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

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James DeMeo, PhD *

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

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Abstract
Basic annual all-cause deaths data, when reviewed in light of a claimed Covid-19 pandemic and decadal expectations from annual increases in population growth, revealed *no overall surge in USA deaths for 2020.* Age-specific analysis also failed to confirm any significant increase in Covid-19 deaths among populations of high-risk elderly 65+ years as compared to all-cause deaths within the same demographic. The Centers for Disease Control's (CDC) "daily confirmed-case and confirmed-deaths" data on Covid-19 were also reviewed as plotted together on the same ordinate scale, along the vertical axis, revealing a less frightening perspective of daily confirmed death numbers from the claimed "pandemic" than is usually reported on "official science" and media websites with graphical and numerical exaggerations. Daily death/case ratios failed to affirm any significant growth or spread of an expected deadly viral pandemic, except for the initial period of March-April 2020, which quickly subsided. *These direct reviews of the official CDC data, formulated within the existing paradigm of a claimed deadly SARS-CoV-2 virus and Covid-19 disease, expose multiple contradictions to basic causality and logic.* Problems in PCR/Antigen tests and electron-microscopy for specific identification of SARS-CoV-2 are exposed, indicating cross-reactivity and confusions with other corona viruses and their DNA/RNA fragments, along with antibodies to them. The claimed Covid-19 tests thereby do not appear specific to the living SARS-CoV-2 virus, which is why lab-confirmed cases among asymptomatic people have soared to dramatically high numbers, while lab-confirmed deaths have not. Other contradictions in CDC data were identified, and can best be understood as deaths from ordinary seasonal respiratory disorders such as influenza or pneumonia being inappropriately reclassified as Covid-19. Soaring "case" numbers therefore would reflect *herd immunity only*, possibly as early as May of 2020. These conclusions are not confined to the USA data, but appear global.

Basic Data on USA Annual Human Mortality

Assuming a deadly virus SARS-CoV-2 causing Covid-19 disease (SARS = Sudden Acute Respiratory Syndrome), and arguing from within that "official" paradigm, we should expect a pandemic to drive up the annual increase in all-cause deaths far more than the average annual increase in lives lost each year as from other causes, and thereby reduce overall life-expectancy for 2020. This is not the case, as seen in Table 1A.

Table 1A firstly exposes a trend of increasing annual all-cause death numbers over the decade starting in 2010, with a natural increase in each subsequent year reflecting centuries of steadily increasing population growth with attending annual increases in deaths. Life Expectancy remains about the same for the decade, at around 78.5 to 78.9 years. The annual increases in all-cause deaths are also variable over the decade with an unexpected minima of 15,633 in 2019, a maxima of 86,212 in 2015, and 61,654 in 2020 – with an overall average annual increase of 44,806. The numbers presented here for 2020 are current through the end of the year, using official CDC data as referenced.

Table 1A: Number of people dying each year in the USA, All Causes, with Increases From the Prior Year, and Life Expectancy

Year	All-Cause Deaths[1]	Annual Increase	Covid-19 Deaths	Life Expectancy[2]
2010:	2,468,435			78.49y
2011:	2,515,458	47,023		78.64y
2012:	2,543,279	27,821		78.79y
2013:	2,596,993	53,714		78.94y
2014:	2,626,418	29,425		78.91y
2015:	2,712,630	86,212		78.89y
2016:	2,774,248	61,618		78.86y
2017:	2,813,503	39,255		78.84y
2018:	2,839,205	25,702		78.81y
2019:	2,854,838	15,633		78.87y
2020:[3]	**2,916,492[3]**	**61,654[3]**	**315,507[3]**	**78.93y[2]**

1. Assembled from various CDC/NCHS web documents for each year.
2. Life Expectancy & Other Data. *For 2020*, estimated without Covid-19: https://www.macrotrends.net/countries/USA/united-states/life-expectancy
3. https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm All 2020 data updated from above website for 26 Dec. with Dec.27-31 data from below. https://ourworldindata.org/grapher/daily-covid-cases-deaths?time=2020-01-01..latest&country=~USA

A cursory look at Table 1A reveals a major contradiction. If Covid-19 deaths in 2020 numbering 315,507 are correct, then *why is the annual increase in deaths from the end of 2019 to the end of 2020 only at 61,654?* Shouldn't the Covid-19 deaths be rather unique, adding to the all-cause death count, driving it up to around 3.2 million, with the *annual increase* in deaths being around 377,000?

This is not apparent in the official CDC records, which suggest a rather ordinary and expected 2020 increase in all-cause deaths, with an annual increase similar to or even less than the all-cause death figures for 2013, 2015 and 2016. Also, if we subtract the CDC's 315,507 Covid-19 deaths in 2020 from the 2020 all-cause death counts, we are left with a number of around 2.6 million, which is *less than the all-cause death counts for every year since 2014!* This cannot be correct, unless the all-cause death numbers for 2020, excluding Covid-19 deaths, were miraculously very low, close to the 2.6 million figure. However, Covid-19 data are already included in the 2020 all-cause data, suggesting *the 315,507 Covid-19 deaths are somehow reducing or displacing the numbers of deaths from other causes, such as influenza, pneumonia, COPD, emphysema, heart disease, cancer, diabetes and so forth, by an equal number. But that cannot be the case, unless there is something dramatically wrong with how Covid-19 deaths are being counted*. Is it possible that Covid-19 death counts are in reality a substitute diagnosis for those who die of those other-cause diseases and disorders? We have all heard the stories of someone dying in a traffic accident, or being shot in a robbery, with the death certificate reading "Covid-19". I will return to this issue shortly.

These numerical incongruities are highly suspect, given how nearly every source from government and mass media has been steadily reporting on cumulative all-cause deaths over the year, being careful to include all known Covid-19 deaths into their totals. The CDC and NCHS (National Center for Health Statistics) has been tracking and presenting Covid-19 death totals, reaching a preliminary but none-the-less confirmed number of 315,507 at the end of 2020. (The Postscript section reviews more recent data, confirming these data incongruities.)

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

Table 2A, below, adds to our concerns, revealing how the Covid-19 and all-cause death numbers by age group, transformed into percentages of the totals of those two groups, shows nearly identical distributions of deaths in the elderly 65 years and older groups. This makes no sense if there is truly a serious pandemic of a new infectious virus that preferentially attacks the respiratory systems of the elderly, killing them.

For example, Covid-19 disease does not affect young children to any extent, given their natural immunity. That aspect is affirmed in the Table 2A data, presented below from a CDC/NCHS website and current to Dec.26 (close to the end of the year). Covid-19 is also supposed to be killing significantly higher percentages of the elderly than other causes. However the Table 2A data does not affirm that to any significance. While the 301,679 Covid-19 deaths constitute 10.4% of the all-cause deaths for 2020, up through Dec.26, this increase is not reflected in the three main Covid-19 death categories, of 65-74 years, 75-84 years and 85+ years. Instead, the percent distributions of deaths in each age group of the Covid-19 column are similar to the percent distributions of deaths in each age group of the All Causes column.

Table 2A: USA 2020 Deaths by Covid-19 & All Causes, by Age (Dec. 26)

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

https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm
Dec.26 update, remained posted through 6 Jan. (**See the confirming updates on Tables 2B and 2C in the Postscript at the end of this article, page 36**).
1. Percent of deaths in each Covid-19 age group relative to Covid-19 "All Ages" total deaths. 2. Percent of deaths in each All Causes age group relative to All Causes "All Ages" total deaths. 3. Percent difference, %Cov minus %All. 4. Excess Death Number Extrapolation from %Diff by Age, of claimed Covid-19 deaths.

After reducing each age-group death number into a percentage of its column total, then extracting the difference in those percentages (%Cov minus %All = %Diff.) and then converting the differences in those percentages into a proportion of the Covid death numbers (Covid-19 Number times %Diff), the numbers of excess deaths for each category were extracted.

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

That number of 4,663 excess deaths beyond normal expectations works out to be around 13 extra deaths per day, for the entire USA. *Thirteen*. And from Table 1A above, we have already established that 2020 is NOT a record year for deaths, above and beyond the normal average annual increases that happen every year.

The data in both the Covid-19 and all-cause death categories parallel each other in the high-risk elderly categories, representing the normal "end of life" period, when people succumb to lung diseases symptomatically characteristic of the claimed Covid-19, as well as various other fatal diseases or conditions, such as cancer, congestive heart disease, diabetes, etc.

The actual Covid-19 death numbers in Table 2A, which rise sequentially with each older age group until peaking out in the 85-years and older category, are shown to be nearly identical in basic distribution to the "All Causes" death numbers, which also rise steadily upwards. The two sets of numbers, of Covid-19 deaths and all-causes deaths, are identical in basic trends. And yet, as revealed in Table 1A above, the overall mortality in the USA *did not increase* from Covid-19 disease by a factor of nearly 10%, as estimated from the CDC data at the top of Table 2A. Had they done so, the *annual increase* in all-cause deaths in Table 1A, for all of 2020 would have been around 377,000 instead of the lower figure of 61,654 as reported in Table 1A. This never happened.

To make the CDC/NCHS figures pan out, they must either "find" an additional several hundred thousand all-cause deaths, or present the claimed 315,507 Covid-19 deaths as a book-keeping duplication or re-definition of deaths by other causes. (See the Postscript section for an affirming update.)

Overall, these data as presented in Tables 1 and 2, do not suggest anything like a major pandemic occurring. Instead, a normal trend of mortality is revealed, with elderly people reaching end of life, and succumbing to a host of other diseases which afflict the elderly every year: Cancer, heart disease, diabetes, obesity-related disorders, pulmonary disorders, as well as pneumonia, influenza and similar conditions that younger people shake off more easily.

The official CDC Covid-19 data reveals a *shifting of diagnoses* based upon biases among physicians, epidemiological "experts", and hospital administrators, to re-classify other expected end of life disorders and diseases into the Covid-19 category. Statements made by many physicians on internet and in video interviews, and eventually by Senator Scott Jensen of Minnesota (also a physician) have identified at least one motivation for doing so: large sums of money are given to hospitals by Medicare and other Federal agencies when they take on a new Covid-19 patient who is placed on a ventilator, around $39,000 in total. A video of Jensen's statement has since been censored by YouTube, but the USA Today newspaper and FactCheck.org launched separate investigations of the subject, concluding his statement was true.

