

29<sup>th</sup> March 2021

**Open Letter from the UK Medical Freedom Alliance to:**

**Rt Hon Boris Johnson – Prime Minister**

**Rt Hon Nicola Sturgeon – First Minister of Scotland**

**Rt Hon Mark Drakeford - First Minister of Wales**

**Rt Hon Arlene Foster - First Minister of Northern Ireland**

**Rt Hon Matt Hancock – Secretary of State for Health and Social Care**

**Rt Hon Michael Gove – Minister for the Cabinet Office**

**Rt Hon Gavin Williamson – Secretary of State for Education**

**Jeane Freeman MSP – Scottish Government Health Secretary**

**Vaughan Gething MS – Welsh Assembly Minister of Health and Social Services**

**Robin Swann MLA - Northern Ireland Assembly Minister of Health**

**Rt Hon Mark Harper – Chair of COVID Recovery Group**

**Sir Graham Brady – Chair of Conservative Party 1922 Committee**

**Calling for an immediate halt to COVID-19 testing of asymptomatic individuals in the community, workplaces, schools and especially children.**

The UK Medical Freedom Alliance (UKMFA) is an alliance of UK medical professionals, scientists and lawyers campaigning for Medical Freedom, Informed Consent and Bodily Autonomy to be preserved and protected.

We are calling on all UK governments and all schools to:

- i. **Stop testing asymptomatic individuals for SARS-CoV-2** using the RT-PCR test, Lateral Flow Test (LFT) or any other test until such time as (1) a fully validated test is available and (2) it is proven beyond reasonable doubt that asymptomatic transmission occurs; and
- ii. **Immediately abolish any mass community testing/screening**, including the testing of children in schools

The reasons for our appeal are:

1. Currently available tests for SARS-CoV-2 are **not validated** and are deeply flawed;
2. There is no evidence for viral transmission from **asymptomatic** individuals;
3. There is no justification for the spiralling **financial costs** incurred by mass-testing;
4. The high **socio-economic cost** for those testing false positive, who are forced to isolate;
5. Potential **discrimination** against people declining to be tested;
6. Unknown risks of regular testing to **children's physical and mental health**

Below, we outline the evidence supporting each of these statements.

## **1. Validity of currently available tests for SARS-CoV-2 (RT-PCR and Lateral Flow)**

The validity of screening programs is based on the 10 Wilson-Jungner Criteria<sup>i</sup>, published by the WHO in 1968 and accepted as the gold standard for more than 50 years. Mass testing for the SARS-CoV-2 virus fails to meet many of these criteria. Screening tests are required to be simple, safe, precise and validated. Currently available tests for SARS-CoV-2 (Reverse Transcriptase – Polymerase Chain Reaction (RT-PCR) tests or Lateral Flow Tests (LFT)<sup>ii</sup>) do not fulfill these requirements.

The RT-PCR test is claimed to be the gold standard of testing for SARS-CoV-2. The test looks to detect fragments of the genetic code of the virus (not whole viruses) from throat and nose swab samples through enzymatic amplification of ribonucleic acid (RNA) in repeated cycles. The principle of the RT-PCR test was invented by Kary Mullis, who was awarded the Nobel Prize in Chemistry in 1993. He advised that this test was not designed to diagnose infectious diseases<sup>iii</sup> <sup>iv</sup>. It is therefore not suitable as a screening tool for infections in asymptomatic populations. Even the test instruction manual states that the test performance has not been evaluated in the absence of symptoms<sup>v</sup>.

With increasing numbers of amplification cycles, indicated by the Cycle Threshold (Ct) value, smaller and smaller amounts of RNA become detectable, which may have no clinical significance. There is currently no standardization of the Ct value to be applied. Test results utilizing Ct values of up to and even more than 40 have been recorded as cases, even though it has been acknowledged in SAGE minutes that Ct values above 25 are unlikely to correlate with infectious disease<sup>vi</sup>. Recent WHO guidance in January 2021 stated that “careful interpretation of weak positive results is needed. The cycle threshold (Ct) needed to detect virus is inversely proportional to the patient’s viral load”<sup>vii</sup>.

