English heritage-bashing, and lockdown-breaking SARS-CoV-2 spreaders-in-chief.

While I was twiddling my thumbs, feet on my desk, and frankly disturbed by the BMA's endorsement of BLM's critical race theory. I began to ponder, to review what had actually happened. Everyone had been in shock, on autopilot.

My senses and faculty of independent, critical thinking had begun to return. I began to think deeply about basic medical sciences, cause and effect, Koch's postulates and normal clinical diagnosis and practice.

What was actually going on here? Ostensibly and hitherto, the government, moreover the WHO, was asking me to suspend my medical training, my clinical disbelief and *trust them*.

I started to look at the clinical timeline. There were many decisions made that did not sit comfortably with my medical sensibilities.

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My trust started to erode in March 2020. Public Health England (PHE) had wisely classified the SARS-CoV-2 entity as a "highly contagious infectious disease" (HCID). This brought it in to the infamous company of long-gone worries such as SARS-CoV, MERS-CoV, bird flu and Ebola virus.

However, the PHE had strangely declassified SARS-CoV-2 from being a highly contagious infectious disease to a non-HCID on 19 March 2020. It seemed to them to no longer merit the company of SARS et al. This was few days before the UK lockdown regulations of 26 March 2020 when the whole world was implementing the most draconian pandemic measures ever. That's an odd timeline. I asked PHE, why? It replied that it was because by 19 March 2020 they knew it was not as fatal as it was first thought. Wasn't that a bit rich? Surely, declassification did not make government sense on 19 March?

My own view is that there was perhaps a different agenda. There was a PPE (I must here confess, like most, I had not come across this term, before) shortage in March, it was a massive political problem. The government was just resiling from a herd immunity approach (more's the pity, in my opinion). Was PHE in more control of advising on the pandemic and matters such as PPE while the bug remained classified a HCID? The government was in a panic trying to requisition all available PPE to the clamouring NHS. Perhaps not recommending masks to the public and nursing homes whilst recommending them for hospitals for an as yet unquantified, airborne, respiratory HCID was a cognitive and scientific dissonance too far for someone at PHE?

Was the quickest way for the government to take control of the coronavirus narrative to have PHE declassify SARS-CoV-2 from its HCID category? Perhaps this explains why after the event we all are being policed into wearing any old ineffective rags over our muzzles. Most of the public still falls for it. I await the day the government edict to not wear masks comes (*if* it ever does). Most obedient citizens will stop without question, suddenly and miraculously feeling safe. The mask totalitarians – those who use incorrect mask etiquette as a proxy for some other odious social prejudice – will have to hide again. Some poor souls will never stop wearing them. Some may never re-emerge from their homes.

In the 1980s we were terrified, mostly via innuendo, by the Thatcher government's "Don't die of ignorance" AIDS campaign. I worked through BSE (1995-97), SARS (2003), swine flu (2009) and MERS (2012). That was all pre-2013, and pre-PHE. Before PHE, we had the more independent and expert *Health Protection Agency* (HPA) to help us. It ran the public health labs and the civilian arm of the biological warfare centre, Porton Down. The HPA was deconstructed by the Cameron-Clegg coalition (as was much else of the NHS) by the *Health & Social Care Act 2012*. HPA's health protection duties fell to the hands of the new quango, PHE with the added distraction of general population "health improvement".

It appeared to me that we had blind trust in China and the WHO

It has been well-documented by Parliamentary Under Secretary of State for Public Health and Primary Care, Steve Brine MP in a letter of 22 March 2019 to PHE CEO, Duncan Selbie, that his government priorities for PHE for 2019/20 were not at all about protecting England against emerging pandemics. During the pandemic there was frustration expressed by the government at the PHE, and the decentralisation of NHS command and control to NHSE. Recall, these were all acts of deliberate NHS deconstruction, decentralisation and quasi-privatisation by the previous Cameron-Clegg coalition government. Matt Hancock's response? Disband much of Public Health England (PHE) and merge it with NHS Test and Trace to create a new quango, the National Institute of Health Protection led by a Tory peer Dido Harding, a business expert with no healthcare credentials. She already led the controversial, dysfunctional SERCO-outsourced test and trace "system". Her husband just happens to be a Tory MP and our UK anti-corruption champion. You couldn't write it. My suggestion is, why not simply bring back the more-expert and independent-of-business interests HPA? It did far better with far more fatal viruses. Why not scrap NHSE, and make the health secretary accountable for our health again? Maybe better still, repeal the *Health & Social Care Act*.

