September 14, 2021

College of Physicians & Surgeons of Alberta (CPSA) Council
2700 – 10020 100 Street NW
Edmonton, AB Canada T5J 0N3

Dear CPSA council members,

RE: Mandatory mRNA vaccine mandate for Alberta physicians

Thank you for allowing me to listen Friday morning during council's discussion on a vaccine mandate for Alberta physicians. Let me please provide the perspective of a physician who loves his job, cares deeply about his patients, and continues to avoid the mRNA vaccines. I am a pediatric neurologist and researcher specializing in epilepsy and neurocritical care at Alberta Children's Hospital (ACH). I have a Master of Public Health from Harvard University and before returning to ACH in February 2020, I spent 6 years on staff at Mayo Clinic where I developed expertise in neuroinflammation. Both medical school and pediatric neurology residency were completed here in Calgary. I am also a father of 3 young children and remain ***very much pro-vaccine***. While I refuse to take this novel experimental mRNA therapy, my wife, children, and I are completely vaccinated, including yearly flu shots. This is not a contradictory stance as these current mRNA vaccines represent a dramatic departure from using, for instance, live attenuated viruses. Rather, they represent ***a completely novel and experimental therapy with no long-term data***. Consider that the CDC just updated the definitions of immunity and vaccine on September 1, 2021 - 13 days ago -swapping out the prior "produce immunity" to "provide protection" (1).

On August 31, 2021, AHS President and CEO Dr. Verna Yiu, issued a vaccine mandate to all staff, physicians and volunteers stating, "workers are required to be *fully* vaccinated for COVID-19, by October 31, 2021". I am now faced with the impending possibility of "an unpaid Leave of Absence to allow for compliance". ***I am so disappointed by this extreme AHS coercion,*** and truly hope that the CPSA will steer clear of mandating this as a condition of my license. You briefly covered the legal aspects during your meeting and a vaccine mandate would certainly appear to violate individual rights as protected under the Canadian Charter of Rights and Freedoms (2), but under the auspice of a pandemic, the Alberta provincial government is presently circumventing these rights with Bill 10 - the public health emergency powers amendment act (3). Of course, these forced experimental mRNA vaccine mandates also directly violate the internationally accepted Nuremberg code, which was developed in 1947 to protect patients from medical experimentation stating as its first declaration that "*the voluntary consent of the human subject is absolutely essential*" (4). **It is *because* I am informed, that *I do not* voluntarily consent to these injections.**

Despite only 3.6% of Alberta physicians continuing to avoid these shots, I appreciate that council remains concerned that an "unvaccinated" physician might spread SARS-CoV-2, resulting in possible patient harm and lawsuits to the CPSA. However, by forcing compliance based on the current data, ***you would be stepping on the bedrock principles of medical ethics – especially patient autonomy.*** The willingness to trample individual legal and moral rights in the name of perceived communal benefits, is ***not justified by the current medical science and will cause predictable and unpredictable harms***.

The ***medical evidence demonstrates*** that the effectiveness of the mRNA vaccines has decreased significantly, they do not prevent SARS-CoV-2 transmission or symptomatic disease, and while evidence for protection against serious illness continues to exist in Calgary, that too is dissipating globally. I will discuss that it is the vaccinated driving mutations, not the unvaccinated. I will show evidence that those who have been fully vaccinated generate similar or higher viral loads than the unvaccinated when challenged with Delta, and further clinical data suggesting that this widespread use of a "leaky" vaccine during a pandemic is leading to antibody-dependent enhancement, including evidence that this is already occurring with Delta. I will highlight some of the long-term safety concerns with these mRNA vaccines in the context of available biodistribution data. Finally, I will speak directly to the extremely low possibility of causing harm to my pediatric patients by transmitting SARS-CoV-2.

(1) Even with 100% forced compliance – you cannot eradicate SARS-CoV-2 through vaccination.

- **The initial randomized controlled clinical trial for the Pfizer/BioNtech mRNA vaccine** (BNT162b2), suggested **95% protection against COVID-19**, as defined by their **primary endpoint** "***efficacy of the vaccine against laboratory confirmed Covid-19 and [2 month] safety*****"**. This was funded by BioNTech and Pfizer (5, 6). **The initial randomized controlled clinical trial for the Moderna mRNA vaccine (mRNA-1273) showed 94.1% efficacy at preventing COVID-19 illness, including severe disease**. This was funded by the National Institute of Allergy and Infectious Diseases (NIAID) and the Biomedical Advanced Research and Development Authority (BARDA) (7, 8).

- **As the virus continued to expectedly mutate**, **the real-world effectiveness derived from these mRNA vaccines has diminished substantially**. This was expected given these mRNA vaccines contain the genetic code for our bodies to produce the original SARS-CoV-2 Wuhan spike (s) protein/antigen only. It is this s protein which binds ACE2 receptors in our body for cell entry (9). The antibodies we generate in response, are directed towards this original s protein only, and as the s protein has continued to mutate away from the initial Wuhan strain, the antibodies produced in vaccinated individuals are having more difficultly recognizing the s protein of subsequent SARS-CoV-2 strains. While these antibodies demonstrate some cross-reactivity to other SARS-CoV-2 variants, the **decreasing vaccine effectiveness partly reflects mutations to the s protein**. Thus, the "vaccine" has become extremely "leaky" in its ability to recognize subsequent variants.

- Recently, Alberta Chief Medical Examiner of Health, Dr. Deena Hinshaw, shared evidence and publicly acknowledged that we cannot eradicate COVID-19 and are rather ***transitioning from a COVID-19 pandemic to endemic*** (8). This, ***despite widespread adherence to severe social restrictions*** including lockdowns, mandatory masks, prolonged quarantines, repeated testing and school closures, and the widespread gutting of pediatric social activities that allow for appropriate neurodevelopmental growth. Meanwhile, **68% of the Canadian population is now fully vaccinated** (11), **including 71% of eligible Albertans (12)**. These rates are comparative to other privileged countries with widespread access to mRNA vaccines and dwarf those rates among less affluent nations (13). Data suggests that **only 29% of the global population is currently fully vaccinated** (13).

- To date, smallpox is the only human virus successfully eradicated through vaccination and it was less transmissible and lacked an animal reservoir (14). **Even if we were to vaccinate all humans with a 100% effective vaccine, SARS-CoV-2 would continue to survive among animal reservoirs,** including the white-tailed deer (15).

(2) Is it really the unvaccinated driving SARS-CoV-2 virus mutations?

- Those who have received a COVID-19 vaccine presumably have generated antibodies that will detect the s protein of SARS-CoV-2 should it enter their body. While those **previously infected with SARS-CoV-2 have antibodies to the s protein AND other parts of the virus, including the nucleocapsid** (16). If the virus wants to replicate in these individuals it ***needs to mutate to evade destruction***. However, *those who did not receive a COVID-19 vaccine and did not become infected with SARS-CoV-2 presumably lack these antibodies and thus the virus does not need to mutate to enter host cells and replicate*.

