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# Dear Doctor, Health Professionals and Fellow Australians

Monday 2nd August 2021

- https://covidmedicalnetwork.com/open-letters/first-do-no-harm.aspx [1]
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We, your fellow doctors, write to you motivated only by our concern for the welfare of our patients and the health of our community.

Every doctor, like any individual, must answer to their own conscience. Doctors in particular must answer to an Oath, the swearing in of which has fallen away, yet not without leaving its spirit alive. This oath was, and is, founded upon "primum non nocere" or "first do no harm".

And so this letter is aimed at reminding all doctors of our ethical obligations and to furnish our consciences with information so that none can claim "I did not know" or "I was wrongly advised" or "I was just following orders".

The people of Australia face unprecedented, pervasive and coercive "States of Emergency" with severe restrictions to liberty and widespread impacts on health, life and livelihoods. "Flattening the curve" for a few weeks has become 18 months of fear, anxiety and control. Much of it unnecessarily contrived through sensationalist media, failed political leadership that has abrogated its responsibilities to academic and health bureaucrats who appear far removed from the realities and sufferings of ordinary Australians.

In early 2020, the Australian government, following the example of other countries, and the sudden aboutturn of the World Health Health Organisation (WHO), abandoned long-established and existing pandemic guidelines in favour of enforced lockdowns, mask mandates, mass-testing, digital surveillance, border closures and the quarantining of the healthy. This approach was novel, untested and unprecedented.

We have had multiple on-again/off-again lockdowns, mask "mandates", the coercion and mandating of novel and unproven vaccine technology, invasions to privacy in the forms of QR check-in codes and severe economic stress. In the reckless pursuit of the mirage of an unattainable 'Covid Zero' state, 400 Australians die every day from all causes. These Australians are dying within a grossly disrupted heath care system and while their loved ones are inhumanely denied the opportunity to properly mourn them.

Whilst in 2021 to the 23rd of July, we had five registered deaths attributed to Covid 19.

Put simply, we have focussed on one disease to the exclusion of all others. This global public health experiment has clearly failed, having caused untold harm to literally billions of people.

A return to long established, evidenced-based pandemic preparedness guidelines must now be urgently sought.

**Some Useful Documents:**

A Protocol for Re-opening Society

A Critical Analysis of the Covid Response
Responding to Covid: Public Health or Public Harm

## LOCKDOWNS

The collateral damage from lockdowns is clear; significant harm is being inflicted upon humanity, and devastating health and wellbeing across the globe. Vulnerable and disadvantaged communities, and especially children, are paying the highest price. Evidence suggests lockdowns have not reduced mortality from COVID-19, and they provide little benefit over less restrictive measures. In addition, there are grave concerns lockdowns may ultimately result in a longer and more lethal pandemic, with many unforeseen and unintended health consequences.

## CASES AND PCR TESTS

Every medical student is taught that clinical diagnosis is founded upon three unshakable tenets. History, Examination, Investigation in that order of hierarchical importance. With the unprecedented utilisation of PCR based diagnosis in the interest of public health and mass screening, the doctor and the issue of symptomatology has been dangerously removed from the diagnostic process.

We now have a situation where an infection has been defined as a positive result on PCR and is now 'formally' defined as a 'case'. This is not good medicine. Both the DHHS and the Department of Health have acknowledged in writing that PCR tests 'cannot distinguish between "live" and uninfected RNA' and may 'not be a predictor of infectivity

PCR has been demonstrated to be inadequate as a measure of illness severity and infectivity and so is not fit for purpose. Excessive Amplification Cycles of 37 - 45 have been used routinely, guaranteeing many possible clinically false positive results.

Many senior data scientists have also raised concerns about the unscientific nature of reporting 'cases' without reference to testing numbers to guide to public policy, rather than case positivity.

We call upon doctors to inform themselves more fully and reject the flawed data and overly severe policies driven by forensic PCR technology.

## MORTALITY RISK

SARS COV-2 is of course a real virus which has caused many deaths worldwide. How many deaths is difficult to calculate as 'covid deaths' have often been defined as ' a death with a positive PCR Test' rather than as a result of the recognised disease process and illness caused by the SARS-CoV-2 virus.

However, we all know that multiple co-morbidities are involved 94% of the time -- CDC: 94% of Covid-19 deaths had underlying medical conditions | WEYI (nbc25news.com) Thus it is more than likely the 3.8 million deaths are an overestimate. Overwhelmingly these deaths have been in the frail elderly and others with serious pre-existing illness, often in populations where the average age of death with/from covid exceeds that of the average life expectancy. That said, estimates of the infectious fatality rate (IFR) cluster around 0.15-0.2% overall, which is similar to the IFR of influenza, and 0.05% for those <70 years. The risk to children is very low, less than for influenza, and the risk to adolescents and young adults is 4 orders of magnitude lower than the elderly and so do not justify any restrictions applied across the population. We endorse the recommendations embodied in the Great Barrington Declaration.

**We call for doctors to restore a sense of proportion to the dialogue.**

'Deaths from All Causes' data from Euromomo in Copenhagen reveals that there has been no pandemic of excess deaths in all of Europe (including the UK) in 2020 or in 2021 beyond what is often seen in a bad Influenza year.

