6. Personal follow-up comments in May 2021

"He is wise who knows what he does not know." (Socrates)
Nevertheless: "Have the courage to use your own intellect!" (Kant)

Today, a year later, little has changed in my original findings:
At certain times in certain places, what is happening is extraordinary.
On the whole, the pandemic has fortunately been overestimated in its immediate effects determined by the infectious events - at least in Europe, for which I have data - because even in phases of excess mortality presumably triggered by the new virus, the virus remained - unlike in the case of the so-called Spanish flu, the plague and cholera - one of several main causes of death and much less significant than cardiovascular diseases, tumours or other respiratory diseases. As I said, in some phases of excess mortality, but not in that of summer heat.
At other times or in relation to a period of one year, the virus, in terms of virulence, remained far behind the latter, ever-present diseases as a cause of death .

I have not yet compared the death rates of different years myself, but I know of complicated calculations that take into account changes in the population pyramid, which I have not yet been able to verify.

The indirect effects of the measures taken and the fear generated are considerable in economic terms in

particular, but also socially and psychologically, especially for children and the so-called risk groups and for all those who are directly related to these risk groups.

I found the best account of the problem on 02/06/2020 in an interview with Amparo Larrauri, epidemiologist and head of the MoMo team and researcher at the Spanish National Epidemiological Centre:

"The excess mortality observed, (...) 'May be due to confirmed COVID-19 cases, unconfirmed COVID-19 cases that surveillance systems do not identify, and the pandemic indirectly. The latter is very important. **We have experienced a change in the social and health structure, and this has meant that many people with underlying pathologies have not gone to the doctor for a multitude of reasons, such as fear of contagion or that their consultations did not work as they usually did. And a host of reasons that are not medical, but social. Many studies suggest that the fact that a vulnerable, older person has been isolated and in confinement affects their health and evolution more than younger people. Unfortunately, we can all see such cases around us. These are deaths that are not due to COVID-19, but they are related to this whole process.'**" (2) (Emphasis mine.)

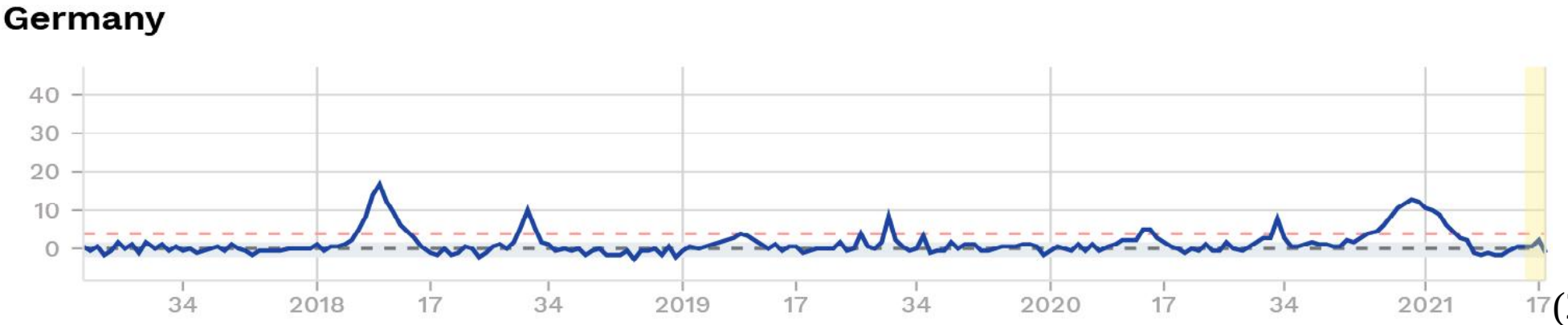
["El exceso de mortalidad constatado, (...) 'Puede deberse a casos con COVID-19 confirmada, a casos con COVID-19 sin confirmar y que los sistemas de vigilancia no identifican, y a la pandemia de manera indirecta. Esto último es muy importante. **Hemos vivido un cambio de estructura social y sanitaria, y eso ha provocado que muchas personas con patologías de base no se hayan acercado al médico por multitud de razones, como que temían el contagio o que sus consultas no funcionaban como lo hacían habitualmente. Y un montón de razones que no son médicas, sino sociales. Muchos estudios sugieren que el hecho de que una persona vulnerable, mayor, haya estado aislada y en confinamiento, infiere en su salud y evolución, afecta más que a personas jóvenes. Desgraciadamente, todos podemos ver casos así a nuestro alrededor. Son muertes que no son por**

COVID-19, pero están relacionadas con todo este proceso.”“] (2) (Emphasis mine.)

