Unproofed Transcript of Sen. Johnson Panel Discussion, COVID-19: A Second Opinion

1/24/2022

On Jan. 24, 2022, Sen. Johnson held his second panel discussion on COVID-19 with world renowned doctors and medical experts who provided a different perspective on the global pandemic response. The roundtable, COVID-19: A Second Opinion, discusses the current state of knowledge of **early treatment, hospital treatment, vaccine efficacy and safety, what went right, what went wrong, what should be done now, and what needs to be addressed long term.**

This is an un-proofed draft produced by citizens in the hope that political leaders and news media will familiarize themselves with the important information shared at this hearing.

Medical Experts and Doctors

Four Pillars of Pandemic Response

- **Dr. Peter McCullough**

Pillar 1: Limit the spread

- **Dr. Bret Weinstein**
- **Dr. Jay Bhattacharya**

Pillar 2: Early at Home Treatment

- **Dr. Ryan Cole**
- **Dr. Harvey Risch**
- **Dr. George Fareed**
- **Dr. Pierre Kory**
- **Dr. Richard Urso**

Pillar 3: Hospital Treatment

- **Dr. Paul Marik**
- **Dr. Aaron Kheriaty**

Pillar 4: Vaccines

- **Dr. Robert Malone**
- **Dr. David Wiseman**

Part 1

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SPEAKERS

Dr. Ryan Cole, Dr. Peter McCullough, Dr. Richard Urso, Senator Ron Johnson, Dr. Christina Parks, Dr. Harvey Risch, Dr. Pierre Kory, Dr. Mary Bowden

Senator Ron Johnson 00:00

I think I'll start ahead of time before all of our doctors get here that they're in the house, they're just not seated. But I want to stay on schedule as much as possible. At least I have my statement here. Again, good morning, the US recorded its first laboratory confirmed case of COVID on January 20, 2020.

Two years and four days ago. We have endured two years of the pandemic, and COVID related deaths have surpassed 5.6 million globally, and 889,000 in the US. The US ranks 22nd in deaths per million at 2575. Sweden, we all recall Sweden early in the pandemic was excoriated by the World Press, Sweden ranks 63rd with 1514 deaths per million. Again, the US were 22nd at 2575, Sweden and 63rd at 1514.

The human toll resulting from economics shutdowns is incalculable. The erosion of freedom and growing divisions within society exacerbated by vaccine mandates should concern us all. The latest variant omicron is sweeping the planet as a weary public praise for it to be the last. The purpose of today's forum is to discuss the global pandemic response, the current state of knowledge regarding early in-hospital treatment, vaccine efficacy and safety, what we did right, what went wrong, what should be done now, and what needs to be addressed long-term. There's still much to learn about the Coronavirus, COVID, the disease and COVID vaccines.

Early in the pandemic, our knowledge was minimal. But even then, because of what we learned from Italy and the Princess cruise ship, it was becoming obvious COVID was disease that targeted the old and those with certain comorbidities. Instead of using that information, public health officials pursued a one-size-fits-all response. They relied heavily on creating a state of fear to ensure compliance. They also kept moving the goalposts. For example, we went from a two-week shutdown to flatten the curve to zero COVID.

From masks weren't necessary to a single mask wasn't adequate. From a vaccine that would prevent infection to a vaccine that reduced severity of the disease. And as goalposts were moving, different viewpoints were being crushed. At the very moment, when outside the box thinking was required, the

internet could have been used by practicing physicians to share their experiences as they developed effective therapies.

The internet was used instead to censor discussion and vilify anyone with a different opinion. Until COVID, a fundamental principle of medicine was early detection, allowed for early treatment, which produced better results. Two years in the pandemic, the compassionless guideline from the NIH, if you test positive is to essentially do nothing. Go home, isolate yourself in fear and pray. You don't require hospitalization. There's also been sound medical advice when dealing with a serious illness to get a second opinion, maybe even a third.

Today is about getting that long overdue second opinion. So just a couple of housekeeping items here. First of all, I want to thank everybody for coming to the event. Here in person. I want to thank the news outlets that are live streaming this, OAN, Rumble, but in particular, I want to thank the courageous doctors who've shown the compassion to actually treat patients, to struggle to provide the information there that is being kept from the American public and suffer the vilification, the censorship, the suppression, the termination, the lawsuits that has come with their courage.

Now, one thing I hope everybody realizes is how highly qualified this panel is. I intended quite honestly for this event to hold me no more than half a dozen. But it was pretty hard to turn down the offers of so many qualified individuals coming here to share their information, their opinion with American public. So just you understand how I met these individuals.

Very early on the pandemic, I was I was witnessing videos being posted by other courageous doctors that were thinking outside the box and coming up with a different theory of what this disease really was. They started posting their videos and they started those videos started being taken down. And somehow, I really don't know how I got involved in... connected to a group of global doctors and medical researchers on a number of different email sites.

And I rarely chimed in, but I was just listening to the flourishing of information, the sharing of different studies, completely different from what I was hearing in the mainstream media. I'm not quite sure how all these experts came together, I'm hoping to ask them, they can kind of tell us exactly how that happened. But again, I just want to thank them for being doctors, for being there in research, for being medical researchers, for being accommodations, that have had the courage to withstand all the criticism.

Now, I do want to point out that we invited folks from the other side of the narrative. Federal health agencies, their heads, or some representative from them, the CEOs or some representative from the vaccine manufacturers. They decided not to show up, which I think is, you know, somewhat telling, but also very disappointing.

Now, I do have, I want to report that one individual I invited was Dr. John Raymond from the Medical College in Wisconsin. And Dr. Raymond again, this was short notice, I don't blame him for not being able to disrupt his schedule and be able to travel here right away. But he was at least courteous enough to send me a letter which I will enter into my own personal record on our website.

I just want to read two of the of the 10 points that he made. The second point is what we need to do is to holistically evaluate our strengths and gaps in medicine, science, society, and policy with humility, integrity, and curiosity, so that our next public health response is efficient, is seamless, and inextricably integrates decisions about human health, our economy, the needs of our communities, and the future of our children. His third point is for each of us, none excluded to openly, honestly, and with respect and compassion, explore how, where and why the roots of division are springing up within our nation, our communities, and our institutions.

I don't think there's an American that can disagree with what Dr. Raymond wrote. I also have to say this is exactly what we are attempting to do here today. So again, I want to thank Dr. Raymond. Sorry, he couldn't come here today. What I'm hoping is that we can assemble probably not as large a panel because a lot of these folks are in here for the anti-mandate rally. But maybe a few of you would come to Wisconsin and sit down actually actually have a discussion in an open dialogue, an honest dialogue. Because I think that'd be very important for not only the folks in Wisconsin, but for the American public.

Now, the way this event is going to unfold, is I've asked each of the presenters to provide an opening statement. I was quite adamant about keeping it to 400 words. So, this should move pretty quickly. Following that, we'll have an open, pretty free flowing discussion. I've got a bunch of questions; they will question each other. We'll have opportunity for the press to ask questions. I will have some opportunity for some members of the audience also to step forward because the other people, we have the opportunity to have them here.

