

PLAN FOR SCIENTIFIC CLARITY II

An Update on the Situation, Data and Prospects for the “Second Wave”

1. GOALS

Given that Covid-19 is a pandemic that is upending the whole planet from a **health, economic and social** viewpoint, last May the **Centro di Gravità [Centre of Gravity]** had put forward a **Plan for Scientific Clarity** with periodic updates on the situation with the purpose of suggesting containment measures for the problem: to safeguard public health, the economy and society, without forgetting educational aspects.

Even though it cannot be denied that the pandemic has caused many deaths, the measures to be taken must take account of the harm and deaths that can also be caused indirectly, either through poor management of other pathologies, or through the risk of impacting the economy and thus putting millions of families into poverty. Both arise from social and psychological harm through the effects of handling education and schooling without proper forethought in these fields. Schools and health are key aspects of society, under the direct control of the State, and absorb a large part of its resources. In particular, they have been put under severe stress by the current handling of the pandemic phenomenon. Without wishing to make any accusations, and whilst understanding that the occurrence has taken everyone by surprise, and unfortunately, off-guard, it seems to us the time has come to open our eyes to the reality **without falling prey to groundless fears**, given that various substantial advances have been made as regards care and scientific knowledge about the virus. The data speaks for itself and it is about time that everyone took notice, in order to avoid catastrophic consequences in all sectors of the life of the Nation: these consequences could turn out to be worse than the illness we are trying to fight.

So, let us set off with an analysis of the facts of the situation:

Compared with March, the current situation is characterised by two distinct processes: a) a considerable increase in the number of infections; b) a reduced death rate and access to intensive care, compared to the total number of persons actually infected.

Regarding the first point it should be noted that there are grounds for doubting the reliability of data obtained from testing. Often these are performed outside of the useful “window” (that is, at times when it is difficult to detect infection, notwithstanding the fact that a person was exposed to it) or they are invalidated by failings of a technical/methodological nature (analysis of only one of the three decisive antigens present in the virus, false positives/negatives due to ineffective sampling, etc.). Furthermore, that fact of having to resort more and more often to a high amplification level (>32) to detect the virus’s mRNA, indicates that in many cases the viral load of an infected person is distinctly low. A recent study showed that this was on average 1000 times less than that encountered in positive cases in March-April. Overall, the increase in cases shows that the virus has started to circulate once again, but with a low viral load, given that compared with the previous period, the corresponding rate of deaths and/or hospitalisations in intensive care are ten times less.

The mortality rate and the rate of entry into intensive care are significantly lower than what was observed last spring. Here too, the data should be handled with caution, given the number of reports that deaths include patients totally free of the infection are multiplying. Additionally, the average age of the deceased has risen (today it is around 82 years old compared with 73 in the previous period) and involves patients with other associated conditions that are absolutely relevant in 75% of cases (cardiovascular

pathologies and tumours) which, according to Istituto Superiore di Sanità [Health Academy], are decisive in at least 10-15% of cases. Lastly, we should recall that it is difficult to distinguish between the ever-possible contribution of influenza which, in general, is responsible for a number of deaths that oscillates between 8000 and 22000 in Italy. Overall, this data tells us that the impact is significant nonetheless, but it can be handled using more appropriate therapies to be actioned during the initial stages of illness (from which there arises the **need for reliable protocol guidelines** for handling such patients at home on the part of general practitioners), with an **increase in intensive care beds** (culpably ignored by the Government and the Regions in many cases), and for timely adoption of therapeutic procedures, as a second resort.

It should be stressed that "contagion" does not mean "illness" and that, at the moment, 97% of positive cases develop no pathologies, because of which the definition of "asymptomatic case" is an oxymoron that leads to serious errors in communications and in public health strategies. The death rate in Covid-19 is now estimated about 0.3-0.6% - about double that of a "normal" influenza - and we should avoid this being translated into an increase in "mortality", that is an increase in death for other causes not due to Covid-19 but which can be attributed to public health upheavals created by the epidemic.