I want to make it clear that my afterthoughts are not about an either-or, but a both-as well. Life is not black and white. It consists of infinite shades of grey. And colours! Which I would like to face up to.

First and second wave in Germany

Since April 2021, the Robert Koch Institute, Berlin, has thankfully provided the EuroMoMo project in Copenhagen not only with data for Berlin, but for all of Germany. It is now possible to easily trace mortality since around early summer 2017 beyond the two regions of Hesse and Berlin.



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Thus, for influenza 2017/18 compared to COVID-19 in spring 2020, it is clear at a glance what was a little more laborious to extract from this table:

Table 2: Monthly deaths (all causes) in Germany at times of influenza and COVID-19[15]

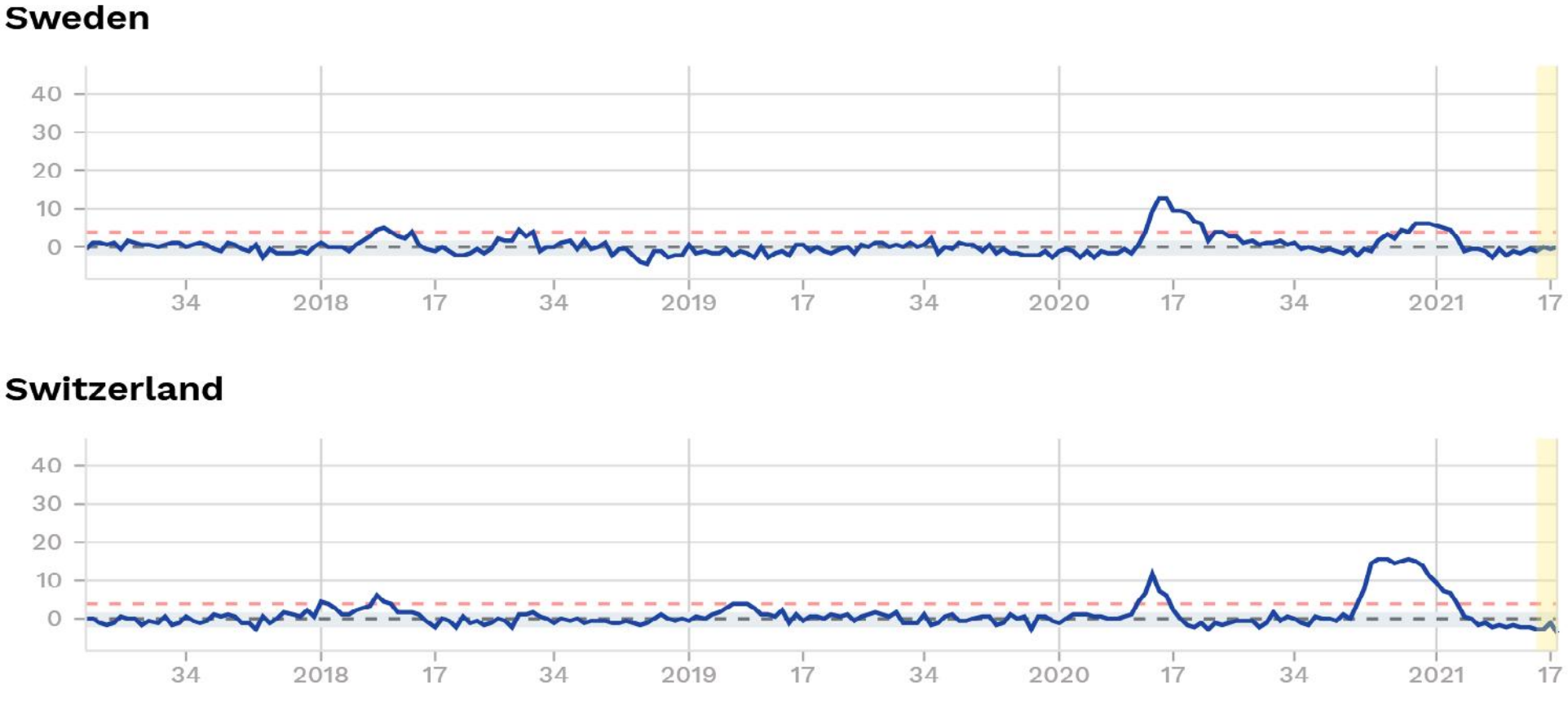
Flu 2016-17	**12/2016**	**01/2017**	**02/2017**	**03/2017**	**Sum 4 months**
	84,339	96,033	90,649	82,934	353,955
Flu 2017/18	**12/2017**	**01/2018**	**02/2018**	**03/2018**	
	81,610	84,973	85,799	107,104	359,486
COVID-19	**01/2020**	**02/2020**	**03/2020**	**04/2020**	
	85,194	79,646	86,825	82,664	334,329

