Interview with Dr. Denis Rancourt

Empire, Mortality, and the Multi-Pronged Attack on Humanity

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Dr. Denis Rancourt's journey from tenured physics professor to pandemic data anal represents one of the most remarkable intellectual transformations of the COVID e His 2019 geopolitical study had already established him as someone willing to follo evidence wherever it led, revealing how empire creates and deploys global narrative around climate, gender, and race as instruments of control. When governments worldwide declared a pandemic in March 2020, Rancourt brought the same rigorou

scrutiny to mortality data that he'd previously applied to condensed matter physics and environmental science. What he found challenged everything we were told: no excess deaths anywhere before the WHO's March 11 declaration, synchronized mortality spikes that defied viral spread patterns, and death rates that correlated nc with international travel or population density, but with specific medical interventi and institutional responses.

The numbers Rancourt uncovered tell a story of institutional catastrophe rather tha viral pandemic. His analysis of 125 countries revealed that 30% showed no excess mortality in 2020 until vaccines were introduced. The geographic patterns defied al epidemiological logic: the virus that supposedly killed 1.3 million Americans could cross the Canadian border despite continuous economic exchange; Milan's region experienced death rates 18 times higher than Rome's despite Rome receiving more flights from China; wealthy Germany had minimal excess mortality while adjacent regions in France and Belgium were devastated. Most damning, he documented mortality rates of 88% for ventilated patients in New York hospitals and vaccine do fatality rates that increased exponentially with age, reaching one death per 100 injections in those over 80. These weren't the patterns of a spreading respiratory disease but of systematic iatrogenic harm concentrated in specific locations that implemented aggressive treatment protocols.

Rancourt's alternative explanation fundamentally reframes our understanding of wl happened during 2020-2023. Rather than a viral pandemic, he proposes that the exc mortality resulted from "transmissionless bacterial pneumonias" triggered by unprecedented biological stress from lockdowns, social isolation, and fear campaig combined with deadly medical protocols. The human respiratory microbiome, he argues, can spiral out of balance under extreme stress, making people vulnerable to pneumonia from their own bacteria without any transmission required. This explai why deaths correlated with poverty levels near large hospitals but not in equally po areas without aggressive medical infrastructure, why mortality peaks synchronized with policy announcements rather than following disease spread patterns, and why demographic correlations shifted completely between spring and summer 2020. His estimate of 31 million excess deaths globally through 2022 represents not victims of virus, but casualties of what he calls "a multi-pronged state and iatrogenic attack or populations."

This September 2025 interview arrives at a perfect moment for those of us who hav been in Rancourt's slipstream for the past few years. His 2019 geopolitical study wa like a sledgehammer to my brain - it cracked it open and for the first time I could se empire with clarity, understand how it creates meta-narratives that alter our perception of reality. When March 2020 arrived, I and many others would have beer

completely lost without Rancourt's searing insight and guidance. While the world descended into orchestrated madness, he provided the data, the analysis, the proof we weren't going insane - that the patterns defied viral logic, that the deaths were r but the pandemic wasn't. I am incredibly grateful for the time and effort he put int these answers, for his willingness to keep fighting this fight when it would have be easier to stay silent. His work documenting how 31 million people died from institutional assault rather than any virus has been nothing short of essential. For those of us trying to make sense of what we lived through, Rancourt didn't just anal data - he provided a lifeline to sanity, a framework for understanding how policy became the pathogen and protocols became the plague.

With thanks and gratitude to Dr. Denis Rancourt.

1. Denis, can you please tell us about your journey from being a tenu physics professor at the University of Ottawa to becoming one of the most prominent critics of pandemic policies? What pivotal moments l you to shift your focus from traditional academic research to analyzi public health data?

My PhD (1984) was in condensed matter physics, from the University of Toronto. I 27 years old. Following two years of post-doctoral research in European laboratorie (France and The Netherlands), I became a nationally funded lead researcher and university professor at the University of Ottawa in Canada. My research laboratory was continuously well funded through competitive awards, and I taught more than 2000 students in my 23 years at this institution. I was promoted quickly to attain th highest academic rank of tenured Full Professor. I have given many invited and keynote talks at international conferences, in several different areas of science. I ha made discoveries and co-discoveries in magnetism, measurement science, metals physics, crystal-chemistry of rock-forming and environmental minerals, soil scienc

aquatic sediments and nutrients, planetary science (meteorites), climate science, theory of health, politics, and epidemiology. A recent CV is linked on my website.

I have always been interdisciplinary and outspoken. I was fired by the University of Ottawa in 2009 for a conflict with the upper administration over academic freedom Following my dismissal, the university entirely funded a million-dollar personal defamation lawsuit against me. After a decade of litigation and support from my union, and pursuant to an open letter and petition signed by several academics (19 March 2018), a global mutual agreement resolving all my issues with the university signed in January 2019.

I acquired extensive direct experience about the high degree to which Western professionals and institutions are corrupt. I have recognized for decades that this is rapidly increasing trend in Canada. In 2009 I wrote an overview article for a sociolo journal: "Canadian Education as an Impetus towards Fascism". Much of this and m is discussed in my 2012 book of essays: "Hierarchy and Free Expression in the Figh Against Racism". Many of my essays are also at Dissident Voice.

During my conflict with the University of Ottawa, and prior to my dismissal, the up administration hired a high-ranking clinical and court psychiatrist to secretly write opinion that stated that I was dangerous. I only learned of the psychiatric opinion years later during legal disclosures. As a self-represented litigant, I eventually won legal disclosure of the psychiatrist's opinion, and then initiated professional-ethics litigation against the Montreal-based psychiatrist. It took years of endless tribunal court hearings, fighting a major law firm, for me to win a disciplinary sentence aga the psychiatrist, which was upheld in an appeal decision dated 10 September 2024. That was a rewarding saga, somewhat covered in French-language mainstream mec in Quebec, largely occurring during Covid.

I diverge. I have never stopped being an independent thinker since I was an infant. remember inventing the knot from the first step in the shoelace bow that I was learning. My mother was not impressed despite my explanations. All of elementary school was extreme boredom except for the occasional intervening parent with a passion. Hearing about atoms, molecules and cells was a universe. I took shop in hi school to avoid history and memory work. Loved it, including welding and machini I could not remember so-called facts but I could figure out anything from fundame principles. Teachers always regretted asking if anyone had questions. I won junior Chess champion at my high school, on pure talent without any theory or memory.

I could never do a job without finding a contradiction leading me to define a new direction, from spectroscopy, to solitons, to nanoparticles, to psychology and politi

My path was populated with burgeoning new enemies everywhere, which is one reason I kept changing fields. I was a member of research institutes for both physic and earth sciences, and I taught scientific methods to graduate students from all th science and engineering departments in two faculties. (As an aside, my dean once barred me from supervising a willing scholarship student in climate science and tol the university president I should not be allowed to work in that field.)