We also have the opportunity for the viewing audience to ask questions through our Rumble web page. Now for the audience. I do want, I'm telling everybody, keep your answers, keep your statements succinct. There's a lot of ground to cover here. And Dr. McCullough will be my co-moderator here and we'll try and keep this going as quickly as possible.

So with that, I think we should start the the opening statements and we'll start with a Dr. Peter McCullough. By the way, I asked the everybody to submit their bios in 75 words. Their qualifications are so extensive. It was very difficult for many of them. I apologize. I've cut them down to 75 words, but you can kind of fill in some of the gaps. But the Dr. Peter McCulloch is an internist, cardiologist, epidemiologist, and a leader in the medical response to the COVID-19 disease disaster.

He published Pathophysiological basis and rationale for early outpatient treatment of SARS-CoV-2 infection, the first multi drug protocol for ambulatory patients infected with SARS-CoV-2 in the American Journal of Medicine, which he subsequently updated in reviews in cardiovascular medicine. He has more than 650 PubMed listings, 52 on COVID-19, and has commented extensively on the medical response and again, this just barely scratches the surface of Dr. McCullough's qualification. So, Dr. McCullough.

Dr. Peter McCullough 11:08

Ladies and gentlemen, it's a pleasure to present now for a second time in the US Senate. And I have organized my comments along the four pillars of pandemic response. I presented this to America November 19, 2020, in the Department of Homeland Security and Governmental Affairs Subcommittee on Early Treatment.

That was one of two historic Senate subcommittee hearings led by Senator Ron Johnson, and in that hearing, I presented the concept that our country should have always had a balanced approach to responding to the pandemic along four major principles.

The first is to limit the spread of the virus. We quickly learned that this virus was a respiratory virus, that it spread from someone who was sick with symptoms, to someone who is susceptible, who could actually acquire the infection, and they themselves become symptomatic. We learned early on that the virus is not spread from an asymptomatic person to another asymptomatic person. It was always symptomatic to susceptible person. And for those reasons, we had an opportunity on contagion control, but our efforts to do so were extremely limited.

You can see the type of effort to limit the spread of control regarding hand sanitizer. It's not a hand infection, we quickly learned that it's not a hand infection. It's not spread by hands or pizza boxes or other objects. It was actually spread by an aerosol in the air. And later on in these proceedings, we've asked Dr. Bata Chara from Stanford to present a brief video on the Great Barrington declaration, because he led that effort with others that addressed some fundamentals on pillar number one.

Pillar number two is the pillar of early treatment. And I think everyone in this room could understand there are only two bad outcomes with COVID-19, hospitalization and death. And if everybody in this room and everyone in the nation understood that they could get a respiratory illness and survive it in the comfort of their own home, assisted by medications, in some individuals who were at high risk for that outcome, they could get along with that and understand that America would get through this illness together. And as we sit here today, there are 217,000 papers in the peer reviewed published literature in PubMed. 94,000 of them deal with hospitalization and death as an outcome and in hospital treatment. 26,279 deal with vaccines and 1417 deal with treatment. And a small fraction of that is early treatment.

We're going to hear from experts today on the principles of early treatment based on drugs used in combination with a signal of benefit and acceptable safety to be used under the guidance of the precautionary principle that this is a mass casualty event, and we cannot wait for large randomized trials that are not forthcoming. And we certainly can't wait for guidelines that depend on those randomized trials.

The third pillar is hospital care. We are going to hear today from experts who have a tremendous experience, some in the outpatient and the inpatient realm in the continuum of care and others exclusively on inpatient care. But I can tell you as a doctor, making an observation being in a large academic medical center currently in Dallas, Texas, but also throughout my career, to this day, we're two years into the pandemic, there is not a single hospital in America that is holding itself out as a center of excellence for the treatment of COVID-19.

Yet those same very medical centers hold themselves out as experts in cardiovascular care or cancer care. There's still not a single academic medical center there in the United States today that has an early treatment program, or even has continuity of care of patients going from the outpatient to the inpatient and back to the outpatient realm.

The fourth pillar is vaccination. And vaccination, as we see it today, has been the central effort of our federal belief in COVID-19. And we're going to have a very careful review of vaccination. In fact, mass discrimination, another term that applies to that is indiscriminate vaccination. Now, I can tell you speaking for the doctors around this table, we widely use vaccines as part of our clinical practice.

This is a part of medicine. It is a standard accepted part of medicine. We have over 70 vaccines that are used in clinical practice, and they do work to help prevent the binary outcome of getting a disease, particularly a disease that is a low prevalence, disease, or a disease that one yet has not acquired. But never in human history have we widely applied vaccinations into the middle of a widely prevalent pandemic where people are falling ill, recovering, and falling ill again, and we will hear about vaccines and their role in pandemic response. So, I've set the table. These are the four pillars of pandemic response, and I'll turn it back over to Senator Johnson.

Senator Ron Johnson 16:36
Thank you, Dr. McCullough. Our next presenter is Dr. Ryan Cole. Dr. Cole is CEO and medical director of Cole Diagnostic. So, there's clinicians throughout Idaho in the nation with expert pathology, diagnosis, and patient centered care.

Dr. Cole completed his residency in anatomic and clinical pathology at the Mayo Clinic, where he was chief fellow during his surgical pathology fellowship, followed by years chief fellow at the Ackerman Academy of Dermatome Pathology in New York City on the direction of world renowned dermatopathologist the late A. Bernard Ackerman. Having seen over a half a million pathology cases in his practice, he was uniquely suited to provide answers quickly and accurately. And I apologize for mispronouncing all these medical terms. Dr. Cole?

Dr. Ryan Cole 17:28
Thank you, Senator. And thank you to my esteemed colleagues. And I must commend you to pronouncing those actually quite well. So, thank you. It's an honor to be here.

I'd like to start really quick with a story. So, a high-risk individual approaches me. A 50 years old, obese, type 1 diabetic, calls me, "I have COVID." This is about a year ago. "What do I do? Help, help, I'm going to the ER my oxygen is 86. I have excruciating pain in my lungs." So, I said, "You're going to the pharmacy. Don't go to the ER." I called in some early treatment medications of the drugs which shall not be named and said individual calls me a couple hours later and says, "You know, that excruciating nine out of 10 lung pain, it's now two out of 10." Six hours later, while I know the mechanisms of the medication I prescribed, a few hours later, and next morning, he calls me he says, "You know that oxygen saturation of 86. It's now 98%." I said isn't that fantastic? Early treatment works. That individual's my brother, I am my brother's keeper.

Now this virus we have known. As we as much as we've been told it's a novel virus. Viruses are novel. This is 80% similar to a virus we experienced two decades ago. There's not a whole lot novel about this, other than the fact that a few sequences are different, but we're physicians and scientists, and we understand virology. We understand how disease works.