What also becomes clear, however, is the marked increase in deaths in Germany around the turn of 2020/21, which goes far beyond what was observed in the so-called "first wave" and - as in Spain in spring 2020 - is unusual for the time of year.

Spain

The peak values in Germany are still below those of the 2017/18 flu, but the flatter curve stretches

longer in time. In any case, the process is more severe than what happened at the same time in Sweden, which has always been unanimously condemned by the media.



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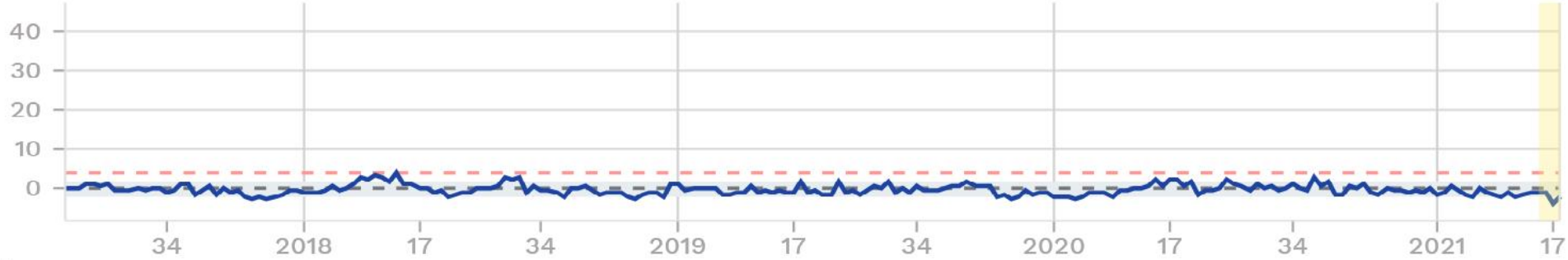
The benefit of lockdowns?

It is true that one cannot draw any conclusions about the benefit of lockdowns from excess mortality: Not only is Germany in a very different situation than Spain, which implemented a much tougher lockdown in spring 2020. Sweden, with its "only" recommendations for citizens and relatively few restrictions, is also in a better position than Switzerland with lockdown.