For me, questioning and disbelieving the latest propaganda of a global threat—whi was the declared Covid pandemic—was not a choice I made. Rather, it was my natu My commitment to noisily resisting became unavoidable as government hysterics became stratospheric. I never believed a word, never wore a face mask (except one time when my wife wanted something for a special event and it could not convenie be purchased otherwise - the experience doubled my anger), and I was never vaccinated. My first written reports to governments and institutions were made in April 2020, with the Ontario Civil Liberties Association. Eventually, I made my own website to fight the censorship, and co-founded CORRELATION Research in the Public Interest. I was banned from several venues, including Research Gate and LinkedIn. I was frustratingly censored on YouTube and Facebook, with much conte removed.

2. Your first major COVID analysis was published in June 2020, titled "All-cause mortality during COVID-19 - No plague and a likely signatu of mass homicide by government response." That's quite a bold statement. What evidence convinced you so early that the pandemic response itself was causing harm?

My very first thought was that a pandemic had to have many deaths, whereas there were no dead bodies in the streets. I also knew no one who had been given emerger care and a social activist friend of mine was finding and filming empty hospitals throughout Ottawa. I needed all-cause mortality data.

I was inspired by the early matter-of-fact video interviews and early paper of the N based German epidemiologist Knut Wittkowski. I have a few German beer-drinkin scientist friends and I generally love those guys. Wittkowski stressed from classic contagion theory and using available reports that lockdowns and school closures co only make things worse and would put the elderly in more danger (our own later theoretical calculations amply confirmed this, assuming correctness of the accepte theory). Among other things, Wittkowski went straight to available mortality data. That got me excited that there was hard data available, as opposed to the PCR garb and so on. Wittkowski spoke from broad experience. He did not see the data the sa way that I came to understand it but his public communications showed its potenti

and the traditional interpretive framework without political bias. I got right into it. That led to my June 2020 paper.

Other early confirmations for me notably included the famous 2020 home-garage vi statement of Mike Yeadon, some 2020 preprints of John Ioannidis, and an early 202 video statement by Professor Sucharit Bhakdi.

I had also by this time made several commentary videos and video interviews on YouTube, see: "COVID-19 with Denis Rancourt" (playlist, >100 videos). I wanted my science background and critical perspective to be of immediate use during the excessive government propaganda.

The early all-cause mortality data available at the time of my June 2020 paper, for Europe and the USA, showed remarkable features that I highlighted in graphs and text:

1. No excess mortality occurred anywhere prior to the 11 March 2020 WHO declaration of a pandemic.
2. A peak of abnormally large mortality surged immediately following the WHO declaration of a pandemic in various jurisdictions but not anywhere else.
3. The peaks of abnormally large mortality, where they occurred, were synchronou across two continents.
4. The magnitudes of whole-population (all-ages) mortality were not particularly alarming in themselves, except for New York City.

It seemed impossible to me that this spatiotemporal phenomenon could be due to t spontaneous spread of a dangerous new pathogen that had originated from some pl in China, and why would the supposed new pathogen follow the 11 March 2020 political pronouncement made by the WHO? In addition, the jurisdictions of large excess mortality peaks had many reports of government and medical assaults agains institutionalized frail and elderly persons. These points, together, made me conclud the way I did: "No plague and a likely signature of mass homicide by government response".

All the work my collaborators and I did in the following several years has consisten corroborated my June 2020 conclusion. In particular, an industry of theoretical epidemiology has arisen to argue that the spatiotemporal patterns of excess mortali arise from contagion theory for a respiratory virus, but in June 2025 we rigorously demonstrated that the empirical all-cause mortality data is inconsistent with these flawed creative adventures in theoretical epidemiology.

3. You've analyzed all-cause mortality data from over 125 countries during the COVID period. For readers unfamiliar with this approach, why is all-cause mortality more reliable than reported COVID deaths, and what patterns emerged that surprised you most?

In the great majority of deaths, assigning a cause of death is necessarily arbitrary ar subject to political, professional and institutional bias. This is not controversial. It i well-known problem. The said problem is unavoidable because of the very nature o death itself, which is a complex and cooperative system failure involving a multitud of damaged components. Even the said damaged components themselves are not ea characterized. On the other hand, recognizing the occurrence of a death, irrespecti of any presumed cause, is straightforward. This is why counting a death (at a time a place, of a person with a given age and sex), like counting a live birth, gives the mos reliable population data one can have. (As an aside, a collaborator and I are workin a "theory of death and aging" that I am rather excited about, which is another story

This all-cause mortality can be counted with high temporal resolution, such as by d thus allowing sudden mortality events to be detected, including summer heat wave large transportation accidents, earthquakes, engineering failures, and the like; with high spatial resolution, down to neighbourhoods and institutions; with high resolu by age of the deceased; by socio-economic status; and by health status, such as vaccination status and presence of diagnosed chronic diseases. As such, all-cause mortality, thus resolved, is an extraordinarily powerful database.

Furthermore, the recording of all-cause mortality is considered of national interest, and is most often required and standardized by law, in virtually all developed countries, for all sub-national jurisdictions. The largest failure in this regard is mos Africa. An additional frustration for researchers is lack of efficient proactive transparency and incomplete disclosure. Rare administrative artefacts are easy to s (such as late registration of deaths during holidays). We have found no reason to thi that state-reported all-cause mortality data is biased or manipulated. Quite to the contrary, we generally find a high degree of consistency, and excess-mortality event that match reports of known catastrophes.

The large patterns of excess all-cause mortality that surprised me are many. They include the following:

- The virtual absence of any excess mortality, anywhere in the world, prior to the March 2020 WHO declaration of a pandemic
- The sudden surges in mortality that occur on cue immediately following the 11 March 2020 WHO declaration of a pandemic

- The extreme geographical (jurisdictional) heterogeneity of excess mortality, compared to the historic pre-Covid-period trends, including within given countries (between states, provinces and counties), and including between citie with virtually identical circumstances (socio-economic, airports, cultural, etc.)
- The large number of countries and sub-national regions that had no detectable excess all-cause mortality in 2020 and until vaccination was introduced
- The large relative (P-score) mortality in all age groups in many jurisdictions during the Covid period (2020-2022) and up to the present
- The large persistent (post-Covid-years, into 2024 and 2025) excess mortalities ir many Western countries, compared to well-established historic pre-Covid-peri trends
- Remarkable correlations in time between well-defined peaks of excess mortalit and rapid rollouts of vaccines, especially booster doses mainly given to elderly populations, in several jurisdictions (India, Australia, Israel, several countries i the Southern Hemisphere, 23 of 87 countries around the world with sufficient data, and many sub-national regions)
- A large East-West divide of mortality patterns in Eastern European vs Western European countries, and a large North-South (Canada-USA-Mexico) gradient o mortality behaviours in North America
- For several countries in the world, the largest annual excess mortality was in 2(following virtual completion (in 2021) of vaccine rollouts

4. In your research, you found that 30% of countries showed no exces mortality in 2020 until vaccines were introduced. Can you walk us through what this means and why it challenges the mainstream narrative about the pandemic?

