Cellphone Tower Emissions, Harmonic Transmission Research, and Protection of Living Environments

Individual consumer and parent perspective
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Tower emissions and ecological research edition | Prepared for review before submission

Purpose and perspective

I urge the Department of Health and Human Services to place the health of people, animals, and ecosystems at the center of its review of cellphone-tower emissions. My principal concern is the radiofrequency energy transmitted into living environments over extended periods. I support investigation of safer transmission methods and of proposed harmonic approaches that could offer demonstrable biological benefits. Harmful exposures, where established, should be reduced rather than allowed to persist.

I submit this comment as an individual consumer and parent. My priorities are independent research, protection of children and wildlife, public access to exposure information, and technology designed around measurable well-being. These recommendations address the notice's questions on exposure assessment, infrastructure, vulnerable groups, and research gaps. This comment does not report a personal diagnosis or measured exposure. [1]

My use of “harmonic” expresses a goal of compatibility with living systems. It is a research proposal, not a finding that a particular tower frequency already heals people or water. The central request concerns tower transmissions themselves. Music, prayer, singing bowls, and water-crystal studies are retained later as background interests; their findings cannot establish the safety or therapeutic value of tower emissions.

I request a research program that tests both possible harm and proposed benefit without requiring a predetermined conclusion. Communities need answers about realistic, repeated exposure, including what happens when a documented harmful exposure continues and which changes would reliably reduce it. Public policy should respond to reproducible evidence with clear responsibilities and timely corrective action.

What a harmonic tower proposal would require

For Questions 13, 15, 16, and 18, I ask HHS to work with communications engineers and independent biological researchers to evaluate whether changes in carrier frequency, modulation, transmitted power, antenna configuration, or operating schedule could improve the biological compatibility of wireless infrastructure. Each candidate should have a defined technical specification and a measurable outcome. Calling a signal harmonic, coherent, natural, or healing should not substitute for these requirements.

In engineering, harmonics are frequency components at integer multiples of a fundamental frequency. Their presence does not assign a beneficial biological effect. A proposal must distinguish the radio carrier from modulation and from audible sound. A music recording transmitted over a network becomes audible through a receiving device and speaker; its therapeutic evidence does not transfer to the intervening RF signal.

I propose staged evaluation: laboratory characterization, independent replication, appropriate preclinical studies, and ethically approved clinical research if justified. Investigators should compare any proposed transmission with a matched conventional signal and a sham condition. They should control absorbed energy and temperature, assess adverse effects, preregister outcomes, and publish unsuccessful results. Any claim of healing must be demonstrated directly, rather than inferred from a frequency label or a short-term biomarker.

The proposed research should distinguish reducing exposure from creating a therapeutic effect. A network setting that lowers measured exposure has achieved an engineering outcome; improved health is a separate hypothesis. Investigators should assess the complete network, including whether a tower adjustment changes handset transmission power or communication reliability. Emergency access and accessibility belong in this assessment.

I do not request experimental therapeutic broadcasting over communities before benefit and safety have been established. The cited research does not establish a cellphone-tower setting that heals people, animals, or environmental water. My request is to investigate the possibility responsibly while prioritizing prevention of demonstrated harm.

Sustained exposure and action when harm is established

For Questions 7, 8, 10, and 15, I request measurements that reflect actual tower operations across time, rather than one convenient reading. Studies should document frequency bands, field strength, average and peak exposure, duty cycle, antenna direction, network traffic, and uncertainty. Multiple nearby transmitters should be considered. Duration and repeated exposure should be recorded without assuming that RF accumulates in the body like a chemical contaminant.

I propose long-term studies of communities, workers, and relevant animal populations with exposure estimates that can distinguish tower emissions from phones, other transmitters, noise, air pollution, and other environmental conditions. Distance from a tower alone should not stand in for a complete exposure assessment. Researchers should include suitable comparison locations and assess changes before and after infrastructure modifications where feasible.

If reliable evidence establishes an adverse effect at the measured exposure, continued exposure could prolong the relevant risk. The response should specify which exposure is harmful, which population or species is affected, and which intervention is supported. Options for evaluation include equipment correction, access controls, reduced unnecessary

emissions, antenna changes, or alternative infrastructure. Agencies should then verify that the action reduces the identified problem.

