

Six Studies and Reports Demonstrating no Successful Transmission of Viral Diseases from Person to Person

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Preface

There have been numerous studies done where medical people have tried to transmit a virus thought to be infectious, into other people. The blood or mucous or whatever it is they are using, to see if it will infect another person, is coming from someone who is "sick" and who they apparently believe is sick because of a particular virus.

Keep in mind that this is a fool's errand from the get-go because there is no way to definitively show that a virus is the cause of the "sick" person being ill. And, as the alleged viruses can't be observed and have never been isolated, there is already no direct evidence for the contagion hypothesis. Observing so called "outbreaks" is the closest thing to evidence virologists have; the narrative is that viruses cause "influenza" and colds, etc. and people sick with them pass the disease on to others. But without transmission being able to be proven, their hypothesis loses any credibility. Hence, the value of these studies and reports.

Having said that, the lack of evidence of the existence of viruses isn't proof that there aren't viruses, but the results of these studies linked to and quoted from in this PDF further undermine the virus hypothesis.

Notes

Text that is in paragraph format such as this paragraph are my commentary and/or introduction to the information.

Text that is in paragraphs indented right and left like this one is quoted from the source, which for each study is linked to in the introduction.

Studies and Reports

[Experiments To Determine Mode Of Spread Of Influenza \(1919\)](#) - Rosenau

[Minimal Transmission In An Influenza A \(H3n2\) Human Challenge-Transmission Model Within A Controlled Exposure Environment \(2020\)](#) - Nguyen-Van-Tam et al.

[Experimental Human Inoculations With Filtered Nasal Secretions From Acute Coryza \(1924\)](#) - Robertson, Groves

[The Common Cold: Etiology, Prevention and Treatment \(1927\)](#) - Cheney

[Poliomyelitis Problems \(1951\)](#) - Hoyne

[The Epidemiology of Poliomyelitis \(1909\)](#) - Batten

Experiments To Determine Mode Of Spread Of Influenza (1919)

Milton J. Rosenau, M.D.

100 volunteers from the Navy were exposed in multiple ways, from blood, mucous, and coughing, to what was believed to be influenza. None of them developed symptoms of influenza. This was carried out during the 1919 "Spanish flu epidemic".

Several paragraphs excerpted [from the report](#) :

The experiments here described were performed on an island in Boston Harbor, on volunteers obtained from the Navy. The work was conducted by a group of officers detailed for that purpose, from the U. S. Navy and the U. S. Public Health Service.

The volunteers were all of the most susceptible age, mostly between 18 and 25, only a few of them around 30 years old; and all were in good physical condition. None of these volunteers, 100 all told in number, had "influenza"; that is, from the most careful histories that we could elicit, they gave no account of a febrile attack of any kind during the winter, except a few who were purposely selected, as having shown a typical attack of influenza, in order to test questions of immunity, and for the purpose of control.

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Our next experiment consisted in injections of blood. We took five donors, five cases of influenza in the febrile stage, some of them again quite early in the disease. We drew 20 c.c. from the arm vein of each, making a total of 100 c.c, which was mixed and treated with 1 per cent, of sodium citrate. Ten c.c. of the citrated whole blood were injected into each

of the ten volunteers. None of them took sick in any way. Then we collected a lot of mucous material from the upper respiratory tract, and filtered it through Mandler filters. While these filters will hold back the bacteria of ordinary size, they will allow "ultramicroscopic" organisms to pass. This filtrate was injected into ten volunteers, each one receiving 3.5 c.c. subcutaneously, and none of these took sick in any way.

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After our volunteer had had this sort of contact with the patient, talking and chatting and shaking hands with him for five minutes, and receiving his breath five times, and then his cough five times directly in his face, he moved to the next patient whom we had selected, and repeated this, and so on, until this volunteer had had that sort of contact with ten different cases of influenza, in different stages of the disease, mostly fresh cases, none of them more than three days old.

We will remember that each one of the ten volunteers had that sort of intimate contact with each one of the ten different influenza patients. They were watched carefully for seven days—and none of them took sick in any way.

Conclusion

Dr. McCoy, who with Dr. Richey, did a similar series of experiments on Goat Island, San Francisco, used volunteers who, so far as known, had not been exposed to the outbreak at all, also had negative results, that is, they were unable to reproduce the disease. Perhaps there are factors, or a factor, in the transmission of influenza that we do not know.

As a matter of fact, we entered the outbreak with a notion that we knew the cause of the disease, and were quite sure we knew how it was transmitted from person to person. Perhaps, if we have learned anything, it is that we are not quite sure what we know about the disease.