That is correct, why would excess mortality occur only with vaccine rollouts in so many countries? It appears the assaults that accompanied vaccine rollouts were deadly.

Establishment theoretical epidemiologists, who accept the standard contagion mod of viral respiratory diseases, have to bend themselves into pretzels to rationalize the geotemporal patterns of excess mortality (all-cause or assigned-cause). Recently, we broke the pretzel by showing that the patterns of mortality are incompatible with a disprove the leading contagion and global spread calculations.

The theory shows that, if we believe the model, then viral respiratory epidemics sur in a given population and are over within a few months. If the presumed virulent ne pathogen is spreading around the globe via airport traffic, then there have to be

corresponding epidemic busts that cannot be virtually synchronous on the planet a that cannot be absent in much of the global network of large airport hubs. The mod is either consistent with the observed geotemporal mortality pattern or it must be abandoned. Unjustified theoretical patches and bootstrapping are not allowed.

In my view, the paradigm of viral respiratory pandemics must be abandoned, and it should be understood as the control and profit-driven scam that it has become.

Deadly respiratory conditions are complex, and pandemics of respiratory deaths ca be induced via biological stress by coordinated assaults against populations. Covid been a global experiment in the effects of such assaults, and analysis corroborates n point. I discussed the biological-stress mechanism for a global pandemic in a recen paper: "Medical Hypothesis: Respiratory epidemics and pandemics without viral transmission".

5. You've estimated that COVID vaccines may have caused approximately 17 million deaths worldwide. This is an extraordinary claim that contradicts official health authorities. What methodology l you to this conclusion, and how do you reconcile this with the appare temporal associations between vaccine rollouts and mortality spikes?

Let me first shock many of your readers with the opening statement that the strikin temporal associations—that we have documented—between large sharp peaks in excess all-cause mortality and rapid vaccine rollouts (especially booster rollouts) are *not* directly due to vaccine toxicity itself. I will explain below in answer to this question how I have come to this conclusion.

This is not to say that the vaccines are not fatally toxic for many individuals and circumstances. Significant fatal COVID-19 vaccine toxicity is proven beyond a doul by adverse-effect vigilance data, disclosed clinical trial data, many published clinica case studies and many forensic autopsies, not to mention thousands of scientific papers on the injurious adverse effects of the vaccines, as we have emphasized in several of our reports (e.g., section "6.1 COVID-19 vaccines can cause death", here).

However, in rigorous all-cause mortality studies, we must distinguish "many vaccin toxicity deaths" and "sufficient vaccine-toxicity deaths to directly produce large exc all-cause mortality peaks".

My first firm realization that the vaccine rollouts could be causing massive excess mortality in many countries came in my 6 December 2022 paper entitled: "Probable causal association between India's extraordinary April-July 2021 excess-mortality event and the vaccine rollout". The paper is well worth reading even today, and

reported a calculated fatal toxicity rate of 1% per injection in rural and urban India. Robert F. Kennedy, Jr. interviewed me about these findings on 8 December 2022.

Following this, our first report of strong temporal associations between large sharp peaks in excess all-cause mortality and rapid vaccine booster rollouts was for Austr and its states. This was our 20 December 2022 paper entitled: "Probable causal association between Australia's new regime of high all-cause mortality and its COVID-19 vaccine rollout". The said association corresponded to a calculated fatal toxicity rate of 0.05% per injection.

In our next paper (9 February 2023), we showed that the remarkable large sharp pea in excess all-cause mortality essentially synchronous with successive rapid vaccine booster rollouts were stratified by age, with apparent fatal toxicity increasing exponentially with age: "Age-stratified COVID-19 vaccine-dose fatality rate for Isra and Australia".

We also estimated that a representative all-ages global value of the calculated fatal toxicity rate would be 0.1% per injection. For 13.25 billion injections up to 24 Janua 2023, this corresponded to approximately 13 million calculated vaccine deaths worldwide up to 24 January 2023. In this way, the 9 February 2023 paper gave our fi estimate of global mortality associated with the COVID-19 vaccine rollouts.

The methodology is simple. One first estimates a calculated fatal toxicity rate per injection, based on observed associations between excesses of all-cause mortality a vaccine rollouts, and one then multiplies this rate with the number of vaccine doses administered. There is always the potential that even a strong association in the tim series of excess death and of vaccine rollout is not due to vaccine toxicity itself but instead results from a death-causing intervention that accompanies vaccine rollout

Next (17 September 2023), using the same basic methodology, we studied 17 countri in the Southern Hemisphere and Equatorial Region, having sufficient data: "COVII 19 vaccine-associated mortality in the Southern Hemisphere". The advantage with t Southern Hemisphere is that the booster rollouts do not coincide with seasons of naturally higher mortality, which is a difficulty in Northern Hemisphere countries. This is the paper in which we first reported the now prominent estimation of 17 million vaccine deaths worldwide. I presented our findings at an international conference in Romania on 18 November 2023. A conference participant (Bret Weinstein) then described our result in a Tucker Carlson interview, and the "fact-checking" industry went wild. The 17 million number became part of the general culture; the stuff of memes.

We followed this up (19 July 2024) with our 521-page in-depth report on 125 countri "Spatiotemporal variation of excess all-cause mortality in the world (125 countries) during the Covid period 2020-2023 regarding socio economic factors and public-he and medical interventions". I believe this is a landmark paper that everyone should study. We argued why the viral respiratory spread paradigm should be abandoned, a we discussed causes of death in depth. In the big picture, we found that the overall excess all-cause mortality rate in the 93 countries with sufficient data in the 3-year period 2020-2022 is 0.392 ± 0.002 % of 2021 population, which corresponds to 30.9 ± million excess deaths projected to have occurred globally for the 3-year period 2020 2022, from all causes of excess mortality during this period.

