From the President

COVID-19 Statistics and Facts: Meaningful or a Means of Manipulation?

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What Does the COVID Data Mean?

The COVID-19 case counts, hospitalization numbers, and death counts are meaningless in their current fluid form. Their malleability primarily serves those who seek to distort reality.

The morphable numbers are reported, then manipulated by federal, state, county, city, and hospital authorities and agencies. The manipulation is driven by power and money and fueled by fearmongering, panic stoking, and promise of monetary and political gain. All this is bought and paid for under the guise of trying to save the world from the COVID-19 pandemic.

We must ask the appropriate questions and demand answers, which must then be verified. We must answer the question of what happened in Texas, Florida, and current "hot spot states" around Jun 14-16. Something did, according to the statistics. Did redefining what constitutes a COVID-19 case, hospitalization, or death change the numbers? Did federal financial aid to hospitals change admitting thresholds and practices? Did the withdrawal of the Emergency Use Authorization (EUA) for hydroxychloroquine (HCQ) by the U.S. Food and Drug Administration (FDA) alter outpatient treatment, resulting in a surge of COVID-19 hospitalizations and deaths? Was it the riots? Or what?

The Council of State and Territorial Epidemiologists (CSTE) adopted new definitions of COVID-19 cases and COVID-related deaths in April that were quickly adopted by the Centers for Disease Control and Prevention (CDC).[1] The states were then encouraged to adopt the new definitions, as the Texas Department of State Health Services (DSHS) did on May 11.[2]

The adoption and implementation of these definitions makes a huge difference in the counting of new COVID-19 cases and deaths. In Texas, the May 18, 2020, Collin County Commissioners meeting is one of the best discussions of the effect of the definitions I have encountered. Listen from the 15:27 to the 59-minute mark on the recording for yourself.[3]

Collin County Judge Chris Hill and commissioners beautifully analyzed what was about to happen and even discussed the necessity of warning Collin County residents that the number of COVID-19 cases and COVID-related deaths were about to go up because of the new definitions. My city and county, San Antonio in Bexar County, adopted the new definitions and state: "COVID-19 cases include both confirmed and probable cases" on the COVID-19 San Antonio Dashboards and Data, which I recorded with a screen shot on July 12. The CDC/CSTE new definition of COVID-19 cases can result in 17 "probable" cases from just one PCR-positive patient. COVID-related deaths can include anyone who has COVID-19 listed on the death certificate as one of the causes of death. It doesn't have to be the first or second cause, and no COVID-19 testing is required. During the exact time frame in which these new definitions would have been adopted and implemented, the new COVID cases and COVID death counts started going up in Bexar County.

What is going on in each of the 254 counties in Texas as well as each of the 50 states? It is impossible to know without checking the definitions that each is using.

While the definitions of COVID-19 cases and deaths were being expanded by the CSTE, CDC, and state health departments, efforts to collect and track this epidemiological data were being increased. On May 13, using federal dollars, Texas Governor Greg Abbott signed a $295.3 million 27-month contract with MTX Group, a New York-born and newly Texas-based company tasked with contact tracing of Texans who meet the definition of a COVID-19 case. The Texas DSHS is administering the contract. Seventeen states started using technology from this same group around this same time, including Georgia, Florida, New Mexico, New York, Massachusetts, Oklahoma, New Hampshire, Vermont, and Illinois. MTX has a $250 million contract with New York plus a second for $46 million for New York City alone. Texas lawmakers questioned a "hastily-awarded" $295 million emergency contract to expand the Texas contact-tracing network.[4]

Many of these states are now deemed "hot spots" because of increasing numbers of reported cases. The COVID-19 contact tracing efforts include tracking and tracing Texans using thousands of contact tracers and personal phone apps. By June 3, Texas lawmakers were calling to end the contact-tracing program, which they called "a gross invasion of personal liberty and privacy" and insisted that recently surfaced evidence that Das Nobel, CEO of MTX, lied about having a "Doctorate of Management, Organizational Development, and Leadership" on his LinkedIn profile was grounds to end the contract.[5] Five Texas lawmakers also sued Governor Abbott over the $295 million coronavirus contact-tracing contract.[6]

Concurrently, the American Medical Association (AMA) was working with the CDC and CSTE on electronic case reporting (eCR) to "transform the way we do business" in collecting patient data from physicians and labs. They proudly proclaimed the data mining does not require extra clicks, but reduces burden, because "it's in the background…so as the data and information is being recorded through the normal healthcare visit process, it's there, and then eCR just allows it to move from health care into public health. It's like plugging in the EHR to public health." They advertise that eCR fulfills clinicians' reporting requirements, automatically sends required information to all appropriate public health agencies, and allows expansion to all reportable conditions.[7]

AMA's daily COVID-19 update, Jun 4, features a video and transcript of the eCR collaborative. This comprises the Public Health Informatics Office at the Center for Surveillance, Epidemiology and Laboratory Services within the CDC in Atlanta; AMA's director of science, medicine and public health; and the CSTE in Atlanta.[8] The eCR is an initiative that has come together with CSTE, the Association of Public Health Laboratories, CDC, and AMA to focus on COVID-19 reporting using electronic case reporting infrastructure that's in place, to develop an eCR app that can be used by EHR vendors that

didn't have eCR capability, and to allow data flow between patient care and public health. The CDC spokesperson claims to have been able to move COVID eCR rapidly, having "onboarded in the last month, around 2000 facilities that come to us from around 17 organizations, and we've seen over 460,000 case reports electronically flow through this and received in 32 different public health jurisdictions for use." They discuss plans to eventually insert treatment guidelines and isolation guidelines for COVID-19 as well.