- The argument that those without a COVID-19 vaccine are driving mutations then depends on the *notion that if we could achieve herd immunity or eradicate the virus more quickly, we would limit its ability to mutate*, which all coronaviruses naturally do. However, **this second argument fails** given our inability to eradicate SARS-CoV-2 through vaccines, including our inability to vaccinate enough people and animal reservoirs globally to achieve herd immunity (13-15). Moreover, as shown below, the current mRNA shots no longer prevent transmission and COVID-19 vaccinated individuals are comprising an ever-increasing proportion of symptomatic patients (17).

- With widespread dissemination of COVID-19 vaccines during the pandemic, we are **placing enormous evolutionary pressure on SARS-CoV-2 to continue mutating to evade our immune system**, gain cell entry, replicate, and possibly cause illness. And, we are **now using very "leaky" vaccines**, making **viral evasion from our antibodies that much easier**. Only the fit will survive. Consider the reasonable **analogy of antibiotic resistance** – this is driven by the widespread and inappropriate use of antibiotics, not by people avoiding antibiotics (18).

- A group of international experts recently stated in the New England Journal Medicine, "***viral variants of concern may emerge with dangerous resistance to the immunity generated by the current vaccines***" (19). Among their recommendations were: "***avoid the use of treatments with uncertain benefit that could drive the evolution of variants; and consider targeted vaccination strategies to reduce community transmission***" (19).

(3) As the effectiveness of mRNA vaccines to prevent transmission and severe disease continues to diminish – *the medical narrative for a forced vaccine mandate evaporated*.

- On July 30, 2021, the CDC director confirmed that "***Delta infection resulted in similarly high SARS-CoV-2 viral loads in vaccinated and unvaccinated people***. *High viral loads suggest an increased risk of transmission and raised concern that, unlike with other variants,* ***vaccinated people infected with Delta can transmit the virus***" (20).

- On August 6, 2021, CDC Director Dr. Walensky stated on CNN: "*Our vaccines are working exceptionally well. They continue to work well for Delta, with regard to severe illness and death -- they prevent it.* ***But what they can't do anymore is prevent transmission***" (21).

- On August 19, 2021, the CDC issued a joint statement advocating for COVID-19 booster shots, citing evidence **that despite full mRNA vaccination, patients were experiencing "*reduced protection against mild and moderate disease*"** (20). This included a very recent U.S. national nursing home prospective observational study which demonstrated diminishing mRNA vaccine ability to prevent infection, with adjusted **effectiveness levels against the Delta variant of 53.1%** (95%CI = 49.1%-56.7%) (22).

- A **Mayo Clinic Health Systems observational cohort study showed that in July 2021** during a period in Minnesota where the **delta variant prevalence** surged from 0.7% to 70% and the alpha strain decreased from 85% to 13%, the effectiveness against hospitalization remained high for Moderna - 81% (95%CI: 33-96.3%) and Pfizer/BioNtech - 75% (95%CI: 24-93.9%) (15). **However, effectiveness against infection** was lower for **Moderna - 76%**, (95%CI: 58-87%); and **Pfizer/BioNtech – at only 42%** (95%CI: 13-62%). Note that **all COVID-19 vaccines approved by WHO and FDA are required to have an efficacy rate of 50% or above** (24, 25).

- A very recent population-based cohort study (n=4,204,859) from Norway showed that vaccine effectiveness against Delta variant among fully vaccinated individuals was 64.6% (95%CI: 60.6-68.2) compared with 84.4% (95%CI: 81.8-86.5) against the Alpha variant (26).

- On July 23, 2021, Israel's Health Ministry indicated that a **complete course of the Pfizer/BioNTech mRNA vaccine was just 39% effective at preventing infections and 41% effective at preventing symptomatic illness with the Delta variant** but remained 91% effective at preventing serious illness and hospitalization (27). However, by August 16, 2021, and despite having 78% of those 12 and older fully vaccinated, **59% of gravely ill patients in Israel were fully vaccinated** (28).

- These data likely explain why the CDC just changed the definition of immunity, from "producing immunity" to "providing protection" (1). While it might be appealing to state that *some protection is still better than no protection* - I will discuss why I do not feel that applies to these current mRNA vaccines - especially in very low risk groups.

(4) Natural immunity from SARS-CoV-2 is more durable and robust than the partial immunity achieved from the current mRNA vaccines.

- Intuitively, one would predict that our immune systems would generate a more complete, robust, and prolonged immune response to SARS-CoV-2, rather than the mRNA vaccines. Indeed, after about 6 months of progressively decreasing mRNA vaccine effectiveness, some governments are **already mandating boosters** with seemingly no end in sight (29). In contrast, those individuals with asymptomatic and symptomatic infections **developed a robust immune response to the entire virus**

(including the nucleocapsid), as opposed to only partial immunity derived through mRNA vaccines towards the s protein.

- A recent Nature paper showed that **17 years after the 2003 SARS outbreak, long-lasting memory T cells were still present to the nucleocapsid** (n protein) in those infected with SARS-CoV, **AND these T-cells displayed a robust cross-reactivity to the N protein of SARS-CoV-2** (16).

- Another recent Nature paper showed **memory B cell response to SARS-CoV-2 evolves between 1.3 and 6.2 months after infection in a manner consistent with antigen persistence**, evidenced by titres of IgM and IgG antibodies against the receptor-binding domain of the spike protein (30).

- A very recent large observational Israeli study **compared SARS-CoV-2 natural immunity to vaccine-induced immunity** during a period when Delta was dominant. "After adjusting for comorbidities, we found a **27.02-fold risk** (95% CI: 12.7-57.5) for ***symptomatic breakthrough infection as opposed to symptomatic re-infection (p<.001)*** (31).

- **Extremely low reinfection rates have been observed since pandemic onset.** For instance, "*with a total of 835,792 Israelis known to have recovered from the virus, the 72 instances of reinfection amount to 0.0086% of people who were already infected with COVID* (32).

- Yet, we are **using coercion to force individuals to take mRNA vaccines even if they have already had a prior COVID-19 infection, and even if they can provide lab confirmation of sustained immunity.**

- Perhaps at minimum, we could **assess for evidence of persistent immunity BEFORE we force EVERYONE to take the shot**, especially among young healthy populations. At present, we have **only 6-month longitudinal adult data to inform risks beyond the acute injection period.**

(5) From a long-term safety perspective, these novel mRNA vaccines should be treated as guilty until proven otherwise, especially in low-risk groups.

- **No crystal ball exists to predict long-term risks.** Do you recall when we received emails from leadership re-assuring us that all 3 shots, including Astra Zeneca, were safe, only to have it recalled a few months later? Do you remember when mRNA vaccines were not associated with myocarditis/pericarditis in male adolescents (33)?