This means that up to the end of 2022, 31 million excess deaths were caused globall by the government, corporate and professional establishment coordinated assaults against people. Three main categories of primary cause of death that we identified a

1. Biological (including psychological) stress from mandates such as lockdowns a associated socio-economic structural changes
2. Non-COVID-19-vaccine medical interventions such as mechanical ventilators a drugs (including denial of treatment with antibiotics)
3. COVID-19 vaccine injection *rollouts*, including repeated rollouts on the same populations

The last point includes the large disruptions (testing, confinement, so-called treatments, denial of normal care, etc.) that accompany rapid military-style rollouts the vaccines in institutions with frail and elderly individuals.

6. In your recent work, you propose that the pandemic was actually a surge of "transmissionless bacterial pneumonias" caused by stress an medical interventions rather than a virus. Can you explain this theory simple terms and how it relates to your finding that essentially all excess mortality was associated with respiratory conditions?

On the one hand, we have demonstrated in several papers that Covid was not a contagious spread of a viral respiratory disease. On the other hand, clearly discerne peaks in excess all-cause mortality often (although there are many exceptions) quantitatively correspond to mortality that is officially assigned to a respiratory condition (COVID-19). We first showed this quantitative agreement for the USA in 25 October 2021 report: "Nature of the COVID-era public health disaster in the US from all-cause mortality and socio-geo-economic and climatic data". Meanwhile, in the government data itself that we used half of the assigned COVID-19 deaths are associated with concomitant bacterial pneumonia, based on reported death certificates, and antibiotic treatment was being shunned, as we showed.

In a given peak of excess all-cause mortality, if the deaths did not occur by spreadin the presumed new respiratory virus, yet were clinically recorded as associated with serious respiratory conditions, then the respiratory conditions had to have arisen otherwise and in the same time period within the excess mortality peak.

Well, as it turns out, the scientific literature is full of descriptions of transmissionle self-infection pneumonias induced by stressful circumstances in frail or elderly individuals. If the said stressful circumstances are suddenly systemically imposed, i bursts, then there will result peaks in excess mortality.

I described this mechanism of transmissionless self-infection pneumonias in some detail on 2 December 2024: "Medical Hypothesis: Respiratory Epidemics and Pandemics Without Viral Transmission".

Basically, the human body is home to three main microbiomes, or large complex changing communities of microorganisms, living in the digestive tract, in the respiratory tract, and on the skin. These microbiomes and their dynamic balance ar essential to life and to health in general. Virtually every known and unknown anima environment microorganism is present in our bodies, and the populations of microorganisms cooperate and compete for turf and resources. These dynamic balances can be significantly impacted by experienced circumstances, including str injury, diet, social isolation, drugs, environmental toxins, etc., and are perturbed mo frequently and more easily with age.

To understand the process, there are many examples with ecological biomes (e.g., which I have studied), such as a sudden loading of nutrients in a lake, which gives toxic algae a competitive advantage, leading to deadly algal blooms that kill planktc and thus fatally disrupt the food web. By comparison, the study of human microbio is relatively new and is a vigorously growing field of medical research.

So, we have everything needed to make us sick from the inside (i.e., we "get" sick), i response to imposed conditions. We don't need spreading invisible novel pathogens for that. The three main microbiomes (lungs, gut, skin) are known to have strong an demonstrated responses to experienced stress.

Consequently, for example, respiratory symptoms may be the best proverbial canary the coal mine for detecting individual stress. As noted by a colleague, I have sugges that there is an evolutionary advantage to this sensitivity, but again I diverge.

Basically, if establishment forces massively disrupt society in ways that increase biological (including psychological) stress, especially among the frail and elderly, th there will always be a corresponding "pandemic" of excess deaths, associated with

symptoms of reacting microbiomes, especially visible respiratory difficulties. I have come to believe this was Covid. All our many analyses of data are consistent with th idea. There was no viral pandemic.

The assaults, in waves, included: mandates, measures (masks, distancing...), continu propaganda, unpredictable changes in imposed measures, lockdowns, closures (services, work, school, religion, leisure), travel restrictions, testing, diagnostic bias, confinement, denial of treatment (especially antibiotics for pneumonia), denial of u care, mechanical ventilation, sedation, experimental and improper treatments, persecution and public mobbing of dissenters, and vaccination.

The resulting excess mortality is modulated by dominant socio-economic factors of the society, including:

- age structure
- hierarchical poverty structure
- societal history of largescale infant and childhood trauma (war, famine, oppression)
- endemic social networks
- state networks of services, including institutions and institutional culture
- spectrum of widespread opioid addictions (including fentanyl and heroin)
- degree of medicalization of health
- susceptibility to deleterious state propaganda

The idea of a spreading viral respiratory disease is irrelevant, disconnected from reality, and designed to manipulate and exploit people and nations.

7. You argue that seasonal mortality patterns and historical pandemic can be explained without invoking viral transmission. What alternativ mechanisms do you propose drive these patterns, and do you believe humanity has ever faced a genuine viral pandemic?

Normal pre-Covid period seasonal all-cause mortality (high in winter, lower in summer) has been well documented in many countries for more than 100 years. It is truly remarkable and stable phenomenon, including in wealthy and advanced societ which is not completely understood. Many have pet theories, such as vitamin D, bu explanation is conclusive at this time. It is an active research project in our group.

The amplitude in seasonal variation in the latest decades in Western countries in th Northern Hemisphere is approximately 10% of summer values. Summer trough valu of mortality vary smoothly over many years, whereas so-called winter burden morta

above the summer baseline is chaotic and can be very different from year to year. There is an industry that tries to link this variable winter burden mortality to circulating viruses but it fails, in my opinion.

It is remarkable that the winter all-cause mortality peaks are essentially synchronou across continents (Europe and North America), within all regions, countries and counties or states, and between these continents in the Northern Hemisphere. Ther no detectable geographical gradient in these winter peak positions in any given wir in the last many pre-Covid-period decades. This has been true prior to mass airline travel and is true now. The said synchronicity, without centers or gradients, is cont to models of spread.

Furthermore, the winter burden peaks in the Southern Hemisphere occur during its winter, during Northern Hemisphere summer months, which would require remarkable equatorial gating of any presumed pathogens, and there is no seasonal variation of mortality in regions near the equator. Clearly, the global and local seas patterns of all-cause mortality (seen to be tied to respiratory, circulatory and many other conditions in the elderly, but not significantly to cancer) are a planetary phenomenon, not one mostly or solely related to models of respiratory pathogen emergence and spread.

The winter burden mortality is probably associated with physiological stressors suc as changing cold temperatures, atmospheric pressure, and humidity, which are driv by seasonal weather cycles and large weather systems on the planet. This is an obvi mechanism for "synchronicity" of winter burden mortality peaks. The seasonal stressors are sufficient to cause seasonal all-cause mortality among the elderly, increasing with age, but no winter burden mortality whatsoever in younger ages.

