CDC confirms that its 2023 Annual Epidemic Intelligence Service Conference became a COVID superspreader event

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Apparently the 2023 Annual Epidemic Intelligence Service (EIS) Conference that was hosted by the Centers for Disease Control and Prevention (CDC) from April 24 to 27 in its hometown of Atlanta, Georgia, with more than 2,000 in attendance, has turned into a COVID superspreader event. The four-day event held at the Crowne Plaza Hotel, free and open to the public, was billed as a showcase for "recent groundbreaking investigations and innovative analyses conducted by EIS officers [during the COVID pandemic]."

Begrudgingly, the CDC reported to the Georgia Department of Health, which has jurisdiction over the state, including the premises where the conference was held, that at least 35 cases of coronavirus infections among attendees had been documented so far. Given the lack of systematic monitoring and the brief time that has passed since the event, this figure must represent only a minute fraction of those infected.

The very same CDC intelligence officers whose work was being highlighted at the conference, known colloquially as "disease detectives," have initiated an internal investigation into the outbreak.

According to the attendees, many, presumably a significant majority, were not masking or maintaining social distance nor adhering to any of the precautions that the CDC had previously recommended. Given that infections with coronavirus can result in severe health issues if not death, the result is worse than hypocritical or embarrassing. It is tantamount to ineptitude and professional negligence on the part of the CDC for the well-being of the attendees and the public.

And it raises a further question: If the top officials of the CDC are so casual and indifferent to the health of their own employees and close associates, what is their real attitude to the health and well-being of the American people as a whole?

On word of infections among attendees just a few days prior to the official announcement of the outbreak, CDC public affairs specialist, Kristen Nordlund, had contemptuously dismissed the suggestion of a superspreader event when she told the *Washington Post*, "These cases are reflective of general spread in the community. It's not news that public health employees can get COVID-19."

Taking on a more cautious tone on Tuesday, Nordlund in an email to the *Post*, wrote, "The CDC is working with the Georgia Department of Health to conduct a rapid epidemiologic assessment of confirmed COVID-19 cases that appear to be connected to the 2023 EIS Conference to determine transmission patterns."

Speaking with *The Hill*, she downplayed the event and covered for the agency, noting, "Whenever there are large gatherings, especially indoors, such as at a conference, there is the possibility of COVID-19 spread, even in periods of low community spread."

These statements and actions by the elite public health agency raise important questions and considerations.

Foremost, if there aren't any real-time trackings taking place, how do they know what the level of community spread really is in Atlanta, or anywhere else in the country for that matter? Why weren't strict infectious disease protocols in place and participants made to adhere to them? Were high-quality masks even made available to everyone and potential risks enumerated to encourage their use? What of HEPA filters and UV lights?

Additionally, if the CDC is opening an investigation into the outbreak at their own conference, will they recommend similar investigations at other events, part of the standard track-and-trace process conducted by epidemiologists in similar outbreaks?

At the recent Drake Relays in Iowa, with over 5,000 high school, college and elite-level competitors and 40,000 fans in attendance, some 76 Drake students have now tested positive. What guidance should the university be given as students are preparing to take their finals before the summer break begins?

In Detroit, a kindergarten student at Garvey Academy recently died of an unspecified flu-like illness, leading to the school's closure. Health Department officials are investigating an "unusually high rate of flu symptoms" among younger students. Although there was no public mention of COVID-19, the CDC should be seeking the pathogen involved in this outbreak.

The CDC investigation into the superspreader event in Atlanta is simply an effort at damage control. Despite more than 250 people dying each day from COVID-19, which remains one of the top killers of Americans, with the deadline for the ending of the public health emergency on May 11 fast approaching, news media after news media are confirming that the CDC will scale back COVID-19 reporting requirements.

Specifically, the agency will make optional the listed data fields that hospitals must report, including: (1) hospitalized pediatric cases with suspected or confirmed COVID-19, (2) hospitalized and

ventilated COVID-19 patients, (3) total ICU adults suspected or confirmed with COVID-19, (4) hospital-onset COVID-19 cases, and (5) previous days' total emergency room visits and COVID-related visits. Additionally, the reporting requirements will shift to once a week, and the enforcement period of compliance will change from 14 days to 28 days.

