

23 July 2021

Open Letter from the UK Medical Freedom Alliance to:

- **Dr Gregor Smith - Scottish Chief Medical Officer**
- **Jeane Freeman MSP - Scottish Government Health Secretary**

Re: Testing asymptomatic people for Covid-19 and the Effect on Health Services

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 appeal to you to refrain from encouraging any further testing of asymptomatic individuals for Covid-19, especially with regards to NHS healthcare workers. We are aware that the rate of testing has recently increased significantly, and healthcare staff are specifically advised to participate in regular testing programs. We are gravely concerned that **this approach threatens to imminently cripple the National Health Service**, as a large proportion of the healthy workforce are having to isolate unnecessarily, causing shortages independent of any clinical illness.

Below we set out specific reasons for our concerns regarding:

- I) Reliability of testing for Covid-19
- II) Prevalence of clinical disease
- III) Provision of healthcare services

I) Reliability of testing for Covid-19

We previously sent an Open Letter dated 29 March 2021, to several government officials, calling for an immediate halt to Covid-19 testing in asymptomatic individualsⁱ. In this letter, we outlined and referenced the reasons for our appeal in detail.

Below we reiterate the points most salient to the current situation:

1. Validity of Covid-19 testing

It is generally acknowledged that the widely applied Lateral Flow Test (LFT) is less reliable (it has recently been deemed unreliable and abandoned by the FDA in the USⁱⁱ) and the reverse transcriptase polymerase chain reaction (RT-PCR) test is the “gold standard” for detection of SARS-CoV-2. However, as we evidenced in our previous Open Letter, the **RT-PCR test has never been validated**ⁱⁱⁱ, and is currently only under emergency use authorisation for use in asymptomatic people^{iv}. In addition, the way in which it has been carried out and interpreted, further compromises its reliability.

These issues need to be carefully considered, when the negative consequences of a positive test result are profound for the individual and their family, and for the sustainability of healthcare provision.

a. Cycle threshold (Ct) values

The principle of the RT-PCR test is to probe for small fragments of the viral genetic code and amplify them repeatedly until they are detectable. It is essential that the number of amplification cycles required for detection is disclosed, to determine whether the detected genetic fragment has any clinical significance in terms of a person’s potential infectivity. With increasing numbers of amplification cycles, indicated by the Cycle Threshold (Ct) value, smaller and smaller amounts of RNA become detectable, which may include inactive viral fragments. For the test to be meaningful, a maximum Ct value should be

set to confer a positive result, that corresponds to the presence of a high viral load in the subject. Samples detecting viral fragments at a higher amplification cycle should be classed as negative.

It has been acknowledged in SAGE minutes that **Ct values above 25 are unlikely to correlate with infectious disease**^v. WHO guidance from January 2021 also 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*”^{vi}.

Data from the ONS survey, however, indicate that samples are **declared positive at very variable Ct values**, often above 25 (Fig 1), which will have a direct impact on the number of reported cases at any time^{vii}. Reasons for this variation have not been publicly disclosed or justified, nor the basis for deciding which Ct values are used to declare a sample positive from one week to the next.

b. Deviation from RT-PCR test manufacturer’s instructions

It is reasonable to expect, as a minimum standard, that the instructions from the test manufacturers are strictly adhered to, especially with an unvalidated diagnostic test. On the contrary, it appears that the application of the RT-PCR test for SARS-CoV-2 in the UK has been highly inconsistent and variable. Commercially available test kits are **intended to detect three separate gene fragments of SARS-CoV-2** in order to declare a positive result. Notwithstanding these manufacturer’s instructions, it has been applied practice to **identify cases via detection of only two, and increasingly also of only one gene fragment** (Fig 2). This clearly impairs the specificity even further, as the detected gene fragment in isolation may not be specific to the SARS-CoV-2 virus. This further compromises reliability, inflates the number of positive “cases” and renders the relevance of declared positive cases highly questionable^{viii}.

c. Contamination

There is a significant difference between the reliability of a test carried out under stringent experimental laboratory conditions to the same test applied to vast numbers of samples on a daily basis in a diagnostic facility. Results may be compromised by human factors, including limited experience and safety awareness of laboratory technicians^{ix}. Undercover footage by the BBC’s Panorama program in a large testing facility in Milton Keynes demonstrated **significant risks of samples being contaminated** during the testing process^x. This implies that the genetic code detected, which results in a sample being declared positive may not even have come from that sample.

d. False positive results

The WHO confirmed that the **predictive value of test results is dependent on disease prevalence**, as the risk of false positives increases with decreasing disease prevalence. This is “*irrespective of the claimed specificity*” of any test^{xi}. This is specifically relevant in the current situation, as disease caused by coronavirus is seasonal, and the prevalence is low during summer months.

