The War on Reality

As the mainstream narrative about the origin of COVID-19 falls apart, it's time to put other widely accepted facts about the virus—and the devastating measures they were used to justify—under the same scrutiny

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On March 13, 2020, the public school district where I teach announced that all classrooms and buildings would be closed for two weeks. Then two weeks turned into two months, and two months turned into over a full year without in-person instruction. My school serves a diverse population of low-income students in the San Francisco Bay Area. It is impossible to overstate the severity of this disruption caused by school closures for these students, many of whom did not have a computer or internet at home when virtual learning began. Online, my students got only a fraction of the regular curriculum. Kids who had once loved the social aspects of school were left with only the parts of school they hated, and students with disabilities who depended on school for daily living needs were cut off from a vital service.

"Public health" and "the safety of our children" came to mean students Zooming from homeless encampments, experiencing severe abuse, regressing academically, falling into depression, going hungry, struggling through catastrophic learning loss, and, in the saddest cases, not making it through the year alive. Despite consistent evidence that schools were not sites of high

transmission for COVID-19, many teachers failed to put aside baseless fears about classroom superspreading and rampant infection. As a result, many of the most vulnerable children in our society suffered outrageous hardships, while their affluent peers attended private schools in person. We've all been told that school closures and lockdowns were mandated by science, but what if these mandates were immoral? What if they were based on a series of lies? In fact, what if the entire rationale for most restrictions was actually rotten to the core?

We're watching the mainstream pandemic narrative starting to unravel. While the Senate and House intelligence committees investigate the origins of SARS-CoV-2, many reporters are openly wondering why they initially dismissed the lab leak hypothesis as "misinformation." Few in media consider the possibility that their approach to the theory was not an anomaly, but rather a long-established pattern of journalistic dereliction of duty. For the public, these renewed questions about the virus (and their hard-to-face answers) speak to a deep sense that something is amiss in the story we've been told by major media outlets. But gain-of-function research is just the tip of the iceberg.

A trove of media darling Dr. Anthony Fauci's emails was recently released to the public. The emails reveal early assertions that asymptomatic transmission is rare, that post-infection immunity is highly likely, and that masks are "not really effective." However, you wouldn't know that from the public messaging since the start of the pandemic, in which bureaucrats and journalists upheld lasting misconceptions that asymptomatic cases are dangerous, natural immunity is not a factor in

protecting the population, and individuals are responsible for viral spread. These misconceptions fueled countless months of lockdowns, business closures, and job losses, pushing millions of people into poverty and despair through the destructive lie that stringent "sick until proven healthy" interventions save lives.

In reality, the rushed doomsday forecasts and commitment to politically correct pseudoscience prompted leaders to abandon decades of pandemic planning. This not only had disastrous economic consequences, but it also exacerbated the effects of COVID-19 itself. And rather than swiftly correct their errors, public health officials and politicians doubled down, manipulated data, and blamed ordinary people for the failure of nonsensical policies. The uncomfortable truth is that "The Science" did not protect vulnerable populations. Instead, "expert" advice served only to make the pandemic more deadly and replace the scientific process with destructive anti-science.

Saving Lives by Killing People

In December 2020, 35% of Americans believed that half of the people with COVID-19 required hospitalization. The correct figure was 1%-5%. Americans also estimated that the share of COVID-19 deaths for people between 18 and 24 was 8%. It was actually 0.1%. These incorrect assumptions were influenced by anecdotes, shocking media coverage, and early projections like the influential Imperial College model, which threatened that without lockdowns there would be 40 million COVID-19 deaths worldwide. The model assumed an infection fatality rate (IFR) of 0.9%, but the actual IFR of COVID-19 is 0.15% and the median IFR for people under 70 is 0.05%.

As a result of mistaken prognostications like this, the media compared COVID-19 to the 1918 influenza pandemic, for which the average age of death was 28. For COVID-19 the average age of death is 73, and about half of all deaths are in people 80 or older. While the CDC projected a one-year decrease in life expectancy for the U.S. population, the overall decrease in life expectancy was only five days, and the U.S.'s excess mortality in 2017 was greater than its excess mortality in 2020.

There is no better example of the harm created by flawed simulations, and the subsequent misguided interventions, than New York's disastrous nursing home policy. While Gov. Andrew Cuomo landed a $5 million book deal and won an Emmy for his televised briefings, conditions on the ground for COVID-19 patients in his state were catastrophic. Over 9,000 elderly COVID-19 patients were sent from hospitals back to nursing homes. Additionally, Cuomo required group homes for people with intellectual disabilities to take COVID-19 patients and attempted to issue a blanket DNR guideline for all cardiac patients in New York City. He also denied nursing homes' requests for testing kits, ignored the concerns of families, and gave immunity to nursing home executives. This resulted in the deaths of nearly 15,000 long-term-care patients.

