1-1

Dr. McCullough: Lawsuits Are Coming for Those Who Defrauded the Public

The allegations: wrongful advertising, fraud, and harm to the population.

The Vigilant Fox February 14, 2023 **Originally Published on DailyClout**

"I'm still seeing [vaccine] ads on TV paid for by the North Carolina government!" objected Real America's Voice commentator John Fredericks. "I'm still seeing ads on TV telling you to get your child, your kindergartner, vaccinated — paid for by the government here in North Carolina! Tell me how that makes any sense," he bade.

"It's true. What's going on is illegal pharmaceutical advertising," attested world-renowned doctor Peter McCullough.

Dr. McCullough is an internist, epidemiologist, and one of the most published cardiologists ever in America — serving as the Chief Scientific Officer of The Wellness Company. Since the outset of COVID-19, Dr. McCullough has contributed to dozens of peer-reviewed publications on the illness and has commented extensively on the botched response and the subsequent injections.

Dr. McCullough elaborates on illegal advertising. "We have multiple laws that apply that all biopharmaceutical products have to be presented with both the risks and the benefits — Americans know that. The companies and the governments together have defrauded Americans in terms of the truth of the vaccine," he conveyed.

3.1 What information must appear in advertisements directed to healthcare professionals?

The FDA's approach to regulation of advertising is based on its view that a manufacturer must present truthful, non-misleading information that adequately balances a prescription drug product's benefits and risks to the intended audience. U.S. law also requires that a manufacturer provide its consumers with adequate directions for the intended use of its prescription drug products. Therefore, while the requirements for both consumer-directed and healthcare professional-directed advertising are generally the same under U.S. law, the FDA will closely scrutinise whether the content is presented in terms that the intended audience can understand, and the FDA has developed special guidance addressing the application of regulatory requirements to consumer-directed broadcast advertising, communications in social media, and other fora.

"A manufacturer must present truthful, non-misleading information that adequately balances a prescription drug product's benefits and risks to the intended audience."

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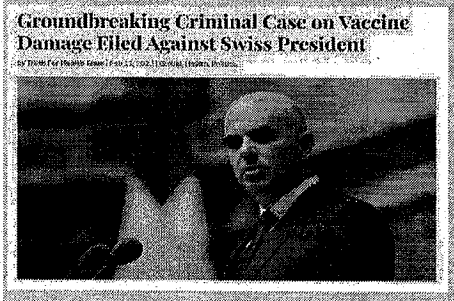
Lawsuits are already underway.

Japanese researchers – led by Professor Fukushima – filed a lawsuit against the Japanese government for suppressing the truth about the harmful side effects of the C19 injections.

Japanese Researchers Sue the Government for Hiding Inconvenient Truths About the Jab

"As a medical doctor and a scientist, I had no choice but to dare to take legal action"

And international banker Pascal Najadi has launched a groundbreaking criminal case against new Swiss President Alain Berset.



So we can expect to see "case after case," stated Dr. McCullough. "And the allegations will be wrongful advertising, fraud regarding the product, and then the harms that are done to the population: injuries, disabilities, and deaths."

Click/tap the link below for the full interview.

Dr. Peter A. McCullough - Covid Vaccine Injury Class Action Lawsuits Coming To Big Pharma

2-1

The Inherent Deceit of Modern Medicine

PAUL FRIJTERS, GIGI FOSTER, MICHAEL BAKER MARCH 29, 2023

In an earlier piece, we explained why academia is drawn to fascism, and how this allure led so many "experts" within the academic sector to go along with the covid control narrative. We now turn our gaze to the medical industry and the mindsets of the people to whom it caters.

Suppose an established doctor sits down to reflect honestly on her long career. In this career she will have provided advice and prescriptions to thousands of patients, and inevitably she will have made some mistakes that carried significant consequences.

Perhaps one patient went mad due to overmedication by thyroid pills that the doctor neglected to dial back before it was too late. Another died because she mistook a developing cancer for a benign lipoma (a subcutaneous fat nodule). Another died after suffering complications from unnecessary tests she prescribed just to keep the pushy patient happy.

Two were permanently disabled from having been prescribed pills they did not really need and that had serious side effects. Four became addicted to the opioid pills she prescribed for their mild depression, eventually losing their jobs and their marriages. Ten more became hyper-anxious after being "fully informed" of all the exotic diseases they might have.

The reasons for her mistakes over the years, this honest doctor would muse, varied. Sometimes she was too tired to pay attention. Sometimes she was too empathic with a neurotic patient, caving in to prescribe the unnecessary medicine they asked for. Sometimes she took her "informed consent" oath too seriously. Sometimes she did not know what to do because she had not really kept up with the latest scientific insights in a particular area, and so took a guess that turned out to be wrong. Sometimes she disliked a patient too much to put in effort. In short: she was a normal, fallible human being.

What would the families of the patients impacted by her mistakes, and the legal profession, do to such an honest doctor, were she to share her musings?

They would throw her to the wolves.

Medical negligence suits would bankrupt her. She would lose her medical license, her social position, and probably her liberty. Her life would be over even if her rate of mistakes per patient was no higher than the average doctor's. No mercy would result from pointing to the many lives saved by her many good judgment calls. Admitting to deadly mistakes would doom her regardless.

Hence, she must lie. She must pretend she has never made any mistakes in her professional life, was always on top of all the new science on every point, and gave her very best in each and every 10-minute consultation she ever held.

The punishment for owning up to human mistakes prohibits her from being honest. We, as a society, force this dishonesty upon her. Our medical negligence and accountability laws presume a degree of perfection in her and in her healing arts that is unrealistic, and thus those laws are themselves mendacious.

What goes for the doctor goes for the hospital, the nursing home, the specialist, the nurse, and the pharmaceutical industry representative: admitting to their own humanity and thus the many deadly mistakes they make on a regular

basis is out of the question. They must lie continuously about their mistakes in order to retain what is seen as a normal life. This was true long before covid came along.

Collective lying stifles science

This problem has been well-recognised for decades in the literature. A 2001 review article estimated that 6% of "active-care patient deaths were … probably or definitely preventable." A report published the previous year, appropriately entitled "To Err is Human," estimated that medical error was the 5th leading cause of death. Yet, to our knowledge, in no country are medical errors reported as responsible for the deaths of people in the mortality statistics released by national statistical agencies (e.g., by Australia's ABS). This means bluntly that the entire system by which we measure cause of death in the modern age is compromised.

As a result of this big fat lie embedded within our systems of medical measurement, it is basically impossible to adjust the medical system to avoid mistakes in a cost-effective manner. If no one can own up to mistakes, then it becomes impossible to evaluate how some particular change (e.g., to procedures or protocols followed by doctors) has 'improved' matters. After all, no mistakes were being made in the first place, so no improvement is possible!

One is thereby forced to grope around in the dark for possible improvements rather than being able to do scientific studies. In this way, ironically, the No-Medical-Mistakes pretence makes the study of medical practice an innately unscientific one. Data on deaths produced by the system must be forged, on pain of financial and social death.