See Sam Bailey's video, [Exploding the Spanish Flu Myth](#), for the bigger picture about the 1919 "flu epidemic".

Minimal Transmission In An Influenza A (H3n2) Human Challenge-Transmission Model Within A Controlled Exposure Environment (2020)

Jonathan S. Nguyen-Van-Tam et al.

The first two paragraphs of the Introduction section of [the report](#) :

Influenza virus is a pathogen of global health significance, but human-to-human transmission remains poorly understood. In particular, the relative importance of the different modes of transmission (direct and indirect contact, large droplet, and aerosols (airborne droplet nuclei)) remains uncertain during symptomatic and asymptomatic infection.

The evidence base for influenza transmission is derived from studies that have assessed: virus deposition and survival in the environment; the epidemiology of disease; pharmaceutical and non-pharmaceutical interventions; animal models; and mathematical models of transmission. Those approaches have yet to produce conclusive data quantifying the relative importance of human-human transmission modes.

This is an interesting study because they didn't use people who were natively "sick"; they infected the "donors" with a "virus", which apparently made most of them sick. See charts below. (Febrile means they had a fever. ILI means Influenza-like illness.)

From the *Abstract* :

Healthy, seronegative volunteer 'Donors' (n = 52) were randomly selected for intranasal challenge with influenza A/Wisconsin/67/2005 (H3N2). 'Recipients' randomized to Intervention (IR, n = 40) or Control (CR, n = 35) groups were exposed to Donors for four days. IRs wore face shields and hand sanitized frequently to limit large droplet and contact transmission.

Table 1. Infected donor status.

Q*	Infected/Inoculated n/n (%)	Clinical Illness n (% of Infected)			Laboratory-confirmed Infection n (% of Infected)		
		Symptomatic	Febrile	ILI	PCR-confirmed	PCR-confirmed & Seroconversion	Seroconversion by HAI: MN: Either
1	15/20 (75)	11 (73)	4 (27)	8 (53)	12 (80)	11 (73)	12: 14: 14
2	11/12 (92)	7 (64)	0 (0)	5 (45)	10 (91)	8 (73)	9: 7: 9
3	16/20 (80)	14 (88)	2 (13)	12 (75)	14 (88)	12 (75)	14: 11: 14
All	42/52 (81)	32 (76)	6 (14)	25 (60)	36 (86)	31 (74)	35: 32: 37

*Quarantine number; Ten Donors had greater than anticipated pre-challenge immunity: 4 in Q1, 2 in Q2, 4 in Q3.

The question is, what did they actually spray or swab into their noses? The only reference I could find was this, the section of the study titled, *Influenza Virus* :

Influenza A/WI manufactured and processed under current good manufacturing practices (cGMP) was obtained from Baxter BioScience, (Vienna, Austria). Stocks of this virus preparation have been sequenced and its evolution in the upper respiratory track of inoculated volunteers extensively analysed.

Since you can't just grab a virus and put on a swab or aerosolize it in water vapor, one has to wonder what else is in the mix that made most of the donors sick?

In any case, they weren't able to show evidence of viral transmission to any but 1 of the 75 people exposed to the donors after being together 15 hours per day for 4 days in rooms, "17-30m²" (roughly 14x14 feet - 18x18 feet).

From the section, *Exposure Events* :

The study was conducted in three, separate, identically-designed quarantine events (Q1, Q2, and Q3). From Day 1 to Day 4 of each quarantine event, all volunteers took part in an Exposure Event (EE). Individual Donors and Recipients were each allocated to a single exposure room per day where they interacted at close distances for approximately 15 hours/day, for four consecutive days. In-room staff supervised activities such as playing board games, pool, and table football, and watching films, whilst ensuring that volunteers mixed freely.

From the section, *Recipient Status* :

Recipient status is shown in Table 3. There were similar rates of symptoms in both IR and CR groups, although more in the CR group met the study definition of ILI, the rates were not significantly different ($p = 0.23$); no Recipient developed fever. One infection was confirmed by serology (HAI increased from ≤ 10 to 40 and MN increased from 10 to 320) in a CR subject who was symptomatic and whose symptoms met the definition of ILI, but whose qRT-PCR evaluations were persistently negative.

Table 3. Recipient status.