So an upper respiratory infection, a virus, will replicate in the body for only about a week. At that point, you only have residual parts of the virus. So, these tests that pick up oh, you're positive still, you're positive still. No, those are the car parts, not the car anymore. So, we have a week of intervention to where we can maybe try to intervene and stop the viral replication. Beyond that, we're really just spitting in the wind. Beyond that, then the virus and the phase of the disease becomes an inflammatory one and we know that this particular disease a clotting one. Well in medicine for aeons we have known how to treat inflammation and clotting.

So, the simple construct or the simple concept that there's nothing we can do, go home let your lips turn blue is a false construct. It just takes the will to say we're smart individuals. I sit here with an esteemed team of bipartisan colleagues from all walks of medicine and politics and life that are highly intelligent, that know how to treat a simple upper respiratory infection and the things this equality that happen after the virus is replicated. So yes, I am my brother's keeper. Yes, I am a scientist. Yes, you're privileged, and I'm honored to be in a room of such intelligent people that know that there is treatment for this disease. Early treatment saves lives. Thank you.

Senator Ron Johnson 20:22
Thank you, Dr. Cole. Our next presenter is Dr. Harvey Risch. Dr. Risch is a professor of epidemiology at Yale School of Public Health. He has been a university epidemiologist for more than 40 years and is a fellow of the American College of Epidemiology and a member of the Connecticut Academy of Science and Engineering.

After getting his MD degree, he completed a PhD in mathematical modeling of infectious epidemics. He has published more than 400 scientific research papers that have been cited more than 44,000 times. Just a quick little aside here. Dr. Risch and Dr. McCullough joined me with Dr. George Free who can't be with us today, in November 2020, in my first hearing on early treatment.

Following that, The New York Times published article a column written by the democrat witness of that hearing, Dr. Ashish Jha, who had never treated COVID patients. I actually read an article later he holed up in his apartment for like over a year until he got a vaccine. But the New York Times titled that paper or that column, The Snake Oil Salesman of the Senate.

I want people to know that because as you listen to Dr. McCullough, as you listen to Dr. Risch, ask yourself, do they really seem to be snake oil salesmen to you? They seem to be very qualified professionals, that again, in Doc McCullough's cases have the courage and compassion to actually treat COVID patients. Dr. Risch?

Dr. Harvey Risch 22:01
Thank you, Senator, colleagues, listeners, it's my honor to be addressing you today and to answer your questions later. We heard at the beginning of the pandemic that one of the medications that has been used in early treatment, hydroxychloroquine or HCL HCQ, was a game changer, and would be effective in the treatment of COVID outpatients starting during the first few days of the illness. And then we heard study after study and media report after media report saying that HCQ doesn't work.

These negative claims continued for months, until the media got bored with all this and then acted as if the case were closed. However, this was a sham. The media reports never covered how the negative studies were actually fake studies. Well, they did cover the surface fear of fraud, with the study that was published that was retracted, but that managed to change the WHO's policy before it got retracted.

And the media never covered how the randomized trials that were put out that were supposedly informative about the lack of benefit of hydroxychloroquine had hid their positive results, were designed for low-risk people who never had any real risk for hospitalization or death outcomes, were not blinded, or had no idea who their internet participants really were, or any of the other numerous flaws that made them essentially irrelevant.

And the media studiously avoided covering the 10 proper trials of hydroxychloroquine outpatient use that showed significant benefit for hospitalization and mortality. And just as a quick aside, the top two figures are for hydroxychloroquine, for hospitalization risk and mortality risk to the left of the vertical line means benefit. The diamond means how big the area of the range of possible values are. There's very significant 50% reduced risk for hospitalization.

75% reduced risk of mortality. And just for comparison, you can see very similar results for ivermectin in the bottom two trials. Okay, this is real evidence. This is real scientific evidence. Now, the media has not reported any of these studies, but that does not make them non-existent. These studies involved, the hydroxychloroquine studies involved more than 40,000 patients, including nationwide studies in two countries. So, we see here that early hydroxychloroquine use dramatically reduces the risk of hospitalization and mortality.

Now we could later or never, if you want, discuss randomized versus non-randomized trials, the scientific issues involved in that, but what you've seen here is essentially scientific proof. Given that, why aren't doctors across the US actually prescribing hydroxychloroquine as part of early outpatient treatment? Well, in fact, in early in 2020, doctors did start using hydroxychloroquine in outpatients.

But this was short circuited by an act of FDA and BARDA employees to use the emergency use authorization regulations to block hydroxychloroquine use in outpatients except in randomized trials. And these trials, that are the same ones that would be cut off by participant fear because of the surgeon's fear of papers.

And then the FDA mounted its biggest fraud of all times by putting up this warning. This warning says, "FDA cautions against the use of hydroxychloroquine in outpatient outside of the hospital setting." But then, in the justification, it says, "We base this on information to treat hospitalized patients." Hospital

disease, as we'll hear, and as we know from two years of dealing with COVID, is a completely different illness treated with different drugs, different medications in the hospital.

Outpatient disease is flu-like, hospital disease is a florid pneumonia. And so, the fact that the FDA would base recommendations and warnings on hospital disease, which is a totally different disease than outpatient disease is a fraud. This website is still there today and constitutes an outright fraud.

Okay, this basically scared everyone across the country against using this on the basis of this fraudulent website. Now, Senator Johnson has twice demanded from the FDA by in writing to release the data that they relied upon to make this claim that of warning, and twice the FDA has refused.

So, at this point, we know it works. We have lots of medicines, not just hydroxychloroquine, not just ivermectin, for that matter, that need to be used. And the FDA has to be held accountable for this website. Thank you.

Senator Ron Johnson 27:01
Thank you, Doctor Risch. We're going to change the order a little bit. We're going to go to Pierre Kory first, then with you Dr. Parks. The reason I want to go to Dr. Kory first is to just point out, I didn't say this initially, but the viewpoints expressed by all these individuals are their viewpoints.

One thing I've certainly noticed, as being part of this group, is they don't all agree. Sometimes they disagree quite strenuously, and there's nothing wrong with that. Again, I'll point out there's so much we don't know, I would have liked to see a much larger dose of modesty coming out of our federal health officials and the legacy media and big tech when it came that we would be so much better off if if there was robust debate and discussion.

So anyway, these are two individuals that differ slightly in terms of what drug they prefer. So let me go to Dr. Pierre Kory. He's a Pulmonary and Critical Care Medicine Specialist, and a former associate professor and chief of the critical care service at the University of Wisconsin, which is how I first noticed him. During COVID, he co-founded and serves as the President Chief Medical Officer of the Frontline COVID-19 Critical Care Alliance, a non-profit organization dedicated to developing effective treatment protocols.