We then need to discredit the belief that no immunity arises from contact, since it would be absurd to hope of defending ourselves with a vaccine if this were true. Immunity is a verified given that cannot be questioned based on a few cases of re-infection that have been found across the whole world. Therefore, in the final analysis the increase in cases translates to an increase of those who have become immune. The continuing increase of the latter could bring about the famous "herd immunity" that would block the spread of the disease.

Given the extreme complexity of the various aspects involved, we have thought it best to provide a list of the latter which is as brief as possible.

2. WHAT IS COVID-19?

Sars-Cov-2, the causative agent of Covid-19, is an **RNA Virus** which enters into our organism by means of a **spike glycoprotein**.

The spike glycoprotein in fact interacts with the ACE 2 receptors present in lung, endothelial, cardiac, renal and intestinal cells even if the highest level of ACE 2 receptors is present in the nasopharynx. The cells of the immune system too can be involved, even though they have a low level of these receptors.

Viral replication is possible through glycoside metabolites, through which on the one hand the virus tends to block oxidative phosphorylation; on the other hand it is furthered by low oxidative phosphorylation, which can arise as a result of diet alterations, bad lifestyles, stress, old age and comorbidity.

We can recognise at least 3 stages of the disease:

1. **Virus entry at the nasopharynx** where initial replications take place. An effective immune system can block the virus at this stage.

If the virus is not eliminated, after about 1 week the following stages occur.

2. **Interstitial pneumonia** and at the same time other organs can be involved, in particular though attacks against vessels.

The possible presence of additional bacterial infection should be pointed out at this stage.

3. **Cytokine storm phase:** systemic activation of the cytokines takes place, with a special role by macrophages that arise in activated form: during this stage the pulmonary inflammation associated with widespread thromboembolisms can lead to serious hypoxia and death.

3. THE CURRENT SITUATION

What has changed in our knowledge of the disease since our first update in July.

The ratio of people hospitalised to those in-home isolation is between **5% and 10%** (people in home isolation can be in a state of asymptomatic insufficiency). The ratio of people hospitalised to those in intensive care is **10/1**. The ratio of people in home isolation to those in intensive care goes from **0.5% to 1%**. Current mortality in Intensive Care is about from **10% to 30%**. The FRC is higher because many deceased did not go through Intensive Care, and because in Intensive Care turnover can be very fast.

Considering one of the worst days of the hottest period, the 12th April, we found 71,000 people in home isolation compared with 53,000 on the 4th October but at the time hospitalisations, instead of representing a number of **5% to 10%** like on the 4th October, were **40%**.

The ratio between Intensive Care and home isolation was 12% thus almost **20 times** the current ratio.

Let us not forget that in April the FRC was **15% as against 1.5%**. Unfortunately, whilst these calculations are approximate, the ratios are not far removed from reality.

They seem like 2 different illnesses even though the number of infections is not very different.

1. **Why was there a major favourable change?**

Even though there have been many mutations, since this is an RNA virus, no favourable mutation has been shown to be underlying these new characteristics;

2. **Why did the viral load go down?**

This hypothesis is the most likely one; it seems that viral load impacts in fact both infectiousness and clinical trends;

3. **How can we improve immune system defences?**

Many people have adaptive immune system defences through having encountered the virus; this is possible not only because of humoral immunity, but because cell immunity also exists. Some studies demonstrate that cell immunity may be activated by other coronaviruses. In fact, it has been seen that part of the population is not (or is no longer) susceptible to this virus.

4. **Why are we doing so many tests as we come close to the theoretical Infection Fatality Rate?**

This is certainly true, to the extent that in the warm summer period tests were only performed on cases with serious symptoms, and the disease in certain regions had a spread 10 times greater than when calculated based on the cases revealed through testing.

4. THE VIRUS. WHAT HAPPENED IN NORTHERN ITALY?

We are faced with a virus with a low death rate, even if it is higher than normal influenza. It has its clinical peculiarities but the most important one seems to be the **role of early**

treatment at home. It must be said that this is more apparent from the experience of **front-line doctors** than from clinical studies that are very difficult to perform.