I request public procedures for reporting suspected excessive exposure, obtaining an independent assessment, and receiving a written explanation of results. Documented compliance failures should be corrected promptly. Where evidence remains uncertain, agencies should identify the gap, explain proportionate precautions, and set a timetable for further investigation. A suspected connection should receive serious investigation without being recorded as a proven causal injury.

Clarifying what frequency means

For Questions 5 and 18, I request clearer public explanations of frequency. Frequency describes cycles per second; it is not a measure of kindness, harmony, toxicity, or healing. Sound involves mechanical vibration, while radiofrequency radiation involves electromagnetic fields. These are different physical phenomena even when their frequencies are expressed using related units. A sound recording cannot be evaluated as though it were a mobile network signal.

The National Cancer Institute describes mobile phone RF as nonionizing, with photon energy insufficient to ionize molecules like X-rays. Sufficiently intense RF can heat tissue, but broad claims of illness from ordinary wireless exposure remain unestablished. This distinction supports accurate assessment while allowing research to continue. [2]

I request that agencies explain these distinctions before discussing beneficial or harmful frequencies. Public materials should identify the exposure type, intensity, duration, location, intended effect, and evidence supporting each claim. A label such as natural, high vibration, positive, or quantum should never substitute for an actual description of what reaches the body.

Similarly, a lower numerical frequency should not automatically be promoted as healthier. A proposed intervention should be assessed through observed benefits and harms under specified conditions. If a sound program helps a person relax, that useful outcome deserves accurate language. It does not establish that the same program repairs DNA, changes cellular water permanently, or counteracts wireless radiation.

This clarity would allow families to discuss harmony and well-being without confusing personal meaning with physical exposure. I ask HHS to preserve room for cultural and spiritual language while keeping medical claims measurable. People should be able to pursue peaceful environments and informed technology choices without receiving contradictory explanations of basic science.

Established hazards and responsible precaution

For Questions 5 and 6, I ask agencies to start with established hazards and then explain what remains uncertain. High RF exposure capable of significant heating is a recognized concern; ARPANSA distinguishes such exposure from the much lower environmental levels generally encountered by the public. Its assessment does not establish harmful biological effects from routine exposure below heating thresholds. [3]

Precaution should therefore be specific and proportionate. I favor measures that improve exposure assessment, disclose conditions of use, prevent excessive exposure, and offer reasonable alternatives. I do not request a blanket finding that every tower, router, or connected household item is dangerous. Such a conclusion would require evidence beyond the presence of a signal.

For each proposed protective measure, HHS should identify the problem it addresses and how success will be evaluated. Is the objective regulatory compliance, lower measured exposure, improved sleep routines, greater personal choice, or relief of distress? These outcomes are different. A policy can support one without demonstrating all the others.

I request an independent review of whether current testing and disclosure practices adequately describe contemporary use. That review should consider ordinary operating conditions and reasonably foreseeable patterns of use, rather than relying on examples chosen to reassure or alarm. It should publish assumptions and explain when conclusions are extrapolated beyond available observations.

Affordable measures deserve attention. Parents should not need expensive products or private consultants to understand a compliance report. Schools should receive usable technical support. Workers should know how to report concerns. Communities should be able to ask for documented evaluations through a clear process.

Public confidence will improve when precaution is connected to a transparent question, a reliable measurement, and an identifiable responsible agency. I favor that approach because it turns concern into work that can produce answers, rather than leaving families to choose between absolute reassurance and absolute alarm.

Cancer evidence and unresolved questions

For Questions 6 and 16, I ask HHS to evaluate cancer evidence across human, animal, and mechanistic research, giving particular attention to exposure conditions relevant to base stations.

NTP's older-generation RF experiments reported malignant heart schwannomas in male rats and findings warranting further attention. The exposure arrangements and technologies differed from ordinary human use and contemporary 5G. NTP also reports limitations in its later experimental system and notes that no further studies with that system are planned. These details should accompany discussion of its findings. [4]

Falcioni and colleagues studied 2,448 rats exposed to a 1.8 GHz GSM far field from prenatal life until natural death, for 19 hours per day. They reported a statistically significant increase in heart schwannomas in males at the highest exposure, 50 V/m. Other reported increases were not statistically significant. This base-station-style animal experiment warrants careful examination and replication, but cannot by itself quantify cancer risk for people living near contemporary towers. [20]

NCI's summary states that evidence overall does not show cellphone use causing cancer in humans. That assessment concerns phone-use research and should not be treated as a complete answer to every tower-specific or ecological question. I request direct comparison of exposure intensity, frequency, duration, and species before extrapolating between studies. [2]

I request an evidence table that separates what each research category can establish. Animal findings can inform hazard investigation and research priorities without providing a direct estimate of human risk. Human studies can inform risk under observed conditions without answering every question about future technologies or lifetime exposure.