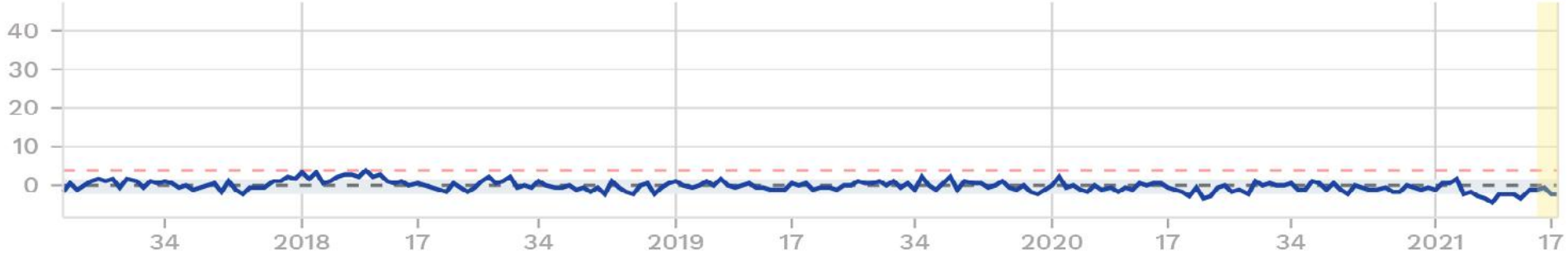
But not better than its neighbouring countries, but much worse:

Denmark

Finland



Norway



(29)

Europe of the two scenarios

Indeed, neighbouring countries are among the 9 out of 27 participating countries with no current excess mortality. 7 have never recorded excess mortality since the beginning of the pandemic. (29)

A comparative study of the measures taken in each case would be interesting in order to get closer to an answer as to the benefit of lockdowns than I can here.

"Desired shock effect"

March and April 2020 will forever be associated with the beginning of a large majority's fear of a new virus, and the beginning of a large minority's fear that it is a set-up.

Thrown back on myself and forced not to leave my little house for weeks during the extreme Spanish lockdown except for necessary shopping (28), I could not believe my eyes and ears: I was constantly exposed to the ubiquitous, frightening and completely detached, absolute figures of infections, ill people, deaths and images in the media that demonstrated the seriousness of the situation. Detached because without relation, without reference to the norm, to the background, to the context: I didn't know how many people were dying all the time anyway and from what. But now I was constantly informed about infection and death figures from every single Spanish autonomous region, from the largest cities, from European and non-European countries - ***without any reference***.

Neither did I know how many people lived there and died all the time anyway, nor how high the share of "COVID deaths" was in the normal mortality.

Like many things, I distrusted a paper entitled "How we get COVID-19 under control" ("Wie wir COVID-19 unter Kontrolle kekommen"), which was "leaked" in the so-called "social media" as allegedly originating from the Federal Ministry of the Interior in April 2020, downloaded on 28.04.2020

(see also Materials): it looked too much like the pipe dream of a so-called "conspiracy theorist" and had too many stylistic weaknesses for me to trust it to a German ministry.

It still had the note "Confidential - Only for official use" ("VS-Nur für den Dienstgebrauch").

Today, exactly this paper is publicly accessible on the page of the Federal Ministry of the Interior, only "VS-Nur für den Dienstgebrauch" has been removed. (Also available at the Materials, downloaded on 16.05.2021.)

On pages 13 and 14 it said under "4. Conclusions for action and open communication" ("4. Schlussfolgerungen für Maßnahmen und offene Kommunikation"):

"4 a. Clarify worst case!

We have to get away from a communication that is centred on the case fatality rate. With a case fatality rate that sounds insignificant in percentage terms and that affects mainly the elderly, many then unconsciously and unacknowledgedly think to themselves: 'Well, this way we get rid of the old people who are dragging our economy down, there are already too many of us on earth anyway, and with a bit of luck I will inherit a bit earlier this way'. These mechanisms have certainly contributed to the trivialisation of the epidemic in the past.

In order to achieve the **desired shock effect**, the concrete effects of the spread of infection on human society must be made clear:

1) Many seriously ill people are brought to hospital by their relatives, but are turned away and die in agony at home, struggling to breathe. Suffocation or not getting enough air is a primal fear for every human being. Also the situation in which nothing can be done to help relatives whose lives

are in danger. The pictures from Italy are disturbing.