The tragedy lived through this Spring in some regions of Northern Italy can be attributed to the **very widespread distribution** of the disease and to **great delay** in actioning containment measures, such as the **use of PPE for health workers** and the introduction of **separate medical access** for suspected Covid-19 cases and other pathologies.

All this goes without mentioning the hospitalisation of patients in nursing homes who were still infectious.

Not only is the death rate modest, but it tends to affect some age groups and certain pre-existing conditions almost exclusively (first amongst them diabetes).

These features mean that Covid-19 can be considered to be an opportunist illness and thus **protection should be targeted at the groups most at risk.**

5. TESTS

We believe that the management of the Covid-19 emergency should be split into 2 separate areas:

- **Epidemic management, using tests, PPE, and separate hospital access.** The rules should be clear, simple and unequivocal across the entire territory of the nation.
- **Patient management:** every patient has the right to receive a reply or an examination within 24 hours from the start of suspect symptoms. In such cases it is the doctor who should take decisions based on awareness and science. However, he/she may also take advantage of simple advice, like that set out in this document, which must also be implemented based on field experience.

Two different tests exist:

- **AT** (antigen test): the viral antigen is looked for with antibodies, very much as happens in urinary pregnancy tests.
- **MT** (molecular test): viral RNA is searched for, just as in the RT-PCR used in laboratories as the reference test on nose/throat swabs.

In order to avoid going into the concepts of sensitivity and specificity, we will limit ourselves to stating that **AT** is a rapid, but very imprecise test (it can even manage to produce double false negatives).

MT is much more precise: one might also be able to find out the viral load connected with infectiousness and clinical gravity by providing a TC parameter (Threshold Cycle).

At more than **35 TC** it is very unlikely that the virus is still active, and therefore this only concerns portions of the virus.

If the number is low, it means that the viral load is high. If it is high it means the viral load is low, but also that there may only be pieces of the virus present, and therefore that infectiousness is virtually nil.

A saliva test has similar characteristics to AT but is a lot less invasive.

To complicate the picture further, as regards molecular tests (MT), which are the most reliable, a study has observed that only **28.9%** of positives has demonstrated a capacity to infect cell lines.

Ninety positive samples of RT-PCR SARS-CoV-2 were incubated on cells, and all were positive swab test results taken independently of the TC. Twenty-six samples (28.9%) showed viral growth. There was no growth in the others.

6. THE DEATH RATE

The death rate is the **percentage of deaths out of those affected by the disease.**

The death rate should be more precisely divided into:

- **CFR** (*Case Fatality Rate*) the percentage of deaths amongst persons we have identified as being affected by this disease, or rather, that have been infected by this virus (in this case);
- **IFR** (*Infection Fatality Rate*) a theoretical statistic that indicates the percentage of deaths out of all persons infected by the virus, and of course, **the more swabs are taken, the more infected people are found;** but at the same time the IFR goes down.

Even though we do not have an undeniable figure, it is clear that the IFR will be much lower than the CFR. A reasonable value, considering also the view from other countries, would be **from 0.5% to 0.8%, compared with a CFR of around 2%.**

To give some context, in April the CFR was more than **15%** in Lombardy.

The IFR was certainly much lower, precisely because of the low number of swab tests; but at the same time the initial poor management of the disease has certainly played a role in the number of deaths.

7. CONTAGION AND INFECTIONS

In the last few months, alongside an **initial stage** of net reduction in hospitalisations and deaths, we were able to witness a **second stage** with net growth in the number of infected, and with a small rise in the number of hospitalisations and in deaths.

At the time of the final draft of this document, hospitalisations are increasing, even though they are far removed from those in March-April.

The number of infections is around 14% of patients subjected to swab tests approximately (data from 3/11).

A certain number of swab tests have been performed as *screening* (for example prior to hospitalisation) or are repeated, and these facts are not always noted.

In any event the number of the infected within the population will be proportional to the number of infected found at random, and therefore will be much higher than the number of the infected identified by swab tests.