The review should state how it handles contradictory findings, corrections, exposure differences, and uncertainty. Its conclusions should remain open to revision as stronger evidence becomes available. Agencies should explain what additional evidence would change an assessment, rather than treating disagreement as a reason to stop investigation.

My request is for careful synthesis, including reassuring evidence and concerning findings. A transparent account of both would help families understand why research continues and what conclusions are justified now. It would also help prevent isolated studies from being used as universal proof of either harm or complete safety.

Animals, pollinators, plants, and ecosystem protection

For Questions 15, 16, and 18, I request an explicit ecological research agenda alongside human health assessment. Laboratory rats, wild birds, pollinating insects, livestock, plants, and aquatic organisms represent different biological questions. A human compliance assessment should not be treated as a substitute for species-specific ecological evidence.

Thielens and colleagues modeled RF absorption in four insect types across 2–120 GHz. Absorption depended on frequency, with generally greater absorption at and above 6 GHz under their modeled conditions. This was a dosimetry study, not an experiment demonstrating insect deaths, colony collapse, or damage from an operating 5G network. It supports measuring species-specific absorption before drawing ecological conclusions. [21]

Engels and colleagues reported disrupted magnetic-compass orientation in migratory birds exposed to broadband electromagnetic noise, with orientation restored under shielding. Their experiment concerned noise in roughly the 50 kHz–5 MHz range, not a test of cellphone-tower GHz carriers. It demonstrates why the actual exposure spectrum and biological mechanism matter; it cannot establish that every tower disrupts bird migration. [22]

I propose field studies that measure both RF exposure and outcomes such as survival, reproduction, pollination, navigation, plant growth, and aquatic ecosystem function. Studies should account for pesticides, habitat loss, artificial light, weather, disease, and other plausible influences. These are proposed endpoints, not a list of established tower injuries. Before-and-after comparisons with matched control sites would strengthen interpretation.

Where credible findings identify an adverse ecological effect, agencies should investigate practical mitigation and monitor whether it works. A response may differ across species and settings. The objective should be to protect living systems through measured improvements rather than assume a universally harmful or universally healing frequency.

Environmental water deserves similarly specific evaluation. Claims of RF-induced harm or benefit should identify changes in chemistry, microbial safety, temperature, or ecosystem function and test those endpoints directly. Ice-crystal aesthetics and sound-related spectral changes do not demonstrate that a tower emission heals water. The water studies retained below are exploratory background for future hypotheses.

Research on mechanisms and whole body outcomes

For Question 16, I propose a coordinated research program covering plausible mechanisms and outcomes that matter to patients. Potential endpoints for study could include sleep, cognition, reproductive outcomes, tissue responses, and selected biomarkers. Naming these endpoints here does not imply that 5G has been shown to damage them. They are proposed questions requiring appropriate study designs.

Laboratory investigations should identify the actual exposure delivered and distinguish intentional RF exposure from temperature changes or other experimental influences. Researchers should use suitable comparison conditions and publish enough technical information for independent laboratories to reproduce the work. A finding should receive greater weight when it survives replication under well-characterized conditions.

I ask agencies to distinguish a measurable biological response from an adverse health outcome. A short-lived change in a laboratory measure should not automatically be described as disease. Conversely, a replicated finding with clear functional consequences should receive timely attention. Interpretation should match the strength and practical meaning of the result.

Study planning should specify what counts as a meaningful change before data collection begins. Researchers should disclose their primary outcomes, analysis plans, and reasons for selecting particular exposure conditions. Exploratory results can be useful, but should be identified as exploratory so that subsequent work can test them properly.