2) "Children will hardly suffer from the epidemic": False. **Children will easily become infected, even with curfew restrictions, e.g. with the neighbour's children. If they then infect their parents and one of them dies in agony at home and they feel they are to blame because, for example, they forgot to wash their hands after playing, it is the most terrible thing a child can ever experience.**

3) **Consequential damage**: Even though we only have reports of individual cases so far, they paint an alarming picture. **Even those who seem to be cured after a mild course can apparently experience relapses at any time, which then quite suddenly end fatally, through heart attack or lung failure**, because the virus has found its way unnoticed into the lungs or heart. These may be **isolated cases**, but they will constantly hover like a **sword of Damocles** over those who have once been infected. A much more common consequence is **fatigue and reduced lung capacity lasting months and probably years**, as has often been reported by SARS survivors and is now the case with COVID-19, although of course the duration cannot yet be estimated.

Furthermore, arguments should also be made historically, according to the mathematical formula: 2019 = 1919 + 1929

One only needs to visualise the figures presented above in terms of the **assumed mortality rate (more than 1% with optimal health care, i.e. well over 3% due to overload because of the spread of infection), compared to 2% for Spanish flu**, and in terms of the expected economic crisis if containment fails, then this formula will be obvious to everyone." (Emphasis mine.)

It read like the blueprint of the communication I experienced simultaneously in the German and Spanish media: no case fatality rate at all, which would have provided realistic information about the real danger. Instead, shocks without end and scaremongering, fed back into the media itself and thus amplified.

Somewhat earlier, around 20 March, a "letter to my friends" from a supposed doctor at the Val d'Hebron Hospital, Barcelona, made the rounds on Spanish social networks. It explained soberly and precisely, what would be in store for the Spanish health system because of the new virus' extremely high infectivity and its transmission even through asymptomatic people: triage, wartime medicine.

"Why is COVID-19 so enormously dangerous? What determines the danger of an infectious agent is the combination of 3 factors: the vector of transmission, morbidity and mortality. COVID-19 has a vector of transmission between 1.5 and 2.5, i.e. 3 times higher than influenza. This means that its **spread is geometric**: 1-2-4-8-16-32-64-128-256... but worst of all, unlike influenza and SARS, which was the last coronavirus epidemic in 2003, **this one also spreads during the two weeks of incubation**, before even having symptoms.

As for morbidity and mortality, it is as follows. One thing is clear: **WE ARE ALL GOING TO BE INFECTED BY COVID-19 in the next three months.**

Now, out of every 1000 people, 900 will have it asymptomatically, including children and young people. 100 will show symptoms. Of those 100, 80 will go through it like a really bad flu: dry cough, headache and muscle pain, i.e. two or three weeks at home sicker than a dog. Of the remaining 20, 15 will develop bilateral pneumonia with difficulty breathing, requiring hospital admission for bronchodilators, corticosteroids and oxygen. The remaining 5 will develop pulmonary fibrosis requiring immediate admission to the ICU with assisted breathing. Of those 5, 3 will die. And the two who are saved will have sequelae that will possibly require a lung transplant.

These are the figures currently used in the western scientific community, as the data in China were worse, but because their health system is not as prepared. Seen in this light, it doesn't seem so bad, does

it? The problem is that, unlike the flu, against which part of the population is vaccinated and which attacks progressively over 5 months of the year, **this infection is a wave (see Italy), so that in two to three months all the infections will occur**. So we already have the data to do the maths.

Of the 40 million Spaniards, only 4 million will have symptoms. Of these, 3,200,000 will suffer at home just like from a bad flu. 600,000 will need hospital admission with oxygen. And 200,000 will need ICU.

The problem is that in Spain, between the public and private health systems, there are only 200,000 hospital beds and 3,800 ICU beds. Do you see the problem? The real problem is not the disease itself, although it has a significant morbimortality, but that, due to its epidemiological characteristics, it comes in a wave infecting a whole population that has no previous immunity in a matter of 2-3 months, COLLAPSING THE HEALTH SYSTEM...!!!!

This means that when hospital beds and ICUs are full, **what is known as war medicine will have to be applied, i.e. when for every bed that becomes free there are 7 people waiting, the professionals will have to decide who to treat and who to send home, telling them that they will send them a doctor and an oxygen cylinder, which will never arrive because they will also have run out.**

This decision will be made on the basis of age and general condition. In other words, the youngest patients will be chosen, who will have a better chance of survival. This is without taking into account the rest of the serious and urgent pathologies: heart attacks, strokes, traffic accidents, etc. All this without beds and without ICU". (Emphasis mine.)