- **Do you want to mandate these experimental mRNA vaccines despite the lack of long-term data?** *Perhaps there are certain vulnerable adult and pediatric groups who will prove to endure higher risk over time from the shots rather than from the virus itself?*

- Consider a young healthy woman who is coerced by AHS to take the experimental shot, and over the next few years it becomes clear that these "vaccines" are associated with fertility issues in some women? Crazy?

- The vaccine companies and medical officials have repeatedly claimed that when we are injected with these mRNA vaccines, **the lipid nanoparticles which contain the s protein mRNA** needed for our cells to produce the s protein **- *stay at the injection site***. ***This appears false***.

- In a recent **prospective** (December 2020 to March 2021) pilot **study of 13 healthcare workers** (≥ 18 years, mean age 24 years) at the Brigham and Women's Hospital, **Harvard investigators obtained longitudinal plasma samples of SARS-CoV-2 proteins from participants who received two doses of mRNA-1273 vaccine (Moderna)**, and lacked a prior history of SARS-Cov-2 illness. These antigens included SARS-CoV-2 antigens spike (S1-S2 unit), S1, and nucleocapsid and antibodies IgG, IgA, IgM against SARS-CoV-2 spike, S1, receptor binding domain (RBD), and nucleocapsid (34).

- **After the first dose**, the mRNA-1273 produced detectable levels of S1 antigen ***in plasma in 11 participants***, and spike antigen was detected in 3 of 13 participants, an average of 15 days post first injection. Protein clearance correlated with production of IgG and IgA. ***Their negative control*** – the ***nucleocapsid antigen from SARS-CoV-2 was expectedly absent***, as the vaccine does not lead to production of the SARS-CoV-2 nucleocapsid antigen. "*In all 13 participants, as expected, IgG levels against spike, S1, and RBD increased after the first injection, whereas IgG against nucleocapsid showed no change over time*" (34).

- Authors concluded, "***The mechanisms underlying release of free S1, and the subsequent detection of the intact spike protein remain unclear***. ***Nonetheless, evidence of systemic detection of spike and S1 protein production from the mRNA-1273 vaccine is significant and has not yet been described in any vaccine study"*** (34).

- ***Why has this not been described in the vaccine studies? Where is the biodistribution safety data?*** *If the s antigen is circulating in our plasma weeks later, could it be causing harm*? Note that the above Boston study was conducted in young healthy people with robust T-cell immunity. I wonder what we would see in a vulnerable elderly person with comorbidities. Does this contribute to SARS-CoV-2 vaccine-induced immune thrombotic thrombocytopenia (VITT) and other instances of adverse thrombotic events (35)?

- As a neurologist, I must wonder if these s proteins are circulating in our cerebral spinal fluid, given that the ACE2 receptors are also present in brain and could gain them access (36). Crazy?

- In a murine model, the virus "**SARS-CoV-2 crosses the blood-brain-barrier** accompanied with basement membrane disruption…," ensued by "inflammatory responses including vasculitis, glial activation, and upregulated inflammatory factors" (37).

- Further when ***injected intravenously, the S1 protein of SARS-CoV-2*** was found to **cross the blood-brain-barrier in mice**. Inflammation potentiated this uptake. ***The S1 protein entered all brain regions, with no statistically different differences among them, including cortex, olfactory bulb, striatum, thalamus and hypothalamus, hippocampus, cerebellum and brainstem*** (38).

- **Canadian immunologist and vaccine researcher Dr. Byram Bridle** (Guelph University) was awarded a large government grant for research on COVID-19 vaccine development. Only through a Freedom of Information Act, did he and other scientists subsequently gain access to Pfizer's rat biodistribution study from the Japanese regulatory agency (39). It clearly showed that **when injected**

intramuscularly, the concentration was highest at the dosing site, then the liver, and then detected in the spleen, adrenal glands, and ovaries (39)**.**

- ***If you are not at least concerned by these studies***, please ask yourself why the bioavailability and biodistribution data in humans, is not readily available to contradict these studies. There is no reason we should not have this data across many different patient populations, especially after 1 year of distributing the mRNA vaccines. I could not find one study that measured mRNA vaccine protein uptake in human CSF. While I understand very well the difficulty obtaining CSF, there are many clinical situations where this could have been readily collected.

- **Instead, they censor and aggressively attack one of our own!** If you search for Dr. Byram Bridle you will readily see the internet smear campaign against him. I listened to his initial interviews months ago when he received the Pfizer rat studies. *He was genuinely petrified and shocked by the data and wanted to warn people.* There is no denying that the mRNA vaccine injection distributes throughout our body based on the existing data. But just because it does circulate, does not mean it is causing harm either.

- Dr. Bridle was especially attacked for his comments that the s protein itself is toxic and can cause harm. Given the biodistribution data I have shared and what we know about some of the rare adverse events that occur post mRNA injection, his opinion is not one that should be aggressively dismissed immediately. It is incredible the attack he has endured for discussing the science. Below is a link to a brief article from the local Guelph News discussing Dr. Bridle. **https://www.thestar.com/local-guelph/news/2021/06/21/immunologists-raise-concerns-on-u-of-guelph-prof-s-views-on-covid-19-vaccine-safety.html**

- SARS-CoV-2 infection disturbs several pathways associated with neurodegeneration, including but not limited to Parkinson and Huntington disease. (40). "*Given the neuroinvasive potential of SARS-CoV-2, deeper investigation is warranted into the virus' contribution to the long-term development of neurodegenerative disease*" (41).

- If some of the s antigen our bodies produce in response to the mRNA vaccine *is indeed entering our brains and cerebral spinal fluid, then we should heed those warnings about the possibility of* ***early neurodegenerative diseases.***

- It was recently shown that "**SARS-CoV-2 S1 RBD binds** *to a number of aggregation-prone, heparin binding proteins including Aβ, α-synuclein, tau, prion, and TDP-43 RRM*. **These interactions suggests that the heparin binding site on the S1 protein might assist the binding of amyloid proteins to the viral surface and thus could initiate aggregation of these proteins and finally leads to neurodegeneration in brain**" (42).

(6) The mRNA vaccine risk-benefit ratio in children.

- **Children are at very low risk from COVID-19 infection itself, and rarely suffer severe disease and death** (43). Data from the American Academy of Pediatrics Children and COVID-19: State Data

Report, **found that 0.1-1.9% of their child COVID-19 cases resulted in hospitalizations, and 0.00-0.03% of all child covid-19 case resulted in death** (43).

- **In a pre-COVID-19 vaccine cohort of 1391 children, 171 (12.3%) were confirmed to have** SARS-CoV-2 infection and treated at the **Wuhan Children's Hospital from Jan 28 – Feb 26, 2020** (Note this is the only center assigned by the central government for treating infected children under 16 years of age in Wuhan). Median age was 6.7 years. 3 patients required intensive care and invasive mechanical ventilation – all had coexisting conditions. 1 patient died, a 10-month-old with intussusception and multiorgan failure (44).