It is essential 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^{xii}, as of 5th March 2021.

To enable determination of the ratio of false positives to true positives, the false positive rate needs to be considered relative to the current prevalence of disease in the population. According to the Office for National Statistics (ONS) on 12 December 2020, the prevalence of SARS-CoV-2 in the UK was around 1%. Assuming the false positive rate is around 1%, this means that 50% of all positive tests were false positives (ie 1,070,775 false positive tests out of the 2,141,551 total positive cases published by the government at 23 December 2020). If the false positive rate is higher than 1%, false positive results would exceed true positives. Combined with high cycle threshold (Ct) values, the **probability of false positive test results may be up to 97%**^{xiii}.

2. Testing asymptomatic individuals

The assumption of the clinical significance of asymptomatic individuals for transmission of disease was made early on in 2020 and has never been re-evaluated or proven. Testing asymptomatic individuals is only justifiable if they pose a significant threat to others. **Good evidence of asymptomatic spread of SARS-CoV-2 has not been demonstrated in the published literature.** Effective transmission is directly correlated to viral load, which is likely to be low in the absence of symptoms.

Data from a large Chinese population study suggest there is **no requirement for measures of source control in asymptomatic people, even after a positive test**^{xviii}. 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 published in a study of nearly 80,000 close household contacts^{xix}.

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^{xx}. 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”*^{xxi}. Therefore, **pre-symptomatic and asymptomatic transmission appear to be rare, posing a negligible risk to the population.**

3. Financial impact of testing

All aspects of healthcare have been significantly restricted by funding constraints. It is hard to justify spending a significant proportion of the National Health Service (NHS) budget on these deeply flawed tests, aimed at identifying asymptomatic individuals, who almost certainly pose no significant threat to anyone.

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^{xxv}.

II) Prevalence of clinical disease

The reason given for encouraging healthcare workers to participate in testing programmes is that Covid-19, and in particular the Delta variant, is extremely infectious.

With the benefit of hindsight, it is now obvious that **overall mortality in 2020, during the Covid-19 pandemic, was no different to preceding years**, despite the detrimental effects of lockdowns and all the measures implemented with the purpose of disease mitigation (Figs 3 & 4). The number of deaths clearly attributable to Covid-19 has not been in the order of magnitude that was initially feared (403) (Fig 5). Indeed, hospital admissions have been lower than in previous years throughout the pandemic (Fig 6).

Virus mutations are exceedingly common and will often result in higher transmissibility but not usually in increased virulence^{xiv}. Whilst rising number of positive tests are reported, this is not reflected in rising numbers of deaths or serious disease requiring hospitalization.

We propose that recommendations should be based on an evidenced clinical threat rather than a count of positive test numbers, especially when numbers of positive tests appear directly correlated to numbers of tests applied, indicating that a **crisis may be created purely by a surge in testing** (Figs 7 & 8). Raw numbers of positive tests are misleading and fear-inducing. It would be more transparent and scientific to report the percentage of tests carried out that are positive, with consideration of the false positive rates.

III) Provision of healthcare services

The cost to healthcare services of encouraging regular Covid-19 testing for all healthcare workers is not limited to funding the test kits. It most significantly extends to the effects on staffing levels within hospitals, as individuals testing positive are then required to isolate.

As we have outlined above, even the “gold standard” RT-PCR test is highly unreliable and likely produces a significant number of false positive results, especially during the summer months, when coronavirus disease prevalence has historically been low. Yet, on the basis of these results **the workforce providing healthcare is severely decimated**, in proportion to the number of tests carried out.

This occurs at a time when waiting times have risen beyond manageable levels everywhere in the UK, and sustaining the workforce is more essential than ever^{xv}. For over a year, the almost exclusive focus has been on managing Covid-19 at the expense of providing timely care and intervention for any other conditions, including life-threatening diseases such as cancer and heart disease, not to mention mental ill-health. **At no point has Covid-19 disease been among the leading causes of deaths, and the effects of any other ailments have accumulated over many months.** Therefore, this is most certainly a state of emergency, as any further impairments to the ability of providing care to these patients will seriously threaten the health and life expectancy of the nation.

Conclusion and Request

We strongly suggest that it is time to take a pragmatic approach and re-evaluate, specifically, the relevance of Covid-19 testing and the allocation of funding within the health service.

