Monograph Two.
The Coronahysteria Series:
'SARS-CoV-2', the 'novel Coronavirus'.
A monograph by an
independent research consultant on
The Pathological Science of
the 'novel Coronavirus'

'An Interactive Anti-Coronavirus Toolkit'

Science Fiction tells of a future where suppression of human nature leads to eugenics, psychosis and murder – *That future is now.*

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Published May 2020 by KPC Research and Consultancy Limited
London, England, Great Britain.

ISBN 978-1-5272-6229-4

Designed and Printed in Great Britain
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How to cite this monograph:

Corbett K (2020) Monograph Two. *An Interactive 'Anti-Coronavirus Toolkit©'*. The Coronahysteria Series: 'SARS-CoV-2', the 'novel Coronavirus'. London, KPC Research and Consultancy Limited, May. ISBN 978-1-5272-6229-4

Frontispiece

"So now - no more football matches, live art, no more concert performances, of pop or classical music, or great singers, or of any 'live' culture

. .unless Government approved, or better, on a screen, in an image, but not the real thing?..

It's an attack on the power of direct visual perception, where an image presented to the eye replaces reality – our personal presence, the direct visual perception of the thing itself

– denying our human sensory perceptions, sensuality and physicality.

Isn't that just the same as what happened with 'HIV' and is now happening with 'SARS-CoV-2'?

Today virologists say ***its there*** *chemically, by means of using molecular and genetic techniques, their technics like surrogate marker tests, ELISA, PCR etc (and for 'HIV': T or CD4+ cells) ...*

..then why is there no morphology given for the 'infectious virus particle' to confirm its physicality, its ***personal presence?***

They say they know ***ITS there*** *chemically, but not physically? They don't care about physical presence, its '****old hat.'***

That's the same as looking in a mirror at an image.

But a mirror image of something is not the reality of that thing - ***the real thing*** *- is it?*

Is that what all this is about
– to replace the <u>real</u> with the <u>imaginary</u>*?"*

Kevin P Corbett, May 2020.

Figure 1. Open Air Maquette. Reflective Base. Perspex . 6"x12"x 3⅝".© Kevin P Corbett1981.

Epigraph / Quotation

Know then thyself, presume not God to scan;
The proper study of Mankind is Man.
Plac'd on this isthmus of a middle state,
A being darkly wise, and rudely great:
With too much knowledge for the Sceptic side,
With too much weakness for the Stoic's pride,
He hangs between; in doubt to act, or rest,
In doubt to deem himself a God, or Beast;
In doubt his Mind or Body to prefer,
Born but to die, and reas'ning but to err;
Alike in ignorance, his reason such,
Whether he thinks too little, or too much:
Chaos of Thought and Passion, all confus'd;
Still by himself, abus'd, or disabus'd;
Created half to rise, and half to fall;
Great lord of all things, yet a prey to all;
Sole judge of Truth, in endless Error hurl'd:
The glory, jest, and riddle of the world!
Go, wond'rous creature! mount where Science guides,
Go, measure earth, weigh air, and state the tides;
Instruct the planets in what orbs to run,
Correct old Time, and regulate the Sun;
Go, soar with Plato to th' empyreal sphere,
To the first good, first perfect, and first fair;
Or tread the mazy round his follow'rs trod,
And quitting sense call imitating God;
As Eastern priests in giddy circles run,
And turn their heads to imitate the Sun.
Go, teach Eternal Wisdom how to rule—
Then drop into thyself, and be a fool!

— Epistle II, lines 1-30, 1733

Alexander Pope

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Prologue

"He had ***moved*** from ***thought*** to ***words***,
and now from ***words*** to ***actions***."
George Orwell, 1984

"Prologue comes from the Greek term prologos, which means "before word", [and] is an opening of a story that establishes the setting, and gives background details."[1]

In this toolkit I draw on the predictive power of fiction together with various medical and other sources to both describe and illustrate how the Hysteria over the 'novel Coronavirus' is leading towards a form of physical and cultural death.

This Hysteria has bred mass delusion biasing medical diagnosis to more fully bolster and grossly inflate the evidence for the spurious disease category of 'Covid-19'. This occurs through the medical creation of illness and death, caused by faulty clinical reasoning during examination and treatment[2] *['iatrogenesis']*. This process of iatrogenesis is assisted also by powerful social forces like Terror and Fear *['sociogenesis']*[3].

All of these medical and social forces are being marshalled and fuelled in Great Britain and overseas by the confluence of Hysteria from the respective elected Governments, The World Health Organisation, the US Centres for Disease Control (CDC) and other non-elected *supranational agencies*[4], which are all now fatally impacting on our national psyches and policy makers.

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[1] https://literarydevices.net/prologue/
[2] For example: Wellbery C (2011) Flaws in clinical reasoning: a common cause of diagnostic error. American Family Physician. 84 (9):1042-8 November 1.Available at: https://www.aafp.org/afp/2011/1101/p1042.html
[3] For example: Radovanovic Z (1996) On the origin of mass casualty incidents in Kosovo, Yugoslavia, in 1990. European Journal of Epidemiology 12(1):101-13 February. Available at: https://link.springer.com/article/10.1007%2FBF00144437; and: Bartholomew, R., & Wessely, S. (2002). Protean nature of mass sociogenic illness: From possessed nuns to chemical and biological terrorism fears. British Journal of Psychiatry, 180(4), 300-306. Available at: https://www.kcl.ac.uk/kcmhr/publications/assetfiles/cbrn/Batholomew2002-proteannature.pdf
[4] Supranational agencies are international and are unelected. They work over, and against, our elected governments.

These unelected agencies include, the 24-7 news cycle of the Mainstream Media (MSM), The Bill and Melinda Gates Foundation (who fund Imperial College London[5], a British source of viral modelling), Gilead, and other pharmaceutical interests.

All of the above respective commercial and academic interests stand to gain financially from any subsequent mandatory mass screening, testing, treatment and travel certification ('passporting').

Investigative journalists are already onto it. Celia Farber cites the above confluence of vested interests, the "*Gates-led Pandemic Reich"*[6]. Jon Rappoport calls them the *"..actual conspiracy theorists —Gates, WHO, CDC—who invented the conspiracy.."*[7].

The sum effect of these forces is arguably to attack the power of direct human visual perception, where their images ('*viewing*') supersede our reality (*'seeing people*' - *'personal presence*').

The result (or *spell*?) is to subordinate *our direct human visual perception and physical-and-sensual experience* in favour of an *image* as opposed to our material physical reality.

This is popularly experienced - after the dissemination of propaganda for the 'novel Coronavirus' and its Lockdown - via our Government's promotion of:

- virtual telemedicine: not the traditional clinical physical exam;
- the displacement of the *physical presence* of family and friends – currently not allowed to actually enter *Hospitals (now essentially Prisons[8])* – except via virtual *viewing on screens*, not in the flesh; and
- loved ones left to die in such 'hospitals' without preferred religious rights[9], or family members, to comfort them; with our notification of their demise only happening via telephone.

I argue that our humanity is being destroyed through this pernicious 'novel Coronavirus' Hysteria and its attendant 'science', with its sinister application to the whole population of statistical epidemiological

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[5] Imperial College London website: $14.5 Million grant from The Bill and Melinda Gates Foundation, December 2019. Available at: https://www.imperial.ac.uk/news/189502/145m-gates-foundation-grant-help-improve/
[6] Farber C (2020). Was the Covid-19 Test Meant to Detect a Virus? Undercoverdc, April 7. Available at: https://uncoverdc.com/2020/04/07/was-the-covid-19-test-meant-to-detect-a-virus/
[7] Rappoport J (2020) Lockdowns: looks like an op, smells like an op, walks six feet apart like an op. No More Fake News May 6 2020 https://blog.nomorefakenews.com/2020/05/06/lockdowns-looks-like-an-op-smells-like-an-op-walks-six-feet-apart-like-an-op/
[8] One London care provider states: "*Communication with families is likely to be difficult for many reasons during periods of extraordinary pressure"*. Lewisham and Greenwich NHS Trust (2020) Critical Care Standard Operating Procedure Novel Coronavirus Disease (COVID-19) Contingency Plan. March.
[99] This is based on my own family's experience; the very same reports have come to me many times over from numerous colleagues, friends and acquaintances; they have also been relayed to me by >20 personal contacts working as doctors and nurses within the British health and social care services. The reports are that no family member is allowed into any care facility; family scrutiny of what goes on is therefore at best severely reduced or at worst totally non-existent. This lack of public oversight and scrutiny should be of major concern.

concepts of ambiguous nature and false benefit, such as: 'The R0', 'Mitigation' 'Social Distancing'; and 'Social Isolation' etc.

In this toolkit I relay how these concepts came from the same ideological processes that technically generated 'HIV' and which have now formulated this current ghastly and inhumane phenomenon.

This ghastly, inhumane and Hysterical phenomenon has several different names:

1. 'SARS-CoV-2' …… ..the alleged 'virus';
2. 'Covid19- disease' ……..the alleged 'disease' caused by the alleged 'virus';
3. The '*novel* Coronavirus' ……..another less technical sounding name for 1 (above).

Non-traditional virologists falsely assure us that these phenomena [1 & 3 above] exist chemically by 'evidence' from molecular and genetic techniques using surrogate marker tests, like ELISA, RT-PCR (and for 'HIV': T or CD4+ cells). However, no *morphology*, no direct *physical presence* of the purified infectious virus particle, is now needed to confirm its physicality - its personal presence.

I therefore argue that these so-called 'science experts' have dispensed with the *physical* and *human physicality* – appearing to *abhor humanity*; they *eschew* the research ethics formulated since Nuremburg; and they will *prospectively* act to undermine and overturn any concept of consensual medicine in propounding this technological Terror across vast populations. The aim is to prepare the global population for mandatory interventions like mass testing, treatment, vaccination and the associated passporting.

Just as in Nazi 'science' and 'medicine'- which produced the Industrial Scale State Killing Machine that targeted The Jews, The Infirm, The Homosexuals and The Others all deemed 'Life Unworthy of Life' - the same technical apparatuses previously used in 'HIV/AIDS' biomedicine are now being deployed in fuelling the creation of this false epidemic – *a fauxdemic*© – using Hysteria based on the *fearful belief* in an obscure and totally arcane agency not traditionally isolated called the 'novel Coronavirus'.

Its biotechnical *prodrome* - like a film 'trailer' for the *real show* – was 'HIV/AIDS' meaning 'HIV' causing 'AIDS': so now we have the full feature *Cinemascope*© version - 'SARS-Cov-2' causing 'Covid-19' disease - defined using the very same testing technologies.

The 'HIV/AIDS' 'film trailer' was confined mostly to targeted specified 'at risk' groups. Today, the global *Cinemascope*© feature film *'Covid-19'* includes the world in its *Risk Group*.

I illustrate how this *dragnet*[10] of medical testing is a modern day embodiment of the characteristics of Langmuir's *Pathological Science*. This 'novel Coronavirus' Hysteria is encapsulated most fully in the British Government's most terrifying public message: **'ANYONE CAN GET IT, ANYONE CAN TRANSMIT IT'**.

[10] "a series of actions taken by the police that are intended to catch criminals; a heavy net that is pulled along the bottom of a river or area of water when searching for something"
https://dictionary.cambridge.org/dictionary/english/dragnet

I do not aim to be exhaustive or attempt any in-depth statistical analysis. Efforts have been made to keep language clear and appropriate for both British and North American (USA and Canada) readers. Where technical terms must be used, definitions are given from commonly available sources, rather than academic ones; a glossary is also included. I welcome feedback on suggestions for improvement and any errors for future editions. The overall thrust of this toolkit is by necessity limited to illustrating and describing - in the style of *'samizdat'*[11]- as *an interactive Anti-Coronavirus toolkit'*© - so as to help enable others' *thoughts, words* and *actions.*

This toolkit uses Isaac Asimov's sci-fi novel *'The Naked Sun'* as a narrative for analysing the British Government's 'novel Coronavirus' Hysteria and the 'science' underneath this 'novel Coronavirus' and its attendant Lockdown.

Fiction can reflect our *here and now* and sometimes predict aspects of the future. Colleagues working in clinical healthcare services are unable to publicly or professionally stand out, and warn the public and the professions of the gross misdiagnosis that is now a daily occurrence.

The aim of the toolkit is to help enable readers to critically discern the damage that is being done to healthcare and diagnostic services. It should hopefully warn people of the risks involved for a trusting public who may have to run the gauntlet of a skewed and biased diagnostic procedure.

Another aim is to provide a rapid *critique* which is theoretical, cognitive, visual and 'sensory' (*meaning 'perceptual'*) – a composite and interactive anti-Coronavirus *toolkit*. This hopefully can contribute to others *thoughts*, *words* and *action(s)* with the characteristic limitations of all 'samizdat[12]'.

This toolkit is self-published given the constraints of voicing openly critical accounts of the 'science' underpinning this 'novel Coronavirus' and its Lockdown. Self-publication is a quick and timely means to warn others as a public duty. A further aim is to undermine the 'science' of the 'novel Coronavirus' and the Lockdown. By undermine I mean attack the essential nature of the applied epidemiological theory, especially with regard to its essential methods, validity, and scope as now applied to our population.

I regard epidemiological concepts as infinitely challengeable in terms of their inhumane application to our Liberty, Health and Humanity. These include the spurious concepts such as the 'R0', 'flattening the curve', 'mitigation', 'social isolation' and 'social distancing', all of which are applied during the Lockdown as official disciplinary forces. They are examples of what I have defined (after Orwell) as *LockSpeak©.*

Like Orwell's fictional *Newspeak,* I argue that this new and very tangible discourse functions to mask the reality with something more saccharine or seemingly benign. In this way it is even more pernicious and dangerous to our health than refined white sugar.

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[11] A form of dissident self-publishing activity across the Eastern Bloc during the Soviet era in which individuals reproduced censored and underground makeshift publications, often by hand, and passed the documents from reader to reader; the term was used to refer to both scientific and political dissidence; see: https://en.wikipedia.org/wiki/Samizdat

[12] Literally means a form of dissident self-publishing activity across the Eastern Bloc during the Soviet era in which individuals reproduced censored and underground makeshift publications, often by hand, and passed the documents from reader to reader; see: https://en.wikipedia.org/wiki/Samizdat

LockSpeak© sweetens our *reality* by trying to blunt our cognitive and physical recoil-response to what is in reality an almost complete removal of our Liberty to assemble, freely associate *and to directly perceive: to touch, to see and to hear*. It is sugar for neutralising our bile, via a discursive calming of the waters of our own intuitive and natural discontent.

Just like Chinese whispers[13], these notions based upon some misunderstood concern over safety become extenuated or attenuated until the original concept becomes completely ridiculous and meaningless.

These insidious and pervasive attacks on our physicality and language will ultimately negatively impact on our thoughts and actions. It is also noticeable how quickly various propagandising 'figures of speech' or particular 'arrays of words' have become ubiquitous parlance since January 2020. As such they are *LockSpeak©* idioms (read Table 1 below).

For example, the following commonly recurring and overly saccharine statements are now in common parlance in e-mails, telephone calls and personal interactions (if occurring) and reported to the author since February 2020 from a range of orators[14] (read Table 1 below).

Table 1 LockSpeak© Idioms And Phrases

Word string / array / idiom	Origin
staying safe	(professional body, routine e-mail)
in these stressful times	*(*professional body, routine e-mail)
saying safe in these stressful times.	(professional body, reduction in service)
Visit [us] without leaving home!	(cultural organisation, trying to drum up online business)
Stay safe till we see you again	(cultural organisation, trying to keep in touch with customer)
In these unprecedented times	*(*bank, advising bad news on reducing their interest rates)
Take every care	*(private health care 'provider', telling users to stay away)*
Until then - stay safe	(cultural organisation, trying to drum up online business)
plenty of ways to stay active	(national chain store, trying to drum up online business)
during this time	(national chain store, trying to drum up online business)

The science of the 'novel Coronavirus' has set ambitious targets to be nationally attained which were subsequently found to be unsustainable, unreachable and totally unattainable (e.g. 'containing the whole population', 'suspension of the economy' etc - the 'Lockdown').

[13] A group game where the first player whispers a message into the ear of the second, which gets repeated down the line; back to first player. Learning is about how the message changes through multiple articulations by different players; errors occur for due to anxiety etc: definition paraphrased from : https://en.wikipedia.org/wiki/Chinese_whispers

[14] The topic of *LockSpeak©* will inform a forthcoming monograph.

The toolkit aims to challenge and help overturn this new order that now appears to be shifting the country towards notions of a totalitarian viral dystopia using population surveillance (like in China). This could be used to justify mandatory testing, vaccination and certification as well the appearance of forms of social credit.

This is by virtue of the currently manufactured, over-zealous 'Covid-19' focus of all health services promulgated- like a confluence of smaller streams coming together into a larger river - by our elected British Government, its SAGE 'experts' and those unelected agencies like WHO, Bill and Melinda Gates Foundation and the pharmaceutical industry. Our elected governments are driven by the 'evidence' financed by those same unelected agencies.

These recent Government-promulgated moves toward a debased form of population medicine are in total opposition to the traditional preference for being properly *physically examined* and *evidentially treated* within our National Health Service (NHS).

The toolkit uses various sources including ***my own experience. It directly criticises the NHS and the*** new ***edifice*** into which the NHS has been rapidly reconstructed since December 2019. Its new industrial sized function is to 'triage' the population as they present to health services for what we are told is 'Covid19 disease' as part of the production of patient data for the fuelling, propelling and sustaining of the fauxdemic©.

The toolkit argues that our Government and its NHS promulgated 'Covid-19' Terror [the 'Lockdown'] is now very close to the micro details of Asimov's novel.

There exists a predictive power in fiction which can ring true in reality. The fictions can be used in helping to criticise the 'novel Coronavirus' and its attendant Lockdown whose 'science' - grounded as it is in knowledge called epidemiology – appears 'untouchable' to almost every politician, healthcare professional and many lay experts.

The aim is to help destroy the pernicious veneer of unassailable respectability and pseudo-certainty of epidemiology, which in this particular context as akin to the 'science' underpinning the German 1930s social developments, leading up to and rationalizing the Nazi era.

This toolkit is a *work in progress* – an *interactive 'samizdat'*[15] *- an anti-Coronavirus toolkit*, for reading, distributing and critiquing. The toolkit may apply in other countries and can be adapted accordingly. Due to space and other limitations, the focus is on the British context.

[15] A form of dissident, self-publishing activity, prevalent across the Eastern Bloc during the Soviet era in which individuals reproduced censored and underground makeshift publications, often by hand, and passed the documents from reader to reader; see: https://en.wikipedia.org/wiki/Samizdat

Tools

"A personal set of resources, abilities, or skills"[16]
"Something that helps you to do a particular activity"[17]

Each Tool can be used stand-alone as a reflexive resource to *think, write and act.* Brief strap lines describe each tool's content. The Tools are:

1. *Predictive Fiction:* how fiction can predict.

2. *"Coronavirus Hysteria'*:
    a. Trigger Warnings
    b. Fear And Terror Causing Public Hysteria
    c. Brainwashing Symptoms
    d. Hysterical Bias In Medicine
    e. Biased Tests

3. 'The Covid-19' Freeway':
    a. Pictures the 'NHS Pathway[18]' as 'The Covid-19 Freeway'
    b. Entry via symptom suspicion propelled via triage[19] and misdiagnosis.
    c. Freeway drivers must be aware of consent, inaccurate tests and dangerous medicines
    d. Use of 'Sat Nav' to avoid the 'On-Ramp' and exit via the 'Off-Ramps'.

4. *What's Bad In 'Corona Science'. The 'science' of the Coronavirus is science 'gone wrong.'*
5. *CoronaGuerillaArt. Visual Guerilla Attacks to Destroy 'CoronaScience'.*
6. Sci-Fact or Sci-Fi? Asimov's dystopia is now.
7. Epilogue.*'I've got to get used to it,* ***don't I****?*' Resistance, subversion and deprogramming.

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[16] Definition of 'toolkit': https://www.lexico.com/en/definition/toolkit
[17]Definition of 'tools': https://dictionary.cambridge.org/dictionary/english/tool
[18] This exists in all Western healthcare systems. The NHS version is defined as: "*The system is an interlinked series of algorithms, or pathways, that link clinical questions and care advice, leading to clinical endpoints. Non-clinical call handlers are presented with a series of questions. Based on the answers given, the most appropriate clinical response with a specific level of care and the time frame, is reached".* https://digital.nhs.uk/services/nhs-pathways#about-nhs-pathways
[19] Triage in medical facilities *is define as ".. the process of determining the priority of patients' treatments based on the severity of their condition or likelihood of recovery with and without treatment. This rations patient treatment efficiently when resources are insufficient for all to be treated immediately; influencing the order and priority of emergency treatment, emergency transport, or transport destination for the patient"* https://en.wikipedia.org/wiki/Triage

1.Predictive Fiction

> *"From Jules Verne to Neal Stephenson, authors have been speculating about — and predicting — technological and social '**advancements'** for as long as the genre has existed."*[20] [emphasis added]

> *"Tomorrow we're launching Science Fiction, a new addition to our acclaimed Documents of Contemporary Art series. Head to our website tomorrow to find out more, especially if you're wondering, like us, **what Sci-Fi might reveal about the strange days of pandemic living**"*[21].[emphasis added]

'Fiction' and art have predictive power.

The Greek myths are not 'just so' stories. They are explanations of humanity's individual and social psychology handed down to us thousands of years ahead of its so-called 'birth' via Freud and Jung[22].

Fiction's predictive power is popularly experienced as scientific 'advancement'. For example, the TV series *Star Trek* predicted cell 'phones; the feature film *2001: A Space Odyssey* electronic tablets.

All well and good, some would argue. More darkly sinister developments are also predicted. Our response is less: *Wow! Isn't that an amazing coincidence!* But more: *However did they get it so right?* For example, a video game called *Deus Ex* was launched in 2000:-,

> *"..set in a dystopic near future in which the gap between rich and poor has reached unprecedented heights, where corporations influence and in essence run governments, and secret organizations vie for power in an underground war. Domestic terrorism is on the rise..the world is afflicted by a plague called the "Gray Death," the synthetic vaccine for which is in extremely limited supply and is thus primarily available only to those in crucial social positions, such as government officials, or those with power and influence, such as the wealthy and the intellectual elite.."* https://u.osu.edu/lemon243eng4563/deus-ex/

Terror, plague and vaccines. Sounds familiar?

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[20] https://u.osu.edu/lemon243eng4563/why-speculate/looking-ahead-to-the-future/the-predictive-power-of-speculative-fiction/

[21] Whitechapel Art Gallery, London; e-mail dated May 2, 2020; sent to subscriber list, entitled New Screening - Raqs Media Collective is now online

[22]From Tristen Westwood; personal communication.

2. Corona Hysteria

The mechanisms driving the 'Coronavirus Hysteria':

A. **Warnings Against Interacting**

B. **Fear And Terror = Hysteria**

C. **Brainwashing Symptoms**

D. **Hysterical Bias In Medicine**

E. **Bias in British 'Covid-19' Testing**

A. Warnings Against Interacting

The British mainstream media (MSM) are now verbally broadcasting Warnings before and after certain television programmes recorded pre-Lockdown.

These subtle and seemingly reasonable messages tell viewers that social distancing and social isolation are now the 'new normal'. Any sort of arena sports, arts, or other cultural performance may subsequently carry Government safety warnings, or even be completely banned, depending upon the cut-off in numbers of people 'allowed' by our Government to assemble.

The subtle appearance of these messages is now propagandising how social distancing is 'pleasurable', 'desirable' or even 'natural' for 'safety's-sake' in these 'uncertain' or 'unprecedented times'. This insidious propaganda if left unchecked may mean that arena concerts like the one from the snippet overleaf may be fatally altered or disappear as a cultural art form, or may be banned. This could equally apply to various forms of athletics, contact sports and other in-door and outdoor assemblies.

The 'new normal' in the promotion of what is officially approved has great potential to kill human 'art' and 'culture' as we have traditionally come to know it -

The Table 2 (below) takes this to an extreme, with the 'unsafe' lyrics of an ordinary pop song, to make a point about the potential impact of trigger warnings, and the current media reappraisal and reconfiguration of our concepts of 'normal' if and when they are carried to their logical extremes. Language curtailed, as Orwell noted, means thought and actions are also curtailed. Humanity thwarted. Table 3 (below) shows the real meaning of our Government's 'health messages'.

! You Have Been Warned !

P.T.O

Interactive 1

Diana Ross Performs

'Touch By Touch':

A LIVE Arena Concert With Thousands Breathing The Same Air

[No Government Social Distancing POSSIBLE]

"The smell of her hair, the taste of her mouth, the feeling of her skin seemed to have got inside him, or into the air all round him. She had become a physical necessity."

- George Orwell, 1984 [emphases added]

30th Anniversary Tour 1994. Ahoy, Rotterdam, The Netherlands

3½ mins approx. Click on the link below or paste this link into your browser:-

https://www.youtube.com/watch?v=7tldM85AVeI

To view the performance click on the link above or copy and paste into your browser

Table 2 '~~Touch~~ ViewBy~~Touch~~View': Public Safety Revision Of Dangerous [~~Sensuous~~] Lyrics
[Aim: Transform pre-*LockSpeak©input* into *LockSpeak©output*]

Pre-*LockSpeak*© input DangerSpeak© isolated in highlights	*LockSpeak*© edit *DangerSpeak© isolated / safely replaced via LockSpeak©*	*LockSpeak*© output *LockSpeak©enhancements accepted by publishers*
*I can tell by the **look** in your eyes* *That you like what you **see*** *I can tell by the **touch** of your hand* *That you've got what I need* *Baby there's no hurry* *We've got no worries* *Let's take all night* ***Give** me sweet lovin'* *Come **taste** my honey* *Into the light* ***Touch** by **touch*** *Your **fingers** do the talking* *I need to **hear** so much* ***Touch** by **touch*** *Now you're getting **closer*** *To what I want so much* *I can tell by the woman **in me*** *You're the man that I need* *So much lovin' that comes from your **heart*** *That you **give** tenderly* *Come **take my hand*** *I'll show you where* *Where you can **lean*** *Baby there's no hurry* *We've got no worries* *Make me believe* ***Touch** by **touch*** *Your **fingers do the talking*** *I need to **hear** so much* ***Touch** by **touch*** *Chemical reaction* *Makes me give it up* ***Touch** by **touch*** *And put your **arms around me*** *Baby **wrap me up*** ***Touch** by **touch*** *Now you're gettin' **closer*** *To what I want so much*	*I can tell by the ~~**look**~~ view in your eyes* *That you like what you ~~**see**~~ view* *I can tell by the ~~**touch**~~ temperature of your gloved hand with my gloved hand* *That you've got what I need* *Baby there's no hurry* *We've got no worries* *Let's take all night* ***Safely Give** me sweet lovin'* *Come **taste** only through a dental dam my honey* *Into the light* ***~~Touch~~** View by view **~~touch~~*** *Your gloved-**fingers** do the talking through FFP3 mask* *I need to **detect** **~~hear~~** so much* ***~~Touch~~ View** by view **~~touch~~*** *Now you're getting **3 feet closer only*** *To what I want so much* *I can tell by the woman **~~in me~~** you view* *You're the man that I need* *So much lovin' that comes from your **~~heart~~ nucleus*** *That you safely **give** tenderly* *Come **take my gloved hand with your gloved hand*** *I'll show you where* *Where you can **lean safely 3 feet apart at least*** *Baby there's no hurry* *We've got no worries* *Make me believe* ***~~Touch~~** View by **~~touch~~ view*** *Your gloved **fingers do the talking through FFP3 mask*** *I need to **~~hear~~ detect** so much* ***View Touch** by **view touch*** *Chemical reaction* *Makes me give it up at safe distance* ***Touch View** by **view touch*** *And put your **arms ~~around me~~ three feet away*** *Baby **wrap me up safely*** ***View ~~Touch~~** by **view ~~touch~~*** *Now you're gettin' **near to 3 feet closer only*** *To what I want so much*	*I can tell by the view in your eyes* *That you like what you view* *I can tell by the temperature of your gloved hand with my gloved hand* *That you've got what I need* *Baby there's no hurry* *We've got no worries* *Let's take all night* *Safely give me sweet lovin'* *Come taste my honey only through a dental dam* *Into the light* *View by view* *Your gloved-fingers do the talking through FFP3 mask* *I need to detect so much* *View by view* *Now you're getting 3 feet closer only* *To what I want so much* *I can tell by the woman you view* *You're the man that I need* *So much lovin' that comes from your nucleus* *That you safely tenderly* *Come take my gloved hand with your gloved hand* *I'll show you where* *Where you can lean safely 3 feet apart at least* *Baby there's no hurry* *We've got no worries* *Make me believe* *View by view* *Your gloved fingers do the talking through FFP3 mask* *I need to detect so much* *View by view* *Chemical reaction* *Makes me give it up at safe distance* *View by view* *And put your arms three feet away* *Baby wrap me up safely* *View by view* *Now you're gettin'* near to 3 feet *closer only* *To what I want so much*

++ [now nationalised] ++Lyrical Transformation follows the UK government approved science of Imperial College London coded as *LockSpeak©.*LockSpeak©* transformation with 'view' is preferred to guarantee maximum public safety deterring high Coronavirus risk and R0<1.0. Songwriters of pre-Lockdown: Barrow Arthur W, Joseph Patrick "beans" Esposito, Richie Zito and W Barrow Arthur Touch by Touch lyrics © Warner Chappell Music, Inc 1989

B. Fear + Terror = Hysteria

For 'public' read 'ordinary people' + *'doctors'* + *'nurses.* Government '*Covid-19 symptoms*' = textbook Hysteria Symptoms in red below.

> *"In modern usage, the term hysteria* ***connotes mass panic (mass hysteria).*** *Hysteria was often associated with events such as the* ***Salem witch trials***
>
> *...****and the term "hysterical suffocation" – meaning a feeling of heat and inability to breathe,*** *was ..used in ancient Greek medicine.*
>
> *Historically, hysteria was* ***thought to manifest itself .. with a variety of symptoms, including:*** *anxiety,* ***shortness of breath,*** *fainting, insomnia, irritability, nervousness..."*
>
> *https://en.wikipedia.org/wiki/Hysteria [Accessed 30-Apr-2020][emphasis added]*

Read the British Government Terror advertisement Figure 2 [overleaf]

–the terrifying message is targeted personally at YOU:

"ACT LIKE YOU'VE GOT IT,

ANYONE CAN SPREAD IT"

It is terrorizing you

It is terrifying you

Telling you to act like you are DISEASED

IT IS PURE HYSTERIA

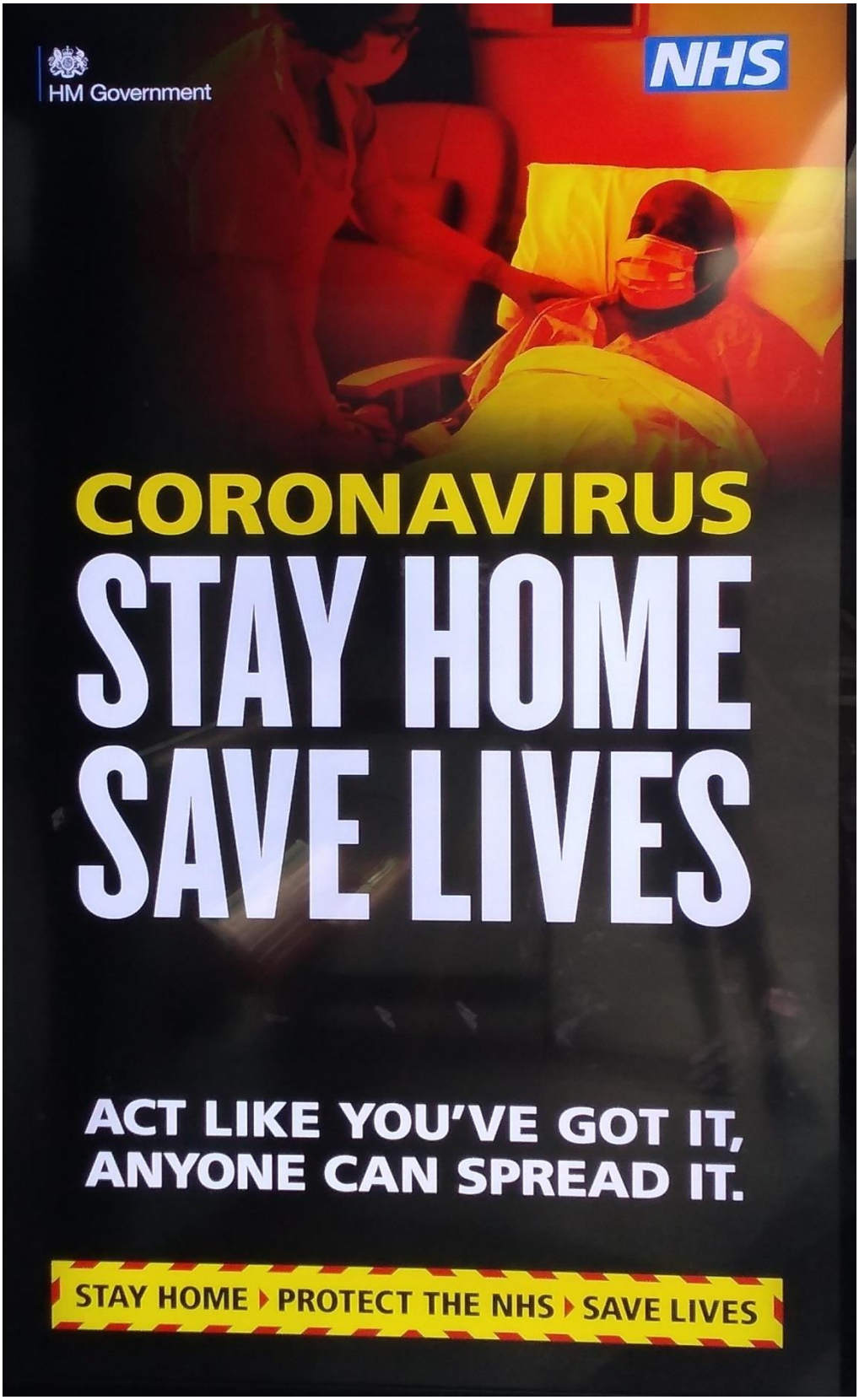


Figure 1 Personalised Government Terror 'Health' Message.

