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Lies, Damned Lies, Statistics and COVID Statistics

Revealing Quotes from Anthony Fauci, Christian Drosten and F. William Engdahl that Explain why Anthony Fauci's and Bill Gates' Economically Disastrous Lock-down was Un-warranted and Unnecessary

By Dr. Gary G. Kohls
Global Research, June 18, 2021

Theme: Media Disinformation, Science and Medicine

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Compiled by Dr. Gary G. Kohls

From Free Press

> ***"There are Three Kinds of Lies: Lies, Damned Lies and Statistics"*** **– Mark Twain**
>
> It has long been known that benign coronavirus species are capable of causing 15 – 30 % of common colds (usual symptoms: runny nose, cough, sore throat). This reality was recently mentioned by an internationally-famous virologist from Germany, in an interview where he also admitted that laboratory confirmation of COVID-19 is next to impossible given the high incidence of both false-positive "COVID-19" PCR swab tests and false positive "COVID-19" serum antibody tests.
>
> Apparently, neither test seems to be able to distinguish between the benign coronaviruses that can cause common colds and the more serious coronavirus that actually causes COVID-19!
>
> Dr Fauci's ignorance of (or his "conflict of interest-generated" failure to reveal) that fact justified his oft-repeated assertions in his endless media rounds and White House press conferences prior to the ill-fated economic shut-down:
>
> ***"I think we should be overly aggressive*** *(even if we)* ***get criticized for over-reacting. I think Americans should be prepared … to hunker down."***
>
> Anthony Fauci, as everybody should know, is the long-time director of the NIH's NIAID (National Institute of Allergy and Infectious Diseases). He is, significantly, also a holder of many HIV vaccine patents and the holder of the patent for the Sanofi-Pasteur Corporation's Dengue virus vaccine that recently killed 600 Philippine children.)

Another expert, Dr Christian Drosten, pictured on the right, is the Director of Berlin University's Institute of Virology. He is known at "Germany's real face of the coronavirus crisis".

The quotes below came during an interview that Dr Drosten made last month, in which he revealed that the benign coronavirus that causes the common cold cannot be differentiated from the actual Covid-19 virus by the PCR test kits, over 200 of which are currently in development by profiteering medical device companies!

The interview can be read here.

Here are a few of the pertinent quotes:

> "*Some virologists now assume that there are people who have become immune to COVID-19 unnoticed because they have had a relatively harmless corona cold in the past."*
>
> *"It is quite the case that we expect that there may be an unnoticed background immunity – due to cold coronaviruses, because they are related to the SARS CoV-2 virus in a certain way."*
>
> "*15 percent of common colds are caused by well-known coronaviruses. These are so similar to the current (COVID-19) virus that they can even cause false positive antibody tests."*
>
> *"It could be that certain people who had a cold virus a year or two ago are protected in an unprecedented way."*

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COVID-19's Phony Death Numbers

Covid-19's Phony Death Numbers are the justification for unprecedented lockdown measures, euthanasia of the elderly, social distancing, detrimental masking, possible mandatory vaccines of dubious effect, all of which are causing the destruction of life and livelihood. But, why do this? And whose interests are being served?

By F. William Engdahl

> *Not only are the coronavirus models being used by the World Health Organization (WHO) and most national health agencies based on highly dubious methodologies, and not only are the tests being used of wildly different quality-only indirectly confirming*

evidence of a possible COVID-19 infection-but now *the actual designations of deaths related to COVID-19 are being revealed to be equally problematic for a variety of reasons. It gives alarming food for thought as to the wisdom of deliberately putting most of the world's people–and with it the world economy–into Gulag-style lockdown on the argument that it is necessary to contain deaths and prevent overloading of hospital emergency services.*

When we take a closer look at the definitions used in various countries for "death related to COVID-19" we get a far different picture of what is claimed to be the deadliest plague to threaten mankind since the 1918 "Spanish" Flu.

