21st Oct 2021

As a retired Senior Hospital Scientist in Australia, I have some concerns about the current vaccination campaign.

A. Use of clinical data

1. All data obtained after the introduction of the vaccine in a population are observational. No one measured antibody levels prior to vaccination, despite the fact that the vaccine was introduced after the first wave of infection which would have created a cohort of subjects with naturally acquired immunity. In comparison to properly designed studies, the conclusions drawn from observational studies are never accurate. Clinical data analyses presented in the media from Israel, and also available through current pharmaceutical research, are from observational studies only.

   For example, in a current publication from Israel, it was stated that their data indicated that the elderly Israeli population had a higher survival rate and reduced disease severity during the second wave of infection.

   Vaccination in Israel was introduced after the first wave, when the virus had already circulated for more than six months. During the first wave, some of the immune compromised elderly population died, mostly because of delayed proper treatment, as no patients or doctors were prepared for the new disease. By the time the next wave of infections came, patients knew the symptoms (called an ambulance early) and doctors were ready with proper treatment; therefore, early interventions improved the survival rate and severity. Also, in nursing homes and in elderly people's homes, sterilisation, protection, isolation and distancing were introduced. Even the vaccinated elderly population used protective equipment during the latter waves of cases. The interpretation of data should involve the consideration of all these factors.

2. Authorities state that vaccinated people will be better off should they acquire SARS-CoV-2 infection. However, we all react differently to the vaccination, as immune response depends on gender, age, genetics, disease, environmental conditions and many other factors. Only data from one kind of study can prove that statement – research on twins. In all sets, one twin should be vaccinated, the other not. They should be infected with the SAME virus at the SAME time, with the SAME dose and live in the SAME conditions during the progress of the illness. There are no such a data. The data presented to the public are only observational, which could be coincidental and does not include all the relevant factors in data analysis.

3. No scientist or medical doctor would accept data that are in the 'statistically insignificant' range. When authorities gave to the media the example of a higher rate of unvaccinated versus vaccinated admissions in a USA city hospital (60% vs 40%), they conveniently forgot to mention that in that city's population, the statistics were 54% unvaccinated and 46% vaccinated. This makes the calculated result of 'no statistical significance'. Did the health authorities' doctors and scientists (demonstrably independent from pharma, I hope) provide this information, or was it prepared and reported to the relevant government bodies by journalists and pharma representatives?

4. The data from Israel show that vaccination doesn't work for the virus's new variants. Just compare data for Jordan and Israel (same environmental conditions, similar living conditions and close genetics). In their spring of 2021, when Jordan had 4% of people vaccinated and Israel had 45%, their rates of infection were the same. Now, on 8 September 2021, Jordan had 30% vaccinated and Israel 60%. However, Jordan had 86 cases (per 100K) and Israel 924 (per 100K) cases per day. This vaccine is highly specific and introduced a spike protein code only for the first variant of virus. However, a newly mutated form (Delta) was present. A future booster mRNA vaccine to control this new form (also known as a variant) would need to be precisely coded for it, and for any other variant/s. However, by the time a specifically coded vaccine is produced, it will be too late. Just as with the current vaccines for any rapidly mutating viruses, for example, viruses of Flu or Covid, variant mismatch is likely to be an ongoing problem. We can never catch-up with such rapidly mutating viruses. Australia has become a dumping ground for an outdated, ineffective product.

B. Revising medical knowledge and experience

1. What was wrong with the previous model of treatment? A patient attended a hospital when feeling sick, was tested and had a treatment, if required. Tracing to find clusters of infection was carried out using a patient address database. Instead of spending millions on the tests and vaccinations, would it not be better to spend that money on improvement of hospital facilities, ICU, Medicare and so on? At least, the taxpayer's money would be spent on long-term improvement of clinical care, which would benefit all taxpayers. Also, the improvements could be useful in the event of another pandemic.

2. Many people fear infectious disease. This fear has been stoked by the media such that many infected patients who would not otherwise go to the hospital do go, and so create a shortage of available treatment. I would say at least half the number of such patients experience shortage of breath from fear. Moreover, others sicken more rapidly and severely from immunosuppression induced by the stress of fear.

3. Vaccinated people have been told that they are threatened by the unvaccinated, when all that the unvaccinated ought to be is a source of a mild to inapparent infection to boost and improve the immunity of the vaccinated. Since the current mRNA vaccines are poorly effective at preventing infection, the vaccinated are also a source of infection to boost the immunity of other vaccinated people. Since vaccination induced immunity is often poor and waning, the threat of and blame for symptomatic vaccinated cases has been unjustly laid on the unvaccinated.

4. Doctors and scientists with concerns about vaccine safety are ridiculed. The label 'anti-vaxxers' has been used to create hate, distrust, division and an illusion of high vaccine demand.

5. A canon of medicine – 'never use vaccination during an endemic/pandemic, as it worsens the situation' – is being completely ignored. The proof of this statement is in the currently released NSW data, which demonstrate a high level of vaccinated in the covid death group.

C. Using taxpayers' funds in clinical aspects and Medicare rebates

1. Medicare rebates for tests

COVID case reports on the health.nsw.gov site are constantly changing. For a few weeks, I calculated the daily rate of cases/tests to follow the trend, as the number of positive cases depends on the number of tests performed. I have recorded daily report numbers for the last three weeks and found an inconsistency in their records. Was any audit performed in regard to laboratory reported cases verses the case numbers claimed in the invoices for the rebates? For example, as per data for the week 23-28 August, when invoiced on 4 September, the number of tests was 954,621 and, when invoiced on 10 September, the number reported for the same week was 936,058, a difference of 18,563 tests. Did they have the data audited? Did they have the invoices audited? Did any audits trace the numbers from the laboratory results up to and including the invoices?

2. Safety and efficacy of RNA vaccine

Did decision making committees include a molecular geneticist with experience in RNA, as it is all about the function of RNA in the body? Who suggested the use of a product (Pfizer vaccine), which requires storage at -70 degrees Celsius and is very unstable at higher temperatures? Furthermore, blood has a very high concentration of RNases (substances that destroy RNA). Were any investigations carried out in real life? Was how a product needed to be stored in hospitals and medical centres considered? What level of intact ingredients is left in the phial between thawing and injection into a person's arm? Perhaps during that time, the RNA deteriorates and breakage occurs. Every scientist knows that small RNA pieces can participate in gene regulation, which may be harmful.

3. Using costly -70° freezer facilities

   Generally in a hospital, -70° facilities are very limited and obviously not suitable for the storage of vaccines at such a scale. Did Pfizer install the additional -70° freezers in the hospitals, or were the freezers and their installation paid for from the health system's funds?

4. Laboratory test results interpretation

   To my knowledge, the main laboratory method used for COVID testing does not distinguish between the new virus variations. Was a data audit performed to prove that the statements about the results from the laboratory were correct? Was it Delta or another variant? It does matter, as Delta is claimed to be more contagious and has been used to create hysteria to increase the demand for further vaccines.

In my opinion, the misleading information from this campaign to reduce virus transmission and promote vaccination has led to gross financial and social burdens on our society and has put unnecessary pressure on our hospitals.

Victoria

S H Scientist, Australia