What would have befallen us if the NHS had already been fully privatised? Probably something akin to America: line the pockets of the private hospitals in a further blind panic. Stop them treating anything but coronavirus. Therefore, inducing the hospitals to fit

everything into a coronavirus-shaped hole. Then, just add fatal ventilation to maximise profit. If we are to learn and improve, an uncomfortable truth that must be acknowledged is the revolving door between government and corporations in public private partnerships causes collusion and corruption. It is failing our nation's health.

Back to the timeline. The alleged first official Chinese case was 17 November 2019. China announced the problem to the WHO on 31 December 2019 as a "atypical pneumonia". On 3 January 2020 Chinese officials provided information to the WHO on the cluster of cases of "viral pneumonia of unknown cause" identified in Wuhan. On 9 January 2020 the WHO reported that Chinese authorities had determined that the outbreak *was a distinct disease* caused by a novel coronavirus. Remarkably, it seemed we in the West had an indirectly-deduced, best-guess PCR test ready-to-go in mid-January 2020 before we even had time to isolate and confirm the suspected *in vivo* causative agent, SAR-CoV-2 for ourselves.

The first two confirmed cases in the UK were 29 January 2020. Had the virus actually been caught in the act, on an electron microscope, isolated and purified from a human Covid-19 victim, yet? The International Committee on Taxonomy of Viruses (ICTV) announced "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)" as the name of the presumed novel coronavirus (nCoV-2019) on 11 February 2020.

It also appeared to me that we had blind trust in China and the WHO, which in a knee jerk, prematurely decided that Covid-19 was a disease (i.e. a condition with a definite aetiology) and not a syndrome (i.e. a collection of symptoms and signs without a definite sole cause – just like the elusive irritable bowel syndrome, or IBS).

For clarity, the "D" in coronavirus means "disease", the second "S" in SARS-CoV-2 means "syndrome". In a sense, the WHO had already decided Covid-19 was a distinct disease entity caused by a novel coronavirus before characterising it as a syndrome called SARS-2, and before the naming of the virus as SARS-CoV-2. The importance of scientific syntax and semantics cannot be overemphasised. Such cognitive slip-ups trickle unnoticed into general parlance and may have fatal consequences for us as a species.

Without a definite cause, one cannot definitively conclude to treat anything in particular. Is Covid-19 a syndrome, a mixed bag of symptoms and signs that has been negligently and politically globally fast-tracked to a scientifically wrong conclusion? Is it, in practice, a conflation of different, distinct disease entities including influenzae, rhinoviruses, pneumoniae and other coronaviruses, not to mention other non-infectious phenomena?

We may now never know, due largely to a fast-thinking panic, and incompetent local and global health systems biased by commercial and political interest.

We destroy jobs, industry and life as we knew it while we wait for a vaccine

Allow me to illustrate what a convincing, normal scientific timeline looks like, with a historical example. The AIDS epidemic (Acquired Immune Deficiency Syndrome) officially began in 1981. Before it was called AIDS, the syndrome was first termed "GRIDS", or gay-related immune deficiency syndrome. The aetiological agent, human immunodeficiency virus (HIV) was confirmed two years later in 1983. The first ever recognised case of AIDS, in retrospect, may have been in the 1960s. The scientists who discovered the causative HIV were awarded the Nobel prize in 2008, 25 years later. That is the normal order and speed of

how good, reliable science used to operate. What we have with the Covid-19 narrative is extraordinary, regardless of intervening new scientific advances; so much so that it is arguably a new pseudo-medical paradigm.

Forget finding a virus first, forget antibody and antigen serology, blood PCR and routine chest X-rays, forget electron microscopy, culture and blood markers of inflammation. Forget even looking for other probable causes and taking a temperature or a pulse; just speculatively swab asymptomatic or vaguely symptomatic scared members of the public's contaminated oral and nasal cavities for bits of RNA, with a poor test, and over-amplify the apparatus. As the WHO's Dr. Tedros said very emphatically at the very outset: "Test, test, test". As a physician, I wish he'd said, "Think, think, think"; or as carpenters say, "Measure twice and cut once".

In March and April 2020, without the proper science, if it felt like coronavirus, it was coronavirus, it was buried as coronavirus. To this day, this irrational, pharma-political new world order narrative persists bullet-proofed, immune as if pre-vaccinated against all the countless eminent medics and scientist amongst the global intelligentsia.

In early May 2020 I was initially amused, but then concerned to read the Reuters report about the Tanzanian government's official samples submitted for PCR testing. It reported that pawpaw and tortoise swabs tested positive for Covid-19.

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The 2020 new infectious disease pseudoscientific paradigm goes something like this: anyone and everyone is a potential coronavirus super-spreader, all the time, regardless of fever, other symptoms, or no symptoms. Whether you have already had it or not, whether one wears a mask or not, the risk is always there. You may even contract it again, and again.

