Children's Health Defense
AUSTRALIA CHAPTER

OPEN LETTER TO ALL DOCTORS AND ALL AUSTRALIANS

RE: Notice of Liability for Doctors, and all parties administering injections.

Signed: a collective of concerned Australian Doctors, (published via Children's Health Defense Australia).

Doctors, health professionals and millions of concerned Australians are demanding a return to transparent and evidence-based pandemic preparedness and early-stage treatment.

'PRIMUM NON NOCERE' – FIRST, DO NO HARM

We, your fellow doctors, write to you motivated only by our concern for the welfare of our patients and the health of our community. Every doctor, like any individual, must answer to their own conscience. Doctors in particular must answer to an Oath, the swearing in of which has fallen away, yet not without leaving its spirit alive. This oath was, and is, founded upon 'primum non nocere' or 'first, do no harm'. And so this letter is aimed at **reminding all doctors of our ethical obligations and to furnish our consciences with information so that none can claim 'I did not know' or 'I was wrongly advised' or 'I was just following orders'**. The people of Australia face unprecedented, pervasive and coercive 'States of Emergency' with severe restrictions to liberty and widespread impacts on health, life and livelihoods.

'Flattening the curve' for a few weeks has evolved into close to two years of fear, anxiety and control. Much of it unnecessarily contrived through sensationalist media, failed political leadership that has abdicated its responsibilities to academic and health bureaucrats who appear far removed from the realities and sufferings of ordinary Australians. In early 2020, the Australian government, following the example of other countries, and the sudden about-turn of the World Health Organisation (WHO), abandoned long-established and existing pandemic guidelines in favour of enforced lockdowns, mask mandates, mass-testing, digital surveillance, border closures and the quarantining of the healthy. This approach was **novel, untested and unprecedented**.

In the reckless pursuit of the mirage of an unattainable 'Covid Zero' state, **400 Australians die every day from all causes. These Australians are dying within a grossly disrupted heath care system and while their loved ones are inhumanely denied the opportunity to properly mourn them**.

We have had 2,056 deaths attributed to **Covid-19 over almost 2 years**, from March 2020 to December 8th 2021. Compare this to **1,974 registered deaths from**

ischaemic heart disease in a two month period; January to February 2021 alone. The average age of death from Covid-19 remains 86.9 which is higher than average life expectancy in Australia which is 82 years. This global public health experiment has clearly failed, having caused untold harm to literally billions of people. A **return to long established, evidenced-based pandemic preparedness guidelines must now be urgently sought**.

CASES AND PCR TESTS

Every medical student is taught that clinical diagnosis is founded upon three unshakable tenets. History, Examination, Investigation in that order of hierarchical importance. With the unprecedented utilisation of PCR based diagnosis in the interest of public health and mass screening the Doctor has been dangerously removed from the diagnostic process. We now have a situation where an infection has been defined as a positive result on PCR. PCR has been demonstrated to be inadequate as a measure of illness severity and infectivity and so is not fit for purpose. **Excessive Amplification Cycles of 37 - 45 have been used routinely, guaranteeing a 95% false positive clinical result. We call upon doctors to inform themselves more fully and reject the flawed data and overly severe policies driven by forensic PCR technology.** As of December 31 2021, the CDC will have withdrawn its' support for this controversial testing method.

MORTALITY RISK

'Covid deaths' have often been defined as 'a death with a positive PCR Test' rather than as a result of the recognised disease process and illness caused by the SARS-CoV2 virus. However, we all know that **multiple co-morbidities are involved 94% of the time** (*CDC: 94% of Covid-19 deaths had underlying medical conditions | WEYI nbc25news.com*). Thus it is more than likely the **3.8 million deaths listed in this reference are an overestimate**. Overwhelmingly these deaths have been in the frail elderly and others with serious pre-existing illness, (often in populations where the average age of death with/from covid exceeds that of the average life expectancy). That said, estimates of the **infectious fatality rate (IFR) cluster around 0.15-0.2% overall which is similar to the IFR of influenza**, and 0.05% for those under 70 years. The risk to children is very low, less than for influenza, and the risk to adolescents and young adults is 4 orders of magnitude lower than the elderly and so do not justify any restrictions applied across the population. We endorse the recommendations embodied in the Great Barrington Declaration which include allowing… "those who are at minimal risk of death to **live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk…[called] Focused Protection**."