Currently, even though the CFR is staying low, the number of infected is increasing (and therefore the number of swab tests, which we shall assess below), and also the number of hospitalisations.

8. MORTALITY RATE

The mortality rate of a disease is the **percentage of deaths out of the entire population.**

As already stated this is a **very different concept from the death rate [lethality]** that only takes account of the percentage of deaths for that specific disease; as stated **according to the WHO the death rate is about 0.6%**. Mortality is affected by how widespread the infection is; the assessment on an annual basis will only be made at the end of the year but it is surely very low compared with several other pathologies such as cardiovascular conditions or cancer.

This statistic is important because currently Covid-19 risks increasing mortality because of the large stress effect it has had upon Public Health.

Once again, organisational aspects are fundamental and every choice must be made taking the context into account, and not just a specific issue, no matter how serious this might be.

9. PREVENTION

Prevention: PPE Problems related to prevention (Remote learning, face masks and distancing). Contradictions in scientific studies

Only a few medicines have shown to be effective in clinical trials (cortisone at a specific stage of the disease and anti-coagulants), and also as regards supplements, it will be very difficult to conduct clinical trials that will show their effectiveness in a conclusive manner. Nevertheless, biochemistry and physio-pathology accompanied by "clinical common sense" and by the experience gleaned by colleagues across the territory can give us indications.

By "clinical common sense" the ability to assess the risks and benefits of a specific molecule in a single person at a given time is meant.

Little has been done in this way to even give simple suggestions on therapeutic approaches that could be used across the land.

Everyone agrees that the battle with Covid-19 is being faced on the ground above all, and involves changing therapeutic approach based on clinical conditions, which can vary from a total lack of symptoms, through few symptoms, right up to a major shortness of breath that requires hospitalisation.

We start from prevention, taking account of the fact that we are not attempting to produce a handbook, but only give general indications that, even though they derive from scientific considerations and personal experience, must only be considered as the opinions of the authors of this document.

Not only for pharmaceuticals in the strictest sense such as, for example, colchicine and acetylcysteine, but also for all other advice on supplements and lifestyle, please refer to general practitioners who are the most appropriate persons to take care of us all. In this case, we are absolutely against self-medication, which can be very dangerous at times.

Once again, it must be clear that no clinical trials exist to demonstrate the following, and above all, that it will be very difficult to complete any.

Prevention for all: Vitamin D (best 2000 U per day and check levels after 3 months), combined with Vitamin K2, Vitamin C (best if from rose hips or acerola) 1-gram morning and evening and Zinc.

First of all, let us distinguish the levels of risk arising from catching the disease:

- **High risk:** age **more than 65-70 years old**, diabetes (especially high risk) high blood pressure, and cardiovascular disease in general;
- **Very high risk: above 80 years old** with pre-existing conditions - start therapy at once - even within the first 24 hours (medical judgement)

Therapy during the first 2 days (the days that seem to be the most important for a good prognosis).

In all cases of disease with symptoms it seems that the approach in the first 2-3 days has a considerable role. The experience of many doctors, even if it needs to be borne out by other studies, has found colchicine or azithromycin may have a significant role.

- **Low and medium Risk:** Vitamin D as prevention (best if 2000 U day and check values after 3 months), associated with Vitamin K2, Vitamin C (best from rose-hips or acerola) 1 gram morning and evening and zinc. In case of symptoms, even at low risk from Covid-19, increase to 1 gram every 2-3 hours, remembering to drink a great deal. If the condition worsens over 24 to 48 hours, take Colchicine 1/2 tablet twice a day with acetylcysteine at least 600 mg per day.

The aim should always be **avoiding hospitalisation** except when we are faced with oxygen desaturation. It is very important to supply all patients with a transcutaneous oxygen meter since the sensation of shortness of breath in Covid-19 may be absent even with very low levels of oxygen saturation. Of course, oxygen can be provided at home but it is important to ensure there is good hydration.

At hospital level, use cortisone, antibiotics and anticoagulants if the practise is in addition to the use of new antiviral drugs.