The higher residence time of aerosol particles in dry air (presumed higher transmissivity of airborne microorganisms and higher suspended dust load in built environments in winter air) probably does not play a significant role in the global ag dependent geo-seasonal pattern of all-cause mortality.

A conceptual link to the peaks of excess (beyond seasonal pattern) all-cause mortali occurring during the Covid period is immediate, since they too are synchronous, an they are tied to stressors from globally coordinated measures and rollouts.

Both normal pre-Covid period seasonal winter burden peaks and Covid period exce mortality peaks are caused by externally imposed drivers (seasonal weather and so-called pandemic response, respectively) that create fatal biological stress for the fra and elderly.

The phenomenon and consequences of biological stress have an eminent scientific history, starting in 1936 with the lifework of Hans Selye, and continuing with the modern speciality of human microbiomes. Biological stress, as first defined by Sely and augmented by decades of research, is the essential mechanism of virtually all ea non-violent death. It should be the grounding for all investigations of mortality eve and patterns, excluding only obvious cases such as earth quakes, if Big Pharma had systematically poisoned the well.

8. Your 2019 report connected globalization, environmental factors li glyphosate use, and the emergence of climate change as a political doctrine. How does this geopolitical analysis inform your understandi of the pandemic response?

My large evidence-based 2019 analysis has received some praise and is entitled: "Ge Economics and Geo-Politics Drive Successive Eras of Predatory Globalization and Social Engineering - Historical emergence of climate change, gender equity, and an racism as State doctrines". I believe it is seminal in many respects. It is also availabl as an audiobook that can be freely downloaded.

My overarching conclusion, starting from the Second World War, is the high degree which USA-regime-based and protected global elites, organizations, corporations a financiers occupied the planet and explicitly designed dominant social ideologies including anti-racism, gender, and climate change ideologies, to permeate every lay of Western and captured societies.

I describe the nexus of the USA Empire's power as reliance on owning and enforcin the global currency that is the USA dollar. They have done this by controlling the currency for exchanges in all major commodities including oil, opioids, agriculture and global medical interventions, and by dominating those sectors. The USA regim further runs a global protection racket based on imposing inflated arms sales (in US dollars) to all its "allies" and protectorates.

The USA regime also controls virtually all influential mainstream media in the occupied world, and has created the largest propaganda infrastructure in history. It propaganda is so influential that it penetrates into the societies of sovereign nation such as Russia and China, especially if the propaganda contains global crisis hyster related to terrorism, weapons of mass destruction, the environment or health.

My 2019 analysis, therefore, is an ideal general framework to understand the multi-pronged attack by the USA regime that was Covid, including prominent direct contractual and operational involvement by the USA DoD. Covid was a geopolitical operation designed and run by the USA regime. Under such pressures, Russia and China had no choice to participate in measures and to develop their own vaccines.

China, in particular, was at high risk of becoming a global scapegoat, largely thanks early top-tier scientific-journal epidemiological models, which are an integral part the propaganda.

See my "Arms sales and mRNA vaccine sales should both be understood as protecti rackets", including a link to a fascinating 25 March 2020 video interview with Ex-Russian Intel officer Vladimir Kvachkov.

9. You've described both arms sales and mRNA vaccine sales as "protection rackets." Can you elaborate on this comparison and what you see as the underlying power structures driving these industries?

Yes, a protection racket is one in which organized crime extracts payments for a guarantee of so-called protection. It is essentially a rent payed to the controllers of territories of exploitation. It is outright extortion, accompanied by unlimited access the premises.

In the case of the USA regime and its military and surveillance technologies, arms sales are imposed on *de facto* occupied countries.

The sales are in USA dollars, thus ensuring a demand for the USA dollar. The client state obtains the needed USA dollars by sales of its resource and labour paid for usi USA dollars that the USA regime prints at will.

As with any major commodity controlled by the USA, the imposed demand for and creation of USA dollars is an endless conveyer belt of exploitation, enforced by military projection and financial dominance. In all of this the USA debt amassed by decades (since the USA's 1971 unilateral withdrawal from the Bretton Woods agreement) of so-called "trade deficits" is essentially irrelevant, except to create an illusion that the exploited parties have "money in the bank". The trade deficits themselves, for most countries, are simply measures of the degree of exploitation.

This all works as long as the USA regime dominates the world and can impose its w We are living in extraordinary and dangerous times in which USA dominance is bei both challenged and surpassed. I say dangerous because the USA regime is extreme violent and has demonstrated little restraint against using war, acts of war, and terrorism via proxies to create chaos and instability that impedes multi-polar emergence. In the present context, the conclusion that Russia-China-India rapprochement increases world stability and safety is rational and justified.

The imposed purchases of massive lots of COVID-19 vaccines were the same kind c protection racket. Like with arms, the sales were imposed both domestically and on the *de facto* occupied countries. Like with arms, the purchases were in USA dollars

subservient currencies. Like with arms, the protection is against an engineered or fictitious threat (military aggression and viral pandemic, respectively). Like with arı the propaganda about the threat is constant and pervasive. Like with arms, the vacc protection racket includes large training exercises to practice and demonstrate efficient deployment.

Covid was a military operation, and no USA regime military operation is without h kickbacks and feeding of the Empire's financial and military-industrial sector.

Covid was also intended to test and advance surveillance, digital control, censorshi and social control agendas. These agendas are not unrelated to the USA Empire's impending meltdown from loss of potency of its USA dollar global currency. Integrated digital control of every individual's financial resources would ensure rob and efficient real-world grounding for the Empire's currency, and complete surveillance and control of its subjects. China has already achieved population coupling to its national currency. The USA lags behind because of in-fighting betw the big tech and financier elite stake holders, as per the 2024 analysis of Yanis Varoufakis delivered to a Chinese audience.

Make no mistake: the Empire (the deep state and the top-tier elite parasites) consid it an existential imperative to impose digital financial control on all its subjects for geopolitical and exploitative reasons explained above; all for your protection of cou Covid was, among other things, a spearhead to test and advance this agenda. Covid was also a demonstration of the Empire's military capacity to rapidly literally inject of its subjects with any substance it chooses, while taxing the public in doing so; ag all for your protection.

From this geopolitical and geo-economic perspective, in my opinion, debates about the nature and origin of the presumed virus and about the designer vaccine and its theoretical health consequences are useful distractions and secondary in relevance best. The large excess mortality was from the societal assaults, and appears to have been collateral. Any successfully propagandized declared threat and vaccine rollout solution would have achieved the same goals and consequences.