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

RESTRICTIONS

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

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

MASKS

Pre-existing WHO guidelines state that there is **no evidence that face masks are effective in reducing transmission**. Cloth masks were not recommended under any circumstances. However, the evidence of harm caused by long term use is well-recognised and well-evidenced. N95, surgical or cloth masks were never designed to, nor are they capable of, stopping or reducing viral transmission. Without any new evidence, and under political pressure, the WHO changed its guidelines to allow governments to enforce mask mandates on its populations. However, it continues to acknowledge that there is **limited evidence to support the use of face masks by healthy people in the community**. Much of the claimed 'evidence' prompting this policy change comes from computer simulations, laboratory studies, or observational studies, which lack the rigour of randomised controlled trials (RCT). However, the recent RCT 'Danmask-19 trial' by Bundgaard et al, found **no statistically significant difference in rates of infection with SARS-CoV-2, between those who wore masks and those who did not in the community**.

EARLY TREATMENTS

There is abundant evidence (outlined below) supporting the use of anti-viral therapies, such as the **Nobel Prize winning** drug Ivermectin – in combination therapies with other agents including Zinc, Doxycycline, Azithromycin and Vitamin D3 – as both a relatively safe prophylactic and an early treatment for Covid illness. Aspirin, inhaled and oral steroids have also shown to be beneficial. Other agents being used in more difficult cases include Montelukast, Anti-coagulants, Maraviroc (a CCR5 Antagonist), Statins and Fluvoxamine. We believe doctors have an obligation to be informed of this and to offer such choices as preventative or early treatment alternatives to their patients. For the scientific evidence base please find the website below. *"In summary, **based on the totality of the trials and epidemiologic evidence presented in this review along with the preliminary findings of the Unitaid/WHO meta-analysis of treatment RCTs and the guideline recommendation from the international BIRD conference, Ivermectin should be globally and systematically deployed in the prevention and treatment of COVID-19***." Ref: American Journal of Therapeutics May/June 2021. All studies - including 44 peer-reviewed studies - on Ivermectin can be found here: https://ivmmeta.com/. An independent data analysis reviewing the effect of Ivermectin on Japans' population can also be found here: https://www.brightworkresearch.com/how-the-media-lied-about-japan-not-using-ivermectin-for-coronavirus/

THE VACCINE TECHNOLOGIES

The issue of Covid Vaccines is a controversial and sensitive one. We (the authors of this letter, and collective of concerned doctors) are unequivocally NOT " anti-vax ". We believe, in the interests of transparency and for the sake of individual patient care, that doctors should be aware of some important, yet lesser-known issues. We are concerned that many members of the public and some medical colleagues seem unaware of vital facts surrounding the current Covid vaccines. **Only provisional**

approval for 2 years has been granted by the TGA, for available covid vaccines, as they are considered investigational. Similarly, in the USA – due to incomplete efficacy and safety data – the available gene-based (mRNA and DNA) vaccines have only been made available by the FDA under Emergency Use Authorisation legislation. The **TGA Deputy Secretary, Professor John Skerritt, and Minister for Health Greg Hunt have both made public statements that this vaccine rollout is a clinical trial (effectively, an experiment) that will conclude in 2022**. Both available vaccines in Australia are totally new gene-based, nucleic acid (mRNA and DNA) vaccines and viral vector vaccines. The mRNA vaccine technology, using Lipid Nano-Particles (LNPs), has never previously been used on humans. Both vaccines carry genetic instructions for the host's cells to make antigen to induce an immune response. Due to the unprecedented 'rush to market' via Emergency Authorisation Usage in the USA, doctors should be aware of the deficiency of **many of the established standards for vaccine development which have been bypassed**. Of particular concern being the **absence of completed Developmental and Reproductive Toxicity (DART) studies. Neither were genotoxicity nor carcinogenicity studies performed. There is also an absence of long-term safety data**.