These medicines, in particular situations, can also be used at home under strict medical control. In any event, hospital therapy is best left to the specialists.

This part of the therapy is left up to the infectiologists, given that the timing for using a "helmet", or the need to perform intubation are both very specialist decisions on which the authors do not wish to comment.

We limit ourselves to reminding everyone that there are two therapeutic approaches that are still little used, despite having to their credit several positive outcomes: **hyperimmune plasma and ozone therapy**.

These are low-cost approaches, that are simple, and have low risks: space should be found for them in all Covid-19 centres, even though there is no conclusive proof of their effectiveness, despite several clinical studies in favour of their use.

It is clear that asymptomatic patients with positive swab tests should be kept under observation with no specific therapy, other than the continuation of the preventive approach. Symptoms should appear **within 2 or 3 days**; only after that period can we relax our guard.

It is also clear that in the presence of a suspicious clinical picture, a swab test will be performed but the therapeutic approach for the first 2-3 days makes sense just as for any other form of virus; thus, it is worthwhile putting it into action even while awaiting a swab test.

Here are a few dietary indications for the first days of illness and during prevention.

In order to multiply, this virus needs glycolysis and thus it tends to block oxidative phosphorylation. We know that an excess of free radicals plays the virus's game to the extent that free radicals move cell metabolism towards glycolysis. These can arise through

chronic stress, and even from the **fear of the virus** itself, from an **unbalanced diet** and also from an **excess of physical exercise** especially in the over-fifties. A good guide would be maintaining a *low carb* diet, possibly using **intermittent fasting** that fosters oxidative phosphorylation.

Modest **daily physical activity** is useful at every age.

We have spoken of resources (therapies) but not of the players; of musical instruments but not of the performing arts. Every act of therapy is first and foremost **a meeting between two or more human beings: the doctor and the patients.** There must be mutual recognition. The doctor's task is to be in attendance, ever able to console, explain and encourage. The fact of being there, is part of therapeutic act. Thinking that therapeutic action is mere pharmacology would be **the end of medicine** and along with that, the end of the human element. Patients left alone for days, without being able to call anyone, without being able to see their own doctor has been a tragedy within a tragedy: something that must never happen again.

The task of the State is fostering and organising the doctor / patient relationship and providing tools for it: certainly not hampering it. Especially if there are safety considerations, the State must provide resources, so that such meetings can take place.

10. THERAPY

Empowering the territory: what to do at home

During the course of the pandemic, there were some doctors who did not follow the guidelines and who, precisely thanks to this, based on their experience and knowledge of their patients, saved the majority of their cases, as in the case of Dr. Roberto Munda (<https://liberopensare.com/covid-sarebbe-bastato-lasciar-lavorare-i-medici-di-base/>)

In this field, the situation has become even worse to the extent that previously – when there was a great deal of uncertainty about therapies – doctors had *carte blanche* with their patients. Today they are required to **strictly follow the guidelines** from the Ministry, whilst patients must turn to the USCA [Special Assistance Continuity Units].

This, in fact, if it does not guarantee either uniform treatment or effective and quality service for all citizens, is also an **act of distrust as regards the medical profession as a whole**, a debasement of personal ability, and an incomprehensible, generalised lack of any sense of responsibility. One question arises spontaneously: if all the handling of the pandemic produces strong relapses in all spheres of social, individual and economic life of the community throughout the nation, both over the short and long term, who are we going to blame?

