

# Another Failure of the COVID Diagnostic Test

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July 29, 2020

In previous articles, I've detailed several key reasons why the PCR test is worthless and deceptive. (PCR article archive [here](#)).

Here I discuss yet another reason: the uniformity of the test has never been properly validated. Different labs come up with different results.

Let's start here—the reference is the NY Times, January 22, 2007, “Faith in Quick Tests Leads to Epidemic That Wasn't.”

“Dr. Brooke Herndon, an internist at Dartmouth-Hitchcock Medical Center, could not stop coughing..By late April, other health care workers at the hospital were coughing..”

“For months, nearly everyone involved thought the medical center had had a huge whooping cough outbreak, with extensive ramifications. Nearly 1,000 health care workers at the hospital in Lebanon, N.H., were given a preliminary test and furloughed from work until their results were in; 142 people, including Dr. Herndon, were told they appeared to have the disease; and thousands were given antibiotics and a vaccine for protection. Hospital beds were taken out of commission, including some in intensive care.”

“Then, about eight months later, health care workers were dumbfounded to receive an e-mail message from the hospital

administration informing them that the whole thing was a false alarm.”

“Now, as they look back on the episode, epidemiologists and infectious disease specialists say the problem was that they placed too much faith in a quick and highly sensitive molecular test [PCR] that led them astray.”

“There are no national data on pseudo-epidemics caused by an overreliance on such molecular tests, said Dr. Trish M. Perl, an epidemiologist at Johns Hopkins and past president of the Society of Health Care Epidemiologists of America. But, she said, pseudo-epidemics happen all the time. The Dartmouth case may have been one the largest, but it was by no means an exception, she said.”

“Many of the new molecular [PCR] tests are quick but technically demanding, and each laboratory may do them in its own way. These tests, called ‘home brews,’ are not commercially available, and there are no good estimates of their error rates. But their very sensitivity makes false positives likely, and when hundreds or thousands of people are tested, as occurred at Dartmouth, false positives can make it seem like there is an epidemic.”

“‘You’re in a little bit of no man’s land,’ with the new molecular [PCR] tests, said Dr. Mark Perkins, an infectious disease specialist and chief scientific officer at the Foundation for Innovative New Diagnostics, a nonprofit foundation supported by the Bill and Melinda Gates Foundation. ‘All bets are off on exact performance’.”

“With pertussis, she [Dr. Kretsinger, CDC] said, ‘there are probably 100 different P.C.R. protocols and methods being used throughout the country,’ and it is unclear how often any of them are accurate. ‘We have had a number of outbreaks where we believe that despite the presence of P.C.R.-positive results, the disease was not pertussis,’ Dr. Kretsinger added.”

“Dr. Cathy A. Petti, an infectious disease specialist at the University of Utah, said the story had one clear lesson.”

“‘The big message is that every lab is vulnerable to having false positives,’ Dr. Petti said. ‘No single test result is absolute and that is even more important with a test result based on P.C.R.’.”

–Sobering, to say the least. Of course, some people will claim that since the date of the Times’ article (2007), vast improvements have been made in the PCR test.

Really? The truth is, something much worse is lurking in the weeds. It has been lurking ever since the PCR was approved for use in diagnostics:

No large study validating the uniformity of PCR results, from lab to lab, has ever been done.

You would think at least a dozen very large studies had checked for uniform results, before unleashing the PCR on the public; but no, this was not the case. It is still not the case.

Here is what should have been done decades ago:

Take a thousand volunteers. Remove tissue samples from each person. Send those samples to 30 different labs. Have the labs run PCR and announce their findings for each volunteer.

“We found the following virus in sample 1...” Something simple like that.

Now compare the findings, in each of the 1000 cases, from all 30 labs. Are the findings the same? Are the outcomes uniform all the way across the board?

My money would be against it. Strongly against.

But this is not the end of the process. SEVERAL of these

large-scale studies should be done. In EACH study, there are 1000 volunteers and 30 labs.

Why? Because, as you can readily see, the whole story about a current pandemic is riding on those tests. The story, the containment measures, the lockdowns, the economic devastation, the human destruction—it's all built on the presumption that the PCR is a valid test.

It's unthinkable that these validation studies of the PCR weren't done decades ago. But they weren't. And there is only one reason why: to avoid the truth. The results of the PCR aren't uniform. They vary from lab to lab.

One lab says positive for virus B. Another lab says negative for virus B. Both labs are looking at the same sample.

No? Couldn't be? Then prove it with the several large-scale studies I'm proposing.

I'll give you a rough fictional analogy for the current testing situation—

In an old-growth forest of immense trees, a government agency tests white spots found on some trunks. The verdict? A highly destructive and novel fungus, for which there is no remedy. Without immediate and drastic action, the fungus will spread to the whole forest and destroy all the trees.

So a government contract is signed with a logging company, and workers move in and start cutting down many trees.

Meanwhile, another lab tests those white spots and reports they're harmless bird droppings. Yet another lab claims they're a mild traditional fungus of no great concern.

The reports of these two labs are suppressed and censored. The labs are put on a quiet blacklist, and their business dries up.

The tree cutting continues.

An analyst at the US Forestry Service sends a memo to his boss. It details the fact that the test which found deadly fungus is unreliable. Different labs doing the test come up with different and conflicting results.

Worse yet, that test was never properly validated as a uniform process before being approved for use. In other words, no one did a large study in which multiple labs used the test to determine the composition of spots found on trees. No one made sure that all labs came to the same conclusions using the test.

The Forestry analyst writes: "The test has inherent flaws. Different labs examining the same sample will always come up with different results. This has disastrous consequences in the real world. You can see that now; we are cutting down half a forest to prevent the spread of a fungus which has been noticed for centuries, and never caused serious harm..."

The analyst is fired from his job and firmly reminded that he signed a non-disclosure agreement, and he better keep his mouth shut.

The tree-cutting goes on. A developer buys up the cleared land at a very low price...

In essence, the pipeline of information from actually reliable sources, to the government, and then to the public, is narrowed, and guarded against unwelcome intrusions of TRUTH.

In the case of the PCR test, that's what is happening.

SOURCE:

[nytimes.com/2007/01/22/health/22whoop.html](http://nytimes.com/2007/01/22/health/22whoop.html)