Barriers to the sole solution concept

The many deliberations about this problem in medical circles have produced several makeshift processes to weed out the worst excesses, like having honesty sessions inside hospitals where medics involved in a case can discuss what happened leading up to a death and what could be improved moving forward. In spite of these good works at a local level, there is no obvious general solution, because no one can personally or professionally afford to have medical errors officially recorded.

The only genuine system-wide solution is for society to become openly comfortable with the idea that people get killed because of mistakes, a bit of laziness, misguided empathy, a normal rather than superhuman level of intelligence, and other facets of the human condition. To avoid deceit at a grand scale, society would have to learn to accept occasional 'gross medical negligence' for which no one person pays the price.

Why is that solution so impossible? Why does no society that we are aware of openly allow "average intelligence" as a valid excuse for killing someone via bad medical judgment calls? Why do societies not recognise that "lack of focus" and "irritation with others" are entirely normal reasons to make the occasional mistake that, in the case of medical professionals, can lead to fatalities? Why is honesty so heavily punished?

The standard excuse for maintaining the No-Medical-Mistakes lie is that punishing open mistakes is a means of forcing medics to pay attention and not be lazy or unfocused. There is a productive point to that incentive effect, but the hard limit of human fallibility cannot be wished away.

A less palatable reason for the persistence of the lie is that the pretence of perfect medicine forms the basis of a good business model for both the medical profession, which then gets to play the "we are Übermensch" card, and the legal profession, which then makes a buck out of the mismatch between imperfect reality and the No-Medical-Mistakes image.

Another reason, also unrelated to anything productive, is that the general population is vulnerable to the myth that they will live in good health forever if only they cough up enough dollars. We all like to believe we will live forever and that any health problem can be fixed. We also like to believe that if we suffer due to the mistakes of others, it cannot be due to bad luck but must be due instead to evil that needs to be punished. The seductive simplicity of the 'good versus evil' paradigm crowds out any role for human foibles.

We don't want to hear that the laziness of others can get us killed and that our families should accept that, because a bit of laziness is inevitable. We don't want to hear that our nagging might cause doctors to give us pills that are bad for us. So, we never hear these things, because doctors never tell us.

In short, we want to be lied to, and on average we are not mature enough to hear about the limitations of ourselves or those we rely on. Politicians, lawyers, and health services have worked this out over time, and today simply cater for our desire to be lied to.

In light of this widespread mendacity, it should be no surprise that hordes of doctors and health managers lied through their teeth in the covid era. Why act aghast that they hide the negative effects of vaccines and overplay the usefulness of lockdowns and masks? How are these lies in any way different from the lies 'we' have forced out of them in previous decades? Indeed, we have gotten what we demanded from them, in spades.

Can life be too good?

Is the same true for other sectors now, and are the lies more prevalent now than, say, 100 years ago?

On the recency of institutionalised lying, an online article discussing medical negligence legislation notes that "claims for compensation for medical negligence against medical practitioners and professionals was very rare prior to the 20th century. Due to several advancements and significant cases in the law, medical negligence claims and personal injury law surrounding medical negligence evolved into the laws that exist today." In other words, pressure to lie resulting from our laws, and particularly our negligence laws, has risen over the past 100 years.

What about other sectors? Could a modern car manufacturer be honest about its role in imperfections leading to fatal accidents? Could a professional accountant today own up to having made a mistake in a company's yearly accounts that then led to bankruptcy? Could a modern farmer own up to having accidentally used too much insecticide that then caused a deadly allergic reaction in consumers? Could a fisherman own up to having caught a protected species?

The answers range from 'hell no' to 'very inadvisable.' As with medicine, the reason for the instinctual truth-suppression in each case comes down to the threat of litigation and the general collection of myths propagated by society: myths of perfect professional advice, perfect machines, and perfect food. Admitting to mistakes is just too costly. 'Caveat emptor' (buyer beware!) has gone out of the culture.

Why the change?

In the US one is tempted to blame the legal profession, but really that would be like blaming the cat for eating the bacon left outside the fridge. Countries without significant numbers of litigation lawyers, like Japan and South Korea, do not have a 'medical error' category in their reported causes of deaths either, as far as we know. The reason then must be more general, related to the shared human condition in the modern era.

We venture that the change is ultimately the result of populations getting used to so much working so well. Faulty cars are now very rare. Most food is extremely reliable. Professional advice is so often right. If we experience

excellence 99 percent of the time, it is only human to close our eyes to the impossibility of getting things 100 percent right and indulge in the soothing fantasy of perfection. Don't we "deserve perfection?" Why "tolerate anything less?" The marketing copy writes itself.

The perfection myth is so appealing that in the long run groups will inevitably evolve that push that myth in order to make a buck or gain our sympathies. Lawyers and politicians have obliged.

Seen in this light, part of the runway to the great covid panic and its sequelae has been that owning up to imperfection has disappeared from our culture. Life is too good. Owning up to mistakes, or even to exaggerated claims of effectiveness, is just not a done thing. It's seen at the minimum as a weakness, and at the worst a legal liability.

Who is to blame for that culture? Individual pushers of the myth, or the public, or even human nature? Should we blame Obama for making the impossible promise that "Yes, we can" get rid of poverty and hunger in the world, or should we blame the millions of enthusiastic voters who turned up in record numbers at the ballot box to reward such a ridiculous promise? Should we blame Trump for not making 'America great again' or 'draining the swamp,' or should we blame the millions who thought he was going to do these things and rewarded him for his marketing slogans?

Where to look for truth

The answer is obvious and staring most of us in the mirror. It is a depressing answer, but not as depressing as the answer to whether we are likely to see significant change in our lifetimes. For in what circumstances are we really going to become more mature in the future, raising our kids with a deep awareness of human imperfections and the need to tolerate deadly mistakes as just 'one of those things?' Only the experience of pain on a massive scale would seem able to reset our culture to one featuring a healthy tolerance of mistakes that kill a good number of us each year.

Looking across history and cultures, examples of healthier attitudes towards human error correlate with recent experiences of misery, enslavement, violence, or some other source of high risk to life. The "Don't worry, be happy" attitude of the Caribbean emerged from a history of pain and loss associated with Colonial-era slavery.

The unconditional acceptance of human weakness featured in Christianity emerged at a time of high violence against Christians in the Roman Empire. Several Hispanic cultures in the US today teach a relaxed, "Que sera, sera" attitude towards life and all its ups and downs, and are downstream of intergenerational stories of immigration, risk, and loss.

The dominant Western culture of the modern era will not relinquish its ingrained deceitfulness without first going through a nasty and lengthy transformation in which we are acutely reminded that life is risky and humans are imperfect. It is conceivable that long-run side effects of the covid vaccines will help to remind us of this. The best we can hope for in the longer run is to design our institutions to lead the population gradually into a mindset of comfort with human limitations.

Escape from the sea of lies in which we now find ourselves requires, as a first step, islands of truth discovery and truth-telling. Universities used to be such islands of devotion to truth, but today's universities have been thoroughly captured by the deceit industry. We need new ones, in which students are unable to hide from the reality of fallibility and the immense cost of pretense to the contrary.

3-1

Elon Musk On When People Will Admit COVID Response Was A "Scam" – "It's Coming"

February 23, 2023

Is a COVID bombshell on the way from the "Twitter files?"