The USA and CDC Definitions

Right now the USA is said to be the nation with the largest number of COVID-19 deaths, as of this writing, with media reporting some 68,000 deaths. Here is where it gets very dodgy.

The US Government agency responsible for making the cause of death tally for the country, the Centers for Disease Control and Prevention (CDC), is making huge changes in how they count so-called novel coronavirus deaths.

As of May 5, the National Center for Health Statistics (NCHS) of the CDC in Atlanta, the central agency recording causes of death nationwide, reported 39,910 COVID-19 deaths. A footnote defines this as "Deaths with confirmed or *presumed* COVID-19".

How a doctor makes the "presumed" judgment leaves huge latitude to the hospital and health professionals. Although the coronavirus tests are known to be subject to false results, CDC states that even where no tests have been made a doctor can "presume" COVID-19. Useful to note for perspective is the number of USA deaths recorded from all causes during the same period of February 1 through May 2, that was 751,953!

Now it gets even more murky. The CDC posted this notice: "As of April 14, 2020, CDC case counts and death counts will include both confirmed and *probable* cases and deaths." From that time the number of so-called COVID-19 deaths in USA has exploded in an alarming manner – or so it would appear. On that day, April 14, New York City's coronavirus death toll was revised with 3,700 fatalities added, with the provision that *the count now included "people who had never **tested** positive for the virus but were presumed to have it."*

The CDC now defines "confirmed" as "confirmatory laboratory evidence for COVID-19," which as we noted elsewhere included tests of dubious precision. Then they define "probable" as "with no confirmatory laboratory testing performed for COVID-19." Just a guess of the doctor in charge.

Now leaving aside the major discrepancy between the CDC headline COVID-19 deaths as of May 5 of 68,279 and their detailed total of 39,910 deaths for the same period, we find another problem. Hospitals and doctors are being told to list COVID-19 as cause of death even if, say, a patient age 83 with pre-existing diabetes or cardiac issues or pneumonia dies with or without COVID-19 tests.

The CDC advises, "In cases where a definite diagnosis of COVID cannot be made but is

“suspected” or “likely” (e.g. the circumstances are compelling with a reasonable degree of certainty) it is acceptable to report COVID-19 on a death certificate as ‘probable’ or ‘presumed.’”

This opens the door ridiculously wide for abuse of coronavirus death numbers in the United States.

A Big Money Incentive

A provision in the March 2020 Coronavirus Aid, Relief, and Economic Security Act, known as the CARES Act, gives a major incentive for ***hospitals in the US, most all of them private, for-profit businesses,*** to deem newly-admitted patients as “presumed COVID-19.” By this simple method the hospital then qualifies for a substantially larger payment from the government Medicare insurance, the national insurance for those over 65. ***The word “presumed” is not scientific***, not at all precise but very tempting for hospitals concerned about their income in this crisis.

Dr Summer McGhee, Dean of the School of Health Sciences at the University of New Haven, notes that,

“The CARES Act authorized a temporary 20 percent increase in reimbursements from Medicare for COVID-19 patients...” He added that, as a result, “hospitals that get a lot of COVID-19 patients also get extra money from the government.”

Then, according to a Minnesota medical doctor, Scott Jensen, also a State Senator, if that COVID-19 designated patient is put on a ventilator, even if only presumed to have COVID-19, the hospital can get reimbursed three times the sum from the Medicare.

Dr Jensen told a national TV interviewer,

“Right now, Medicare is determining that if you have a COVID-19 admission to the hospital you get $13,000. If that COVID-19 patient goes on a ventilator you get $39,000, three times as much.”

Little wonder that state governors, such as Massachusetts’ Governor Charlie Baker, suddenly began back-dating causes of death (totals back to March 30, significantly inflating COVID death numbers, or that New York Governor Andrew Cuomo began demanding 30,000 ventilators and emergency equipment around the same early April time, equipment that was not needed.