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

These revelations further suggest that many deaths are classified twice, firstly by the real cause of their deaths (influenza, pneumonia, heart problems, cancer, diabetes, etc.) and later as Covid-19, by the determinations of hospital staff.

These two sets of official CDC confirmed-death data in Tables 1 and 2, refute the exclusive and singular claim of a deadly viral pandemic destroying the lives of people in the USA at high numbers. Many lives are being destroyed, but we must ask if this is more due to questionable diagnoses, and the severe anxiety, panic, hysteria and forced lockdowns than by a claimed SARS-CoV-2 viral pandemic. There is significant documentation to support this interpretation. https://www.nber.org/system/files/working_papers/w28304/w28304.pdf

Covid-19 Death Data Inconsistencies Identified by Genevieve Briand

In early December, I learned of a similar study comparing age-specific Covid-19 and all-cause US deaths, mirroring what is summarized in my Table 2A data. This study, "Covid-19 Deaths: A Look at U.S. Data" was presented in an early November webinar by Dr. Genevieve Briand, Assistant Director of the Applied Economics Program at John Hopkins University.
https://www.youtube.com/watch?v=3TKJN61aflI

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

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

In fact, after reviewing the CDC data, Briand's analysis and conclusions were anything but inaccurate: As CDC-confirmed Covid-19 deaths increased during the April 2020 peak, most all other causes of death *declined, indicating a shifting of other diseases into the Covid-19 category*. Her closing webinar statement was *apropos*:

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

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

My Table 2A above extends the analysis as was independently undertaken by Briand into the end of 2020, wherein I observed similar data inconsistencies, and came to similar conclusions.

Seasonality of Covid-19 Data, and the Absence of Lockdown Benefits

The seasonality of Covid-19 data also supports similar conclusions, that Covid-19 diagnoses (by clinical observations or by laboratory tests) are primarily the consequences of re-classifications of other better-known diseases and conditions, notably influenza and pneumonia as occur during wintertime. Northern and Southern Hemisphere nations reveal a general wintertime pattern in Covid deaths, at opposite times of year, as shown in Figures 1 and 2.

These Figures reveal a component to Covid-19 deaths which at first was denied early in 2020 by the CDC and WHO, but is today too obvious even for them to ignore. However, Covid-19 seasonality is still being hushed up by websites preaching Covid orthodoxy, as with the following contradictory comparison:

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

"Nuisance"!? Certainly it is a "year-round" problem if we look at the whole-Earth average. But individual nations and regions show different peaks of claimed Covid-19 at different times of year. The issue of seasonality is a sensitive one, because by conventional wisdom, Covid-19 does indeed afflict populations quite similar to "common flu viruses", primarily, though not exclusively, during the cold winter months. Figure 1 presents Covid-19 daily death data for Germany, Italy, France, Spain, Canada, Sweden, Greece and Japan, all of whom show the conventional Northern Hemisphere winter pattern.

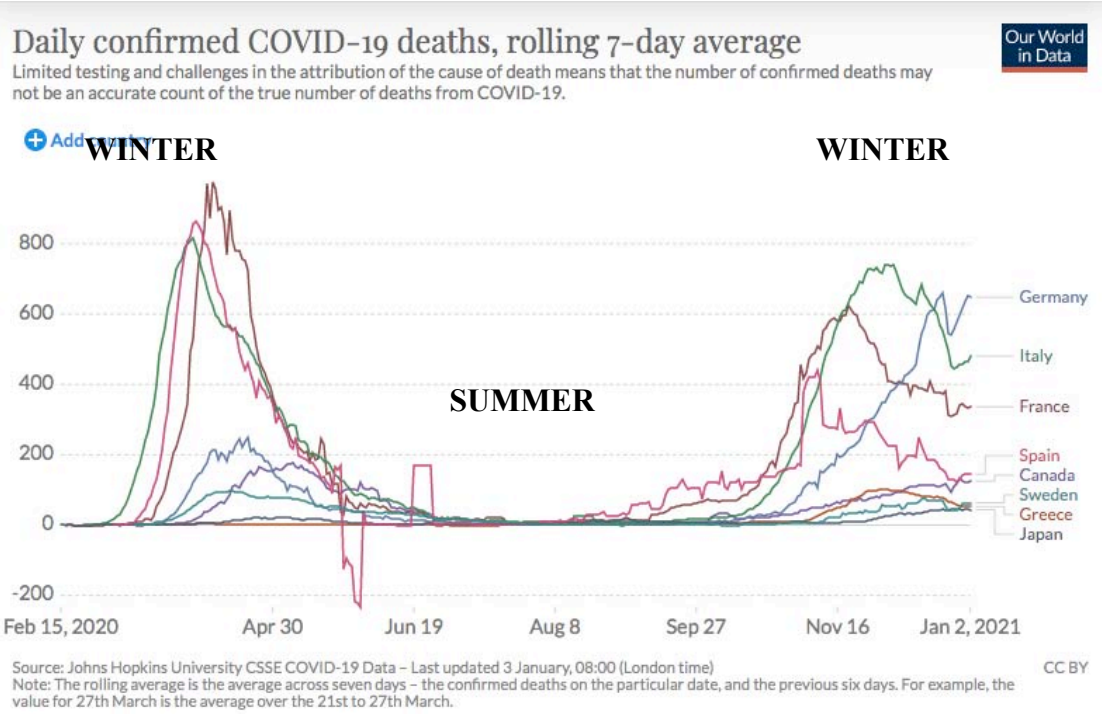


Figure 1: Covid-19 Daily Deaths in Northern Hemisphere Nations
https://ourworldindata.org/covid-deaths?country=CAN~FRA~GUF~DEU~GRC~ITA~JPN~ESP~SWE

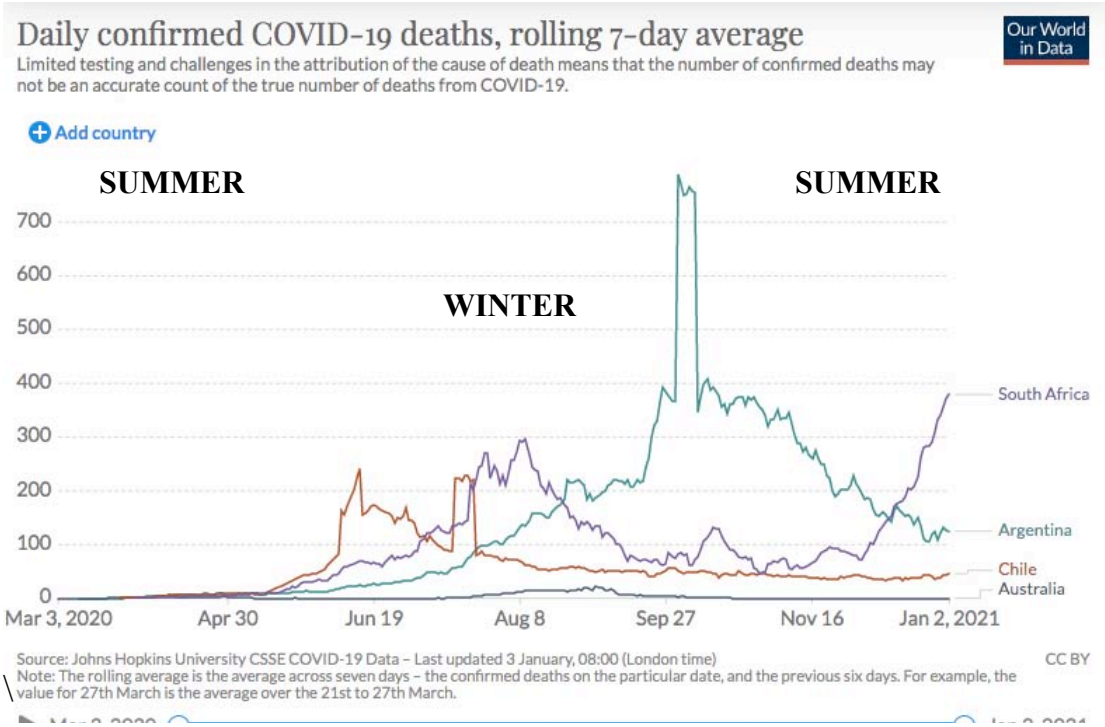


Figure 2: Covid-19 Daily Deaths in Southern Hemisphere Nations
https://ourworldindata.org/covid-deaths?country=ARG-AUS-CHL-ZAF

Figure 2 presents similar data for South Africa, Argentina, Chile and Australia, the most southerly Southern Hemisphere nations with significant Covid-19 deaths. Both figures reveal a clear wintertime climate pattern.

This issue of seasonality should be well-known to epidemiologists, who today mostly seem to have forgotten their science, or lost their voices. The best review of this was presented in a video, which also documented the lack of benefits from lockdowns upon those deaths, as presented by Ivor Cummins: https://www.youtube.com/watch?v=3cjgicrA504

Cummins' video, which is one of the best overviews of this issue I have seen, presented various data graphics showing how daily Covid-19 deaths were already on a clear downward trend at the time when nation-wide or state-wide lockdowns were instituted, undermining the claim that they were of any help. Data was also presented where lockdowns were instituted and Covid-19 deaths increased thereafter, or had no changes at all, not having any benefits. Likewise, ending of lockdowns had no significant effect upon national or state populations, either positive or negative. However, all states and nations showed the above-noted trends increasing Covid-19 deaths as the weather turned damp and cold, and decreasing deaths as it turned dry and warm. States which locked down most ferociously often had the most intensive spikes in death afterwards, perhaps due to the secondary health issues created by the lockdowns.