Rapper and popular influencer Zuby asked on Twitter, "When will everybody admit the whole Covid-19 'pandemic' response was a scam?"

Elon Musk responded by saying, "It's coming."

Read: Demand For Physical Precious Metals Skyrockets As Central Banks Buy Everything In Sight

Back in January, Elon Musk said a "key researcher" on Fauci was traveling to Twitter.

Trending Politics reported:

On Wednesday, Twitter CEO Elon Musk appeared to suggest that he had information that would prove the entire COVID pandemic response was a scam.

Over the past several months, Musk has released the 'Twitter Files,' showing widespread government collusion with the tech giant. He has also teased upcoming Fauci Files which have been delayed due to a 'key researcher.'
Elon Musk has already exposed Twitter had a "Fauci Fan Club" before he took over.

https://twitter.com/elonmusk/status/1607993481300951040?s=20

No wonder the establishment is so scared of Elon Musk.

4-1

Indoor Vaccine Mandates in US Cities, Vaccination Behavior, and COVID-19 Outcomes

Vitor Melo, Elijah Neilson, Dorothy Chebet Kemboi

- Download the Working Paper PDF
- Download the Research Summary PDF

During the pandemic, many of the largest cities in the United States introduced vaccine mandates. Their goal? To increase the number of people being vaccinated, thereby limiting the spread of COVID-19.

In "Indoor Vaccine Mandates in US Cities, Vaccination Behavior, and COVID-19 Outcomes," Vitor Melo, Elijah Neilson, and Dorothy Kemboi question the efficacy of these efforts in nine cities that implemented the mandates: Boston, Chicago, Los Angeles, New Orleans, New York, Philadelphia, San Francisco, Seattle, and Washington DC.

Intended and Unintended Effects of Indoor Vaccine Mandates

City vaccine mandates were arguably among the most restrictive and polarizing regulations ever enacted in the United States. Millions of people were prevented from entering restaurants, bars, gyms, theaters, sports arenas, and other public indoor areas without proof of COVID-19 vaccination. The mandates negatively affected unvaccinated individuals and businesses that were not allowed to serve unvaccinated customers.

In New York City, for example:

- More than 90 percent of restaurants reported having customer-related challenges, such as losing customers who objected to the mandate.
- Three-quarters of restaurants reported staff-related challenges because of the city's vaccine mandate.
- 1,430 city workers were fired for failing to comply with the mandate.

Previous research has shown that similar country-level mandates increased vaccine uptake substantially. However, city-level mandates are easier to evade than country-level mandates because it is generally easier to travel to a neighboring city that does not have a mandate than to cross national borders.

Cost-Benefit Analysis

Most supporters of the regulations claim that the benefits associated with the increase in vaccination rates as a result of the mandate—and its implied reduction in the spread of COVID-19—outweigh the costs of its disruptions. However, the authors find that indoor vaccine mandates had no significant impact on COVID-19 vaccine uptake, cases, or deaths across all nine cities that implemented the policy.

Key Takeaway

Public health restrictions and regulations were widespread during the COVID-19 pandemic, and so understanding their consequences is essential. The authors find that city-level mandates had smaller effect on vaccine uptake (and consequently on COVID-19 cases and deaths) than nationwide mandates— and thus failed to achieve their intended objectives.

5-1

MERCATUS WORKING PAPER

INDOOR VACCINE MANDATES IN US CITIES, VACCINATION BEHAVIOR, AND COVID-19 OUTCOMES

Vitor Melo, *Mercatus Center and Clemson University*

Elijah Neilson, *Southern Utah University*

Dorothy Kemboi, *West Virginia University*

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MERCATUS CENTER
George Mason University

5-2

In most instances, the estimated effect is quite small; even in instances where the estimated effect appears large (e.g., San Francisco in figure 3), our placebo variance analysis suggests that these estimates are not large when compared to the distribution of placebo estimates. This can be most easily seen in figures A1, A2, and A3 in the appendix, which show the distribution of all placebo estimates for each outcome and treated MSA, and where the corresponding actual estimated effects for each treated MSA (denoted by the vertical lines) fall within each distribution. Regardless of the outcome and MSA in consideration, these placebo estimates appear normally distributed around zero, and in most cases the actual estimated effects do not approach the tails of these distributions. Even for cases like San Francisco in figure A3, where the magnitude of the estimated effect is relatively large, the corresponding distribution of placebo estimates suggest that a nontrivial amount of control MSAs—which did not actually have an indoor vaccine mandate in place—saw a relatively larger change in the outcome when compared to their SDID counterfactual.

The plots in figures 1, 2, and 3 also allow for a visual assessment of pre-trends. In each instance, the chosen SDID weights perform well at finding a weighted average outcome of control MSAs that is approximately parallel to that of the treated MSA in the pre-treatment period. This instills confidence that the SDID synthetic controls provide valid counterfactual trajectories of the treated MSAs throughout each treatment period.

While we cannot claim, based on our results, that the indoor vaccine mandates in these US cities were not effective at all, our results do suggest that if they were effective, the effect was likely smaller or at least less statistically noticeable than the effects of country-level and province-level mandates studied previously.

6 Conclusion

Many of the largest cities in the United States introduced COVID-19 indoor vaccine mandates with the goal of increasing vaccine uptake and thereby reducing COVID-19 cases and deaths. These mandates were among the most stringent policies ever implemented in US cities, and they neg-

5-3

atively affected thousands of citizens and businesses. This paper explores the efficacy of these mandates. Using the synthetic difference-in-differences method, we find that indoor vaccine mandates had no significant impact on COVID-19 vaccine uptake, cases, or deaths across all nine cities that implemented the policy. We also find that our results are robust to the synthetic control and the difference-in-differences methods.

Our findings are important for at least two reasons. First, they highlight that policies implemented at different jurisdictional levels have different outcomes. Karaivanov et al. (2022) and Mills and Rüttenauer (2022) show that indoor vaccine mandates in European countries and Canadian provinces significantly increased vaccine uptake. However, we find that in all US cities that implemented the mandate, the effects are not statistically noticeable. If they had any effect on vaccine uptake, it was likely smaller than the mandates previously studied. Second, our findings bring to question the efficacy of city-level indoor vaccine mandates. These mandates imposed severe restrictions on the lives of many citizens and business owners. Yet, we find no evidence that the mandates were effective in their intended goals of reducing COVID-19 cases and deaths.

6-1

Approximately Zero

John Tierney - February 17, 2023

Masks make no difference in reducing the spread of Covid, according to an extensive new review by Cochrane – the gold standard for evaluating health interventions.

We now have the most authoritative estimate of the value provided by wearing masks during the pandemic: approximately zero. The most rigorous and extensive review of the scientific literature concludes that neither surgical masks nor N95 masks have been shown to make a difference in reducing the spread of Covid-19 and other respiratory illnesses.