There are multiple and significant concerns regarding the validity of this widely used RT-PCR test. A validated test should be standardized and shown to produce the expected results, reliably and consistently, in any given sample, from individuals who are known to have or to not have a specific condition. A review report by an International Consortium of Scientists in Life Sciences (ICSLS) has called for a retraction of the publication that led to the development and deployment of the RT-PCR test to diagnose COVID-19 cases, due to a catalogue of errors<sup>viii</sup>. These errors include the lack of standardization, omission of a definition when a test is called positive or negative (Ct value), and inability to discriminate between the whole virus and inactive viral fragments. Detection of viral fragments may indicate the presence of dead, inactive, and therefore insignificant remnants without any potential to cause or transmit clinical disease. Fragments may remain, and thus the RT-PCR test may be positive, for up to 90 days after an infection has subsided<sup>ix</sup>.

As the RT-PCR test is currently not validated, it therefore does not comply with the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA) in the UK and the Food and Drug Administration (FDA) in the US for diagnostic tests. The expected rates of false positive and false negative results are unknown<sup>x</sup> <sup>xi</sup>. Results may be further compromised by human factors, including limited experience and safety awareness of laboratory technicians<sup>xii</sup>. A test with such highly questionable validity should not be applied.

As an added compromise to reliability, the application of this test in the UK has been highly inconsistent and variable. The commercially available test kits are intended to detect three separate gene fragments of the SARS-CoV-2 virus in order to declare a positive result. Notwithstanding the manufacturer’s instructions, it has been applied practice to identify cases via detection of only two and increasingly also of only one gene<sup>xiii</sup>. This clearly impairs the specificity of this unvalidated test even further and renders the statistics and relevance of declared positive cases highly questionable<sup>xiv</sup>.

The Lateral Flow Test (LFT) has been assessed using the RT-PCR test as a gold standard. Therefore, its validity is at least equally questionable. Professor Deeks, leader of the Cochrane Collaboration's COVID-19 Test Evaluation, has stated that LFTs are being used off-label<sup>xv</sup>, for a purpose they were not designed or approved for. A Cochrane Review of mass-testing published on 24 March 2021 found virtually no evidence to support mass screening of asymptomatic individuals using rapid antigen tests in people with no known exposure<sup>xvi</sup>. In addition, they found no evidence evaluating the repeated use of tests and raised concern that multiple tests may increase false positive results. Professor Allyson Pollock, Clinical Professor of Public Health has called for mass testing using the LFT to be abandoned due to poor reliability<sup>xvii</sup>. The LFT is therefore no more suitable as a screening tool than the RT-PCR test.

## **2. Transmission of the virus by asymptomatic individuals**

Testing asymptomatic individuals is only justifiable if they pose a significant threat to others and good evidence of asymptomatic spread of SARS-CoV-2 is not demonstrated in the published literature. Data from a recent large Chinese population study suggest there is no requirement for measures of source control in asymptomatic people, even after a positive test<sup>xviii</sup>. In this study, over 10 million residents in Wuhan, China, were screened in May 2020, finding no new symptomatic and only 300 asymptomatic cases. There were no positive tests amongst 1,174 close contacts of asymptomatic cases. Similar findings were found in a published study of nearly 80,000 close household contacts<sup>xix</sup>. Of the participants who tested positive for SARS-CoV-2, symptomatic people had an 18% risk of passing the illness on to close household contacts, compared to only 0.7% risk from asymptomatic people.

A detailed analysis of the literature by consultant pathologist Dr Clare Craig FRCPath, highlighted the paucity of persuasive evidence that asymptomatic transmission is of any clinical significance<sup>xx</sup>. On close examination of the raw data from meta-analyses, it was revealed that any conclusions about the relevance of asymptomatic transmission are “based on a surprisingly small number of cases (six in total globally)” adding a caution that “the possibility that they are all coincidental contacts with false positive results cannot be ruled out”<sup>xxi</sup>. Therefore, pre-symptomatic and asymptomatic transmission appears to be rare, posing a negligible risk to the population.

The risk certainly appears to be negligible with regards to children. Epidemiologist, and member of the UK Government Scientific Advisory Group (SAGE), Mark Woolhouse stated that children are “minimally involved in the epidemiology of this virus” with “increasing evidence that they rarely transmit”<sup>xxii</sup>.

Prior to 2020, asymptomatic spread of a respiratory virus has never been observed. Any scientific data to support the continued official statements and assumptions regarding asymptomatic transmission of SARS-CoV-2 should be made transparent and released immediately, as in their absence, none of the currently implemented pandemic policies are justifiable.