- Currently in Alberta, the average age of COVID cases that died is 80 years, with a range from 20 -107 years (10). Thankfully, no pediatric patients have thus far died in Alberta. And, contrary to media portrayal, children with COVID-19 are **also very rarely susceptible** to *multisystem inflammatory syndrome* (45) and *neurological sequelae* (46). Since the pandemic, I have seen more devastating neurologic conversion disorders and psychiatric disease, including several heart-breaking teenage suicide attempts, then I have my entire career. In contrast, I have not encountered a single child with neurological sequelae from COVID-19 itself.

- The American Academy of Pediatrics also confirmed that ***while Delta is infecting more children, it is not causing increased disease severity*** (47).

- While many studies suggest pre-symptomatic/asymptomatic spread may comprise > 40% of vertical transmission, ***numerous large observational population studies show that children are POOR COVID-19 spreaders.*** This includes studies from Ireland, Iceland, Italy, France, and Australia (48, 49, 50, 51, 52). For a link to a more complete reference list, see Washington University Pediatric & Adolescent Ambulatory Research Consortium: http://wupaarc.wustl.edu/COVID-19-and-Children/Information-about-COVID-19-Transmission-in-Schools-and-Daycares

- The CDC and FDA's **Vaccine Adverse Reporting System (VAERS)** "*is the nation's **early warning system** that monitors the safety of vaccines after they are authorized or licensed for use by the FDA*" (53). It is a self-reporting system that does not prove causality but rather is designed to help identify adverse events signals (*i.e.*, COVID-19 vaccine thrombotic events and myocarditis). "*VAERS **scientists look for unusually high numbers** of reports of an adverse event after a particular vaccine or a new pattern of adverse events*" (54).

- While you would certainly expect a spike in the reports submitted during a pandemic where we are using an experimental vaccine technology, it is also true that adverse events reported in VAERS are historically vastly underreported. In the 2009 Harvard Pilgrim Health Care study assessing the VAERS, "***fewer than 1% of vaccine adverse events are reported***" (55).

- During **1997-2013, VAERS received 2149 death** reports and "no concerning pattern" was observed (56). But as Senator Ron Johnson wrote August 22, 2021: "***the 12,791 deaths related to Covid-19 vaccines reported on VAERS over the period of 8 months, compares to 8,966 deaths related to all other vaccines reported on VAERS since the inception of VAERS – a period of 31 years***". He continues*, "VAERS is also reporting 16,044 permanent disabilities, 51,242 hospitalizations, and*

571,831 total adverse events related to the Covid-19 vaccines" (57). Anyone can verify these numbers, as I have previously done, at the VAERS website.

- ***Why then, given these clearly unusually high numbers, does the CDC continue to refuse to allow an independent safety panel investigation of outside experts?*** Consider that on July 16, 1999, the CDC recommended that healthcare providers *suspend* the use of the licensed…RotaShield – a rotavirus vaccine – *after only 15 cases of intussusception were reported in VAERS!* (58)

- Recently, despite clear decreased mRNA vaccine effectiveness, *Dr. Fauci and President Biden have expressed their desire to start giving the mRNA shots to children aged 6 months – 11 years*, and indeed, trials with Pfizer/BioNtech and Moderna are underway. Dr. Fauci stated August 31, 2021: "I believe that mandating vaccines for children to appear in school is a good idea" (59). Further, President Biden said July 21, 2021, that children under age 12 could be eligible for a COVID-19 vaccine within the next few months, as results from clinical trial for ages 6 months to 12-years become available (60).

- **Even IF** these pediatric RCTs show efficacy and 2-month safety data similar to the initial Moderna and Pfizer-BioNtech trials, *are we still going to inject even low risk children*? Children seem to be their own best defense against SARS-CoV-2, are poor transmitters of the disease and have exceedingly low risk of death and severe disease from the virus. We now know that the real-world effectiveness of these mRNA vaccines is mediocre at best and continuing to diminish. And we have zero long-term data. **Just because industry funded studies may show "efficacy" in the pediatric trials, I strongly argue that we should not be injected children with these very experimental therapies.** At least show us the biodistribution data first.

(7) Following the science?

- On August 31, 2021, despite several decade long careers with the FDA, the individuals leading the FDA office in charge of approving vaccines (Marion Gruber and Philip Krause), resigned over the Biden administration's booster-shot plan, ***saying it insisted on the policy before the agency approved it*** (61).

- And recently, ***the UK's vaccine advisory board REFUSED to approve mRNA vaccines for healthy 12-to 15-year-olds*** (62). Despite this, the government may overrule and is already telling teenagers they can circumvent their parents. ***How many of our teenagers are actually making an uncoerced informed decision?*** Do they really understand their risk-benefit analysis? (63)

- ***Many censored international experts*** in public health and virology have long-called for focused protection and the need to carefully weigh the risk-benefit of these experimental mRNA vaccines among those individuals with very low risk from the disease, including children (64).

1) The Great Barrington Declaration (2020) was co-authored by Dr. Martin Kulldorff (Harvard), Dr. Sunetra Gupta (Oxford) and Dr. Jay Bhattacharya (Stanford) – 3 giants in public health, epidemiology, and vaccines surveillance (https://gbdeclaration.org/). This declaration advocates for "focused protections" for COVID-19 and currently has collected > 850,000 signatures worldwide

including from > 58,000 medical professionals and scientists. Despite these credentials, and recommendations that were not novel but in fact reflected longstanding public health policy, Dr. Kulldorff, and the others have been heavily attacked and censored. I have provided a link to a fantastic interview with Dr. Kulldorff in the reference section. Towards the end, he addresses the censorship issue directly (65).

(8) Is it possible that antibody dependent enhancement (ADE) is contributing in some people to the aggressive Delta outbreaks seen in Israel, India and … Calgary?

- **ADE occurs when antibodies facilitate viral entry into host cells and enhance viral infection in these cells.** It is an appreciated concern of coronaviruses as described in a multicenter paper that included Dr. Zhengli Shi from the Wuhan Institute of Virology, known for her work with bat viruses (a.k.a. the "*Bat Lady*"), entitled "*Molecular mechanism for antibody-dependent enhancement of coronavirus entry*." This paper was published in the Journal of Virology on February 14, 2020 (submitted pre-pandemic November 27, 2019) (66).