This verdict ought to be the death knell for mask mandates, but that would require the Centers for Disease Control (CDC) and the rest of the public-health establishment to forsake "the science"—and unfortunately, these leaders and their acolytes in the media seem as determined as ever to ignore actual science. Before the pandemic, clinical trials repeatedly showed little or no benefit from wearing masks in preventing the spread of respiratory illnesses like flu and colds. That was why, in their pre-2020 plans for dealing with a viral pandemic, the World Health Organization, the CDC, and other national public-health agencies did not recommend masking the public. But once Covid-19 arrived, magical thinking prevailed. Officials ignored the previous findings and plans, instead touting crude and easily debunked studies purporting to show that masks worked.

The gold standard for medical evidence is the randomized clinical trial, and the gold standard for analyzing this evidence is Cochrane (formerly the Cochrane Collaboration), the world's largest and most respected organization for evaluating health interventions. Funded by the National Institutes of Health and other nations' health agencies, it's an international network of reviewers, based in London, that has partnerships with the WHO and Wikipedia. Medical journals have hailed it for being "the best single resource for methodologic research" and for being "recognized worldwide as the highest standard in evidence-based healthcare."

It has published a new Cochrane review of the literature on masks, including trials during the Covid-19 pandemic in hospitals and in community settings. The 15 trials compared outcomes of wearing of surgical masks versus wearing no masks, and also versus N95 masks. The review, conducted by a dozen researchers from six countries, concludes that wearing any kind of face covering "probably makes little or no difference" in reducing the spread of respiratory illness.

It may seem intuitive that masks must do *something*. But even if they do trap droplets from coughs or sneezes (the reason that surgeons wear masks), they still allow tiny viruses to spread by aerosol even when worn correctly—and it's unrealistic to expect most people to do so. While a mask may keep out some pathogens, its inner surface can also trap concentrations of pathogens that are then breathed back into the lungs. Whatever theoretical benefits there might be, in clinical trials the benefits have turned out to be either illusory or offset by negative factors. Oxford's Tom Jefferson, the lead author of the Cochrane review, summed up the real science on masks: "There is just no evidence that they make any difference. Full stop."

This lack of evidence would be enough to keep any new drug or medical treatment from being approved—much less one whose purported benefits had not even been weighed against the harmful side effects. As the Cochrane reviewers disapprovingly note, few of the clinical trials of masks even bothered to collect data on the harmful effects on subjects. Most public-health officials and journalists have ignored the downsides, too, and social-media platforms

have censored evidence of those harms. But there's no doubt, from dozens of peer-reviewed studies, that masks cause social, psychological, and medical problems, including a constellation of maladies called "mask-induced exhaustion syndrome."

Yet public-health officials, in violation of the first-do-no-harm principle, continue recommending or mandating masks without good evidence of their effectiveness or any pretense of cost-benefit analysis. Masks are still required in many hospitals and other institutions. Despite all the data showing that Covid-19 poses virtually no risk to healthy children, the CDC continues to recommend masking all students in communities where infection rates are rising. While the WHO advises against masks for children under six, and the European Union advises against them for students under 12, the CDC cruelly recommends masking everyone from age two on up.

The CDC's director, Rochelle Walensky, remains determined to ignore the best research on masks, as she made clear in a congressional hearing earlier this month. "Our masking guidance doesn't really change with time," she said when asked how the new review from Cochrane would affect the agency's policies. "This is an important study," she conceded, "but the Cochrane review only includes randomized clinical trials, and, as you can imagine, many of the randomized clinical trials were for other respiratory viruses."

It was a statement remarkable for its chutzpah as well as its scientific incoherence. One of the worst mistakes of the CDC and other lavishly funded federal agencies was the failure to conduct randomized clinical trials to determine whether their policies were effective. The Cochrane review had to rely on pandemic mask trials conducted in other countries—and now Walensky has the gall to complain that other countries didn't do enough of the research that U.S. agencies shirked. She's right that some of the trials involved other viruses, but why dismiss them as irrelevant to the coronavirus? And while one can always wish for more studies to include in a meta-analysis, that's no excuse to ignore the best available evidence in favor of the shoddy science peddled by her agency to defend its policies.

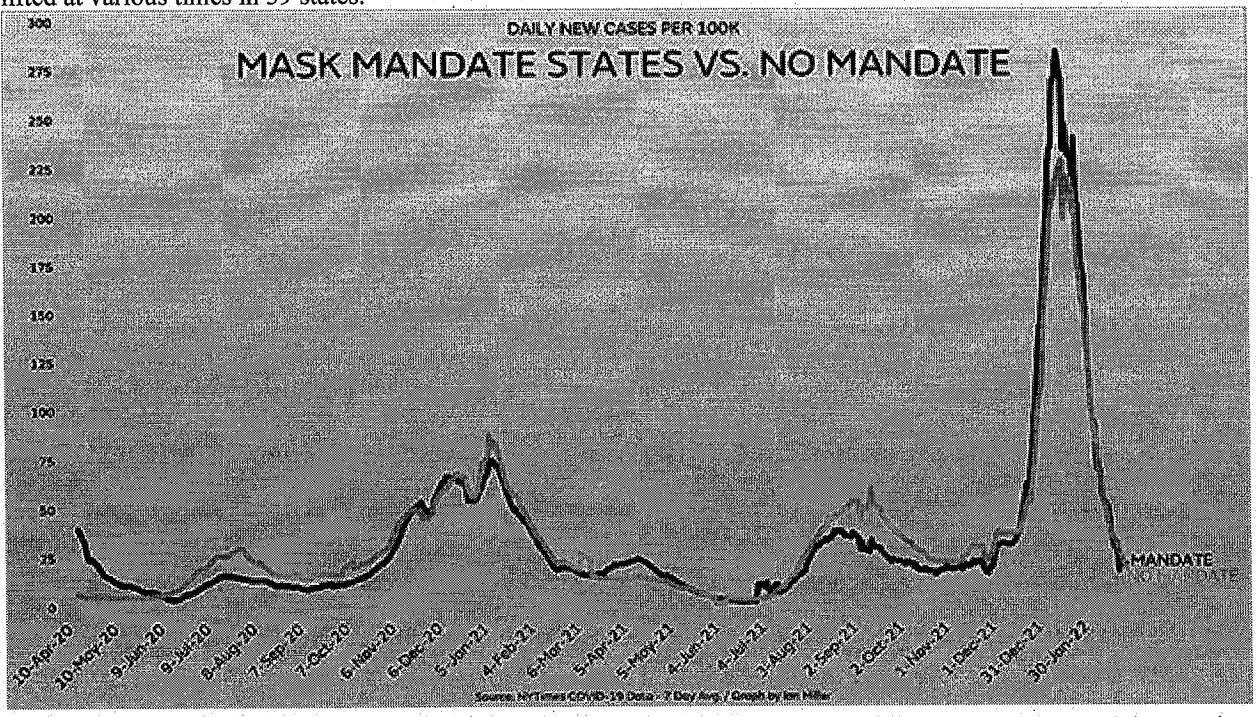
Early in the pandemic, the CDC justified its newfound enthusiasm for masks in a press release hailing "the latest science" from a case study of a hair salon in Missouri. "Wearing a mask prevented the spread of infection from two hair stylists to their customers," the CDC proclaimed, a preposterously sweeping conclusion to draw from a small observational study that lacked a control group and had other obvious limitations (most of the salon's customers were never even tested for Covid). On national television, Walensky touted another study, of schools in Arizona, as proof that masks dramatically reduced the spread of Covid, but the study's methodology was so clearly flawed—and the results so out of line with rigorous studies—that other Covid researchers dismissed it as "ridiculous" and "so unreliable that it probably should not have been entered into the public discourse."