He has published over 10 peer-reviewed manuscripts on COVID-19, is considered one of the world's clinical experts on the role of ivermectin in early treatments. As a further introduction, I did become aware of Dr. Kory early in the pandemic, as I put on my first hearing. To just put things in perspective, we had Johnny Anita, so a bunch of very qualified individuals just talking about this disease versus others in terms of mortality rates, that type of thing.

But a few days before the hearing, I heard of Dr. Kory and his group's recommending corticosteroids as a in hospital treatment. And it intrigued me, so I invited him, he testified virtually as we were doing back in May. I had doctors come up to me afterwards, crediting me with saving their patient's life because they listened to Dr. Kory. Six, seven months later, after the New York Times called these gentlemen

and me snake oil salesman in the Senate didn't deter me and I had Dr. Kory, come back and talk about his group's work on ivermectin.

His impassioned opening statement, which I think was prompted by my ranking member's insults, basically called him a partisan hack, but in Senate speak, diplomatically, fired him up, and he offered an impassioned opening statement, which was viewed by 8 million people on YouTube before he was taken down and censored. So, without further ado, Dr. Kory.

Dr. Pierre Kory 30:09
Thanks, Mr. Johnson. I'm going to close, okay. So, I'm really tired. I'm really tired of watching the US health systems failed response to this pandemic. I cannot list and I do not have the time today to talk about the innumerable failed policy responses.

Some of them are so obscene, absurd, illogical and non-scientific, that they're almost unspeakable. Things like, if you guys remember, not testing the vaccinated, things like not recommending vitamin D, not checking vitamin D levels, I mean, things that are so, so fundamental, basic about science and medicine, and that they've been avoided. And I have to say, I'm going to call it out. And I'm known for this, I call it like I see it. I'm calling attention to the corruption.

If you look at these innumerable failed policies, there's only one way to understand them. They are literally written by pharmaceutical companies. Almost every single policy serves the interests of a pharmaceutical company. However, if you look outside the United States and look around the world, there have been numerous successes.

As one of the world's experts on ivermectin, let me just talk about some programs which used ivermectin. My colleagues here, as Dr. Risch just pointed out, there are a number of compounds that we've identified that are effective in early treatment. Almost all of them are repurposed or generic. But let me just say a few words about ivermectin and what it's doing around the world, not in the United States.

In the United States, it's a horse dewormer. It's horse paste, and only the illiterate, ignorant and/or unvaccinated use it. But let's talk about some of those successful programs. Number one. Across the world, there have been programs by health ministries, which employed either widespread distribution or test entry programs.

I'm going to list them for you today. Listen, well. That medication has been shown to literally solve the pandemic in numerous regions around the world. Mexico City, December of 2020. Their state health system deployed an early test and treat program.

They deployed 250 mobile testing units throughout Mexico City, and they had treatment kits. They used and they collected data on 120,000 people. 50,000 of them took treatment kits, and they found in those who were given treatment kits that up to 75% avoided hospitalization. Up to 75% avoided hospitalizations.

Their hospitals emptied. Argentina, La Misiones, another house ministry, early test and treat with significant dosing for five day strategy. They found that over 4000 patients again 75% reduction in need for hospitalization, and an 88% reduction in death. They were avoiding hospitalization and avoiding dying. The miracle of Uttar Pradesh, which is not covered in any newspaper in almost any country around the world.

They literally eradicated COVID from its borders. It's a poor state in northern India, using 90 over 70,000 healthcare workers distributed across the country or their state. They visited 97,000 villages. They tested early. They gave everyone ivermectin in early treatment. They gave household members ivermectin for prevention and all of the health care workers took it.

In September of 2021, they reported that in 67 of the 75 districts, there was not one active case. Their positivity rate in the previous two and a half million tests was .007%, which is effectively zero. They eradicated COVID from their borders. This was not covered. This was not covered. Two newspapers in India covered this and the word ivermectin was not mentioned.

The Brazilian city of Itajai. This is a paper that was published in the last two weeks. It is one of the most remarkable studies in the history of medicine, because it included complete data on 160,000 people in the city of Itajai where that health ministry in June of 2020, offered its entire citizens inhabitants the opportunity to take ivermectin as a preventative.

113,000 people decided to and something around 50,000 did not. And when you compare the two groups, even though the group that elected to take it was sicker, older, more overweight, much more disease, they got the disease 50% less, they went to the hospital 68% less and they died 70% less often. It is a truly remarkable study using immense amounts of data. La Pampas, Argentina, same thing - early test and treat program showing that the need for ICU or death fell by 50 and 60%.

Peru did mass distributions long ago in 2020 until they stopped doing it because their administration changed. But they showed in all of the reasons why they did mass distributions, mortality rates and case counts fell. It is a highly effective medicine, even in Japan. Even in Japan, the president of Tokyo Medical Association announced to all doctors during a summer surge that they should use ivermectin in a treatment.

Within weeks, the hospitalization rates reported out of Japan were lower than at any other time in the pandemic. That medication works. And when you deploy an early test and treat strategy, you can cure and solve this pandemic. That information is being buried. Why is that happening, you might ask. I'm going to say that what I've just reported today that information is being suppressed across most of the world.

United States health agency structures and policies created over the last 50 years have tightly intertwined the pharmaceutical industry with public health institutions, resulting in repeated policies, placing pharmaceutical industry interests ahead of the welfare of US citizens. The industry's capture of our health agencies combined with their increasing financial control of most major media, social media

and medical journals has led to an ability to widely suppress and/or distort any information which supports the efficacy of repurposed low-cost off patent medicines.

This war has been going on for decades and there's decades long war on repurposed drugs waged with the ever present goal of protecting the market for novel patented, obscenely profitable and often barely tested and toxic medications has reached a pinnacle in COVID-19. It's an absurdity. It's an obscenity and it's a crime. It has to stop.

The impacts of their disinformation war and repurposed medicine now constitute crimes against humanity, given the global morbidity and mortality and loss of social, societal and economic liberties that could have been avoided if such information would have been widely disseminated.

Senator Ron Johnson 37:44
Thank you, Dr. Kory. Next presenter will be Dr. Richard Urso. Dr. Urso is a medical doctor and scientist who graduated AOA with highest honors from the University of Texas School of Medicine. He continued with five years of postgraduate training and research, is the sole inventor of an FDA approved wound healing drug.

He's gone on to repurpose many other medications for usage in scarring, wound healing, inflammation, and viral infection. He is the former chief of Orbital Oncology at the University of Texas, MD Anderson Cancer Center. He's been involved in COVID-19 since March 2020, discussing pandemic response and he's treated over 1600 COVID patients.

Quick, Dr. Urso, I've always thought of you as an ophthalmologist. You are ophthalmologist, correct? So obviously, you have far greater qualifications, but I always did, I always was wondering what was the ophthalmologist treating adult COVID patients? But...

Dr. Richard Urso 38:46
Yeah, that's a great question. So, what I'll... I'll get to that. I'll weave that into the story. Because I have a really... I think a really positive message. So, it's been a great tragedy this last two years, but it really didn't have to be that way.