Importantly, the said social assaults installed during Covid now continue in many Western countries, in the form of:

- institutionally normalized wide-spectrum abuse of frail and elderly patients an care home residents,
- continued attacks against political and economic prospects of the domestic middle classes (with their troublesome desires for freedom and influence), and

- increased large-scale opioid dependence.

The installed and continued assaults produce the persistent excess all-cause mortal that we have studied.

10. In your work on social dominance hierarchies, you suggest that illness serves an evolutionary function in maintaining these hierarchie How does this theory apply to what we witnessed during the pandem

The overriding organizational principle in any group of social animals is dominanc hierarchy. Empirical evidence is overwhelming in this regard. Irrespective of one's preferred political theory, every group and society is a dominance hierarchy, with potentials for both maintained stability and totalitarian extremes. Furthermore, the overriding determinant of individual health and longevity is one's position in the dominance hierarchy and the nature or steepness of the dominance hierarchy.

The dominance hierarchy is a form of self-organized structured cooperation and it powerful survival and realization strategy for any species of social animal. Therefor there is a large evolutionary pressure to form maintained dominance hierarchies.

In 2011 I advanced this original (as far as I know) idea:

> Social-dominance-hierarchy oppression makes us sick, which has a large evolutionary advantage in that this permits and stabilizes the said hierarchy, thereby making the species competitive in its harsh environment. Therefore evolution selects mechanisms of biological-stress-induced ill-health. As a corolla there is necessarily a health gradient tied to the social-status gradient in a social hierarchy.

I first explained the idea on my "Activist Teacher" blog in the 20 December 2011 po "A Theory of Chronic Pain—a social and evolutionary theory of human disease and chronic pain". The article was also published at Dissident Voice and in my book.

What this means is that oppression will make you sick, by many complex biological mechanisms that have evolved in animal bodies over millions (billions) of years. Thi why there is a strong connection between biological (including psychological) stres and health. This connection is centrally important and is ignored and covered up by Pharma-dominated establishment medicine. Dominance oppression is the root cau of sickness and poor health, more so in the most violent and authoritarian dominan hierarchies, for most individuals.

The older you are, the more effectively oppression and biological stress will kill you and this is exponentially so. At the same time, one's identity is viscerally tied to one place and value in the dominance hierarchy, and purposeful self-image is an essenti

driver for life in sentient beings. A loss of social status often means death for the individual, by one chronic disease or another. Therefore, confinement is a huge provider of biological stress and sudden imposed social isolation is deadly, again exponentially so with age.

Given the extensive knowledge of the deadly effects of confinement, loss of social status and social isolation, Covid can be considered mass homicide perpetrated by institutions, professionals and their hierarchical bosses, in a march towards a more totalitarian state.

11. You've been highly critical of clinical trials for vaccines, particularl those involving children. What fundamental flaws do you see in how vaccine safety and efficacy are assessed, and what evidence supports your position that childhood vaccination programs may cause more harm than benefit globally?

I gave a principled critique against all childhood vaccine programs in my recent article: "Opinion: Invalidity of counterfactual models of mortality averted by childhood vaccination".

Despite decades of study, there is no known example, in high or low childhood mortality countries, of any childhood vaccine rollout being associated with a decrea in childhood all-cause mortality. On the contrary, there is an apparent slowing dow of the childhood survival benefit from development associated with childhood vacc rollouts. In this context, development means improving sanitation and nutrition.

Given this hard reality of at best undetectable benefits for reducing childhood mortality, there is no reason to look for elusive vaccination benefits in contrived clinical trials controlled by the same industry that profits from the scam and that ha amply demonstrated its illegal and criminal behaviour in concocting the said trials.

See the landmark book "Deadly Medicines and Organised Crime: How big pharma corrupted healthcare" by Peter Gøtzsche (2013, CRC Press: Taylor & Francis Group) The institutional capture and corruption have only increased since the book was written. Jablonowski et al. (2025) have recently demonstrated that rigged clinical tri were certainly the practice with COVID-19 vaccines.

If we want to help children, we should help children, not exploit them for Big Phar padded scientific careers and increased revenues for medical professionals. The Western globalist elite exploiters and their corporations need to be driven out of maternity and paediatric care wards.

Here again, therefore, I have shown that all-cause mortality data is a razor's edge th can be used to discern health benefits from medical-industry scams.

Most of these highly profitable scams (add chemotherapy, blood chemistry drugs, psychiatric drugs, pain management drugs, etc.) are enabled using elaborate, protec and institutionalized deception based on concocted clinical-trials that select specia subjects, exclude undesirable results, underpower to mine advantageous outcomes, virtually never examine long-term harm, no longer use placebo arms, and do not disclose data to independent researchers.

12. You maintain some skepticism about complete "germ theory" den while acknowledging that bacteria can cause disease under certain conditions. How do you navigate this nuanced position, and where do you draw the line between terrain theory and germ theory?

The debate about germ theory versus terrain theory is centered on belief or criticisı of the germ hypothesis that a presumed specific disease can result from one being infected with a corresponding specific disease-causing pathogen, and that epidemi of specific diseases can be generated by transmission of the presumed correspondi specific pathogen.

Germ theory is motivated by the wishful thinking that there are such specific disea that can be cured by a magic bullet that kills or neutralizes the presumed corresponding specific pathogen, or that the disease can be prevented by avoiding t pathogen.

Terrain theory postulates that disease is not fundamentally caused by pathogenic microorganisms and that health and resilience, including resistance capacity agains assaults from the individual's environment, depend on the body's "terrain", which i turn depends on the body's life history of being subjected to assaults and deficienci but also inherited characteristics.

Basically, many terrain theory advocates would say that no exposure to a microorganism or to a dose of microorganisms, and no microorganisms in one's bo microbiomes can be an initiating cause of harm, and that ill-health is always a consequence of poor terrain, irrespective of exposure to or challenge from any presumed harmful microorganisms.

Terrain theory advocacy appears to be motivated by promotion of the importance o nutrition and life style choices, justified rejection of Pharma-driven establishment medicine, a desire to expose egregious lies of establishment medicine, and a desire find a magic bullet argument (non-existence of viruses, benign danger from bacteri that would collapse much of the irrational practice of establishment medicine.

An AI description of terrain theory is: "Terrain theory proposes that the body's internal health ("terrain") dictates its susceptibility to disease, rather than germs be

the primary cause." There is much empirical evidence supporting the terrain perspective, but the debate or binary opposition (internal bodily fitness vs exposure pathogens) cast in this way leaves out the centrally important role of the immediate and changing environment or life circumstances that are the source of biological (including psychological) stress.

As such, the debate is plagued (no pun intended) by two ill-defined and tunnel-visic hypotheses set in binary opposition to each other.