The CDC and the entire public health apparatus are abiding by the wishes of the financial institutions that have given the White House their marching orders. That is the determinant of policy, not the CDC's professed obligation as an institution for "developing and applying disease prevention and control."

Despite emerging data of the infective and severe nature of the latest Omicron XBB.1.16 now spreading through South Asia and India, in particular, it is doing everything in its power to shut down all surveillance trackers on the pandemic leaving the public to fend for itself.

As infectious disease specialist and population health professor at Weill Cornell Medicine, Dr. Jay Varma, recently noted, "This is, unfortunately the new normal. While it is unsettling to see widespread COVID-19 transmission at CDC's premier public health conference, it's probably the clearest example of the global situation."

The Biden administration plans to end COVID-19 vaccine requirements for federal workers, federal contractors and international air travelers. In conjunction with moves, the White House announced that HHS (Health and Human Services) and DHS (Department of Homeland Security) "will start the process to end their vaccination requirements for Head Start educators, CMS-certified healthcare facilities, and certain noncitizens at the land border."

In the statement, the White House concluded: "While vaccination remains one of the most important tools in advancing the health and safety of employees and promoting the efficiency of workplaces, we are now in a different phase of our response when these measures are no longer necessary."

The question emerging from these developments moving forward is what does this mean for the working class, considering the continuously spawning of newer subvariants that are both more contagious and remain extremely immune-evading, even as governments around the world have abdicated any responsibility for fighting the pandemic?

In a critical modeling study conducted by Arijit Chakravarty and colleagues at Fractal Therapeutics titled "The Gray Swan: model-based assessment of the risk of sudden failure of hybrid immunity to SARS-CoV-2," the authors attempt to offer an answer to this question. For clarification, "hybrid immunity" promoted by the CDC and the White House means the combination of infection-induced and vaccine-induced immunity as though it affords greater protection than either alone. It has been part of the evolving approach by the ruling elites to force the public to accept high levels of infections despite prior vaccinations.

However, with the end of vaccine mandates and removal of nonpharmaceutical interventions like masking, social distancing, quarantining and isolation, and the continuing rapid evolution of the viral spike proteins that evade neutralizing antibodies, the number of annual infections in the hundreds of millions could undermine the notion of hybrid immunity.

The continuing evolution of immune evasion will mean a higher infection mortality ratio. If immune evasion did not develop through mutation and thus undermine a robust hybrid immunity, there would still over 80,000 deaths annually. Because mutation leads to newer subvariants and increased immune evasion, even if disease severity is not increased, this could lead to the tripling of infections, which would translate to almost a quarter million deaths annually.

The study authors modeled "COVID-19 outcomes under conditions of variant emergence." They continued, "We evaluated the impact of sudden shifts in neutralizing antibody potency driven by viral evolution accompanied by possible changes in the viral reproduction number." They noted, "[i]mmune evasion can significantly increase the apparent fatality rate of reinfections."

It is precisely here that vaccine compliance could blunt rates of infection and severity of disease. However, without the means to track virus evolution and the number of infections or to mitigate, let alone, eliminate the virus, such dangers are inevitable.

The authors concluded, "The findings presented here are broadly consistent with previously published work by us, where we showed that even small changes in the infection fatality ratio under endemic conditions could lead to large death tolls. Here, we have extended that work by demonstrating behavior under excursions from endemicity. We have examined a specific mechanism (antigenic shift leading to large evolutionary decrease in neutralizing antibody binding potency) and found it leads to increased mortality via a transient change in the infection fatality ratio or via a spike in the total number of cases."

A preprint study from India on the clinical presentation of XBB.1.16 infections among 386 such cases showed a high rate of symptomatic infections (92 percent). Close to 92 percent had previously received at least one dose of the COVID-19 vaccines. A quarter required hospitalizations, with a third of these cases requiring oxygen therapy. There were seven deaths among this group (2.5 percent), who were all 60 years or older. Although the number of infections in the period of study is not known, it offers a first glimpse into the nature of these newer subvariants.

The precautionary principle—avoiding any new initiative whose negative consequences are unknown—continues to apply, regardless of the decisions emanating from the CDC and the White House. The virus continues to remain a dangerous public health pathogen. The ending of the public health emergency will only offer more leeway in SARS-CoV-2's evolutionary drive to grow stronger and more vaccine-resistant and wreak havoc on the population's health.