(Chancery Lane Bus-Stop, London, England, April 2020)

NOW READ FIGURE 3 ON THE NEXT PAGE:

ANOTHER SHOCKING EXAMPLE OF THE BRITISH GOVERNMENT'S

TERROR

FEAR

&

PROPAGANDA!

AIMED AT EVERYONE

THESE GOVERNMENT MESSAGES PROMOTE:

NO *TOUCHING..*

FEAR OF THE *PHYSICAL* - THE *SENSUAL..*

GLOVE AND MASK *WEARING..*

PARANOIA..

SOCIAL *DISTANCING* AND *ISOLATION..*

HUMAN *LONELINESS..*

SOCIAL, PSYCHOLOGICAL, PHYSICAL AND SPIRITUAL ..

DEATH.

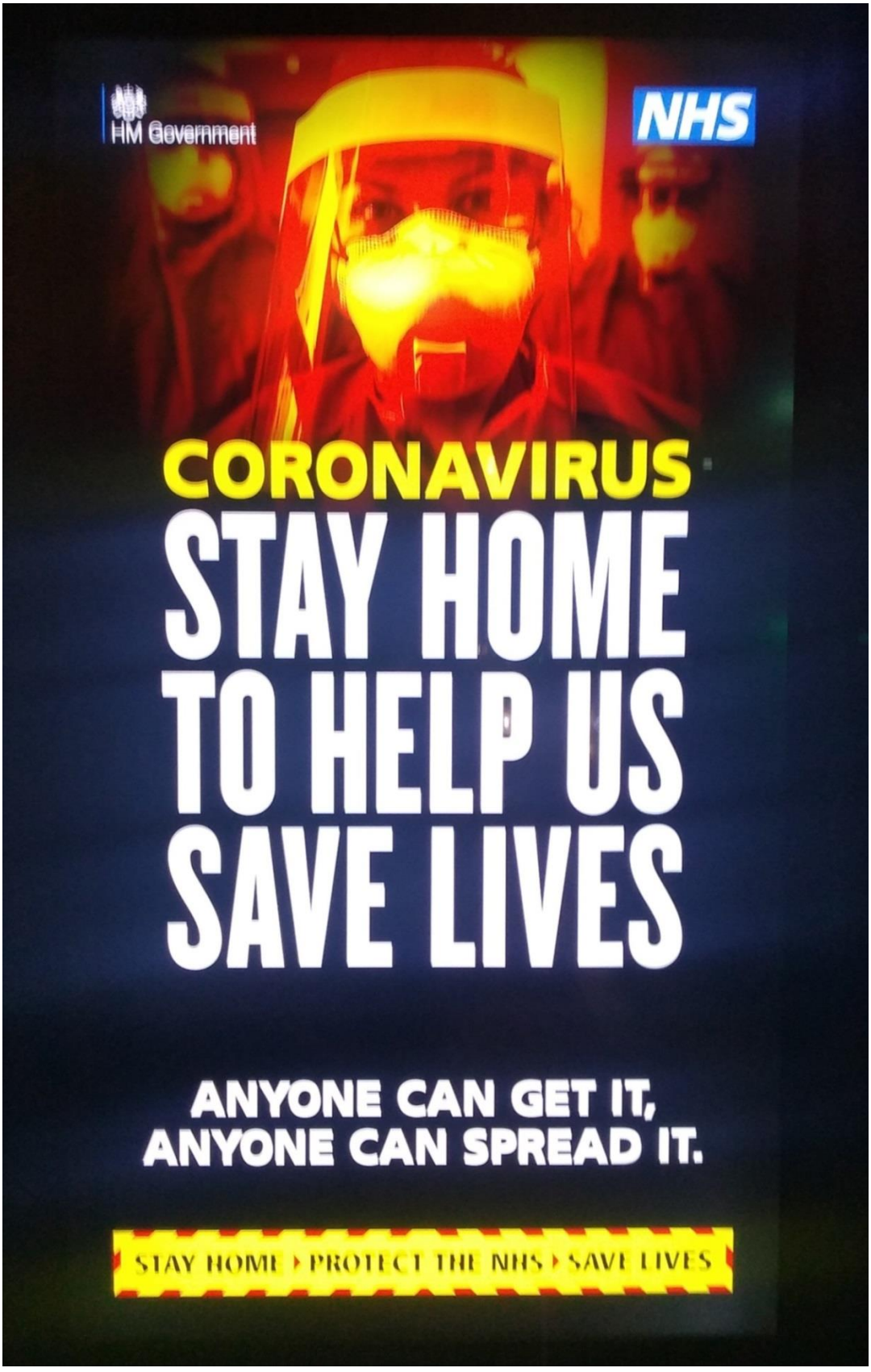


Figure 2 Government Terror 'Masked' As A 'Health' Message.

(Chancery Lane Bus-Stop, London, England, March 2020)

Table 3 The Pathology Underneath The British Government 'Health' Messages

BRITISH GOVERNMENT 'HEALTH' MESSAGES	PUBLIC INTERPRETATION	REAL UNHEALTHY EFFECTS
'Anyone Can Get It, *Anyone Can Spread It'*	You Are Dangerous Your Family Are Dangerous The Population Are Dangerous You Are A Potential Killer Your Family Are Potential Killers The Population Are All Potential Killers You Are A Suspect Your Family Are Suspects Your Neighbours Are Suspects The Population Are Suspects	• ***Creates Fears*** • ***Creates Anxieties*** • ***Creates Loathings*** • ***Creates Paranoia*** • ***Creates Obsessional Compulsions***
'*Save Lives'* *'Stay at Home'* *Only Call 111'* *'Go to NHS.UK'* *'Do Not Go To Your GP or Hospital'*	House Arrest Don't Bother Health Services Leave Health Services Alone	• ***Untreated morbidity*** • ***Exacerbation of mortality*** • ***Destroys Constitutional Right*** • ***Destroys Human Right***
'*Restrict Movement'* *'Do Not Meet Others, Even Family or Friends'* *'Isolate Your Household'* *'Prohibit Proximity'* *'Stay Away From Health Services'* *'Everyone in your household must stay at home'*	Tyranny / Creates Mental Illness Fraud / Theft / Rationing: Physical-Presence with Health Care Provider Withdrawn or Severely Reduced All Contrary to Public Expectations And Taxation (Social Contract)	• ***Destroys Human Instinct*** • ***Creates agoraphobia*** • ***Creates Fears*** • ***Creates Anxieties*** • ***Creates Loathings*** • ***Creates Paranoia*** • ***Creates Obsessional Compulsions*** • ***Withdraws Service Your Taxes Already Paid For***

C. Brainwashing Symptoms

Notice How Common and Similar [meaning: 'Protean'[23]] These Are? How Medically 'Non-Specific'- How Common Or General They Are? 'Generic'? (Red=hysteria symptoms)

Great Britain, National Health Service[24]	**United States, Centres For Disease Control[25]**
• *"a **high temperature** – this means you feel hot to touch on your chest or back (you do not need to measure your temperature)"* • *"a new, continuous cough – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)"*	• *"Cough* • ***Shortness of breath or difficulty breathing*** *Or at least two of these symptoms:* • ***Fever*** • ***Chills*** • *Repeated shaking with chills* • *Muscle pain* • *Headache* • *Sore throat* • *New loss of taste or smell"*

[23] 'Protean' means 'changeable', 'ambiguous', 'slippery': Cambridge Online Dictionary defines 'protean' as: "*easily and continuously changing*": https://dictionary.cambridge.org/dictionary/english/protean

[24] https://www.nhs.uk/conditions/coronavirus-covid-19/check-if-you-have-coronavirus-symptoms/

[25] https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

D. Hysterical Bias in Medicine

In the current climate of Hysteria and Government propaganda, the Differential Diagnosis is skewed.

When people attend a physician, nurse practitioner or any registered healthcare practitioner the proper assessment should aim to resolve the differential diagnosis.

The ***differential diagnosis*** is the traditional process whereby a suitably trained and registered ('licenced') healthcare practitioner (HCP) differentiates between all conditions which share similar signs/symptoms.

This is completed on the basis of evidence from physical examination ('clinical signs': what the HCP observes), laboratory workup [so-called 'objective'] and the patient's story ('self-report' symptoms).

A decision is then made, usually (traditionally) with the patient, about these particular collections of signs/symptoms and what they definitively imply in terms of pointing to one particular condition (diagnosis) as opposed to any of the others which could potentially apply – thus the HCP *formulates* a 'definitive diagnosis'.

Read below in Table 4 what is said by a practising American physician about medical experts' own propensity to make the wrong call '[wrong diagnosis'] based on hearsay, propaganda and peer pressure, when deciding on the differentials for the 'correct' diagnosis:

Table 4 Diagnostic Biases and Corrective Strategies (adapted from Wellbery 2011)

BIAS	DESCRIPTION	CORRECTIVE STRATEGY
Anchoring	Sticking with a diagnosis	Examine the impact of nonresponse or new information on the original diagnosis
Availability	Referring what comes to mind most easily	Know baseline prevalence and statistical likelihoods of the condition diagnosed
Confirmation	Assigning preference to findings that confirm a diagnosis or strategy	Use an objective source (e.g. differential diagnosis checklist) to evaluate whether the diagnosis correlates with technical findings
Framing	Assembling elements that support a diagnosis	Elicit different perspectives by broadening the history to search for other causes or associations
Premature closure	Failing to seek additional information After reaching a diagnostic conclusion	Review the case, seek others opinions (e.g. radiology backup) and consult objective sources (e.g. other reviews)

Table 5 List of Diagnostic Biases

(cited in Wellbery 2011[26])

- "Many medical errors have been identified as systemic and addressed with interventions, such as **checklists**. However, a substantial number of errors that occur in diagnosis and treatment are attributed to **flaws in clinical reasoning.** It is unknown how often such errors occur, but they are **most common in primary care specialties**

- Errors in diagnostic reasoning are often attributed to biases or heuristics[27]

- A wide variety of diagnostic biases have been described in the literature. **These include the notions that common diseases occur more often,** and that a **single diagnosis accounting for numerous symptoms is better than cobbling together several explanations**. However, at times, pearls become pitfalls. They can lead to **erroneous conclusions**

- One commonly described bias is known as the **availability bias**, which refers to the ease with which a particular answer comes to mind. For example, a physician might make a diagnosis based on a recent patient with similar symptoms. ***This bias often excludes diagnostic possibilities..in the differential diagnosis.***

- Sometimes a ***constellation of findings***..suggests one diagnosis more readily than another. ***This constellation then becomes a frame***, which is ***a sort of narrative that disallows other diagnoses..Disregarding the possibility of other diagnoses also can lead to premature closure. With this bias, the physician does not seek additional information after reaching a conclusion about a diagnosis.***

- Availability and framing biases ***may anchor a diagnosis in the physician's mind***, making it hard to dislodge***. When a patient does not respond to treatment, an anchoring bias would lead a physician to prescribe a stronger dose or a different formulation of a previously prescribed medication rather than consider another diagnosis***.

- ***Relying on another physician's opinions illustrates the bias of groupthink, or blind obedience, in which an agreement is reached based on an authoritative source (e.g., laboratory and imaging test results) without sufficient examination. Another bias associated with diagnostic tests is the confirmation bias, which leads the interpreter to overemphasize findings that support the original diagnosis…there is considerable overlap among biases.***

- ***How can diagnostic errors be prevented? Unfortunately, it is easier to elucidate[28] the barriers to error prevention than to remedy them.."*** (Wellbery 2011, emphases added).

---

[26] Wellbery C (2011) Flaws in Clinical Reasoning: A Common Cause of Diagnostic Error American Family Physician 84(9):1042-1048. Available at: https://www.aafp.org/afp/2011/1101/p1042.html#afp20111101p1042-b1

[27] Rule of thumb process, or a process based on experience https://www.vocabulary.com/dictionary/heuristic

[28] Make something clear, give it a clear explanation: https://www.merriam-webster.com/dictionary/elucidate

Question: Given the above, why is 'Hysteria'[29] not part of the Differential Diagnosis when people present ***themselves*** to any *Accident and Emergency department (ER)*[30] with these symptoms instead of the 'novel Coronavirus?

Symptoms: ***feeling heat, shortness of breath, inability to breathe, high temperature, fever, chills***

Answer: **The Terror messages that have been put out in the media by the Government about the belief in the 'novel Coronavirus' influence the assessment undertaken by health care practitioners: biasing and skewing the traditional process of the Differential Diagnosis towards a 'presumed' or 'clinical' diagnosis of 'Covid-19'.**

[29] Or: choose a more *'politically-correct'* equivalent psychiatric diagnosis reflective of the SAME symtpoms.
[30] In Britain medical emergency triage and treatment facilities are commonly called 'Accident and Emergency' ('A&E's) departments; in the US, the equivalent facilities are commonly called 'Emergency Rooms' ('ER's).

E. Biased Testing

Reader:

Consider the above information.

Then put it together with the following information below.

This information was recently disclosed by Public Health England in the e-mail trail overleaf.

The information is about test accuracy.

To summarise, it reveals the following:

- no proper gold standard exists for any 'Covid-19' tests – RT-PCR or Antibody Tests;
- *'no commercial kits validated for use in the UK'*.

Then, you Readers of this Toolkit might like to have been asked, and to answer, the following:

> *How many of you feel comfortable about taking a test, or being medically assessed, by any health care practitioner who could so misdiagnose you today by 'viewing' you though the **'Covid-lens'** biased by Symptom Propaganda and 'tests' which the British test authorities acknowledge (in e-mail[31] below) are of unproven accuracy and have no proper gold standard?*

Now please read the e-mail trail OVERLEAF:

[31] Read the profiles British Government's science advisors like Professor Zambon, director of Reference Microbiology Services at Public Health England, and head of the UK World Health Organization National Influenza Centre: https://www.theguardian.com/world/2020/apr/24/coronavirus-whos-who-on-secret-scientific-group-advising-uk-government-sage

E-mail One: Sent by Dr Corbett to Public Health England on April 25th 2020

from Dr Kevin P Corbett to Professor Maria Zambon (director of Reference Microbiology Services at Public Health England, and head of the UK World Health Organization National Influenza Centre).

Dr Corbett asked the following questions:

Dear Professor Maria Zambon

I wonder if you could help me?

I am writing to you in your role as director of the Reference Microbiology Service at Public Health England (and SAGE member).

I am preparing an educational presentation on COVID-19 and need some data to illustrate the PPVs for teaching purposes.

In relation to the SARS-CoV-2, I need data for:

i) RT-PCR test(s); and
ii) antibody test(s)
used in England and Wales, or in all of the UK countries, if available.

I've included the respective matrices below for each test methodology.

Would you be able to provide me with some actual numbers or signpost me to as source, as I have not been able to find any.

Perhaps they are in the manufacturers' test kit packet inserts, which I also cannot find.

I'd be most grateful for any assistance you can give in this difficult time.

Kind regards

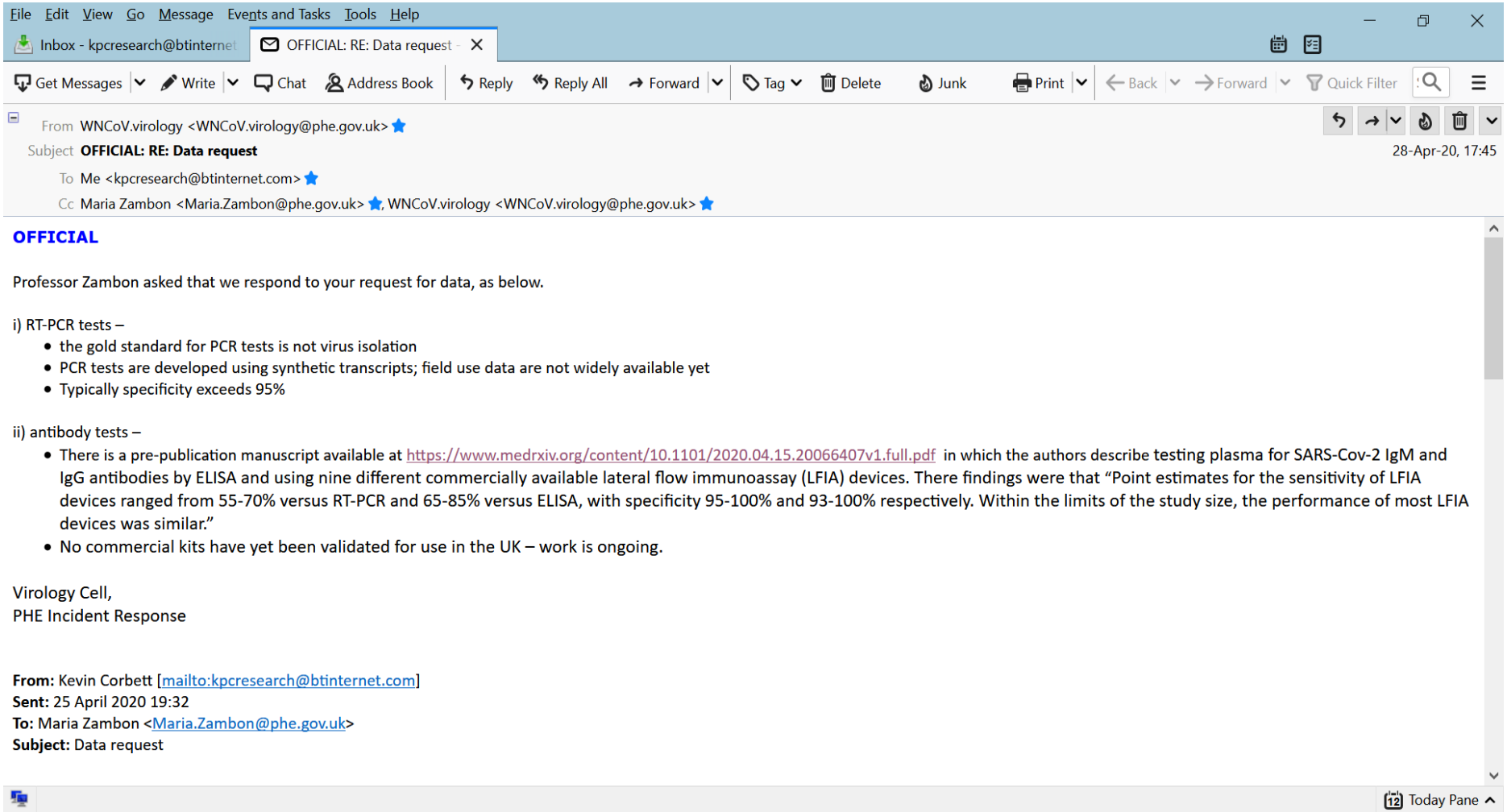
Kevin Corbett
--
Kevin P.Corbett MSc PGCE PhD

Test Result	Virus isolated	Virus not isolated	Totals
RT-PCR **POSITIVE**	A	B	A+B
RT-PCR **NEGATIVE**	C	D	C+D

Test Result	Virus isolated	Virus not isolated	Totals
Anitbody **POSITIVE**	A	B	A+B
Antibody **NEGATIVE**	C	D	C+D

E-mail Two: Received by Dr Corbett from Public Health England April 28th 2020

From Professor Maria Zambon (director of Reference Microbiology Services at Public Health England, and head of the UK World Health Organization National Influenza Centre). Professor Zambon gave the following answers to the questions asked above [E-mail One]:



File Edit View Go Message Events and Tasks Tools Help

Inbox - kpcresearch@btinternet | OFFICIAL: RE: Data request

Get Messages | Write | Chat | Address Book | Reply | Reply All | Forward | Tag | Delete | Junk | Print | Back | Forward | Quick Filter

From WNCoV.virology <WNCoV.virology@phe.gov.uk>

Subject **OFFICIAL: RE: Data request** 28-Apr-20, 17:45

To Me <kpcresearch@btinternet.com>

Cc Maria Zambon <Maria.Zambon@phe.gov.uk>, WNCoV.virology <WNCoV.virology@phe.gov.uk>

OFFICIAL

Professor Zambon asked that we respond to your request for data, as below.

i) RT-PCR tests –

- the gold standard for PCR tests is not virus isolation
- PCR tests are developed using synthetic transcripts; field use data are not widely available yet
- Typically specificity exceeds 95%

ii) antibody tests –

- There is a pre-publication manuscript available at https://www.medrxiv.org/content/10.1101/2020.04.15.20066407v1.full.pdf in which the authors describe testing plasma for SARS-Cov-2 IgM and IgG antibodies by ELISA and using nine different commercially available lateral flow immunoassay (LFIA) devices. There findings were that "Point estimates for the sensitivity of LFIA devices ranged from 55-70% versus RT-PCR and 65-85% versus ELISA, with specificity 95-100% and 93-100% respectively. Within the limits of the study size, the performance of most LFIA devices was similar."
- No commercial kits have yet been validated for use in the UK – work is ongoing.

Virology Cell,
PHE Incident Response

From: Kevin Corbett [mailto:kpcresearch@btinternet.com]
Sent: 25 April 2020 19:32
To: Maria Zambon <Maria.Zambon@phe.gov.uk>
Subject: Data request

Today Pane

E-Mail Three: Sent by Dr Corbett to Public Health England on 05 May 2020

Text of the e-mail below was sent by Dr Kevin P Corbett to Professor Maria Zambon, director of Reference Microbiology Services at Public Health England, and head of the UK World Health Organization National Influenza Centre. Dr Corbett asked the following questions:

Dear Professor Zambon

Thank you for your reply received last weekend [see below].

Based on your reply I have further questions to which I would be grateful for answers.

I've highlighted in red the sections of your reply to which I have 13 questions.

"i) RT-PCR tests –

- *the gold standard for PCR tests is not virus isolation"*

Q1. Why is isolation of the COVID-19 virus [SARS-CoV-2] not the gold standard in the PCR test for the virus?

Q2. What gold standard does PHE use to evaluate the RT-PCR test for SARS-Cov-2 infection?

- *"Typically specificity exceeds 95%"*

Q3. Which specificity? Analytical or clinical? As per the MIQE guidelines [1].

"*Analytical sensitivity* refers to the minimum number of copies in a sample that can be measured accurately with an assay, whereas *clinical sensitivity* is the percentage of individuals with a given disorder whom the assay identifies as positive for that condition".

Q4. Do you agree that in the case of the test under discussion, the "assay" is RT-PCR and the "given disorder" is SARS-CoV-2 infection?

Q5. What gold standard does PHE use to calculate clinical specificity?

The UK population is approximately 67 million and the prevalence of SARS-Cov-2 infection unknown. Estimates based on ELISA have been published but the specificity of ELISA is based on a PCR gold standard (as per Professor Crook's paper you supplied). The gold standard for the ELISA cannot be any better than the gold standard for the RT-PCR. However, although you replied "the gold standard for PCR tests is not virus isolation", you have not told me what is.

It is elementary that the amount by which "the specificity exceeds 95%" is critical for calculating the probability that a positive test (positive predictive value, PPV), is proof of infection. Applying a 95.1% specific test to a 1/1000 prevalence population for example, results in a PPV of 2%with 98% false positives. The PPV for a prevalence of 1/100 is marginally better at 17% PPV with 83% false-positives. Even a specificity of 99% is far from desirable. It means that if 670,000 UK citizens were SARS-CoV-2 infected, 335,000 of them would be false positives.

Q6. Do you agree with the calculations in these examples?

Summarised in my table below.

Sensitivity 100%			**Sensitivity 100%**		
Specificity 95.1%			**Specificity 99.0%**		
Prevalence	1/1000	1/100	Prevalence	1/1000	1/100
PPV	2%	17%	PPV	9%	50%
Prob. false positive	98%	83%	Prob. false positive	91%	50%

Q7. Are RT-PCR tests reported PCR positive/negative or SARS-CoV-2 positive/negative?

Q8. Which authority, PHE or the ordering physician, interprets a positive RT-PCR as proof of virus infection?

Q9. Is the caveat of PPVs reflected in reports PHE and other laboratories issue to physicians?

In the table below I contend that whatever gold standard PHE employs, that GS is, by definition, what the RT-PCR procedure tests for.

Q10. Do you agree?

Test result	PHE GS +	PHE GS -	Totals
RT- PCR test +	A	B	A+B
RT-PRC test -	C	D	C+D

In my previous e-mail, I requested data proving the sensitivity and specificity of the RT-PCR test for SARS-CoV-2 infection.

Test result	?? pos	?? neg	Totals
RT- PCR test +	A	B	A+B
RT-PRC test -	C	D	C+D

Q11. Would you please send me these data and indicate PHE's column titles?

ii) antibody tests –

- *"There is a pre-publication manuscript available at https://www.medrxiv.org/content/10.1101/2020.04.15.20066407v1.full.pdf in which the authors describe testing plasma for SARS-Cov-2 IgM and IgG antibodies by ELISA and using nine different commercially available lateral flow immunoassay (LFIA) devices. There findings were that "Point estimates for the sensitivity of LFIA devices ranged from 55-70% versus RT-PCR and 65-85% versus ELISA, with specificity 95-100% and 93-100% respectively. Within the limits of the study size, the performance of most LFIA devices was similar."*
- *No commercial kits have yet been validated for use in the UK – work is ongoing."*

Q12. Are gold standards other than RT-PCR used to evaluate antibody tests for infection with SARS-CoV-2?

Q13. If so, what is this gold standard?

Online calculator http://vassarstats.net/clin2.html
1. Bustin, S. A., V. Benes, et al. (2009). "The MIQE guidelines: minimum information for publication of quantitative real-time PCR experiments." Clinical Chemistry **55**(4): 611-622.

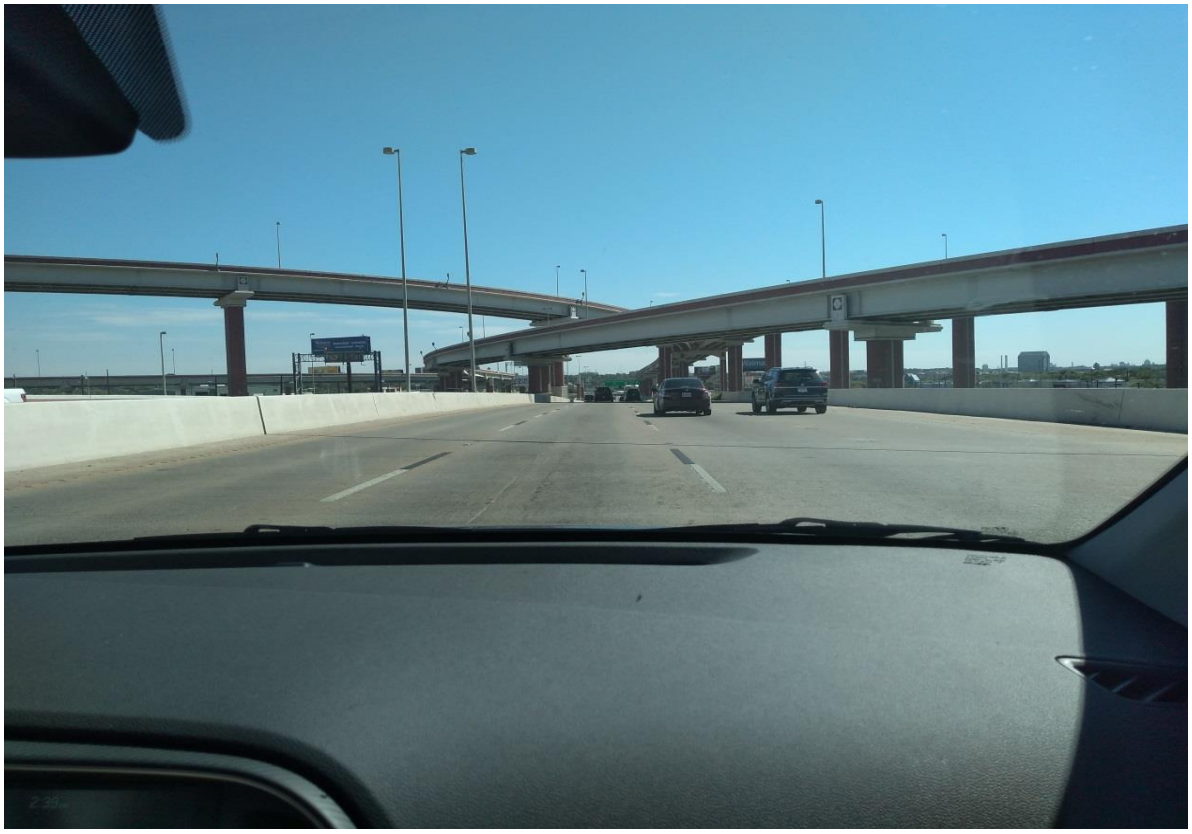
3.'The Covid19-Freeway'©

Medical triage is like 'Freeway' driving
You may be drawn along too fast?

Here is a 'Sat Nav' for seeing the

On-Ramp
Off-Ramp 1
Off-Ramp 2
Off-Ramp 3
Off-Ramp 4

On-Ramp



To understand how Asimov's novel reflects today's situation you do not need 'Rocket Science'.

Our so-called 'Free World' Governments – all of them – have ordered and legally imposed 'rules' that prescribe 'social isolation', 'social distancing' and 'dogmatic mandatory telemedicine'.

Whilst telemedicine has its uses, as do isolation/distancing in cases of genuine emergency, how such extreme measures have all been globally imposed across all care provision by diktat[32] based on fear and terror is a matter of grave concern and needs investigating and challenging.

This chapter messages peoples about how they can use their FREE WILL and their LEGAL CONSENT to AVOID, RESIST and to hopefully DEFEAT the COVID-BIAS now CORRUPTING our healthcare.

The well-known British high street store *Boots* - health product retailer – sent an e-mail recently to all of its registered ophthalmic customers, saying:

[32] Meaning something imposed upon a subjugated or defeated person or persons a victor, or imposed by a dogmatic decree. It is pejorative; it describes rules dictated by an alien power or an unpopular local power; see: https://en.wikipedia.org/wiki/Diktat

> *"We've suspended all routine care to support government efforts in reducing the spread of COVID-19, but we wanted to let you know* ***we are still here for you if you need us.***
>
> *Our expert clinicians are providing care by phone and if they advise that you need to be seen in store, we can offer face to face appointments with the appropriate PPE, social distance and enhanced cleaning measures so you can access the urgent and essential care you require.* **If you do need our support, then please do not visit a Boots Opticians store** *without calling us first on* 0345 125 3768 *and our team of expert colleagues will advise on the best solution for you."* [emphasis original, Director of Professional Services, Boots Opticians May 2, 2020].