Prior to 2020, asymptomatic spread of a respiratory virus has never been observed. In the absence of scientific data to support the assumptions regarding asymptomatic or pre-symptomatic transmission of SARS-CoV-2, **the application of an unvalidated test on a mass scale should cease immediately**, especially within the health service, where the consequences of false positive results are devastating to care provision. It is time to consider all aspects of the healthcare service rather than a myopic focus on results of a single test.

We appeal to you to reassess this policy that has been followed for months without question, and urgently appraise the presented data critically, before the care of the people is further compromised.

We thank you for taking the time to read and consider this letter.

UK Medical Freedom Alliance

www.ukmedfreedom.org

Cc: Prof Chris Whitty – UK Government Chief Medical Adviser
Rt Hon Sajid Javid – Secretary of State for Health and Social Care

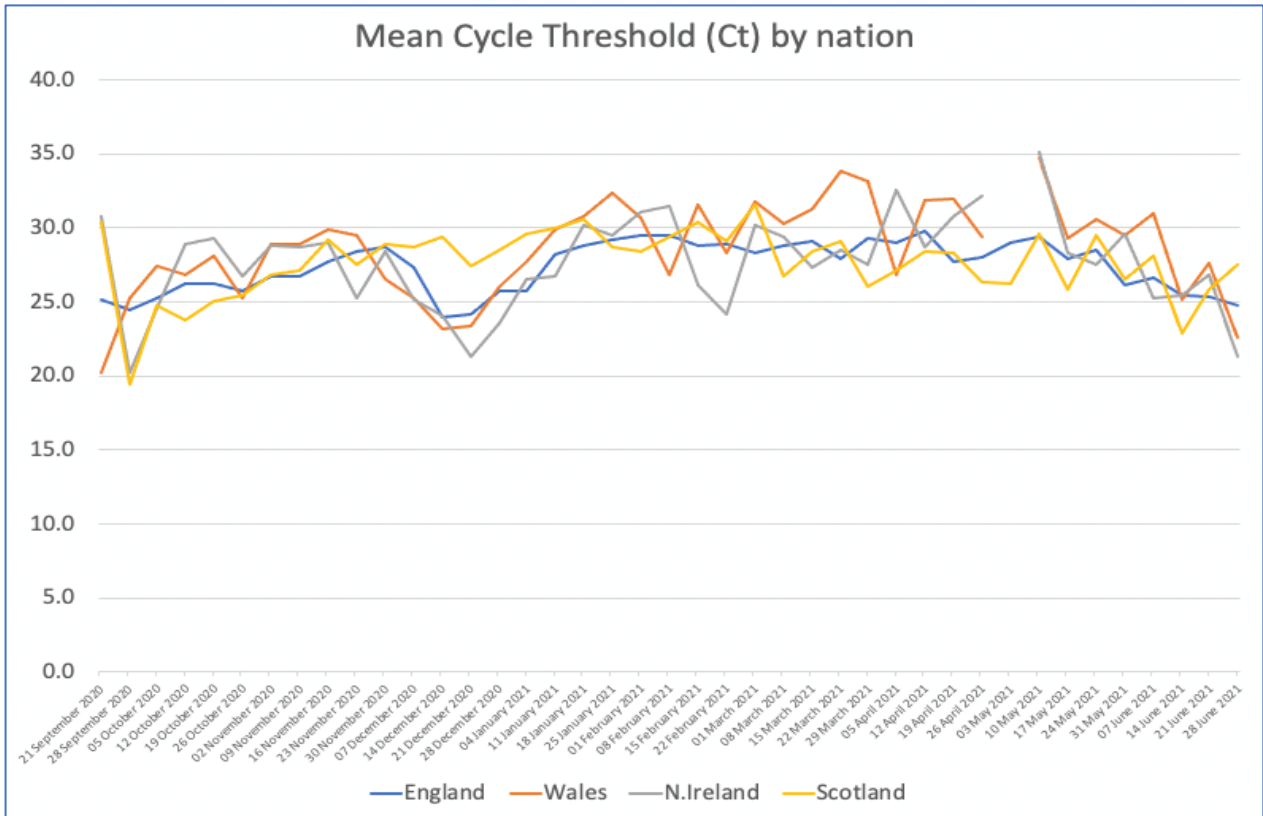


Fig 1 Mean Ct values used to declare RT-PCR tests positive for SARS-CoV-2^{xvi}

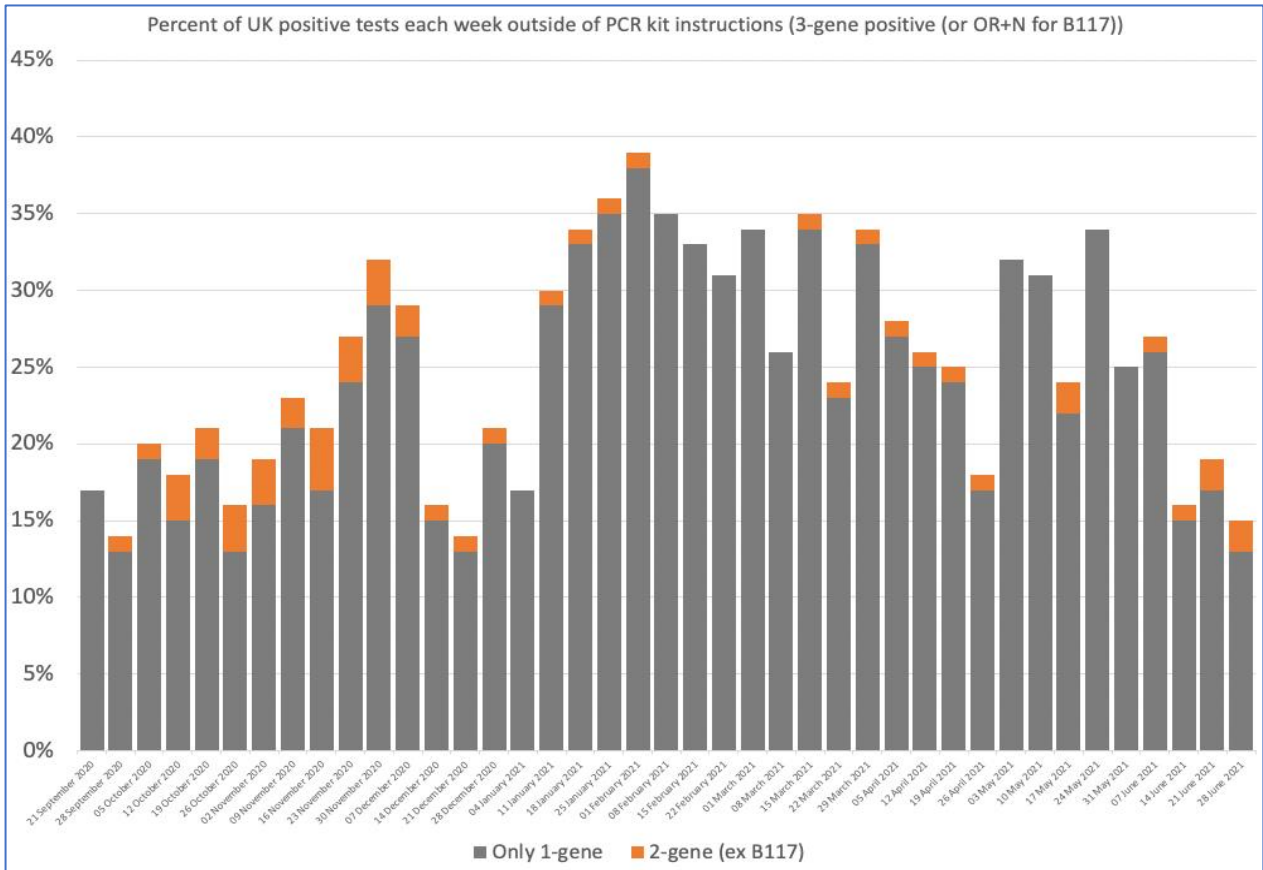


Fig 2 RT-PCR tests declared positive outside manufacturer's instructions^{xiv}

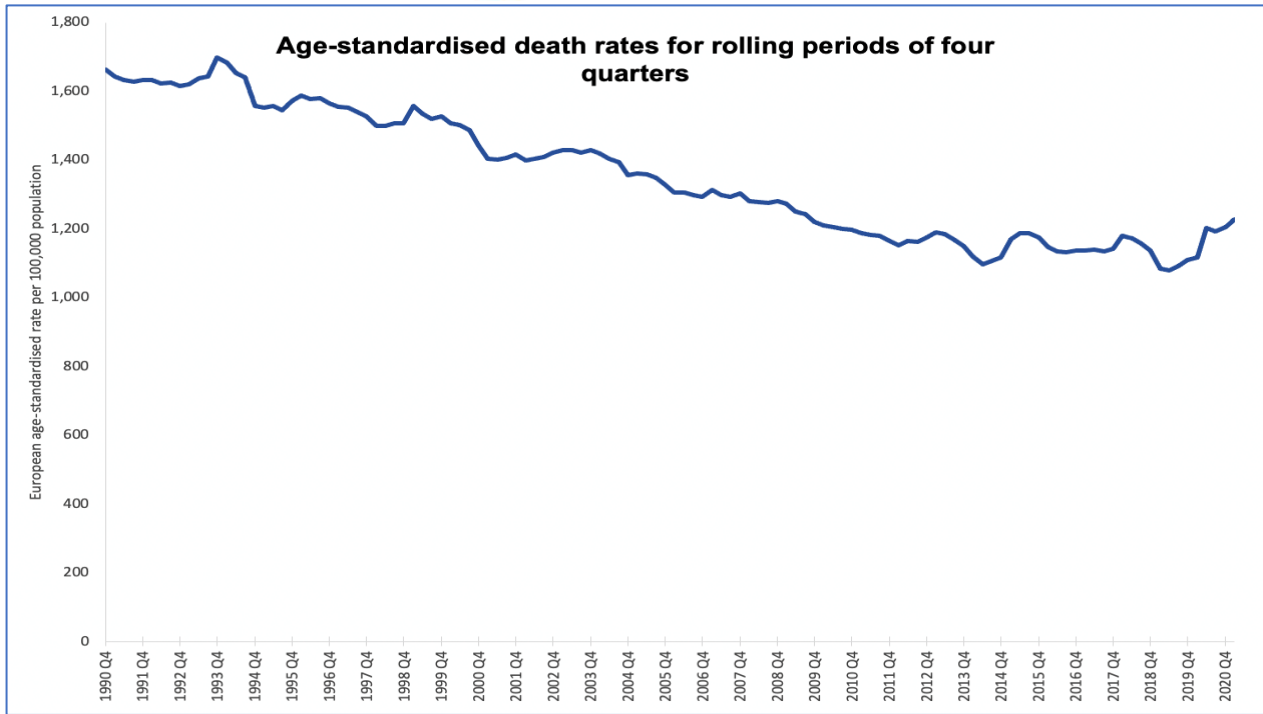


Fig 3 National Records Scotland - Overall Mortality^{xvii}

Scotland all-cause mortality rate past 30 years - Weeks 1-53 of each year

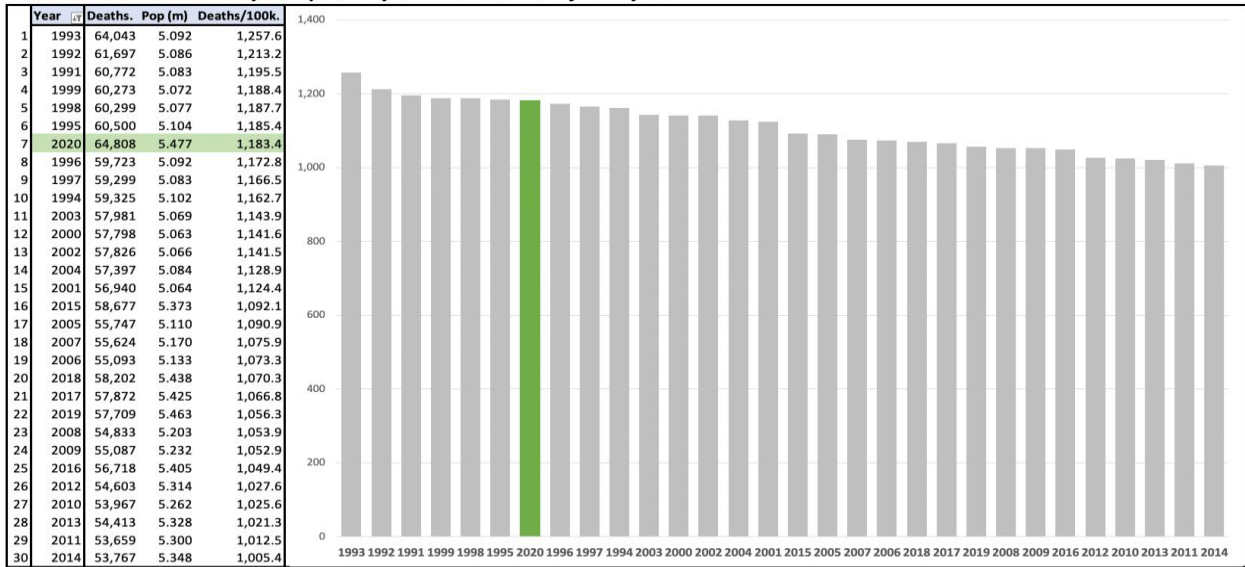


Fig 4 National Records Scotland – All-cause Mortality for the past 30 years

1.0 FREEDOM OF INFORMATION REQUEST RESULTS FROM NHS SCOTLAND BOARDS				
NHS Board	Only Covid-19 on death certificate (to 25/5/21)	Covid-19 recorded on death certificate (NRS 31/5/21)	All deaths in 2020 (Source: NRS)	Population (from NHS Board)
NHS Ayrshire & Arran	51	913	5,227	367,990
NHS Borders	7	150	1,411	115,240
NHS Dumfries&G**	8	168	2,074	148,290
NHS Fife	14	503	4,285	374,130
NHS Forth Valley	21	598	3,593	305,930
NHS Glasgow GGC	Awaiting FOI appeal	3047	14,471	1,185,240
NHS Grampian	29	604	5,914	585,550
NHS Highland	12	235	3,860	320,860
NHS Lanarkshire	73	1702	8,356	661,960
NHS Lothian	Awaiting FOI appeal	1447	8,816	912,490
NHS Orkney	0	4	254	22,400
NHS Shetland	0	11	208	22,870
NHS Tayside	33	735	5,259	416,550
NHS Western Isles	0	9	356	27,000
Ratio per person	1 in 13583.75	1 in 5,632	1 in 85	n/a
Total (to date)	248	10,126	64,084	3,368,770
Scotland	403*		64,084	5,466,500

Notes

1. Based on NRS data available to 31/5/2021

* Estimate. Based on 1 in 13,584 ratio from other NHS boards

** As FOI response December 2020

Data from National Records Scotland

<https://www.nrscotland.gov.uk/files//statistics/covid19/covid-deaths-21-report-week-24.pdf>

<https://www.nrscotland.gov.uk/files//statistics/covid19/covid-deaths-21-report-week-02.pdf>

Date from National Health Service, Freedom of Information Requests for each Health Board area (attached)