After having provided some general indications, we can make a few observations about the most significant and highly-debated medicines:

Colchicine: it has a powerful anti-inflammatory action, has been known for several years and is very well tolerated overall; there are some very promising small studies, and it is very inexpensive. A major Canadian study is expected;

Hyperimmune Plasma: there are a few very interesting non-interventional studies, and some studies show a halving of mortality. It is an inexpensive product and safe overall;

Remdesivir: it is very expensive, has an antiviral action, and controlled trials have shown a good decrease in mortality;

Aspirin. Its use has shown how it reduces the number of intensive care hospitalisations, and how effective it is in improving the response to other therapies;

Corticoids, in particular **Dexamethasone:** have shown effectiveness in patients that need oxygen therapy, even if they could be useful in earlier stages because of the anti-inflammatory action;

Anticoagulant Therapy: this is certainly effective, but a problem could lie in the choice of the time to start it;

Hydroxychloroquine: this would deserve a report on its own; however, at present, except for special cases, it has been prohibited by the WHO and by the ISS [Health Academy], even if some studies have shown it to be safe, providing certain small precautions are followed. Its usefulness was put in doubt initially, but it is currently being taken into consideration again;

Neutralising monoclonal antibodies: initial studies show high efficiency and safety. They could prove to be a decisive weapon.

11. VACCINES

There is little to be said about a specific vaccine against Covid-19. On the other hand, it is worthwhile stating considerations about the anti-influenza vaccine used to decrease those episodes of fever which could be confused with Covid-19.

If we are doctors, it is not possible **to be against** vaccines **on principle**, just as we cannot be against surgical operations.

What is necessary is examining their validity; discussing anti-influenza vaccine, it can be valid for some people, and useful for making a differentiated diagnosis for Covid-19 for others.

For example, one study of healthy Australian children demonstrated that seasonal influenza vaccines have doubled the risk of infection from non-influenza viruses. It was seen that **the vaccine increased the risk of acute respiratory disease** associated with viruses, including influenza, by 70%. (<https://pubmed.ncbi.nlm.nih.gov/21079528/>)

From another controlled randomised study with placebos on children in Hong Kong, it has emerged that influenza vaccines increase the risk of non-influenza viral ARI (Acute Respiratory Infection) by 500% (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3404712/>).

Notwithstanding the fact that each year it is repeated that anti-influenza vaccines are effective, from CDC studies we can see that the percentages for success are fairly low (<https://www.cdc.gov/flu/vaccines-work/effectiveness-studies.htm>).

But how can anti-influenza vaccines foster other infections?

Two mechanisms are possible:

- Anti-influenza vaccines could alter our immune system in a non-specific way, thus increasing the possibility of other infections; this has been observed in DPT and other vaccines. (<https://pubmed.ncbi.nlm.nih.gov/23680130/>)

- So-called "*viral interference*" could take place, where a viral infection can lead the immune system to provide temporary non-specific protection as regards other viruses. By preventing an influenza infection, a vaccine could prevent this positive effect even if it is unforeseen. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3404712/>). A study of dynamics in viral populations has shown, for example, that influenza A prevents later infections by rhinovirus and influenza B prevents infections by adenovirus. (<https://www.pnas.org/content/116/52/27142>). Setting up **mass anti-influenza vaccination has no data to support it, derived from controlled random studies about safety and effectiveness**. In particular as regards routine vaccinations for small and healthy children, some paediatricians and infectiologists have asked for multiple centre randomised studies to be performed for various seasons in order to avoid harmful effects, and the possibility that the risks from annual vaccination may outweigh the benefits. (<https://www.nejm.org/doi/full/10.1056/nejm200001273420409>). It has emerged that those who recover from influenza seem to have a widespread and lasting protection from various influenza viruses. This is provided by the first infections in small children – so-called "*imprinting*" – which is cancelled by any infant vaccinations. According to some researchers, the protection in adults who still benefit from childhood *imprinting* can be cancelled out by vaccination against seasonal influenza. This has been demonstrated by a Canadian study. (<https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2019.24.46.1900585>).

However, we should ask ourselves if we are truly fostering the immunity of the world population by mass vaccination against influenza. It could be that the annual influenza epidemics **could get worse instead of slighter**. In addition we need to understand what effects years of vaccination against seasonal influenza could have upon pandemics. In Quebec, for example, it has been seen that the risk of a serious disease pH1N1 has increased considerably in proportion to the number of seasonal anti-influenza vaccines received over the previous years. That risk has grown by 300% in individuals who had received five vaccinations over five years, compared with unvaccinated individuals. (<https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000259>). Lastly, we need to check if vaccination really decreases deaths from influenza.