Anyone who dies within 28 days of a positive coronavirus test is a coronavirus death. The nominated standard community test for Covid-19 is an unprecedentedly bad one, far from any gold standard test. Potentially up to 93 percent may be false positive. This will create a synthetic "case-demic" spike because the health secretary pushes poor mass-testing hard and fast. This will be used to frighten those of the public who do not understand statistics, and who understandably instinctively trust their government. Testing simultaneously for more probable causes such as colds, flu and pneumonia will not be done. Everyone else with any other disease can go rot or go private. Children who are almost never at fatal risk (unlike with influenza) will be denied proper social care, an education and freedom of association.

This is not normal clinical medicine, nor public health medicine Where was this year's flu, respiratory viruses and pneumonia mortality spikes? Perhaps they were parasitically conflated with that will-o-the-wisp SARS-CoV-2?

It is an irrational doomsday reading of the situation by our government, which is nothing of the sort in reality. It is a wilful governmental catastrophizing of a situation I have not actually encountered in my professional nor my personal reality this year. Certainly, the emergent case-fatality data is not reflective of the government's persistent narrative of fear. I find myself asking is this melodrama, or medicine I am being asked by the government to practise?

We may all be suffering the consequences of the many mistakes by Matt Hancock's department such as his face-saving personal target and vanity-project of more than 100,000 community tests per day for which perfectly decent, independent scientific laboratories such as Sir Paul Nurse's were dismissed or ignored and contracts awarded to favoured, corporate, inner circle cronies. Presumably they are also more apt to adhere to the official narrative. (Do not forget the other reactive decisions such as his white elephant Nightingale hospitals and the costly and harmful ventilator crusade.)

My fear is the government wants to sustain this disproportionate narrative of fear, and a lockdown until we either find a vaccine or die of loneliness, other disease and a broken heart. Is this incompetence, political face-saving, health and safety-gone-mad or something else?

The state narrative is in contradiction to the statistical facts

What we might realise when we recover from our national PTSD is the new normal might be perpetual social isolation if Parliament continues to have its way. Maybe the government should take a moment of collective maturity and wisdom to acknowledge the real risk: the average age of death dying of Covid-19 is around 82 years, similar to the average age of general death in the UK. Any hospital junior doctor who has worked with the elderly knows an attachment in the UK winter is like working in killing season. Most of us don't suffer from Covid-19, and when we do get it, we are fine, or have mild upper respiratory symptoms. The fact is, when (or *if*) we are eventually released back to our lives, our risk of death from trauma and accidents will increase simply by being allowed outside to play, again. Will the government frighten the life out of us by over-emphasising these, and swabbing it for Covid-19, too? Has anyone asked the question what would be the Covid-19 swab positive rate had we sent out the army to do it two years ago in winter 2018? I suspect it would not be zero.

The state narrative is in contradiction to the statistical facts, the science, and clinical experience of many doctors and scientists, many of whom are eminent, but easily brushed off with scathing, fearful rhetoric by the health secretary, as in his recent parliamentary performance disparaging the sensible, scientific, but censored Great Barrington Declaration authors and its 580,000+ signatories. We forget Sweden never locked down or masked up, and yet it continues to cope well, as we used to for any other seasonal viral epidemic.

My greater fear is that, for the government it is a simple waiting game; wait for the normal winter spike of deaths, unscientifically read it up to the worst possible case scenario, and class it all as Covid-19 again, contrary to the old, normal medical paradigm. Then, extend the lockdown measures for another six months to September 2021. Presumably, the government will repeat the "no vaccine, no freedom" mantra, and continue to ignore the cheap, effective community treatments being propounded by my global colleagues, who are being censored, and no-platformed by government and social media.

The promulgators of the official global narrative anticipated dissent and prepared for a global infowars. On 18 October 2019, Event 201 sensed a coronavirus pandemic was imminent and advised in its headline: "The next severe pandemic will not only cause great illness and loss of life but could also trigger major cascading economic and societal consequences that could contribute greatly to global impact and suffering."

Except, it wasn't the pandemic the triggering the "major cascading economic and societal consequences". It was the extraordinary, co-ordinated global government and media over-reaction that did the triggering all by itself. Its entire recommendations are predicated on this flawed first heading andsentence:

Event 201's luminaries went on in recommendation 7: "Governments and the private sector should assign a greater priority to developing methods to combat mis- and disinformation prior to the next pandemic response."

One only has to look at the echoes of this in Ofcom's radical, very prescient, and human rights-violating bulletin guidelines released on 23 March 2020 to be even more concerned:

Ofcom will consider any breach arising from harmful Coronavirus-related programming to be potentially serious and will consider taking appropriate regulatory action, which could include the imposition of a statutory sanction.