First, neither hypothesis sufficiently defines ill-health, sickness or disease. A suffic definition would require much more and integrated knowledge, or at least more incisive paradigms than are presently used.

Second, the germ-hypothesis branch unrealistically postulates the hypothetical effe of a single microorganism, whereas bacterial microorganisms in nature always occu as communities or microbiomes or bio-films or infusions of populations of a great number of different bacterial species.

Third, the debate opposes a specific mechanism on the one hand (infection) and on other hand a non-specified general manner in which ill-health or disease spontaneously occurs or does not occur (terrain).

The debate in its usual form therefore is not strictly scientific. Following the scient method is simpler. One receives a well-delimited precise hypothesis to examine whether it can be disproved. If the hypothesis is not one that can be disproved in principle, if it is not testable, then the hypothesis itself is not valid.

If the hypothesis is that the pathogen is invisible and cannot reliably be identified a manipulated for the purpose of testing the hypothesis, then it is not a valid hypothe In my opinion, the virus advocates have not demonstrated that the viral hypothesis disease causation is itself a valid (testable) hypothesis. The onus is on them to make this demonstration. At this time, therefore, in my opinion, the only scientific debat regarding the viral hypothesis of disease is whether the virus advocates have even demonstrated a testable hypothesis with current technology. If they have not, then they are simply practicing voodoo and promoting the practice of voodoo.

If the hypothesis involves a bacterial cause of disease, then it is at least testable in principle with current technology. And the debate is whether the appropriate tests have been performed, and whether the hypothesis has been disproved. (Note that as scientist I have performed research on bacteria.)

Tuberculosis has been highly studied and is believed to be an infectious bacterial respiratory disease. However, many coexisting bacterial species are now seen to be concomitantly associated with the disease, contrary to the original view of a single causal bacterial species. Performed transmission experiments from diseased humar to animals are argued to be conclusive evidence of the infectious nature of tubercul or at least that transmission is possible; however the long-standing persistent and pervasive presence of the infection in the global population makes the contagiousn debate somewhat irrelevant, compared to an evolutionary coexistence paradigm, an the spectrum of individual manifestations rather supports a "terrain" interpretatior

I am not aware of any controlled experiments on humans or non-human animals of challenges using doses from pure cultures of single species of bacteria. If a battery such experiments were to produce null results, then the bacterial hypothesis of dise causation would be disproved, for the specific bacterial species, dose delivery meth and animal model.

If we relax the hypothesis to challenges using doses containing varied bacterial species, then the experiments are easier to perform and are more realistic in terms what would occur in reality, such as in aspiration pneumonia. I believe these experiments would give positive results (induced disease manifestations) in many circumstances, depending on the state ("terrain") of the test subjects.

In addition, for example, a reputable scientific review of 36 clinical trials concluded "antibiotics [reduce respiratory tract infections] and overall mortality in adult patie receiving intensive care". Similarly, in a recent large population based cohort study authors concluded: "In elderly patients with a diagnosis of urinary tract infection ir primary care, no antibiotics and deferred antibiotics were associated with a signific increase in bloodstream infection and all-cause mortality compared with immediat antibiotics."

These studies support the idea that a large chemical disruption of microbiomes of bacteria associated with severe health conditions can provide lifesaving benefit in certain circumstances. This ties to the immoral Covid-period widespread practice c denying antibacterial treatments, discussed above.

In human history, anthropologists tell us that the main cause of death limiting life expectancy to barely more than 30 years has been infections, in open wounds (from fights and accidents), from exposure to hostile environments and from acquired aggressive parasites, and the like. Reliable historical studies in the USA showed significant decreases in mortality rates associated with sanitizing water supplies, o

using filtration and chlorine. In such deaths, the primary apparent cause is injury fr consumption of bad water, not transmission of a specific pathogen.

In our research we have stressed the important distinction that must be made betw a true primary cause of death and an accompanying proximal or clinical cause of de (such as recorded on a death certificate). This is important in giving a correct conte to the germ vs terrain debate.

A primary cause of death is the agent that actually caused the fatal injury to the boc For example, a car accident can be a primary cause of death where massive loss of blood and specific systems failures would be proximal causes. Aggressions that cau fatal biological stress are primary causes, many system dysfunctions result, and the first proximal cause might be recorded as “pneumonia” or “heart failure”.

Beyond that, we can debate whether the bacterial manifestations that accompany th cooperative failure known as death were harmful or beneficial, or intended (by the bacteria?) to be beneficial but caused collateral harm, and so on.

My view is that the body’s microbiomes (lungs, gut, skin) can be perturbed by exter stressors to spiral out of balance and cause or contribute to causing death. In aspiration pneumonia, the gut and respiratory microbiomes both contribute to the outcome.

The degree to which an external stressor can perturb a microbiome and the recover capacity both depend on the “terrain”, and the said terrain (the state of the body) is dramatically and necessarily impoverished with age, in addition to the impact from other factors.

I believe that colonies (microbiomes) of bacteria can negatively impact health, to th point of death, and that susceptibility to such events depends on both “terrain” (boc state) and ambient conditions (biological stress). For example, exposure alone to pathogens (such as respiratory pathogens associated with tuberculosis) is not sufficient to cause disease manifestations of tuberculosis, and as such may never be primary cause of tuberculosis.

I agree that the virus paradigm of disease is tenuous. I have not been able to find ar conclusive evidence that supports the virus paradigm. Invisible causes are convenie to rationalize complex phenomena but the viral invisible cause is demonstrably use in real terms measured by mortality, as we have repeatedly shown.

13. Your research indicates that medical interventions during COVID, including mechanical ventilation and denial of antibiotics, were prima

causes of death. How did these harmful practices become so widespread, and what does this reveal about institutional medicine?

Let me answer by broadening the question. How are harmful medical practices initiated and how do they become widespread and institutionalized?

The starting point of our query should be to recognize that fatal recommended medical practices certainly are widespread, in general and at every level of the medi establishment. I emphasized this in my 2015 critical review of the cancer paradigm. The epidemic of medical harm is too widespread and persistent over many decades be considered as "errors". It is not controversial to affirm that medicine is one of th few leading causes of premature death in the Western world and has been so for tw more generations. How did this arise and how is the situation robustly maintained?

This brings us back to societal dominance hierarchy. The medical establishment's structural societal purpose is primarily to manage and bolster the dominance hierarchy. Health provided by professionals is entirely an illusion, not unlike virtue provided by clergy and the church. Corporate medicine is intended to ensure servit and dependence, and it may be the state's most powerful instrument in this regard, manned by innumerable professionals, workers, teachers, and managers, and imbedded in a large finance, corporate and government structure. Medicine is part the finance-industrial-congressional-military-intelligence-academic-medical-medi complex of the USA regime, and therefore of the Western world.