I also favor investment in methods that can produce reliable negative findings. A study that finds no effect under adequately tested conditions contributes useful information. Public research should reward accuracy rather than a particular direction of result. Investigators should be encouraged to share unsuccessful replications and technically limited experiments.

The goal should be an evidence base that can explain whether a finding represents a repeatable interaction, whether that interaction matters for human health, and whether it occurs under realistic exposure conditions. These are separate steps, each requiring support before broad public claims are made.

Children and other priority populations

For Question 11, I request that children receive explicit attention in research planning and public guidance. This is a priority based on my concern for their well-being and the need for appropriate evidence, rather than a claim that harm has already been demonstrated. Childhood use patterns and changing technologies should be investigated through ethically designed studies.

Research should address the settings where children spend time, including homes, schools, childcare facilities, and transportation. Participation should require appropriate consent and safeguards. Study reports should describe which age groups were included and avoid presenting adult findings as though they directly resolve every pediatric question.

Parents should receive guidance that separates RF exposure considerations from other aspects of device use. For example, a school policy intended to reduce distraction should explain that objective. It should not be presented as proof that classroom wireless signals cause injury. Likewise, a supportive bedtime routine need not rely on an unverified radiation diagnosis.

Pregnant people, older adults, workers with elevated exposure, and people with implanted medical devices should also be considered through relevant protocols. Recommendations should identify the evidence and device-specific conditions that apply, instead of assigning all these groups the same assumed vulnerability.

I propose public consultation with caregivers, pediatric specialists, teachers, accessibility experts, and people with relevant lived experience. Their input can improve study feasibility and communication, while scientific conclusions remain grounded in the resulting evidence. Families should be represented in decisions about research priorities and information needs.

Supportive environments should be accessible to children with different sensory preferences. A sound program described as calming should remain optional and adjustable. Some children may prefer silence. Public guidance should support individual comfort and appropriate care, rather than requiring every child to respond to one supposedly universal healing frequency.

Exposure measurement that communities can understand

For Questions 7 and 8, I request an investment in exposure assessment that communities can interpret. Studies should report frequency bands, intensity measures, exposure duration, equipment settings, and relevant uncertainty. They should distinguish measured values from modeled estimates and explain the strengths and limitations of each method.

I request a transparent comparison of applicable domestic exposure requirements, the endpoints those requirements address, and any remaining research gaps. Reports should state which limits and averaging periods were used and distinguish compliance from a claim that every possible biological question has been resolved.

I propose measurements at representative times and locations, with protocols that can be independently audited. A reading from one position should not be presented as a complete description of an entire school, neighborhood, or workplace. Reports should make clear what was sampled and what remains outside their scope.

Communities should receive summaries that explain units, comparison limits, and interpretation. Technical appendices should remain available for specialists. Public dashboards should avoid color schemes that imply medical danger solely because a signal is detectable. They should show the actual metric and explain the basis for any threshold.

Measurement programs should include procedures for calibration, quality assurance, and repeat assessment when operating conditions materially change. Agencies should also evaluate whether consumer measurement devices produce dependable results for the questions they are advertised to answer. Inadequate instruments should not become the foundation of public health claims.

The intended outcome is accountability. Residents should be able to understand what was evaluated, whether applicable limits were met, and who can answer follow-up questions. Better measurement would support both public reassurance when justified and prompt corrective action when a documented problem is found.

Transparency and public participation

For Questions 9 and 15, I request accessible disclosure of exposure evaluations and the assumptions used to conduct them. Communities should be informed through materials that support practical understanding. A technically available report is insufficient if residents cannot locate it or interpret its conclusions.

Disclosure should identify the responsible organization, assessment date, measurement or modeling methods, relevant operating conditions, and contact for questions. It should describe how compliance was determined and when reassessment may be appropriate. HHS should work with relevant agencies to define a consistent format for this information.

I propose opportunities for schools, childcare centers, healthcare facilities, and neighborhood representatives to raise questions before and after significant infrastructure changes. Consultation should explain the available evidence and applicable responsibilities. It should also identify which concerns can be resolved locally and which require federal technical review.

Public participation should include people with limited technical knowledge, limited English proficiency, disabilities, or constrained time. Plain language summaries and accessible

formats would help. Meetings should avoid assuming that every resident can obtain specialized expertise or attend during standard working hours.