## **3. The cost incurred by mass-testing**

Historically, all aspects of healthcare have been significantly restricted by funding restraints. It is very hard to justify spending a significant proportion of the National Health Service (NHS) budget on a deeply flawed test, aimed at identifying asymptomatic individuals, who almost certainly pose no significant threat to anyone. Viral transmission from such individuals is highly unlikely, and the disease which is potentially transmitted has an infection fatality rate (IFR) comparable to commonly

encountered respiratory diseases. COVID-19 is now known to have an IFR of less than 0.1% for the majority of the population (aged <70 years)<sup>xxiii xxiv</sup>.

In a BMJ Editorial in December 2020, Allyson Pollack, Professor of Public Health argued that mass testing “risks the harmful diversion of scarce resources” and that the “use of inadequately evaluated tests as screening tools in healthy populations” is concerning<sup>xxv</sup>.

#### **4. High socio-economic cost for those testing false positive**

There is no high-quality evidence showing that RT-PCR or LFT screening programs are effective in reducing illness or deaths<sup>xxvi</sup>. Yet the implications for any individual testing positive are profound and the risks to those testing false positive need to be considered.

The WHO recently confirmed that “*disease prevalence alters the predictive value of test results*” and therefore “*as disease prevalence decreases, the risk of false positive increases*”. This is “*irrespective of the claimed specificity*” of any test<sup>iv</sup>. It is important to note that any given **rate of false positives is a percentage of tests carried out** rather than a percentage of positive test results. Assuming a false positive rate of 1%, there will have been up to 898,870 false positive cases from a total of 89,887,019 PCR tests<sup>xxvii</sup>, as of 5<sup>th</sup> March 2021.

The false positive rate must be considered relative to the prevalence of the disease in the population, to determine the ratio of false positives to true positives. According to the Office for National Statistics on 12 December 2020, the prevalence of SARS-Cov-2 in the UK was around 1%. If the false positive rate was also 1%, it implies that 50% of all positive tests are false positives (i.e. 1,070,775 false positive cases out of the 2,141,551 total positive test results published by the government at 23 December 2020). If the false positive rate is higher than 1%, false positive results would exceed true positives, even in this high prevalence scenario. It has been shown that with high Ct values, the probability of false positive test results is up to 97%<sup>xxviii</sup>.

The recent WHO guidance in January 2021<sup>xxix</sup> cautioned against the interpretation of weak positive results and recommended that in cases where “*test results do not correspond with the clinical presentation, a new specimen should be taken and retested*”. By definition, a positive result from an asymptomatic individual does not correspond with any symptoms and will therefore be of highly questionable value.

False positive results have far reaching socio-economic consequences. They trigger the requirement for a person to self-isolate for 10 days, along with their family and close contacts. Outbreaks are declared, businesses are shut, and schools are closed, all under a false premise. This imposed isolation affects the ability to earn a living and children’s education is disrupted, with serious implications for mental and physical health, causing immeasurable harms to society.

#### **5. Potential discrimination against people declining to be tested**

UK and International Law is clear that consent must be given freely to any diagnostic or therapeutic intervention, without pressure or undue influence, and after receiving all relevant information. Informed consent, whether by adults, or by children under the Gillick principle, has, by law, to comply with the following principles:

1. You should be free to accept or refuse treatment that is offered.
2. Your decision should be voluntary and must not be influenced by pressure from medical staff, friends, or family. Your decision must be respected<sup>xxx</sup>.

3. Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be expressed and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice<sup>xxxii</sup>.

Any attempt by the Government or by schools to “strongly encourage” a test is a direct breach of the above, as consent must be “free” and “voluntary”. “Strongly encouraging” a test is coercion to have a test. Informed consent by the individual is a requirement for all medical screening programs, as the risks and harms to the individual, resulting from both false positives and false negatives, are real and significant.

It is of grave concern that **provision of healthcare has been made conditional on undergoing this deeply flawed and unreliable test**, which asymptomatic patients are required to undergo prior to admission and prior to any diagnostic and surgical procedures. This amounts to coercion, giving people no option but to submit themselves to invasive testing, which they may otherwise not have given their informed consent to, as they are otherwise denied medical care that they require.