Really, I would say with my esteemed colleagues here, thank you, for all of... All of you have sort of influenced a lot of my thinking. And I think all of us will say that we have this. We know how to treat diseases. So, COVID-19, the novel Coronavirus, right from the get-go, right from the get-go...

I spent nine years in tissue culture lab doing inflammation, scarring, tumor virus work. I really just looked at it. Okay, it's a respiratory virus. What do we know about respiratory viruses? We know that respiratory viruses live about five to seven days. So, I was... As I looked at this, I thought, "Well, that, you know, that's probably going to be true for this virus." We didn't have it cultured yet, but as it turned out, in the first year of culturing the virus, I don't think any live virus was cultured past eight days.

It is usually about five, six days. So that held true. So, back in March of 2020, a bunch of my colleagues, we assembled, we started looking at options of what we can do. And it became quite

evident after talking to people in Italy and South Korea and elsewhere that that it was a respiratory virus is going to be causing a lot of inflammation. And then one of the unique things that was happening here, this respiratory virus for Coronavirus was causing a lot of blood clotting.

So, we had respiratory distress, blood clotting and inflammation. And so, as a physician, you know, those are not that... Those are easy conditions to treat. The difficult part was really attacking the virus. And at the time that I first looked, again in March, early March 2020, I found about eight things that might work based on mechanisms. And so, I think these are like, in a sense, tools in the toolbox that we ought to be trying.

So, my first patient, I treated with hydroxychloroquine, erythromycin, vitamin D, aspirin and steroids. And I literally was shocked when I went and talked about it that people were really coming at me about the steroids. Because anybody who treats respiratory syncytial virus and other viruses, the inflammatory phase is typically one of the most important phases. And of course, when Dr. Kory came out and said that he was attacked mercilessly too, but to anybody who treats disease, it really, to me, I was kind of surprised to get attacked. I was getting attacked by people who really didn't know what they were talking about.

So, what I'll say is, as people who are listening, it's inflammatory disease. It's a blood clotting disease. We have lots of medicines for inflammation. Why would you not treat inflammation as an outpatient? We have so many different drugs. Why would you not treat blood clotting? We have every... Who gets admitted to the hospital for blood clotting? Maybe a day or two, and then you go back out.

There's lots of things we have attacking the virus, you have to do that in the first week. And what has happened? We actually have drugs like remdesivir, which are being applied day 15 and 20. They have no chance of working. It's a one trick pony. It has to work when the virus is replicating.

So, at that point, what I tell people is the problem is, these drugs are... Viruses and cancer cells are unique. They use our own machinery. So, if you're not killing the virus, you're killing something. You're killing our mitochondria, you're killing ourselves. So, these are just strategies that it doesn't take a lot of thinking as a physician, I literally am shocked to see people using these drugs, you know, two and three and four, and five weeks later. They can't work.

So, at the end of the day, I think the message that I kind of want to send is, as Dr. Cole said earlier, the virus isn't killing people. It's, in sense, you know, it's the viral particles creating the inflammation, creating the blood clots. The cars versus the car parts. So, it's not dying from the cars, you're dying from the car parts. And we've had this the whole time. And I want to make one mirror, which I think is an important point.

I would tell everybody, you can take any two drugs away, hydroxychloroquine, ivermectin, and still save almost all the lives. And that's the end message, we have so many tools in the toolbox. That's the message I want everybody to hear. We can beat this disease. I'll give you one more caveat. As we went from delta to omicron, one of the things that happen and we all sort of we work together as a team, in a sense, we recognize that omicron did not employ TMPRSS2 binding.

What that means it's like, in a sense, the virus grabs onto cells, and it uses an ace2 receptor and it also uses another receptor called TMPRSS2. It's a serine protease. The bottom line is, we realized that a lot of the drugs that we were using for delta, we didn't need in this new disease. That's called the practice of medicine. We adjust, we make... That's what we do. That's, that's how we've always done it. And that's why an ophthalmologist can figure this out.

Because I had a big background in clinical medicine. I've treated, over my career, over 300,000 patients. And I'm going to say that I think what you found here, which I want to answer your… the last point that the Senator Johnson made is Why is an ophthalmologist treating? Because patients were languishing at home.

And I've treated over 1600 patients because patients were languishing at home with no treatment for inflammation, with no treatment for respiratory distress, with no treatment for blood clotting. It's absolutely absurd. And I wasn't going to let it happen. And I think, as you see in this room, all of us feel the same. Thank you.

Senator Ron Johnson 44:34
Well, thank you, Dr. Urso. I'm going to break protocol here, because I'm in charge. Because there's another question I have. And this is the $64,000 question and we'll all... I'll have all of you answered it in some way, shape or form. Why aren't other doctors using their medical skill? Why aren't they practicing medicine?

Listen, I think it's appropriate to use practice protocols. I mean, you are developing protocols and you're practicing them. But why haven't more doctors thought outside the box and again, have the courage and compassion to actually treat patients as opposed to follow the, the compassion was guideline from NIH, just succinctly.

Dr. Richard Urso 45:15
So, succinctly this. When we first came down in March, we were getting messages to go home. And some of those messages were really strong. They basically said, if you don't... If you... And this is the start, the fear came into doctors' hearts. They said in Texas, for instance, if you use PPE, that you might be criminally liable for interfering with an emergency use act. And it was pretty scary.

A lot of us were like, "What are we going to do?" or like, "Well, I guess I will wear a mask." But that only continued. It was a coordinated attack, creating fear. And doctors felt that. And many doctors are actually working in employed positions. And as time went on, they were told, in no uncertain terms, if you use these drugs, you probably will be fired. And nobody had to tell them. They're smart people. You don't have to draw a map.

Senator Ron Johnson 46:11
We'll delve in the timeline in terms of when that initial fear and let's face it, there was so much we didn't know early, but then we started finding things out to a point we are now two years later. But I want to explore that timeline with all of you in terms of... Because we have to diagnose what happened. What...

what... Why are we today in the state, in the position we're in today, with all we have learned, but we'll cover that. I'm going to have a Dr. McCullough kick off our… the next portion here.

Dr. Peter McCullough 46:37
I'm going to finish up just on this last bullet point on pillar number two, which is home treatment. And I want to see a show of hands in the room. We have roughly 100 people in the room. How many of you in the room yourself have had COVID-19?

Okay, it's probably about 70% of this room. How many of you in this room, recognizing there are doctors, there are PhDs, there are attorneys, media experts, other scientists, public citizens, how many of you personally have witnessed censorship, intimidation, or professional reprisal and damage as a result of your advocacy for patients? I want this to be recorded.

That is 80% of this room have experienced something negative in their life in trying to promote and help compassionately something positive for patients suffering with a potentially fatal illness. I want to recognize Dr. Christina Parks, and I'm going to ask her to give a few brief comments regarding her experience. Christina Parks is a PhD in Cellular Molecular Biology at the University of Michigan. She's been widely recognized as a leader scientifically, in the African American community, Dr. Parks.

