

6 Questions an Honest, Intelligent Reporter Would Ask Dr. Fauci About COVID-19

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If you had been going down the rabbit hole of COVID-19 research for long enough, a few things would be astounding to you. First, how uninformed, uncurious, or deceptive reporters in the corporate media are on a matter of life and death. Second, how much publicly available information about COVID-19 is on the internet contradicts what is reported and said by Health Experts™ on cable news. Finally, it is impossible to believe Dr. Anthony Fauci enjoys a 62% approval rating.

Of course, part of the reason Dr. Fauci enjoys this level of trust is that reporters who interview him put a sort of religious faith in every word he utters. Having worked with doctors for years, I don't suffer from any such affliction. There are some great ones, some awful ones, and some who are great at one thing and not another.

It is also quite reasonable for doctors to disagree. Medicine is the art of applying science and it is [rarely "settled."](#) This healthy tension is why patients get second opinions. Yet during the COVID-19 pandemic, only one doctor has had almost no pushback in any public interview. This is journalistic malpractice, but not surprising. Most of the corporate media agree with his recommendations or can use panic porn clicks.

However, if there were a courageous and intelligent reporter who could score an interview with Dr. Fauci, here is a list of questions I would suggest.

1. How is COVID-19 a novel virus?

Dr. Fauci, can you please explain how COVID-19 is a novel virus when it has an overlap with the structure of SARS at a rate of 79%? In addition, there are several human coronaviruses that we have dealt with seasonally for years. Is "novel," as in completely new, an unnecessarily shocking term?

I cannot find a reference to [MERS that calls it a "novel" virus](#). All coronaviruses have the telltale spike protein we have all become familiar with and [MERS was less similar to SARS than COVID-19 is](#). Why add the qualifier to COVID-19 when even the NIH published an article with the following "facts" on June 26, 2020:

Only minor differences have been found between the genome sequences of SARS-CoV-2 and SARS-CoV

In another section of the same paper, it says:

Genome sequence analysis has shown that SARS-CoV-2 belongs to the Betacoronavirus genus, which includes Bat SARS-like coronavirus, SARS-CoV, and MERS-CoV [6].

SARS-CoV-2 possesses a genomic structure which is typical of other betacoronaviruses.

Typical and novel are hardly synonyms. Framing the virus as something completely new makes it scarier.

2. Why should we worry about COVID mutations?

Often news reports are discussing new mutations of COVID-19. Aren't virus mutations expected and common? It appears that there has not been a mutation that significantly increases the way the virus works in the body making it more deadly or dangerous.

[Viruses mutate](#). This is not news and breathless reports about it in the case of COVID-19 only serve to increase panic. The changes to the virus so far are helpful in documenting its spread. There has not been a single change that warrants additional concern and it is not surprising a single patient may have multiple mutations. Mutations generally happen when the virus replicates. It does this inside the body's cells.

3. Doesn't COVID-19 behave like SARS?

Both SARS and COVID-19 have a spike protein that uses angiotensin-converting enzyme 2 (ACE-2) receptors to enter the respiratory tract cells, correct? I understand COVID-19 may be more efficient at doing so, but the cell entry is highly similar?

The method of cell entry was documented to be the same as SARS on January 23, 2020, in the [Journal of Virology](#).

4. Why not give patients hydroxychloroquine and zinc?

In [2005 the NIH did a study on chloroquine](#) that found it was effective in inhibiting and eliminating the SARS virus in vitro. It affected the functioning of the ACE-2 receptor. It is also a zinc ionophore that allows zinc to more efficiently enter the cell. [In 2010 an NIH study demonstrated zinc interfered with the replication of coronaviruses](#). What is the scientific basis to reject its use in the outpatient setting where there are significant observational studies indicating it is effective in early illness?

When asked, Dr. Fauci said he would take this medication if he were diagnosed with COVID-19. It is likely because he clearly [understands the drug's safety profile, how it acts, and previous studies on it](#). His failure to combat the media narrative of hydroxychloroquine being a terribly dangerous drug was astounding. Standing silently by while governors and professional boards interfere with the doctor-patient relationship by prohibiting or denying prescription is unconscionable.

There is no requirement for a double-blind randomized study for off-label use of an FDA approved drug at the approved dosage. Observational studies are more than acceptable in the medical and research community. The decision to use this medication needs to remain between a doctor and a patient.

5. Doesn't the wide range of symptoms make sense?

In 2003 an [article in New Scientist](#) documented that patients who died from SARS actually died of a cytokine storm. This appeared to be well known in the research community. There are 4,735 NIH-funded studies on the phenomenon after the SARS outbreak. Was this overlooked in preparing for the pandemic response? Doesn't this immune response explain the myriad of symptoms in severe disease?

The panic porn industry loves the range of symptoms that COVID-19 causes. Unfortunately for them, these are all explained by the overwhelming damage that can be caused by an immune system overreaction. [Blood clots, organ damage, and heart dysfunction](#) can all be caused as the immune system attacks the body's own tissue.

6. How does the government respond to broader immunity than you expected?

There are now several studies that indicate that some significant portion of the population has T-cell or long-term immunity to COVID-19 due to exposure to coronaviruses in the past. How does this research impact public health measures and the approach to the virus?

Immunologists had theorized about this idea for some time in order to explain the resilience of children and the fact that some members of a household that contained an infected person never fell ill despite close contact. It also may explain so-called "asymptomatic" cases.

The PCR type test looks for pieces of the COVID-19 virus RNA. It does not determine whether the virus is alive or dead. A T-cell response would leave viral debris in the body for some period of time. A PCR test given in the absence of symptoms may detect this debris, giving the impression of an "asymptomatic" case.

Because I actively look for information and follow the data about COVID-19, it is easy to see there is a lot of good news. This is not a novel virus and it works in ways very similar to SARS. Cytokine storms have been studied for years and there are some good therapies available. Death rates are falling likely because doctors and patients are employing these therapies.

The virus is fading in the sunbelt and there are very good data to believe there are large swaths of the population that will not become ill with it. With improved treatment and some level of immunity in the population, everyone should feel confident in our ability to protect the vulnerable and return to a much more normal life.

The nation should not be discussing wearing goggles, additional lockdowns, testing asymptomatic people, and maintaining any policy that limits the civil liberties of its citizens. There is every reason to take greater steps toward reopening the economy, our schools, and normal life.

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