Medical clinics and institutions play the same role as the police-judicial apparatus: systematically and randomly assault individuals in order to assert dominance (see: S 2002), while also appearing to resolve some injustices in order to retain legitimacy a prevent rebellious outbursts. As such, human society is essentially a troupe of baboons, and its institutions are designed and evolve accordingly.

With medicine, the control apparatus has the advantage over police and employers that it can directly make you weak or sick without relying solely on the physiologic mechanism based on stress from physical and psychological aggression. Medicine c literally prescribe sickness and dependence.

If we escape the massive propaganda regarding benefits from establishment medici and once we understand the sociological truth of its actual design, we must conclud that examples of medical practices providing real net benefit to individual health ar either accidental or simply allowed to create the needed trust and legitimacy.

In this context, the medical system constantly experiments with new so-called treatment protocols that, with the help of propaganda, fit nicely as new tools in the project of asserting subservience and dominance, while robbing the targets of

resources and removing useless dependants such as the chronically ill and elderly. T is observed in any social animal dominance hierarchy; only the methods are differe

As with any systematic assertion of dominance, the behaviour can go too far, spin o of control in a sense. In animal groups this can catalyze mobbing against dominant for example.

In our stable societies, there are constant corrective resets of institutional policy an behaviour, following events of media outrage or of resistance (such as so-called vaccine hesitancy). At the same time, elite corruption pushes laws and policies towa excessive exploitation. I described this societal pushing, pulling and corruption in r 2017 essay entitled "Cause of USA Meltdown and Collapse of Civil Rights". This is a longstanding historic pattern, across millennia (see: "The Great Wave: Price Revolutions and the Rhythm of History" by David Hackett Fischer, 1996).

The important and beneficial present MAHA movement at USA federal agencies, I would argue, is this kind of corrective reset needed to preserve and strengthen the medical establishment's legitimacy and acceptance, while leaving in place most of i practices demonstrably harmful to individual health.

The pandemic paradigm is exceptionally insidious on a higher level than regular aggressive maintenance of the dominance hierarchy. They want us to believe in a constant risk of virulent airborne-pathogen pandemics that each could threaten humanity on the scale of a massive meteorite impact, requiring global responses tha bolster elite exploitation and control. My research has convinced me that there probably never has been such a pandemic in history, including 1918 and the Black Death.

Regarding specific circumstances of harmful medical interventions applied during Covid period, we again discussed examples in our most recent paper disproving pandemic viral spread.

14. Your 2019 geopolitical analysis predicted many aspects of what w later saw during the pandemic response. How do you view the COVID period within the broader context of globalization and US dollar hegemony?

Covid was a planned and executed USA-regime military exercise that coordinated many major corporate players including: Pharma, Medical, Finance, Media (includi Social media), Intelligence, Transport, Army, Congressional and Parliamentary hou Governments at all levels, international bodies, Police, Judiciary, Science, and Academia.

Russia and China felt compelled to play along, given world opinion and penetration the USA-run propaganda, and to develop their own vaccines and measures. Rulers v rejected the pandemic fraud were assassinated or otherwise removed or silenced.

In reality there was no pandemic-causing virus and the vaccines were demonstrably harmful. The lab leak dimension is irrelevant, since there was no deadly viral agent

The responses and measures caused more than 30 million deaths worldwide (up to 2022, virtually all sick, elderly and opioid-addicted individuals) and left permanent societal scares including serious vaccine adverse effects.

The newly installed institutional practices now cause large persistent excess all-cau mortality to this day in many countries, not to mention broader social acceptance o infringed civil freedom rights and protections. Work, leisure and health cultures we changed discontinuously. The medical establishment became more aggressive and authoritarian than even before in generational memory. A complete list of consequences would be very long.

The Covid pandemic was possible because of USA-controlled globalization and US world dominance. As other major poles of geopolitical power grow, and as USA dominance is eroded, such a global event of transformation and exploitation is less likely to be as successful again in the coming years. The window for the USA-regim to pull off such global scams as Covid is closing. The driving force of profit and Western elite influence are also waning as global multi-polarity increases.

Increasing global multi-polarity, in the long run, will probably improve basic and ci rights of citizens of the USA more than any declared good intensions of their leade as global comparisons of and competition for good living and working conditions increases. Tourism interest and quality immigration flows are already increasing towards Russia and China. But first, conditions for Western citizens will get worse, especially in so-called allied countries pillaged by the USA, and especially for the working classes, not to mention the virtual certainty of increasing USA-led wars as USA dominance window closes.

15. What are you currently focused on in your research with CORRELATION, and how can people who want to follow your work st connected with your ongoing findings?

Presently, our main immediate research projects that are advanced to various degre include: a theory of health and death, seasonal variations and geotemporal patterns mortality in normal periods, an extensive study of almost 100 socio-economic facto associated with excess mortality, proof of manipulations of global temperature records, a large study of vaccine-status-resolved excess mortality, theoretical limits

spatiotemporal models of disease spread, and a study of unscientific Canadian government behaviour during Covid from accessed documents.

Three main places to follow all our upcoming work are:

The CORRELATION website: https://correlation-canada.org/research/

My website: https://denisrancourt.ca/

My substack:

Denis's Substack

My personal Substack

By Denis Rancourt

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Thank you for inviting me and I would like to thank my co-authors and collaborato since 2020 for many and continued discussions and challenges, and all the individua who support our research.

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Baseline Human Health

Watch and share this profound 21-minute video to understand and appreciate what health looks like without vaccination.

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Anne Sep 15

That was brilliant.

As a nurse in Victoria, Australia, I tried to navigate my way through the Covid scam from the very beginning. I fought endlessly against the corruption but I was called an anti vaxxer and conspirac theorist, then I finally lost my job and my career.

It taught me a valuable lesson though ... don't just believe in the science, always challenge it!

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The Cosmic Onion Sep 15

Doc, you are singing my song—only better with lots more words. This wolf writes the Reader's D versions of hot stories, but you cut to the marrow. You followed all-cause mortality instead of slo

and found switches, not waves—spikes that clicked on with policy and rollout ops, synchronous a
borders. That's not a virus map; that's a logistics map. Stress the frail, isolate the elders, deny anti
jam ventilators, rebrand the collateral as "science." Policy became the pathogen; protocols the pla
Your frame—biological stress → microbiome collapse → "transmissionless" pneumonias—tracks v
the field felt in our bones. And the "protection racket" lens? Nailed: arms and mRNA ride the sam
pipeline. Keep swinging the data sledgehammer. I'll keep boiling it down for the pack: follow ACI

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