Routine dental work across Great Britain has also been ***totally*** cancelled. Only dental emergencies are reportedly being triaged through the British Accident and Emergency Centres and the British National Health Service 111 Online telephone triage system[33].

Translating the above Boot's quote from *LockSpeak©* into *pre-LockSpeak©* this means a double-bind:

> *"*if you do need our support, then stay physically away from us as you could kill us
> - because you could have 'IT'.."

Other powerful double-bind cognitive mechanisms are silently at play. For example none of the Government advertising cited in this toolkit refers explicitly to offering testing because as shown above within the paradigm of the Government, it is a mess and is being developed – as the British say - like on the back of a '*fag packet'*[34]. But the subliminal message is quite worrying:

> "Because we can't get tested, we can't know if we have the covid-19 virus or not
> "We have to act as if we have the virus, so that we don't spread it to others.
> "We have to act as if we'd never had the virus, because if we haven't had it, we're not immune.
> "Therefore we simultaneously have and don't have the covid-19 virus."[35]

The above quotes all imply *double-binds for the reader*. The above examples are not exhaustive. No doubt a more in-depth search and analysis could reveal more. However, this cursory glance shows how these examples tell readers to identify their care needs, expecting them to be met by the HCPs in person, then thwarts any traditional means of addressing those needs [personal-presence; 'accurate testing'], with only the offer of a virtual, not a physically-present, at-distance/remote service, unless someone deems you *urgent* or *essential.* Who will do that? Again, this appears to be yet another quantum of high anxiety that the population has been given and left to live inside of.

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[33] https://www.nhs.uk/common-health-questions/dental-health/how-can-i-access-an-nhs-dentist-in-an-emergency-or-out-of-hours/.
[34] British slang for 'cigarette packet' – meaning an idea sketched out quickly whilst smoking a cigarette.
[35] Cowper A (2020) Cowper's Cut: Schrodinger's Virus. Health Services Journal, April 11. Available at: https://www.hsj.co.uk/comment/cowpers-cut-schrodingers-virus/7027387.article

This is all completed at distance, or online, or via telephone, if you can get through. The anti-professional nature of distancing was commented on in a personal communication from a registered nurse with considerable mental health expertise as well as significant academic and clinical training:

> *"Another [key] issue is about the 'distance' aspect of all this and **how unnatural and anti-professional that is in healthcare**. The other aspect of 'distance' for me is that distance itself creates an artificial 'clarity' by removing the normal complex messiness of life. Whether that artificial clarity is achieved in research by operationalising variables, such that the parameters are so narrow that most of real life is cut out of view, or whether it's **statistics** as an example of that type of vehicle, or a type of self-comforting delusion of clarity. For example, I read somewhere about a man standing on a cliff looking happily out to sea and being comforted by the 'regularity' of the waves breaking on the shore, and **seeing that as some giant type of clock ticking away neatly and precisely from his distant high perch**. But the person in the sea among those frothing and foaming peaks, the churning waves realises things **are far more messy and knows that the same wave pattern second by second changes and will never ever be repeated."***[36]

Double-binds, created by distancing or whatever, cause stress, anxiety and ultimately, mental illness[37], as discussed far back by Gregory Bateson and RD Laing. This stress and anxiety is now being manufactured by the British Government and rolled out across the whole population on an industrial-sized scale.

Furthermore, any apparently 'small' micro-level attacks on our mental health are acting minute-by-minute throughout the language of the 'novel Coronavirus' and its attendant Lockdown.

Our Government and NHS have taken the lead on promoting viral Terror - with full page frightening adverts and by the government scientists (Britain's Ferguson or Whitty; US's Fauci or Birx) acting like TV evangelists. We have also received volumes of personally targeted e-mails from companies, agencies and personal contacts that further instil fear, paranoia and terror through a bombardment of superficially *simple arrays of words*.

These *arrays* subvert the usual meanings of advertising messages in a capitalist system, where businesses should only be too happy to have physically-present customers always flooding in.

'Lockdown rules' have been enacted so quickly and somewhat frighteningly they now seem just like modern day equivalents of Asimov's *trimensional* dystopia in *The Naked Sun*.

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[36] A Registered Mental Health Nurse; personal communication; cited with permission.

[37] See: Bateson, Gregory (1960) Minimal Requirements for a Theory of Schizophrenia. *Archives of General Psychiatry*. **2** (5): 477–491. Available at: https://jamanetwork.com/journals/jamapsychiatry/article-abstract/487780 ; Laing, R. D., & Esterson, A. (1970). Sanity, madness, and the family: Families of schizophrenics. Baltimore, Md: Penguin; Scott S and Thorpe C (2006) The Sociological Imagination of R. D. Laing. Sociological Theory 24 (4), pp 331-352 December. Available at: https://journals.sagepub.com/doi/10.1111/j.1467-9558.2006.00294.x

Inside our currently emerging Corona dystopia is the Sacred Corona Cow of what was once our National Health Service (NHS) – now sinisterly reconfigured as 'The Covid-19 Freeway' – to which we must clap every Thursday at 8pm[38].

The current Government Orders prohibit social gatherings which like the Asimov story all go against human instinct for touch, assembly and gregariousness. In this human intimacy we breathe in the same air like in the above pop concert. Effective healthcare cannot be delivered without touch, skin to skin, and so this is one of the fundamental perversions operating in the current climate of Government promulgated fear and panic. Medical jargon talks of 'patient pathways' as tools for rationing and apportioning. These imply a medical 'route march' propelling one into experiences of different haphazard events. These pathways are also ***machines*** for the production and reproduction of 'patients', tests and above all, statistics.

As the fifth biggest global employer[39], the British NHS has suddenly morphed into a newly configured INDUSTRIAL-SIZED MACHINE. It has been repurposed in order to *manufacture, disseminate and turn around Covid-19 tests, record Covid-19 'diagnoses' and 'Covid-deaths'.*

Thinking of this as a giant *Freeway* streamlines the concept for us. The British NHS, so lauded by many as the pinnacle of the post-war social welfare settlement, has become in this era of the 'novel Coronavirus' Hysteria, a forward thrusting industrial production line, streamlined with very few intersections ['off-ramps']. *This 'Covid-19 Freeway'©* is so fast moving that it has the power to propel any unwitting would-be patient forwards starting with some generic symptom. Before the Corona Hysteria era the sets of symptoms now labelled 'Covid-19' were considered harmless.

Currently, after receiving 'triage' in the era of Corona Hysteria – a perversely skewed differential diagnosis - the unwitting and passively-perceived patient is thrust into the *Freeway production line* quickly, speeding further and further along, always on a *non-touch, view-at-distance* trajectory – "*as the virus is so infectious".* This is how The *'Covid-19 Freeway'©* thrusts you forwards:-,

> ***Any member of the public attending their HCP expects optimum treatment and places their blind trust in health services. In the age of the 'novel Coronavirus' they are treated as the passive object of management who is sucked along The Freeway Covid-19 and whose progress along it is controlled as if they had no wishes or preferences of their own."*** (adapted from Kitzinger[40])

This impact on the person is like a *'cascade'*. It inevitably leads the person presenting to health services towards 'Covid-19'-focused medical interventions testing, treatment and finally 'discharge': into the

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[38] In New York City this occurs every night and was experienced during a telephone call to a colleague.

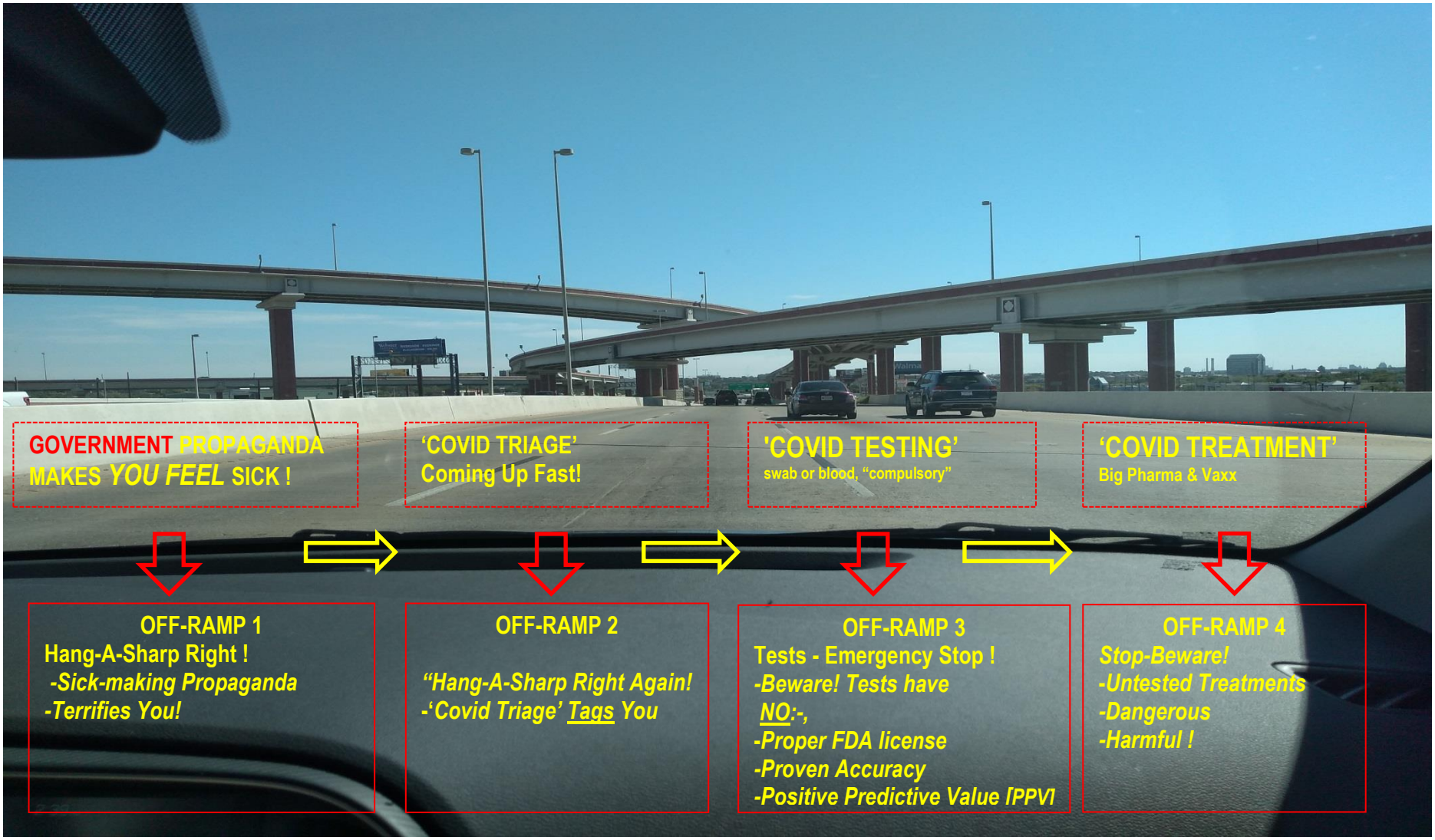
[39] World Economic Forum (2015) Who is the world's biggest employer? The answer might not be what you expect. https://www.weforum.org/agenda/2015/06/worlds-10-biggest-employers/

[40] Professor Sheila Kitzinger was a British midwifery pioneer and academic. The above quote is a direct adaptation of her 1982 statement. It reflects her research findings about how the 'normal' can be made to appear abnormal by medical practice and the medical perception of women as 'passive' within the NHS: *"The expectant mother is treated as the passive object of management, who is fed into the system and whose progress through it from point to point is controlled as if she had no wishes or preferences of her own."* Kitzinger, S. (1982) Change in Ante-natal Care. A report of a working party. London, National Childbirth Trust.

morgue, or into further home-based Lockdown. *Home* itself has also become a debased term. It is now essentially a form of Government-prescribed House Arrest, from which we will emerge, as and when, in limited ways that the Government decrees[41]. Like *Freeway* driving amidst a fast flowing traffic stream, there are only a limited number of sequenced *intersections (*'off-ramps') to enable the patient [if the 'driver'?] to exit from the direction of flow (if consent allows), whose onward traction keeps sucking oneself ever forward as if magnetically. Luckily, there is a *Sat Nav* for *'The Covid-19 Freeway'*©; read Figure 4 [overleaf].

[41] See: https://www.telegraph.co.uk/politics/2020/05/07/coronavirus-government-plan-update-lockdown-end-boris-johnson/

Figure 3 YOUR SAT NAV ON 'THE COVID19-FREEWAY'©



Off-Ramp 1

"Hang-A-Sharp Right!" **- Don't Believe The Government Terror**

The British *Government's ordering or pleading ('exhortation'[42])* – ***STAY AT HOME -*** has become the hallmark of British 'medical advice' coming from all Government/Government-appointed health care professionals (HCPs) and other non-NHS care services. It is propaganda.

The following messages implicit in Government Terror (read: Table 3 above) should be ***disliked*** by (***'an anathema to'***) HCPs to ***see, hear or read*** – like the direct opposite ('obverse') of ethical healthcare - because they really mean:

"***GO AWAY, YOU"***

"STAY AWAY, YOU"

"DON'T COME NEAR US, YOU'RE INFECTIOUS"

[42] Meaning:*" the act of strongly encouraging or trying to persuade someone to do something":* https://dictionary.cambridge.org/dictionary/english/exhortation

The author's photographs of Government 'health messages' included in this toolkit attest to the frightening visage of 'sci-fi'-looking people behind respirators with full-face visors (read Figures 2,3 above). These are everywhere in London, England, and all over Great Britain. Viral Imaginaries and Viral Agencies permeate our London side-walks e.g. Figure 5 (below).

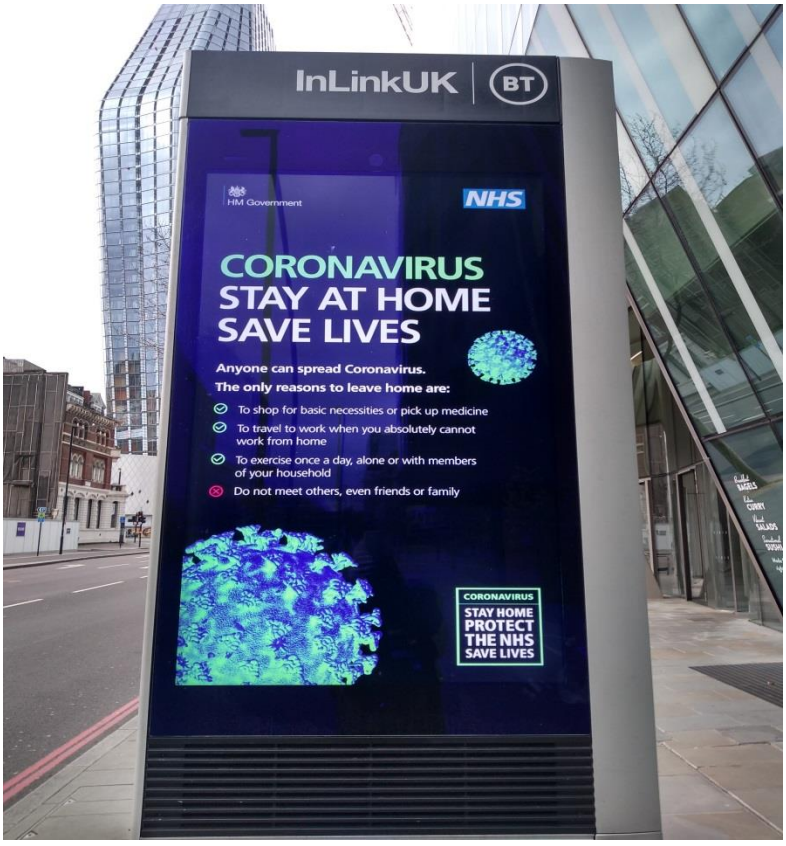


Figure 4 British Government 'Monolith' Terror Billboard (Southwark, London, England, March 2020)

Hard to fight against?

How to fight against?

Do you just: 'Stay Outside' (i.e.: do the opposite of the above Government message')?

These are exceptional, explicit Government orders, pleading, fully exhorting the public and conversely health care providers (HCPs), to do what runs totally contrary to which any trained and ethical HCP normally does.

They are the most extreme messages – more extreme even when compared to those used by the British Government for the 'killer AIDS virus' in the 1980s – 'The Tombstone' crashing down on people – but even then we weren't hearing "-*Stay Away!"* - The Government in the 1980s did not say to those possibly affected or known to be 'infected':-,

"-Go Away!"

The population is understandably disturbed, confused and indeed TERRORIZED by the sudden pervasiveness, the frightening content and the visual imagery used in such dreadful messages.

They are also most disconcerting economically, especially in European societies, where we have been forced to pay for health services by mandatory taxation deducted from earnings by employers acting on behalf of the state.

There has been no opt-out for the mandated tax payer, who must continue to pay for the National Health Service (NHS), yet due to this 'emergency' the State can now opt out of *seeing* us by the authority exercised over our bodies by THE HEALTH PROTECTION (CORONAVIRUS) (ENGLAND) REGULATIONS 2020[43]; and the changes enacted through THE PUBLIC HEALTH (CONTROL OF DISEASES) ACT 1984[44].

As a result, with no declaration of war the British public is now subject to

- *"Stricter conditions. In particular by preventing them from remaining outside their residences rather than restricting them from leaving them save for a 'reasonable excuse'..*

- [regulations which] *are* ***ultra vires*** *s45C of the Public Health (Control of Diseases) Act 1984 ("the 1984Act"), the provision relied upon by Her Majesty's Government ("the Government") as delegating powers of secondary legislation by which they may impose the Regulations;*

- *Imposed restrictions that were not proportionate, contrary to the limitation imposed by s 45D of the 1984 Act"*[45]

Ultra vires is the legal phrase to describe how the British Government is acting or exceeding its actual legal power or authority by enacting the Lockdown.

Meaning: the British Government is acting ILLEGALLY.

THE BRITISH GOVERNMENT IS ILLEGALLY OPPRESSING THE BRITISH PEOPLE.

THE MAJORITY OF THE BRITISH PEOPLE VOTED FOR SOVEREIGNTY - NOT SERVITUDE - IN THE 2016 BREXIT REFERENDUM BY VOTING TO LEAVE THE FEDERALISING EUROPEAN UNION.

Now we have **servitude:**

..Not under the EU..But under hysterical viral governance: the *'novel Coronavirus' Hysteria*.

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[43] http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted.
[44] http://www.legislation.gov.uk/ukpga/1984/22.
[45] *Join the Legal Challenge to the UK Govt Lockdown by Simon Dolan:* https://www.crowdjustice.com/case/lockdownlegalchallenge/

Off-Ramp 2

***"Hang-A-Sharp Right – Again!* " Avoid 'Triage' Onto the Freeway Covid-19**

The *biased triage*[46] has become the new *modus operandi* for all first access points of the public to all health services in Great Britain.

Just as in Asimov's dystopia, for reasons of 'perceived contagion', now the only permitted primary care is v*iewing* of the body through 'telemedicine'.

In British cities this happens through a NHS helpline or online where you dial 111. This is not the medical expert *seeing the body* in its physical presence as in a traditional clinic facility. Another key issue is that if you call or go online with *'Covid-type'* symptoms your POSTCODE ['ZIP CODE'] MUST BE ENTERED TO GAIN ACCESS TO THE SERVICE.

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[46] This occurs on the telephone and/or at an uncomfortable 2 metre/6 feet distance with no or minimal 'hands on' examination tacitly discomforting to the training of the Health Care Practitioner who are subject to real / reported lack of protective equipment and also confused; thereby in receipt of confounding and misunderstandings over the risk of contagion (fear-based 'practice-overreach').

'TRACK + TRACE[47]' is what 'they' call the app, meaning: *GOVERNMENT* KNOWS WHERE YOU LIVE.

This Government-promulgated fear and panic is skewing the ***differential diagnosis*** towards 'Covid-19'.

The ***differential diagnosis*** is the everyday process whereby a suitably trained healthcare practitioner (HCP) differentiates between all conditions which share similar signs/symptoms. This uses evidence from physical examinations ('signs' – what the HCP observes), laboratory workup ('lab tests'), the patient's story ('self-report' symptoms). Following review of the latter different forms of data a decision has to be made about what these particular data imply: one particular condition as opposed to any of the others – thus HCP *formulates* a definite ['definitive'] diagnosis.

Currently, the differential diagnosis is skewed by the heavily advertised and Government-promulgated list of generic non-specific symptoms which include previously harmless phenomenon like sore throat, runny nose, cough, feeling hot etc.

This extremely subjective set of symptoms – ***all now promulgated through fear based messages as denoting a 'killer virus'*** - moves the HCP rapidly towards the 'Covid-19' diagnosis.

A spurious *'Covid-19 diagnostic interpretation'* is projected subjectively *onto* the patient's self-reported symptoms, in the absence of any Covid-19 test (the result of which, even if taken, takes days to return). This projection of symptoms into the construction of a 'Covid-19-case' can even occur over the telephone or even at closer distance in any emergency medical facility like an Accident and & Emergency department (A&E). In reality those non-descript set of symptoms can literally mean hundreds of things to an appropriately trained HCP but they are now being framed as ***ONLY*** indicating 'Covid-19'.

This process is a ***medical perversion*** of the differential diagnosis to bolster statistics for a 'novel Coronavirus' disease, on the back of a set of subjective clinical findings without proper laboratory evidence ('Covid19-test', 'SARS-Cov-2', 'antibody-test', 'RT-PCR' tests etc).

Even if whatever 'test' is declared 'positive', the accuracy of all those tests is unknown. This means that the tests will give false positive readings and any patient is then at risk of receiving a wrong diagnosis and dangerous medication[48]. The implications of being so diagnosed is that it can have serious and lethal effects: death induced in the absence of any disease – *iatrogenesis – that is why a statement in the Hippocratic Oath acknowledges that medicine is a double edged sword - it can kill as well as cure.*

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[47] "*the app is designed to significantly speed up contact tracing, helping reduce the chance of the virus spreading by enabling us to rapidly identify people most at risk of infection so they can take action to protect themselves, the people they care about and the NHS"* https://www.gov.uk/government/news/coronavirus-test-track-and-trace-plan-launched-on-isle-of-wight.

[48] Corbett K (2020) Monograph One. Where is the Evidence For The Existence of The 'novel Coronavirus', SARS-CoV-2? The Coronahysteria Series:'SARS-CoV-2', the 'novel Coronavirus'. London, KPC Research and Consultancy Limited. April 2020. ISBN 978-1-5272-6214-0. https://kevinpcorbett.com/onewebmedia/WHERE%20IS%20THE%20EVIDENCE%20FOR%20THE%20EXISTENCE%20OF%20THE%20CORONAVIRUS%20FINAL.pdf

It is also a ***social perversion*** of our human instinct to medically prohibit *touch* unless dealing with a true **High Consequence Infectious Disease (HCID) with** high mortality.

The British Government says 'Covid-19' is **NOT** a 'High Consequence Infectious Disease'[49].

The British Government also says 'Covd-19' has a **"low mortality"** overall[50].

This ***fatal perversion*** of traditionally accepted socio-medical practice is now happening in British healthcare facilities. Death rates attributed to the 'novel Coronavirus' have been many orders of magnitude less than those originally predicted. For example, predicted deaths for Great Britain were cited as 250,000[51]/500,000[52] from Imperial College London (e.g. Ferguson et al 2020)[53].

As of May 7th 2020, there has been the following number of deaths in Great Britain published by the British National Health Service:-,

Table 6 NHS Data on Covid-19 All Announced Deaths

NHS England Covid-19 All Announced Deaths [published 06 May 2020]	
Age group [yrs]	Number
TOTAL	22,049
0 – 19	11
20 – 39	155
40 – 59	1761
60 – 79	8547
80+	11,575

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/ [Accessed: 07.05.2020]

[49] https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid#definition-of-hcid

[50] https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid#definition-of-hcid
[51] Ferguson et al (2020): https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf
[52] Popular reporting of modelling statistics. For example, London's Evening Standard: https://www.standard.co.uk/news/health/coronavirus-worst-case-scenario-government-document-a4371726.html
[53] Ferguson et al (2020): https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf

Even with other data from non-NHS providers and associated outliers[54] ['c.40k']:-,

Actual[55] 'Covid-19' deaths= 22,049 [or circa ≤40k] [NHS + MSM]

250,000 / 500,000= predicted deaths [Imperial College London]

22,049 or even 40,000 ≠ 500,000[56] or even 250,000[57]

Other voices now show that in this current situation, people <65 years old have very small risks of death, and that death for people <65 years, without underlying predisposing conditions, are "remarkably uncommon" (Ioannidis et al 2020[58]).

The above grossly inflated and arguably manipulated Imperial College London projection - of 250,000 - 5000,000 deaths - is forever being revised downwards, and is continuously being disproven.

The above cursory data are changing daily and are not exhaustive; as stated earlier an exhaustive statistical analysis is not the aim of this toolkit. The above data serve the purpose of showing how:-,

The 'novel Coronavirus' *fauxdemic*© is just that: a fake, pure *Hysteria*.

[54] https://coronavirus.data.gov.uk/
[55] These statistics are almost meaningless as many confounding variables are not excluded e.g. Corbett and Crowe (2020) Problems with current UK government lockdown policy. Journal of Advanced Nursing *interactive Friday, 10 April 2020* https://journalofadvancednursing.blogspot.com/2020/04/problems-with-current-uk-government.html
[56] Popular reporting of modelling statistics. For example, London's Evening Standard: https://www.standard.co.uk/news/health/coronavirus-worst-case-scenario-government-document-a4371726.html
[57] Ferguson et al (2020): https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf
[58] Ioannidis et al (2020): https://www.medrxiv.org/content/10.1101/2020.04.05.20054361v2

Figure 5 British Government Tube Station Terror Poster (London March, 2020).

People are now *triaged* in the above *'CoronaTriage'*© way. Self-triage is encouraged (read Figure 6 above)

This differs to the traditional triage by order of the Government and its *National UnHealthy Service*.

CoronaTriage© determines that any one of a generic list of previously benign (not harmful) symptoms is now solely due to the 'novel Coronavirus'. This pernicious *CoronaTriage*© identifies the symptoms you have and designates them as due to the 'novel Coronavirus' ('Covid-19').

So, now a cold, a sore throat, a fever etc. all become *'CoronaSymptoms'* within *CoronaTriage*© *and you* become a *case of the 'novel Coronavirus' ('Covid-19').*

This occurs via a *cognitive* and / or a *real physical separation* of people attending services.

Depending on the available hospital space, it may be that a physical separation occurs between those with / without respiratory symptoms; or it may be that physical space does not allow this, but in those cases a *cognitive* separation occurs in the minds of those treating patients, followed by over-zealous use of personal protective equipment *just in case*.

The overall thrust is to create two-'tiers', or BINARY CATEGORIES, into which all attendees at any NHS, or private facility, are *sorted / classified / categorized*:

- Tier 1 *GENERIC RESPIRATORY SYMPTOMS*: [ALL CURRENTLY PRESUMED 'COVID-19'] those people perceived to have or perceived by the NHS to exhibit 'Covid19-like' symptoms, either now, or recently, or been somewhere foreign that is or was perceived to have had 'it';

  And

- Tier 2 *NO GENERIC RESPIRATORY SYMPTOMS*:
  those people minus any of the above.

Hard to ***counter***?

How to ***counter***?

Do not attend in the first place?

It is possible – but unlikely, if one feels one's symptoms are serious? Then the inclination is to attend.

Once declaring 'symptoms' can one just say: 'I'm Fine' and walk away? One may not be allowed to.

CoronaTriage© is a 2-tier triage, like a grid held against you, to match any of your symptoms AT ANY POINT OF ENTRY TO THE BRITISH HEALTH CARE SYSTEM, via telephone or via distance in hospital or clinic.

Once this grid is applied to you it cannot be unapplied.

The Government message is **'ANYONE CAN GET IT, ANYONE CAN SPREAD IT'.**

Therefore, the whole British population is now SUSPECT.

The Coronavirus Act 2020 in the United Kingdom states in '*Section 21 Powers relating to potentially infectious persons' that SUSPECTS can be removed by Government order and subjected to screening and medical testing with the requirement to give biological samples. 'R*easonable grounds' for suspicion thereby include any Covid19-like symptoms. Anyone now can be so judged, and removed, for screening/assessment, and isolation, and in so doing must provide biological samples as part of this process (Section 21, clause 10: 2a (i) and 2a (ii))[59].

This 2-tier triage ***CoronaTriage***© categorization will skew the range of possible causes which are hypothesized to help explain what ***may be*** wrong with you – what is called the 'differential diagnosis' – towards a 'Covid-19'-explanation.

[59] http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted

This pernicious and skewed form of medical triage - really a bastardization of the diagnostic differential - then enables Freeway onward movement towards a confirmed 'Covid-19 diagnosis' instead of towards flu or other possibilities. It is part of the 'Covid19-lens' which is applied through which to ***view*** the patient.

This 2-tier triage categorization is what Dr Katherine Hendersen, President of Royal College of Emergency Medicine (United Kingdom), outlined on the Andrew Marr Show (BBC1 TV, 29/03/2020) as the ***'new structure'*** of the British NHS.

Dr Hendersen implied on national television that ***new structure*** had now been ***'created'*** in order to ensure the public's own safety.

What Dr Hendersen chillingly revealed was the same rapid ***root-and-branch*** re-organization described by Max Pemberton, a NHS psychiatrist, in The Spectator 28/03/2020[60].

The NHS Standard Operating Procedure for Covid-19 testing explicitly states:

> *testing should be* ***prioritised*** *above other pathology tests as urgent and high priority, including the return of results* (p.7 emphasis added)[61]

The ***CoronaTriage© is just like an INDUSTRIAL mechanism, apparatus or device.***

The aim is to marshal the population into that NHS INDUSTRIAL-SIZED MACHINERY for the processing of and the deliberate manufacture of test results (+/-).

This depends on the MEDICAL perception of whether or not those so triaged **DISCLOSE** any from a very generic set of symptoms. This perception can be formed by a doctor, a nurse or a nurse practitioner: anyone who is authorized to formulate a clinical diagnosis in a treatment facility or online or via the telephone.

Figure 7 (below) is just one example of many which were published in the British MSM.

It unintentionally highlights how dangerous it is to admit to having any symptoms.

It reveals the way unofficially appointed health agencies outside of Britain, together with our Government, have grossly and perniciously constructed the abnormal – 'Covid-19' symptoms – out of the everyday experience of people with flu, colds etc.

This chart shows the so-called *difference* between conditions.

However, the symptoms now considered dangerous are so *non-specific* and so *common* that the chart only serves to *frighten*, *confuse* and *instil* in any reader the idea that they may have **'IT'** – that they are

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[60] See: https://www.spectator.co.uk/article/on-the-nhs-front-line-were-braced-for-whats-coming

[61] National Health Service and National Health Service Improvement (2020) Guidance and standard operating procedure COVID-19 virus testing in NHS laboratories. London, UK Department of Health. Publications approval reference: 001559. Available at: https://www.england.nhs.uk/coronavirus/publication/guidance-and-standard-operating-procedure-covid-19-virus-testing-in-nhs-laboratories/

INFECTED = CONTAGIOUS. The probability is that many readers only have common symptoms of no serious concern.

In this way such charts not only induce confusion and fear, but they also **TARGET** the reader/viewer as a potential **SUSPECT= CARRIER** of the 'novel Coronavirus'.