12. SCHOOLS

What is known about infections in schools – contradictory communications.

Over the long term, the ministerial guidelines contained in the 2020-21 school plan will **probably produce irreversible psychological harm** to children and youths, harm that has been highlighted in a letter from more than 700 Italian psychologists and psychiatrists.

As Solange Hutter stated in her speech to the Chamber [of Deputies]: "*Children in infant school are forced not to live in a spontaneous and healthy way, kept from a harmonious development of personality, and condemned in very great likelihood to contract neuroses and psychoses; forced to live amongst people under horrible masks*".

On this topic, even though it varies from land to land, infections in the school context are always very low, that is to say **less than 10%** of the total. It should also be pointed out that the ability to contract the disease on the part of the young and very young, is much lower than in the remaining population.

In this case, as has been happening in the last few days, an increase of hospitalisations and in Intensive Care (as already pointed out, the number of positive swab tests is not a good indicator) should lead to much more attention being given to the management of patients and their contacts, for which no precise or consistent behavioural indications exist.

In many cases currently in nurseries and primary schools (up to the fifth primary class), the number of children per class has been reduced, and the teacher workforce has been strengthened. Despite these children are not taking off their face masks: not even when invited to do so by the teachers! **A stronger disease than Covid-19 has infected them:** fear of their mothers and the adults around them.

In secondary school intervention by the institutions in charge has done very little, despite the long months of lockdown and the summer break: ridiculous apparent intervention such as providing single desks on wheels, face masks and disinfectants...but the crumbling buildings, the inadequate number of classrooms and the lack of staff have remained.

Leveraging scholastic autonomy, compulsory micro-management through ministerial directives and service orders has occurred, tending to demand the impossible without providing adequate means and resources, and discharging responsibility away from the centre onto schools, that is, onto teachers and managers. The watch-word has been *"sort it out or you will be held liable in civil and criminal law."*

Health protocols have provided that: when symptoms arise at school the case has to be immediately isolated, entrusted to the 'Covid delegate' and taken to the 'protection room' set aside for the purpose. The phone number of the Covid protection unit at the ASL Local Health Authority shown on the noticeboard will then be called, and they will take charge of the child and will establish who will undergo swab tests, and if quarantine will be triggered, based on documentation provided by the school (the class belonged to, and movements to go to the bathroom are recorded – every day and every hour of lessons – on the class register and noted by teachers). Every ASL Local Health Authority's Covid protection unit can run as it chooses.

If 'a positive case' arises in a pupil's family or contacts, the school shall be made aware of it, if and when it is informed about the fact by interested parties. If management is informed, it is not required to inform the ASL Local Health Authority; it may do so, but it is not certain that the ASL Local Health Authority will be the one responsible for the family or for the group of people: thus, it is not certain whether swab or other tests will be performed. Common sense and personal liability are triggered, and it is possible that the class involved will be subjected to 'remote learning' for two weeks.

In the meantime, adolescents and teachers come to school on crowded transport with no distancing measures, given that the 80% of capacity rule is rarely observed.

In order to 'lighten' the burden on transport and for this 'terrible and pressing second wave of the epidemic' they are thinking of making remote learning compulsory, like during the lockdown, for the third, fourth and fifth years in upper schools!

Furthermore, instructions given to headmasters by their superiors, to teachers by headmasters and even during training courses are intended to reduce teaching and content to a minimum (for exams we saw 'everyone passes' last year) because the main task of schooling has become "entertaining and supervising", strengthening, note well, the use of technology and computers. Face masks, limited movement (anyway you move with a desk on wheels) complete the picture of life for these youngsters in the flower of youth: what effect will it have on their growth, training and maturity?

Meanwhile, without even much concealment, even if on paper things remain the same as ever, reality is transformed in a pernicious and violent way, pervading even the simplest gestures and manifestations of humanity, habits, relations, prospects and expectations.