Concerns about biodistribution are also now being raised about both the 'produced' Spike Protein and LNP components of the vaccines. Evidence of their delivery and expression systemically, beyond the injection site, is now available, including the **unexpected accumulation of LNPs in the ovaries as revealed in the Japanese Ministry of Health animal studies, as well as studies revealing spike protein biodistribution concerns among health workers from Harvard's Brigham Women's hospital.** Both findings raise significant concerns about future fertility issues for young people. Concerns have also been raised that the induced **Spike Protein itself can act as a pathogen independent of the virus**, as has been revealed in the Salk Institute study, entitled: *COVID-19 is a Vascular Disease: Coronavirus' Spike Protein Attacks Vascular System on a Cellular Level*. Doctors, their patients and the general public should also be made more aware of the concerning and unprecedented 'safety signals' being raised through official reporting systems both in Australia and around the world (see **Appendix 2**), for example, the adverse events and deaths following vaccination that have been reported to the TGA. As of December 2021, **705 deaths and 91,346 adverse events** have been reported. Although this does not prove causation, the **comparison with previous incident reporting experience and comparative reporting systems raises grave concerns**: *https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report*

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

INFORMED CONSENT

Doctors have a legal obligation to inform patients of the important, 'material' risks involved in any proposed procedure or treatment. In keeping with the principle of shared-decision making, the NHMRC's informed consent guidelines, and Australian Vaccination Handbook Guidelines, it our opinion that **informed consent cannot be said to have been granted if the doctor has not informed the patient that,**

a) **they are a trial participant**
b) **effective preventive and early treatment therapies exist,**

c) **there are a wide range of possible adverse effects including death**
d) **people below 70 years are a low risk of death from the virus and**
e) **breakthrough infection and transmission is a possible side effect.**

We also believe that **the conditions of free and informed consent are not being met if the patient is under duress regarding their employment or freedom to travel**. We believe any medical therapy, including vaccination, should not be mandatory, consistent with the right to bodily integrity as recognised by Universal Declaration of Human Rights as well as other national and international human rights documents and covenants.

PROFESSIONAL AUTONOMY AND THE DOCTOR PATIENT RELATIONSHIP

The government has decided it is the best arbiter of what information you are provided access to and has **threatened practitioners with disciplinary action should they offer any critique against the government's public health responses, including the vaccine rollout**. They have also been inhibited in discussing and recommending early treatment alternatives such as Hydroxychloroquine and Ivermectin, even risking jail for 6 months in Queensland for transgressing such draconian directives and legislation. We, your colleagues, believe **it is the duty of doctors to advocate for their own professional Doctor – Patient relationship and stand against undue government interference in the consulting room.** Doctors who fail to do this **risk placing their patients' needs secondary to the interests of the State**, thereby risking damage to our noble profession as a source of independent, considered and fair advice. **Legal penalties will apply to both our position and our person should we neglect the information enclosed in this letter and as a consequence, neglect our sacred duties to our patients and to our primary oath, to 'first, do no harm'.** We thank you for your consideration of these important matters and urge you to join with us in returning our nation to rationality and excellence in medical care, and stand against any directive that places the state between a doctors duty and interest in care for our patients.

Sincerely,
A collective of your fellow concerned Australian Doctors
**Published via Children's Health Defense Australia*

APPENDIX 1

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

https://www.gov.uk/government/publications/regulatory-approval-of-pfizerbiontech-vaccine-for-covid- 19/information-for-healthcare-professionals-on-pfizerbiontech-covid19-vaccine

AstraZeneca classification:
The AstraZeneca Vaccine (ChAdOx1, AZD1222) is a chimpanzee adenovirus which enters host cells but has been modified to prevent replication. It is a double strand DNA vaccine carrying a gene encoding the SARS Co-V-2 spike protein surface glycoprotein.
The product contains genetically modified organisms.

https://newdrugapprovals.org/tag/sars-cov-2-vaccine/

Australian Product Information:
AstraZeneca

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

Pfizer (Comirnaty)

https://www.tga.gov.au/sites/default/files/auspar-bnt162b2-mrna-210125.pdf

APPENDIX 2

TGA Weekly Safety Report:

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

Possible Unintended Consequences of the mRNA Vaccines Against COVID-19:

https://ijvtpr.com/index.php/IJVTPR/article/view/23

Australian and International summary of Vaccine adverse reports:
Includes detailed source data downloads. Website maintained by Dr John Goss.

https://johnplatinumgoss.com/covid-19-vaccination-statistics/

CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel For Emergency Use Only Instructions for Use:

www.fda.gov/media/134922/download

Diagnostic detection of 2019-nCoV by real-time RT-PCR:

www.who.int/docs/default-source/coronaviruse/protocol-v2-1.pdf