Fig 5 Deaths attributable to Covid-19 in Scotland

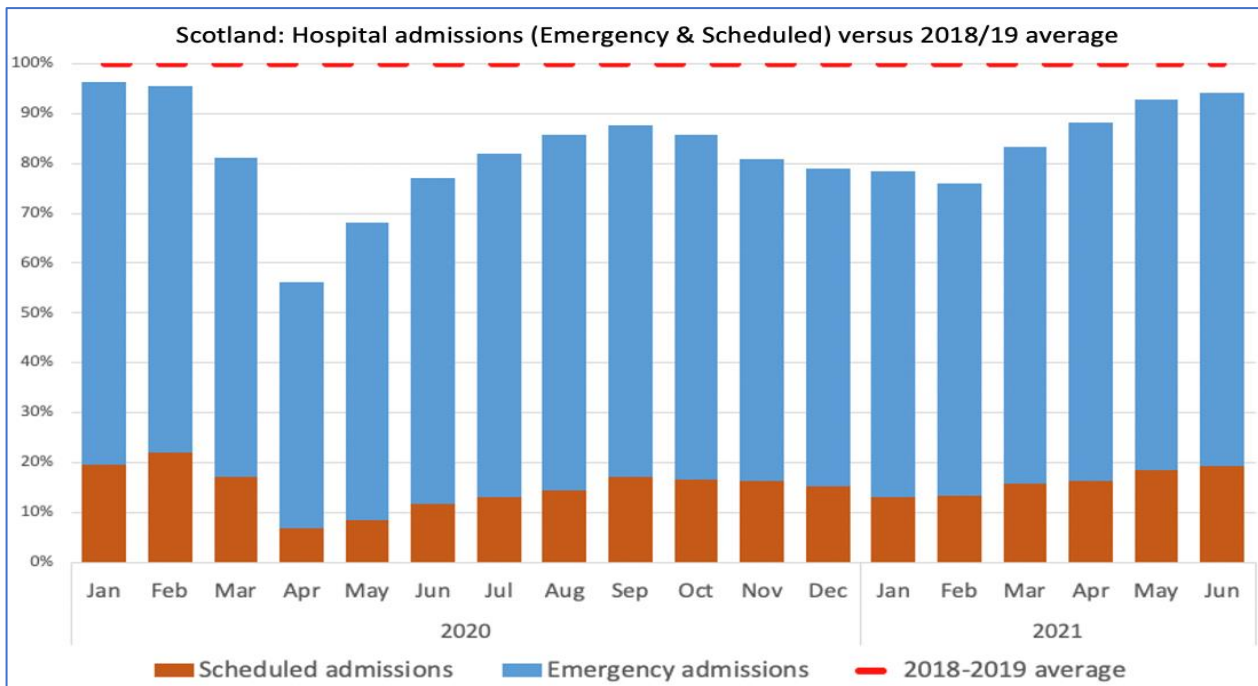


Fig 6 Hospital admissions in Scotland compared to 2018/19^{xviii}