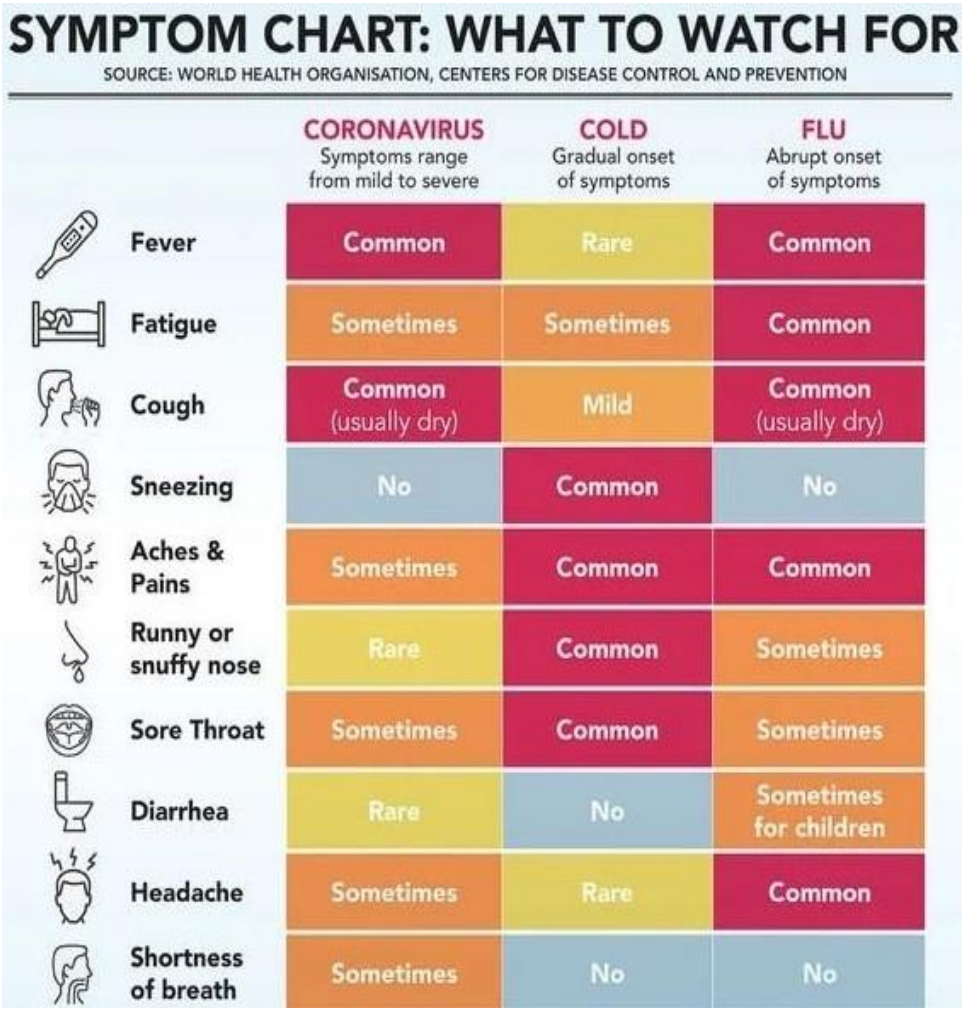
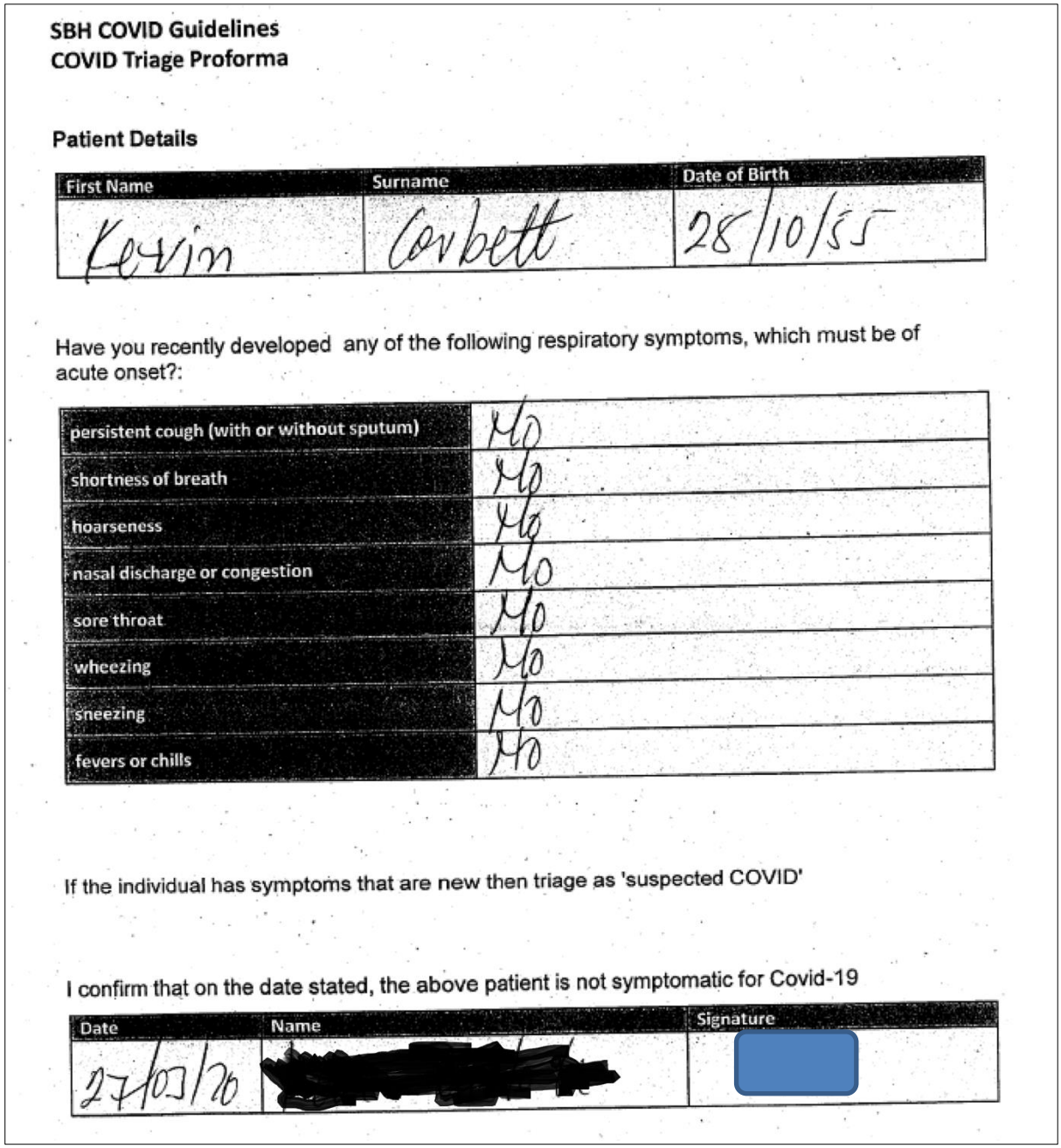


Figure 6 Common Chart Conflating Symptoms [British MSM, May 2020, London, England]

Figure 7 Detecting 'SUSPECTS': We Are All 'Covid-19 Suspects'

SBH=St Bartholomew's Hospital, March 27, 2020 [interrogator's identity is redacted].



SBH COVID Guidelines
COVID Triage Proforma

Patient Details

First Name	Surname	Date of Birth
Kevin	Corbett	28/10/55

Have you recently developed any of the following respiratory symptoms, which must be of acute onset?:

persistent cough (with or without sputum)	No
shortness of breath	No
hoarseness	No
nasal discharge or congestion	No
sore throat	No
wheezing	No
sneezing	No
fevers or chills	No

If the individual has symptoms that are new then triage as 'suspected COVID'

I confirm that on the date stated, the above patient is not symptomatic for Covid-19

Date	Name	Signature
27/03/20	[redacted]	[redacted]

As a ***visitor*** in March 2020, I went to St Bartholomew's Hospital in West Smithfield London (one of the many campuses of what is now called Barts Health NHS Foundation Trust, London)(read Figure 8 above).

Before my entrance to the campus was permitted, I had to verbally answer a set of questions recorded by hand on a questionnaire in front of me *at distance* by a masked interrogator. I was being *viewed at distance* in terms of symptoms – 'Covid-19 symptoms' (as above). This all happened in the lobby that you would normally walk straight through without a care in the world. Now the security has become so tight it is like entering a **Prison.**

A copy of the above questionnaire was filled out given to me by my ***masked interrogator*** and I was told verbally by them to hand the completed questionnaire over to the destination department ***"before anyone there can see you"*** (see my profile as potential 'Covid-suspect' -above). This official symptom-declaration check list was handed back to me once the department receiving me judged me 'safe' after they *viewed* this form (read Figure 8 above).

Again, like in Asimov's novel, I was told I would be *viewed* ('symptoms' checked) prior to being *seen*.

This screening / viewing process took 26 minutes in total before I could transact the visitor-related business I was already scheduled to complete. Officially, the Covid-19 screening form [see above] classified me as a ***'patient'*** yet I explicitly attended ostensibly as a *visitor* for a particular non-clinical reason (see above).

My reason for attendance was non-clinical yet this was not recorded in the completed questionnaire. So a 'visitor' automatically can become a 'patient' if they have a cough (see above). This resonates with accounts of entering buildings in China where personal medical and other data must be routinely recorded and shared to legitimize movement.

People may laugh at the current round of conspiracy theories yet the seed for their growth is here already within my account of the everyday and the minute categorization already underway. These measures which some argue as 'reasonable' can so easily and quickly become the informational basis and rationale for implementing tomorrow's more 'efficient' cell phone app, the Track + Trace.

Such is this 'emergency' that anyone can be so *perceived, officially recorded* and *classified:* how easy can a 'visitor' statistically become a 'patient' through some (mis-)perception of a generic symptom e.g. 'sore throat' (see above). The whole experience of simply trying to enter the campus of what after all is my local community hospital (which I'd done often over the last 30 years) was now akin to entering a high secure facility for a Category A-type prisoner[62].

My self-declared list of any symptoms or non-symptoms – *together with my name and date of birth* – were all captured as 'data', like in Asimov's Solaria, the symptom profile of the (***suspect***) person was *viewed* ahead of their being physically *seen as* in person. If a 'Covid19-symptom' was declared I would not have been *viewed* but *'CoronaTriaged'*© - either sent home to self-isolate – 'GO AWAY YOU' - or depending upon further questioning and 'expert-perception' - categorized into a Tier 1 patient for further 'Covid-assessment': meaning possibly forced but definitely coerced testing, treatment etc. This is the *inevitable prescription of the 'Covid19-test'* as applied on ***The Freeway Covid-19*** to those perceived of having any one of a very generic set of symptoms (see above).

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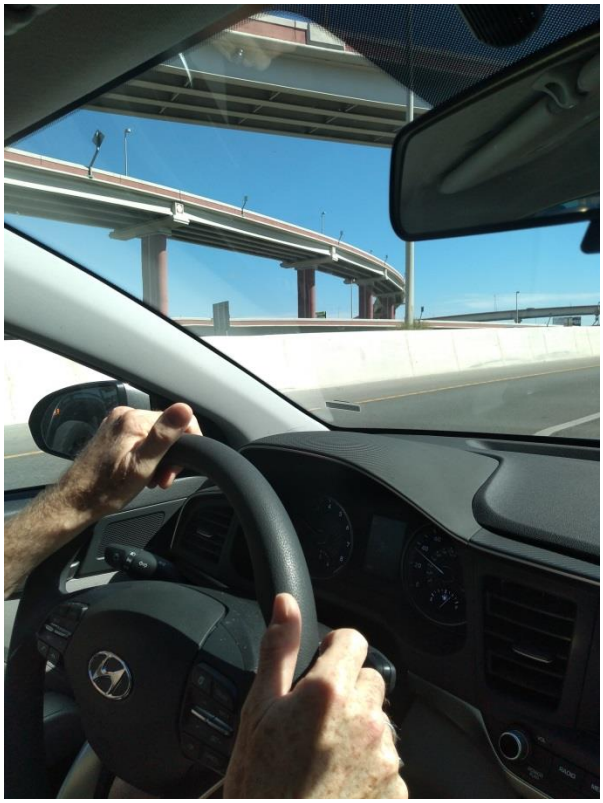
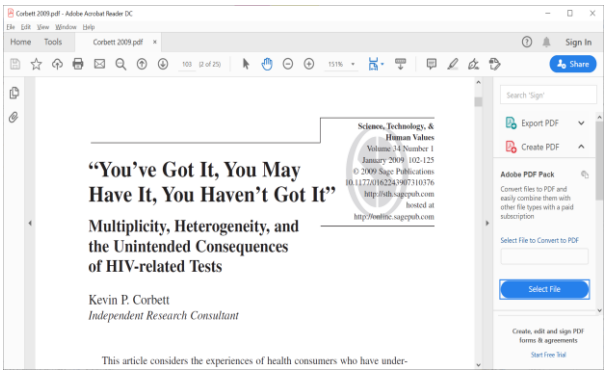
[62] I have undertaken health services workforce development research within British high secure facilities hosting Category A prisoners, who are defined as those whose escape would be highly dangerous to the public or national security, and whose offences can include (Attempted) Murder, Manslaughter, Wounding with intent, Rape, Kidnapping, Indecent assault, Robbery or conspiracy to rob (with firearms), Firearms offences, Importing or supplying Class A controlled drugs, Possessing or supplying explosives, Offences connected with terrorism and Offences under the Official Secrets Act. See: http://eprints.mdx.ac.uk/17660/

Off-Ramp 3

"Emergency Stop !" - Tests for *Coronavirus No Official* Accuracy





Corbett (2009)[63]

Five decades ago virologists began to eschew their long held definition of viruses as infectious particles. Now they view them instead as having molecular and genetic identities, despite their knowing that molecules are not viruses. The traditional isolation of viruses begins with culture of putatively[64] infected material, electron microscopic proof for the existence of purified virus-like particles, followed by demonstrating their replication when introduced into an uninfected culture, thus proving that the particles are indeed a virus. Abandoning this traditional method in favour of molecular techniques is a serious mistake. Viruses remain infectious particles. Indeed if they were not, a new theory of virus

[63] Corbett K (2009) *"You've got it, you may have it, you haven't got it":* multiplicity, heterogeneity, and the unintended consequences of HIV-related tests. Science, Technology and Human Values, 34 (1),102-125. ISSN 0162-2439 doi:10.1177/0162243907310376

[64] 'Putatively' means generally thought to be or to exist even if this may not really be true; see: https://dictionary.cambridge.org/dictionary/english/putative

pathogenesis would need inventing. As the first papers reporting COVID-19 confirm[65], a novel virus is now "isolated" on the basis of a nucleic acid sourced from cell culture material without proof that the source contains virus-like particles, much less purified particles. The transition from the old to the new, marginalises the methods underling the discovery of viruses and the specialty of virology, with their emphasis on viruses as replicating particles. It amounts to the replacement of virology with chemistry and will inevitably turn virologists into chemists.

For over 30 years, The Perth Group (TPG)[66] has published papers demonstrating how this traditional process was elided[67] in the 1980s in the "isolation" of the "human immunodeficiency virus" ('HIV'). And that the laboratory phenomena interpreted as the existence of a novel retrovirus 'HIV', the *sine qua non* of the HIV theory of AIDS, remains an unproven hypothesis. At the outset of the AIDS era, TPG also offered an alternative theory based on cellular oxidation, a feature common to all the AIDS risk groups[68]. Unlike the HIV theory, the predictions of this theory have come to fruition. TPG's arguments about the role of oxidation in causing AIDS were subsequently embraced by Montagnier[69].

It is now claimed by Crowe that virologists have never purified the 'novel Coronavirus' 'SARS-Cov-2', said to cause what is termed 'Covid-19'[70]. Scientists are coming out, questioning the veracity of the technology underlying the tests[71].

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[65] Zhu N et al. (2020) A Novel Coronavirus from Patients with Pneumonia in China, 2019. N Engl Journal of Medicine. January 14. https://www.nejm.org/doi/full/10.1056/NEJMoa2001017
Park, Y.; Ahn, J.W.; Hwang, S.; Sung, K.S.; Lim, J.; Kwack, K. Structural Similarity Analysis of the Spike Protein of SARS-CoV-2 and Other SARS-related Coronaviruses. *Preprints* 2020, 2020030409 (doi: 10.20944/preprints202003.0409.v1).

[66] Papadopulos-Eleopulos, E., V. F. Turner, et al. (1993). "Is a positive Western blot proof of HIV infection?" Bio/Technology 11: 696-707.http://www.theperthgroup.com/SCIPAPERS/EPENatBioTech1993.pdf
Papadopulos-Eleopulos, E., V. F. Turner, et al. (2017) HIV- A virus like no other. http://theperthgroup.com/HIV/TPGVirusLikeNoOther.pdf

[67] 'Elided' means to omit pronouncing a word while speaking; the meaning in this sentence is 'to silence' and 'to ignore'; see: https://dic'tionary.cambridge.org/dictionary/english/elide

[68] Papadopulos-Eleopulos, E. (1988). "Reappraisal of AIDS: Is the oxidation caused by the risk factors the primary cause?" Medical Hypotheses 25: 151-162. http://www.theperthgroup.com/SCIPAPERS/EPEMedHyp1988.pdf;
Papadopulos-Eleopulos, E., V. F. Turner, et al. (1992). "Oxidative stress, HIV and AIDS." Research in Immunology 143: 145-148. http://www.theperthgroup.com/SCIPAPERS/EPEOxstressHIVAIDS.pdf.

[69] PasteurAd (1991). "Pasteur Mérieux Sérums & Vaccins - advertisement offering post-doctral Fellowship in "Oxidative Stress and HIV Infection".." Nature 252: Classified 14 .http://leederville.net/links/PasteurLetters/PasteurAd18July1991.pdf;
Papadopulos-Eleopulos, E., V. F. Turner, et al. (1992). "Oxidative stress, HIV and AIDS." Research in Immunology 143: 145-148.http://www.theperthgroup.com/SCIPAPERS/EPEOxstressHIVAIDS.pdf

[70] Crowe D (2020) Flaws in Coronavirus Pandemic Theory. May 4. Version 8.1. Available at: http://theinfectiousmyth.com/book/CoronavirusPanic.pdf; Crowe D (2020) The Infectious Myth.A Book Project By David Crowe. Available at: http://theinfectiousmyth.com/; Crowe D (2020) The Incredible and Scary Truth about COVID-19 Tests. Available at: http://theinfectiousmyth.com/coronavirus/FDATestSummary.pdf; version published on British Lockdown Sceptics website. Available at: https://lockdownsceptics.org/the-incredible-and-scary-truth-about-covid-19-tests-2/; Rasnick D (2020) The Infectious Myth. David Rasnick on the Coronavirus. Interviewed by

The British Governments NHS blatantly admits that the tests it is deploying are inadequate by its own adopted standards. This is due to the Government's hysteria over the 'novel Coronavirus'. For example:

> *"Due to the **public health requirement for this action to be taken at pace** we do not expect these assays to be provided in scope, initially, in terms of UKAS ISO 15189 accreditation."*[72] (emphases added)

The UKAS is" *"the UK's National Accreditation Body, responsible for determining, in the public interest, the technical competence and integrity of organisations such as those offering testing, calibration and certification services*"[73].

Furthermore:

> *"ISO 15189 Medical laboratories — **Requirements for quality and competence** is an international standard that specifies the **quality management system requirements particular to medical laboratories**. The standard was developed by the International Organisation for Standardization's Technical Committee 212 (ISO/TC 212). ISO/TC 212 assigned ISO 15189 to a working group **to prepare the standard based on the details of** ISO/IEC 17025:1999 **General requirements for the competence of testing and calibration laboratories**."*[74] (emphases added)

The above citations from the British Government's own test operating procedure shows how it permits sub-standard tests to be used on the public by abandoning the internationally agreed scientific precautionary principles. The same disregard for public safety is occurring in the United States[75]. To further compound the above in-built capacity for test error, the British NHS makes a further revealing statement:-,

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David Crowe. Available at: https://infectiousmyth.podbean.com/e/the-infectious-myth-david-rasnick-on-the-coronavirus/

[71]Bustin S (2017) Talking the talk, but not walking the walk: RT-qPCR as a paradigm for the lack of reproducibility in molecular research. European Journal of Clinical Investigation 47 (10) October, 756-774. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/eci.12801; Bustin S (2020) The Infectious Myth: Stephen Bustin on the Challenges with the RT-PCR. Available at: https://infectiousmyth.podbean.com/e/the-infectious-myth-stephen-bustin-on-challenges-with-rt-pcr/

[72] National Health Service and National Health Service Improvement (2020) Guidance and standard operating procedure COVID-19 virus testing in NHS laboratories. London, UK Department of Health. Publications approval reference: 001559. Available at: https://www.england.nhs.uk/coronavirus/publication/guidance-and-standard-operating-procedure-covid-19-virus-testing-in-nhs-laboratories/

[73] https://www.ukas.com/

[74] https://en.wikipedia.org/wiki/ISO_15189

[75] For example: Roche (2020) Covid-19 Factsheet. Cobas®-SARS-CoV-2. Fact Sheet. Roche Molecular Systems Inc., Pleasanton, California. https://www.fda.gov/media/136047/download

> *"Positive results that are sent..for* ***confirmation*** *to a PHE laboratory will be considered presumptive positives until confirmed..****Confirmation is not required*** *if network laboratories are confident in the test they have adopted and* ***assured*** *of an accurate result. If in any doubt, samples can be referred to a PHE regional laboratory local to the NHS testing laboratory for* ***confirmatory testing****, for an initial period until the NHS network laboratory is* ***assured*** *their testing is robust, accurate and safe. After this time* ***confirmation by local PHE laboratories will no longer be required****.* ***Presumptive positive/positive results will be notified to the co-ordination centre for contact tracing, which will start immediately.***

This means that there is open door to interpret test results as positive ['presumptive positive'] with tests of unknown quality, not conforming to pre-existing agreed standards, with the confirmation processes for results interpretative and non-objective. Test accuracy for both the antibody-tests and the RT-PCR is underdetermined. No accuracy is established. There is no proper gold standard for the tests. Their positive predictive value is unknown[76]. In 1999, a public challenge was made to Public Health England (Public Health Laboratory Service- PHLS) which exposed the same anomalies with respect to 'HIV' (read Appendix One[77]).

The diagnostic use of these tests by our Government's health agencies is both scientifically fraudulent and medically dangerous. It will lead to vastly inflated test-positive [false-positive] numbers attributed to 'Covid-19'. Investigative US journalist, Jon Rappoport has already noted the above in the US. He rightly calls this unscientific process: "*..creating the illusion of a pandemic through diagnostic tests.*"[78]

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[76] Corbett (2020a) Where Is The Evidence For the Existence of the 'novel Coronavirus','SARS-CoV-2'? https://kevinpcorbett.com/onewebmedia/WHERE%20IS%20THE%20EVIDENCE%20FOR%20THE%20EXISTENCE%20OF%20THE%20CORONAVIRUS%20FINAL.pdf;
Corbett K (2020b) The Regulation of British HIV Testing. London, KPC Research and Consultancy Ltd. [Forthcoming May 2020: www.kevinpcorbett.com]

[77] The above arguments were included in a series of articles published in 1999. These articles challenged the accuracy of similar tests. Public Health England (PHE)(then 'Public Health Laboratory Service'- 'PHLS') were backed into a corner and caught out over these publications. PHE (PHLS) had not reckoned on any journal questioning their national promotion of inaccurate tests. PHE (PHLS) were forced into issuing a rebuttal to defend the glaring inaccuracies of their national testing strategy. (A complete set of articles illustrating these issues is included in chronological publication order - Appendix One): Harrison, R. and Corbett, K (1999) Screening pregnant women for HIV: the case against. The Practising Midwife, 2 (7) . pp. 24-29. ISSN 1461-3123; Nicoll A, Steele R and Mortimer P (1999) Pregnant women and testing for HIV. The Practising Midwife 2(8) pp34-37 ISSN 1461-3123; Chrystie I (1999) Screening of pregnant women: the case against. The Practising Midwife, 2(8) pp38-39 ISSN 1461-3123; Brett P, Kennedy J, Sutherland J, Ward C, Clayton F (1999) Screening of pregnant women: the case against (2). The Pracitising Midwife 2 (8) p. 39 ISSN 1461-3123; Mercey D, Gibb D (1999) HIV screening and pregnancy.The Practising Midwife 2(9) p.32 ISSN 1461-3123; Stewart G (1999) More doubt required. The Practising Midwife 2(9) p.33 ISSN 1461-3123. Authors' reply. Harrison R, Corbett K (1999) The Practising Midwife, 2 (9) . pp. 34-35. ISSN 1461-3123. All of the latter are included in publication order in Appendix One.

[78] Rappoport J (2020) Corona creating the illusion of a pandemic through diagnostic tests. No More Fake News blog. Available at: https://blog.nomorefakenews.com/2020/03/30/corona-creating-the-

Given the above cited demonstration by TPG over the non-isolation of 'HIV' and now claims over this 'SARS-CoV-2' phenomenon, there are fundamental questions still unresolved over the scientific validity of the current testing strategies for these phenomena, which need to be urgently resolved.

The very same issues are now prescient over test accuracy for detecting the 'novel Coronavirus' - given these tests are those used to define the new disease 'Covid-19' by the British Government and others. These are the same sorts of tests challenged for their inaccuracy twenty-one years ago in 1999.

Furthermore, in April 2020 public health scientists in the US State of Georgia judged that:-,

> *"there is no gold standard for COVID-19 since this specific virus has never been properly purified and visualized. Thus, the accuracies of the tests are unknown. The development of these test kits is contrary to the FDA's guidance document."*[79]

The above shows how public health science acknowledges the lack of accuracy of the tests for 'SARS-CoV-2' ('Covid-19'). False-positive for these tests are being reported in Britain[80]. The award winning investigative journalist, Celia Farber, referred to this about the PCR test whose Nobel inventor Dr Kary Mullis judged it as only a manufacturing technique and not a clinical or a diagnostic medical test[81].

In April 2020 clarification was sought from the British regulator Public health England (PHE) over test accuracy [Read above: Bias In Testing]. The reply indicated that PHE thinks 'viral isolation' is not the 'gold standard' for the tests. PHE also said that: *"No commercial kits have yet been validated for use in the UK – work is ongoing."*

Appendix One details the 1999 challenge to Public Health England over the official parameters used for defining national test sensitivity/specificity very similar to those now used for 'SARS-CoV-2' and for defining the disease category 'Covid-19'[82].

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illusion-of-a-pandemic-through-diagnostic-tests/; also Jon Rappoport's website: https://blog.nomorefakenews.com/

[79] Ogenstad S, Peace K, Liu L (2020) Accurate COVID-19 Testing in Clinical Trials. Unpublished paper reportedly submitted to Journal of Bioharmaceutical Statistics.p.3-4.

[80] https://lockdownsceptics.org/testing-do-you-have-the-disease/#comment-402

[81] Farber C (2020). Was the Covid-19 Test Meant to Detect a Virus? Undercoverdc, April 7. Available at: https://uncoverdc.com/2020/04/07/was-the-covid-19-test-meant-to-detect-a-virus/; also for PCR and HIV test technologies: Farber C (2006) Serious Adverse Events. New York, Melville House.

[82] The Perth Group defines sensitivity and specificity: *"It is essential to understand the test parameters sensitivity and specificity. Sensitivity is a number, usually expressed as a percentage, indicating how often the test is positive given that a particular condition or disease is known to be present. For example, how many of 100 patients with histologically proven appendicitis have an elevated white blood cell count? The method of determining the presence of the condition, the test's gold standard, cannot be the test. The gold standard must be independent of the test. As another example, an ultrasound examination conducted at six weeks of pregnancy can serve as a gold standard for evaluating a blood test to diagnose pregnancy. If 99/100women pregnant on ultrasound have a positive test then the test is 99% sensitive. Specificity is a more difficult concept because it is defined as a double negative. Specificity is the percentage of negative tests in a group of individuals who are known not to have the condition or disease. For example, if 99/100 women who are not pregnant on ultrasound have a negative blood test the test is99% specific. The one non-pregnant woman with a positive test is a false-positive. This occurs for example in some gynaecological malignancies. The easy way to calculate the percent false-positives is to subtract the percent specificity from 100. Hence if the "HIV" PCR is 40% specific then 60% of individuals*

Currently there exist for 'SARS-Cov-2' different standards governing British laboratory decisions over what constitutes the cut-offs for both judging and measuring 'positive' and 'negative'[83]. The validity and veracity of these official claims are at best, highly questionable, or at worst, incorrect[84].

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who are not infected will have a false-positive test. One cannot over-stress the requirement for using a superior reference test (the gold standard) to prove the condition or disease is present or absent. In the case of the "HIV" antibody tests there has never been a study documenting the test against HIV itself, despite the fact that proving HIV infection is the purpose of the test. The "HIV" antibody test is evaluated using either another antibody test (which is evaluating the test against itself), or by defining "HIV" infection as individuals who have AIDS. Neither method can prove that the antibodies that react in the test are caused by HIV. One must use HIV isolation/purification as the gold standard. See: Griner PF, Mayewski RJ, Mushlin AI. Selection and interpretation of diagnostic tests and procedures. Ann Intern Med 1981 94:559-563." Papadopulos-Eleopulos, E et al. HIV – A virus like no other. Posted at the Perth Group website July 12th 2017. www.theperthgroup.com/HIV/TPGVirusLikeNoOther.pdf;

[83] National Health Service and National Health Service Improvement (2020) Guidance and standard operating procedure COVID-19 virus testing in NHS laboratories. London, UK Department of Health. Available at: https://www.england.nhs.uk/coronavirus/publication/guidance-and-standard-operating-procedure-covid-19-virus-testing-in-nhs-laboratories

[84] Bustin S (2017) Talking the talk, but not walking the walk: RT-qPCR as a paradigm for the lack of reproducibility in molecular research. European Journal of Clinical Investigation 47 (10) October, 756-774. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/eci.12801

Bustin S (2020) The Infectious Myth: Stephen Bustin on the Challenges with the RT-PCR. Available at: https://infectiousmyth.podbean.com/e/the-infectious-myth-stephen-bustin-on-challenges-with-rt-pcr/

Off-Ramp 4

'Covid-19 Treatments' Are 'Repurposed' Drugs

Once through the NHS Covid19-triage, if classified under respiratory tier 1, then one may become a Covid-presumed case statistic until proved otherwise. Proving infection will be via tests with unpublished specificity and sensitivity: meaning tests with no proven accuracy (see above e-mail dialogue with Public Health England). It may be hard to resist that category if so classified as *test-positive* and perceived of as *highly symptomatic.* There will be further possibilities of testing positive and then negative, and *vice-versa*; and other discordances difficult to reconcile between the differing test methodologies e.g. antibody versus RT-PCR and *vice-versa* etc.

There is also the likelihood of receiving fear-induced biased treatment interventions that are perceived of by official medical sources as avoiding or reducing any risk to HCPs of aerosol generating procedures (AGPs), such as tracheal intubation and mechanical ventilation.

Even with tracheal intubation the HCP perception of these patients is so biased, so skewed, and so conditioned by Government-fear based propaganda, that even more hazardous interventions (e.g. elective sedation) are chosen in order to try to reduce the 'AGP risk'.

One London healthcare provider's operating policy states:

1. *"AVOID **awake** tracheal intubation (ATI) unless specifically indicated. Atomised local anaesthetic **will aerosolise the virus**. Consider use of video laryngoscope as first line*
2. *Plan for rapid sequence induction (RSI) and ensure skilled assistant is available.*
3. *Minimum 5 minutes of preoxygenation with 100% oxygen to **avoid need to manually ventilate**. Avoid use of High Flow Nasal Oxygen (HFNO) techniques. If unable to avoid manual ventilation, **small tidal volumes should be applied**."*[85]

The fear induced in staff has led to hysterical implication of AGPS in 'novel Coronavirus' transmission through surface and other environmental contamination based on biased evidence of questionable quality. One London healthcare provider's operating policy states:

> *"Respiratory Support in COVID-19 Infections*
> *Patients admitted to critical care with COVID-19 **invariably** have hypoxic respiratory failure due to bilateral multi-focal viral pneumonitis. Non-invasive ventilation (NIV) and High Flow Nasal Oxygen (HFNO) is **not appropriate** in the management of respiratory failure precipitated by COVID-19 associated viral pneumonitis. NIV and HFNO are techniques **likely to be associated** with aerosolisation of the virus and **increased risk** to staff. The use of NIV or HFNO in this clinical context should only be utilised in exceptional circumstances on direct authorisation from the critical care consultant on-call. **Intubation and ventilation is the preferred** management of **suspected** / confirmed COVID-19 infection giving rise to hypoxic respiratory failure. All intubated patients should be managed with a **closed-suction system**. Post-extubation NIV or HFNO in a patient recovering from acute infection may be*

[85] Lewisham and Greenwich NHS Trust (2020) Clinical Guideline for Airway Management in Suspected Coronavirus. February.