Q*	Recipient [†]	Infected/Exposed n/n (%)	Clinical Illness n (% of Exposed)			Laboratory-confirmed Infection n (% of Exposed)		
			Symptomatic	Febrile	ILI	PCR-confirmed	PCR-confirmed & Seroconversion	Seroconversion by HAI: MN: Either
1	CR	0/11 (0)	4 (36)	0 (0)	3 (27)	0 (0)	0 (0)	0: 0: 0
	IR	0/10 (0)	2 (20)	0 (0)	1 (10)	0 (0)	0 (0)	0: 0: 0
2	CR	1/9 (11)	2 (22)	0 (0)	2 (22)	0 (0)	0 (0)	1: 1: 1
	IR	0/10 (0)	3 (30)	0 (0)	2 (20)	0 (0)	0 (0)	0: 0: 0
3	CR	0/15 (0)	6 (40)	0 (0)	4 (27)	0 (0)	0 (0)	0: 0: 0
	IR	0/20 (0)	6 (30)	0 (0)	2 (10)	0 (0)	0 (0)	0: 0: 0
All	CR	1/35 (3)	12 (34)	0 (0)	9 (26)	0 (0)	0 (0)	1: 1: 1
	IR	0/40 (0)	11 (28)	0 (0)	5 (13)	0 (0)	0 (0)	0: 0: 0

*Quarantine number; Eleven recipients had greater than anticipated pre-challenge immunity: 3 CR and 3 IR for Q1; no Q2 Recipients; 3 CR and 2 IR for Q3. None seroconverted.

[†]CR: Control Recipient; IR: Intervention Recipient.

Experimental Human Inoculations With Filtered Nasal Secretions From Acute Coryza (1924)

Robert C. Robertson and Robert L. Groves

100 healthy individuals were exposed to the bodily secretions from 11 different people suffering from influenza. None of the 100 whom they deliberately tried to infect got sick.

(Note: Coryza is irritation and inflammation of the mucous membrane inside the nose.)

From [the report](#):

In selecting cases for these experiments we limited ourselves to uncomplicated coryza which appeared during the fall, winter, and spring; and of these we endeavored to select the more virulent type, therefore apparently the most infectious.

The nasal secretions of persons suffering with such coryza were collected, from 6 to 144 hours after the onset, in a container which had been thoroughly sterilized and kept from contamination so far as possible; they were mixed with sterile salt solution in varying dilutions, from 1:10 to 1:50, and the mixture was shaken with glass beads in a small jar until homogeneous and free from lumps of mucus.

Inoculations with the filtrate were made into the nostrils of volunteers free from coryza or catarrhal affections as soon after filtration as possible. In no case did this time exceed 24 hours after the collection of the secretions, which in the meantime were kept in the icebox.

The results of the 100 human inoculations are positive for bronchitis, 1 case (1%) ; coryza, 1 case (1%) ; influenza, 1 case (1%); and laryngitis, 2 cases (2%). There were 95 negative cases, or 95%, free from any respiratory infection following the inoculation.

Summary

In this series of experiments, nasal secretions were secured from 11 persons suffering with acute uncomplicated coryza. After being diluted and passed through a Berkefeld filter, these secretions were sprayed onto the nasal mucosa of 100 volunteers.

The experiments presented no convincing evidence indicative of a filter passing organism as the exciting factor in acute coryza. We believe the cases recorded as positive to be the result of factors independent of the inoculations.

The Common Cold: Etiology, Prevention and Treatment (1927)

Volney S. Cheney, M. D., Fellow A. P. H. A.
Medical Director, Armour and Co., Chicago, Ill.

Doctor Cheney was concerned with the economic impact of loss of work time because of colds. He tried to infect people with secretions from people who had colds.

This report does not include much specific clinical data; it is an overview of his experiences and conclusions, including looking at the bigger picture - the circumstances and terrain of the the individuals who get "colds".

From the section of [the paper](#), *Cold Is Not Infectious* :

The first thing that I want to oppugn is that "a cold is an acute infection." I have been able to disprove this by experiments on a number of people free from cold by trying to inoculate them with the secretions of an individual suffering from an acute cold. As infectious diseases are generally most contagious in the period of incubation or the early stages, I chose the time when the secretions were most profuse for my inoculations. In no single instance was a cold contracted.

If a cold were an acute infection, its origin or source could nearly always be definitely traced; but this is rather a hard thing to do and it is generally turned off with the remark, "I must have been exposed to a cold somewhere." It is true that a cold will frequently run through families and through offices where the clerks are closely associated, but this does not prove that a cold is spread by contact with other persons. These individuals, in the home and in the office, are subjected to the same unhygienic conditions of environment, and those conditions are the factors in bringing about an altered metabolism and a systemic disturbance affecting all the fluids and secretions of the body.

In the report he explains his history of observations:

In a study of several thousand cases of colds extending over a period of 11 years, and after numerous unsuccessful attempts to inoculate cold-free persons with the secretions from acute colds, I am thoroughly convinced that an acute cold affecting the upper respiratory tract is not primarily an infection but only a symptom syndrome of a systemic disturbance.