- ***Animal model studies of prior SARS-CoV raise potential safety concerns*** (67). Decades ago, **kittens were immunized** with a viral recombinant encoding the **spike protein of the coronavirus**, producing low titres of neutralizing antibodies. After challenge with the feline virus, these animals succumbed earlier than did the control group – "*early death syndrome*" (68). More recently, the anti-S IgG produced in **macaques immunized** with a modified **viral vector expressing the SARS-CoV protein**, enhanced pulmonary infiltration of inflammatory macrophages, and resulted in more severe lung injury compared to unvaccinated animals (69). Similarly, **immunized macaques with four B-cell peptide epitopes of the S protein**, found that while 3 peptides elicited antibodies that protected the macaques from viral challenge, one of the peptides induced antibodies that enhanced infection *in vitro* and resulted in more severe lung pathology *in vivo* (70). Further, **pulmonary immunopathology was observed upon** a subsequent challenge to the SARS virus**, among SARS coronavirus vaccine-treated mice and ferrets** (71). However, it appears dependent on the vaccine type. In 2 studies with rhesus macaques, immunization with an **inactivated SARS-CoV vaccine**, did not show ADE (72, 73).

- A recent study of **healthcare workers in Vietnam** assessing the transmission of SARS-CoV-2 Delta variant found that **the previously mRNA double-vaccinated group had 251 times higher nasopharyngeal viral loads compared to those unvaccinated**. AND there was **no correlation between vaccine-induced neutralizing antibody levels and viral loads or the development of symptoms** (74).

- Very recently, **researchers found "facilitating" antibodies bound to the NTD region of the Delta spike variant** (located behind the contact surface so that it does not interfere with the virus-cell attachment). Their data suggests FcR-independent enhancement of infection induced by anti-NTD antibodies involving lipid rafts. "***Inasmuch as neutralizing antibodies overwhelm facilitating antibodies, ADE is not a concern. However, the emergence of SARS-CoV-2 variants may tip the scales in favor of infection enhancement. Our structural and modeling data suggest that it might be indeed the case for Delta variants***" (75).

- **More data is needed to determine what role is being played by ADE but the evidence that does exists, suggests that we should be concerned and following this carefully.** ***If ADE is not contributing, then prove the silenced experts wrong! If it is, the plan to double down on widespread mRNA vaccines and boosters, needs to change.***

(9) Relevant Examples of Egregious Censorship and Misinformation.

**** I hesitate to include this section largely because the scientific data itself is so convincing and I do not want to detract from these arguments. However, you cannot understand why these data are so incongruous with the prevailing narrative, unless you appreciate the medical censorship for yourself. ****

Example 1: SARS-CoV-2 virus origin – manipulated in a lab or jumped species?

- Do you recall when SARS-CoV-2 escaping from a lab in Wuhan - as opposed to jumping from bats to humans - was a demonstrably false conspiracy theory? The Washington Post, among others, was even forced to retract prior statements claiming this was "debunked" (76). Based on the virus' genetic code, Prof. Montagnier was among the first to state publicly and with extreme certainty that this virus was manipulated in a lab. He was demonized then for that too (77).

- **In March 2020**, it was Andersen and colleagues' paper appearing in Nature Medicine: "***Proximal origins of SARS-CoV-2***" – that framed this discussion early (78). They concluded: "*In the midst of the global COVID-19 public-health emergency, it is reasonable to wonder why the origins of the pandemic matter …. Although the* ***evidence shows that SARS CoV-2 is not a purposefully manipulated virus****, it is currently impossible to prove or disprove the other theories of its origin described here*."

- While 100% proof of origin is unlikely to arise, the media ***continuing to paint the issue so nebulously is also disingenuous***. I defy you to read this balanced and detailed pro and con argument for each origin theory and still perceive this to be a grey zone. (https://www.zerohedge.com/health/tracing-origins-covid-19).

- For those with basic science background, a more complex SARS-CoV-2 genetics analysis was provided by the **Chinese whistleblower Dr. Li-Meng Yan's original scientific paper** (79). This swayed me enough back in June 2021 when it first appeared on-line to realize that Fauci's earlier adamant assertions to the contrary were untrue. While there may not have been proof to definitively confirm one theory over the other when he made his statements in Spring 2020, **he certainly could not state that the lab manipulation theory was proven false. So why lie?**

- ***Why care? The evidence undeniably implicates Dr. Fauci's knowledge and involvement (including the proximal origin paper), and he indirectly continues to help inform policy in Canada.***

- It is likely impossible to wrap your head around what I am saying unless you see his duplicity for yourself. For a succinct, fact-based video of what we know for sure, including his own Senate testimony around his leaked emails at that time, please watch: https://www.theepochtimes.com/five-questions-for-fauci-truth-over-

news_3941146.html?&utm_medium=TruthOverNews&utm_source=EET&utm_campaign=FiveQ%20&utm_content=8-13-2021

- Alternatively, Tyler Durdin who wrote the ZeroHedge article above on the virus origins, outlines the Fauci emails and ties to the Wuhan Institute of Virology, with embedded links to original documents and his emails here: https://www.zerohedge.com/covid-19/emails-reveal-how-influential-articles-established-covid-19-natural-origins-theory-were

- If you watched the video, it is difficult to conclude that his actions can be dismissed by ignorance or incompetence. But even if you give him the benefit of the doubt, ***how has he maintained his job and remained a guiding voice in the context of these past actions and clear personal and financial conflicts of interest?***

Example 2: Nobel Prize winning French Virologist, Professor Luc Montagnier

- There are several impressive experts, including Professor Montagnier, who stated that **the COVID-19 vaccine is creating variants and NOT the unvaccinated.** He also **warned about the risks of trying to vaccinate everyone DURING a pandemic,** as you risk secondarily causing harm by perpetuating **antibody dependent enhancement**.

Please listen to the brief 2.5 min video link here: (https://www.youtube.com/watch?v=RZGuTNhNxOE)

****Not surprisingly, when I reviewed this letter to ensure all links worked, this video had been removed from YouTube for violating their platforms rules. It disappeared within 24 hr of grabbing the link. So, I found the video again on Vimeo and copied it with Camtasia. I can provide it to you if interested. ****

- As described, there is evidence emerging for ADE and Delta, but **regardless of whether Prof Montagnier proves to be correct –** the censorship is egregious. Science is about debate, especially during times of uncertainty. While I doubt, I would agree with everything Prof. Montagnier has said or done in his life, to censor the 2008 Nobel Laureate in Virology who helped to discover HIV, at a time when we are dealing with the novel pandemic and all its uncertainty, seems unbalanced. Given the seriousness of this issue - ***prove him wrong, do not censor!***

- It was not just that his videos were removed, BUT WORSE - a demonstrable lie was created on the internet and perpetuated in the media, stating that during the interview he also claimed everyone who took the mRNA vaccines would be dead in 2 years. He never said this, and yet there it remains as the prominent narrative on most internet search engines.

- ***Consider that while big tech and social media are still aggressively removing any video link to Prof. Montagnier's comments without evidence to dispute his claims, they are continuing to proliferate the character assignation lie on their platform that discredits him.***

- *Censoring facts and reasonable expert opinion* ***to prevent vaccine hesitancy, is coercive and unscientific nonsense***.