**Euromomo Graphs:**

and maps — EUROMOMO and
EUROMOMO

## RESTRICTIONS

Restrictions on our liberties (lockdowns, border controls etc) have been used as an article of faith in the absence of empirical evidence of benefit. Evidence to date from multiple global comparisons supports the conclusion that there is a lack of relationship between the stringency of restrictions and mortality. Indeed, if anything, restrictions appear more harmful than helpful with delayed medical care resulting in many deaths, increased morbidity and adverse psychological impact. World renowned epidemiologist, Prof John Ioannidis of Stanford University has described lockdowns as 'pro-contagion'.

We find it unethical and anti-scientific to support the punitive policies of Australian governments both state and federal, and call for an immediate and permanent end to lockdowns in all its forms and all 'states of emergency' in peacetime.

## MASKS

Pre-existing WHO guidelines state that there is no evidence that face masks are effective in reducing transmission. Cloth masks were not recommended under any circumstances However, the evidence of harm caused by long term use is well-recognised and well-evidenced. The increasing evidence of harm to children is also of grave concern. N95, surgical or cloth masks were never designed, nor are capable of, stopping or reducing viral transmission.

Without any new evidence, and under politic pressure, the WHO changed its guidelines to allow governments to enforce mask mandates on its populations. However, it continues to acknowledge that there is limited evidence to support the use of face masks by healthy people in the community.

Much of the claimed 'evidence' prompting this policy change comes from computer simulations, laboratory studies, or observational studies, which lack the rigour of randomised controlled trials (RCT). However, the recent RCT 'Danmask-19 trial' by Bundgaard et al, found no statistically significant difference in rates of infection with SARS-CoV-2, between those who wore masks and those who did not in the community. More information and evidence about mask effectiveness and safety can be found at our website

## EARLY TREATMENTS

There is abundant evidence supporting the use of anti-viral therapies, such as Ivermectin in combination therapies with other agents including Zinc, Doxycycline, Azithromycin and Vitamin D3, as both a relatively safe prophylactic and early treatment for Covid illness. Aspirin, inhaled and oral steroids have also shown to be beneficial.

Other agents being used in more difficult cases include Montelukast, Anti-coagulants, Maraviroc (a CCR5 Antagonist), Statins and Fluvoxamine. We believe doctors have an obligation to be informed of this and to offer such choices as preventative or early treatment alternatives to their patients.

*"In summary, based on the totality of the trials and epidemiologic evidence presented in this review along with the preliminary findings of the Unitaid/WHO meta-analysis of treatment RCTs and the guideline recommendation from the international BIRD conference, ivermectin should be globally and systematically deployed in the prevention and treatment of COVID-19." Ref: American Journal of Therapeutics May/June 2021.*

Ivermectin for Prevention and Treatment of COVID-19 Infection: A Systematic Review, Meta-analysis, and Trial Sequential Analysis to Inform Clinical Guidelines

The Federal Health Minister Greg Hunt MP and other senior federal politicians have acknowledged and even encouraged 'off-label' prescribing of some peer-reviewed and well-evidenced early treatments for Covid, such as Ivermectin, recognising it as a lawful and common practice within the doctor-patient relationship.

https://spectator.com.au/2021/07/hunt-goes-off-script-with-ivermectin

A brief overview of the latest peer-reviewed literature and informative websites:

The recommendations of the TGA and the Australian National Covid-19 Clinical Evidence Taskforce can be found here and here

## THE VACCINE TECHNOLOGIES

The issue of Covid Vaccines is a controversial and sensitive one. The Covid Medical Network is NOT 'anti-vax'. We acknowledge vaccination may curb the pandemic and is aimed at reducing hospitalisation and death from SARS-CoV-2 virus. However, we believe, in the interests of transparency and for the sake of individual patient care, doctors should be aware of some important,yet lesser-known issues. We are concerned that many members of the public and some medical colleagues seem unaware of some basic facts concerning the current Covid vaccines.

Only provisional approval for 2 years has been granted by the TGA, for both available covid vaccines, as they are considered investigational. Similarly, in the USA, due to incomplete efficacy and safety data, the available gene-based (mRNA and DNA) vaccines have only been made available by the FDA under Emergency Use Authorisation legislation. The TGA Deputy Secretary, Professor John Skerritt, and Minister for Health Greg Hunt have both made public statements that this vaccine rollout is a clinical trial (effectively an experiment) that will conclude in 2022.

Both available vaccines in Australia are totally new gene-based, nucleic acid (mRNA and DNA) vaccines and viral vector vaccines.

The mRNA vaccine technology, using Lipid Nano-Particles (LNPs), has never previously been used on humans. Both vaccines carry genetic instructions for the host's cells to make antigen to induce an immune response.

Due to the unprecedented 'rush to market' via Emergency Authorisation Usage in the USA, doctors should be aware of the deficiency of many of the established standards for vaccine development which have been bypassed. Of particular concern being the absence of completed Developmental and Reproductive Toxicity (DART) studies. Neither were genotoxicity nor carcinogenicity studies performed. There is also an absence of long-term safety data.