The state of Florida, whose Governor DeSantis lifted all lockdowns in late September, showed a gradual lowering Covid-19 death rates. Strong lockdown states such as New York, New Jersey, Minnesota, New Mexico, Ohio, Michigan, Illinois, Kentucky, California, Massachusetts, Washington and Oregon, all had higher death numbers than Florida for Covid-19 cases, hospitalizations, and death rates.
https://www.nytimes.com/interactive/2020/us/states-reopen-map-coronavirus.html

An entire webpage now exists to identify and provide weblinks to all the different published studies in science journals that refute benefits of lockdowns (25 publications and counting), as well as those which detail and expose the terrible deadly consequences of doing so (18 and counting).
https://thefatemperor.com/published-papers-and-data-on-lockdown-weak-efficacy-and-lockdown-huge-harms/ Also see: https://collateralglobal.org/

Interesting also, in 2019 (pre-Covid-19) the WHO issued pandemic guidelines that explicitly forbade – "Not recommended in any circumstances" – the use of "Contact tracing, Quarantine of exposed individuals, Entry and exit screening,

Internal travel restrictions, Border Closures". This statement, reproduced below in Figure 3, was for both epidemic and pandemic circumstances.

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

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

NPI: non-pharmaceutical intervention; UV: ultraviolet.

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

Why did the WHO change their views, less than a year later for Covid-19?

Reviewing the "PCR/Antigen Confirmed" USA Covid-19 Data

Early in 2020, when horror stories and videos from Wuhan China began to appear in the American and European media, diagnoses of Covid-19 disease were made solely by clinical observations. The Covid-19 diagnostic criterion included difficulty breathing, fever, chills, heavy mucous coatings in the throat

and upper windpipe, a "shattered (ground) glass" opacity on chest x-rays, and other pulmonary symptoms, often accompanied by heart irregularities. Great fear of a deadly super virus also spread around the world, with reports of massive numbers of people dying in Wuhan, and videos of panicked people overwhelming hospitals, or sometimes dropping dead in the street. Fears of an escaped bioweapon virus created a panic among both the general public and in the front-line doctors and nurses. Hazmat suits, gloves, masks, isolation wards and other protective measures were instituted, to protect hospital staff, and to contain the spread of the presumed new and potentially deadly airborne virus. Patients with the above symptoms were rushed into isolation wards, and often onto ventilators, given paralytic drugs also to keep them immobilized, which in many cases drove up the death numbers. Panic and anxiety added to physical distress, and people with just about any respiratory symptoms typical of influenza or pneumonia, were being given a Covid-19 diagnosis.

Whether or not these steps were justified, deaths increased among elderly populations who sought refuge or treatments in the hospitals, and many more died in nursing homes where isolation and anxiety was widespread. Some states like New York transferred sick elderly people from hospitals into nursing homes, where isolation and containment was impossible. The issue of whether these people were suffering from a new disease and potential bio-weapon, Covid-19, or merely from ordinary pneumonia, influenza and other lung and heart disorders exacerbated by panic and anxiety (which causes sphincter muscles as in the throat and bronchial tubes to contract), thereby creating similar presenting symptoms, remains an open question rarely asked.

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

Figure 4 below shows the actual *daily confirmed cases and deaths* but placed together upon the same linear scale of numbers on the ordinate, vertical scale. The red line soaring upwards are the *cases*, while the nearly flat, horizontal black-grey line at the bottom are the *deaths*. The daily PCR/Antigen confirmed cases and deaths are *not congruent and therefore cannot be causally linked*. Other "official" websites as discussed below, frequently present those same data on a logarithmic scale, or separated into two different graphs with the death

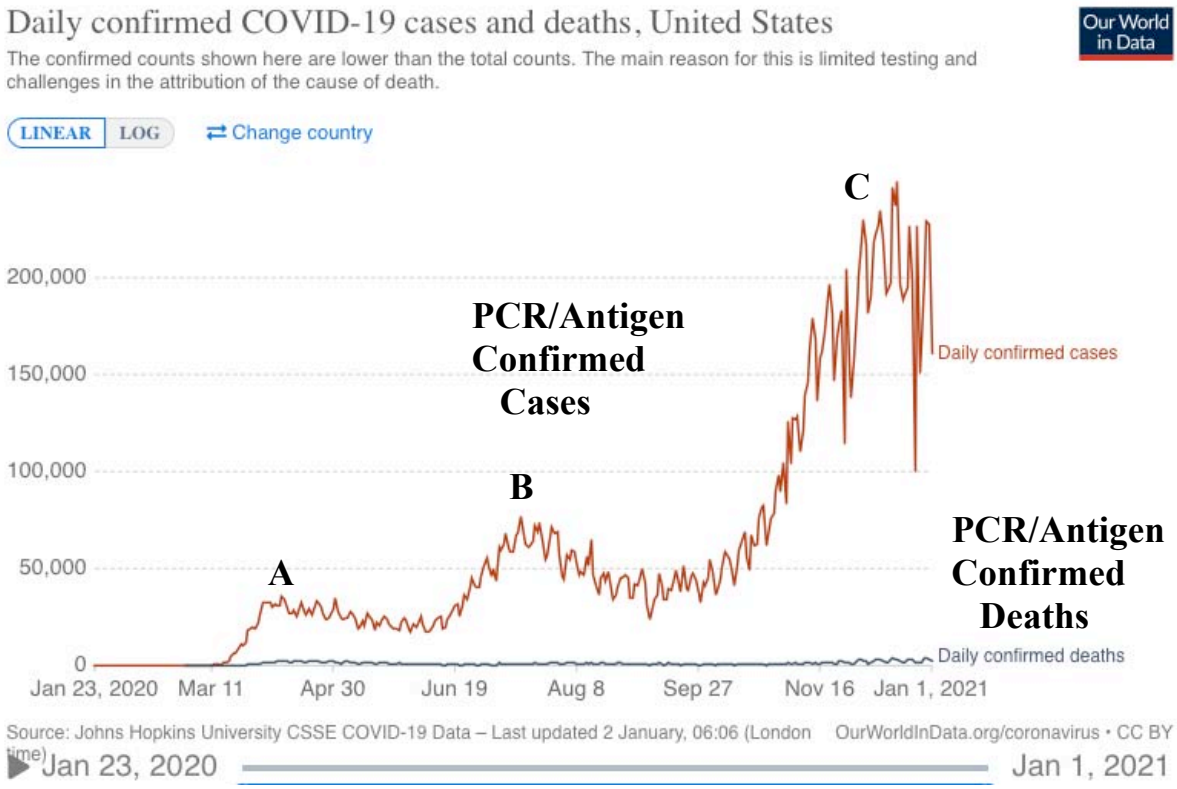


Figure 4. Daily Covid-19 PCR/Antigen Lab-Confirmed Cases & Deaths, USA only, from January 23, 2020 to January 1, 2021. Data from CDC as reported by the European CDC (ECDC) at the Our World in Data website. https://ourworldindata.org/grapher/daily-covid-cases-deaths?time=2020-01-01..latest&country=~USA

data being exaggerated in size by several orders of magnitude. Such exaggerations misrepresent the death data as nearly identical to the case data, when they are not. Figure 4 sets the record straight on that matter:

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

2. By contrast, *the numbers of daily lab-confirmed deaths have not followed such a dramatic pattern*. Confirmed deaths have instead remained on a fairly steady level, from several hundred to 1500 daily confirmed deaths, with the exception of the initial period from March through April, and again in late

November into mid-December, winter periods when confirmed deaths went above 2000/day to over 3000/day on some days in December.

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

If the daily confirmed cases truly reflected the spread of a living deadly and airborne viral agent able to cause death in patients, then there would be a predictable and steadily increasing number of daily deaths, recording the spread of such a contagious deadly virus into the population as an increasing phenomenon. Absolute numbers of deaths would then more closely match the curve of daily confirmed cases with a slight lag period. However, that is not what the Figure 4 graph reveals.

Additional answers can be found in Figure 5 below, presenting a graphic of daily Covid-19 *test* numbers. Figure 5 reveals a generally constant and steady increase in confirmed 7-day averaged Covid-19 PCR/Antigen tests, starting in early March 2020 and continuing until the end of the year. The correlation between the curves of test and case numbers in these figures is strong.

The actual number of Covid-19 PCR/Antigen tests has soared to over a million per day since early October, reaching 1.8 million daily tests in late November. However, this test-number curve also shows a subtle bulge or increase in the numbers of tests over late March into mid April (point A), with another peak in daily tests from late June through July (point B). Both of those peaks in daily PCR test numbers match in rise, but not in numbers, with the first and second peak in daily confirmed Covid-19 *cases* (A and B) in Figure 4. There also is a dramatic increase in the PCR/Antigen test and case numbers starting in mid-October, which together reach a maximum in December (point C).

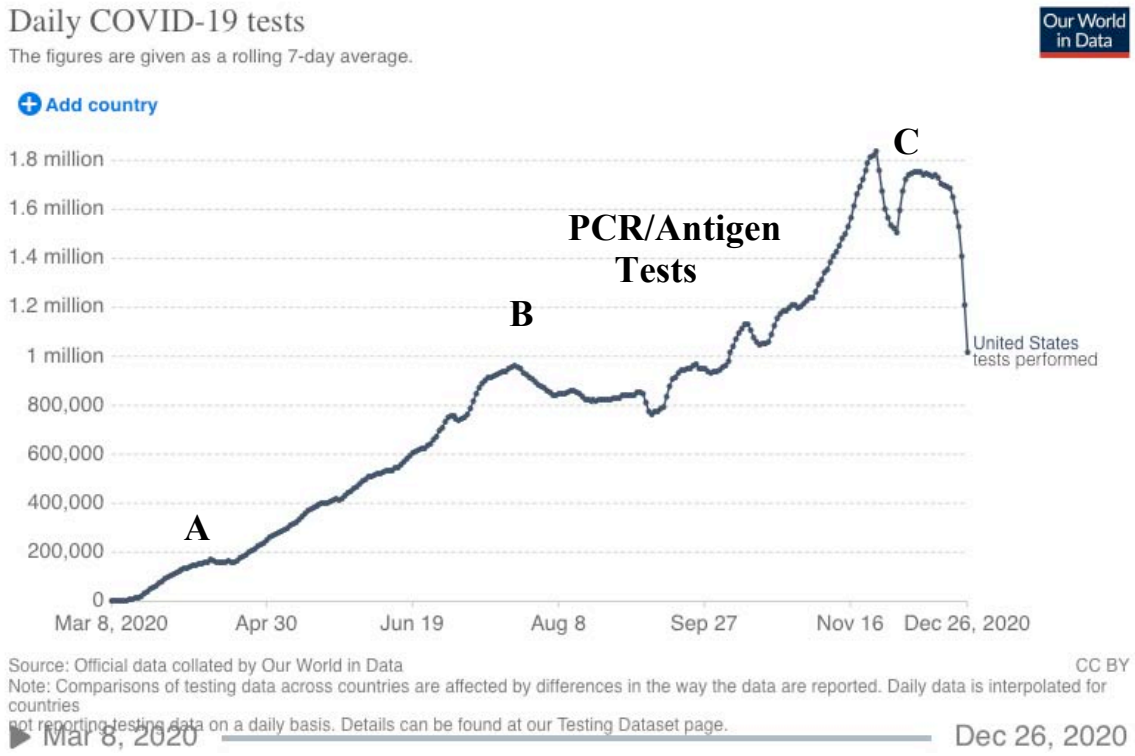


Figure 5. Daily Covid-19 PCR/Antigen Tests Administered, USA only, from March 8 to December 26, 2020, with 7-day averaging. Data from CDC as reported by the European CDC (ECDC) at the Our World in Data website. https://ourworldindata.org/grapher/daily-covid-19-tests-smoothed-7-day?time=earliest..latest&country=~USA