Example 3: Dr. Robert Malone, co-inventor of mRNA vaccine technology

If you search in Google for Dr. Robert Malone, who holds multiple patents for mRNA vaccine technology, you will find that his provable accomplishments are discredited. They state he is an "antivaxxer" and zealot seeking media attention.

I have listened to Dr. Robert Malone speak during numerous interviews, and thus far have found him to be balanced scientifically, insightful, and sharing genuine concern with our course of action. He is not an antivaxxer, he has himself taking the mRNA vaccines but cautions about their widespread use during a pandemic, especially among low-risk groups. *Pease judge for yourself - even if you only watch the first 15 minutes of Part II* where he responds to the criticism and censorship.

2) Epoch TV, American Thought Leaders, September 2, 2021, interview with Dr. Robert Malone discussing the latest covid-19 data, booster shots and the shattered scientific consensus. Link to full PART 1 video: https://www.theepochtimes.com/dr-robert-malone-mrna-vaccine-inventor-on-latest-covid-19-data-booster-shots-and-the-shattered-scientific-consensus_3979206.html

3) Epoch TV, American Thought Leaders, September 4, 2021, interview with Dr. Robert Malone on ivermectin, escape mutants, and the faulty logic of vaccine mandates. Link to full PART 2 video: https://www.theepochtimes.com/part-2-dr-robert-malone-on-ivermectin-escape-mutants-and-the-faulty-logic-of-vaccine-mandates_3981859.html

10) Without a mRNA vaccine, DOES MY RISK TO PATIENTS increase?

- The mRNA vaccine effectiveness has decreased significantly to SARS-CoV-2. The fully vaccinated can transmit SARS-CoV-2, have similar or higher viral loads compared to the unvaccinated, and are comprising an ever-growing proportion of the symptomatic patients, including need for hospitalization and critical illness support.

- To estimate my current risk to pediatric patients with or without vaccine, consider that to date, 5.98% of Albertans have had COVID-19 (264,539 cases/divided by 4,421,876 total AB population). So, my risk of SARS-CoV-2 infection is about 6% every 12-18 months (but this could increase or decrease). *I would have to be a pre-symptomatic spreader since I would not come to work with symptoms, and if I developed symptoms I would get tested.* Assume 50% of all transmission is from pre-symptomatic individuals, so now the risk of catching the virus and spreading pre-symptomatically drops to 3% every 12-18 months. Then you consider all the handwashing, gloving, and PPE that I abide by, and my risk of transmission decreases further. I do not know by what factor all this PPE and hand hygiene lower my risk, but I would think substantially, perhaps even to 1% or less? If you multiply that by the child's starting absolute risk using the U.S. State data - *of all child COVID-19 cases* - 0.1-1.9% hospitalizations, and 0.00-0.03% death (41) - ***that suggests a hospitalization risk = 0.01 – 0.19%, and mortality = 0.00 – 0.0003%, every 12-18 months.***

CONCLUSIONS

Please judge the data and interviews for yourself and open your mind to the possibility that the blatant medical censorship is negatively impacting our profession, and our ability to make informed policy! Recall that we are living during a time when original articles in Lancet and the New England Journal of Medicine regarding COVID-19 treatment are being retracted because they were completely fabricated (80, 81).

While I grew to respect and trust long-standing health organizations like the WHO and CDC, financial and political interests have crippled their independence, and during this pandemic, they have egregiously misrepresented facts and helped to censor scientific experts worldwide. This is not surprising, as it has been proven in court that WHO did not act ethically during the 2009 H1N1 swine flu "pandemic" when it came to their global vaccine agreements (82). These organizations that inform Canada health policy are completely compromised by vaccine and big pharma interest money. Unfortunately, we can no longer rely on the global media cabal to be independent and forthcoming. Consider CDC Director Dr. Rochelle Walensky's July 16, 2021, declaration that we are facing "a pandemic of the unvaccinated" (83) which perpetuated unneeded societal hatred and division, seemed backwards scientifically, and is now contradicted by the global epidemiology as you have read.

Consider that 20-40% of vaccine eligible individuals living in countries with high mRNA vaccine availability like Canada, still REFUSE to take the jab, including many healthcare workers worldwide (84). As this is despite the enormous social backlash, despite the ongoing confusion & hatred received by others including family members, and despite being faced with ongoing and constantly increasing punitive restrictions including the inability to travel, visit family, enjoy a meal at restaurant, and EVEN earn a living. In my case, after 18 years of medical training and a highly specialized consultancy practice, and despite my informed medical decision, I either capitulate to medical tyranny or leave a dream job at the Alberta Children's Hospital (via the AHS mandate). I strongly urge you to fight back against this wave of medical tyranny and NOT mandate forced mRNA vaccinations among those remaining physicians who have made the informed medical choice to abstain.

Thank you for taking the time to read this. Please don't hesitate to contact me should you have any questions or concerns with the presented data. I would welcome the opportunity to discuss further. If nothing else, I hope that as you listen to the media and officials prospectively over the next few weeks to months, you consider if what they are saying aligns with the existing scientific data.

Yours Sincerely,

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REFERENCES

1. https://www.cdc.gov/vaccines/vac-gen/imz-basics.htm
2. Canadian Charter of Rights and Freedoms: https://www.canada.ca/content/dam/pch/documents/services/download-order-charter-bill/canadian-charter-rights-freedoms-eng.pdf.
3. Bill 10 Public Health (Emergency Powers) Amendment Act, 2020. The legislative Assembly of Alberta: https://www.qp.alberta.ca/Documents/AnnualVolumes/2020/ch05_2020.pdf.
4. Shuster E. Fifty years later: The significance of the Nuremberg code. New England Journal of Medicine. 1997; 337:1436-1440.
5. Polack FP, Thomas SJ, Kitchin N, et al. Safety and Efficacy of the BNT162b2 mRNA Covid-19 vaccine. New England Journal of Medicine. 2020;383(27):2603-2615.
6. Product monograph, Pfizer-BioNtech COVID-19 vaccine. https://covid-vaccine.canada.ca/info/pdf/pfizer-biontech-covid-19-vaccine-pm1-en.pdf
7. Baden LR, El Sahly HM, Essink B, et al. Efficacy and Safety of the mRNA-1273 SARSCoV-2 Vaccine. New England Journal of Medicine. Published online Dec 30, 2020. doi:10.1056/NEJMoa2035389
8. Product monograph, Moderna COVID-19 Vaccine. https://covid-vaccine.canada.ca/info/pdf/covid-19-vaccine-moderna-pm-en.pdf
9. Scialo et al. ACE2: The major cell entry receptor for SARS-CoV-2. Lung. Nov 2020. **https://doi.org/10.1007/s00408-020-00408-4**
10. Shifting from pandemic to endemic. https://www.alberta.ca/assets/documents/health-covid-19-pandemic-to-endemic.pdf
11. Canada COVID-19 statistics. https://covid19tracker.ca/vaccinationtracker.html
12. Alberta government COVID-19 statistics. https://www.alberta.ca/covid-19-alberta-data.aspx
13. Hannah Ritchie et al., 2020. - "Coronavirus Pandemic (COVID-19)". *Published online at OurWorldInData.org.* Retrieved from: 'https://ourworldindata.org/coronavirus' [Online Resource].
14. Belongia & Naleway. Smallpox vaccine: the good, the bad, and the ugly. Clinical Medicine and Research. 2003: 1 (April): 87-92.
15. Palmer et al. Susceptibility of White-Tailed Deer (Odocoileus virginianus) to SARS-CoV-2. Journal of Virology. June 2021. 95(11): 1-16.
16. Le Bert N, et al. SARS-CoV-2-specific T cell immunity in cases of COVID-19 and SARS, and uninfected controls. Nature. August 20, 2020. Vol 854.
17. Puranik A, Lenehan PJ, Silvert E, et al. Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence. [Preprint posted online August 9, 2021]. https://www.medrxiv.org/content/10.1101/2021.08.06.21261707v2
18. Holmes et al. Understanding the mechanisms and drivers of antimicrobial resistance. Lancet 2016: 387:176-87.
19. Krause et al. SARS-CoV-2 variants and vaccines. New England Journal of Medicine. Jun 23 2021. DOI: 10.1056/NEJMsr2105280