Dr. Christina Parks 47:59
Hi, I just want to clarify, I do not currently work at University of Michigan. That's where I received my degree in cytokine signaling in 1999. Today, I come both as an African American, as a scientist.
As a scientist, it's quite baffling to me that we have an avalanche of data showing that it's the spike protein that causes the deleterious effects of COVID.

Alright, so but we don't see any problem with putting genetic material into the cells of our body that tell it to make tons and tons of spike protein, right. We're not adding a little bit like a traditional vaccine, and then having your body make an antibody response. We've decided let's just make the body just make tons of the spike protein. And we know that the spike protein is toxic.

The Guincho lab at Georgetown showed that the spike protein signals through the ace2 receptor, which usually doesn't signal at all, and that leads to pulmonary hypertension. This is causing inflammation. Avolio and at the Bristol Medical Center in the UK showed that the spike protein severely disrupts the functions of cells that support the heart. Maybe it's just me, but I want my heart cells to work right.

Lee et al. at a Hong Kong demonstrated the antibodies made to the spike protein cross react with our own tissues so that many people, when they make antibodies to the spike protein, they're getting an autoimmune response that can be devastating. I could go on and on and on. We know the spike protein is toxic. Why are we having our bodies make it. As an African American scientist, I'm extremely troubled about this one-size-fits-all approach to vaccination and vaccine mandates.

There is now a growing body of data showing that people of African descent respond more vigorously to vaccines containing RNA viruses and may need a lower dose. This is Gregory Poland's work out of the Mayo Clinic.

And basically, he showed that they have both a higher innate and a higher humoral response. And in order for those vaccines to be safe, we're looking at something like the MMR with measles, mumps and rubella all RNA viruses, they may need a lower dose because the higher dose when you activate your immune system, it becomes inflammatory.

If you activate it too much, it becomes hyper inflammatory. If you lack vitamin D, with much most African Americans are deficient and you cannot shut out that inflammation. So, this is something that we should have been looking at, and we're not looking at. We have decided to do one size fits all.

Dr. Peter McCullough 50:23
Dr. Parks just to keep it on track and because we're going to get to the vaccines, so...

Dr. Christina Parks 50:28
Oh, okay, I'm sorry.

Dr. Peter McCullough 50:29
Little bit, but I want your comments, just very briefly, on African Americans and early treatment, your understanding as a scientist.

Dr. Christina Parks 50:38
We need to have vitamin D, right? We need to have vitamin D sufficiency. In fact, we need to have hydroxychloroquine, not only is it... It's anti-inflammatory, but it actually modulates many of the predispositions for diabetes and hypertension that African Americans suffer from.

So, regardless of the fact that it's used to prevent viral replication and things like that, it can actually modulate the fat, the predispositions and so why wouldn't you want to give it in order to stabilize things like blood sugar levels, and in order to stabilize inflammation?

Dr. Peter McCullough 51:15
Very specifically, African Americans have double the mortality of non-African Americans and the mortalities all happen in the hospital. Are African Americans... Are they denied early treatment in the community?

Dr. Christina Parks 51:29
Well, yes, they are. My dad just died. Right? He died Friday. Couldn't get a test, couldn't get monoclonal antibodies. We treated him at home. Unfortunately, we had an oxy machine that didn't work. So, his blood saturation went down to the point where he was incoherent.

We called the EMS; they said your problem is your oxy machine doesn't work. They put oxygen on him. He went to 98% saturation. We moved him to the hospital, he recovered all his cognitive functions, he was doing quite well. But he was no longer getting medications that reduce inflammation.

He was no longer getting medications that block the histamine response, he was no longer getting the medications that he needed. And he was no longer getting, you know, lung steroids. And he just declined and declined and declined until he passed away on Friday, and I say he passed away from lack of appropriate care.

Dr. Peter McCullough 52:24
Thank you.

Senator Ron Johnson 52:24
Did you have no right to insist that your father was treated, as a as a practicing physician, you?

Dr. Christina Parks 52:32
I'm not... I'm not a physician. I'm a PhD.

Senator Ron Johnson 52:34
Okay. I'm sorry. So, but you had no right as a family member?

Dr. Christina Parks 52:38
No, it says these are our protocols. And this is all we'll do. I mean, we asked for those things specifically. I mean in my father's case; things went fairly quickly. First, they told us, "we'll send him home tomorrow with oxygen." Then they changed their story. And you know, and we asked for particular medications and they said those weren't part of those... of their protocols, they could not give them to us.

Senator Ron Johnson 52:58
We are deeply sorry. And even more deeply sorry, the fact that yours isn't the only story I've heard like that. I've heard countless stories. But Dr. McCullough.

Dr. Peter McCullough 53:07
There may be 800,000 stories like this. I want to recognize Dr. Mary Bowden. Dr. Bowden is an ear nose and throat specialist and respiratory specialist, who previously had medical staff privileges at Houston Methodist Hospital. And I want Dr. Bowden as an early treatment doctor to tell us about her hospital interrelationships to her private practice and how this has influenced her life as an early treatment advocate.

Senator Ron Johnson 53:34
And put the mic very close to your mouth, about three inches.

Dr. Mary Bowden 53:36
Can you hear me? Okay, thank you. Thank you for having me. And so, I'm sort of the real world doctor, I don't have any. I don't have the academic credentials that the rest of these esteemed colleagues have. But I am a solo Ear, Nose and Throat doctor. I'm double board certified in otolaryngology and sleep medicine in Houston, Texas. And prior to COVID, I was sort of the resource for second opinions.

I was who people came to to get an honest opinion before sinus surgery because I'm known to be very conservative. I use surgery as a last approach. And since the pandemic, now I've become basically one of the few resources for patients in the fourth biggest city in the country to get early treatment for COVID. I, you know, it all started because I had patients that needed testing and they couldn't get testing and testing was being rationed, if you remember, because we didn't have test supplies. And I was the first person in Houston to advocate the saliva test, which was great because it was contact free. And we didn't run out of supplies.

So, my practice became a hub for COVID because of that, and today I've run over 80,000 COVID test. So, in the last six months, I've really evolved into a early treatment advocate. I've used a combination of medications and up until recently, I was using monoclonal antibodies and sadly, we can't get those anymore. But, you know, I just hear so many stories. At first it was, you know, my PCP won't see me. So, they came to see me and EMT, I became the PCP.

Now, it's people are terrified to go to the hospital. So, I've become the emergency room. I'm giving high dose IV steroids. I'm giving, you know, 25 grams of IV vitamin C, but I am keeping people out of the hospital, and I've kept over 2000 people out of the hospital. If you look at current statistics, 20 of those people should be dead and they're not. So, I see a lot of high-risk patients.