The Figure 5 graphic of daily test numbers shows a very close agreement and correlation with the actual Figure 4 daily confirmed cases, but not with daily confirmed deaths.

Overall, the most obvious and real correlation in the Figure 4 and 5 graphs is that between the *daily PCR/Antigen laboratory tests* and *daily confirmed cases*. However, neither of those two variables shows agreement with *daily confirmed deaths*, which remain at a relatively low number throughout the "pandemic". Arguably, if a real pandemic was occurring, the lab tests would accurately predict who got sick and who remained healthy, in which case, laboratory confirmed cases and death numbers would more closely correlate. *They do not.*

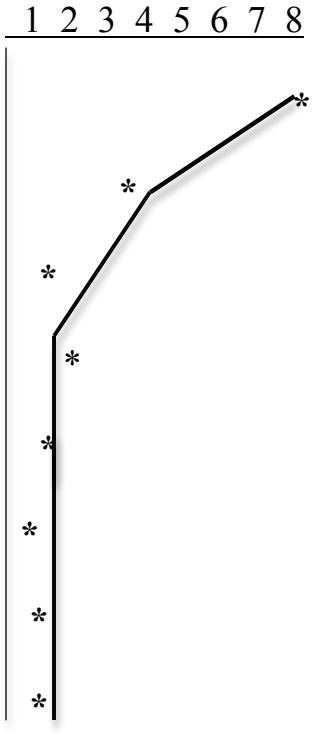
Analysis of the Death/Case Ratios

The ratio of daily lab-confirmed Covid-19 deaths to the daily lab-confirmed Covid-19 cases, or the death/case ratio, further supports the criticism of *no correlation*, as revealed in a separate analysis of selected 15-day periods within the Figure 4 data. The dates I selected align with major maxima and minima

inflection points of the Covid case data (across point A and beyond B) as well as across four regions of the last major upward surge of cases, from October through December (ending at point C). These are identified with given death/case percentages in Table 3, below. This Table, in association with the Figure 4 CDC data (from which they were extracted) reveals an initial possible infectious but short-lived epoch of correlation (point A) lasting over March and April of 2020, when testing was mostly confined to hospitals and symptomatic people. The death/case ratio for that 15-day period was high, at over 8%, but thereafter it declined dramatically. The confirmed death/case ratios continued to subside down to lower levels until the end of 2020, when in spite of soaring daily confirmed cases, reflecting major testing of non-hospitalized and generally asymptomatic people, the average daily death/case ratios declined, to 1.38%, 0.88%, 1.1% and 1.3% (point C).

Table 3. Data Averages from Figure 4 over Selected 15-Day Periods

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



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

How else to interpret these data trends except to say *the "confirmed cases" being detected by laboratory testing have No Correlation to the numbers or percentages of people dying.* Meanwhile, the number of laboratory tests being done shows a good correlation to the number of "confirmed cases". *This indicates the PCR/Antigen tests are reacting to something in the body fluids of healthy asymptomatic test subjects, but not to a deadly virus, and most likely being DNA/RNA fragments and cellular-viral debris plus suppressed antigens and antibodies associated with prior corona-type viral exposures. Those exposures would include such things as colds, influenza, pneumonia, emphysema or contact with dormant coronavirus material which has stimulated the healthy immune systems of larger segments of the population than were anticipated*. The PCR/Antigen tests, then, have little or no predictive value in determining who is or will become sick from Covid-19, but merely are detecting healthy biochemistry from prior exposures to one or another non-lethal corona-virus illness. The large numbers of "positive" laboratory tests are primarily indicative of *Herd Immunity Only. Widespread testing results do not signal any kind of persisting or resurgent deadly viral pandemic.*

Figures 6 and 7, below, further confirm this interpretation of *no infectious viral pandemic*. They show the same graphics as in Figures 4 and 5, of daily PCR-confirmed cases, deaths and tests, but this time with regression lines drawn in, showing the general trend of data for all three variables. As one can readily see, there is a direct and solid correlation between the number of daily PCR/Antigen *tests* being made, and the number of daily confirmed PCR/Antigen *cases* being reported. Again, *no correlation exists from either of those two variables, tests and cases, to the more important number of daily confirmed deaths as seen in the lower horizontal regression line at the bottom of Figure 6*. Death numbers have remained relatively steady with minimal variation over all of 2020.

This alone supports a widely held sentiment among Covid-19 critics: *The more PCR/Antigen tests being done, the more asymptomatic "cases" are being identified, but with no living virus, few sick people, and of little significance to public health other than to identify a higher level of herd immunity within our populations than anticipated.* If the Covid-19 laboratory test kits were truly accurate in detecting "confirmed cases" reflecting a living airborne infectious virus, whereby those "cases" would succumb to illness and could infect other people by aerosol exhalations, sneezing, or direct touch-contact, then the confirmed deaths would have accordingly exploded to very high numbers in a manner of weeks, and would today be strongly correlated to both PCR/Antigen tests and cases, and with a similar pattern in their incidence graphs. *But they have not,* except as misreported by medical, media and political hysterics.

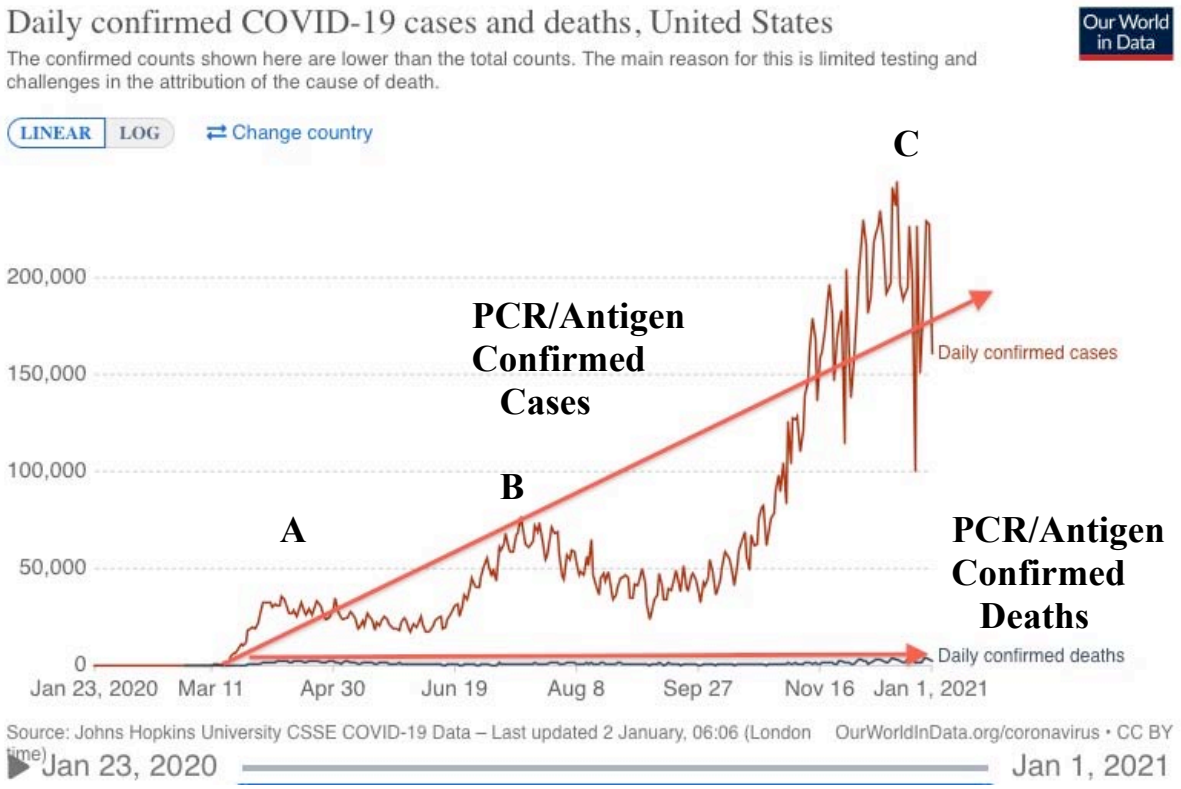
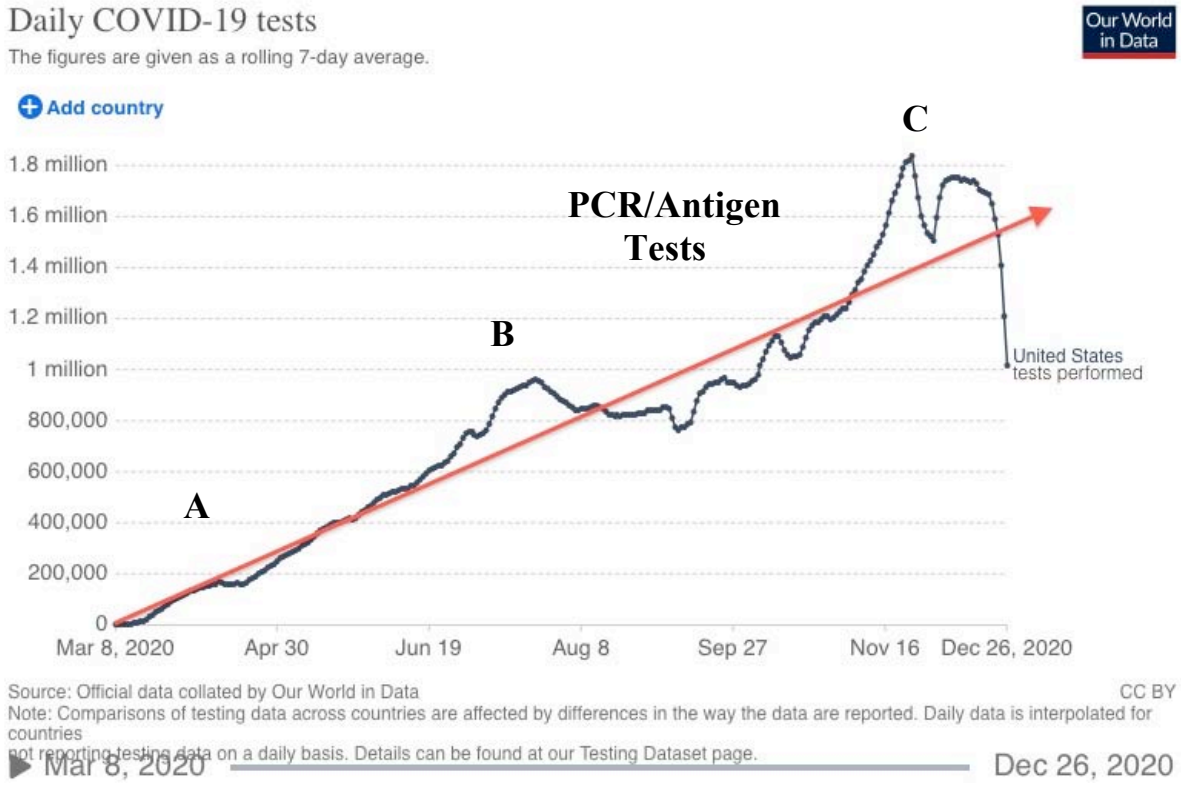