20. Delta infection resulted in similar viral loads in vaccinated and unvaccinated individuals. Statement from CDC Director Rochelle P. Walensky, Friday July 30, 2021. https://www.cdc.gov/media/releases/2021/s0730-mmwr-covid-19.
21. CDC Director - pandemic of the unvaccinated. https://www.cnn.com/2021/08/05/health/us-coronavirus-thursday/index.html
22. CDC Joint statement from HHS public health and medical experts on covid-19 booster shots. Wednesday August 18, 2021. https://www.cdc.gov/media/releases/2021/s0818-covid-19-booster-shots.html
23. Nanduri S, Pilishvili T, Derado G, et al. Effectiveness of Pfizer-BioNTech and Moderna Vaccines in Preventing SARS-CoV-2 Infection Among Nursing Home Residents Before and During Widespread Circulation of the SARS-CoV-2 B.1.617.2 (Delta) Variant — National Healthcare Safety Network, March 1–August 1, 2021. MMWR Morb Mortal Wkly Rep 2021;70:1163-1166. DOI: http://dx.doi.org/10.15585/mmwr.mm7034e3
24. https://www.who.int/news-room/feature-stories/detail/vaccine-efficacy-effectiveness-and-protection.
25. FDA development and licensure of vaccines to prevent covid-19 guidance for industry. https://www.fda.gov/media/139638/download
26. Seppala E, et al. Vaccine effectiveness against infection with the Delta (B.1.617.2) variant, Norway, April to August 2021. Euro Surveill. 2021;26(35). https://doi.org/10.2807/1560-7917.ES.2021.26.35.2100793.
27. https://www.forbes.com/sites/roberthart/2021/07/23/pfizer-shot-just-39-effective-against-delta-infection-but-largely-prevents-severe-illness-israel-study-suggests.
28. https://www.science.org/news/2021/08/grim-warning-israel-vaccination-blunts-does-not-defeat-delta
29. https://www.cnn.com/2021/08/27/politics/booster-shot-interval-biden/index.html
30. Gaebler C et al., Evolution of antibody immunity to SARS-CoV-2, Nature. 2021 March; 591(7851): 639-644.
31. Gazit et al. Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections. Pre-print at: https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1
32. Reinfection rates Israel. https://www.israelnationalnews.com/News/News.aspx/309762
33. Jain, S et al. COVID-19 vaccination-associated myocarditis in adolescents. Pediatrics. 2021. DOI: 10.1542/peds.2021-053427
34. Ogata et al. Circulating severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) vaccine antigen detected in the plasma of mRNA-1273 vaccine recipients. Clinical Infectious Diseases. 2021;XX(xx):1-4. DOI: 10.1093/cid/ciab465
35. Cines DB & Bussel JB. SARS-CoV-2 Vaccine-Induced Immune Thrombotic Thrombocytopenia. New England Journal of Medicine. 2021. 384;23.
36. Verdecchia et al. The pivotal link between ACE2 deficiency and SARS-CoV-2 infection. European Journal of Internal Medicine. 2020. 76:14-20. https://doi.org/10.1016/j.ejim.2020.04.037.
37. Zhang et al. SARS-CoV-2 crosses the blood-brain barrier accompanied with basement membrane disruption without tight junctions alteration. Signal Transduction and Targeted Therapy. 2021. 6:337. https://doi.org/10.1038/s41392-021-00719-9.
38. Rhea et al. The S1 protein of SARS-CoV-2 crosses the blood-brain barrier in mice. Nature Neuroscience. Mar 2021. Vol 24: 368-378.
39. Pfizer Japan biodistribution rat studies: https://www.dropbox.com/home?preview=Pfizer_ovaries_study_in_English.pdf