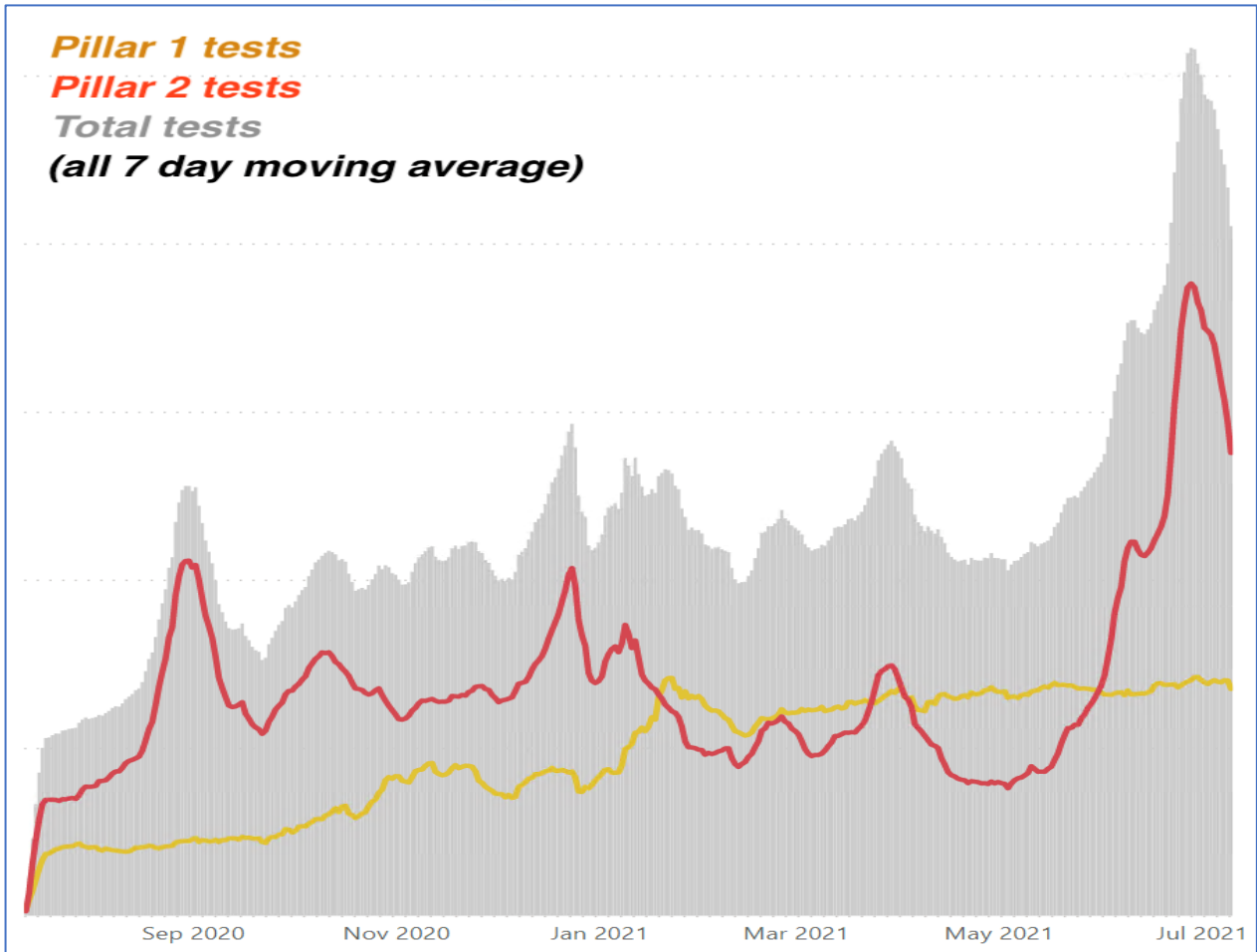


Fig 7 RT-PCR tests carried out in Scotland in Pillar 1 (NHS) and Pillar 2 (Community Testing)^{xix}