It reads like an edict from Orwell's Ministry of Truth. But it could equally apply to the government department of health's own Covid-19 narrative. A senior UK doctor, Mr Mohammed Adil, prominent in the fight for medical sense has been suspended by the GMC for simply exercising his right to freedom of speech and dissent within the law, having been no-platformed from YouTube. His European and 1st Amendment-protected American colleagues continue to be allowed to practice.

How are we to operate as a democracy, involving our medical professionals and our royal colleges in constructive, reasoned debate to reach a scientific, reasonable consensus of opinion when the GMC stifles doctors on the front line, and when the government regulators crush, manipulate and censor their way through the usual democratic and scientific discourse? It seems even reasonable inferences, debate, and the right to speculate out aloud to progress our collective knowledge (particularly when we are not even allowed freedom to associate) is not official government policy. Not journalistically, professionally nor socially. It is tantamount to thought policing. Certainly, professional safety in my medical workspace involves suspending one's disbelief and zipping one's mouth in order to stay in a job. What is striking is that my colleagues avoid talking to each with scrutiny about Covid-19, to do so truthfully would be to dissent and risk unemployment. How as a society are we meant to join the dots, physically isolated, mentally compartmentalised and electronically censored? How can we progress unified and intelligently in this Parliament- created police-state?

The *Coronavirus Act* legislates for one doctor-approved cremations and mental health act sectioning. Before these required two. Medical abortions can now be done at home by tele-consultation under 10 weeks' gestation via "pills-by-post", without the gestation being confirmed by the usual scan.

The NHS feels like it has been weaponised by the state

I have heard of medical colleagues who have been informed that if they wanted a relative's body quickly released for Muslim burial, it could be done within 24 hours if Covid-19 was accepted as the cause of death, but 2 weeks if the cause of death was the more logical stroke. In London, there seems to be in at least one hospital where a confidentiality clause or non-disclosure agreement must be signed before being allowed to work on coronavirus units. It appears the so-called whistle-blower protections for doctors continue to be trounced. What is

there worth hiding that we all cannot be privy to? After all, isn't this a public health matter concerning us all?

Is this coercive, controlling pharma-political alliance of fear-mongering the government's new democratic normal? Is it a disproportionate response, deluded self-deception, spurious pseudoscience, fraud or a hoax? Is Sweden wrong? I don't know, but how can we ever decide if the GMC forces doctors into the corners of anonymity and joblessness, and the government shuts its ears to us? It feels intellectually embarrassing to be anything other than Swedish.

Even the WHO is turning about-face on lockdown with Tedros Ghebreyesus' former WHO nemesis and new Covid-19 envoy, Dr. David Nabarro leading a change of narrative.

Nabarro vigorously fought Tedros for the director-generalship of the WHO. Nabarro's campaign team member suggested Tedros was implicated in covering up three cholera epidemics in his own country whilst health minister for Ethiopia. Whom can you trust?

In the Hong Kong flu pandemic of 1968 and 1969 where in total an estimated 80,000 people died in the UK, and an estimated 1-4 million worldwide, there was no lockdown, no draconian loss of liberty, and no destruction of the economy. No one scared the life out of us, shutdown the economy and closed down the NHS then. So why now?

From PHE reports, in England alone, the number of deaths associated with influenza observed through the FluMOMO algorithm was 28,330 in the 2014-15 season, and 26,408 in the 2017-18 season. I really didn't notice these, did you? They are certainly not scarred on my psyche by the government in the same manner as Covid-19. We also seem to be in the exceptional situation of having conveniently avoided an annual influenza-associated mortality spike in the 2019-20 season. Could it be that a significant proportion were subsumed into Covid-19 associated deaths?

What of vaccines? We still don't have one for HIV. We've never had one for a human coronavirus. Vaccines for flu can be ineffective and damaging. We may never have a viable candidate for Covid-19. Yes, medical technology has moved on, but not enough to compress the natural academic and clinical medical science response to this novel coronavirus into this timeline: the official narrative of less than one year.

What of mortality: a fraction of a percent, and 10 times less than predicted by the inadequate and presumptive Imperial College models? What about the age-specific mortalities: the younger, the more fractional the risk? Yet, some mask children and we destroy the lives of the least at risk (that's most of the workforce under 60 years). We destroy jobs, industry and life as we knew it while we wait for a vaccine. The NHS feels like it has been weaponised by the state and used paradoxically to damage our health. Isn't that a hell of a timeline?

The Covid Physician is an unheroic NHS doctor. This article is a personal view and does not necessarily represent the views of the NHS. Dr. TCP tweets at ***@tcp_dr***