**Testing has also been recommended for all secondary school pupils.** Although voluntary, this guidance risks breaching the requirement for informed consent as the testing is “strongly encouraged” putting pressure on students to be tested or face being denied entry to school or segregation. We are aware of reports of schools where consent is not “free” or “voluntary” as such coercion is applied. This is in direct violation of the pupil’s right to bodily integrity and/or personal autonomy. This can also negatively affect the culture inside schools resulting in peer- and societal-pressure and even bullying in schools, directed at those who exercise their right to decline testing.

Similar concerns regarding undue peer pressure and potential discrimination applies to any environment or workplace where regular testing is introduced.

## **6. Potential risks of regular testing to children’s physical and mental health**

It is not clear why it is necessary to introduce a swab deep into the nasal cavity and throat to obtain a sample to test for a virus that is deemed highly contagious. It should be possible to use a saliva sample for testing and the application of a nasal swab appears unnecessarily invasive. Especially in children, this is not only uncomfortable but incurs a risk of trauma. **Cases of leaking cerebrospinal fluid, a severe injury, have been reported following the application of such a swab**<sup>xxxii xxxiii</sup>.

The risk of distress, discomfort, and trauma must be balanced against any benefit from the procedure, which is miniscule in children. As demonstrated in section 2 above, there is complete lack of evidence surrounding asymptomatic transmission. Furthermore, a comprehensive review of more than 50 published scientific papers by Professor John Ioannidis of Stanford University has shown that SARS-CoV-2 is less dangerous to children than yearly circulating flu viruses<sup>xxxiv</sup>. Therefore, **screening does not benefit the children, raising important ethical questions.**

There is emerging data regarding the swabs used for LFT SARS-CoV-2 testing, which have been sterilised in an agent called Ethylene oxide<sup>xxxv</sup>. Ethylene oxide is a highly carcinogenic chemical used in anti-freeze and pesticides. This US government website states that in addition to cancer, headache, stomach upset, fitting, coma and heart problems may also occur following inhalation<sup>xxxvi</sup>. Swabs of this nature are not intended for testing healthy people (especially children) repeatedly but are usually used for one-off DNA collection for forensic or paternity testing. Schoolchildren over the age of 12 will be encouraged to take the test twice a week for several weeks

or months. Potential long-term risks to children due to repeated exposure to ethylene oxide are unknown at this stage. Therefore, this practice of regular testing should not be introduced without a detailed risk assessment, which ought to be made available to the public. Parents should be informed regarding this potential toxic exposure, resulting from taking part in mass screening programs.

Scientific evidence does not support the hypothesis of children posing a risk as asymptomatic carriers<sup>xxxvii</sup>. Children are less likely to transmit the virus than adults. 300,000 households of healthcare workers in Scotland were found to be less likely to be infected or hospitalized if they had young children. **Transmission between children is limited and from children to teachers is exceedingly rare in schools.**

It is also important to consider the **negative effects of undergoing regular testing procedures on children's mental health**. The suggestion that they may pose a danger to their friends and even their own families may be distressing. The notion that testing is required to allow human interaction is unprecedented, and the effect on children's social development and their ability to form healthy relationships is entirely unaccounted for, and potentially a significant risk.

As a result of lockdowns, children's fundamental right to education has been severely restricted and will be further denied if individuals are required to self-isolate, or schools closed, following positive test results, which may be false positives. This is unacceptable and causes physical and psychological harm caused as well as the loss of education.

### **Conclusions and Requests**

Considering the weight of evidence presented in this letter, we hope that you will agree that **it is time to abolish the mass-testing of healthy, asymptomatic people in all communities, workplaces and schools, with immediate effect.**

There is simply no justifiable reason to continue mass-testing asymptomatic individuals, especially children, and we ask for your confirmation that the same will immediately cease.

We thank you for your time reading this letter and look forward to receiving your response.