40. Bojkova et al., Proteomics of SARS-CoV-2-infected host cells reveals therapy targets. Nature. 2020 Jul;583(7816):469-472.
41. Sharma et al. Comparative transcriptomic and molecular pathway analyses of HL-CZ human pro-monocytic cells expressing SARS-CoV-2 spike S1, S2, NP, NSP15 and NSP16 genes. Microorganisms. 2021, 9(1193): 1-27.
42. Idrees D & Kumar V. SARS-CoV-2 spike protein interactions with amyloidogenic proteins: Potential clues to neurodegeration. Biochemical and Biophysical Research Communication. 2021. 554:94-98.
43. Children and COVID-19: State Data Report. A joint report of the American Academy of Pediatrics and the Children's Hospital Association. Version 9/2/21. https://downloads.aap.org/AAP/PDF/AAP%20and%20CHA%20-%20Children%20and%20COVID-19%20State%20Data%20Report%209.2%20FINAL.pdf
44. Lu et al. SARS-CoV-2 infection in children. New England Journal of Medicine. 382;17. Apr 2020. DOI: 10.1056/NEJMc2005073
45. Feldstein et al. Multisystem inflammatory syndrome in U.S. Children and Adolescents. New England Journal of Medicine. July 23, 2020. 383(4): 334-346.
46. Lin J, et al. Neurological issues in children with COVID-19. Neuroscience Letters. 743(2021) 135567.
47. https://www.aappublications.org/news/2021/09/03/covid-delta-variant-children-hospitalizations-090321
48. Heavey et al. No evidence of secondary transmission of COVID-19 from children attending school in Ireland, 2020. Euro Surveill. 2020;25(21):pii=2000903.
49. Gudbjartsson DF et al. Spread of SARS-CoV-2 in the Icelandic population. New England Journal of Medicine. 2020; (April):14. PMID: 32289214.
50. Lavezzo et al. Suppression of COVID-19 outbreak in the municipality of Vo, Italy. medRxiv.
51. Lachassine et al. SARS-CoV-2 transmission among children and staff in daycare centres during a nationwide lockdown in France: a cross-sectional, multicentre, seroprevalence study.
52. COVID-19 in schools and early childhood education and care services – the Term 3 experience n NSW. https://www.ncirs.org.au/sites/default/files/2020-10/COVID-19%20Transmission%20in%20educational%20settings%20in%20NSW%20Term%203%20report_0.pdf
53. https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vaers/index.html
54. https://www.cdc.gov/vaccines/hcp/patient-ed/conversations/downloads/vacsafe-vaers-color-office.pdf
55. Lazarus et al. Electronic support for public health – vaccine adverse event reporting system (ESP:VAERS) https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf
56. Moro et al. Death Reported to the Vaccine Adverse Event Reporting System, United States, 1997-2013. Clinical Infectious Disease. September 2015; 61(6): 980-987.
57. https://www.ronjohnson.senate.gov/2021/8/sen-johnson-to-federal-health-agencies-expediting-approval-process-appears-to-serve-the-political-purpose-of-imposing-and-enforcing-vaccine-mandates
58. CDC and rotavirus vaccine. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5334a3.htm
59. Dr. Fauci comments re vaccine in kids. https://www.cnn.com/2021/08/30/health/us-coronavirus-monday/index.html
60. https://www.webmd.com/vaccines/covid-19-vaccine/news/20210722/children-covid-vaccine-within-months-biden

61. "2 top FDA officials resigned over the Biden administrations booster-shot plan, saying it insisted on the policy before the agency approved it, reports say. https://news.yahoo.com/2-top-fda-officials-resigned-103227868.html
62. https://www.huffingtonpost.co.uk/entry/jcvi-childen-covid-12-15_uk_613231c7e4b0aac9c0165142
63. "COVID-19 Vaccines and Kids" link at www.19toZERO.ca https://drive.google.com/file/d/17cuUHAFhotVNipLtdAkHIQw4GfP72dUG/view.
64. Dr. Martin Kulldorff (Harvard), Dr. Sunetra Gupta (Oxford) and Dr. Jay Bhattacharya (Stanford). Great Barrington Declaration. 2020. https://gbdeclaration.org/
65. Epoch TV, American Thought Leaders, August 10, 2021, interview with Dr. Martin Kulldorff. Link to full video: https://www.theepochtimes.com/harvard-epidemiologist-martin-kulldorff-on-vaccine-passports-the-delta-variant-and-the-covid-public-health-fiasco_3942556.html **(Instead of fact checking or using Wikipedia – please listen to Dr. Kulldorff speak!)**
66. Wan et al., Molecular mechanisms for antibody-dependent enhancement of coronavirus entry. Journal of Virology. March 2020, Volume 94 (5) e02015-19.
67. Lee et al., Antibody-dependent enhancement and SARS-CoV-2 vaccines and therapies. Nature Microbiology. Oct 2020, Vol 5. 1185-1191.
68. Vennema et al. Early death after feline infectious peritonitis virus challenge due to recombinant vaccinia virus immunization. Journal of Virology. Mar 1990. 64(3): 1407-1409.
69. Liu L et al. Anti-spike IgG causes severe acute lung injury by skewing macrophage responses during acute SARS-CoV infection. JCI Insight. 2019. 4:e123158.
70. Wang Q et al. Immunodominant SARS coronavirus epitopes in humans elicited both enhancing and neutralizing effects on infection in non-human primates. ACS Infectious Disease. 2016. 2:361-376.
71. Tseng et al. Immunization with SARS coronavirus vaccines leads to pulmonary immunopathology on challenge with the SARS virus. PLOS one. 2012. 7(4): e35421.
72. Luo F et al. Evaluation of antibody-dependent enhancement of SARS-CoV infection in rhesus macaques immunized with an inactivated SARS-CoV vaccine
73. Qin et al. Immunogenicity and protective efficacy in monkeys of purified inactivated Vero-cell SARS vaccine. Vaccine. 2006. 24:1028-1034.
74. Chau N, et al. Transmission of SARS-CoV2 Delta variant among vaccinated healthcare workers, Vietnam. Lancet preprints. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3897733
75. Yahi N, et al. Infection-enhancing anti-SARS-CoV-2 antibodies recognize both the original Wuhan/D6414G strain and Delta variants. A potential risk for mass vaccination? Journal of Infection. Pre-print. On-line August 16, 2021. https://www.journalofinfection.com/action/showPdf?pii=S0163-4453%2821%2900392-3
76. https://www.acsh.org/news/2021/06/03/covid-19-origins-debate-undermines-case-social-media-censorship-15580
77. https://www.ibtimes.sg/france-opposes-nobel-winning-scientist-luc-montagniers-claim-about-coronavirus-origin-wuhan-lab-43325
78. Andersen K et al. The proximal origin of SARS-CoV-2. Nature Medicine. April 2020. Vol 26. 450-455.
79. Yan L-M, Kang S, Hu S. Unusual features of the SARS-CoV2 genome suggesting sophisticated laboratory modification rather than natural evolution and delineation of its probable synthetic route. Available on Research Gate Sept 2020 here: https://www.researchgate.net/publication/344240007_Unusual_Features_of_the_SARS-CoV-2_Genome_Suggesting_Sophisticated_Laboratory_Modification_Rather_Than_Natural_Evolution_and_Delineation_of_Its_Probable_Synthetic_Route

80. RETRACTED - Mehra et al., Hydroxychloroquine or chloroquine with or without a macrolide for treatment of COVID-19: a multinational registry analysis. Lancet. May 22, 2020.
81. RETRACTED – Mehra M., et al. Cardiovascular disease, drug therapy, and mortality in covid-19. New England Journal of Medicine. June 25, 2020; 382:2582.
82. "Trust WHO" documentary film featuring 7-year investigation into the independent practices of the WHO and infiltration of non-public money. Directed by Lilian Franck. Highlights the 2009 H1NI flu pandemic. Film allegations were proven in court, yet YouTube continues to censor the film. 9 min video trailer link https://www.youtube.com/watch?v=9MvB5hoIQok. (If link removed, search for "vimeo removes our film "trustWHO").
83. Walensky warns of "pandemic of the unvaccinated". Friday July 16, 2021. https://www.reuters.com/video/watch/idOVEM3I9R3.
84. Provides link to multiple MSM stories and videos of healthcare workers globally refusing the mRNA shots. https://truthref.wordpress.com/2021/02/19/many-healthcare-workers-worldwide-are-refusing-the-covid-vaccine-let-that-sink-in/