Testing, reporting, and tracing are big-money industries with potential for overreach, over-reporting, and error resulting in loss of liberty and livelihood for Americans. All of this money is coming from taxpayers, and none has gone toward actual treatment. From information technology (IT) vendors and data brokers to the AMA, which profits as an "implement, comply, and coding" arm of the Department of Health and Human Services (HHS), there are monetary and power incentives to increase testing, tracing, and reporting of COVID-19.

Why would someone want to inflate case counts, and what are the risks and benefits of doing so? As reported in *Modern Healthcare*, HHS was to send $10 billion in round two of relief grants to COVID-19 hot spots: "Hospitals that had more than 161 COVID-19 admissions between January 1 and June 10 will be paid $50,000 for each COVID-19 admission. HHS asked hospitals to start submitting COVID-19 admission data on June 8."[9]

Hospitals that use the new CDC definition stand to make millions of dollars. The first round of HHS grants was $12 billion and paid $76,975 per admission to hospitals that had more than 100 COVID-19 admissions from Jan 1 through Apr 1. Obviously, states hit early got huge sums of money. Illinois received $740 million; New York, $684 million; and Pennsylvania, $655 million. Additionally, Medicaid will pay out $15 billion in relief funds. Hospitals must apply by August, so the more cases the better the return. Remember, this is on top of the extra money commercial insurers pay and the extra 20 percent Medicare pays to hospitals for patients hospitalized "with COVID-19." The hospitals reporting the most cases get the most money.

Because of expanding the definition of a new COVID-19 case to include exposure to a COVID-positive patient and a self-reported fever, lowering admission thresholds, and requiring testing on every admission, it is easy to code a hospital admission as "with COVID." A colleague reported to me that her scheduled Caesarian section patient was asymptomatic but tested positive on the required admission COVID test, so she too became a hospitalization "with COVID." The army of hospital billers and coders is no doubt hard at work scouring EMRs and community contact-tracing data to find any links that could raise their bounty. This may also explain why the average hospital stay for COVID-19 was around 1.4 days last time I checked—just long enough to go beyond a 24-hour emergency room observation status to count as an actual hospital admission.

Doctors, nurses, and patient-care staff do not get this money. In fact, many of my fellow physicians received pay cuts as great as 20 percent while being asked to step up and care for the increasing number of admissions, and many nurses and other members of our patient-care teams were in fact fired or furloughed because of financial devastation resulting from the initial premature and prolonged shutdowns.

Hospital beds and operating rooms sat empty as a consequence of governors' executive orders banning all non-urgent care. The premise was to reserve bed capacity for the anticipated COVID-19 surge. The result was near financial ruin for hospitals at the very time they were charged with preparing for a pandemic. The state governments' bans on non-urgent care had the opposite of the desired effect. Rather than increasing capacity, Texas lost staffed hospital beds. Thus, when our COVID-19 wave came, 3 months after the governor's executive order declaring a disaster, we were less prepared, with fewer staffed beds and more financial stress. Now we have fewer doctors and staff members, who are overworked and underpaid, to care for more patients. This is compounded by the new public health problem created by the bans and shutdown; all the non-COVID patients who delayed or were denied care during the near 2-month ban on treating them are all now in desperate need of care, and they are sicker. The hospitals now have more COVID patients, more non-COVID patients, and fewer staffed beds.

Yes, thank and pray for our critical-care doctors, nurses, and teams. They are doing more with less under great stress, but they are doing phenomenally good work. Death rates in Texas, for example, are remarkably low in spite of the new definition of COVID-related death. As discussed earlier, being coded as a COVID-related death does not require a COVID test but does come with a big payout for the hospitals. Definitions matter.

Another sad consequence of the inflated numbers is that we are losing freedoms and destroying our state and country. Our re-openings are based on these numbers. We have lost our ability to congregate in groups of 10 or more; go to church, school, weddings, funerals, sporting events, concerts; go anywhere without a mask; or hug our parents, grandparents, children, grandchildren, and the lonely. In Texas, there are Hospital Trauma Service Areas where larger counties with state and county hospitals take transfers from counties and rural hospitals less equipped. Bexar County covers for 22 counties. Our case reports did not separate out who was a Bexar County resident and who was from another county or country—we are a 2.5-hour drive from Mexico. Ironically, while Bexar County is taking care of all the sickest patients transferred in, we are penalized because of increasing COVID-19 hospitalizations and deaths; simultaneously, the counties that sent the patients to us, record fewer COVID-19 admissions and deaths and remain open with greater freedom and liberty. San Antonio is not allowing us to gather in groups of more than 10. Meetings and events are being canceled. Some are being rescheduled to other counties that we cover. This inflicts severe economic and psychological damage on our community.