UK Medical Freedom Alliance

<http://www.ukmedfreedom.org>



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- <sup>i</sup> <https://www.gp-training.net/ebm-audit-statistics/wilson-jungner-screening-criteria/>
- <sup>ii</sup> <https://www.bmj.com/content/371/bmj.m4436>
- <sup>iii</sup> <https://www.youtube.com/watch?v=rXm9kAhNj-4>
- <sup>iv</sup> <https://uncoverdc.com/2020/04/07/was-the-covid-19-test-meant-to-detect-a-virus/>
- <sup>v</sup> <https://cdn.website-editor.net/6f54caea7c6f4adfba8399428f3c0b0c/files/uploaded/Innova-SARS-Cov-2-Antigen-test-IFU.pdf> Limitations Point 14
- <sup>vi</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/952613/s0989-covid-19-sage-73-minutes-171220.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/952613/s0989-covid-19-sage-73-minutes-171220.pdf) Points 39 and 40
- <sup>vii</sup> <https://www.who.int/news/item/20-01-2021-who-information-notice-for-ivd-users-2020-05>
- <sup>viii</sup> <https://cormandrostenreview.com/report/>
- <sup>ix</sup> <https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings>
- <sup>x</sup> <https://bpa-pathology.com/covid19-pcr-tests-are-scientifically-meaningless/>
- <sup>xi</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/895843/S0519\\_Impact\\_of\\_false\\_positives\\_and\\_negatives.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/895843/S0519_Impact_of_false_positives_and_negatives.pdf)
- <sup>xii</sup> <https://www.bbc.co.uk/news/health-54552620>
- <sup>xiii</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/coronaviruscovid19infectionsurveydata>
- <sup>xiv</sup> <https://www.bmj.com/content/372/bmj.n208/rr-3>
- <sup>xv</sup> <https://www.bmj.com/content/371/bmj.m4469>
- <sup>xvi</sup> <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013705.pub2/full>
- <sup>xvii</sup> <https://www.msn.com/en-gb/news/uknews/scrap-rapid-covid-tests-in-england-s-care-homes-experts-urge/ar-BB1bBPPq>
- <sup>xviii</sup> <https://pubmed.ncbi.nlm.nih.gov/33219229/>
- <sup>xix</sup> <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774102>
- <sup>xx</sup> [https://dryburgh.com/wp-content/uploads/2020/12/Clare\\_Crag\\_Evidence-of-Asymptomatic-Spread-of-COVID-19-been-Significantly-Overstated.pdf](https://dryburgh.com/wp-content/uploads/2020/12/Clare_Crag_Evidence-of-Asymptomatic-Spread-of-COVID-19-been-Significantly-Overstated.pdf)
- <sup>xxi</sup> <https://lockdownsceptics.org/has-the-evidence-of-asymptomatic-spread-of-covid-19-been-significantly-overstated-2/>
- <sup>xxii</sup> <https://www.thetimes.co.uk/article/no-known-case-of-teacher-catching-coronavirus-from-pupils-says-scientist-3zk5g2x6z>
- <sup>xxiii</sup> [https://www.who.int/bulletin/online\\_first/BLT.20.265892.pdf](https://www.who.int/bulletin/online_first/BLT.20.265892.pdf)
- <sup>xxiv</sup> <https://onlinelibrary.wiley.com/doi/epdf/10.1111/eci.13423>
- <sup>xxv</sup> <https://www.bmj.com/content/371/bmj.m4851>
- <sup>xxvi</sup> <https://www.bmj.com/content/371/bmj.m4438>
- <sup>xxvii</sup> <https://coronavirus.data.gov.uk/details/testing>
- <sup>xxviii</sup> <https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1491/5912603>
- <sup>xxix</sup> <https://www.who.int/news/item/20-01-2021-who-information-notice-for-ivd-users-2020-05>
- <sup>xxx</sup> <https://www.nhs.uk/conditions/consent-to-treatment/>
- <sup>xxxi</sup> [http://portal.unesco.org/en/ev.phpURL\\_ID=31058&URL\\_DO=DO\\_TOPIC&URL\\_SECTION=201.html](http://portal.unesco.org/en/ev.phpURL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html)
- <sup>xxxii</sup> <https://www.forbes.com/sites/ninashapiro/2020/10/05/covid-19-nasal-swab-test-led-to-spinal-fluid-leak/?sh=72cd3cc635e9>
- <sup>xxxiii</sup> <https://www.onlinelibrary.wiley.com/doi/epdf/10.1002/lary.29462>
- <sup>xxxiv</sup> <https://www.medrxiv.org/content/10.1101/2020.05.13.20101253v3>
- <sup>xxxv</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/95727/1/COVID-19-self-test-instructions.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/95727/1/COVID-19-self-test-instructions.pdf) page 20
- <sup>xxxvi</sup> <https://www.cancer.gov/about-cancer/causes-prevention/risk/substances/ethylene-oxide>
- <sup>xxxvii</sup> <https://www.bmj.com/content/371/bmj.m4851>