Concerns about biodistribution are also now being raised about both the 'produced' Spike Protein and LNP components of the vaccines. Evidence of their delivery and expression systemically, beyond the injection site, is now available, including the unexpected accumulation of LNPs in the ovaries as revealed in the Japanese Ministry of Health animal studies, as well as studies revealing spike protein biodistribution concerns among health workers from Harvard's Brigham Women's hospital. Both findings raise significant concerns about future fertility issues for young people.

Concerns have also been raised that the induced Spike Protein itself can act as a pathogen independent of the virus, as has been revealed in the Salk Institute study, entitled: COVID-19 is a Vascular Disease: Coronavirus' Spike Protein Attacks Vascular System on a Cellular Level.

Doctors, their patients and the general public should also be made more aware of the concerning and unprecedented 'safety signals' being raised through official reporting systems both in Australia and around the world. For example,

the adverse events and deaths following vaccination that have been reported to the TGA. Currently 377 deaths and 39,077 adverse events have been reported. Although this does not prove causation, the comparison with previous incident reporting experience and comparative reporting systems raises grave concerns

https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-15-07-2021

The issue of the claimed 'efficacy' from initial studies has also been criticised regarding the use of Relative Risk Reduction ("95%") instead of the more useful and appropriate Absolute Risk Reduction (0.7 % - 1.1 %). This critical issue is important in properly estimating efficacy and risk/benefit analysis for particular demographics. These articles may be of help on this issue:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8057721/ https://pubmed.ncbi.nlm.nih.gov/33652582/

## INFORMED CONSENT

Doctors have a legal obligation to inform patients of the important, 'material' risks involved in any proposed procedure or treatment. In keeping with the principle of shared-decision making and the NHMRC's informed consent guidelines, and the Australian Vaccination Handbook Guidelines, it is the opinion of the Covid Medical Network that informed consent cannot be said to have been granted if the doctor has not informed the patient (a) that they are a trial participant (b) that effective preventive and early treatment therapies exist, (c) that there are a wide range of possible adverse effects including death (d) that people below 70 years are a low risk of death from the virus and (e) that breakthrough infection and transmission is possible.

We also believe that the conditions of free and informed consent are not being met if the patient is under duress regarding their employment or freedom to travel.

Patients should be made aware of the adverse events and deaths following vaccination that have been reported to the TGA. Currently 377 deaths and 39,077 adverse events have been reported.

https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-15-07-2021

We believe any medical therapy, including vaccination, should not be mandatory, consistent with the right to bodily integrity as recognised by Universal Declaration of Human Rights as well as other national and international human rights documents and covenants.

## PROFESSIONAL AUTONOMY AND THE DOCTOR PATIENT RELATIONSHIP

The government has decided it is the best arbiter of what information you are provided access to and has threatened practitioners with disciplinary action should they offer any critique against the government's public health responses, including the vaccine rollout. They have also been inhibited in discussing and recommending early treatment alternatives such as Hydroxychloroquine and Ivermectin, even risking jail for 6 months in Queensland for transgressing such draconian directives and legislation.

**We of the Covid Medical Network believe it is the duty of doctors to advocate for their own professional Doctor - Patient relationship and stand against undue government interference in the consulting room.**

Doctors who fail to do this risk placing their patients' needs secondary to the interests of the State, thereby risking damage to our noble profession as a source of independent, considered and fair advice.

We thank you for your consideration of these important matters and urge you to join with us in returning our nation to rationality and excellence in medical care.

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https://www.cmnnews.org

**For more information and to receive updates please visit:**

https://www.covidmedicalnetwork.com

**To add your name as a signatory to this letter please email:**

admin@covidmedicalnetwork.com

Sincerely

**Your Fellow Australian Doctors and Health Professionals**

## APPENDIX 1:

**VACCINE DEFINITIONS:**

**The Pfizer vaccine** contains single strand messenger RNA (mRNA) encoding the SARS-CoV- 2 spike protein antigen which, after administration, is delivered into host cells. The spike protein is subsequently expressed, stimulating neutralising antibody and cellular immune responses. See: Information for Healthcare Professionals on Pfizer BioNTech Covid-19 Vaccine', Government of the United Kingdom, Medicines and Healthcare Products Regulatory Authority (Web Page, 31 March 2021)

https://www.gov.uk/government/publications/regulatory-approval-of-pfizer-biontech-vaccine-for-covid-19/information-for-healthcare-professionals-on-pfizerbiontech-covid-19-vaccine

**The AstraZeneca Vaccine** (ChAdOx1, AZD1222) is a chimpanzee adenovirus which enters host cells but has been modified to prevent replication. It is a double strand DNA vaccine carrying a gene encoding the SARS Co-V-2 spike protein surface glycoprotein. The product contains genetically modified organisms. See: Australian Product Information Covid-19 Vaccine AstraZeneca, Australian Government, Department of Health, Therapeutic Goods Administration (Web Page)

https://www.tga.gov.au/sites/default/files/auspar-chadox1-s-covid-19-vaccine-astrazeneca-210215-pi.pdf