Figure 6 (above). Daily PCR/Antigen Confirmed Covid-19 Cases & Deaths
Figure 7 (below), Daily Covid-19 PCR/Antigen Tests
Same as Figures 4 and 5, but with regression lines added by author



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

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

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

Assuming that trend would continue, and extrapolating those data, the 2020 death rate from pneumonia and influenza combined would have claimed around 2.3% of USA deaths. That percentage is *higher* than the average Covid-19 confirmed death/case ratios in the latter part of 2020, of 1.17%, as summarized in Table 3 above. However, the same data source for these pneumonia/ influenza data, cited above, also have a segregated classification of "Lower Respiratory Disease" which constituted around 7% of USA deaths averaged over the 1999 to 2016 period. And that group includes pneumonia, adding to the potential numbers of deeper-lung diseases and disorders that could be misdiagnosed as Covid-19, and which due to their similarities also react positively on PCR/Antigen tests (more on that below). It is admitted by physicians that diagnoses of Covid-19 versus other major lung disorders can be difficult, the symptoms overlap to a considerable degree, as stated on the following University of California at San Francisco Covid-19 website:

> **Is it possible to tell the difference between flu symptoms and COVID-19 symptoms?**
>
> "I think it's tough because both the flu and COVID-19 can have a variety of overlapping symptoms... fever, chills and body aches, upper respiratory symptoms like runny nose and sore throat, lower respiratory symptoms like cough and pneumonia, and some gastrointestinal symptoms like nausea, vomiting and diarrhea. While you could say certain symptoms are slightly more associated with one virus than the other, there's enough overlap that there's uncertainty... we wouldn't use the presence or absence of those symptoms to rule in or out either illness." [Jahan Fahimi]

> "The typical symptoms of flu are relatively consistent – fever, cough and muscle aches. These are also common in COVID-19, but it's become clear as the pandemic has progressed that COVID-19 symptoms vary more wildly than those of the flu – from no symptoms at all in some 45 percent of cases to deadly pneumonia and myriad cardiovascular and neurological issues..." [Chin-Hong] https://www.ucsf.edu/news/2020/09/418606/can-you-tell-if-its-flu-or-covid-19-doctors-say-its-not-so-clear

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

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

> "Influenza has been renamed COVID in large part ...There may be quite a number of influenza cases included in the 'presumed COVID' category of people who have COVID symptoms which Influenza symptoms can be mistaken for, but are not tested for SARS RNA ... [Those patients] also may have some SARS RNA sitting in their nose while being infected with Influenza, in which case the influenza would be 'confirmed' to be COVID."
> https://justthenews.com/politics-policy/coronavirus/influenza-levels-continue-cratering-some-cite-covid-measures-even-covid

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

CDC websites also reveal a common lumping of pneumonia and influenza with Covid-19, in the same categories. For example, on one website presenting the

incidence of pneumonia and influenza by week, produced by the National Center for Health Statistics Mortality Surveillance, they speak about the "Percent P&I" (pneumonia and influenza) in text and on the ordinate (vertical) scale of a dominant graphic.
https://gis.cdc.gov/grasp/fluview/mortality.html

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

These overlaps and mixing of influenza, pneumonia and Covid-19 is quite apparent on the CDC's weekly reports, as seen in this banner identifying variant group definitions. While the banner reveals all deaths involving Covid-19 (defined by code U07.1), it also lists several categories that mix up Covid-19 with influenza and/or pneumonia, either individually or together. However, it does not show the isolated figures for influenza, pneumonia and Covid-19 independently, which would be the proper method for any authentic scientific review of the different maladies.

Sex	Age group	All Deaths involving COVID-19 (U07.1)[1]	Deaths from All Causes	Deaths involving Pneumonia, with or without COVID-19, excluding Influenza deaths (J12.0–J18.9)[2]	Deaths involving COVID-19 and Pneumonia, excluding Influenza (U07.1 and J12.0–J18.9)[2]	All Deaths involving Influenza, with or without COVID-19 or Pneumonia (J09–J11)[3]	Deaths involving Pneumonia, Influenza, or COVID-19 (U07.1 or J09–J18.9)[4]	Population[5]

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

Those CDC data did not reveal the centrally important question of how many people died of a strictly Covid-19 diagnosis, as per PCR/Antigen testing, without pneumonia, influenza or any other diseases or disorders. And that question becomes doubly important given how in a "Comorbidities, Table 3" section of the same weblink above, they make a very long list of exactly what other diseases and disorders people with a positive PCR/Antigen "confirmed case" or "confirmed death" were suffering from. They list six categories under the heading of "Respiratory diseases", seven categories under "Circulatory diseases", plus separate listings for "Sepsis, Malignant neoplasms, Diabetes, Obesity, Alzheimer disease, Vascular and unspecified dementia, Intentional and unintentional injury, poisoning and other adverse events, and All other conditions and causes (residual)". Those categories are further broken down into age groups, as given in the Table 2A above, from which we observe that the overwhelming number of deaths in all those comorbidity categories

occurred in elderly groups of 55 years and older. But nowhere can we find a discussion or number of people who died of Covid-19 *without* those comorbidities. The comorbidity data does inform us, however, that most of the Covid-19 deaths must be afflicted by more than one or two comorbidities, given how two or three of those individual categories, when added together, exceed the "total Covid-19 deaths".

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

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

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

Ealy et al. also produced a time-line of CDC methods for acquiring and reporting of epidemic deaths, revealing how in February 2020, CDC changed its method of data collection and counting – as in the *Medical Examiners' and Coroners' Handbook on Death Registration* and the *Physician's Handbook on Medical Certification of Death* – thereby abandoning a methodology they had successfully employed nationwide since 2003. From February 2020 onward, the CDCs data reports on Covid-19 became increasingly confused and obscure, and by Ealy, et al., "violated data quality, objectivity, utility and integrity requirements". By using the 2003 methods of computing Covid-19 fatalities, the conclusions given in the above Abstract, of 6% of deaths being due only to Covid-19, without comorbidities, was founded. Six percent of the 2020 year end total USA Covid-19 deaths, including comorbidities, as from my Table 1, of 315,507, suddenly drops to 18,930 deaths for the year, which works out to be 52 deaths per day. That is a dramatically different picture of this "pandemic".

Also suspicious is how the CDC graphics on its "Covid Weekly" websites, and others, confine their weekly data analyses to the years 2017 to 2020, thereby avoiding comparisons to the high mortality years of 2015 to 2016, as shown in Table 1A. Is this because 2020 "P&I" and/or "PIC", comorbidities redefined into the Covid-19 category, are not so different from 2015-2016? We are reminded of the statements above by Briand.

Electron Microscope Image Errors?