Agencies should disclose relevant financial interests in commissioned assessments and advisory processes. A declared conflict does not by itself invalidate research, but transparency allows the public to understand relationships and evaluate safeguards. Review procedures should protect scientific judgment and make their reasoning visible.

I ask HHS to publish a response framework showing how public comments contribute to research priorities and communication. The agency need not agree with every claim to explain how it evaluates concerns. A clear pathway from public question to technical assessment would make this consultation useful beyond the submission period.

Symptoms deserve care and careful investigation

For Questions 10 and 11, I ask agencies to support respectful care for people who report symptoms they associate with wireless environments. A person’s distress deserves care even when its proposed environmental cause remains unconfirmed. I request investigation that measures exposure and evaluates alternative explanations without prejudging either the patient or the result.

Clinical guidance should encourage a thorough evaluation of symptoms and relevant circumstances. It should avoid prematurely labeling a person as harmed by 5G, while also avoiding dismissive language that discourages care. Patients should be offered help with the symptoms and functional difficulties they actually experience.

I propose a voluntary reporting pathway with clear privacy safeguards and careful interpretation. Reports could help generate research questions, but should not be treated as confirmed causal cases. Public summaries should distinguish reported beliefs about exposure from independently verified measurements and medical findings.

Where feasible, researchers should study symptoms using appropriately blinded comparison conditions. Study design should account for expectations and other environmental factors, and reports should explain limitations. Participants should receive respectful treatment regardless of whether the findings support their initial explanation.

Supportive sound environments and music-based interventions could be evaluated for comfort and symptom management where appropriate. If they help, the result should be described as the observed benefit. Improvement following an intervention should not automatically be interpreted as evidence that a particular radiation mechanism caused the original problem.

I favor a patient-centered approach that combines clinical care with scientific discipline. People should not have to prove an environmental theory before receiving help. At the same time, accurate causal language matters because an incorrect explanation can lead families toward ineffective interventions and away from conditions that need proper evaluation.

Supporting background: rose windows, bells, and singing bowls

The following complementary topics preserve my broader interests in harmony and healing. They are supporting background, not evidence for therapeutic tower broadcasts. For Question 18, I favor spaces that combine visual beauty, comfortable acoustics, and opportunities for reflection. Rose windows and stained glass can be included as aesthetic and spiritual design choices. I request evaluation of how people experience such settings, without assuming that their geometry or colored light emits a medically proven healing frequency.

Singing-bowl research provides preliminary support for some aspects of well-being. Goldsby and colleagues observed 62 participants before and after a sound meditation and reported reductions in tension and other negative mood measures. Without a randomized comparison group, improvement cannot be attributed specifically to the bowls rather than rest, expectation, or the shared setting. [17]

A 2025 systematic review by Cai and colleagues examined 19 clinical studies and identified potential benefits, particularly for psychological outcomes. Differences between interventions and study quality limit firm conclusions. I support stronger trials of singing bowls, including clinically relevant outcomes and follow-up, while describing the present findings as promising rather than proof of accelerated tissue healing. [18]

Bells, chimes, and bowls could be offered as optional elements of supportive sound environments. Their use should account for volume, duration, hearing comfort, cultural meaning, and individual preference. Evidence for one intervention should not automatically be applied to every instrument or frequency. Programs should welcome silence as another legitimate preference.

I also support respectful space for prayer and water blessings as voluntary spiritual practices. Claims that these practices heal environmental water need a defined measurable endpoint and separate evidence. Restorative design, spiritual meaning, and changes in water chemistry are different questions. Each deserves accurate language so that a valued experience is neither dismissed nor presented as an unverified medical or environmental treatment.

Harmonious sound and music as a public health priority

For Question 18, I ask HHS to include restorative sound environments and music-based interventions in its broader research priorities. This recommendation extends beyond RF risk assessment and should be identified as a complementary public health proposal. It should not be interpreted as a request to replace communication signals with musical tones.