This is not just a result of perverse financial incentives, but this is clearly also a political fight. San Antonio has a liberal Democrat mayor and Bexar County has a liberal Democrat county judge. Their approach is totalitarian. Their goal is for Democrats to win on Nov 3. Perhaps they are willing to draw this siege out to achieve personal political goals. Already school openings have been delayed based on manipulated numbers. Other counties being punished, such as Harris County and Dallas County, also have county hospitals and Democrat local leaders. Look at their numbers, definitions, and counting and reporting methods—and their loss of liberty.

A Better Response

Our response has been all wrong. We must stop repeating our mistakes and instead learn from them. Imagine if the $37

billion dollars HHS is now sending to hospitals had been spent instead hiring and training doctors, nurses, and medical teams, building out COVID hospitals and rehabilitation units for post-COVID care, and preparing outpatient facilities and operating rooms to care for non-COVID patients. This money would have been better spent helping urgent care clinics, outpatient clinics, and rural clinics strengthen their patients' immune systems with vitamin D3, vitamin C, zinc, exercise, weight loss, and control of their blood pressure, diabetes, and asthma. Imagine preparing our nursing homes and long-term care facilities. Imagine offering residents the choice of participation in outpatient studies of low-dose hydroxychloroquine (HCQ) and zinc that have proven effective when administered early in safe doses around the world, or other affordable, repurposed treatments such as ivermectin and nebulized budesonide. Frontline medical workers and high-risk patients could have been offered the same safe, potentially life-saving choices as prophylaxis. Imagine having 84 percent fewer hospital admissions to deal with, along with more doctors and staffed beds. "Shoulda, woulda, coulda" doesn't matter now, but let's learn from our mistakes. Let's demand that our numbers be meaningful, not means of manipulation.

I have not discussed here the contemptible intellectual dishonesty, scientific fraud, and falsification of data that has been used to sabotage outpatient use of hydroxychloroqine and zinc in order to profit large drug and vaccine makers, such as Gilead Science, which makes remdesivir. The trillions of dollars, billions of lives, and immeasurable conflicts of interest tying the CDC, FDA, National Institutes of Health, and Dr. Anthony Fauci's National Institute of Allergy and Infectious Disease (NIAID) into one giant tangled web are beyond the scope of this article. You must research this on your own.

Did the FDA Contribute to the Rise in Cases?

Concerning the question of what happened Jun 14-16, does the rise in COVID-19 cases in any way tie back to the FDA's removing the Emergency Use Authorization (EUA) for HCQ from the Strategic National Stockpile for COVID-19 on Jun 15? False data from a questionable company, Surgisphere, was exposed by brave citizen scientists and investigators, resulting in retractions of articles that sabotaged the use of HCQ for COVID-19. *Lancet* and the *New England Journal of Medicine* retracted two articles based on this falsified data, but not before the World Health Organization (WHO) halted major studies of HCQ based on the fake science.

Mathematical analysis suggests that this has indeed contributed to increased COVID cases and death. Who bears responsibility for such evil? Needless to say, in spite of 35 years at NIAID and more than $20 billion in the last 4 years alone, Dr. Fauci failed us. We were not prepared, and preparedness was his charge. He can no longer be trusted. Former President Ronald Reagan famously said, "Trust, but verify." I'm sorry to say, the only thing we can trust is that most of those in charge of this pandemic from Dr. Fauci on down cannot be trusted. The critical questions must be asked by us, and their answers must be pursued and verified by us. Definitions, semantics, data, and statistics matter. There are a few good men and women out there. It is up to us to identify them and help them help us.

Sadly, as exemplified by the attack on America's Frontline Doctors, physicians who speak out against this corruption are denigrated, censored, threatened, and fired. As more physicians become employees, they fear reprisal for speaking out in truth. AAPS is the only organization that has had physicians' backs and defended those who are threatened with loss of licensure by their state's medical board, fired by their hospital or private equity group, or worse. The rest of organized medicine is part of the problem and complicit in the take. COVID-19 is the 2020 weapon of mass destruction; this is bioterrorism resulting in financial terrorism, economic devastation, and loss of Americans' life and liberty. Even our annual AAPS meeting cannot be held in person due to government-imposed restrictions on public gatherings.

The virus is bad, but the collateral damage from the failed response is worse. Everyone from Dr. Fauci to the media and half of our own profession wants to shut us down, but we must stand strong for our patients and posterity; it is we who must save the world or die trying. AAPS is the last best hope. Somehow, we must find a way to let all physicians and patients know we are here for them.

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