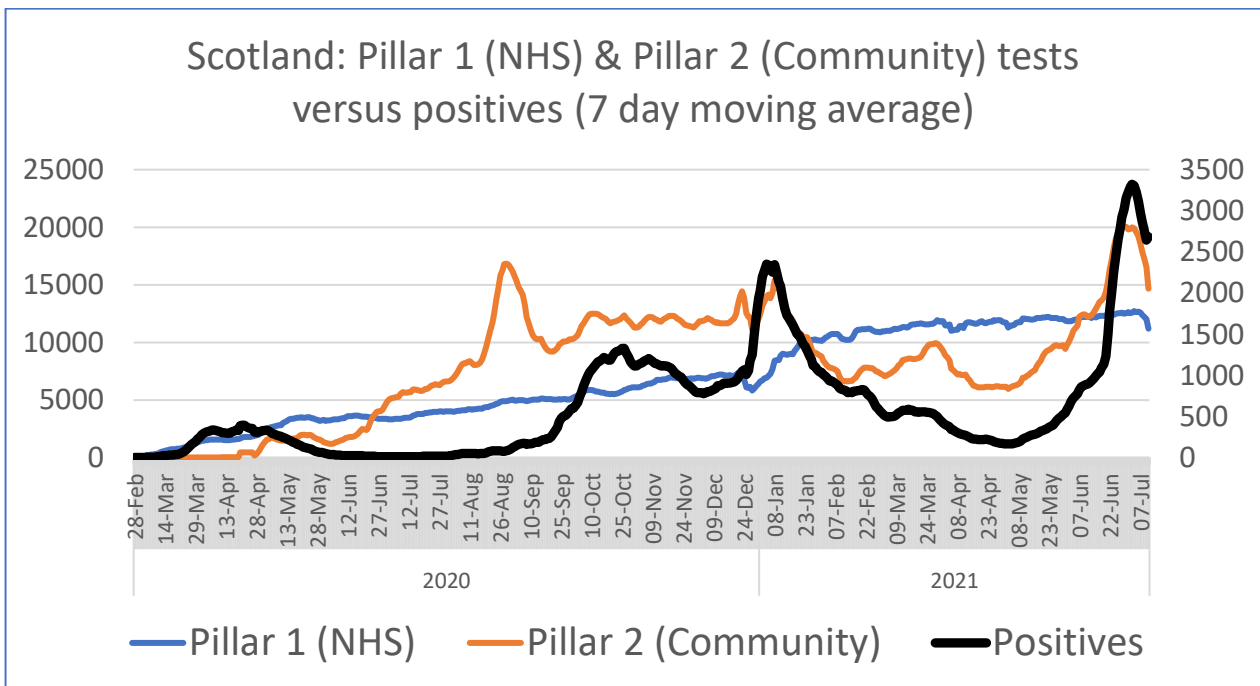


Fig 8 Positive RT-PCR tests in Scotland^{xvii}



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- ⁱ https://uploads-ssl.webflow.com/5fa5866942937a4d73918723/6062f5754d5cde81f4d39e40_UKMFA_Open_Letter_Mass_Testing_Community.pdf
- ⁱⁱ <https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/removal-lists-tests-should-no-longer-be-used-and-or-distributed-covid-19-faqs-testing-sars-cov-2>
- ⁱⁱⁱ <https://cormandrostereview.com/report/>
- ^{iv} <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-first-diagnostic-test-screening-people-without-known-or>
- ^v 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
- ^{vi} <https://www.who.int/news/item/20-01-2021-who-information-notice-for-ivd-users-2020-05>
- ^{vii} <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/coronaviruscovid19infectionsurveydata>
- ^{viii} <https://www.bmj.com/content/372/bmj.n208/rr-3>
- ^{ix} <https://www.bbc.co.uk/news/health-54552620>
- ^x <http://www.bbc.co.uk/news/uk-56556806>
- ^{xi} <https://uncoverdc.com/2020/04/07/was-the-covid-19-test-meant-to-detect-a-virus/>
- ^{xii} <https://coronavirus.data.gov.uk/details/testing>
- ^{xiii} <https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1491/5912603>
- ^{xiv} <https://www.nature.com/articles/s41564-020-0690-4>
- ^{xv} <https://www.bbc.co.uk/news/uk-57793122>
- ^{xvi} <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/covid19infectionsurveytechnicaldata>
- ^{xvii} <https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/births-deaths-and-other-vital-events-quarterly-figures/1st-quarter-2021>
- ^{xviii} <https://www.opendata.nhs.scot/dataset/covid-19-wider-impacts-hospital-admissions/resource/f8f3a435-1925-4c5a-b2e8-e58fdacf04bb>
- ^{xix} <https://www.opendata.nhs.scot/dataset/covid-19-in-scotland/resource/427f9a25-db22-4014-a3bc-893b68243055>