("¿Por que el COVID-19 es enormemente peligroso? Lo que determina el peligro de un agente infeccioso es la combinación de 3 factores: el vector de contagio, la morbilidad y la mortalidad. El COVID-19 tiene un vector de contagio entre 1,5 y 2,5, es decir, 3 veces superior a la gripe. Lo cual implica que su **propagación es geométrica**: 1-2-4-8-16-32-64-128-256... pero lo peor de todo es que, a

diferencia de la gripe y del SARS, que fue la última epidemia por coronavirus de 2003, **éste se contagia también durante las dos semanas de incubación**, antes de tener incluso síntomas.

En cuanto a la morbi-mortalidad, es la siguiente. Hay que tener una cosa clara: **TODOS VAMOS A INFECTARNOS POR EL COVID-19 en los próximos tres meses.**

Ahora bien, de cada 1000 personas, 900 lo pasarán asintomaticamente, incluidos niños y jóvenes. 100 mostrarán síntomas. De esos 100, 80 lo pasarán como una gripe muy jodida: tos seca, dolor de cabeza y muscular, es decir, dos o tres semanas en casa más malo que un perro. De 20 que quedan, 15 desarrollarán una neumonía bilateral con dificultad para respirar, que requerirá ingreso hospitalario para administrar broncodilatadores, corticoides y oxígeno. Los 5 restantes desarrollarán una fibrosis pulmonar que exigirá inmediato ingreso en la UCI con respiración asistida. De esos 5, 3 morirán. Y los dos que se salven presentarán secuelas que obligará posiblemente a trasplante de pulmón.

Estas son las cifras que se manejan actualmente en la comunidad científica occidental, ya que los datos en China han sido peores, pero porque su sanidad no está tan preparada. Visto así no parece tan grave, ¿verdad? El problema es que, a diferencia de la gripe, ante la cual una parte de la población se vacuna y además ataca progresivamente a lo largo de 5 meses al año, **está infección es una oleada (Ver Italia) De forma que en dos-tres meses se van a producir todos los contagios.** Así que ya tenemos los datos para hacer las cuentas.

De los 40 millones de españoles, solo 4 millones van a tener síntomas. De los que 3.200.000 la pasarán como una gripe mala en casa. 600.000 necesitarán ingreso hospitalario con oxígeno. Y 200.000 necesitarán UCI.

El problema es que en España existen, entre el sistema sanitario público y el privado, solo 200.000

camas hospitalarias y 3.800 camas de UCI. ¿Veis el problema? El auténtico problema no es la enfermedad en sí, a pesar de que tiene una morbimortalidad importante, sino que, debido a sus características epidemiologicas, viene en una oleada infectando a toda una población que no tiene inmunidad previa en cuestión de 2-3 meses, COLAPSANDO EL SISTEMA SANITARIO...!!!!

Eso significa que cuando las camas hospitalarias y las UCI estén llenas **habrá que aplicar lo que se conoce como Medicina de Guerra, es decir, cuando por cada cama que se quede libre haya 7 personas esperando, los profesionales tendrán que decidir, a quién atienden y a quién mandan a su casa diciéndoles que les mandarán un médico y una bombona de oxígeno, que no llegará nunca porque también se habrán acabado.**

Esa decisión se tomará en función de la edad y el estado general. Es decir, se escogerá a los más jóvenes, que tendrán más posibilidades de sobrevivir. Esto sin contar el resto de patologías graves y urgentes: infartos, ictus, accidentes de tráfico, etc. todo esto sin camas y sin UCI." (Emphasis mine.)

The hospital and the doctor exist; when interviewed, he stated that he had not written the letter himself, but had only forwarded it.

Paternalistic fearmongering and shock doctrine?

The justification for all this was the danger perceived by the decision-makers then and now. My paper tries to contribute to answering the question whether the danger was and is realistically assessed.