These deaths did not occur because Cuomo ignored scientists and researchers. They occurred precisely because Cuomo was adhering to predictions from his team of experts who projected the need for 140,000 hospital beds and 40,000 ICUs. Ultimately, New York's actual bed and ICU use peaked in mid-April at 18,825 and 5,225, respectively. The deadly decisions the governor's office made were motivated by a perceived need to save resources and

space—a manufactured imperative based on fictitious IFR figures and a baseless belief in universal risk.

Moreover, although some New York hospitals were overwhelmed, many were not. While Elmhurst hospital in Queens was at full capacity in April, the hospital had 26 new ambulances to take patients to 3,500 empty beds in New York City, many within a 20-minute drive. Because of panic induced by horrific forecasts, New York City doctors cited the need for "wartime ethics" when advising patients and families about DNRs. At some hospitals, doctors were informally allowed to override patients' desires for medical intervention. These ethical violations were urged on by crazed media coverage and an environment of psychological terror, but they were not justified by the true level of danger involved in treating patients.

Despite concerns about hospital beds and ICUs, field hospitals across the country remained largely empty, costing taxpayers $660 million despite the fact that most of them did not serve any patients. Cuomo's nursing home order was replicated by four other Democratic governors, and one-third of all American deaths from the virus are now linked to nursing homes. As a consequence of these practices, New York State has the second-highest COVID-19 mortality rate in the country.

Following the Science

Three of the top four states in overall COVID-19 mortality have Democratic governors who "followed the science" long after the initial promises that it would only take "two weeks to flatten the curve." Although these states have high population density, density is often associated with lower COVID-19 death rates. After Texas

Gov. Greg Abbott lifted all his state's restrictions in April, Texas saw no resulting surge in cases, hospitalizations, or deaths. In fact, many states that continued restrictions saw higher cases and deaths than states that lifted restrictions early.

These trends are consistent with dozens of peer-reviewed studies and retrospective analyses indicating that stay-at-home orders did not have an impact on rates of fatal infection and that comparisons between many countries do not show superior outcomes from lockdowns. Besides hospitals, nursing homes, and other health care settings, households show some of the highest rates of transmission, while the share of transmission that has happened outdoors is less than 0.1%. Furthermore, vitamin D and exercise have both been linked to better outcomes for COVID-19 patients. In the U.S. 78% of people hospitalized for COVID-19 were overweight or obese. Lockdowns caused Americans to gain an average of two pounds per month and reduce their daily steps by 27%, thereby increasing the likelihood of adverse COVID-19 outcomes.

Not only were government orders confining people to their homes highly detrimental, but the early recommended treatment procedures for the virus were often fatal. Although experts and the media claimed that ventilators were lifesaving, death rates in most states actually dropped dramatically once the use of ventilators was abandoned in favor of other treatments. In order to meet what was supposed to be an astronomical medical demand, the U.S. spent $3 billion manufacturing ventilators, but by August 2020, the Department of Health and Human Services

had distributed only 15,057 ventilators, leaving 95,713 of them untouched in a federal stockpile.

Usually, 40%-50% of patients in severe respiratory distress die on ventilators, but in New York City the death rate for COVID-19 patients on ventilators was 88%. Hospital staff often intubated patients prematurely or left them on ventilators for 10-15 days. Patients were given unusually heavy sedatives so that staff would be able to check on them less frequently. U.S. hospitals received $13,000 for each Medicare COVID-19 patient and $39,000 for each Medicare patient they intubated. These patients were separated from their families and had no one to advocate for them. Many people died after terrified doctors, misinformed about the scale of the risks, used intubation as a way to avoid virus exposure.

When lockdowns began, commentators referred to herd immunity as a "genocidal" concept that meant exposing vulnerable people to disease. That is actually what happens when natural immunity is prevented. Lockdowns limit and delay the acquired immunity of the younger population, making older people more vulnerable to exposure, especially in the absence of focused protection measures. Long-lasting immunity from COVID-19 is acquired after mild or asymptomatic cases, and sensational stories about "long COVID" and "COVID heart" have been debunked. In-person learning was not correlated with higher rates of student illness and school closures may have actually worsened death rates.

Clearly, quarantining the healthy did exactly the opposite of what was sold to the public: It increased non-COVID-19 excess deaths while leaving elderly and immunocompromised people completely unprotected. While some may excuse the

destructiveness of lockdowns as a simple error, the sheer volume of reversals public health officials have made during the pandemic paints a picture of bureaucrats intentionally misleading the public in order to cover up their failures or pursue agendas unrelated to public health.