*appropriate as the patient's **viral load is likely to be considerably less**, or even undetectable, in the recovery phase of illness".*(emphasis added; N.B. increased viral load≠ disease severity)[86]

These policies imply that for those testing positive there is a greater risk of ***iatrogenic*** injury from the biased *rush to intubate and mechanically ventilate* using closed-circuit ventilation.

"Multi-Organ Failure in COVID-19 infection
*Evidence from China suggests **30-50% of patients** admitted to critical care with COVID-19 infection may develop **multi-organ failure** complicating their viral pneumonitis. Vasopressors and renal replacement therapy have been used widely in China in the supportive care of critically ill COVID-19 infected patients. **Outcomes at this time remain unclear**".*[87]

Fearful HCPs think these close-circuit measures reduce the AGP-risk by increasing the *distance* between patient and staff. Any closed circuit ventilation strategy is supervised through *viewing* and instrument surveillance. This biased rush to intubate/mechanically ventilate has ignored the potential utility of less intensive and safer methods such as non-invasive ventilation (NIV). This fearful approach has been perniciously instigated in this context which the British Department of Health has de-listed as a "high consequence infectious disease" with a mortality rate they describe as "low overall"[88].

No NHS treatment protocol exists for Covid-19 as a unitary disease. Treatment will involve 'repurposed' drugs such as antivirals, antiretrovirals, anti-inflammatories and other drugs of dubious proven evidence depending upon the biased medical perception of symptom severity and clinical presentation. As one London care provider's operating policy states:

"Pharmacologic therapies in COVID-19 infection
*There is no currently proven effective anti-viral treatment at this time for COVID-19 infection. Patients treated in China have received a range of treatments **for which at this time there is currently no evidence**."*[89]

A cursory glance at the Covid-19 webpage for the agency of the Department of Health in England which publishes clinical guidelines (the 'National Institute for Health and Care Excellence' or acronym 'NICE') clearly shows the actual amalgam of other conditions now existing under the umbrella of 'Covid-19 treatment'[90]. The early diagnoses of HIV/AIDS (Cochrane 2003) showed that 'presumptive' diagnoses were often based on highly inconclusive and contradictory laboratory test results no more than generic symptoms, and the suspicion of doctors, or the public health bureaucracy[91]. This appears similar for the 'novel Coronavirus' and 'Covid-19'.

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[86] Lewisham and Greenwich NHS Trust (2020) Critical Care Standard Operating Procedure Novel Coronavirus Disease (COVID-19) Contingency Plan. March.
[87] Lewisham and Greenwich NHS Trust (2020) Critical Care Standard Operating Procedure Novel Coronavirus Disease (COVID-19) Contingency Plan. March.
[88] See Government statement: https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid#definition-of-hcid
[89] Lewisham and Greenwich NHS Trust (2020) Critical Care Standard Operating Procedure Novel Coronavirus Disease (COVID-19) Contingency Plan. March.
[90] https://www.nice.org.uk/covid-19
[91] Cochrane M (2003) *Where AIDS Began*. San Francisco, Routledge.

4. What's Bad In 'Corona Science'?

Science 'Gone Horribly Wrong'.

Alchemy

"A process that is so effective that it seems like magic"[92]

A new alchemy has been spawned from the 'science' underpinning the ***'novel*** Coronavirus' and its attendant Lockdown. It includes the current application to global populations of epidemiological concepts such as 'the R0', 'Suppression' and 'Mitigation' etc.

These concepts appear effective in terms of their arcane genesis and application across the population which many lack the 'scientific grammar' and perceived status in order to successfully challenge. It may also convey another veneer of respectability and enchantment helping to explain a reflexive deficit on behalf of the scientists.

The Imperial College London epidemiological team – led by a scientist (Niall Ferguson) now disgraced for believing himself exempt from the ramifications of his own science - made the following statement in their paper:

> *"We do not consider the* ***ethical or economic implications.***
> *...**Instead** we focus on **feasibility**"*

Here we see the team's ethical and moral standpoint – or lack of one - as they inflate the *fauxdemic© in the very same paper*[93].

How *humane* is that?

How ***inhumane*** is that?

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[92] https://dictionary.cambridge.org/dictionary/english/alchemy
[93] Ferguson et al (2020): https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf

It also shows how these epidemiologists think that they are immune from the ethical constraints that apply to science, especially in the Health Sciences. They are only concerned with the means and not the ends. They are saying that the focus must be on *their* particular mechanism of this *fauxdemic©* *whilst* ignoring its blatantly inhumane ethical and economic effects.

Such inhumane irresponsibility should arguably not be accepted by any Research Ethics Committee because it fails to address any social ramifications[94]. All health scientists have both ethical and moral obligations. As Ferguson and colleagues have absented themselves from these important scientific responsibilities established at The Nuremburg Trials, it raises a further set of questions over who are the ethical and moral Arbiters? Our elected Governments were not, are not, and most likely will not be those Arbiters.

> *"Funding*
> *This work was supported by Centre funding from the UK Medical Research Council under a concordat with the UK Department for International Development, the NIHR Health Protection Research Unit in Modelling Methodology and Community Jameel."*[95]

The above cited funders of Ferguson's study at Imperial College London must be required to face their moral and ethical responsibility for underwriting such inhumanity.

The Table 7 [below] offers alternative definitions for each of the above 'alchemical' concepts ('The R0' etc) based on epidemiological ideology. It was this ideology which our Governments so zealously and uncritically enshrined into law and public policy. At the start of the AIDS era, various obscure and arcane measures of 'health' such as the T Cell Count and The Viral Load came to totally dominate and over regulate the daily lives of many people in contact with 'HIV/AIDS' services[96].

'W*hat's your count doing today?'*

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[94] Personal experience as a faculty member on a health sciences research ethics committee for St George's Healthcare NHS Trust Research Ethics Committee, 2001-2004

[95] Ferguson et al (2020): https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf

[96] Corbett, K (2001) Contesting AIDS/HIV: the lay reception of biomedical knowledge. PhD thesis, London South Bank University. Available at: https://lispac.lsbu.ac.uk/record=b1015575~S1
Corbett, Kevin (2009) "You've got it, you may have it, you haven't got it": multiplicity, heterogeneity, and the unintended consequences of HIV-related tests. Science, Technology and Human Values, 34 (1), pp. 102-125. ISSN 0162-2439 Available at: https://doi.org/10.1177%2F0162243907310376

Table 7 TOOLKIT DEFINITIONS OF KEY 'COVID-CONCEPTS'

Epidemiological Term	Imperial College London definition[97]	Toolkit ['critical'] Interpretation
'THE R0'	The "Reproduction Number"- the "growth rate" of the "infection"; *"we make a baseline assumption that R0=2.4 but examine values between 2.0 and 2.6. We assume that symptomatic individuals are 50% more infectious than asymptomatic individuals. Individual infectiousness is assumed to be variable, described by a gamma distribution with mean 1 and shape parameter =0.25"*	***'Dragnet[98] Zero': Propaganda On Epidemic Transmission Rate From A Mythical 'First Patient' - 'Patient Zero'.***
'SUPPRESSION'	*"Here the aim is to reduce the reproduction number (the average number of secondary cases each case generates), R, to below 1 and hence to reduce case numbers to low levels or (as for SARS or Ebola) eliminate human-to-human transmission."*	***'Dragnet Zero' Total Oppression Of Everyone.***
'MITIGATION'	*"Here the aim is to use NPIs['non-pharmacological interventions'](and vaccines or drugs, if available) not to interrupt transmission completely, but to reduce the health impact of an epidemic, akin to the strategy adopted by some US cities in 1918, and by the world more generally in the 1957, 1968 and 2009 influenza pandemics. In this scenario, population immunity builds up through the epidemic, leading to an eventual rapid decline in case numbers and transmission dropping to low levels."*	***'Dragnet Zero' Kills Some, 'Frees' Others.. until the next Diktat…***

*This w*as the question for everyone with the HIV+ label. They were asked by their doctors; then they asked their friends; and finally themselves. Burrowing deeply into the psyche to cause anxiety and depression, just like an earworm[99], and also endlessly repeated like an incessant mantra.
These 'counts' symbolised *unattainable* goals – the *Alchemical Goals* of the AIDS Experts.

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[97] Ferguson et al (2020): https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf

[98] *"a series of actions taken by the police that are intended to catch criminals; a heavy net that is pulled along the bottom of a river or area of water when searching for something"* https://dictionary.cambridge.org/dictionary/english/dragnet

[99] *"Earworms are a generally benign form of rumination, the repetitive, intrusive thoughts associated with anxiety and depression".* https://www.scientificamerican.com/article/how-do-you-solve-a-problem-like-an-earworm/

The R0, Suppression and Mitigation are now the new unattainable goals, the *'new Corona Alchemy'*, replacing their 'AIDS-era' equivalents.

Figure 8 A Common Figure In The British Mainstream Media (MSM) [London, May 2020]

Just like those spurious AIDS 'counts', now we have 'The R0', 'Suppression' and 'Mitigation' all 'virally infecting' our talk, our minds and our psyches (Figure 9 above). These notions, as currently applied by our politicians and policy-makers, are pure brainwashing and propaganda that can only serve to heighten the hysteria of this pernicious *fauxdemic*©. They are another *Alchemical Mechanism*, like the casting of spells, for *disciplining* both the politicians and the populace. These misleadingly simple metrics as shown above (Figure 9) in provide a *magical* veneer of social respectability and political immunity to this 'science'

.

'Follow The Science' is now the 'new mantra', just like those unobtainable AIDS 'counts'. This 'science' is like a musical spell cast by a set of Pied Piper Epidemiologists who have already led us badly astray. Like those poor children in Hamlin, we are led into a future of incarceration: no arena concerts; no football matches; no overseas travel at will; no theatres; and no Christian communion. Arguably some

say - *'pay' the damn Piper and be done with it*. Or face eternal purgatory or worse – the eternal damnation of the 'R0', 'Suppression', 'Mitigation' etc burrowing into our *psyches* like a magical *earworm.* To extend this metaphor further:

These British Pied Piper Epidemiologists will always demand a Puritan's price for their role in creating this *fauxdemic*©. The cost is already too high reportedly being set at: *social isolation*; no *personal presence*; *bankrupt economy; no jobs*; and a prospective rollout of mandatory testing and treatment with no free movement [like China], unless enough social credit exists on your app and you are deemed symptom-free.

Let's stop our British Pied Pipers now and refuse to pay.

Here is one example of a price too high to pay. British companies are now putting in place 'compulsory testing' [their words] for all staff, with no opt outs. This means disciplinary action or termination for non-compliers. Being fired for poor job performance is one thing, but being fired for not agreeing to take an oral swab test is a price too high. The Epilespy Society in Great Britain is already requiring its care staff to line up every 7-day period for just such a swab at a London Hospital. Line up every time at that hospital. You will be given a card. It must be stamped by your tester. It must be shown to the 'right person' before you are let back into the office, or onto any 'frontline' work. Any independent contractors who fail to comply ['agree'] will be immediately 'discontinued' – the exact words the Epilepsy Society uses. Is Resistance really Futile?

The politically bewitching applications of these concepts from this *fauxdemic*© requires not just in-depth scientific rejection(s), and total scientific obliteration, but also social and cultural forms of attack that must totally and utterly obliterate its magical programming[100]. These epidemiological spells of the 'R0', 'Suppression' and 'Mitigation' are cast on a variety of fronts other than the scientific. They cannot be broken by a simple kiss from any handsome Prince Charming. All of those Hollywood clichés about

[100] Hysteria and group fantasy theories were advanced at the outset of, and well into, the AIDS era: Schmidt CG (1984) The group-fantasy origins of AIDS. The Journal of Psychohistory, 12(1), 37–78. https://www.virusmyth.com/aids/hiv/csfantasy.htm; https://psycnet.apa.org/record/1985-14989-001
Lauritsen J (1997) The Psychohistorical Origins Of Aids. An Interview with Casper Schmidt. In Lauritsen J, Young I, 'The AIDS Cult: Essays on the gay health crisis' Asklepios, USA 1997, ISBN 0-943742-10-2. https://www.virusmyth.com/aids/hiv/iyinterviewcs.htm

ending hysteria use real slaps that suddenly wake the victim up from their trance in the nick of time to avoid danger.

Of course, I am using *metaphors,* and not seriously advocating slapping each other, although it does cross my mind every time I see people wearing those ridiculous gloves and masks. However, it was this order of 'Anti-Pied Piper' de-programming that the late Michael Ellner[101] and Tom Di Fernando completed in New York City under the auspices of HEAL[102]. For years they helped people who were trapped inside those weird spells cast by those scary AIDS counts;- like mice inside spinning wheels, forever going round and round, chasing the numbers: the 'optimum count'. Often exhausted from trying to achieve the unachievable, people were shown how to *break the spell* and escape.

Other social and cultural means of *attack-and-destroy*, in parallel with those which are more scientific, can further help to remove the veneer of untouchability and respectability with which these bewitching concepts have been so carefully painted by the Epidemiologists. They act as if **God** (*read again the Epigraph/Quotation opening this than monograph*). The *CoronaGuerillaArt* included in this toolkit is tentatively offered as an example of such an *attack-and-destroy mechanism.* It is not just 'science' that has got us into this mess. More than science is needed to get us out and *break the spell*.

[101] DiFerdinando T (2018) Michael Ellner, AIDS Warrior April 10, 1949 – February 26, 2018. Rethinking AIDS website: https://rethinkingaids.com/index.php/michael-ellner-aids-warrior-april-10-1949-february-26-2018
[102] Giraldo R, Ellner E, Farber C et al. (1999) Is it rational to treat or prevent AIDS with toxic antiretroviral drugs in pregnant women, infants, children, and anybody else? The answer is negative. CONTINUUM 5(6), 39—53 SUMMER: http://www.immunity.org.uk/wp-content/uploads/2013/06/v5n6.pdf

Pathological

"You describe a person or their behaviour as pathological when they behave in an extreme and unacceptable way.."[103]

The 'science' underpinning the 'novel Coronavirus' and its attendant Lockdown is coming to resemble the characteristics of Irving Langmuir's ***'pathological science'*** or the ***'science of things that aren't so'*** (Langmuir 1953).

Pathological science was a concept developed from experimental physics. It was loosely defined by its creator Irving Langmuir using several key characteristics (Table 8, below).

One of these characteristics is the claim of impressive experimental results, like impressive "statistical significance", which were subsequently proven wrong. A major causative factor was that pathological science reflected not fraud but ***scientists' belief*** in wrong findings. Langmuir thought that psychological processes were instrumental in its development even though there was a superficial resemblance to the normal scientific method. However, the normal scientific method was subtly changed through unconscious processes of pathological wish fulfilment in terms of data interpretations, akin to both the observer-expectancy effect and cognitive bias.

Langmuir never determined this concept definitively. He only gave examples with a list of characteristics. Table 10 [below] shows how these characteristics of Langmuir's concept of pathological science are arguably fulfilled in relation to the scientific characteristics underpinning the 'novel Coronavirus'.

Of concern are the *'claims of great accuracy',* now refuted (e.g. Imperial College London's 'model epidemic'); the *fantastic over-reach* theories - contrary to our knowledge/experience - of this 'novel Coronavirus' that certain contagion occurs through the normal quotidian of *'touch'*; *'receiving holy communion'*; *'breathing'*; *'sitting on a park bench'*; *'attending funerals'; 'CPR'*; *'non-invasive ventilation'*; and *'being present with hospitalised loved ones on their death beds'* etc [these examples will prospectively change].

103

This fauxdemic©'s '*high ratio of scientific supporters to critics' was initially increasing* but is now arguably *falling,* as we see an emergent *Lockdown ennui* amongst scientists.

Amongst the lay public there may be a similar pattern. However, the 'flattening' of that curve may differ due to the nature of the Terror instigated by our Government and its science advisory, chillingly referred to by the acronym 'SAGE'[104].

All of the above italicised characteristics of Langmuir's 'pathological science' are now arguably fulfilled in the case of this 'novel Coronavirus' ('Covid-19'). By turning *the normal into the abnorma*l this *fauxdemic*© is a clear example of 'pathological science' embodying as it does so well Langmuir's original idea of the "*..'science of things that aren't so'..*"

Many scientists now counter the zealotry of Imperial College London's epidemiology, but with little apparent MSM coverage. For example, the work of Carl Heneghan and Tom Jefferson of Oxford University did not greatly impact in the MSM, even though they showed good evidence that this fauxdemic© is a *"..late seasonal effect in the Northern Hemisphere on the back of a mild ILI season[105]."* (Heneghan and Jefferson 2020).

Furthermore, daily *snitch*[106] reports by the media show how the mystical spell cast by the pathological science can wear off, as sections of society can ***wake up*** to the reality of what has been so zealously perpetrated in the name of 'epidemiological science'. This is the creation in the Western world of an inhuman dystopia of prospective mandatory screening, flawed testing and fast-tracked vaccination (akin to Communist China), from which all our ***elected*** 'Free World' politicians have failed to protect us.

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[104] "Scientific Advisory Group for Emergencies (SAGE)": https://www.gov.uk/government/groups/scientific-advisory-group-for-emergencies-sage

[105] 'ILI'=influenza-like illness.

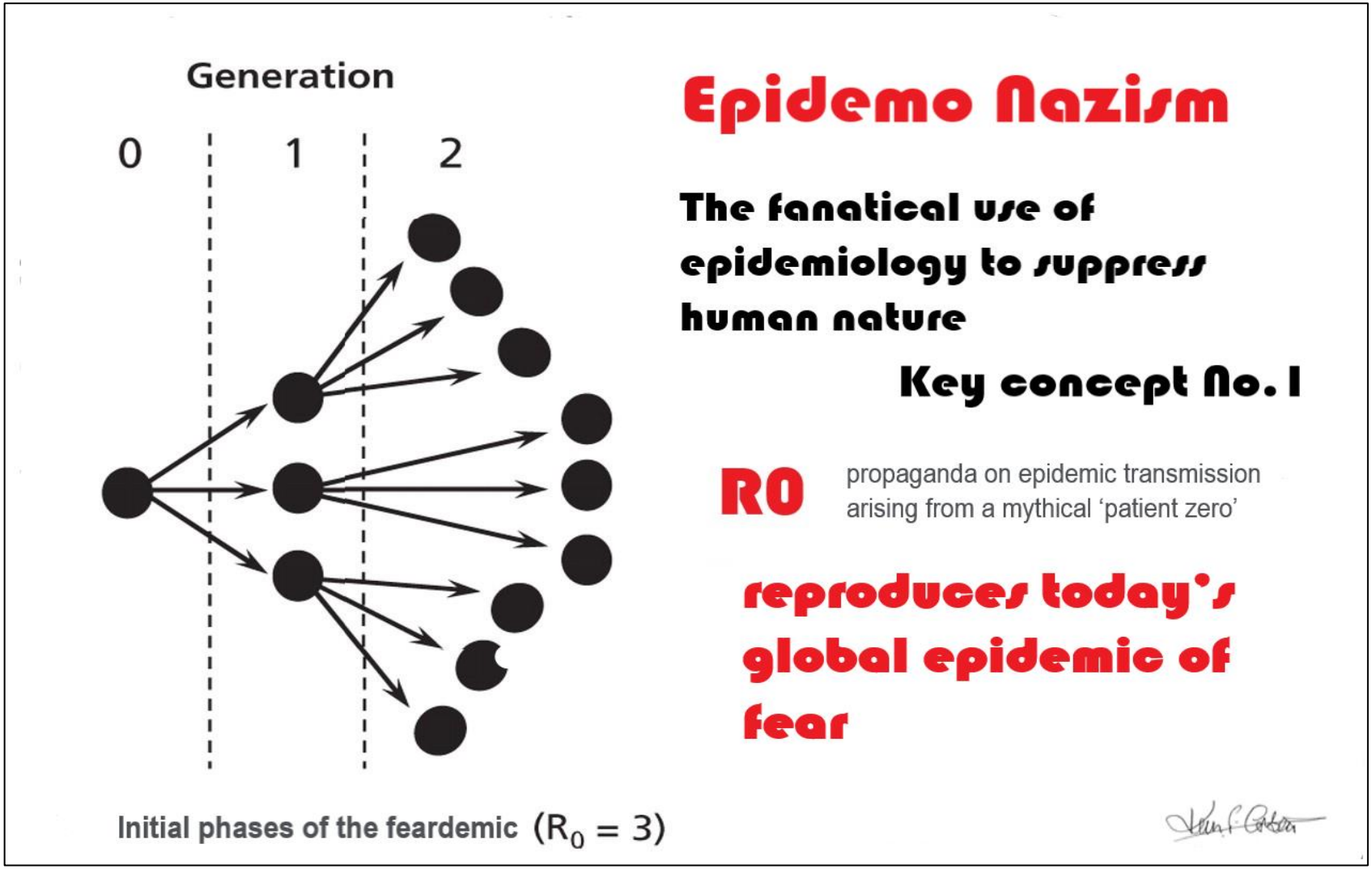
[106] Meaning: "*to secretly tell someone in authority that someone else has done something bad, often in order to cause trouble";* see*:* https://dictionary.cambridge.org/dictionary/english/snitch

Table 8 The 'Pathological Science' of Covid-19 / 'novel Coronavirus'

Langmuir's Characteristics of 'Pathological Science'	'Scientific' characteristics of the 'novel Coronavirus'	
The maximum effect that is observed is produced by a causative agent of barely detectable intensity, and the magnitude of the effect is substantially independent of the intensity of the cause.	**No correlation: 'viral load' with disease severity** Only detectable as 'RNAaemia' Accuracy of RT-PCR / Antibody tests underdetermined All Koch's postulates unmet 'Syndrome' disease Covid-19	Syndrome disease Covid-19 Syndrome of non-specific symptoms Everyday symptoms weaponised Symptom list lengthening Putative agent 'SARS-CoV-2' Never purified Never Isolated Not isolated as live virus in blood
The effect is of a magnitude that remains close to the limit of detectability, or many measurements are necessary because of the very low statistical significance of the results.	**Only detectable as 'RNAaemia'** RT-PCR / Antibody tests Koch's postulates unmet	
There are claims of great accuracy.	Imperial College London modelling RT-PCT /Antibody tests	
Fantastic theories contrary to experience are suggested.	'highly infectious' 'Aerosol Generating Procedures' transmit 'Breathing stops transmission' Symptoms continually expanding Cardiopulmonary resuscitation 'transmits' Breathing transmits	
Criticisms are met by *ad hoc* excuses.	Modelling statistics Death statistics Seroconversion statistics Disease statistics	
The ratio of supporters to critics rises…	Public support for the Lockdown Scientific support for the Lockdown	
The ratio of supporters to critics rises ~~then falls gradually to oblivion.~~	Public support Scientific support for the Lockdown	
The ratio of supporters to critics rises and then falls gradually ~~to oblivion~~.	~~Public support~~ Scientific support for the Lockdown	
The ratio of supporters to critics rises then falls gradually to oblivion~~.~~	~~Public support~~ ~~Scientific support for the Lockdown~~	
The ratio of supporters to critics rises and then falls gradually to oblivion.	Public support Scientific support for the Lockdown	

5. *CoronaGuerillaArt*

CoronaGuerillaArt: ‘The R0’
CoronaGuerillaArt: ‘SUPPRESSION’
CoronaGuerillaArt: ‘MITIGATION’



Interactive 2 *CoronaGuerillaArt:* 'The R0'. April 2020©

Epidemo Nazism

Epidemiology can be used to justify human suppression..

Remember?

The fanatical use of epidemiology to suppress human nature

keep **Key Concept No. 2**

R0<1 propaganda on epidemic transmission arising from a mythical 'patient zero'

Epidemiological suppression:

<1 ethical or moral conscience

***Fauxdemic*: Fear + hysteria**

Interactive 4 *CoronaGuerillaArt*: 'MITIGATION'. April 2020©

Epidemo Nazism

The fanatical use of epidemiology to *suppress* human nature

Mitigation

Key concept no. 3

propaganda on reducing the 'painfulness' of the lockdown

'Mitigation' really means:

Lockdown **kills**
- some are *'freed'*
..until the next **Diktat**

6. Sci-Fact or Sci-Fi?

Asimov's dystopia is now

Spatial Radar

I first started reading Asimov's sci-fi when I was fourteen. The first was '*The Naked Sun'* in which humans left Earth for Solaria to escape overcrowding and agoraphobia. The Solarians led a controlled technocratic existence in empty estates tended by robots. A virtual Arcadia until an unsolved murder perplexes. The deceased married to a glamorous female protagonist – Delmarre - and the other protagonist – Earthman police Baley - is rocketed from Earth to boost the local forensics.

Since December, I kept thinking of this book especially now the viral hysteria, the novel's *contagion-fear and its* difference between *seeing/viewing*. I bought it to reread the touching *'Adieu'* between the protagonists, the only scenario I could recall.

Asimov had proposed a world in which generations had outlawed s*eeing* as in *'personal-presence' disavowing in-the-flesh close physical proximity*. *Seeing along with other aspects of human nature* had become forbidden fruit, a filthy, dirty and germ-ridden perversion. A scientific technocracy had seeded this new *modus operandi* in the popular psyche, redrawing its interactions in an Orwellian twist that redefined linguistic meaning and concepts. The story is of a 'society' where the *action of seeing* as a form of *direct visual perception is divorced from* the *instance of viewing* an *image as a representation of the original* eschewing the *object itself*. It activated my personal 'radar' partly due to training in the visual arts[107] but also experience in forensic healthcare and the health sciences[108]. This background coalesced with the growing hysteria since December into a renewed interest in this story.

Twenty years ago I researched the public experience of non-binary medical test results[109]. Questions over test accuracy remained. I saw how those same tests were now used on 'Covid' patients. Old debates resurfaced for me rereading Asimov's apartheid of *viewing* / *seeing.* The 'Coronavirus' research I was reading showed no *morphologically*, *biologically, physically* purified or isolated agent was proven to come from outside of human cells. The *viral* image had gone global yet its physical presence is unproven. *Detection was* claimed – *viewed* chemically, genetically, molecularly but never *'seen'* as a physical morphology with the methods of traditional virology. Tradition overturned? ***Seeing*** *not* ***viewing?*** *Well, wasn't that precisely the perverse world in the Asimov novel?*

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[107] www.kevinpcorbett.com

[108] https://www.linkedin.com/in/kevin-p-corbett-7a176b71/
http://eprints.mdx.ac.uk/view/creators/Corbett=3AKevin=3A=3A.html

[109] Results neither +/- or discordant for the same person (+ then - and vice versa): Corbett, K (1998) The problematic for empowerment: the surrogacy of antibody tests and the erosion of the medical gold standard. Continuum, 5 (4), pp. 51-56. ISSN 1461-1597 Available at: http://www.altheal.org/continuum/Vol5no4.pdf; Corbett, K (2001) Contesting AIDS/HIV: the lay reception of biomedical knowledge. PhD thesis, London South Bank University. Available at: https://lispac.lsbu.ac.uk/record=b1015575~S1; Corbett, Kevin (2009) "You've got it, you may have it, you haven't got it": multiplicity, heterogeneity, and the unintended consequences of HIV-related tests. Science, Technology and Human Values, 34 (1), pp. 102-125. ISSN 0162-2439 Available at: https://doi.org/10.1177%2F0162243907310376

Figure 9 The Author In Sneakers Confronts The Hysteria
(tube station: Central Line St Paul's, London, England, April 2020).

Asimov's *Dystopia*

A plot device in Asimov's 'The Naked Sun' has people always ***staying home,*** and only being socially permitted to *view* each other via trimensional screens[110]. *The* 'society' was programmed to abstain from *seeing* one another *in situ – no 'personal-presence' - no in the flesh or close physical proximity*.

Seeing had become socially forbidden, prohibited and eventually deleted from sane human behaviour. As physical isolation was the norm those wishing to be physically present with others were now classed as ***perverse[111]*** *- the word one of Asimov's characters uses to describe an experience outdoors in unobstructed space***.** The novel's characters thought sex - like bodily fluids since AIDS - highly unpleasant, a physically discomforting social duty for procreation only. AIDS was our warning - a *prodrome[112]* - for current hysteria where not only bodily fluids are contagious but so too is physical presence.

Asimov's suggests we could swap normality for perversity – the new 'normal' – overturning millions of years of human development. Just like the 'novel Coronavirus' and its attendant 'science' which radically subverts common sense. Breathing in and out now a perversity, contagion-filled risk not an aesthetic recreation; coughing or clearing one's throat publicly is suspicious even more taboo; and wearing masks, once the preserve of Halloween and bank robbers, is now nearly a normal expectation for entry to the public sphere.

In the 1950s, Asimov envisioned this future, which is arguably both perverted and dystopic[113].

How? What particular crystal ball did he possess?

Figure 9 [above] shows the ludicrous nature of the paranoid intrusion of the 'science' of the 'novel Coronavirus' and its attendant Lockdown into our personal space, distancing one person away from the other, all based on some epidemiological notion whose true evidence base is continually revised. The Table 9 [overleaf] shows the resemblance of our current situation to Asimov's novel. There are some emerging similarities [*] and differences. Read Table 6 [overleaf]:-,

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[110] This resembles our existing 21st century technologies, such as holography. The noun 'Trimensional' now refers to:"*The Trimensional app is a 3D scanner app created by Trimensional, LLC for the iPhone and the iPod. Users can scan friends and family to create 3D models ..that uses the screen and the front-facing camera and detects patterns of light on your face to build a 3D model. Turn the screen brightness to maximum and turn off all the lights. The Trimensional scanner works best in the dark. Then take close-ups of your subject."* See: https://www.whiteclouds.com/3DPedia/trimensional-app.html

[111] The plot balances this touch 'perversion' with Earthmen's 'agoraphobia' which is never presented in the plot as a social perversion like the story's prohibition on touch, gregariousness and physical proximity.

[112] A prodrome is medical term for an early sign or symptom (or set of) that often indicates the onset of a disease before more diagnostically specific signs and symptoms develop. It is derived from the Greek word *prodromos*, meaning "running before"; see: https://en.wikipedia.org/wiki/Prodrome

[113] The genre of dystopic future-time is large and includes, Marge Piercy's 'Woman On The Edge of Time'

Government Lockdown Rules = Science Fiction = appearing in Asmov's *'The Naked Sun'* *[pages numbers given]* ***As nouns the difference between 'viewing' and 'seeing'; is that viewing is an instance of viewing something while seeing is the action of the verb to see ; eyesight or visual perception***	
Our 'New Normal': Our Lockdown Rules *['new modus']* **[Asimov's: '*the Solarian normal*']**	**Our New 'Abnormal': Our Pre-Lockdown *modus operandi*** **[Asimov's: '*the Earth normal*']**
INTERPERSONAL RELATIONS LIVED VIA IMAGES NOT VIA DIRECT VISUAL PERCEPTION p57	***INTERPERSONAL RELATIONS LIVED VIA DIRECT VISUAL PERCEPTION AND IMAGES –personal choice [p57]***
The meaning of Words is perverted p58	The meaning of Words is not perverted
Social isolation / distancing / Non-touch* [whole book]	Touching*
Masks / gloves / nasal filters [p.16]	Breathing the same air as others*
Inattention	Personal presence*
Flattened affect [p.151]	Gregariousness [p.151]*
Social and sexual frigidity	Wanting physical and sexual contact*
Loveless-ness	Love + affection*
Verb *to see* means being personally present, in situ, close quarters, connotes anxiety, dread, terror p.57	Verb to see has normal meaning, no connotation of anxiety, dread, terror
Verb *to view* means at distant p57	Verb to view normal meaning
Viewing onscreen nakedness* p57/p55	*Seeing in situ* nakedness*
*Viewing : personal distance**	*Seeing : personal presence**
Viewing and seeing are completely different and carry vastly different social connotations	*Viewing and seeing are the same and do not carry different social connotations*
*Seeing is an ordeal – personal presence stressful p.60**	*Viewing is an ordeal, personal presence comforting*
Visual perception of seeing with the eye is outlawed	*Visual perception of seeing with the eye is not outlawed*
Looking at as viewing is the only socially acceptable mode	*Looking at as viewing is often the least socially acceptable mode*
*Dead bodies only viewed p.63**	*Dead bodies seen*
Lack of geospatial awareness, *lost-in-space* without social media, like *zombie or Smombie* [p62] *	Geospatial awareness, positioning
Only abstract non-figurative *portraiture*	Figurative art + abstract art as *personal tastes**
Identity-ill defined	Identity-clearly defined
Essential occupational roles socially assigned	Occupational roles freely chosen
Productive work [p62]	Work for fun
Genetic make-up seen as sole determinant of human behaviour	Genetic make-up seen as one determinant among many of human behavior
Total engineered genetic ['genic'] health [p.149]	No total genetic engineering
All dead bodies burned* [p.63]	Dead bodies burned and buried
Instincts engineered through education*	No instinctual engineering through education
Reproduction/sex is *necessary pleasure-less* ***perversion***	Reproduction/sex is *necessary pleasure-ful normality*
Asking about how many kids you have is indecent and perverted p59	Asking about how many kids you have is normal or maybe insensitive but not perverted
Telemedicine: virtual *ex-situ* examination*	Physical *in-situ* examination*
No concept of forensic medicine	Concept of forensic medicine
No concept of forensic criminal evidence	Concept of forensic criminal evidence
Family or personal ambitions curtailed [p.162]*	Family and personal ambitions encouraged++
No apparent motives for violence [p162]	Clear motives for violence++
'Affection' = *attention – emoting/emotion* [p.150]	Affection = *attention + emoting/emotion* [p.150]
Husbands + Wives socially assigned to each other* [some Islamic countries]	Husbands + Wives not socially assigned to each other [in 'Free World' modernity] *
Government instructs when to reproduce [c.f. China] *	Government does not instruct when to reproduce
Growing children incrementally isolated and conditioned into social distancing / isolation [p151] *	Growing children incrementally gregarious and conditioned into socialization [p151]

Table 9 How the Lockdown is a Dystopia: Asimov's perverted future is now our reality

The peculiar and rigid *modus operandi* in Asimov's story dictated that - from artificially gestated foetus to full adult - the population had their natural human instincts for *gregariousness*, *sociability* and *sensory foci*, like touch etc, *curbed* in a contrived, perverted and technocratic way.