Through observations and an open mind, explaining why he didn't buy into the bacteria or virus theories, Dr. Cheney came to this conclusion, an excerpt from the *Summarizing Findings* section of the paper:

These findings seem to point the way to the conclusion that a cold is a local manifestation of a systemic disturbance; namely, a disturbance of the alkaline balance or reserve, in other words, a mild acidosis, or perhaps better stated, a lessening of the "buffer" action of the blood plasma through a decrease in its bicarbonate content. This conclusion is strengthened by treatment in which thorough alkalinization will always abort and cure a cold - a radical statement but nevertheless true, provided the treatment is thorough.

Poliomyelitis Problems (1951)

Archibald L. Hoyne, M.D., F.A.C.P.

At the end of this report the author mentions that in Cook County Contagious Disease Hospital there were no cases of polio being transmitted between any of the staff or patients over a period of at least thirty-five years.

As the title of this report suggests, it looks at the unresolved issues regarding what is known about polio. The very last section of [the paper](#) lists them in the section, *A Summary of the Problems*.

1. Still unknown etiologic agent.
2. Warm weather prevalence, unusual for a communicable disease.
3. Undetermined manner of transmission.
4. Susceptibility in the exceptionally well nourished.
5. Variability of symptoms.
6. Lack of a practicable laboratory diagnostic test.
7. Diagnostic difficulties added by the "new virus."
8. Reliable measures for prevention.
9. Dependable methods for treatment.
10. Question whether isolation of poliomyelitis patients is an effective means of controlling the disease.

The last three paragraphs, in the sub-section of the *Treatment* section of the report, titled, *Isolation Period*:

The isolation period required is "one week from the date of onset and thereafter until temperature is normal for twenty-four hours." There are no

restrictions for contacts but it is recommended that they be kept under medical surveillance for two weeks from date of last exposure.

There is little to indicate that isolation has been a controlling influence in the spread of the disease during epidemics. In this respect poliomyelitis is similar to epidemic meningitis. However, isolation regulations tend to insure more prompt and accurate diagnosis and therefore early treatment.

Patients should be cared for according to medical aseptic methods. Since the virus may be found in the intestinal tract for thirty-five days or possibly longer after onset of the disease it would seem logical to disinfect all body discharges before their disposal. However, in the Cook County Contagious Disease Hospital where the latter procedure has not been used there has never been a doctor, intern, nurse or any other member of the personnel who contracted poliomyelitis within a period of at least thirty-five years, nor has any patient ever developed poliomyelitis after admission to the hospital.

The Epidemiology of Poliomyelitis (1909)

Frederick E. Batten, M.D

In the introduction [of the paper](#) the author states the purpose of the paper:

The purport of this paper is to collect and put together in a concise form the facts which are known in relation to poliomyelitis as an infective and epidemic disease.

While maintaining the belief that polio is an "infective and epidemic disease", the author reports on his observations from an epidemic in Austria. From the section, *The Steiermark Epidemic, 1909*:

This epidemic began in September, 1909, and amounted to 434 cases, 60 of which occurred in Graz, and there was a mortality of 13 per cent. The question of the contagiousness of the disease was discussed. In favour of such a view is the fact that more than one member of the family may be affected, and also that persons coming in contact with the infected develop the disease.

Against the infectivity of the disease may be urged, first, the absence of spread of infection in hospital. The cases of poliomyelitis admitted to hospital freely mixed with other cases in the ward without any isolation or disinfection, some 70 children came in contact, but no infection took place. On these grounds it is probable that the paralytic stage of the disease is

not contagious. Secondly, the striking absence of infection when contact has been most close. In November, 1909, H. E. was taken ill with poliomyelitis; all five brothers and sisters, although in closest contact, remained unaffected. In October, 1909, M. K., aged 2 ½, was taken ill; two sisters, aged 6 and 11 respectively, slept with and were in close contact with the child and remained unaffected. Twin sisters, aged 2 ½, one was affected, the other unaffected. Thirdly, that contact is not the only possible method of dissemination of poliomyelitis is proved by the fact that the disease may arise in persons in whom all contact with affected persons can be excluded.

The instances given of this are as follows: In 1908 the child of a cowkeeper, 30 kilometres removed from the next place in the Alps, was taken ill with poliomyelitis. The child of a railway watchman, whose house could only be reached through a long tunnel, was affected. The contact in school to which Wickman attaches so much importance could not be shown to be a factor in the Steiermark epidemic. It is striking that a large percentage of children are affected before the school age - viz., between 1 and 5 years.