Instead of sponsoring—or at least heeding—clinical trials, the CDC kept searching for confirmation from less reliable research. It repeatedly cherry-picked observational data, crediting masks for a short-term reduction in Covid rates in some localities while ignoring contrary data from more systematic analyses, such as a study that tracked rates nationwide over the entire first year of the pandemic—and found that neither mask mandates nor mask usage correlated with infection rates.

Can anything persuade the maskaholics in the public-health establishment and the public to give up their obsession? Some researchers, echoing Walensky, concede that the Cochrane review is the gold standard but argue that the clinical trials so far haven't been extensive enough to rule out the possibility that masks might do some good. But

that vague possibility is no reason to force masks on people: a public-health intervention is supposed to be based on solid evidence, not wishful thinking.

In his book *Unmasked: The Global Failure of COVID Mask Mandates*, data analyst Ian Miller devotes an entire chapter to graphs exposing the CDC's statistical malfeasance. He also prepared a graph for a previous *City Journal* article that is worth showing again, because it's a visual confirmation—from nationwide data, not clinical trials—of the conclusions in the Cochrane review. The graph tracks the results of the natural experiment that occurred across the United States in the first two years of the pandemic, when mask mandates were imposed and lifted at various times in 39 states.



The black line on the graph shows the weekly rate of Covid cases in states with mask mandates that week, while the orange line shows the rate in states without mandates. As you can see, the trajectories are virtually identical, and if you add up all those numbers, the cumulative rates of Covid cases are virtually identical, too. So are the cumulative rates of Covid mortality (the mortality rate is actually a little lower in the states without mask mandates). Hundreds of millions of Americans dutifully covered their faces in the states with mandates, and the result was the same as in the clinical trials analyzed by Cochrane: the masks made no difference.

7 - 1

Cochrane Database of Systematic Reviews

Physical interventions to interrupt or reduce the spread of respiratory viruses

Tom Jefferson[a], Liz Dooley, Eliana Ferroni, Lubna A Al-Ansary, Mieke L van Driel, Ghada A Bawazeer, Mark A Jones, Tammy C Hoffmann, Justin Clark, Elaine M Beller, Paul P Glasziou, John M Conly

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Abstract

Background

Viral epidemics or pandemics of acute respiratory infections (ARIs) pose a global threat. Examples are influenza (H1N1) caused by the H1N1pdm09 virus in 2009, severe acute respiratory syndrome (SARS) in 2003, and coronavirus disease 2019 (COVID-19) caused by SARS-CoV-2 in 2019. Antiviral drugs and vaccines may be insufficient to prevent their spread. This is an update of a Cochrane Review last published in 2020. We include results from studies from the current COVID-19 pandemic.

Objectives

To assess the effectiveness of physical interventions to interrupt or reduce the spread of acute respiratory viruses.

Search methods

We searched CENTRAL, PubMed, Embase, CINAHL, and two trials registers in October 2022, with backwards and forwards citation analysis on the new studies.

Selection criteria

We included randomised controlled trials (RCTs) and cluster-RCTs investigating physical interventions (screening at entry ports, isolation, quarantine, physical distancing, personal protection, hand hygiene, face masks, glasses, and gargling) to prevent respiratory virus transmission.

Data collection and analysis

We used standard Cochrane methodological procedures.

Main results

We included 11 new RCTs and cluster-RCTs (610,872 participants) in this update, bringing the total number of RCTs to 78. Six of the new trials were conducted during the COVID-19 pandemic; two from Mexico, and one each from Denmark, Bangladesh, England, and Norway. We identified four ongoing studies, of which one is completed, but unreported, evaluating masks concurrent with the COVID-19 pandemic.

Many studies were conducted during non-epidemic influenza periods. Several were conducted during the 2009 H1N1 influenza pandemic, and others in epidemic influenza seasons up to 2016. Therefore, many studies were conducted in the context of lower respiratory viral circulation and transmission compared to COVID-19. The included studies were conducted in heterogeneous

settings, ranging from suburban schools to hospital wards in high-income countries; crowded inner city settings in low-income countries; and an immigrant neighbourhood in a high-income country. Adherence with interventions was low in many studies.

The risk of bias for the RCTs and cluster-RCTs was mostly high or unclear.

Medical/surgical masks compared to no masks

We included 12 trials (10 cluster-RCTs) comparing medical/surgical masks versus no masks to prevent the spread of viral respiratory illness (two trials with healthcare workers and 10 in the community). Wearing masks in the community probably makes little or no difference to the outcome of influenza-like illness (ILI)/COVID-19 like illness compared to not wearing masks (risk ratio (RR) 0.95, 95% confidence interval (CI) 0.84 to 1.09; 9 trials, 276,917 participants; moderate-certainty evidence. Wearing masks in the community probably makes little or no difference to the outcome of laboratory-confirmed influenza/SARS-CoV-2 compared to not wearing masks (RR 1.01, 95% CI 0.72 to 1.42; 6 trials, 13,919 participants; moderate-certainty evidence). Harms were rarely measured and poorly reported (very low-certainty evidence).

N95/P2 respirators compared to medical/surgical masks

We pooled trials comparing N95/P2 respirators with medical/surgical masks (four in healthcare settings and one in a household setting). We are very uncertain on the effects of N95/P2 respirators compared with medical/surgical masks on the outcome of clinical respiratory illness (RR 0.70, 95% CI 0.45 to 1.10; 3 trials, 7779 participants; very low-certainty evidence). N95/P2 respirators compared with medical/surgical masks may be effective for ILI (RR 0.82, 95% CI 0.66 to 1.03; 5 trials, 8407 participants; low-certainty evidence). Evidence is limited by imprecision and heterogeneity for these subjective outcomes. The use of a N95/P2 respirators compared to medical/surgical masks probably makes little or no difference for the objective and more precise outcome of laboratory-confirmed influenza infection (RR 1.10, 95% CI 0.90 to 1.34; 5 trials, 8407 participants; moderate-certainty evidence). Restricting pooling to healthcare workers made no difference to the overall findings. Harms were poorly measured and reported, but discomfort wearing medical/surgical masks or N95/P2 respirators was mentioned in several studies (very low-certainty evidence).

One previously reported ongoing RCT has now been published and observed that medical/surgical masks were non-inferior to N95 respirators in a large study of 1009 healthcare workers in four countries providing direct care to COVID-19 patients.