Human *love* and *affection* had become historically perverted into the one socially allowable behaviour neutrally termed *attention. Only* robots would *attend,* as i*nstinctual love/affection/touch/physicality* were now fully taboo,

Our normal daily behaviours like seeing in person would never be ideally undertaken, or even spoken of, without the taint of 'perversity' and the need for 'genetic' intervention to eliminate the 'pathology'.

Problems arose when *in situ* forensic examinations were required physically of doctors and police, hence the novel's sleuth plot. The 'society' (is it?) *disabled* medical expertise accrued through 'hands on' examination (via touch) and *disappeared* forensic evidence without a trace as robots automatically cleaned after humans, even their crime scenes.

Both medical and forensic *in situ* examination, for the pursuit of truth, was fatally delimited by this genetically hardwired prohibition which disavowed and outlawed physical contact, gregariousness, sociability and truth-seeking. Eugenics and effective self-imposed social conformity meant only a minimum of official surveillance was needed as *the Solarian people themselves were socially conditioned to self-enact the necessary authorized discipline with minimal if any external force*[114]*.*

Now this seems familiar. Even though it was written in 1950's America, it could so easily be a description of what we are now experiencing in Great Britain.

So 'fiction' has become fact.

[114] The plot has the 'Earthman' detective forensically 'seeing' through this perverted reality.

'The Future Dystopia Is Now'

In Asimov's socially distanced and human-isolated future, human's instinctive responses like touch, love, gregariousness and sociability were all curbed from cradle to grave. This suppression of human instinct eventually led the plot towards eugenics, psychosis and murder.

The overarching similarity of this 1950s sci-fi to our present and our future zealous prohibition on physical proximity and social distancing is obvious. This is occurring within both our personal lives and professional encounters with HCPs, and with everyone else.

In our country which so successfully fought Hitler and ably thwarted his German plan to engulf Europe

- ***why is there***:-,

- No overwhelming public outcry?
- No large-scale public demonstration(s)?
- Pervasive and stifling conformity?
- Zombie-like face mask and glove wearing?
- Frenzied communistic clapping for the NHS?

Are we all ***sheeple***? [115]

In Great Britain, we pay for our health services through taxation but the *personal-presence* of traditional healthcare is now mostly inhibited, prohibited, and even denied to us; all based on this ideological zealotry feeding the Hysteria of the *'novel Coronavirus'*.

It is not only an economic anomaly, as these services are paid for via taxation and have been withdrawn - 'services not rendered' - but also this prohibition over personal-presence is an anathema to the science and art of ethical health care provision and normal human social functioning. It is also an anathema to our functioning within every other sphere of human activity from sports to art and our religious/spiritual attendances.

Isolation inhumanely objectifies and delimits the patient's agency within their encounter with HCPs. This prohibition on personal-presence further aims to totally reduce that professional and social encounter, akin to Asimov's novel, to a *viewing-only* situation, critically lacking in the personal presence. It makes the 'new normal' the abnormal ('*touch'/'proximity*'), and vice-versa.

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[115] Derogatory term: "combination of the words "sheep" and "people" meaning that the person or persons are acting as a group or to only behave based on what is trending"
https://www.urbandictionary.com/define.php?term=Sheeple

This elevation of the abnormal ('isolation'/'distancing') into the very opposite of the humane application of medical science, within which our HCPs have been trained, is an extremely pernicious characteristic of this particular application of the above epidemiological tenets to the whole population.

The particular touch prohibition is a distinctly pathological turn not being based on any evidence related to the clinical context of and the actual equipment used in hospitals or other occupational workplaces.

The *CoronaHysteria mechanism* uses a small amount of rudimentary and spurious 'evidence' which propel erroneous ideas forward on a ***tide of hysteria*** solely reliant upon deep seated ***psychological fears*** of contagion and personal contamination, effectively spreading a climate of suspicion, paranoia, neurosis and obsessional compulsive behaviour throughout the population.

The *CoronaTriage*© categorization of patients into those with or without some generic list of non-specific symptoms (attributable to many illnesses), is an unscientific classification. It has already been extended through ***projection*** (another example of 'sociogenesis') based on anecdote and suspicion e.g. 'olfactory symptoms', 'ear, nose and throat symptoms', 'paediatric symptoms' etc.

Previously, 'official' diagnostic categories and whole tiers of service emanating from the British Government were critically interrogated and later revealed as suspect tools of ideological-infused policy e.g. The New Labour Government's much lauded diagnosis of *'Dangerous and Severe Personality Disorder-'DSPD'* (Corbett and Westwood 2005)[116] .

The mid-2000s rush to institutionalise 'DSPD' is now largely defunct. It is seen as a discredited 'failed experiment' (Tyrer et al 2010)[117]. Studies of similar phenomena also reveal how such moves are blunt instruments of totalitarian control. For example, the Soviet era's discredited diagnosis of 'Sluggish Schizophrenia' (Popov 1992)[118].

The recent Hysterical upsurge in the 'novel Coronavirus' will follow the same trajectory as these failed, yet dangerously abusive, diagnostic traps. In so doing it will cause a disproportionate and inordinate degree of economic and social carnage.

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[116]Corbett, K and Westwood, T. (2005) 'Dangerous and severe personality disorder': a psychiatric manifestation of the risk society. Critical Public Health, 15 (2) . pp. 121-133. ISSN 0958-1596 print/ISSN 1469-3682 online (doi:10.1080/09581590500144918). Available at: https://www.tandfonline.com/doi/abs/10.1080/09581590500144918

[117] Tyrer P, Duggan C, Cooper S (2010) The successes and failures of the DSPD experiment: the assessment and management of severe personality disorder. Medicine, Science and the Law 50, 95–99. https://journals.sagepub.com/doi/10.1258/msl.2010.010001

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7. Epilogue:

'I've got to get used to it, don't I'?

Resistance, subversion and de-programming

I searched Asimov's *'The Naked Sun'* to find the *'Adieu'* scene which I had vaguely recollected from adolescence. The novel closes with the protagonist Baley witnessing the character of Gladia escaping her social conditioning:

> "Baley was expecting her; she had asked for a last interview; but his eyes widened when she appeared.
> He said, "I'm **seeing** you."
> "Yes," said Gladia, "how can you tell?"
> "You're **wearing gloves**."
> "Oh." She looked at her hands in confusion. Then, softly, "Do you mind?"
> "No, of course not. But why have you decided **to see, rather than view**?"
> **"Well" - she smiled weakly - "I've got to get used to it, don't I?...**
>
> ..Step by step, she came **closer**, her eyes glowing, yet looking apprehensive, too. She stopped **three feet away**[119], then slowly, **as though in a trance**, she began to remove the glove on her right hand.
> Baley started a restraining gesture. "Don't be **foolish**, Gladia."
> "I'm **not afraid**," said Gladia.
> Her hand was **bare**. It **trembled** as she extended it.
> And so did Baley's as he **took** her **hand in his**. They remained so for one moment, her **hand** a shy thing, **frightened** as it **rested** in **his**. He opened **his hand** and **hers escaped,** darted suddenly and without warning toward **his face** until **her fingertips rested** feather-light upon **his cheek** for the **barest** moment."
>
> (Asimov,'The Naked Sun', 1956 pp230-232, emphases added.)

This extract helps the reader to reflect on the awfulness of our own era.

We don't have to get used to it.

We must take **political action(s)** to resist, subvert and deprogram.

We can **act** bravely both *inside* and *outside* of our personal relationships thereby **liberating** ourselves. By ***thinking*** about role modelling 'simple' **acts, like glove-free touching,** Asimov shows us how to publicly ***act*** and ***demonstrate*** freeing ourselves from the mind controlling tyranny of 'viral governance'. Such liberating acts emerge "*as through a trance".*

This optimistically suggests that we can take action(s) to free ourselves and others, via deprogramming, from the bewitching 'viral trance' spun by the Pied Piper Epidemiologists.

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[119] The social distancing in the British Lockdown is reportedly 2 metres, double the length in this passage in Asimov's novel. Reports are circulating that officials doubled the 'true' length as they felt people needed to be kept 'safe' or as the public could not be trusted. If the 'research' showed only 1 metre was needed then Asimov's crystal ball was truly accurate. Again, what sort of crystal ball did Asimov actually possess?

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Appendix One

Great Britain's 1999 Testing Debate

(All articles appear overleaf in published chronological order.)

Rosalind Harrison and **Kevin Corbett** present some surprising information about HIV testing

Screening of pregnant women for HIV: *the case against*

IT IS NOW DEPARTMENT OF HEALTH POLICY to offer HIV testing to all pregnant women in the United Kingdom.[1,2] This policy has been endorsed by the Royal College of Midwives, and all midwives are now being asked to implement this policy.[3] The issues around screening of pregnant women are, we feel, much more complex than they appear, and in this article we present the case against offering universal HIV testing to pregnant women.

The size of the problem

Research data in support of antenatal testing for HIV was presented in the 24th January 1998 edition of the *British Medical Journal*[4] which showed that only about a quarter of HIV-positive pregnant women were identified by the current voluntary testing programmes.

It was argued that HIV testing must be made more available and accessible so that pregnant women could be given interventions that would reduce the transmission of HIV to the child. These interventions include termination of pregnancy, caesarean section, abstention from breastfeeding, and the perinatal administration to mother and child of the drug Zidovudine, or AZT.

The table from the BMJ is represented here.[4] The total percentage prevalence figures were not included in the original table, so we have added these in red at the bottom. The percentage prevalence is calculated by dividing the number of positive HIV-1 tests with the total number of tests undertaken per year of antenatal testing multiplied by 100, and is important because it reveals the actual prevalence of HIV positivity in pregnancy. As can be seen, this is very low for the United Kingdom and has not increased since 1990. Even if the 1988/89 figures are included, there was only a small rise in non-metropolitan England, and the increase in the London area has in fact stabilised since 1993. From these figures, an average of one in 2,000 pregnant women in the UK is HIV positive. In London, this is one in 700 (one in 550 during the period 1993-1996), in Scotland one in 3,500, and in the rest of the UK outside London it is less than one in 8,000.

When studying the heterosexual spread of HIV in western countries, transmission of HIV has been considered in three categories: primary transmission to members of high risk groups, i.e. homosexuals, IV drug users and haemophiliacs; secondary transmission from members of high risk groups to their heterosexual partners; and tertiary transmission from these heterosexuals to others.[5] Only 6% of births of HIV positive children (49 of 797) in the nine years of the study were to mothers 'apparently infected heterosexually in the United Kingdom by a man without a known history of high risk'.[4] Thus an average of only five HIV-positive children a year were born to mothers with tertiary transmission of HIV occurring within the United Kingdom. Arguably, therefore, most UK-born women at risk of giving birth to an HIV-positive infant could be identified by asking them about their own and their partner's risk behaviours.

Test reliability

Although the implications of receiving a positive HIV result are very serious, there has been almost no discussion about the possibility that HIV tests may not always be reliable.[6,7] This is rather surprising, as the manufacturers of the test kits are well aware of the problems with reliability of their tests. The test used for first line screening for HIV is called ELISA or EIA, an acronym for Enzyme-Linked Immunosorbent Assay, and Abbott Laboratories, a leading manufacturer of HIV tests, state the following in the information that comes with their kit:

'In order to afford maximum protection of the blood supply, the EIA was designed to be extremely sensitive. As a result, non-specific reactions may be seen in samples from some people who, for example, due to prior pregnancy, blood transfusion, or other exposure, have antibodies to the human cells or media in which the HIV-1 is grown for manufacture of the EIA...

'Repeatedly reactive specimens obtained from people at increased risk for HIV-1 infection [e.g. homosexual men, haemophiliacs, or intravenous drug users] are usually found to contain antibodies by additional more specific, or supplemental, testing. However, when the EIA is used to screen populations in which the prevalence of HIV-1 infection is low (e.g. blood donors), non-specific reactions may be more common...

'Although for all clinical and public health applications of the EIA both the degree of risk for HIV-1 infection in the person studied and the degree of reactivity of the serum may be of value in interpreting the test, these correlations are imperfect. Therefore, in most settings, it is appropriate to investigate repeatably reactive specimens by additional more specific or supplemental tests...

'The Abbott studies show that: sensitivity based on an assumed 100% prevalence of HIV-1 antibody in AIDS patients is estimated to be 100% (144 patients tested)...

'Specificity based on an assumed zero prevalence of HIV-1 in random donors is estimated to be 99.9% (4777 random donors tested)...

'At present there is no recognised standard for establishing the presence or absence of HIV-1 antibody in human blood. Therefore sensitivity was computed based on the clinical diagnosis of AIDS and specificity based on random donors.'[8]

For every 8,000 pregnant women tested, 8 will have a false positive test and only one will have a true positive test

There is an obvious circularity to this, as HIV tests are used to diagnose AIDS, and AIDS diagnoses are used to determine the specificity and sensitivity of the tests. The essence of the problem, though, is the lack of a 'gold standard' for the HIV tests. Many tests for infection use 'markers' of one kind or another, but a gold standard test uses the purified infectious agent, i.e. the bacteria, virus or other micro-organism causing the disease. If antibodies in the patient's serum kill or otherwise alter the micro-organism it is highly likely that the patient has been infected. Gold standard tests are not used routinely, as live micro-organisms can infect laboratory staff, and the tests are expensive. They are used to test the reliability of the more commonly-used tests, and for cases where the test results are equivocal. There is no gold standard for HIV because HIV has not been isolated in purified form, free from contamination with debris from the cell culture in which it has been grown.[9] Instead, both ELISA and Western blot HIV tests use proteins from cells believed to be infected with HIV but from which purified HIV has not been isolated.

More recently, polymerase chain reaction, or PCR, has been used as a confirmatory test. PCR is a technique that amplifies small fragments of DNA or RNA, but the same fundamental problem exists as for the other tests. Unless you can isolate the virus free of cellular contamination, you cannot be certain that the DNA/RNA fragments you are identifying are viral and not cellular. Although 'viral load' tests using PCR are widely used for AIDS patients, it is ironical that the inventor of this technique, Kary Mullis, who received the Nobel Prize for his work, disputes the orthodoxy that AIDS is caused by Human Immunodeficiency Virus.[10]

Predictive value of HIV tests

Most doctors are unaware that there is no gold standard and believe HIV tests to be accurate and reliable. If, likewise, we put aside all doubts, what are the implications for a pregnant woman with a positive HIV antibody test result? Abbott Laboratories state that their ELISA test is 100% sensitive and 99.9% specific and this would seem excellent, more reliable, in fact, than many other tests used elsewhere in medical practice. It would seem reasonable to assume that a false positive result would be very unlikely, but this is not at all the case. The sensitivity of a test is the percentage of people with a positive result who actually have the disease (100% sensitivity means that all patients with disease test positive). The specificity of a test is the percentage of people with a negative test in whom disease is absent.[11] The false positive rate is the percentage of people without disease who have a positive result. Thus if the specificity is 99%, the false positive rate is 1%.

The Abbott Laboratories ELISA test has a specificity of 99.9%, and therefore the false positive rate is 0.1%. This means that if 1,000 people without HIV infection are tested, one will give a false positive reaction. The importance of specificity is therefore dependent on the incidence of the disease in the population. If we assume the test has 100% sensitivity and the incidence of HIV is 10%, in a population of 1,000 there will be 100 true positives and one false positive, and the test would be considered pretty reliable. If, though, the incidence of HIV infection in the population was 0.1%, in a population of 1,000 there would be one true positive and one false positive, and the test would be considered very unreliable.

If the ELISA test is used to screen pregnant women and we assume that the results published in the BMJ represent true HIV positivity, how many true and false positives would be detected? In 'the rest of the UK', i.e. outside London and Scotland, where the incidence is

0.012%, for every 8,000 pregnant women tested, eight women would have a false positive test and only one would have a true positive test. In London, where the incidence is higher at 0.17%, for 3,000 women tested there would be approximately three false positives for every four true positives. (Nicoll et al. are not explicit about the tests they used, but we assume they used ELISA confirmed with Western blot.)

More than 70 different diseases can give a positive HIV test

There is no public information about the antibody test kits that are actually used for testing pregnant women for HIV, but presumably a woman will have an initial ELISA screening test, and if positive, will be recalled for further testing and counselling. From the available information, the Department of Health appears to be completely unaware that the great majority of women who test positive on an initial ELISA test will have a false positive result. We argue that this information should be an integral part of pre-test counselling as the Department of Health advises that informed consent for HIV testing is required.[12]

Unfortunately, as alluded to above, the difficulties with the initial screening test do not end with the confirmatory tests, which are themselves different across the United Kingdom. The Western blot is not used routinely as a confirmatory test in England and Wales but is reportedly used for confirmation in Scotland. In addition, this particular test is prone to operator biases within the test laboratory. For example, researchers who used Western blot to study 8,073 samples from potentially infected persons commented, 'Different criteria of interpretation of Western blot provide different degrees of sensitivity and specificity. The Western blot is a non-standardized, expensive, laborious technique of subjective interpretation which provides an appreciable number of undetermined results.'[13]

In England and Wales the confirmatory test used is PCR, and research has revealed significant problems with the interpretation and reliability of this test as well.[14] PCR test results do not correlate with HIV antibody-test results and authors of a recent paper on PCR commented that 'Despite considerable effort, the [PCR] technique is still technically difficult and has not yet proved to be reliable or reproducible'.[15] In addition, false-positive results arise through cross-contamination of PCR samples making it almost impossible to judge the true origin of any DNA/RNA fragments that are reportedly detected. An international study on PCR reported that such contamination of samples can occur 'at any step in the procedure, from the point of collection of the samples through to the final amplification', thus fatally undermining the validity of the PCR test.[16] A multicentre study on quality control in PCR found that 'False-positive and false-negative results were observed in all laboratories (concordance with antibody-tests ranged from 40% to 100%)'.[17]

The problem of false-positive results, found to occur with PCR tests 'even under the most stringent test conditions',[18] has led some researchers to conclude that '..considerable caution should be exercised in the interpretation of results generated using PCR in situ'.[15]

Like the manufacturers of HIV antibody test kits, the manufacturers of PCR test kits are also aware of these problems. Perhaps mindful of the potential for consumer litigation they have published warnings concerning the methodological caveats of PCR tests, but these circulate with the test kits amongst laboratory staff and are usually not seen by patients. For example, one manufacturer's literature, inserted with a popular kit to run PCR, states 'The Amplicor HIV-1 Monitor test is not intended to be used as a screening test for HIV or as a diagnostic test to confirm the presence of HIV infection'.[19] However, it is precisely as a screening and diagnostic test for HIV that PCR is now increasingly employed within the United Kingdom, seemingly against the manufacturer's own advice.

False positives

If the meaning of a positive HIV test is uncertain, what other diseases or conditions can give rise to a positive test? A search of the medical literature reveals there are more than 70 diseases that can give a positive test. For example, in the United States in December 1991 there was an unusual increase in false positive blood donations, and false positivity was found to be significantly associated with any brand of influenza vaccination, or a history of recent acute illness and allergies.[20] The cluster of false-positive donations in 1991 was most likely caused by the test kits used. High rates of false positivity have been found in patients with an autoimmune disease called systemic lupus erythematosus, and in patients with alcoholic liver disease.[21,22] As mentioned above, even previous pregnancy can trigger a false positive result.[8] A number of researchers have concluded that antibodies to malaria can cause a false positive HIV test.[23,24] As 80% of the cases of malaria occurring world wide are found in Africa, this will undoubtedly cause false positivity in African immigrant women in this country.

A large and well conducted study from Zaire reported that patients with leprosy had high rates of false positivity. 'Caution should be exercised when interpreting HIV-1 ELISA and WB data from regions where leprosy or other mycobacterial diseases [i.e. tuberculosis] are endemic'.[25] Nicoll et al reported that the ethnic group of approximately half the children diagnosed with paediatric AIDS was black African.[4] Given the high incidence of both tuberculosis and malaria in this group, an automatic assumption that a positive HIV test means a diagnosis of AIDS is worrying. The Department of Health does not mention such important issues in their published guidelines on HIV testing, yet this information exists within the medical literature.[12]

HIV infection among pregnant women by area of residence. Unlinked anonymous surveys, United Kingdom 1988-96

	Year of birth of child									
	1988	1989	1990	1991	1992	1993	1994	1995	1996	Total
London										
Total tested	31 009	74 450	67 153	82 678	106 946	103 862	105 097	104 501	104 666	780 362
No HIV-1 positive	10	39	55	105	160	182	180	192	200	1 123
Prevalence (%)	0.032	0.052	0.082	0.130	0.150	0.180	0.170	0.180	0.191	0.170
Scotland										
Total tested	-	-	56 773	66 758	65 519	64 624	61 799	60 893	59 539	444 905
No HIV-1 positive	-	-	19	19	21	18	18	15	15	125
Prevalence (%)	-	-	0.029	0.028	0.032	0.028	0.029	0.025	0.025	0.028
Rest of UK										
Total tested	20 649	55 676	60 948	126 741	213 992	270 448	357 713	346 791	347 407	1 800 365
No HIV-1 positive	1	3	6	13	22	25	47	38	56	211
Prevalence (%)	0.005	0.005	0.010	0.010	0.010	0.009	0.013	0.011	0.016	0.012
Total										
Total tested	51 658	180 126	198 874	276 177	386 457	438 934	524 609	512 185	511 612	3 080 632
No HIV-1 positive	11	42	80	137	203	225	245	245	271	1 459
Prevalence (%)	0.021	0.023	0.040	0.050	0.053	0.051	0.047	0.048	0.053	0.047

Reducing vertical transmission

Whatever the anxiety and distress a positive HIV test may cause a pregnant woman and her family, the purpose and justification for testing is to identify HIV-positive pregnant women so that they can be offered interventions that will reduce the rate of transmission of HIV to the child. Although it is not made at all clear in the information issued to midwives, even if nothing is done 85% to 90% of HIV-positive women in the United Kingdom will not infect their children.[3,26] Administration of AZT, caesarean section, and abstention from breast-feeding has been reported to reduce transmission by half to two-thirds, i.e. from around 15% to 5%.[26] (In the leaflet for pregnant women, *Better for your baby* and the letter to health professionals, *Antenatal testing for HIV*, issued by the Department of Health, it is claimed that transmission is reduced to 1%.[1,2] We can find no evidence to support this claim in the medical literature).

There is evidence that transmission rates are higher in women with more advanced disease and higher viral loads.[27] One study reported that transmission was greatest in women who used intravenous drugs, who had another sexually transmitted disease, and who were the most immunocompromised.[28] HIV-positive women detected by screening are less likely to have known risk factors for HIV and symptoms of HIV-associated illnesses. We could find no reports of rates of vertical transmission in well HIV-positive women detected by screening, but it is probable that transmission rates will be lower in this group. The mechanisms by which illicit drugs may increase transmission of HIV are not understood.[29] Nutritional factors may also be important.[30] A study in Malawi, Africa, found that the HIV transmission rate for mothers with the lowest vitamin A levels transmission was 32.4%, and for those with the highest levels it was 7.2%.[31]

Current advice is that all HIV-positive pregnant women should accept measures to reduce risk of transmission. Nicoll et al estimate that about 300 HIV-positive women in the United Kingdom will give birth each year.[4] If we assume that these are all true positives and the transmission rate without intervention is 15%, 45 of the 300 children will be HIV positive and 255 will

be HIV negative. If interventions reduce HIV positivity in the children by two-thirds, 15 children will be HIV positive, and transmission would be prevented in 30. To prevent HIV transmission in these 30 children, 270 women will be given AZT, caesarean sections, and the child will not be breastfed.

Risks of intervention

The benefits of any medical intervention must always be weighed against the risks. The risk of psychological harm to pregnant women from the intensity of obstetric surveillance is now becoming more generally known,[32,33] and in the case of a false positive HIV result this could be substantial.

For any woman considered to have a true positive HIV result, there are additional risks for each of the interventions proposed to reduce the transmission of HIV. For example, AZT is a toxic drug, and gene and chromosome abnormalities have been found in animals treated in utero.[34,35] The teratogenic risks and other more long term effects in humans are still relatively unknown.[36] Furthermore, caesarean sections increase the risk of complications in subsequent pregnancies. This risk may be small in the United Kingdom, but is greater for an African woman returning to her country of origin where supervised delivery in hospital may not be an option.

The incidence of HIV positivity in pregnant women is low

The lifelong benefits of infant breastfeeding have been established without question, and again these benefits are likely to be even more important for a child returning to Africa than one remaining resident in the United Kingdom. The immunological benefits of breast-feeding may be particularly important for the 5% of children for whom transmission is not prevented. Even the outcome for HIV-positive children is not clear, as research is on-going. However, it is known that a proportion of HIV-positive children are able to survive childhood and grow into adolescence without receiving antiretroviral medication.[37]

Summary

In summary, from the data presented to support the introduction of universal screening for HIV in pregnancy, the following conclusions can be drawn

- The incidence of HIV positivity in pregnant women is low, approximately 1 in 2,000 women in the UK, and is not increasing.
- Most HIV-positive pregnant women have known risk factors and should be identifiable by questioning.
- Even without intervention, only a minority of HIV-positive women, about 15% or less, will give birth to an HIV-positive child. This is approximately 1 in 13,500 live births.
- Interventions can reduce the risk of transmission of HIV by about two thirds.
- For each child in whom HIV transmission is prevented, 9 women will have unnecessary caesarean sections, their children will not have the benefit of breastfeeding, and the mothers and children will be exposed to the risks of toxicity of AZT.

In arguing against HIV screening of pregnant women we consider the following to be important:

- Where the incidence of a disease in a population is low, even tests of high specificity will identify many more false positives than true positives.
- HIV tests do not have a gold standard and it is therefore not possible to distinguish between false and true positives. There is, therefore, a risk that healthy women and children will be subjected to unnecessary treatment with recognised risks.
- More than 70 diseases and conditions can give rise to a false positive HIV test. These diseases are more common in women from Third World countries, particularly Africa, and HIV tests may be much less reliable in these women than in UK born women.
- Many more women and children will have unnecessary interventions to reduce HIV transmissions than women and children in whom HIV transmission is prevented. The risks to these HIV negative children and their mothers has to be weighed against the benefits of reducing transmission of HIV positivity.
- Other unknown or poorly understood factors such as illicit drugs and nutritional status may affect HIV transmission. These need further study.
- Long term survival rates for HIV-positive children are unknown, but some HIV-positive children are surviving into adulthood.

Conclusion

In today's NHS, midwives are being persuaded to assume the lead responsibility for promoting HIV testing to pregnant women under the powerful guise of extending the role of the midwife to benefit public health. That such practice is advocated based on technologies over which there are scientific doubts, uncertainties and social concerns is not openly discussed. Given our analysis of the epidemiology of HIV in pregnancy, based on data from published medical research, the arguments for dedicating increasing amounts of funding to universal HIV testing in pregnancy appear insufficient from the perspective of both public health and good science.

Even within accepted medical understanding of the meaning of HIV antibody tests, serious ethical problems arise as there is potential for HIV tests to be inaccurate

and for this inaccuracy to be unwittingly translated into the administration of medical treatment to clinically healthy pregnant women and their unborn offspring for a disease they may not actually have. In light of professional and ethical guidelines which direct practitioners always to seek to do good and minimise harm and to act always to inform the public, we argue that these issues are a genuine cause for serious professional and social concern.

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Angus Nicoll, Rosaline Steele and **Philip Mortimer** offer a strong rebuttal to last month's article

Pregnant women and testing for HIV

THE ARTICLE Screening of Pregnant Women for HIV: The Case Against[1] that appeared in the July/August edition of *The Practising Midwife* contained major inaccuracies and misinterpretations concerning HIV, and HIV testing and antenatal testing policy. These should not go uncorrected and unchallenged. We focus here on the current situation with HIV as it affects pregnant women and their babies in the UK. We outline the new Department of Health policy, and we correct the errors as they appear in the summary and conclusion to the original article, point by point.

Recent policy developments

Harrison and Corbett stated that *'it is now Department of Health policy to offer HIV testing to all pregnant women'*.[1] Since 1994 it had been Department of Health policy to encourage offer voluntary testing to all women attending antenatal clinics in higher prevalence areas.[2] This advice was reinforced in 1998 by the Intercollegiate Working Party on Antenatal HIV Testing (whose conclusions were endorsed by the Royal College of Midwives).[3] The Working Party further recommended that such an offer and recommendation of HIV testing should be routine in London, where its provision should be obligatory on those providing antenatal care, and that the HIV test should be integrated with other routine tests.[3] However on August 13th of this year following the recommendations of an Expert Group Tessa Jowell, the Minister of Public Health announced a significant further development of the policy.[4] This was to the effect that all women should be offered and recommended an HIV test as an integral part of antenatal care, and that testing targets should be set.[5,6] However the Department of Health, Mrs Jowell and the Intercollegiate Report all emphasised that testing for all infections in pregnancy needs to be with a woman's prior knowledge, and verbal consent.[2-6] The testing targets set are progressive between now and the end of 2002[6] (though some hospitals in London are already more than achieving the targets for the end of year 2000[7]).

International position

Compared with other developed Western countries, the UK is not doing well in making available to pregnant women the benefits of new therapies in HIV.[8] Children have been disadvantaged by this failure. In countries such as the United States and France higher proportions of pregnant women are tested than in the UK and those women found to be HIV infected are able to choose to take interventions that reduce the risk of mother-to-child transmission.[9,10,11] In the USA rates of early paediatric

The new national antenatal HIV targets

All Health Authorities should ensure that information systems for offering and recording uptake of antenatal HIV testing are in place as soon as possible so that progress towards achieving the following targets can be effectively monitored. All health authorities should ensure that arrangements are in place by 31 December 2000 at the latest for:

- all pregnant women to be offered and recommended an HIV test as an integral part of their antenatal care
  (not including women arriving in labour or too late for antenatal care, who should be offered and recommended a test after delivery)
- an increased uptake of antenatal HIV testing to a minimum of 50% to be achieved
- health authorities that have effective monitoring systems in place and are already achieving 50% or more to increase uptake by a further 15%.