I don't know if you saw my press conference, but I had, you know, a woman in her late 60s, diabetic, not taking her medications, came to me with an oxygen saturation of 82%. And she came to my clinic three days in a row she got IV steroids, I gave her 80 milligrams of solumedrol based on the FLCC protocol. Thank you. I gave her two grams of vitamin C, I gave her a slew of medications, I threw the kitchen sink at her because she refused to go to the hospital. And in prior times, I would say, "you need to go to the hospital," but she refused.

But now she's alive and doing wonderfully. And, you know, there's... it's just sickening how many patients did not receive that kind of care. And the turning point for me when I really got angry was a patient that his wife reached out to me, he's trapped in the ICU, father of six, sheriff's deputy, refused to give anything. But, you know, these hospitals give them low dose steroids, they give them six milligrams of dexamethasone, you know, three times a day.

A lot of these hospitals won't even give breathing treatments. It's ridiculous. They won't give them the vitamins. I mean. And so basically, she called me in desperation, and I testified, she sued the hospital to try to get her husband the medications he needed. I testified, we won. The hospital refused to grant me privileges, even though I have a spotless record. And I was furious. Because that's when it all changed for me and I became I became thrust into the public because of Methodist Hospital, But it's just, you know, we I've seen a lot and I'm angry and I'm exhausted.

I mean, I have one hospital I can send patients to that I feel safe to. I have one doctor, Dr. Joe Varon, who I trust that I will send my patients to, out of enormous city and I'm exhausted, I can't find any doctors to help me. And it's a huge problem.

Part 2

Tue, 2/1 6:18PM • 1:00:33

SPEAKERS
Dr. Jayanta Bhattacharya, Dr. Robert Malone, Dr. Harpal S. Mangat, Dr. David Wiseman, Dr. Richard Urso, Senator Ron Johnson, Dr. Paul E. Marik, Dr. Christina Parks, Paul E. Alexander, Dr Aaron Kheriaty, Dr. Peter McCullough

Senator Ron Johnson 00:00
First of all, thank you Dr. Bowden for having the courage and compassion to treat patients and sharing that story. We're going to come back in greater detail in terms of how the treatment has evolved, for those of you who actually treating patients, versus how it has not evolved for over two years throughout the rest of the medical establishment.

But our next presenter is Dr. Harpal Mangat. Mr. Mangat, went to medical school at the Royal College of Surgeons in Ireland, interned at Trinity College, Dublin, and then completed residencies at London and Oxford Universities before arriving in the US in 1992, where he did the same again. He is currently in private practice in Germantown and created over 1000 and has treated over 1000 COVID positive patients with good results. Mr. Mangat or Dr. Mangat.

Dr. Harpal S. Mangat 00:51
Thank you very much. First of all, I'd like to compliment you on what you said. I've been through the same here in Maryland. And it's a terrific, but what you can do is just

Senator Ron Johnson 01:01
Doctor, get your mic right about three inches from your--

Dr. Harpal S. Mangat 01:04
Okay, I want to thank you for sharing your experiences, I've had the same experiences. I'm currently at COVID Center, and a lot of people call me up for everything. And it's evolved, you have to pick up the challenge and help the patient. And the most important thing is seeing how it has evolved. When we started... We understand this disease. What I've learned from it, it's a two-step disease.

The first step is the early phase, the viral phase, and there are generic antivirals, which aren't as expensive as vitravene or these other drugs which can be used. But the whole point is after you have day seven to 10, you enter the immune or the inflammatory response. And the only way to treat it is high-dose steroids. And we should be careful as physicians because one of the problems that Peter Kory was saying, and other people have been saying all these papers came out, well, they were essentially treating the inflammatory phase with the wrong drugs.

So you got to look critically at some of these papers and understand that. So but I wanted to do is to thank my patients for allowing me to push me because they refused to go to hospital, like your your patients. And I had to figure out what... how do I treat this obese diabetic and keep him alive. And it worked.

And each time we had to bring them in, and I'm giving IV antibiotics, IV steroids as well, and I am having very good results, I am having the same experience as you did with hospitals. So, it's not just you. It's all of us. But I want to thank you for the comments you made because I think a lot of us are in the same position as we try and help our patients get better every day.

Senator Ron Johnson 02:57
Thank you, doctor. Our next presenter is Dr. Paul Marik. Dr. Marik received his medical degree from the University of Witwatersrand, Johannesburg, South Africa. He is board certified in internal medicine, critical care medicine, neurocritical care and nutrition science.

Dr. Merik is professor of medicine and chief of pulmonary and critical care, critical care medicine, Eastern Virginia Medical School in Norfolk, Virginia. He has written over 500 peer-reviewed journal articles, 80 book chapters, and authored four critical care books and has been cited over 48,000 times in peer-reviewed publications. And Dr. Merik is certainly one of those doctors who've been persecuted for treating patients, Dr. Merik.

Dr. Paul E. Marik 03:45
Thank you, Senator Johnson. And it's a privilege to be here with my esteemed colleagues. So as you said, I'm a critical care doctor, I've practiced in the ICU for 35 years, until recently and before my job was terminated, I've been treating COVID patients in the ICU since March of 2020. I've treated hundreds and hundreds of COVID patients.

So, what I need to tell you is that between four to 10% of symptomatic patients with COVID-19 ever required hospitalization across the world. With omicron, it's about 2%. In this country, 4 million patients have been hospitalized with COVID. And of those 850,000 poor souls have died. 850,000 people have died. These have been unnecessary, needless deaths.

The NIH guidelines for the treatment of hospitalized patients for COVID include remdesivir and low dose dexamethasone. Consequently, almost every single patient in this country, almost every single patient in this country is treated with a combination of remdesivir and low dose dexamethasone. The PALM study group investigated four drugs for the use of ebola The results were published December the 12th, 2019, in the New England Journal of Medicine, and that date is particularly important, because that signaled the beginning of COVID.

The data safety monitoring board of that study terminated the study of RM remdesivir, terminated because remdesivir increased the risks of death and renal failure. It was such a toxic drug; the data safety monitoring board terminated the use of remdesivir. Yet, in January and February of 2021, the NIH and the act one study enrolled patients in a study looking at remdesivir for the treatment of COVID-19.

The last patient was enrolled April 19, 2020. 10 days later, 10 days later, before the study had actually terminated, Dr. Fauci sat in the Oval Office of the White House. And he said the trial was good news. What Dr. Fauci did not tell you was that the primary endpoint of the study was changed halfway during the study. We all know that is scientific misconduct. Because the study was not going to be positive, they changed the primary endpoint.

The original endpoint was an eight point ordinal scale that included death, and the requirement for mechanical ventilation. Knowing that remdesivir would not affect those endpoints, they invented a bogus endpoint called time to recovery, which they showed in the study was statistically significant. And based on this bogus endpoint, remdesivir was approved by the FDA on October the 20th, 2020.

So, if one does a matter analysis, looking at the studies of remdesivir, the two studies which were sponsored by Gilead, show a reduction in mortality. However, if you look at the full independent studies, including the large study by the WHO, it shows the opposite effect. Remdesivir increases the risk of death.