Hand hygiene compared to control

Nineteen trials compared hand hygiene interventions with controls with sufficient data to include in meta-analyses. Settings included schools, childcare centres and homes. Comparing hand hygiene interventions with controls (i.e. no intervention), there was a 14% relative reduction in the number of people with ARIs in the hand hygiene group (RR 0.86, 95% CI 0.81 to 0.90; 9 trials, 52,105 participants; moderate-certainty evidence), suggesting a probable benefit. In absolute terms this benefit would result in a reduction from 380 events per 1000 people to 327 per 1000 people (95% CI 308 to 342). When considering the more strictly defined outcomes of ILI and laboratory-confirmed influenza, the estimates of effect for ILI (RR 0.94, 95% CI 0.81 to 1.09; 11 trials, 34,503 participants; low-certainty evidence), and laboratory-confirmed influenza (RR 0.91, 95% CI 0.63 to 1.30; 8 trials, 8332 participants; low-certainty evidence), suggest the

intervention made little or no difference. We pooled 19 trials (71, 210 participants) for the composite outcome of ARI or ILI or influenza, with each study only contributing once and the most comprehensive outcome reported. Pooled data showed that hand hygiene may be beneficial with an 11% relative reduction of respiratory illness (RR 0.89, 95% CI 0.83 to 0.94; low-certainty evidence), but with high heterogeneity. In absolute terms this benefit would result in a reduction from 200 events per 1000 people to 178 per 1000 people (95% CI 166 to 188). Few trials measured and reported harms (very low-certainty evidence).

We found no RCTs on gowns and gloves, face shields, or screening at entry ports.

Authors' conclusions

The high risk of bias in the trials, variation in outcome measurement, and relatively low adherence with the interventions during the studies hampers drawing firm conclusions. There were additional RCTs during the pandemic related to physical interventions but a relative paucity given the importance of the question of masking and its relative effectiveness and the concomitant measures of mask adherence which would be highly relevant to the measurement of effectiveness, especially in the elderly and in young children.

There is uncertainty about the effects of face masks. The low to moderate certainty of evidence means our confidence in the effect estimate is limited, and that the true effect may be different from the observed estimate of the effect. The pooled results of RCTs did not show a clear reduction in respiratory viral infection with the use of medical/surgical masks. There were no clear differences between the use of medical/surgical masks compared with N95/P2 respirators in healthcare workers when used in routine care to reduce respiratory viral infection. Hand hygiene is likely to modestly reduce the burden of respiratory illness, and although this effect was also present when ILI and laboratory-confirmed influenza were analysed separately, it was not found to be a significant difference for the latter two outcomes. Harms associated with physical interventions were under-investigated.

There is a need for large, well-designed RCTs addressing the effectiveness of many of these interventions in multiple settings and populations, as well as the impact of adherence on effectiveness, especially in those most at risk of ARIs.

8-1

The True Lesson of Mask Mandates Goes Far Beyond the Fact That They Didn't Work

March 4, 2023 Jon Miltimore

Writing in the New York Times on Tuesday, columnist Bret Stephens *highlighted* new research from an Oxford University epidemiologist who found that masks—and mask mandates—did nothing to slow the spread of Covid-19 or protect people from the virus.

The most rigorous and comprehensive analysis of scientific studies conducted on the efficacy of masks for reducing the spread of respiratory illnesses — including Covid-19 — was published late last month. Its conclusions, said Tom Jefferson, the Oxford epidemiologist who is its lead author, were unambiguous.

"There is just no evidence that they" — masks — "make any difference," he told the journalist Maryanne Demasi. "Full stop."

But, wait, hold on. What about N-95 masks, as opposed to lower-quality surgical or cloth masks?

"Makes no difference — none of it," said Jefferson.

What about the studies that initially persuaded policymakers to impose mask mandates?

"They were convinced by nonrandomized studies, flawed observational studies."

The op-ed has gathered a great deal of attention, especially from opponents of mask mandates who for years have argued masking did not offer the protection against the virus that mask proponents claimed. I must point out, however, this isn't the first time the Grey Lady has taken aim at masking or mask mandates. In June 2022 I highlighted an article written by Pulitzer Prize-winning writer David Leonhardt that explored the ineffectiveness of mask mandates.

In U.S. cities where mask use has been more common, Covid has spread at a similar rate as in mask-resistant cities. Mask mandates in schools also seem to have done little to reduce the spread. Hong Kong, despite almost universal mask-wearing, recently endured one of the world's worst Covid outbreaks.

Advocates of mandates sometimes argue that they do have a big effect even if it is not evident in population wide data, because of how many other factors are at play. But this argument seems unpersuasive.

Not to toot my own horn, but I was writing against mask mandates when it was still considered verboten to do so. I was called anti-science for pointing out uncomfortable truths. Some readers even said they hoped my children would die of Covid for writing such a thing.

In reality, it was the mask mandate proponents who were anti-science.

How did they make such a mistake? Some might argue they simply relied on bad studies, and that is of course part of the problem. But the truth is they made two mistakes that were even bigger.

The first was ignoring that masking came with serious tradeoffs, something some scientists learned the hard way. The second mistake was to focus on ends instead of means.

As I pointed out last summer, libertarians are fond of a popular adage: good ideas don't require force. Libertarians don't use this line just because we have an aversion to coercion. We use it because we are aware that force also produces dismal ***results***.

We often forget this, and I don't just mean humans.

A lot of *libertarians* forgot this lesson during the pandemic. Many notable libertarian leaders and institutions (I'll refrain from naming them) were notably silent about lockdowns and other NPI (Nonpharmaceutical Interventions) in 2020. (Some of them found their voices in 2021 and 2022.)

Whether this was out of cowardice or the belief that these mitigations would actually work we'll never know. Either way, they would do well to read FEE founder Leonard Read, who in his 1969 essay "The Bloom Pre-Exists in the Seed," argued that one could reasonably predict the ends of an action by the means employed.

Examine the actions—means—that are implicit in achieving the goals.

Implicit in the collectivistic approach...is the masterminding of the people...The control of the individual's life is from without. [But for] an individualist...what is valued above all else [is] each distinctive individual human being.

Any conscientious collectivist, if he could...properly evaluate the authoritarian means his system of thought demands, would likely defect.

However lofty the goals, if the means be depraved, the result must reflect that depravity.
In his Times article, Stephens asks: "Will any lessons be learned?"

It's an important question, but the real lesson from the pandemic isn't that masking doesn't work. It's that we need to focus on the means we use, not the ends we seek.

9-1

Pfizer Knowingly Allowed Dangerous Components In Its Vaccines

FEB 21, 2023

Yuhong Dong M.D., Ph.D and Qinyang Jiang via The Epoch Times,

Pfizer's COVID-19 vaccine contains mRNA fragments called "truncated mRNA." This is a serious issue on top of the vaccine's life-threatening safety events. Stunningly, Pfizer submitted falsified mRNA analytical reports to multiple health authorities.

The issue of truncated mRNA led the European Medicines Agency (EMA) to raise a "major objection" before its December 2020 conditional approval of the vaccine. What has happened? How have these issues been considered resolved? This two-part series article will address the matter in depth and examine its potential consequences for human health.