NCCIH summarizes evidence that music-based interventions can help with selected outcomes involving stress, anxiety, and pain, while noting limitations and variation across studies. Music therapy involves a trained professional and a therapeutic relationship; listening to a recording is a different type of intervention. These distinctions should inform how programs are described. [5]

A systematic review by Hole and colleagues in The Lancet included 73 randomized trials of music around surgery. It found reductions in postoperative pain, anxiety, and analgesic use, alongside greater satisfaction. Hospital length of stay did not significantly improve. These findings support music as an aid to recovery and comfort; they do not establish faster wound closure or tissue regeneration. I request wider access to appropriate music interventions alongside usual care. [12]

A program should respect personal preference and cultural context. Participants should be able to choose suitable music or decline it. Institutions should not assume that one style, tuning, or instrument is calming for everyone. A person who prefers silence should have that preference honored.

Evaluation should include adverse experiences and practical barriers, alongside benefits. Sound levels, accessibility, staffing needs, and participant feedback should be documented. Programs should be judged by meaningful improvements in comfort or function, rather than by the popularity of a frequency label.

I want public policy to recognize that healing involves the experience of care as well as technical treatment. Supportive sound can be studied and used with precision, compassion, and appropriate limits. This direction gives harmonious frequencies a credible place in health policy by connecting the idea to outcomes people can actually experience and researchers can assess.

Studying particular tunings without exaggeration

For Questions 16 and 18, I support appropriately designed research comparing musical tunings and other sound parameters. Popular interest in 432 Hz and 528 Hz can be translated into specific questions, rather than accepted as proof of special healing powers. Researchers should specify whether the intervention is a pure tone, a tuning reference, a musical composition, or a broader listening experience.

A randomized dental trial involving 42 patients found lower anxiety after listening to either 432 Hz or 440 Hz music than in the no-music group. Both tunings showed benefit. The study concerned short-term anxiety and cortisol measurements before extraction, not the speed of wound healing. It therefore supports further investigation without establishing a universally superior tuning. [6]

Akimoto and colleagues studied nine healthy adults listening to music described as 528 Hz. They reported changes in cortisol, oxytocin, and mood after listening. This very small, short-term study is exploratory. Statistical significance within one condition and its absence within another do not alone prove a difference between conditions. It did not test tissue healing, disease recovery, DNA repair, or RF protection. [16]

Future studies should compare like with like. Where the question concerns tuning, other features should be controlled as far as practical. Volume, tempo, musical selection, listening duration, expectations, and participant preference should be recorded. Researchers should explain any features that could not be held constant.

Study outcomes should match the claim. A study of immediate relaxation cannot establish long-term disease prevention. A change in a self-report score should be interpreted according to its magnitude and reliability. A claim of tissue repair would require direct evidence relevant to that claim, rather than an inference from enjoyment.

I request public explanations that allow people to enjoy personally meaningful sounds without being told they must purchase a special recording for protection. Affordable access and truthful descriptions should be central to any program. Commercial claims should identify the specific evidence they rely on.

The research question should remain open. If an effect is reproducible and meaningful, it deserves further investigation. If apparent differences disappear under better controls, that finding should also be published. A commitment to harmonious environments is strongest when it welcomes reliable answers rather than requiring a predetermined result.

Masaru Emoto and water crystal research

For Question 18, I ask HHS to acknowledge public interest in Masaru Emoto's work and consider whether narrowly defined hypotheses merit independent testing. His water-crystal imagery has encouraged discussion of intention, words, music, and harmony. His office describes photographing frozen-water crystals and acknowledges concerns about selecting representative images from many observations. This is the stated approach, rather than proof of a health effect. [7]

A 2006 pilot paper by Dean Radin, Gail Hayssen, Masaru Emoto, and Takashige Kizu investigated distant intention and ice-crystal appearance. It reported higher aesthetic ratings for images from the treated condition. The experiment used four source bottles, with treated and control bottles stored in different locations before analysis. Those design features limit what can be inferred from the many subsequent image ratings. [8]

A later paper involving Radin and Emoto described a triple-blind replication and also reported a difference in aesthetic ratings. It remained a study of photographed ice crystals involving members of the same research group, rather than an independent clinical demonstration of healing. These publications should be described in those terms. [9]

My proposed next step is a preregistered replication by independent laboratories. It should use enough independently randomized samples, identical handling and environmental conditions, and a predetermined method for photographing and scoring every eligible sample. Analyses should account for the source sample rather than treating multiple photographs as wholly independent experiments.

Researchers should distinguish sound exposure from spoken meaning and distant intention. These are different proposed interventions and require different controls. If music is tested, the sound delivered should be measured. If intention is tested, handling and environmental differences should be minimized without assuming the mechanism in advance.