Visual identifications of SARS-CoV-2 in the electron microscope also reveal variations which, to my eye as a skilled microscopist (youtu.be/-PVnS72IIY8) and probably to many others, suggest different viral entities. Electron micrograph images of claimed SARS-CoV-2 are not so clearly distinguishable from other corona viruses typical of influenza, pneumonia or other respiratory disease. Figure 8 below shows two dissimilar images of claimed SARS-CoV-2 virus, as obtained from NIH/NIAID. Aside from the false-color variations added to enhance their contrasts, without clarifications they do not appear to be the same viral entities. A caption above the images revealed the difficulty in making assessments of what is SARS-CoV-2, and what is something else:

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

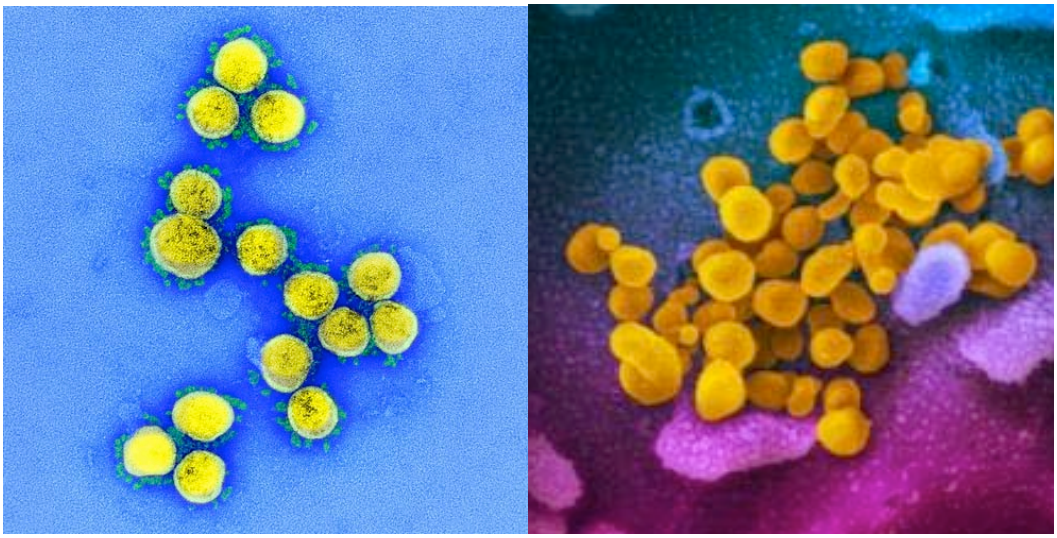


Figure 8: Two Dissimilar Images of Claimed SARS-CoV-2. (NIH/NIAID)
https://www.niaid.nih.gov/news-events/novel-coronavirus-sarscov2-images

For reference, similar viral images appear on the NIAID's MERS-CoV page:
https://www.flickr.com/photos/niaid/albums/72157634229836113
The following website also shows many different electron micrograph images of claimed SARS-CoV-2, only some of which appear identical to others.
https://www.flickr.com/photos/niaid/albums/72157712914621487

The Fallacy of PCR/Antigen Testing "Accuracy"

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

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

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

1. PCR tests cannot distinguish between a living infectious virus and a dead virus of the same type. It will also yield a positive indication when detecting DNA or RNA fragments from the break-down products of a multitude of viral entities similar to the one the test is supposed to be looking for. This is why vast numbers of asymptomatic people with zero living Covid-19 virus in their systems are getting false-positive results from these tests.

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

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

Kary Mullis, who invented the PCR method of DNA/RNA amplification and won a Nobel Prize in Chemistry in 1993 for doing so, did not accept the HIV theory of AIDS due to its heavy reliance upon PCR magnification to prove its existence. HIV was also criticized by top virologist Peter Duesberg as being a harmless "passenger retrovirus", while other AIDS critics considered it to be a non-existing creation of haphazard PCR magnifications. No pure culture isolation has been made of either HIV or SARS-CoV-2, nor of other corona viruses. Mullis, who died in 2019, was basically excommunicated from the world of science for his public criticisms of PCR methods and the HIV theory of AIDS, even as myriad biotech and pharmacy companies, but not Mullis, raked in billions from his discovery. Today, the same big problems and inaccurate claims that emerged during the bogus "HIV epidemic" (which was supposed to depopulate Africa and kill tens of millions of people by now), have come back once again under the umbrella of Covid-19.
https://www.nobelprize.org/prizes/chemistry/1993/mullis/lecture/

Such problems as these are why many PCR testing labs around the country have reported 100% positive for entire populations they tested. This created a major scandal in Florida, where several labs were consistently reporting 100% Covid-

19 results, alerting Governor DeSantis to their bogus nature, and to end the massive lockdowns the "experts" had been advising. https://www.clickorlando.com/news/local/2020/07/15/high-coronavirus-positive-case-rate-reveals-flaws-in-florida-department-of-health-report/

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

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

Alarmist Reporting on Death Counts

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

Deliberate fear and panic has also been promoted by medical and government health bureaucrats, with support from power-drunk politicians. For example, the CDC Covid Tracker website screams out misleading full-year cumulative numbers for the USA in a manner conflating "cases" with deaths. On Dec.19,

they post in large text "OVER 17 MILLION TOTAL CASES", "1.6 MILLION CASES IN LAST 7 DAYS" and "312,636 TOTAL DEATHS". By early January 2021, it was "20.5 MILLION CASES" and "350,644 DEATHS". https://covid.cdc.gov/covid-data-tracker/ - cases_casesper100klast7days

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

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

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

How can the average person *not* be deeply frightened by these irrational and unnecessary displays of total numbers since January 2020, rather than the actual lower trends, as I've presented them here. How can they not believe that their very lives and those of their children are in severe danger, unless they lock down and shelter at home, with forced masking, etc., especially if that's all they hear or see? The massive censorship exerted today by mainstream media, and by the internet billionaires running Google, Facebook, Twitter, YouTube and the like, suggests a massive cover-up of all the facts that run counter to such panic-stricken official pronouncements. The true goal appears to be, *to erase any publicly-uttered opinion contrary to the WHO or CDC fear-porn, so that*

ordinary people won't hear much of anything beyond what the new Medical Police State, or Pharmaceutical Big Brother, is telling them.

Such alarmist reporting also parallels a trend where the all-cause death numbers for 2020 are being reported, again and again by grim-faced media stars, as "higher than any prior year!!" or "more people have died in 2020 than last year!!" as if the natural annual increase in deaths due to population growth as seen in the second column of Table 1A is something new or unexpected. It isn't.

These incongruities in the all-cause death numbers for 2020, and their hysterical reporting by mainstream media, with censorship of anyone expressing a contrary opinion, are not the way public health is best served or advanced. Such hysteria causes additional deaths due to the lockdowns and economic devastation that follows, as by suicide, drug overdose, alcoholism, family violence, psychological and iatrogenic factors. These factors alone might have driven up the death numbers for 2020. How many of them are mis-identified as "deaths due to Covid-19"? Though indirectly they are, due to *Covid hysteria*.

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

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

The data incongruities presented in this paper suggest a quite logical explanation, however unsettling: *The medical profession, hospitals and the WHO and CDC have been inappropriately shifting or duplicating deaths from other causes into the Covid-19 category. These shifted death numbers appear to*

include those dying of better-known respiratory disorders – COPD, influenza, pneumonia, asthma, emphysema, lung-cancers, congestive heart failure and other diseases and disorders. And all these diseases and disorders are driven up by annual cycles of frigid and moist wintertime weather, which are clearly seen in the Covid-19 data, further indicating the duplication and overlap.

Whatever the reasons, be they inaccurate clinical diagnoses and/or inaccurate PCR/Antigen testing, or just plain ignorance or criminal data-fudging at "high" levels of government or by hospital administrators, *such a procedure hides the shifting or duplicating of deaths from one category to another, but leaves the total number of 2020 all-cause deaths relatively unchanged* (see the Postscript).

Problems in Medical Diagnosis, and Suppression of Dissent

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

Today, modern medicine accepts the existence of infectious microbes, but additional medical disasters have taken place by stretching the germ theory beyond all rational limits. So-called "hiding" or "slow viruses" are a case in point. These were proposed as disease mechanisms starting in the 1980s, with the Acquired Immune Deficiency Syndrome (AIDS), when physicians ignored the original "Acquired" component and embraced a viral causation even when it could not be definitively isolated. The "infectious HIV" theory spread panic, claiming that while you got infected today, symptoms for AIDS would not appear for 10 years or more. And when you did get sick, the symptoms imitated over 60 different "indicator diseases". PCR tests were developed for HIV, which were no more accurate than the modern PCR tests are for Covid-19. Critics of the slow-hiding virus theory, such as top virologist Peter Duesberg,

were attacked and isolated. Duesberg was subjected to censorship of his articles in scientific publications, and punished by his Department of Cell Biology at the University of California at Berkeley. Many others became critical of speculative "infectious HIV" theory, all of whom were attacked and censored, and vilified in the mainstream media as "AIDS deniers". Today, due to massive censorship and cover-up of medical errors and toxic pharmaceuticals such as azidothymidine (AZT), that killed unknown thousands of people, major open questions persist about the legitimacy of the infectious HIV theory. Few today even know about the HIV controversies due to persisting censorship.

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

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

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

Pellagra is characterized by fatigue, diarrhea, dermatitis, open sores and dementia, culminating in death. It afflicted families and populations in the rural US Southern states. Starting in the early 1900s and running into the 1940s, some 3 million people were afflicted, with over 100,000 deaths. For reasons of close proximity it was assumed to be an infectious disorder, caused by an as-yet

undefined microbe. "Pellagrites" were frequently shunned, and due to dementia were placed in long-term mental hospitals. It was eventually found to be caused by poor diets lacking in Vitamin B3 (niacin) and tryptophan, as is typical of corn-based diets of poverty regions that are low in dietary milk, fresh fruits and vegetables. Physician Joseph Goldberger made that discovery in 1915, after bringing pellagra patients back to health by dietary changes and supplementation. He also proved pellagra could not be infectiously transmitted by deliberate injection experiments. Many years passed, with additional deaths, before his findings were widely accepted.

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

The skepticism against Goldberger's and Hansson's findings, and the personal opposition they were greeted with, is repeated today in a far worse manner by highly organized medicine, in the vilification, censoring and silencing of physicians and scientists who dare challenge the government-backed "official truth" about Covid-19. Some political totalitarians are today already advocating detention camps for Covid-19 lockdown dissenters, for those who refuse to be vaccinated, or who are "disobedient" to medical authority. Similar demands to lock people up were heard during the AIDS years, to silence critics of the conventional "infectious HIV" theory of AIDS. They were called "AIDS Deniers", just as today the term "Covid Deniers", have become popular curses, to demonize rational critics as being equal to neo-Nazi Holocaust deniers. Today the virologists' blundering errors are compounded, to both prescribe generally ineffective but toxic and expensive medicines against Covid-19, or the influenza and pneumonia which defines it, while at the same time working to deny and make illegal effective and inexpensive out-of-patent medicines.