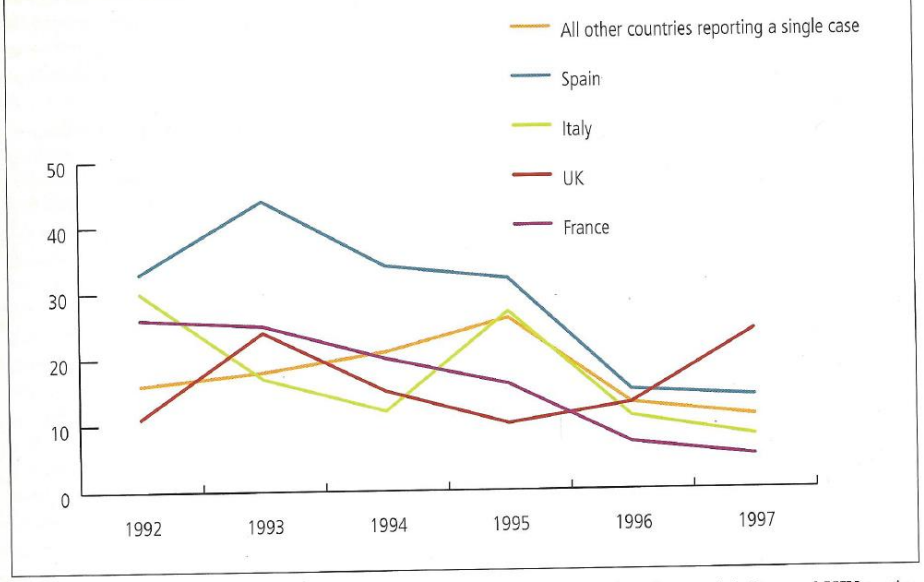
All health authorities should ensure that arrangements are in place to achieve the following by 31 December 2002:

- an increase in uptake of antenatal HIV testing to 90%
- that nationally 80% of HIV infected pregnant women are identified during antenatal care.

These targets should result in an 80% or so reduction in the number of children born with HIV.

Summary of Recommendations from the Expert Group on Antenatal HIV Targets as recorded on Health Services Circular August 13th 1999 (HSC 1999/183)

Figure 1: Mother to child HIV transmission in European countries: AIDS cases in children aged less than 1 year at diagnosis



AIDS have declined by 80% since the new interventions became available.[9] While rates of early paediatric AIDS across Europe have also declined generally, those in the UK have not and are now higher than in any other European country (Figure 1). It is striking that the French, with a prevalence of HIV infection in the adult population three to four times higher than in the UK, now have a rate of paediatric AIDS that is much lower.[12]

Too many HIV positive women in the UK only become aware of their own infection when their child becomes ill

Far too many HIV positive women in the UK only become aware of their own infection when their child becomes ill from HIV or develops AIDS.[3] These women, as well as having to come to terms with their child's and their own infection are also left with the knowledge that they probably could have prevented their child's infection if they had only known their own HIV status. It also must be remembered that these women, through not being offered antenatal testing, will have missed opportunities to improve their own health.

Can the UK situation be improved?

The question whether the UK was failing HIV infected women and their children was reviewed by the Intercollegiate Working Party for Enhancing Voluntary Confidential HIV Testing in Pregnancy.[3] It concluded that many of the problems, and solutions, were professional rather than social. Rates of HIV testing varied greatly between hospitals[13] and between individual midwives,[14] much more so than could be explained by patient wishes or social factors. This meant that the likelihood that a woman would be offered and recommended HIV testing varied according to which hospital she attended, and who she saw for her antenatal care, scarcely an equitable situation.[3] Subsequently, midwives in Edinburgh and London have confirmed this since once they made an offer and recommendation as a routine part of antenatal care (as recommended in the recent policy changes) rates of testing rose dramatically.[7,15] Detection rates have now started to rise.[16] It is worthwhile noting that the rates achieved have rarely exceeded 90% i.e. women are not being universally tested without their knowledge or consent.

Some of the major errors in the original paper's summary are addressed below as follows.

The incidence of HIV positivity in pregnant women is low[1]

The latest available estimate of levels of HIV (1997) are: London 1 in 530 births (a fivefold rise since 1988); England and Wales outside London 1 in 6,200 (a significant rise since 1995); and Scotland 1 in 480.[16,17] Hence every year there are about 300 births to HIV infected women, over 200 of which are to women who are unaware of their infection, mostly because they have not been offered a test.[3,18] These are scarcely trivial numbers and the levels are higher than for a number of other conditions for which women are routinely screened in pregnancy (syphilis) and for which babies are screened at birth (phenylketonuria and hypothyroidism).

Most HIV positive women have known risk factors and should be identifiable by questioning[1]

Selective screening, i.e. only offering testing to pregnant women recognised as at higher risk has failed for HIV[3] just as it has failed for Hepatitis B (where policy has already changed from a selective to universal antenatal screening).[19] Screening only women of particular ethnic groups is unacceptable to some minorities and some midwives also feel uncomfortable enacting such policies. This has meant that women at higher risk, such as those from Africa, are currently often not offered testing.

Even without intervention only about 15% of HIV infected women will give birth to an infected child[1]

Breastfeeding is common among UK women who are HIV infected and infants who are born uninfected by HIV may still become infected through breast milk. A better estimate of the risk of mother-to-child transmission in the UK is between 20 and 25%.

Interventions can reduce the risk of transmission of HIV by about two thirds[1]

The French find that when HIV infected women choose to have zidovudine and a caesarean section, and avoid breastfeeding, under 1% of their infants end up being HIV infected.[20] We prefer to be more conservative and estimate that these interventions reduce the risk to under 5%. Hence we expect to reduce the risk from 1 in 4 or 1 in 5 to less than 1 in 20.

For each child who avoids HIV transmission many women will have been given zidovudine, received caesarean section, etc[1]

Certainly some HIV infected women who choose to take zidovudine would not have had an HIV infected baby anyway. This is explained to the women who have to make a series of difficult decisions for which they require and receive expert help and advice once it is known they are infected.[3] Most women still choose to have the interventions.[21] This situation is not unique to HIV. For instance, the majority of women who are treated for hypertension and pre-eclampsia in pregnancy would not have gone on to develop toxaemia. However no one would argue that therapy should be withheld.

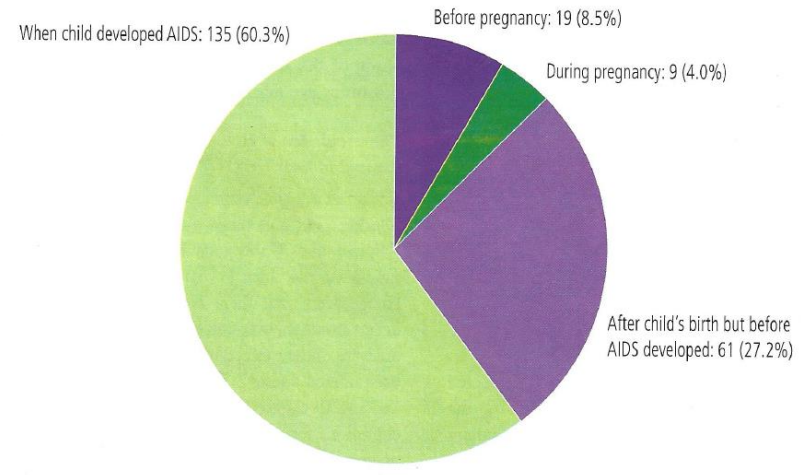
HIV testing is inaccurate and many false positives will result[1]

This assertion comes as a considerable surprise to those who actually perform these laboratory tests. They know, firstly, that anti-HIV assays are among the most accurate serological tests of all and, secondly, that in any reputable laboratory a confirmatory procedure immediately follows the finding of a positive test reaction. It is most unlikely that any confirmed positive result is erroneous; but if any such a test is in doubt, UK laboratories are only too willing, and indeed anxious, to check the result. We know of no instance of a pregnant woman in the UK undergoing interventions to prevent transmission of HIV to their infant on the basis of a false positive HIV result.

We do not know the long term side effects of these interventions[1]

There may be long term unwanted side effects of these drugs which have yet to be observed. However the relevant data were recently reviewed by international experts and by the UK's independent Committee on Safety of Medicines. Both concluded that there was no evidence that there were such side effects. The benefits of treating maternal infection and preventing HIV infection in children far outweigh any possible risks to either pregnant women or their children.[22,23]

Figure 2: For children with AIDS born in the UK, at what stage were the maternal infections diagnosed?



Some HIV-positive children are surviving into adulthood[1]

Very few HIV-infected children are surviving into adulthood in good health. A substantial number of these children die early from their infection and most of those who remain alive have episodes of chronic ill health and are on lifelong medications.

Investing in universal HIV testing in pregnancy is contrary to both public health and good science[1]

HIV testing in pregnancy has twice been carefully evaluated for the UK by independent expert groups. Both times the conclusion was that HIV testing should be made universally available to women in London, and elsewhere if the costs of testing can be kept to a minimum.[24,25]

Midwives are being persuaded to assume the lead responsibility for promoting HIV testing to pregnant women[1]

The Royal College of Midwives is not persuading midwives to be involved in antenatal HIV testing. Based on the best available evidence, the College is educating and informing midwives of the health benefits for women, neonates and children if a woman's HIV status during pregnancy is known.[26]

Conclusion

The UK's record on antenatal HIV testing has up to now been weak. Babies have become infected unnecessarily and HIV infected women have not been allowed access to interventions that would benefit their own health and protect their babies. Recently some hospitals have begun to fare better thanks to the commitment of midwives and others who have made HIV testing available to women and explained its advantages. As a consequence rates of testing have also begun to rise. As of August 1999 national policy has changed. The challenge is to implement this new policy, to generalise the improvements achieved and to make them sustainable.

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Screening of pregnant women: the case against

HARRISON AND CORBETT[1] are correct in that it is standing UK Department of Health (DH) policy to make available antenatal HIV testing to all pregnant women in the UK. However, they omit to point out that this policy was reinforced in April last year by the Intercollegiate Working Party for Enhancing Voluntary Confidential HIV Testing in Pregnancy. This body recommended that HIV testing should be available to all women attending antenatal clinics and should be offered and strongly recommended to women at higher risk; and that, in areas of high seroprevalence such as Greater London the test should be offered and recommended as part of routine antenatal care (this being obligatory on those providing care).[2] They might also have pointed out that a similar policy of offering an HIV test as part of an integrated package with other established antenatal tests formed part of a recently published European consensus[3]; and that US[4] and Canadian[5] policies of testing all pregnant women have also been recently produced. So the UK DH is not alone!

Harrison and Corbett[1] criticise the current policy in a number of respects including universality of testing and test reliability.

Harrison and Corbett[1] suggest that, since virtually all HIV positive women in the UK are from recognised risk groups, the DH objectives could be achieved by 'asking them about their own and their partner's risk behaviours'. However this option relies on patients revealing, and midwives identifying, risk factors. It was demonstrated some years ago that a selective screening programme for hepatitis B virus infection among pregnant women failed to identify 50% of infected women.[6] In London in 1995-1996, only some 23% of HIV positive women detected by anonymous screening programmes were identified before or during pregnancy[7] and this phenomenon has also been demonstrated in the USA[8,9] and Sweden.[10] Furthermore, the apparent stigmatization of a selective approach may be counterproductive as, in Baltimore, the proportion of 'at risk' women agreeing to be tested rose from 77% to 90% when testing was offered to all pre-partum women.[8] This, together with the obvious fact that any reliance on patients knowing and revealing that they have been at risk can never identify all relevant women, is why selective screening has been rejected as a policy. Targeted testing of pregnant women is specifically NOT recommended in the Canadian guidelines.[5]

Harrison and Corbetts' discussions[1] relating to the reliability of current HIV tests and testing algorithms are flawed insofar as they seem to be unaware of the currently accepted UK testing algorithm. This uses one test (for example, a peptide-based EIA) as a screening assay. If this test is reactive the test is repeated. If this second assay is reactive two further assays (for example, a second EIA based on a different chemistry and an agglutination assay) are performed. All assays will have been performed on the original clot. If all assays are reactive, that sample is considered positive and the clinician informed accordingly. However, to trap any clinic or laboratory errors, a second sample is requested, and tested, to confirm positivity and patient identity. If any of the assays is equivocal, the sample will be sent to a reference laboratory for further investigation.

One Abbott Laboratories HIV assay that is in common use is the AxSYM microparticle enzyme immunoassay. The manufacturer's specificity figure of 99.94% is based on testing 6340 samples from blood donors (package insert dated September 1998). Of these, four were repeatedly reactive but none of these four could be confirmed by either a Western Blot assay or an Abbott monoclonal assay. Some assays have even lower false positive levels. For example, the current Wellcozyme HIV Recombinant Assay Protocol (issued Nov 1998) states that none of 11542 routine donor samples tested were repeatedly reactive (a sensitivity of greater than 1 in 10,000). Note that this assay and the Abbott AxSYM assay utilise recombinant antigens, not '...proteins from cells believed to be infected with HIV...' as Harrison and Corbett appear to believe.

However, even if one uses a relatively conservative 'false positive' error rate of 1:1000 for each assay, the chance of three assays giving a false positive result is 1:1,000,000,000. Harrison and Corbetts' highlighted calculation on page 25 might therefore read 'For every 1,000,000,000 women tested 120,000 will have a true positive test and only one will have a false positive test'. It is only the very occasional human error, for instance in labelling, which compromises this predicted high level of accuracy. Hence the testing of a second blood sample.

Other countries use different assays to confirm positivity. For example, in the USA and Canada the accepted confirmatory assay is the Western Blot. False positive tests with this assay are extremely rare. Thus no false positive results were detected in one study of more than 290,000 blood donors[11] and only one detected among over 135,000 military recruits tested in a second evaluation.[12]

With regard to PCR, Harrison and Corbett state that 'More recently [PCR] has been used as a confirmatory test'; 'In England and Wales the confirmatory test used is PCR'; and '...it is precisely as a screening and diagnostic test for HIV that PCR is now increasingly employed within the United Kingdom'. However they give no evidence for these statements. Those laboratories which undertake HIV screening and confirmation assays understand fully the technical problems associated with PCR and other amplification assays and it is precisely for those reasons that PCR is NOT used as a confirmatory assay (as discussions with any competent virologist would have informed them). The major uses of such assays are: determining the infection status of newborn babies of HIV-infected mothers; subtyping; and sequencing for monitoring drug resistance. Finally, although it might be interesting that Kary Mullis disputes the causal relationship between HIV and AIDS, it is surely totally irrelevant to the discussion. This is not Dr Mullis's primary area of expertise and his opinions should be considered in that light.

As Harrison and Corbett state, there have been reports of misdiagnosed HIV infection in pregnant women. One reported in 1994 that eight of 900 HIV-positive women enrolled in a research study were, in fact, negative. However, the false positivity in all cases was considered to be related to failure to follow recognised diagnostic algorithms, possible misunderstanding of results by patients, or factitious disorder.[13] In no case was the reliability of the assays used questioned. Similarly, an earlier report of five cases of erroneously diagnosed HIV infection (not in pregnant women) implicated mis-

labelling errors and failure to follow accepted algorithms rather than inherent problems with the assays.[14] A recent Canadian report of a false positive result in a pregnant woman restated the problem of pregnancy and potential false positive reactions[15] but, again, meticulous following of testing algorithms would have eliminated the problem.[16]

Current evidence and experience of many laboratories, most of which are conducting several thousand or more HIV antibody assays per year, would suggest that the assays now available have unprecedentedly high levels of sensitivity and specificity and that these, combined with currently accepted testing algorithms, have reduced the possibility of false positive diagnoses to extremely low levels.

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Screening of pregnant women: the case against (2)

WE ARE RESPONDING TO this article as a group of midwives working with HIV positive women in London. We have several concerns that inaccuracies in the information may have a detrimental effect on midwifery practice and care.

'Most UK born women at risk of giving birth to a HIV positive infant could be identified by asking them about their own and their partner's risk behaviours'. Such identification relies on women revealing and midwives identifying risk factors. Research has shown that women do not always perceive themselves to be at 'risk' or disclose any known 'risk' factors at the antenatal booking appointment.[1] Additionally, health professionals often overlook risk factors.[1] These findings have also been noted in our own clinical experience.

'The risk of psychological harm to pregnant women from the intensity of obstetric surveillance is now becoming more generally known'. However, experience of HIV testing in pregnancy shows that a policy of offering testing to all women does not increase anxiety or dissatisfaction.[2] It should also be considered that there is substantial psychological harm to having a sick HIV infected baby.[3]

'Even if nothing is done, 85-90% of HIV positive women in the United Kingdom will not infect their babies'. This statement is factually inaccurate. The published evidence[4] states that known positive women who breastfeed doubles the risk of vertical transmission to 30%. This point is particularly pertinent, especially as women who are unaware of their status are encouraged to breastfeed as maternity units seek baby friendly status.

Harrison & Corbett can find no evidence to support the claim that vertical transmission is reduced to 1%. A thorough literature search would have revealed a study[5] which reported that the rate of vertical transmission can be reduced to 0.8% through the use of zidovudine, elective caesarean section and not breastfeeding.

Harrison & Corbett say there are 'additional risks for HIV positive women attached to interventions proposed to reduce the transmission of HIV'. We acknowledge that there remain concerns about the potential risk of antiretroviral medication in pregnancy. These concerns are fully discussed with all known HIV positive pregnant women with appropriate health professionals. All known positive women make an informed choice about antiretroviral treatment. The philosophy of informed choice in maternity care[6] applies equally to decisions about delivery and infant feeding for HIV positive women. Most women choose to take these drugs to significantly reduce the chance of their baby having HIV.[7] Unfortunately undetected HIV Positive women do not even have the opportunity to access this intervention.

We believe that if readers are misinformed about HIV testing in pregnancy, this could do considerable damage to this public health concern – that of undiagnosed HIV infection in mothers and preventable HIV infection in babies. This article poorly attempted to present the case against routinely offering HIV testing in pregnancy. We have discussed this article with a number of experts in this field who share our concerns and believe that the case for testing should be presented so that your readers are accurately informed of antenatal HIV testing issues.

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Perineal tears – Audit and proposed RCT

In 1998 I carried out an audit on management of second degree perineal tears within the Luton & Dunstable Hospital Maternity Unit; a busy unit, delivering approximately 3,800 women per year. Since qualifying in 1996 I had noticed an increase in the words 'second degree tear not sutured' appearing on birth notifications.

In the first quarter of 1996, 75% of second degree perineal tears were sutured, compared with only 51.8% in the first quarter of 1998. The trend towards non-repair was increasing, with 48.8% of second degree tears being sutured in the last quarter of 1998.

It was obvious that, locally, midwives' management of perineal trauma had changed dramatically in a very short period. Yet a thorough literature search revealed no supportive clinical evidence. Were newer midwives less confident regarding perineal repair? With no clinical evidence on which to base our practice, where do we stand in the event of legal action? Is short-term lessening of pain costly in terms of longer term morbidity, urinary/faecal incontinence, dyspareunia?

Do we explain to women who ask not to be sutured the physiology of healing and the possible long-term sequelae of not suturing? There is no clinical evidence to support non-suturing but where is the evidence to support suturing?

We looked closely at our practice and are developing guidelines for perineal management, particularly regarding contraindications to not suturing and giving standardised, evidence based advice regarding post-partum perineal hygiene.

A proposal for a large randomised controlled trial was drawn up. I believe that some of the differences in outcome between the two groups will be difficult to measure, but that it is important to measure all differences if we are to offer informed choice and evidence based practice. We should set up a national trial, including enough women to reveal even small differences in outcome. I now have a working research proposal and am seeking collaborators and funding. I believe passionately that by failing to suture second degree tears without evidence to support this (non)practice, we are doing the women in our care a great disservice.

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HIV screening and pregnancy

Testing is accurate

Harrison and Corbett supply data from unlinked anonymous surveys of HIV infection in pregnant women, claiming there has been no overall increase in the prevalence of HIV in the UK since 1990. Applying a simple chi squared test for linear trend to the results gives a value of 16.637 with a P value of 0.00005. Thus, the chances of these increases being due to chance alone are 1 in 20,000. Further, they quote figures up to 1996 only. Figures to 1998 show that the prevalence has increased in the last two years.

The authors are wrong in their definition of specificity; it refers to the proportion of people without the disease who test negative.

If clinical diagnoses of HIV infection were based on a single screening assay, then many of the authors' concerns would be true. However, before a pregnant woman or any other person requesting an HIV antibody test is told that their result is positive, their blood sample will have been subjected to at least three different antibody assays. It is true that each will have a specificity below 100%, but as each assay uses a different methodology, any false positive reaction on one test is easily identified.

The authors also wrongly assert that PCR testing is used for confirmatory testing in England. If this were the case, the situation would be even worse amongst blood donors; several million specimens per year are tested in a population with a much lower prevalence than that of antenatal clinic attendees. In practice there are no problems with false positives.

The authors are confused about mother-to-child transmission rates for HIV. They state that 85-90% of women will not transmit HIV to their children, and incorrectly refer to the 1994 Connor paper, describing the first placebo-controlled trial to reduce mother-to-child transmission.

The Connor paper is misquoted again as stating that 'zidovudine, caesarean section and abstention from breastfeeding reduced transmission from 15% to 5%'. The Connor trial in fact showed that in a non-breastfeeding population, zidovudine therapy reduced transmission from 24% in the untreated arm to 8% in the treated arm.

Abstention from breastfeeding has been shown to reduce transmission by approximately a half.[1] Caesarean section has been shown in observational[2] and randomised studies[3] to reduce transmission by approximately a half. Observational studies in France, the US and the UK have shown that combining these interventions led to transmission rates of around 2%.

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More doubt required

I WOULD LIKE to comment on the paper by Harrison and Corbett[1] and the criticisms made of it by others.[2,3,4,5]

With only 16,028 cases registered by the PHLS since 1982, AIDS is an uncommon disease in the UK with a cumulative prevalence to January 1999 of 14,154 cases in males, 1,874 in females, and an annual incidence of about 1,000 new cases. This is falling despite three arbitrary expansions of criteria for diagnosis in 1987, 1992 and 1998, which increased registrations especially in women, raising concerns about the possibility of an increase in vertical transmissions to infants.[6] To investigate this, Harrison and Corbett examined data[7] which showed no recent increase in the overall frequency of positive results (0.040 - 0.053%) in a nationwide serological survey of over three million pregnant women. They did not have access to a more complete database[8] for antenatal women in London which shows a decrease in the age group 25 - 29 with a much higher prevalence (0.5%) of sero-positivity but a recent increase in the age group <20 - 24, especially in the younger ages.

Vertical transmission of AIDS to infants is more difficult to estimate because many of those born to seropositive mothers are, or revert to, seronegative. Surveillance by the PHLS however shows that this most serious of all transmission problems in AIDS is uncommon in the UK, where sample-seroprevalence of HIV in infants rose from 26 in 1984-85 to 112 in 1992-93. It has since dropped to 77 in 1996-97 giving, cumulatively, a total of 543 seropositive infants of whom 313, out of over ten million born since 1982 to date (1:33,000), have developed AIDS. Over 70% of these cases are in London where black African and Caribbean immigrants and visitors account for the higher prevalence of 0.5% which far exceeds that in the resident population (about 0.07%, lower in Asiatics). Elsewhere in England, Wales and Northern Ireland, perinatal HIV/AIDS and indeed all forms of AIDS are uncommon or even unknown.

Alarmed by the possibility of a further increase in HIV/AIDS in London and a spread to the rest of the country, the government has accepted advice from paediatricians, obstetricians and other advisers[10] to extend sero-testing to all pregnant women everywhere. In many parts of the country this will mean not only that 6,000 or more women will need to be tested to detect one who is seropositive, but also that many who are seropositive will need to be retested to eliminate indeterminate or false positive results. Since the expanded classification accepts 27 independent clinical conditions for registration as AIDS, since many other conditions give cross-reactions in serological tests for HIV and since there is no independent standard for validation of any result, doubts are bound to arise in the waking (and sleeping) hours of hitherto unworried pregnant women, spouses, partners, families and doctors who are confronted with contradictory or indeterminate results. Nicoll, Steele and Mortimer[2] are wrong in dismissing the doubts expressed by Harrison and Corbett because they are well aware of the imperfections which necessitate the repetitions required for 'Confirmation' of original results in this 'Most accurate' of all serological tests.

Chrystie[3] seems to equate confirmation with reproducibility. It is obvious that tests subjected to quality control as described by Nicoll et al will be reproducible. But this does not in itself confirm the specificity and therefore reliability of the test unless it is validated by an independent measurement of the specified outcome variable. Brett et al[4] make the same mistake by assuming that the probability of error in a second test on the same specimen is necessarily independent instead of possibly additive.

Mercey and Gibb[5] are equally dismissive. They find that 'In practice, there are no problems with false positive diagnoses'. In saying this, they ignore relevant peer-reviewed literature, manufacturers' cautions and the experience of patients and families who have lived with the agony of mis-information. They also, wrongly, accuse Harrison and Corbett of misunderstanding the definition of specificity and, in their own definition, make no allowance for the probability of error and omissions in low frequency results.[10]

There is a rise in seroprevalence of HIV in London, as stated above, but the same data show no significant increase elsewhere in England. Investigation of local situations, lifestyle, personal behaviour and contact-tracing may be more consistent than serology in identifying those at risk.[6] For these and other reasons, it is entirely reasonable to question the extension of serotesting into areas where risks of HIV/AIDS are conceivably lower than those of the proposed interventions. The need for differentiation between localities and respect for parents' experience has been endorsed latterly by UN agencies[11] but Harrison and Corbett, in their reply, give fuller reasons for seeking better information, and above all for caution in interventions. The responses of all of their critics show just why.

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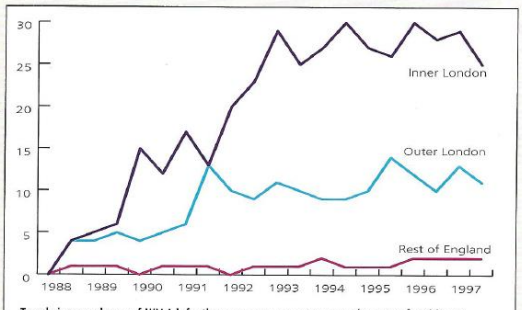
Authors' reply

THANK YOU for providing a forum for this important debate.[1] Our leading critics[2] had previously declined several invitations to open this debate. As there is little space to reply to each correspondent, we will discuss their criticisms as a whole.

Nicoll et al's criticism of our statement that the prevalence of HIV positivity in pregnant women is 'low' is inexplicable. How else can a prevalence of 0.05% be described? Surely not as high, frequent, or even moderate? Perhaps this misperception of the meaning of 'low' led Nicoll et al to miscalculate the prevalence in Scotland in 1997 as one in 480 when it is one in 4,800.[3] The number of Scottish cases has been decreasing for the last six years, from 21 cases in 1992 to 14 cases in 1997. Despite any claims by Mercey and Gibb (who say we should have quoted 1998 figures that are unavailable even to Nicoll et al), seroprevalence actually fell in 1997.[3,4] This is very clearly shown in the graph we have reprinted from the 1997 Department of Health report.[5]

Mercey and Gibb make a further statistical error. A chi-square test on the UK data for 1990 to 1996 does not reject the null hypothesis of no change. (Chi-square of 6.82. A value of 10.64 needed for significance at .01.) Contrary to Mercey and Gibb's assertion, our definition of specificity is correct.[6] The five-fold increase in London since 1988 mentioned by Nicoll et al is a five-fold increase from 1988 to 1992; since then there has been no significant increase.[7] Different tests for HIV were used from the early 1990s (Western blot was discontinued in England and Wales, and recombinant ELISA tests were introduced); comparisons between early and later seroprevalence figures may be invalid.[8]

Our critics concede that most HIV-positive pregnant women come from recognised risk groups, but say that selective screening has failed and cannot be made to succeed.[2,9,10] Others believe that selective screening failed because those implementing the policy were given insufficient time and training.[11,12] One study revealed that an average of 1.7 minutes was spent discussing HIV infection in a consultation that lasted a mean of 33.1 minutes, hardly a circumstance in which a midwife could obtain relevant information or the pregnant woman could make an informed choice over a complex issue.[13] In the Netherlands, where seropositivity rates in pregnant women are five times the United Kingdom's, the policy has changed recently from universal to selective screening.[14]



Trends in prevalence of HIV-1 infection among pregnant women by area of residence: 1988-97 (newborn infant dried blood spots taken for metabolic screening)

Nicoll et al seek to justify HIV screening on the basis that routine screening is undertaken for less common conditions, such as phenylketonuria. This, is incorrect, because the incidence of HIV in mothers is being compared with the incidence of phenylketonuria in babies. Phenylketonuria affects approximately one in 10,000 babies, about the same number born with HIV.[15]

None of our critics addresses the absence of a gold standard for HIV testing,[16,17] the importance of which is emphasised in virology texts.[18] Their assertion of infallibility as regards HIV-test algorithms is at odds with the statement from the UK National Screening Committee that all screening for disease is a balance between sensitivity and specificity.[19] Nicoll et al justify their assertion by mere belief in the validity and reliability of HIV tests/ test algorithms, whilst Chrystie, Mercey and Gibb attempt to use evidence from blood donors.[2,4,9] Yet false positivity is unlikely to be a serious problem with UK blood donors as the transfusion service actively selects donors without current infectious or inflammatory diseases. A potential donor with a self-reported history of any of the 70 or so diseases that cause false HIV-positivity (like systemic lupus erythaematosis, alcoholic liver disease, malaria, tuberculosis, leprosy, visceral leishmaniasis etc.) would very likely be rejected before testing for HIV.[20-27] Women can become pregnant whether healthy or not, and false positivity is thus likely to be a greater problem, especially in women from third world countries.

It is surprising that Chrystie asserts that false positivity with the Western blot is extremely rare, as there is substantial literature to the contrary, including a paper by Dr Mortimer.[8,16,28-30] We are puzzled that Chrystie so boldly asserts that PCR is not a confirmatory test because of the technical problems with the procedure, then in the next sentence says that it is used to detect, i.e. confirm, the infection status in the newborn.[9] We knew that PCR was used routinely as a confirmatory test in children and assumed, and were informed by clinicians, that the same was true in adults.

Nicoll et al criticise us for quoting a figure of 15% for vertical transmission (comparable to the 1 in 6 transmission rate quoted in the *Better for your Baby* leaflet and the 16.4% reported from the European collaborative study), and without any supporting references claim an additional 5-10% transmission through breastfeeding.[2,31,32] There is very little evidence for transmission by breast milk in Western countries, as so few HIV-positive women breastfeed. African studies have been flawed as rates for fully breastfed babies and babies receiving mixed feeding have been combined and compared with rates for fully

bottle fed infants.[33,34] A prospective study of babies of HIV-positive women at three months of age did not demonstrate a higher risk for transmission of HIV in babies that were fully breastfed compared with those that were fully bottle fed; the authors concluded that breastfeeding policies for HIV-1 infected women required urgent review.[34]

We questioned the evidence for the claim in the *Better For Your Baby* leaflet that a 1% transmission rate could be achieved.[1,31] Brett et al actually reference a study that reported a 6% transmission rate from retroviral therapy and/or caesarean section.[10,35] Nicoll et al referred to a French study reporting 0.8% transmission, and we have since found another similar study.[36,37] Careful reading of these studies reveals that the 0.8% refers to just one baby in each (1 of 133 and 1 of 119 births respectively), not in the whole study, but in a subset of women excluding those who went into premature labour and had vaginal or emergency caesarean deliveries (circumstances under which transmission of HIV is reported to be higher). Use of study findings in this way is equivalent to a surgeon reporting the results of his or her operations after excluding patients who had complications. Using such misleading information in a leaflet used for obtaining informed consent constitutes a breach of a healthcare professional's duty of care to the patient.[31]

Nicoll et al concede that there may be long-term unwanted side effects of antiretroviral therapies given to HIV-positive pregnant women and their babies.[2] Like others, we question the science, safety and ethics of current prescribing practices regarding antiretroviral therapy in pregnancy.[38] Recent events only support this view. French doctors, praised by Nicoll et al for their success in reducing vertical transmission, have reported that eight of approximately 1,000 babies whose mothers had been treated with combination therapy have died of what is normally an extremely rare neurodegenerative disorder.[39] These babies were all HIV-negative. A study from the National Cancer Institute near Washington DC found that AZT was incorporated in the DNA of white blood cells of pregnant women and their babies, and researchers warned that the changes may increase the risk of cancer.[39] Thus, Nicoll et al are clearly wrong in stating long-term negative side effects are 'yet to be observed'.[2]

Whether the benefits of measures to reduce HIV transmission outweigh the risks can only be determined if health outcomes for mothers and both HIV-negative and positive babies are measured against the benefits for both mother and baby of a drug-free pregnancy, a normal vaginal delivery and a breastfed baby.[40-42] Despite assertions to the contrary, this information is not yet available. Our critics do the general public and health professionals a disservice by disseminating misperceptions and false assertions.