In short, the COVID-19 death statistics in the USA are highly dubious for a variety of reasons, not least of which is the huge financial incentives to hospital administrators who had been told to cancel all other operations to make extra room for a “predicted” flood of coronavirus illnesses. That “rising” death toll said to be “COVID-19-or presumed to be-COVID-19” brings on the decisions to lock down the economy and in effect create an economic pandemic of unparalleled dimensions.

The lack of uniformly agreed tests and the inaccuracies of many tests used, as well as the extremely doubtful criteria for declaring a cause of death as being “from” COVID-19 suggests that it is well past time to re-examine the unprecedented lockdown measures, social distancing, masking, possible mandatory vaccines of unproven effect, all of which

are producing personal, social and economic devastation.

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De-mystifying the Misleading COVID-19 Statistics

Understanding the Statistics: Provisional Death Counts and COVID-19

"There are Three Kinds of Lies: Lies, Damned Lies and Statistics" – Mark Twain

Part Three: The CDC's National Vital Statistics System is where the numbers come from

> ***Provisional death counts deliver our most comprehensive picture of lives lost to COVID-19.***
>
> ***These estimates are based on death certificates, which are the most reliable source of data and contain information not available anywhere else, including comorbid conditions, race and ethnicity, and place of death.***
>
> How it Works
>
> The National Center for Health Statistics (NCHS) uses incoming data from death certificates to produce *provisional* COVID-19 death counts. These include deaths occurring within the 50 states and the District of Columbia.
>
> COVID-19 deaths are identified using a new ICD–10 code.
>
> When COVID-19 is reported as a cause of death – *or when it is listed as a "probable" or "presumed" cause*— the death is coded as U07.1. ***This can include cases with or without laboratory confirmation.***
>
> Why These Numbers Are Different
>
> Provisional death counts may not match counts from other sources, such as media reports or numbers from county health departments. Our counts often track 1–2 weeks behind other data for a number of reasons:
>
> ***Death certificates take time to be completed****.* There are many steps involved in completing and submitting a death certificate. Waiting for test results can create additional delays. States report at different rates.
>
> Currently, 63% of all U.S. deaths are reported within 10 days of the date of death, but there is significant variation among jurisdictions.
>
> ***It takes extra time to code COVID-19 deaths.*** While 80% of deaths are electronically processed and coded by NCHS within minutes, most deaths from COVID-19 must be coded manually, which takes an average of 7 days. *Other reporting systems use different definitions or methods for counting deaths.*
>
> **Things to Know About the Data**
>
> ***Provisional counts are not final and are subject to change*****.** Counts from previous

weeks are continually revised as additional records are received and processed.

Provisional data are not yet complete. Counts will not include all deaths that occurred during a given time period, especially for more recent periods. However, we can estimate how complete our numbers are by looking at the average number of deaths reported in previous years.

Death counts should not be compared across jurisdictions. Some jurisdictions report deaths on a daily basis, while others report deaths weekly or monthly. In addition, vital record reporting may also be affected or delayed by COVID-19 related response activities.

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Dr Gary G. Kohls is a retired rural family physician from Duluth, Minnesota. For the past decade since his retirement, Dr Kohls has written a weekly column for the Reader Weekly, Duluth's alternative newsweekly magazine. His column, titled Duty to Warn, has been re-published and archived at websites around the world.

Dr Kohls practiced holistic mental health care in Duluth for the last decade of his family practice career, primarily helping psychiatric patients who had become addicted to their cocktails of dangerous, addictive psychiatric drugs to safely go through the complex withdrawal process. His Duty to Warn columns often deal with various unappreciated health issues, including those caused by Big Pharma's over-drugging, Big Vaccine's over-vaccinating, Big Medicine's over-prescribing, over-screening, over-diagnosing and over-treating agendas and Big Food's malnourishing and sickness-promoting food industry.

Dr Kohl is a a frequent contributor to Global Research.

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