Banned and Slandered, but Effective Remedies

Examples of the banned medicines include hydroxychloroquine, an anti-malaria and anti-lupus drug widely available in many parts of the world, notably in Africa as an over-the-counter drug against Malaria. It is an effective drug for Covid-19 as well. https://aapsonline.org/hcq-90-percent-chance/ https://drive.google.com/file/d/1w6p_HqRXCrW0_wYNK7m_zpQLbBVYcvVU/view

Another remedy is high-dose vitamin C therapy, firstly advocated by Nobel-Prize winner Linus Pauling in the 1980s, but severely attacked by American medicine given its better efficacy against colds, influenza, and cancer than conventional pharmaceuticals. Many physicians use it today for lung-distressed patients, as an IV-drip of 20 to 40 grams per day. Usually only a few days of such therapy are necessary for significant recovery. One can also home-treat with high-dose vitamin C (powdered calcium ascorbate is best), dissolved in water. http://orthomolecular.org/resources/omns/v16n12.shtml

Similarly, high-dose vitamin D therapy is very beneficial against lung-heart problems, something which modern medicine deprives people of by promoting lockdown madness that keeps people away from sunlight. https://www.academia.edu/44719317/COVID_19_Vulnerability_and_Vitamin_D_Deficiency

Ivermectin or azitheromycin are other out-of-patent economical medicines proving help against breathing disorders, also showing benefits to those with a Covid-19 diagnosis who are truly ill, whether it is factually influenza, pneumonia or something else. https://dominicantoday.com/dr/covid-19/2020/09/29/doctors-cure-6000-patients-with-covid-19-with-ivermectin/

Also the use of zinc or silver-ion supplements or lozenges, in various mixtures with the other things mentioned above, as a natural remedy approach for home treatment, and alternative to questionable hospitalization.

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

Changing Definitions of a Disease Case

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

"Evidence-Based Medicine" Often Ignores the Evidence

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

1) The bacteria must be present in every case of the disease.

2) The bacteria must be isolated from the host with the disease and grown in pure culture.

3) The specific disease must be reproduced when a pure culture of the bacteria is inoculated into a healthy susceptible host.

4) The bacteria must be recoverable from the experimentally infected host.

Point number 2 above is a sticking point for claimed viral disorders, such as HIV or the Hepatitis C virus, for which environmental or lifestyle factors within narrow high-risk groups play the major role in immune-system stress and sickness. Space does not permit a full discussion of Koch's Postulates and its growing abandonment, but it seems necessary to point out how the corona viruses have not been isolated in pure cultures by which their pathogenicity on lab animals could be identified in conditions free of other factors. And that weakens the large claims of the new "warp speed" vaccines supposedly based

upon such viruses. Even experimental inoculations of volunteers with mucous from influenza patients do not necessarily create influenza symptoms in volunteers. Such are the kinds of evidence that often places modern medicine at loggerheads with epidemiology, biology and other science disciplines, in determining the true causes of diseases, and their most effective treatments.

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

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

Entire books have been written on these subjects, on the over-reach and deadly nature of certain branches of modern medicine. Too often the claims of viral- and genetic-causation of diseases today become the abandoned theories of tomorrow, for what are later proven to be environmental, dietary or emotion-driven maladies. Genetics and biochemistry has their place, and successes, but far too many failures.

I will end this section by sharing a Covid-19 anecdote of a "death by hospital" which happened to a local friend's father. The elderly man, about 80 years old, developed a cough and fever, typical of influenza. In a panic about Covid-19, his wife rushed him by car to the hospital emergency room. Upon arrival, the medical staff came out in full haz-mat gear, and put him on a stretcher and took

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

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

POSTSCRIPT: 7 January 2021 – CDC/NCHS Data Gymnastics in the Last Week of 2020?

This article was basically completed on the 3rd of January. Since then, new data has become available which is addressed in this section.

On page 4 of this article, I wrote:

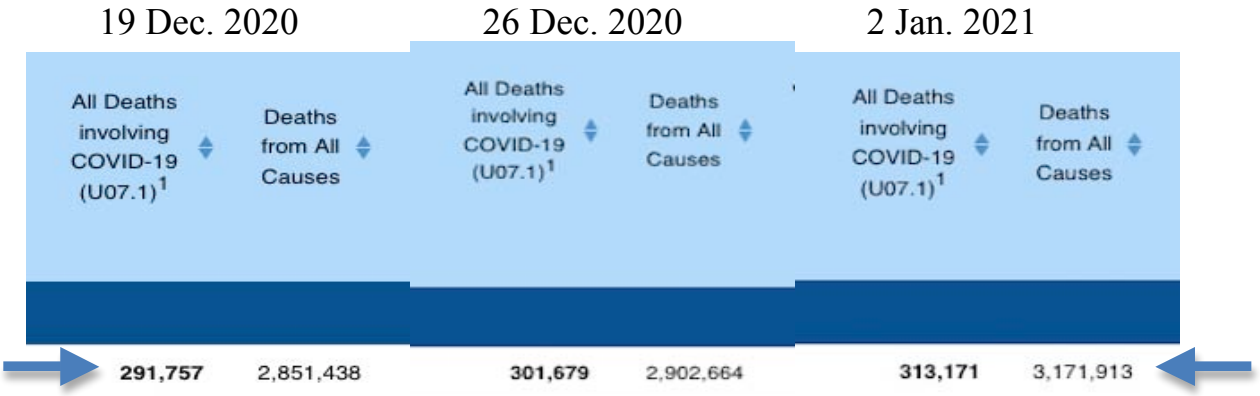
> " ... Covid-19 data are already included in the 2020 all-cause data, suggesting *the 315,507 Covid-19 deaths are somehow reducing or*

displacing the numbers of deaths from other causes, such as influenza, pneumonia, COPD, emphysema, heart disease, cancer, diabetes and so forth, by an equal number. But that cannot be the case, unless there is something dramatically wrong with how Covid-19 deaths are being counted."

And on page 5, I also wrote:

" To make the CDC/NCHS figures pan out, they must either "find" an additional several hundred thousand all-cause deaths, or present the claimed 315,507 Covid-19 deaths as a book-keeping duplication or re-definition of deaths by other causes."

Today, 7 January 2021, it appears the CDC/NCHS has done exactly what I predicted, adding several hundred thousand all-cause deaths into their end of 2020 calculations. Here are three screen shots from the CDC websites, for their Dec.19, Dec.26, 2020, and Jan.2, 2021 calculations (released on 7 Jan).



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

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

Table 4.	**Rise in**	**Rise in**
Week of	**Covid-19 Deaths**	**All-Cause Deaths**
19 to 26 Dec.	9,922	51,226
26 Dec. to 2 Jan	11,492	**269,249**

The rise in all-cause deaths in the last week of 2020 is a giant number, five times what might be expected, and appears quite suspicious. It is incongruent with all prior weeks of more gradual increases. Noting my prior statement from page 5, that "*To make the CDC/NCHS figures pan out, they must ... "find" an additional several hundred thousand all-cause deaths..."*

If we review those early January figures as I previously did in my Table 1A, we find the new numbers merely replicate the previously described data incongruities, as shown in Table 1B, below.

Table 1B: Number of people dying each year in the USA, All Causes, with Increases From the Prior Year

Year	All-Cause Deaths	Annual Increase	Covid-19 Deaths	
2010:	2,468,435			
2011:	2,515,458	47,023		
2012:	2,543,279	27,821		
2013 :	2,596,993	53,714		
2014:	2,626,418	29,425		
2015:	2,712,630	86,212		
2016:	2,774,248	61,618		
2017:	2,813,503	39,255		
2018:	2,839,205	25,702		
2019:	2,854,838	15,633		
2020 end Dec.31:	**2,916,492**	**61,654**	**315,507**	
2020 end Jan.2:	**3,171,913**	**317,075**	**313,171**	**- 2,336**

Table 1B repeats my original data from Table 1A, also with comparisons to the prior years back to 2010, as well as the 2020 end of year data from my Table 1A. To this, I have added the total 2020 CDC numbers through 2 Jan.2021, but released to the public only on Jan.6th. Recall that *the original 315,507 Covid-19 deaths were already included in the original all-cause death number of 2.9 million*. Now, with over 3.17 million all-cause deaths, we must ask where did those additional death numbers come from? The CDC also curiously lowered the total Covid-19 deaths by 2,336.

Additional evidence of data incongruities is found if we replicate my Table 2A using the more recent CDC 2020 data on age-groups as they exist on the same CDC website, which includes the Covid-19 and all-cause deaths over that last week of 2020 (plus Jan.1-2 in 2021). Table 2B, given below, shows the re-calculation.

Table 2B: USA 2020 Deaths by Covid-19 & All Causes, by Age (Jan.2)

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

https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm
Jan.2, 2021 update, remained posted through 7 Jan.
1. Percent of deaths in each Covid-19 age group relative to Covid-19 "All Ages" total deaths. 2. Percent of deaths in each All Causes age group relative to All Causes "All Ages" total deaths. 3. Percent difference, %Cov minus %All. 4. Excess Death Number Extrapolation from %Diff by Age, of claimed Covid-19 deaths for the same age-group.

The recalculation on Table 2B changed very little from Table 2A. The percentage of total Covid-19 deaths as a portion of the all-cause death dropped a bit, from 10.95% to 9.87%, while the comparative calculation of excess Covid-19 deaths went up by 223 persons, from 4,663 to 4,866. However, even with these larger numbers of total 2020 all-cause deaths, claiming over 3.17 million persons, the age-distributions have not significantly changed before or after the large increase of 269,249 deaths were added in the last week of 2020.

One clarification for my calculations above is that, the figure of 3.17 million all-cause deaths, in Table 2B, includes within it the 313,171 Covid-19 death counts, and so any proportional calculations must remove the Covid-19 counts from the all-cause counts. Consequently, I made a third re-calculation, from Table 2B, where the Covid-19 death numbers for each age-group were

subtracted from the same age categories of all-causes deaths. That data revision is presented in Table 2C below, providing the most robust calculation to date, *assuming that the original CDC data is itself robust, which is an open question*.