Crystal appearance is not a direct measurement of human cellular healing or persistent changes to liquid water molecules. A visually appealing crystal does not establish that drinking the water improves health. I therefore request exploratory investigation, rather than recognition of Emoto's claims as established medical knowledge or proof that positive frequencies neutralize 5G.

A 2022 pilot aquaphotomic study reported near-infrared spectral differences in water after audible 432 Hz and 440 Hz exposure. This is exploratory laboratory evidence about sound-water interactions, not a demonstration of healthier drinking water or environmental restoration. I propose independent replication with control of temperature and sample handling. A claim of improved water quality would require direct tests of contaminants, microbial safety, or another clearly defined outcome; changes in spectra or crystal appearance cannot establish those benefits by themselves. [19]

Prayer and music as complementary recovery support

For Question 18, I ask HHS to recognize patient-chosen prayer and spiritual care alongside beneficial music interventions. My position favors care that attends to comfort, hope, meaning, and recovery. Clinical claims should describe the outcomes that studies actually measured, while respecting the personal and spiritual value of prayer.

A systematic review by Jarego and colleagues included six randomized trials of participatory prayer for pain. It reported promising findings, but the pooled analysis used only two studies and the authors could not draw firm conclusions. This provides a reason for further research into prayer as supportive pain care, rather than proof of accelerated physical healing. [13]

A 2026 randomized trial by Jacobson and colleagues assigned 180 primary-care participants to brief in-person Christian prayer or a soft-music comparison. The prayer group reported greater pain reductions immediately and at two weeks, with anxiety benefits through six weeks. The intervention included interpersonal contact and touch. Lack of blinding, loss to follow-up, and differences in personal attention limit causal interpretation. It measured symptoms, not tissue repair, and was not a test of prayer combined with music. [14]

Different prayer interventions should be distinguished. The STEP trial enrolled 1,802 cardiac bypass patients and found that distant intercessory prayer did not improve complication-free recovery. That finding addresses a particular clinical question; it does not measure prayer's spiritual meaning or every form of personal and in-person prayer. It does show why a blanket claim that prayer is proven to speed physical healing would overstate the evidence. [15]

I request voluntary access to appropriate music interventions and spiritual support, with respect for each patient's beliefs and preferences. Research should evaluate music alone, prayer alone, and their combination using suitable comparison groups. Studies claiming faster healing should directly measure time to wound closure, functional recovery,

complications, or other relevant endpoints. Symptom relief is valuable in its own right and should be reported accurately.

The wording I support is that music can improve important aspects of recovery, while prayer may provide additional symptom relief and spiritual support for people who welcome it. Specific healing frequencies and faster physical healing from music plus prayer remain questions for rigorous research. This approach supports compassionate care and protects the credibility of its evidence.

Clinically directed electromagnetic therapies

For Question 18, agencies should explain that certain electromagnetic applications are already used for specific medical purposes. FDA guidance addresses repetitive transcranial magnetic stimulation systems for major depressive disorder under defined regulatory conditions. The guidance includes device requirements and risk controls. This provides an example of a therapeutic application evaluated for a particular purpose. [10]

NCCIH describes pulsed electromagnetic field therapies and notes that evidence for pain outcomes is mixed across conditions. It also distinguishes these technologies from static magnets, whose effectiveness for pain is not conclusively established. Device authorization and evidence should be checked for the specific intended use, rather than generalized to all products described as energy healing. [11]

I propose clearer patient information about these distinctions. Families should be able to understand which device and indication were evaluated, which claims remain experimental, and what supervision is appropriate. A legitimate application should not be used to validate every consumer frequency device.

Public education should also separate therapeutic benefit from environmental risk conclusions. A device that intentionally applies energy to a particular target does not prove that ordinary wireless exposure is harmful. Similarly, a generally reassuring environmental assessment does not prove that every therapeutic device or dose is safe.

This precision supports the direction I favor: beneficial uses of energy guided by evidence and care. The aim is to identify applications that help people under defined conditions, expand access where justified, and maintain accurate information about limits. Therapeutic frequency research deserves serious evaluation through that pathway, with safety and clinical outcomes treated as essential parts of the work.