School, simplified, impoverished in its contents, and deprived of its natural relationships, comparisons, and sharing aspects is driven towards the standardisation of didactic modules, computer testing and impersonal relations: is this what we want? Is it really necessary? Why? What for? For whom?

13. INFORMATION

Responsibility for information – Where news ends and manipulation begins – News standardisation

Alongside the **responsibility for governing**, that of informing has contributed decisively to **spreading false and unverified news, anxiety and fear across populations**.

The standardisation of the *media* has been almost total since the initial stages of the epidemic.

Skimming through newspaper headlines and television news, it has been easy from the start to realise that the “propaganda organization” was the same worldwide; journalists from single papers did no more than copy and paste press agency handouts, often using the same words and the same headlines. No checking has taken place – the famous *fact-checking* demanded of anyone who does not share the official narrative – **on news, and above all on the figures** for the pandemic.

Then, the CTS in Italy being the sounding board for official statements – often contradicted by facts – the lack of space given to any conflicting opinion has shown with extreme clarity that we are no longer dealing with information, but only with the **manipulation** of public opinion.

Even more serious is the total press irresponsibility, not only through broadcasting unverified numbers, but also by amplifying **feelings of fear and anguish** in the population, contributing in this way to making entire populations enter a vicious *loop* of resignation, impotence and isolation.

14. GOVERNMENTS, MEASURES, DATA ON RESPONSIBILITY AND PURPOSE

Government responsibility – what is the meaning of proclaiming a state of emergency and restrictions, when there are no items to justify it?

The most significant factor in this Covid-19 pandemic historic event is the conformity by all – or almost all – of the Governments in the world in their reactions, and in this case, in coercive and freedom-killing measures.

The first victim of the pandemic was truth. Once the real unfolding of events was replaced by an **artificial narrative**, and credence was given to the broadcasting of propaganda and manipulation by *media*, which are totally enslaved by the dominant single way of thinking, no more space has been given to any comparison with other opinions, even if represented by eminent scientists, internationally renowned research centres, or the learned and intellectuals of great depth.

Fear has become the lever through which a large part of governments continue to keep society as a whole in check, contributing to **splitting** people up, isolating them physically,

and putting them in opposition to each other by creating anathemas, inciting real 'witch hunts', or encouraging people to become informers. Through social exclusion for anyone who challenges the groundless imposition of restrictive measures, as, in this case, the repeated proclamation of a **state of emergency that is contradicted by the facts**, they aspire to set up a new State Inquisition, reducing vital areas of freedom, the ability to have **peaceable** comparisons, and the possibility of a good and balanced civil cohabitation.

Since the "*War on Terror*" that followed the events of 11th September we have been able to clearly see the paradigm used by the *establishment* to subjugate populations; **through the fear of terrorism yesterday, and that of disease today, it has been managed for people to barter away their own freedoms and constitutional rights more and more, yesterday for the sake of safety and today for the sake of health.**

15. SUMMARY CONCLUSION

To conclude this analysis, we consider:

- That Covid-19 exists;
- That its lethality is around **0.6%** (WHO data) and maybe even lower;
- That it mainly strikes certain sectors of the population (the elderly, diabetics and the obese) but that, like all illnesses, there are limited individual cases of any age, even in excellent health;
- That it is absolutely necessary to protect and safeguard the said sectors of the population (the elderly, diabetics and the obese), which has not been done adequately to date;
- That at the moment **prevention** systems exist that strengthen the immune system, and that are probably effective, but which are not being distributed;
- That **therapies** with proven effectiveness exist, and others have high levels of effectiveness: verification studies should be performed on them very quickly;
- That in addition to known prevention systems, **lifestyles and diet should be improved through information and education;**
- That it is essential to **strengthen territorial medicine**, and that it is fundamental for the therapeutic approach to be applied from the very first days following infection, where necessary;
- That **indications about the approach to therapy** should be provided to doctors in each territory, even if they have not been checked; doctors should make their own choices related to the real clinical issues;
- That the situation, whilst it is serious, **is not such that it requires heavy-handed interference in schools, healthcare, and personal freedoms.**

Prepared

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