Table 2C: USA 2020 Deaths by Covid-19 & All Causes, by Age (Jan.2)

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

https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm
Jan.2, 2021 update, Same as Table 2B, except All Causes deaths are minus the Covid-19 number for each age-group.

Question: How did the above numerical subtraction procedure in Table 2C change the outcome?

Answer: Even while the total percentage of claimed Covid-19 deaths on Table 2C went up to 10.9% of the all-causes total, the *distribution of percentages for each age group*, for Covid-19 and all-cause deaths, remained about the same, with only small increases in the 65+ age groups. This is not what one expects to see in widespread deadly viral pandemic, but is congruent with all what has been presented here about mis-diagnoses of other respiratory diseases into a new but apparently artificial "Covid-19" category. Table 5, below, provides a summary:

Table 5: Total Deaths:	All Causes	Covid-19 (?) Deaths Num	%	Covid-19 (?) Excess Deaths
Table 2A (page 5)	2,902,664	301,679	10.39%	4,663
Table 2B (page 41)	3,171,913	313,171	9.87%	4,866
	All Causes in 2B *minus* Covid-19			
Table 2C (page 42)	2,858,742	313,171	10.9%	5,399
	Averages:		**10.4%**	**4,983**

Three different calculations have been provided, using different iterations of the publicly-announced CDC Covid-19 and all-cause death numbers for the whole of 2020. No matter how these numbers have been reviewed or calculated, in either Table 2A, 2B or 2C, the final annual excess deaths are low by standard expectations of a raging pandemic requiring massive lockdowns, and justifying state-enforced totalitarian measures.

The last two Tables 2B and 2C included the large data dump of early January 2021, of 317,075 all-cause deaths. However, neither those data-dumps, nor other variations in data or calculations mattered, in terms of providing a significantly different outcome.

The official CDC data on total Covid-19 and all-cause deaths, segregated into different age-groups, shows approximately the same percentage of deaths, with a total Covid-19 excess deaths averaging 4,983 for 2020. That works out to be around 14 deaths per day, or 15 deaths if we use only the data from Table 2C. These figures for the excess deaths due to Covid-19 are extremely low, even lower than the above-mentioned 6% of Covid-19 deaths without comorbidities, which computed amounted to 18,930 deaths for the year, which works out to be 52 deaths per day. In neither case can justifications be found for such massive governmental and medical panic-peddling, with lockdowns and other fanatical interferences in the lives of ordinary people.

One must keep in mind how respiratory illness has always been a major factor in the deaths of elderly people. Those over 65 years of age constitute about 88% of all cases of pneumonia and influenza. Given the questionable accuracy of Covid-19 PCR/Antigen test kits, the re-definitions pneumonia, influenza and other comorbidities as "Covid-19" (eg, "PIC" confusions, discussed above), and the fact that the majority of claimed Covid-19 cases and deaths occur during wintertime cold-damp conditions, we can expect the mis-diagnosed and inflated Covid-19 category to be biased towards inclusion of more people in the older age groups, whether or not they were truly infected with a new and deadly virus. This is aside from the financial or virus-ideology motivations for hospital

administrators to place Covid-19 on death certificates rather than the comorbidities which actually killed them. Such factors all trend for *a biased and unscientific selection of deceased elderly patients into the Covid-19 category.*

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

It is also unlikely that additional Covid-19 and all-cause death numbers added in the future, later in 2021, will significantly change the above comparisons.

Beyond my conclusions as given in the prior sections, I also raise a red-flag on that strange last-minute data-dump of 269,249 new all-cause deaths in the last week of 2020, as well as the final tally of 3.17 million all-cause deaths for 2020 as a whole, which is derived from it.

This appears to be either an egregious error or a fabricated number added to the CDC/NCHS data at the time of New Year celebrations and subsequent political turmoil. Did the CDC/NCHS do a last minute "number drop", to "balance the books" to account for the possible overlap of Covid-19 deaths within "P&I" or "PIC" death tallies, as I discussed starting on page 20? Or was this an innocent data-update, typical of prior years? These questions, I cannot answer.

Conclusions and Recommendations

The various issues raised above – trends in population and deaths, incongruent case-death data, seasonal variations, similarities and overlaps in clinical diagnoses between what is influenza or pneumonia versus what is Covid-19 disease, electron micrograph puzzles and PCR/Antigen testing inaccuracies – lead us to an "impertinent" question, an "outrageous hypothesis", which when taken seriously has always been of great value in science and medicine. This hypothesis, supported by abundant facts, appears to explain all the variations and evidence characteristic of this Covid-19 *epidemic of error and hysteria*:

Is this current "pandemic" one large error of misdiagnoses, an error of categories, of book-keeping, of inaccurate PCR and antigen tests, where seasonal influenza, pneumonia, colds and various upper and lower respiratory disorders are being misidentified as Covid-19? And once so "diagnosed" people

are not given less expensive, proven remedies for those "lesser conditions and diseases", but instead are given toxic meds and put through a hellish set of abusive treatments in hospitals which wreak havoc upon human biology, worsening symptoms and making death more probable?

Some have commented on this factor of shifting diagnoses, as a difference between those who *die of* a SARS-CoV-2 infection specifically, versus those who *die with* SARS-CoV-2. And that includes many people with influenza or pneumonia, or related COPD, congestive heart disease, etc., who then "test positive" for Covid-19. But that equation assumes the SARS-CoV-2 virus is a real and toxic entity, an assumption which, when put under critical scrutiny of its central claims, appears inadequate, or just plain wrong. In such a situation as described above, the death is recorded in both the "P&I" (pneumonia and influenza) category, as well as in the "PIC" (pneumonia, influenza and Covid-19) category, and is counted primarily as a death by Covid-19, no matter what kinds of deadly diseases or disorders they already had, and which were already taking them down into a death spiral. One can do a basic internet search for "died from cancer and Covid-19" or "TB and covid" or "diabetes and covid" or even "hip injury and Covid-19" and find numerous memoriam articles where Covid-19 was inappropriately placed on death certificates by physicians, to the alarm or confusion of the relatives of the dead. So what really killed those people? And do those deaths get double-counted in both Covid-19 and all-cause categories, thereby pushing upwards the death counts in both?

From all the above discussions, these additional summary points can be made:

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

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

* While Covid-19 laboratory tests do, by circular reasoning, generally predict Covid-19 *cases*, that is as far as it goes. From such test results, one cannot say

who will or will not get sick, or who will or will not die, aside from possible psychosomatic alarm and upset due to an hysterically presumed "Covid-19 Death Sentence". *As such, the entire theoretical basis of a new and unique "Covid-19 pandemic" appears as only an artificial diagnostic and theoretical construct.* People are dying, but ought to be diagnosed according to pre-Covid-19 symptomology.

* The numbers of all-cause deaths in the USA over the period from 2010 through the end of 2020, show the same approximate annual increases, of around 46,000 average added deaths per year, due to population growth alone. The largest numbers of deaths are concentrated among high-risk elderly in their end-of-life years. That natural increase in all-death numbers in 2020 is frequently being ignored, or is ignorantly blamed on Covid-19.

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

* Deaths by pneumonia and influenza are being deliberately mixed up with Covid-19 deaths in some government health agencies, suggesting they may be double-counted in both Covid-19 and all-causes categories, thereby magnifying the numbers of Covid-19 deaths, even *without* lowering the influenza and pneumonia deaths.

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

* PCR testing for Covid-19 is highly error-prone due to the intrinsic high sensitivity of that method, especially when the numbers of cycles on PCR-testing machinery are set too high. PCR test methods react to many things, including dead virus, non-living viral DNA/RNA fragments, and antibodies created by healthy people who are no longer at risk of the disease, or of spreading it. Antigen tests also cross-react with such things, but lesser so.

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

* Numerous studies have shown that mask-wearing and lockdowns do not result in fewer deaths. Instead, a large number of people are dying due to consequences of ruthless and insane lockdowns: suicides, drug overdoses, alcoholism, with increases in depression, addictions, family violence, and other horrors. Those factors are being totally ignored by the "experts in power" during this claimed but as yet unproven viral pandemic.

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

Recommendations:

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

2. Intelligent protections of the elderly and at-risk should continue, but without the strictly punitive, sadistic and cruel "protections" such as isolation wards, forced masking and removal from families. Outdoor exposure to natural sunlight and fresh air is a live-enhancing remedy all by itself.

3. Proven but suppressed remedies for all kinds of respiratory diseases, such as high-dose Vitamin C, Vitamin D, zinc supplements, hydroxychloroquine and other inexpensive, out-of-patent medicines must be fully legalized and made legally secure for over-the-counter purchase and use. Or at minimum, without prosecution or slander of physicians who choose to use them for treatment of their patients. There should also be a decisive end to medical-pharmaceutical media advertisements as was the case in prior decades.

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

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

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

7. The public must be alerted to this serious situation of emotionally-plagued medical, media and academic misreporting, where contrary rational voices are censored and the public is being misled and driven into unnecessary panic and self-destructive actions, to include lockdowns, masking, anti-social distancing, economic collapse and bankruptcy, treating friends and relatives like lepers, keeping children away from school, or placing them into plastic cages as if they were laboratory rats, and many similar alarmingly Medieval and fractious conduct. None of it is rational, or necessary. It is social suicide, in which "top" levels of sadistic, irrational and arrogant politicians, bureaucrats and medical officials are leading entire nations over a cliff.

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

THIS MUST END NOW!

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Additional citations:

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Update on 19 January 2021: Data on Tables 2A, 2B and 2C were re-computed for more precise decimal rounding in the calculations.
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* Dr. James DeMeo has an earned PhD in the field of Geography, with a specialization in Earth and Atmospheric Science. He is author or editor of nine books and over a hundred published research papers in science journals and popular media on environmental-atmospheric issues, biophysical experiments, science history, cross-cultural studies, and health-related subjects. A former university professor, he is today retired doing private research and writing. His scientific works can be reviewed on the Academia.edu and ResearchGate.net websites.
https://www.researchgate.net/profile/James_DeMeo
https://orgonelab.academia.edu/JamesDeMeoPhD