Practical guidance for families and institutions

For Questions 5, 9, and 11, I request simple guidance that families can use without purchasing expensive protection products. Agencies should explain available choices and identify whether advice concerns exposure reduction, device safety, hearing protection, sleep routines, or general well-being. These purposes should remain distinct in public materials.

For those who want to reduce close-to-body RF exposure, NCI describes options such as speaker mode and a headset. Such choices should be presented as optional exposure-reduction measures, without implying that their use proves ordinary exposure is harmful or that avoiding them causes illness. [2]

Institutions should provide reasonable opportunities for quiet, optional music listening, and comfortable participation. Programs should have a clear purpose and remain responsive to individual preferences. A sound environment can be called restorative when that describes participants' experience, while medical claims require additional evidence.

Music volume deserves attention. NCCIH notes that excessive volume can contribute to hearing loss and that particular music can cause distress for some people. These considerations should be included in programs intended to support well-being. The word healing should never be used to excuse poor sound-level practices or disregard of participant comfort. [5]

Public guidance should help families assess commercial claims. Sellers should explain the actual intervention and evidence, especially when promising disease prevention, cellular repair, or radiation neutralization. Agencies should direct people toward reliable information and appropriate care when symptoms persist.

I want practical recommendations to support confidence and choice. A household should be able to enjoy peaceful music, use communications technology, and seek medical care without being told that one particular product is necessary for safety. Responsible guidance would make supportive options easier to access while keeping their benefits and limits understandable.

Federal coordination and requested action

For Questions 16 and 17, I request a coordinated federal agenda with published priorities, responsible agencies, and regular updates. Its primary work should include sustained tower exposure, ecological effects, transparent measurement methods, appropriate attention to children, and controlled investigation of proposed safer or beneficial transmission characteristics. Complementary sound and therapeutic-device research should retain its own evidence standards. These work streams should share evidence standards while remaining distinct in purpose.

The agenda should identify near-term deliverables that the public can review. Examples include a clear evidence summary, a comparison of relevant exposure frameworks, a standardized disclosure format, and a prioritized list of research gaps. Each deliverable should explain its methods and how new evidence will be incorporated.

Funding should support independent replication and publication of negative results. Agencies should disclose relevant interests, invite qualified methodological review, and provide understandable explanations of disagreements. Community participation should help define information needs and practical barriers, while evidence determines scientific conclusions.

I also request a defined route for exploratory proposals, including water-crystal hypotheses and specific musical tuning comparisons. Such proposals should be assessed for feasibility and value without being confused with established treatment. Their evaluation should not displace higher-priority research merely because they attract public attention.

My preferred outcome is public policy that supports harmony, comfort, and healing through demonstrable benefits. That means investigating potential harms carefully, improving environmental accountability, and expanding credible supportive care. It also means being willing to revise conclusions when good evidence changes the picture.

I urge HHS to make this consultation lead to visible action: accessible information, rigorous research, respectful care, and practical choices for families. A healthier technological environment should be evaluated by how well it serves people. My central request is for cellphone-tower technology that demonstrably protects people, animals, and ecosystems, together with rigorous investigation of proposed harmonic transmissions. Benefits must be measured, and exposures shown to be harmful should be corrected rather than allowed to persist.

References and scope of evidence

Numbered citations identify supporting sources. Research requests and policy preferences are proposals. Exploratory crystal and tuning studies are not presented as evidence of RF neutralization or clinical cures. Online sources were consulted October 11, 2026.

[1] HHS. Request for Information on Electromagnetic Fields EMFs Radiofrequency RF Radiation and Wireless Radiation Exposure. September 21, 2026. Docket HHS-OASH-2026-0397.
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[2] National Cancer Institute. Cell Phones and Cancer Risk. Current online fact sheet consulted October 11, 2026.
https://www.cancer.gov/about-cancer/causes-prevention/risk/radiation/cell-phones-fact-sheet

[3] ARPANSA. Radiofrequency radiation. Official radiation protection guidance consulted October 11, 2026.
https://www.arpansa.gov.au/understanding-radiation/what-is-radiation/non-ionising-radiation/radiofrequency-radiation

[4] National Toxicology Program. Cell Phone Radio Frequency Radiation. Current program summary and follow-up study limitations; updated June 25, 2026.
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