Here and now I say that deliberately planned fearmongering by the government to get the masses to obey orders is profoundly contrary to a democratic polity. It is a prime example of deliberate manipulation.

The severity of the feedback in the communication media has already reached the level of a pathogen in its own right, especially, but not only, when I think of the psychological effects on the "risk groups" and on children.

I have found out through press reports from past years that, for example, the health system in northern Italy and some areas of Spain is already on the verge of collapse in normal flu waves. In many Third World countries, which have been in the headlines lately, it is non-existent for the mass of the population anyway.

Images from these environments were and are the means of choice to create compliant behaviour.

As an aside: I have no idea how funerals **normally** go in northern Italy, New York or Brazilian, Indian or Nepalese cities during times of flu.

Hopeless questions

With questions like:

"How many people were tested?"
"How were they selected?"
"Was a representative cross-section of the population tested to gain knowledge about the real spread of the virus?"
"What is the proportion of those tested in the total population?"
"What is the proportion of positive test results?"
"What is the proportion of those tested positive who become ill?"
"What is the proportion of those become ill who require hospital treatment?"

"What is the proportion of those hospitalised who require intensive care?"
"What is the proportion of those receiving intensive care who die?"
"So what is the proportion of deaths in the number of people infected or ill in relation to other infectious diseases, e.g. influenza?"

I quickly stopped bothering because of both opaque testing strategies and opaque communication of results focusing on absolute numbers without any reference.

Furthermore: According to the Robert Koch Institute, the corresponding data for influenza are only *estimates*, as there are no corresponding test results: Whoever goes to the doctor gets sick with flu statistically. The lethality of influenza is estimated on this basis, not on the basis of those infected or actually ill, who are not tested either, not to mention those who are asymptomatic. Comparison at this level is difficult or impossible.

Accordingly, I know of comparisons between the lethality of influenza and that of the new virus which are of only limited use. In the official communication of danger, the small difference was compensated for by emphasising the extraordinarily easy transmission of the new virus, even by asyptomatics, which is also a regular theme with new variants: The danger is not so much the high case fatality rate, which should not be talked about anyway, but rather the overloading of the health system due to an unusually large number of people being affected in an unusually short time, as seems to be shown by the excess mortality in the first wave in Spain. [See the statements of epidemiologist Amparo Larrauri at the beginning of this chapter! (2)]

"Corona deaths" and excess mortality

In *Germany*, during the period covered by my study, many more "corona deaths" were reported than the mortality rate allows. What does this mean logically?

The "corona deaths" are deaths with a positive test result, but did not die of corona. It is also conceivable that all the measures taken have reduced the overall mortality rate so much that the "corona deaths" are not statistically significant.

However, all this has prevented neither the media nor politicians from politically instrumentalising these deaths with positive test results.

In Spain, the recording of the "corona deaths" lagged behind the excess mortality. Amparo Larrauri, epidemiologist in charge of the mortality monitoring team and scientist at the National Centre for Epidemiology, whom I quoted above, has explained this perfectly. (5)

What is reality?

I was deeply worried and frightened, which was triggered by the initially puzzling reporting. At first, I did not believe it to have the intention of scaring. I thought it was stupidity and unconscious feedback from supposed sensationalist news. Fear was added by reports of an extremely high infectivity of the new virus. So in my own personal situation an urgent need developed **for me and my going on living** amidst the fear created around me to gain information about the real significance of what was happening. It was "*for me*", because this was a kind of "therapy" against fear, anxiety and disorientation. It was an attempt to defend *myself* against the rigidity of fear, whether because of the virus or because of something else.

The most feasible thing seemed to me to be to inform myself about the development of the death figures,

because - according to my thinking - a pandemic would have to be reflected there without a doubt.

If you put what is happening at the moment in relation to "normal", everyday dying, which is blanked out in our culture, the omnipresence of which we are hardly aware of and about the extent of which we usually know nothing, you can get closer to reality than through the absolute numbers and shocking images and ideas provided in abundance and with attention to detail.