Summary of Key Facts

- Pfizer's COVID-19 vaccine contains truncated mRNA, which the EMA flagged as a reason for its "major objection," indicating a preclusion of their approval.
- Pfizer has not investigated the detrimental outcomes of truncated mRNA in its vaccines.
- Pfizer submitted Western blot figures to the Food and Drug Administration (FDA) and the EMA that were digitally generated—not from actual experiments.
- There has been an alarming lack of action taken by health authorities on this issue.
- Truncated mRNA potentially contributes to multiple vaccine-related injuries, including misfolded spike protein-induced fibrous blood clots, autoimmune disorders, and cancer.
- These problems with the Pfizer vaccine could have resulted in drastic product quality variations from batch to batch. This could explain the difference in adverse events experienced by vaccine recipients.
- The root cause of such irresponsible conduct by pharma and health authorities is a lack of ethics.

When you go to a supermarket and want to buy 10 bottles of whole milk for your children, you usually assume the chemicals and concentrations in these 10 bottles are the same or similar. No one would expect five of the bottles to be filled with watered-down milk while the other five were filled with yogurt.

Most store-bought foods meet our expectations because of regulations and quality control. The same criteria also exist in the pharma industry, including vaccine products.

We expect consistent physical and chemical parameters of key ingredients across different batches of drug or vaccine products. Consistency is the foundation that allows patients and consumers to have confidence in the safety and effectiveness of medications.

The CMC process—short for chemistry, manufacturing, and controls—involves defining manufacturing practices and product specifications that must be followed to ensure product safety and consistency between batches. This is a mandatory criterion for global health authorities to approve a drug or vaccine.

9-2

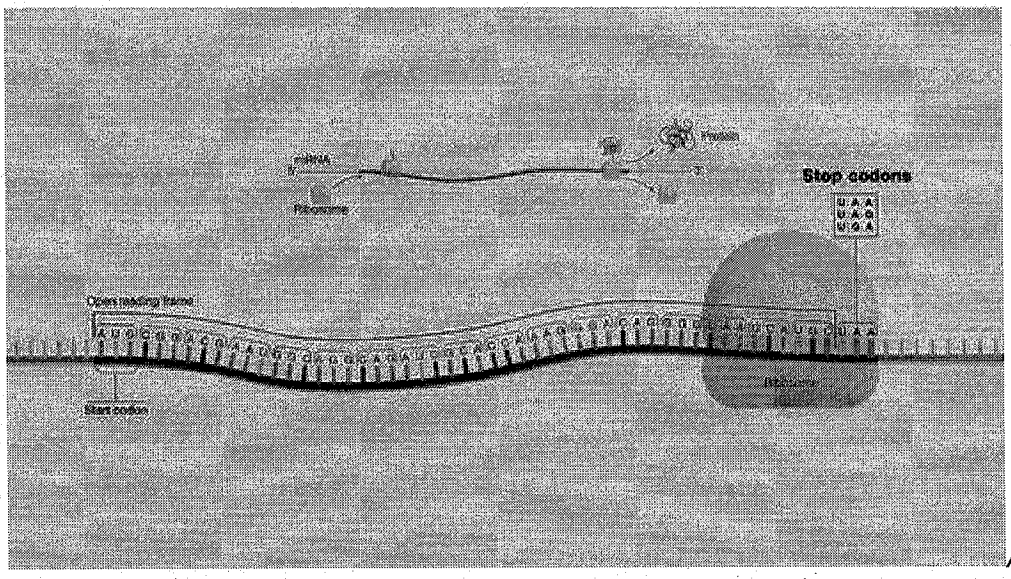
Controlling the quality of a traditional chemical product is relatively straightforward, but for a biological product, like an mRNA, things become more complicated.

What Is Truncated mRNA? Why Does it Matter?

Our DNA contains gene codes composed of nucleotides. DNA makes proteins consisting of amino acids. Between the gene code and protein, there is a bridge molecule, a "translator"—called messenger RNA (mRNA).

The full-length mRNA sequence of the Pfizer vaccine coding for the spike protein is 4,284 nucleotides in length.

It consists of a 5′ CAP structure to prime its translation into a spike protein. It works like an ignition box of a car. At the end of the translatable region, the open reading frame, there is a stop codon, which is like a car's brakes. If a truncated mRNA does not contain a stop codon, it fails to give a "brake" signal. The protein translation process will continue endlessly.



An mRNA translation into a protein and the role of the stop codon. (Courtesy: National Human Genome Research Institute)

Truncated mRNA's missing stop codon is highly detrimental to humans. It can lead to the production of toxic protein products.

Pfizer's COVID-19 Vaccine Contains Truncated mRNA

The EMA is responsible for approving all medicinal products for human use in Europe, including drugs and vaccines. The Committee for Medicinal Products for Human Use (CHMP) is the EMA's committee responsible for interpreting the agency's opinions.

In an EMA assessment report coded EMA/CHMP/448917/2021, the EMA requested that Pfizer address the impurities of its vaccine product, which the EMA report described as "truncated and modified mRNA."

Pfizer's report to the EMA clearly showed that Pfizer's vaccine contained impurities, as indicated by "Peak 1" in the graph below, based on a screenshot from page 14 of the EMA's August 2021 report.

10-1

Recent Evidence from Three Major Healthcare Systems Suggests Lack of COVID-19 Boosters Does Not Increase Hospitalization (VIDEO)

Jim Hoft Feb. 21, 2023

Contrary to claims made by the Biden regime and the media, the decline in the number of young people receiving a COVID-19 booster compared to those of older ages has not been linked to a surge in hospitalizations.

Recently released information from three major healthcare systems, two in New York and one in Israel, indicated that a lack of COVID-19 booster doses for younger people are not becoming severely ill and did not increase hospitalizations.

"Data from the three large health care systems in New York and Israel since September 1 indicate that the low booster uptake for people under 65 has not led to high Covid hospitalization rates for this group," CNN **reported**.

"Even if they're not getting boosted, young, healthy people are not getting super sick from this," said Dr. Mangala Narasimhan, a senior vice president at Northwell Health, the largest health care provider in New York state. "We're not seeing it. It's not happening."

The outlet added, "The US Food and Drug Administration has proposed a framework for annual Covid vaccinations for all Americans over the age of 6 months, but at a meeting with its vaccine advisers last month, it did not come up with a concrete plan. Vaccine advisers to the US Centers for Disease Control and Prevention are scheduled to meet February 24 to discuss the future of the US Covid-19 vaccination program."

The bivalent booster was released in September, but it has seen little uptake. According to the CDC, just around 16% of the US population has received it and the rate is even lower for those under the age of 65.

"I don't think that's the case anymore," said Dr. Ran Balicer, Director of the Clalit Research Institute and chairman of Israel's Covid-19 National Expert Advisory Panel.

"I think when you're under 65 and healthy, it's a much more complex question, and I think that's where individual risk assessment and personal preferences come into play," he continued.

Dr. Daniel R. Kuritzkes, Chief of Infectious Diseases at Brigham and Women's Hospital, said that the data from these three major healthcare systems was consistent with what was happening in Massachusetts.

"We know that hospitalizations are much higher for people age 80 and above, somewhat higher for people in their 70s, and very, very low for people who are younger than 60s. So, that's very much like the data that you've seen," Kuritzkes told WVBC-TV, an ABC affiliate in Boston.

"We know health officials would want to improve those rates, but if younger people don't really get that sick from COVID do we need to worry so much about whether they are in fact boosted or not?" Anchor Erika Tarantal asked.