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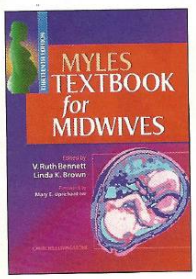

Myles textbook for midwives

V Ruth Bennett and Linda K Brown (Editors)
Churchill Livingstone
ISBN 0 443 05586 6 £29.50

IT ONLY SEEMS like yesterday that the previous edition of Myles appeared; in fact it is 6 years ago. This, the 13th edition, has a number of welcome changes and developments. The list of contributors reads like a list of 'who's who' in midwifery circles, many of whom write from their own area of experience and expertise.

There are two major changes to this edition – formatting of chapters, and referencing. Chapters are sectioned in a more contemporary manner. The 12th edition separated normal labour and puerperium from abnormal; this edition amalgamates them, with comprehensive sections on pregnancy, labour and the puerperium, covering both normal and abnormal. This reflects current thinking, as the boundaries of practice between midwifery and obstetrics become less defined.

The book is organised more logically, making it a helpful reference text for students and qualified midwives. The re-arrangement of chapters and topics enhances the overall feel of the book. Many new authors are included, giving the book a fresh, inviting appeal and adding to the currency of the text. The only error I noticed was on page 528, in relation to vaginal breech delivery. It is suggested that the attendent place a finger in the baby's mouth. This practice is no longer recommended, because the traction exerted can cause dislocation.

With regard to referencing, previous shortcomings have been well addressed. As an example, the chapter on Preparing for Pregnancy in the 12th edition had an inadequate four references (althought it also had recommendations for further reading). The 13th edition, with a new author, boasts 44 references.

Midwives and students are encouraged to base their practice on relevant research and evidence. *Myles Textbook for Midwives* can now play a genuine role in promoting midwifery education and practice – some might say: not before time!

Georgina Lessing-Turner MA RM ADM
Senior lecturer in midwifery,
University of Huddersfield

Erratum

In the July/August issue of The Practising Midwife, there is an error in the article 'Screening of pregnant women for HIV: the case against'. On page 27 the sentence which reads: 'Although it is not made at all clear in the information issued to midwives, even if nothing is done 85% to 90% of HIV-positive women in the UK will not infect their children' should read: '...even if nothing is done, 75% to 85% of HIV-positive...' etc. This figure is supported by reference 27. The authors apologise for this mistake.

Three women (extract)

First voice:

There is no miracle more cruel than this
I am dragged by the horses, the iron hooves.
I last. I last it out. I accomplish a work.
Dark tunnel, through which hurtle the visitations,
The visitations, the manifestations, the startled faces.
I am the centre of an atrocity.
What pains, what sorrows must I be mothering?

Can such innocence kill and kill? It milks my life.
The trees wither in the street. The rain is corrosive.
I taste it on my tongue, and the workable horrors,
The horrors that stand idle, the slighted godmothers
With their hearts that tick and tick, with their satchel of instruments.
I shall be a wall and a roof, protecting.
I shall be a sky and a hill of good: O let me be!

A power is growing on me, an old tenacity.
I am breaking apart like the world. There is this blackness,
This ram of blackness. I fold my hands on a mountain.
The air is thick. It is thick with this working.
I am used. I am drummed into use.
My eyes are squeezed by this blackness.
I see nothing.

Sylvia Plath, 1962

Extract from *Three Women: a poem for three voices*

Appendix Two

Web Resources

Listed By Nation

[Alphabetical Order – indicative only; non-exhaustive as of May 2020; under constant revision]

NOTE TO READERS:

IF YOUR NATIONAL RESOURCE(S) ARE NOT LISTED BELOW PLEASE E-MAIL DETAILS TO KPCRESEARCH@BTINTERNET.COM FOR INCLUSION IN FUTURE EDITIONS.

Argentina

Axel Makaroff
Activist working against CORONAHYSTERIA
www.axelmakaroff.com

Australia

- **The Perth Group** ['TPG'] ['HV/AIDS science-critical']:
  Direct quote below from TPG website:

  "What is needed to prove or disprove the HIV theory of AIDS?
  There are three ways to resolve this debate:
  The first is to garner enough public opinion to mandate a public debate between a small number of protagonists and dissidents. This debate should be international, public and adjudicated by a number of disinterested scientists of Nobel Laureate class who must present the international community with a resolution as to the way forward.
  The second is for HIV seropositive individuals to have the evidence for their diagnoses of "HIV" infection examined in courts of law.
  The third is to perform isolation experiments to prove whether or not a retrovirus "HIV" exists in individuals with a positive antibody test or AIDS. An outline of these experiments can be found in the Presidential AIDS Advisory Panel report.
  http://www.theperthgroup.com/ "

Austria [all 'Covid-critical' and all 'science-militant']

- Website Initiative Corona Info

  www.initiative-corona.info (in German)

- Two Successful Demonstrations [others planned]

  New York Times coverage of Austrian protest:
  https://www.nytimes.com/reuters/2020/04/24/world/europe/24reuters-health-coronavirus-austria-protest.html

  Jerusalem Post Coverage of Austrian Protest
  https://www.jpost.com/international/austrians-chant-we-are-jews-at-anti-coronavirus-restrictions-protest-625823

Germany [all ‘Covid-critical’ and all ‘science-militant’]

Torsten Engelbrecht, Journalist
https://www.torstenengelbrecht.com/de/home.html

> *“Torsten Engelbrecht lives and works as a freelance journalist in Hamburg. For his article "The Amalgam Controversy" (Nature & Healing 09/2008) he was awarded the Alternative Media Prize. He has contributed to various publications such as Medical Hypotheses , Süddeutsche Zeitung , NZZ and NZZ am Sonntag , Frankfurter Allgemeine Sonntagszeitung , Geo Saison , weekly newspaper , message , Ecologist , Greenpeace Magazin , Publik-Forum , Welt am Sonntag, The bank , Friday and taz .*
> *Torsten Engelbrecht has been running the SPIEGELblog.net website since December 2008 . At the end of 2009 the book "The Future of Cancer Medicine" was published , which Torsten Engelbrecht wrote together with the three doctors Claus Köhnlein, Inez Maria Pandit and Juliane Sacher.*
> *In 2006 the book "Virus-Wahn" was published , which he wrote together with the Kiel internist Claus Köhnlein. The German original edition of "Virus-Wahn" is now in its 5th extended edition. At the end of 2007 the English version "Virus Mania" was released .*
> *Torsten Engelbrecht worked from 2000 to 2003 as a permanent business and financial editor at the Financial Times Deutschland . Before that, he worked as a financial editor for the internet trade newspaper Net-Business and for the media magazine message as a trainee. Torsten Engelbrecht received his diploma in economics from the University of Hamburg.”*

Great Britain [all 'Covid-critical' not all 'science-militant']

- **Website***: Evidence Not Fear* ['Covid-critical' ;'science militant']
  https://evidencenotfear.com/
  https://evidencenotfear.com/discuss/

- **Website:** *In This Together* ['Covid-critical' ;'science militant']
  https://in-this-together.com/

- **Website:** *OffGuardian* ['Covid-critical' ;'science militant']
  https://off-guardian.org/

- **Website:** Journal of Advanced Nursing Blog
  https://journalofadvancednursing.blogspot.com/2020/04/problems-with-current-uk-government.html

- **Website:** Legal Challenge (England)['Covid-critical]'
  https://www.crowdjustice.com/case/lockdownlegalchallenge/

- **Website:** *Lockdown Sceptic*s [less 'science-militant'; 'Covid-critical']
  https://lockdownsceptics.org/the-incredible-and-scary-truth-about-covid-19-tests-2/
  https://lockdownsceptics.org/testing-do-you-have-the-disease/#comment-402

- **JOAN SHENTON:**

  Award Winning science critical and Covid-critical filmmaker and investigative journalist and runs **'THE IMMUNITY RESOURCE FOUNDATION'**:

  "The Immunity Resource Foundation offers a digitised information base on medical and scientific issues. The IRF website features regular contributions from scientists and journalists about the AIDS debate, challenging the HIV/AIDS hypothesis, and provides access to the AIDS and medical archives of Meditel Productions and Continuum Magazine"

  http://www.immunity.org.uk/blog/
  http://www.immunity.org.uk/articles/kevin-corbett-2/

  > *"The Immunity Resource Foundation (IRF) will provide a digitised information base offering:*
  >
  > *an educational facility and internet database of 120,000 documents comprising the 20 years of changing scientific evidence surrounding HIV/AIDS and other health, nutrition and medical issues.*
  >
  > - *A unique and extensive record of challenges to current thinking in medical and public health fields, and the debates surrounding them.*
  > - *regularly collated website updates from the frontiers of present research on medical and public health issues and their financial and political contexts.*

- *search and viewing facilities of Meditel's unparalleled library of 200 hours of televisiondocumentaries, original footage and video material.*
- *a broadband video channel transmitting Meditel's television archive with issue updates.*
- *the complete library of Continuum magazine editions which include articles of major scientific and academic interest, mostly rejected by mainstream journals.*
- *Also contains collected publications, proofing copies and editorial correspondence.*
- *educational materials including interactive CD/DVD ROM, seminars, lectures and legal advice on health and medical issues.*

THE RESOURCE

Through twenty years of investigative television programmes, Meditel Productions in London has collected a unique archive – the Meditel Archive – of the science and law surrounding AIDS and injury from prescribed drugs. The resource of 120,000 of Meditel's research documents plus the 8 year archive of specialist magazine Continuum, plus 20 Meditel videos, and video footage, demonstrates in incomparable detail, debates that have taken place behind the closed doors of a scientific community. The Meditel and Continuum archives are on permanent loan to IRF."

North America
(Canada/United States of America)

- Protests across many US states [check online]

- Celia Farber, Investigative Journalist *[**'Viral Critical'/'militant']***

  "Celia Farber is half Swedish, raised there, so she knows "socialism" from the inside. She has focused her writings on freedom and tyranny, with an early focus on the pharmaceutical industry and media abuses on human liberties. She has been under ferocious attack for her writings on HIV/AIDS, where she has worked to document the topic as a psychological operation, and rooted in fake science. She is a contributor to UncoverDC and The Epoch Times, and has in the past written for Harper's, Esquire, Rolling Stone and more. Having been gravely injured in legacy media, she never wants to go back. She is the recipient of the Semmelweis International Society Clean Hands Award For Investigative Journalism, and was under such attack for her work, she briefly sought protection from the FBI and NYPD. She is the author of "Serious Adverse Events: An Uncensored History of AIDS," and the editor of The Truth Barrier, an investigative and literary website. She co-hosts "The Whistleblower Newsroom" with Kristina Borjesson on PRN, Fridays at 10am."
  Twitter: @CeliaFarber
  Web: www.truthbarrier.com
  Writes for Epoch Times, *Undercoverdc*
  - https://www.thetruthbarrier.com/
  - https://uncoverdc.com/2020/04/07/was-the-covid-19-test-meant-to-detect-a-virus/
  - https://uncoverdc.com/
  - https://www.theepochtimes.com/

- David Crowe, President Rethinking AIDS **['Viral Critical'/'militant']**
  Biological and mathematical sciences background.
  Leading world expert on critical science re: 'Covid-19', 'SARS-CoV-2' and 'HIV'.

  - Infectious Myth Book Project
    - https://theinfectiousmyth.com/book/CoronavirusPanic.pdf
    - https://theinfectiousmyth.com/
  - Infectious Myth Radio/Podcasts
    - https://prn.fm/show/infectious-myth/

  David.Crowe@cnp-wireless.com David.Crowe@cnp-wireless.com
  Twitter:@DavidRCrowe

- Jon Rappoport Investigative Journalist **['Viral Critical'/'militant']**

"Jon Rappoport has worked as a free-lance investigative reporter for over 30 years. He is the author of three explosive collections, THE MATRIX REVEALED, EXIT FROM THE MATRIX, and POWER OUTSIDE THE MATRIX. He has written articles on politics, health, media, culture and art for LA Weekly, Spin Magazine, Stern, Village Voice, Nexus, CBS Healthwatch, and other newspapers and magazines in the US and Europe."

- https://nomorefakenews.com/
  New Tips, Guest Appearances: qjrpress at gmail.com
  Consulting: qjrconsulting at gmail.com
  Email List, Product Questions: orders at nomorefakenews.com

- Pamela Geller - anti-Sharia Law/anti-Shari self-censorhip campaigner
  [Lockdown critical, 'anti-Christian awarenessl']
  - https://gellerreport.com/

- Breitbart New Network - right of centre non-MSM news network
  ['Lockdown critical', 'anti-Christian awarenessl']
  - https://www.breitbart.com/

- US Roman Catholic Appeal ['Lockdown-critical' 'anti-Christian awareness']
  - https://veritasliberabitvos.info/appeal/

    "The Appeal for the Church and for the world is an initiative of HER Archbishop Carlo Maria Viganò, Archbishop and Apostolic Nuncio. Some cardinals, bishops and numerous priests have joined this appeal, as well as an increasing number of leading personalities of society (doctors, researchers, journalists, professors, lawyers), associations and private citizens. Those who adhere to the appeal share its content, but their adherence is obviously not extended to the personal ideas of all the signatories."

    "Public health must not and cannot become an alibi for infringing on the rights of millions of people around the world, let alone for depriving the civil authority of its duty to act wisely for the common good,"
  - https://veritasliberabitvos.info/
  - https://veritasliberabitvos.info/appeal/

Republic Of Ireland

Both of the Irish journalists listed below are leading on an Irish legal challenge against the Irish Government's Lockdown:

- Gemma O'Doherty Award Winning Journalist ['Science Critical'/'militant']
  https://gemmaodoherty.com/defending-our-freedom/
  "Gemma O'Doherty is a multi award-winning journalist whose work has shone a light on some of the darkest corners of Irish life. Former Campaigning Journalist of the Year, her investigations have led to the reopening of a number of unsolved murder cases involving police corruption and political interference.
  A Master's graduate from University College Dublin, she was Chief Features Writer with the Irish Independent and has contributed to The Sunday Times, Daily Mail and Village magazine. She established her credentials as a filmmaker in 2016 when she released 'Mary Boyle: The Untold Story', a gripping documentary about a high-level police and political cover-up surrounding Ireland's longest and youngest missing person. It has been viewed almost 1 million times on YouTube.
  Her investigation into the Fr Niall Molloy murder brought about a new police probe and state enquiry. In the Irish parliament, her investigation was described as revealing 'the biggest cover-up in the history of the state.' She exposed widespread abuse of Ireland's road safety laws by high-level VIPs including Ireland's chief of police, politicians, journalists and members of the legal profession. Gemma is currently working on a number of projects including the unsolved murder of Raonaid Murray.
  *Her recent report on the Madeleine McCann case exposed striking errors in the BBC's coverage of the British toddler's disappear*ance."

- John Waters Journalist ['Science Critical'/'militant']
  "Having started his career in 1981 with the Irish Music journal Hot Press, John Waters later wrote in The Irish Times from 1990 to 2014. His first book, Jiving at the Crossroads (1991), about the cultural underbelly of Irish politics at the height of the Haughey era, became a massive best-seller. He went on to write and publish eight other books, including An Intelligent Person's Guide to Modern Ireland (Duckworth, 1997) and Was it for this? Why Ireland lost the plot (Transworld Ireland, 2012). He has written a number of plays for stage and radio and currently writes a fortnightly essay for the American magazine of religion in the public square, First Things. He is a Permanent Research Fellow at the Center for Ethics and Culture, University of Notre Dame, Indiana, USA."
  https://www.firstthings.com/web-exclusives/2020/04/freedom-isnt-just-another-word

Switzerland

- Swiss Propaganda Research
  https://swprs.org/

Glossary

Agoraphobia	Fear of open spaces. A person who is frightened of open spaces is sometimes labelled 'an agoraphobic'.
Chinese whispers	A group game where the first player whispers a message into the ear of the second, which gets repeated down the line; back to first player. Learning is about how the message changes through multiple articulations by different players; errors occur due to players' anxiety, etc: definition paraphrased from https://en.wikipedia.org/wiki/Chinese_whispers
CoronaHysteria Mechanism	A mechanism that uses a small amount of rudimentary and spurious 'evidence' e.g. ['virus' on surfaces'] which then gets propelled forward on a tide of Hysteria solely reliant upon deep seated psychological fears of contagion, and personal contamination, effectively spreading a climate of suspicion, paranoia, neurosis and obsessional compulsive behaviour throughout the population. For example, the rudimentary evidence of 'virus' in aerosols is being used to ask for cessation of cardiopulmonary resuscitation and other drastic unprofessional actions including Registered Nurses not attending to patients as expected.
'CoronaTriage'©	Identification by others of any symptoms you have in order to designate them as due to the 'novel Coronavirus' ('Covid-19 disease'). [see **'Triage'** below]
Covid-19, 'Covid', 'Covid-'	Defined: "Officially the virus is called SARS-CoV-2 and the disease it is believed to caused, COVID-19."cited in http://theinfectiousmyth.com/book/CoronavirusPanic.pdf I use 'SARS-CoV-2' and 'novel Coronavirus' interchangeably as they imply the same concept; my preference is for the latter, as it is a less technical term. I also use 'Covid-19' and 'Covid-' interchangeably to imply the same concept.
DangerSpeak©	Extreme, unapproved, unofficial language requiring immediate screening with *LockSpeak*© software. Includes verbal utterances on perverse unnatural and contagious *Pre-CoronavirusAge* activities like: 'touch', 'sense/sensuality', 'loving', 'physical affection', 'licking', 'sweat', 'breathing' etc.
Dragnet	*"a series of actions taken by the police that are intended to catch criminals; a heavy net that is pulled along the bottom of a river or area of water when searching for something"* https://dictionary.cambridge.org/dictionary/english/dragnet

Differential diagnosis	Traditional process whereby a suitably trained and registered ('licenced') healthcare practitioner (HCP) differentiates between all conditions which share similar signs and symptoms. This is completed on the basis of evidence from physical examination ('clinical signs': what the HCP observes), laboratory workup [so-called 'objective'] and the patient's story ('self-report' symptoms). A decision is then made traditionally together with the patient about these particular collections of signs/symptoms and what they definitively imply in terms of pointing to one particular condition as opposed to all of the others it could be – thus the HCP *formulates* a 'definitive diagnosis'.
Fauxdemic©	A false epidemic in terms of being created from Fear and Hysteria irrespective of any claims concerning a virus. *Fauxdemic©* =Fear+Hysteria
'Freeway Covid-19'© ***or*** ***'The Freeway Covid-19'©***	A metaphor to help understand the nature of the fast moving way that a presumed, incorrect or assumed medical diagnosis, made by a **HCP** [see below] or any person, can powerfully propel any unwitting person forwards as a 'patient'; it starts with some generic non-specific symptom(s). Before the Corona Hysteria era the list of symptoms now labelled 'Covid-19' was considered harmless and commonly experienced annually as part of the 'flu' round.
Great Britain	I use 'Great Britain' or GB and GBR***:".. instead of 'UK'*** [for political reasons] ..to refer to the United Kingdom.." 'Great Britain', 'GB', and 'GBR' are used "in some international codes..including the Universal Postal Union, international sports teams, NATO, the International Organization for Standardization country codes ISO 3166-2 and ISO 3166-1 alpha-3, and international licence plate codes, whilst the aircraft registration prefix is G***"*** https://en.wikipedia.org/wiki/Great_Britain My political reasons for so doing are: the term 'Great Britain' is more traditional than 'UK'; often heard on the tongues of those asserting national sovereignty against the federalising power of the 'European Union' ('EU') in opposition to the overwhelming advice and globalising influence of the mainstream media (MSM), socio-political 'experts' and our elected career politicians many of whom are explicit globalists. The democratically expressed wish of the British nation to exit the 'EU' was evident for the world to see both in: i) the Brexit Referendum result 2016; and ii) re-expressed again in the British General Election result in 2019; shortly before the creation of the disease category 'Covid-19'.
Health Care Practitioner(s) (HCP(s)), Health Care Professional(s) (HCP(s))	Doctors, registered nurses, and registered nurse practitioners who are authorised by their national professional regulators to clinically diagnose, prescribe and treat various medical conditions; the term can also refer to paramedics, pharmacists, physiotherapists and occupational therapists.
Heuristics	A 'rule of thumb' process, or a process based on experience https://www.vocabulary.com/dictionary/heuristic

Hysteria	*"In modern usage, the term hysteria connotes mass panic (mass hysteria). Hysteria is associated with events, such as the Salem witch trials..the term "hysterical suffocation" – meaning a feeling of heat and inability to breathe, was ..used in ancient Greek medicine.. Historically, hysteria was thought to manifest itself .. with a variety of symptoms, including: anxiety, shortness of breath, fainting, insomnia, irritability, nervousness..."* https://en.wikipedia.org/wiki/Hysteria
Iatrogenesis	Illness and death, caused by faulty clinical reasoning due to medical examination and treatment. From the Greek meaning: *"brought forth by the healer":* Greek- 'healer':*'iatros'* + 'creation':*'genesis'*, definition paraphrased from https://en.wikipedia.org/wiki/Iatrogenesis
LockSpeak©	Words spoken commonly in opening or closing phrases of human interaction reflecting a subtle mechanism at play that operates through something akin to Chinese whispers. These are words, strings / arrays of words conveying English-language platitudes or simple notions, which since the dawn of the 'novel Coronavirus' era, have taken on a radically different meaning to their original ones e.g***. "in these difficult times", "stay safe"*** etc. The mechanism can become over extended, or attenuated, until an inflation of the original concept based upon some misguided notion of 'safety', eventually makes the term completely ridiculous and meaningless. These discursive phenomena are insidious, and represent pervasive attacks on our physicality (by replacing physical presence), and our language (real emoting), and will negatively impact on our thoughts and actions, like Orwell's Newspeak, after which they are named ('1984' novel by George Orwell).
'MSM' - Mainstream Media	*"forms of the media, especially traditional forms such as newspapers, television, and radio rather than the internet, that influence large numbers of people and are likely to represent generally accepted beliefs and opinions"* from https://dictionary.cambridge.org/dictionary/english/msm
'NHS' - The National Health Service	*"The National Health Service (NHS) is the publicly funded healthcare system in England, and one of the four National Health Service systems in the United Kingdom. It is the second largest single-payer healthcare system in the world..Primarily funded by the government from general taxation (plus a small amount from National Insurance contributions), and overseen by the Department of Health and Social Care, the NHS provides healthcare to all legal English residents and residents from other regions of the UK, with most services free at the point of use. Some services, such as emergency treatment and treatment of infectious diseases, are free for everyone, including visitors"* cited in https://en.wikipedia.org/wiki/National_Health_Service_(England)
[NHS] Patient Pathway	This exists in all Western healthcare systems. The NHS version is defined as: "*The system is an interlinked series of algorithms, or pathways, that link clinical questions and care advice, leading to clinical endpoints. Non-clinical call handlers are presented with a series of questions. Based on the answers given, the most appropriate clinical response with a specific level of care and the time frame, is reached".* https://digital.nhs.uk/services/nhs-pathways#about-nhs-pathways

Positive Predictive Value [of a medical test]	The positive predictive value (PPV) is the proportion of patients with a positive test result who have the disease; the negative predictive value (NPV) is the proportion of patients with a negative test result who do not have the disease. PPV/NPV are key concepts used to determining test accuracy: https://www.ncbi.nlm.nih.gov/pubmed/6452080?dopt=Abstract http://www.theperthgroup.com/HIV/HIVABTestsFinal.pdf
Prodrome	A medical term for an early sign or symptom (or set of) that often indicates the onset of a disease before more diagnostically specific signs and symptoms develop. It is derived from the Greek word *prodromos*, meaning "running before" paraphrased from https://en.wikipedia.org/wiki/Prodrome
Protean	'Changeable', 'ambiguous', 'slippery': Cambridge Online Dictionary defines 'protean' as: "*easily and continuously changing"* cited in https://dictionary.cambridge.org/dictionary/english/protean
Public Health England	An agency which regulates NHS technologies; "*..an executive agency of the Department of Health and Social Care in the United Kingdom that began operating on 1 April 2013. Its formation came as a result of reorganisation of the National Health Service (NHS) in England outlined in the Health and Social Care Act 2012. It took on the role of the Health Protection Agency, the National Treatment Agency for Substance Misuse and a number of other health bodies"* as cited in https://en.wikipedia.org/wiki/Public_Health_England
'The Naked Sun'	"*..is a science fiction novel by American writer Isaac Asimov, the second in his Robot series. Like its predecessor, The Caves of Steel, this is a whodunit story. The book was first published in 1957 after being serialized in Astounding Science Fiction between October and December 1956."* Cited in https://en.wikipedia.org/wiki/The_Naked_Sun
Samizdat	A form of dissident self-publishing activity across the Eastern Bloc during the Soviet era in which individuals reproduced censored and underground makeshift publications, often by hand, and passed the documents from reader to reader; the term was used to refer to both scientific and political dissidence; see: https://en.wikipedia.org/wiki/Samizdat
'SARS-CoV-2' or 'novel Coronavirus'	Crowe states: *"Officially the virus is called **SARS-CoV-**2 and the disease it is believed to cause, COVID-19."* [emphasis added] cited in http://theinfectiousmyth.com/book/CoronavirusPanic.pdf I use 'SARS-CoV-2' and 'novel Coronavirus' interchangeably as they imply the same concept; my preference is for the latter, as it is a less technical term.

'Sensitivity', 'specificity' and 'gold standard' for medical tests **[read 'The Perth Group' below]**	The Perth Group [read 'The Perth Group'] defines sensitivity and specificity: "*It is essential to understand the test parameters sensitivity and specificity. Sensitivity is a number, usually expressed as a percentage, indicating how often the test is positive given that a particular condition or disease is known to be present. For example, how many of 100 patients with histologically proven appendicitis have an elevated white blood cell count? The method of determining the presence of the condition, the test's gold standard, cannot be the test. The gold standard must be independent of the test. As another example, an ultrasound examination conducted at six weeks of pregnancy can serve as a gold standard for evaluating a blood test to diagnose pregnancy. If 99/100 women pregnant on ultrasound have a positive test then the test is 99% sensitive. Specificity is a more difficult concept because it is defined as a double negative. Specificity is the percentage of negative tests in a group of individuals who are known not to have the condition or disease. For example, if 99/100 women who are not pregnant on ultrasound have a negative blood test the test is99% specific. The one non-pregnant woman with a positive test is a false-positive. This occurs for example in some gynaecological malignancies. The easy way to calculate the percent false-positives is to subtract the percent specificity from 100. Hence if the "HIV" PCR is 40% specific then 60% of individuals who are not infected will have a false-positive test. One cannot over-stress the requirement for using a superior reference test (the gold standard) to prove the condition or disease is present or absent. In the case of the "HIV" antibody tests there has never been a study documenting the test against HIV itself, despite the fact that proving HIV infection is the purpose of the test. The "HIV" antibody test is evaluated using either another antibody test (which is evaluating the test against itself), or by defining "HIV" infection as individuals who have AIDS. Neither method can prove that the antibodies that react in the test are caused by HIV. One must use HIV isolation/purification as the gold standard. See: Griner PF, Mayewski RJ, Mushlin AI. Selection and interpretation of diagnostic tests and procedures. Ann Intern Med 1981 94:559-563."* Cited in: Papadopulos-Eleopulos, E et al. HIV – A virus like no other. Posted at the Perth Group website July 12th 2017." www.theperthgroup.com/HIV/TPGVirusLikeNoOther.pdf
Sheeple	Derogatory term: "combination of the words "sheep" and "people" meaning that the person or persons are acting as a group or to only behave based on what is trending" https://www.urbandictionary.com/define.php?term=Sheeple
Sociogenesis	"The social origin of a particular phenomenon" for example, how a disease category is created or socially perceived. From https://en.wiktionary.org/wiki/sociogenesis
Solaria	A fictional planet politically hostile to Earth in Isaac Asimov's novel called 'The Naked Sun'. Populated by a small number of humans whose ancestors fled from an overcrowded Earth on which humankind had become frightened of open spaces ('agoraphobic'). https://en.wikipedia.org/wiki/The_Naked_Sun

'TPG' - The Perth Group
http://www.theperthgroup.com

The Perth Group - 'TPG' state:
"What is needed to prove or disprove the HIV theory of AIDS?
There are three ways to resolve this debate:
The first is to garner enough public opinion to mandate a public debate between a small number of protagonists and dissidents. This debate should be international, public and adjudicated by a number of disinterested scientists of Nobel Laureate class who must present the international community with a resolution as to the way forward.
The second is for HIV seropositive individuals to have the evidence for their diagnoses of "HIV" infection examined in courts of law.
The third is to perform isolation experiments to prove whether or not a retrovirus "HIV" exists in individuals with a positive antibody test or AIDS. An outline of these experiments can be found in the Presidential AIDS Advisory Panel report" http://www.theperthgroup.com

Supranational agencies

These are unelected agencies working over, and against, our elected governments and which are fatally impacting on our national psyches and policy makers. These unelected agencies include, the 24-7 cyclical Mainstream Media (MSM), The Gates Foundation (who fund Imperial College London a British source of Lockdown modelling), Gilead, and other pharmaceutical interests.

Triage

Triage in medical facilities is defined as: *".. the process of determining the priority of patients' treatments based on the severity of their condition or likelihood of recovery with and without treatment. This rations patient treatment efficiently when resources are insufficient for all to be treated immediately; influencing the order and priority of emergency treatment, emergency transport, or transport destination for the patient"* cited in https://en.wikipedia.org/wiki/Triage

Trimensional

Used by Asimov in The Naked Sun in 1956 to refer to hologram-like images of reality that were very believable so people could *'view'* each other and be greatly convinced they were *seeing* the real thing. Asimov's coinage predates our currently existent 20th/21st century technologies, such as holography. The noun 'Trimensional' now refers to: "*The Trimensional app is a 3D scanner app created by Trimensional, LLC for the iPhone and the iPod. Users can scan friends and family to create 3D models ..that uses the screen and the front-facing camera and detects patterns of light on your face to build a 3D model. Turn the screen brightness to maximum and turn off all the lights. The Trimensional scanner works best in the dark. Then take close-ups of your subject."* Cited in https://www.whiteclouds.com/3DPedia/trimensional-app.html

DESIGNED AND PUBLISHED IN MAY 2020
KPC RESEARCH AND CONSULTANCY LIMITED
An independent research and management consultancy owned and directed by Kevin P Corbett.

ABOUTH THE AUTHOR

Kevin P Corbett completed both undergraduate and postgraduate training in Art at the University of Reading (1979) and The Slade School of Fine Art, University College London (1981), receiving a Special Award from The Stanley Picker Trust (1981). Kevin qualified as a Registered Nurse in 1986 becoming part of the commissioned staff for Broderip Ward at The Middlesex Hospital, London, Britain's first purpose-built HIV/AIDS unit, opened by Princess Diana in 1987. Postgraduate nursing research followed at King's College London (1987-1989) into improving metred dose inhalation through patient training in the physiology of the inhaled route. This won support from the Stimulating Progress fund of London's North East Thames Regional Health Authority and *Vitalograph* Ltd (UK). Doctoral research (1995-2001) focused on patients' indeterminate experiences of the tests used in HIV/AIDS, the ELISA, Western blot and PCR tests. Kevin has more than thirty years' experience in gaining £150k+ in research funds for leading and participating as principal and co-instigator. He is a qualified nurse educator who has worked in university education, research and public health at Kingston/St.George's University of London, University of York, Liverpool John Moores, Canterbury Christ Church University and Middlesex University. Kevin also has experience in acute clinical, forensic and community nursing with over one hundred research outputs in peer-reviewed, patient-reviewed and citizen science publications. Current research and consultancy is focused on human physiology, visual art and citizen participation in science and technology.

ACKNOWELDGEMENTS

KPC Research and Consultancy Limited gratefully acknowledge the valuable feedback received from all of the reviewers during preparation of the manuscript revision prior to publication. Monograph design by KPC Research and Consultancy Limited. Sub editing and proof reading by Gerard Egan.

ISBN 978-1-5272-6229-4

Designed and Printed in Great Britain
KPC Research and Consultancy Ltd
E-mail: kpcresearch@btinternet.com
Web: www.kevinpcorbett.com
Twitter: @KPCResearch

ISBN 978-1-5272-6229-4
9 781527 262294 >