So I started to deal with a very narrow area, fortunately accessible to me in my isolated situation and to all of us, that of so-called excess mortality in Spain and Germany in comparison with each other, in the temporal comparison of the present epidemic with past epidemics, and against the background of the general mortality of the two societies. I have chosen both countries because of my personal closeness to them as home and adopted country and because of the strong contrast in the course of the pandemic, of which most people with only a national perspective are not aware. Everywhere the perception prevails: What is happening here is happening everywhere. This is not even true within the same state: the course of the disease varies greatly from region to region.

Excess mortality is particularly suitable for getting closer to reality, since the question of how many people have died in a precisely defined region within a precisely defined period of time - regardless of the cause - seems to be quite uncontroversial and relatively easy to answer statistically. The authorities that register births do so just as reliably for deaths.

The idea was that the officially recorded and presented course of mortality - placed in the framework of the deaths that occur anyway and usually - could allow conclusions to be drawn about the real significance of the pandemic events. I have tried to portray my conclusions above, at the beginning of these afterthoughts.

I have talked to a few people about my findings. Some were quick to see me as a "conspiracy theorist"

just because I asked questions and did irreverent research on the un-topic of dying. Some agreed, some didn’t like it because I found out that COVID is something extraordinary at certain times in certain places - and because lots of open questions remain. Most have said nothing.
In the meantime, I have not been able to find any serious errors and none have been brought to my attention. So in the last few days I have set about publishing this on my internet site.

In view of everything that is happening, I wanted to do what I can to support those who want to deal with the situation as sensibly as possible. Unfortunately, there are not that many.
I, for one, know that I know and can know only a little. I don’t believe anything, I need evidence, and I have looked for and found some, for the little I can know. And anyone who doesn’t believe me can check it out - and please let me know of any errors they find.

The "rest" of the world

Is it a coincidence that the African country that was most recently decolonised and has a strong and still influential white minority seems to be the most affected by the pandemic?

Or does it rather indicate that in the majority of African countries either no or little data are collected or that these data are irrelevant in view of other health (malaria, tuberculosis and other infectious diseases) and political problems and the chronic health undersupply of the population?

The events are multifactorial

The course of infections, illnesses and deaths appears to be dependent on
- demographics / age structure and the nature of social institutions: The majority of deaths in the severely

affected European countries occurred in homes for the elderly, mostly privatised in Spain, with obviously inadequate infection precautions and precarious employment conditions that may even force people to work in several homes at the same time, with all that this implies for the incidence of infection;
- the general health of the population;
- population density;
- possibly air quality;
- possibly the climate;
- the state of the health system: the supply of doctors, nurses, beds, intensive care beds. Long-, medium- and short-term bad decisions regarding health care are not addressed, neither at national nor European level, not even by the socialist Spanish government vis-à-vis its conservative predecessors, who - as in all southern European countries - have imposed drastic austerity measures with the corresponding effects on care, in addition to privatisation, as a consequence of the financial crisis.

Cui bono?

Conservative German members of the Parliament (Bundestag), calling themselves christian, have enriched themselves on the masks that have been declared compulsory. And who on the vaccines, beyond the manufacturers and shareholders?

In her 2007 book *The Shock Doctrine*, Naomi Klein writes about former Secretary of Defence of the United States of America, Donald Rumsfeld:

(The pharmaceutical company) "Gilead, for its part, sees epidemics as a growth market, and it has an aggressive marketing campaign to encourage businesses and individuals to stockpile Tamiflu, just in case. Before he reentered government, Rumsfeld was so convinced that he was on to a hot new industry

that he helped found several private investment funds specializing in biotechnology and pharmaceuticals. These companies are banking on an apocalyptic future of rampant disease, one in which governments are forced to buy, at top dollar, whatever lifesaving products the private sector has under patent." (30)

One of Gilead’s three product groups is drugs and vaccines against viral diseases. Pfizer and Gilead work together on the production of remdesivir. I have no information about the ownership, i.e. which of the investment funds have invested in which companies, and of course even less knowledge about the institutions and people who have invested their money in these investment funds.

The famous revolving doors between business and politics are certainly also important when it comes to pharmaceutical products, not just masks.