"I think that's an important question, to be honest. We really just don't know. That was a big point of controversy at the recent FDA advisory panel hearings on exactly what to advise younger people. To paraphrase the old World War II song, someday we'll boost again, don't know how, don't know when, but people will be boosting at some point, but we honestly don't know how soon they'll need it." Dr. Kuritzkes said.

"I think we'll have to see is there a time at which younger people begin to start getting more seriously ill. And I think it's important to point out these have to be healthy young people. I wouldn't defer a vaccination if you had a preexisting condition that places you at greater risk for severe COVID regardless of age," he continued.

In the UK, the British government officially declared that it would no longer require healthy people under the age of 50 to receive COVID booster doses.

As the UK begins to recover from the pandemic, the universal Covid vaccine program will be phased out this year.

"As the transition continues away from a pandemic emergency response towards pandemic recovery, the [Joint Committee on Vaccination and Immunisation] JCVI has advised that the 2021 booster offer (third dose) for persons aged 16 to 49 years who are not in a clinical risk group should close in alignment with the close of the autumn 2022 booster vaccination campaign," the government **said** in a news release.

In Denmark, it was **no longer possible** for children and adolescents aged under 18 to get the first COVID vaccine injection and the second injection.

Only those who are over 50 and those who are at higher risk are eligible for COVID shots.

11-1

Deep sequencing of the Moderna and Pfizer bivalent vaccines identifies contamination of expression vectors designed for plasmid amplification in bacteria

February 16, 2023

Introduction

As universities in the United States continue to mandate liability-free injections (COVID vaccines) for students at limited risk of contracting COVID, it becomes imperative that more public information be made available for the ingredients of these experimental vaccines. Both the EMA and the TGA have made note of fragmented RNA and smeary western blots suggesting the vaccine manufacturing process lacks fidelity and transparency. Shortly after the TGA data was released, Patel *et al.* (Pfizer) published a paper attempting to defuse these concerns. Jessica Rose has covered this topic here.

Informed consent cannot be obtained with poorly characterized therapeutics.

We are now entering the third year of COVID and it has become increasingly clear which demographics are at risk. The student age group (under 25) has repeatedly been shown to have very low risk of COVID yet the vaccine induced adverse events for students in this age bracket is higher than any vaccine ever administered. Krug *et al.* observed a risk of 1:6250 risk for myo/pericarditis in 16-17 year olds (Krug et al).

> Trop Med Infect Dis. 2022 Aug 19;7(8):196. doi: 10.3390/tropicalmed7080196.

Cardiovascular Manifestation of the BNT162b2 mRNA COVID-19 Vaccine in Adolescents

Suyanee Mansanguan [1], Prokaykaew Charunwatthana [2], Watcharapong Piyaphanee [2], Wilanee Dechkhajorn [3], Akkapon Poolcharoen [4], Chayasin Mansanguan [2]

Affiliations + expand

PMID: 36006288 PMCID: PMC9414075 DOI: 10.3390/tropicalmed7080196

Free PMC article

Abstract

This study focuses on cardiovascular manifestation, particularly myocarditis and pericarditis events, after BNT162b2 mRNA COVID-19 vaccine injection in Thai adolescents. This prospective cohort study enrolled students aged 13-18 years from two schools, who received the second dose of the BNT162b2 mRNA COVID-19 vaccine. Data including demographics, symptoms, vital signs, ECG, echocardiography, and cardiac enzymes were collected at baseline, Day 3, Day 7, and Day 14 (optional) using case record forms. We enrolled 314 participants; of these, 13 participants were lost to follow-up, leaving 301 participants for analysis. The most common cardiovascular signs and symptoms were tachycardia (7.64%), shortness of breath (6.64%), palpitation (4.32%), chest pain (4.32%), and hypertension (3.99%). One participant could have more than one sign and/or symptom. Seven participants (2.33%) exhibited at least one elevated cardiac biomarker or positive lab assessments. Cardiovascular manifestations were found in 23.24% of patients, ranging from tachycardia or palpitation to myopericarditis. Myopericarditis was confirmed in one patient after vaccination. Two patients had suspected pericarditis and four patients had suspected subclinical myocarditis. In conclusion, Cardiovascular manifestation in adolescents after BNT162b2 mRNA COVID-19 vaccination included tachycardia, palpitation, and myopericarditis. The clinical presentation of myopericarditis after vaccination was usually mild and temporary, with all cases fully recovering within 14 days. Hence, adolescents receiving mRNA vaccines should be monitored for cardiovascular side effects. Clinical Trial Registration: NCT05288231.

This research document is 49 pages long. Go to https://anandamide.substack.com/p/curious-kittens for full document.

12 -1

Dr. Naomi Wolf on the War Room: Based on a Recent Sample of Deceased COVID Vaccine Is Likely Causing Catastrophic Damage to Recipients

Joe Hoft February 17, 2023

Video Interview at https://rumble.com/v29scem-naomi-wolf-autopsies-revealed-catastrophic-lesions-on-many-organs-likely-ca.html

Dr. Naomi Wolf discussed the results of a recent study that she and a team of doctors put together regarding health issues after taking COVID-19 vaccines. The results were shocking.

Dr. Naomi Wolf joined Steve Bannon on the War Room on Thursday and discussed the result of her team's **Report 56**. The results were frightening.

Here are parts from the summary of the report:

Dr. Arne Burkhardt is one of eight international pathologists, physicians and scientists who were asked to perform a second autopsy, requested by friends and family of the deceased who were not satisfied with the results of the first autopsy.

Thirty autopsies and three biopsies were evaluated; 15 cases with routine histopathology (Step 1), three with advanced methods (Step 2), and some of the remaining 15 are included as illustrative cases...

...Causation by SMGT [Spike-Mediated Gene Therapy]: Very probable in five cases, probable in seven, unclear in two and no connection in one.

Lesions were on multiple organs including: Brain, Heart, Kidney, Liver, Lungs, Lymph Node, Salivary Gland, Skin, Spleen, Testis, Thyroid and Vascular.

Lymphocyte Infiltration, present in 14 of 20 cases (70%), was a common feature and involved multiple organs. Case 19 had at least five different organs involved. CD3+ Lymphocytes were dominant.

The Vascular System was targeted by Lymphocyte Infiltration in seven (35%) of the cases and included sloughing endothelium, destruction of the vessel wall, hemorrhage and thrombosis.

A condition called Lymphocyte Amok was described by Dr. Burkhardt: Lymphocyte accumulation in non-lymphatic organs and tissues that might develop into lymphoma.

Five cases of unknown foreign material in blood vessels were identified. The favored explanation for origin of this material was aggregated Lipid Nanoparticles (LNPs).
These results are a bit technical. Dr. Wolf explains these findings in her interview below.

"...Report 56 is just incontrovertible proof that we are at war. Because it shows that this injection, that I've been saying is a bioweapon, is causing catastrophic damage in at least these 30 deceased people who were autopsied...

...So what they found is catastrophic leisions throughout the body on many, many organs...They found probable cause, or likely cause that the vaccine was the cause.