Moving the Goal Posts

Experts have consistently taken an imprecise approach to statistics, changed their minds, and withheld information while claiming the mantle of "scientific consensus." Over the summer of 2020, the WHO quietly changed its definition of herd immunity from protection acquired through both natural immunity and vaccination to one acquired only through vaccination. Similarly, in December 2020, Fauci declared that he was changing his estimate for vaccination rates needed to achieve herd immunity from 60% to 90%. When asked for a scientific rationale, Fauci said he changed the percentage based purely on polling that indicated more Americans were willing to take the COVID-19 vaccine.

When lockdowns failed to yield meaningful mitigation results, public health agencies that had previously recommended against masking changed their position. Although simulations suggested that 80% mask compliance would do more to stop the spread of COVID-19 than lockdowns, regional analysis in the United States does not show that mandates had any effect on case rates, despite 93% compliance. Moreover, according to CDC data, 85% of people who contracted COVID-19 reported wearing a mask.

Research has shown that once unquestioned rules like 6 feet for social distancing are arbitrary and not actually associated with lower transmission. Reporting of death and hospitalization rates was also inexact, and mass asymptomatic testing distorted public understanding of the virus. Ninety-five percent of COVID-19 deaths had an average of four related underlying conditions and the CDC's death count includes "deaths involving unintentional and intentional injury." As a result of testing children hospitalized for unrelated conditions, the number of pediatric COVID-19 hospitalizations was exaggerated by at least 40%.

The PCR testing protocol for COVID-19 was based on a paper by Christian Drosten, which was peer-reviewed and published within just two days in a journal on whose editorial board Drosten sits. The method was created "without having virus material available," using instead a genetic sequence published online. The PCR test amplifies genetic material of the virus in cycles but does not determine whether a case is infectious. A higher number of cycles indicates a lower viral load. The cycle threshold for PCR tests used in the U.S. was usually limited at 37 or 40, highly sensitive levels. In July 2020, Fauci remarked that at these levels, a positive result is "just dead nucleotides, period."

For vaccinated Americans, the CDC has lowered the cycle threshold for "breakthrough infections" to only 28 cycles and announced that post-vaccine cases will only be counted if they result in hospitalization or death. CDC Director Rochelle Walensky stated that vaccinated Americans who died and tested positive for COVID-19 merely died "with" COVID-19, not "from" COVID-19. This method of tallying would eliminate many pre-vaccine cases. It is also likely that 85%-90% of tests that are

positive at a cycle threshold of 40 would be negative at a cycle threshold of 30.

Despite this lack of accurate data, authorities have consistently scapegoated members of the public as “anti-maskers” or “anti-vaxxers” responsible for prolonging the pandemic. They have used divisive messaging and disorienting scare tactics in order to justify months of COVID-19 restrictions that were based on dogma, not on science.

Scientific Inversion

Our current state of scientific inversion has sown intense division in the U.S. and threatens to rip apart the social fabric. For the past 16 months, the public has been told that it is our duty to serve the needs of medical institutions and personnel, not the other way around. Effective low-cost therapeutics like ivermectin were dismissed in favor of a vaccine program that transferred billions of dollars from taxpayers to pharmaceutical executives and shareholders. Critics of measures like school closures were accused of far-right white supremacy, even though these measures were most damaging to working-class people and minorities. Deadly policies were portrayed as lifesaving, and public health protocols caused immense clinical damage.

A few people have benefited from this war on reality while many have paid a heavy price. In 2020, workers lost $3.7 trillion, while billionaires gained $3.9 trillion and 493 new individuals became billionaires. During this same period, decades of progress against diseases like malaria and tuberculosis were reversed. Disruptions to health and nutrition services

killed 228,000 children in South Asia. Globally, the impact of lockdowns on health programs, food production, and supply chains plunged millions of people into severe hunger and malnutrition.

In the U.S., we are facing a crisis of cardiovascular disease and undiagnosed cancer. Unemployment shock will cause 890,000 additional deaths over the next 15 years. Overdoses from synthetic opioids increased by 38.4%, and 11% of U.S. adults considered suicide last June. Three million children disappeared from public school systems, and ERs saw a 31% increase in adolescent mental health visits.

Now, the stories that were used to justify these hardships are continuing to unravel. Many of the people responsible will insist that the second-order consequences are the horrible symptoms of a magic virus and that the mistakes made in handling such a crisis were inevitable. But preventing young children from reaching crucial developmental milestones in the face of mounting evidence is not just a "mistake." Forcing hospital patients to die alone without saying goodbye to their families is not just a "mistake." Pushing millions of people into poverty and starvation is not just a "mistake." These are crimes.

Basic civil, human, and economic rights were violated under demonstrably fraudulent pretenses. The sacrifices we thought we were making for the common good were sacrifices made in vain. Unlawful lockdowns demoralized the population and ruined lives. The tragic reality is that this was all for nothing. The only way to prevent these events from recurring is to exhaustively investigate not just the origin of the virus, but every corrupt and misguided decision made by politicians, NGOs, public health

organizations, and scientific institutions made since its fateful emergence.

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