Let me say that again.Remdesivir increases the risk of death by 3%. It increases your chances of renal failure by 20%. This is a toxic drug. But just to make the situation even more preposterous, the federal government will give hospitals a 20% bonus on the entire hospital bow, if they prescribe remdesivir to Medicare patients. The federal government is incentivizing hospitals to prescribe a medication which is toxic.

So, it should be noted that remdesivir costs about $3,000 a course. Dr. Kory spoke about ivermectin. Ivermectin reduces the risk of death by about 50%. It costs the WHO two cents, two cents. So, as regards dexamethasone, this is the wrong drug in the wrong dose for the wrong duration of time. Yet, every clinician in this country will absurdly use this homeopathic dose of dexamethasone. Why? Because the NIH tells them to do this. So, what the NIH and other agencies have ignored are multiple FDA approved drugs.

These are FDA approved drugs. These are not experimental drugs, which are cost effective and safe and have unequivocally, unequivocally been shown to reduce the death of patients in the ICU and in hospital. For example, there are 25 high-quality, so people complain about the quality of these studies, so if you select out the high-quality randomized control trials, they showed that ivermectin reduces the risk of death by 26%.

This is an extremely safe and cheap drug. In fact, it is one of the safest drugs on this planet, you are more likely to die from taking Tylenol, you are more likely to die from taking Tylenol than ivermectin. Yet, the FDA calls this a dangerous horse deworming medicine.

So, we have a whole host, as Dr. Urso and other clinicians have said, there are a whole host of drugs that have been proved highly effective for the treatment of hospitalized patients, including antiandrogen therapy, spironolactone, fluvoxamine, nitazoxanide, melatonin, vitamin C, and I can go on. So, the question is, why? Why have cheap, safe and effective drugs been ignored for the treatment of COVID-

19, which could have saved maybe 500,000 lives? And I think Dr. Kory has told us exactly why. Thank you.

Senator Ron Johnson 11:50
Thank you, Dr. Merik. And that again, that is the $64,000 question that there's not a there's not an innocent answer for it. Our next presenter is Dr. Aaron Kheriaty. Dr. Kheriaty is chief of ethics at the Unity Project, fellow at the Ethics and Public Policy Center, and the Zephyr Institute, and senior scholar at the Paul Ramsey Institute.

He was formerly professor of psychiatry, and director of medical ethics at UC Irvine School of Medicine and Ethics Committee Chair at the California Department of State Hospitals. He has testified before the California Senate on health policy and consulted on COVID policies for the University of California and the California Department of Public Health, Dr. Kheriaty.

Dr Aaron Kheriaty 12:35
Thank you, senator, for that introduction for this opportunity to speak. I want to talk about medical ethics, because I'm concerned that many of our pandemic policies have ignored foundational principles of medical ethics. During the initial lockdowns in 2020, hospitals sat empty.

For weeks hospital staff and including doctors were even sent home as we had canceled surgeries and other procedures, and we were waiting for an influx of COVID patients that did not arrive until months later. Healthcare systems spurred by perverse payment incentives from CMS, Dr. Merik overted just one of those, there are several others, caused our healthcare systems to focus narrowly on one single disease.

This had the effect of, for example, biasing our COVID hospitalization and death counts. We've heard quite a bit about that in the media in the last couple of weeks, but people in this room have known about that for two years. We effectively abandoned patients that were suffering from other conditions and had other medical needs.

The disastrous fruits of this myopia include an unprecedented 40% increase in all-cause mortality among working age adults 18 to 64 over the last year, most of which, two thirds to three quarters depending on the state, was not related to COVID. Actuaries tell us that a 10% rise in all-cause mortality is a once in 200 year disaster. This was a 40% rise. Our public health establishment has no answer for what caused that.

The ethical principle of free and informed medical consent guaranteed by the Nuremberg Code, the Helsinki declaration, the Belmont Report commissioned by our own federal government, the common rule in federal law, this basic principle of medical informed consent was abandoned. For example, when vaccine mandates required experimental EUA vaccines, the common good argument to get vaccinated in order to protect others quickly fell apart with clear evidence that the COVID vaccines do not prevent infection or transmission of the virus.

Yet, these one-size-fits-all mandates for vaccines remained. Meanwhile, public health authorities ignored natural or infection-induced immunity. Even though this remains our primary path out of this pandemic, especially as vaccine efficacy declines with time and with new variants, as we've seen clearly with omicron. Transparency, which is a central principle of public health ethics was likewise abandoned.

Along with several colleagues, some of whom are in this room, I had to file a FOIA request to obtain the Pfizer vaccine clinical trial data from the FDA, which the FDA is required under federal law to release on the day in which this vaccine was authorized. The agency came back saying that it wanted 75 years to release this data. The data for the vaccine that had been mandated for millions of Americans. Data that took the FDA only 108 days to review.

Fortunately, the federal judge just ordered this data released in eight months. Thousands, like me, have lost our jobs for declining a novel injection, whose safety and efficacy data still remains hidden. My firing from the University of California, where I served for 15 years, my entire professional career, as a professor in the School of Medicine and director of their medical ethics program, came shortly after I challenged the constitutionality of the university's vaccine mandate in federal court, a case that's ongoing.

The scientific method also suffered by a repressive academic and social climate of censorship and silencing of competing perspectives that we've heard a little bit about already. I certainly experienced that at the university. This projected to the public the false appearance of a scientific consensus. A consensus that was often very strongly influenced by economic or other political, external interests. Finally, our government and public health authorities have still not defined the thresholds for this state of emergency that is renewed every three months.

The supposed legal justification, this state of emergency, this public health emergency, for all the burdensome, COVID counter measures, right, a term that's emerged in the last few months with the militarization of public health. This is not a medical term. Physicians, scientists don't talk about COVID counter measures.

But these COVID counter measures, the infringement on our civil liberties, the censorship, of dissenting voices, all justified, supposedly, in the name of a public health emergency, the criteria for which has never been clearly defined. The assumption of emergency powers by both elected officials and unelected bureaucrats, therefore, continues indefinitely, with no end in sight, without any critical scrutiny or appropriate checks and balances. Thank you.

Senator Ron Johnson 18:46
Thank you, Dr. Kheriaty. Our next presenter is Dr. Robert Malone. Dr. Malone is a physician and scientist who serves as the chief medical and regulatory officer of the Unity Project, and president of the 17,000+ strong international lines of physicians and medical scientists.

Dr. Malone also operates a consultant practice specializing for over 20 years in advanced development of medical countermeasures for infectious diseases, vaccines and drugs. Dr. Malone is an

internationally recognized scientist and the original inventor of mRNA vaccination, DNA vaccination, and mobile non-viral DNA and RNA/mRNA delivery technologies. Dr. Malone.

Dr. Robert Malone 19:30
Thank you, Senator Johnson, ladies and gentlemen. I'm speaking to you not only as a physician and scientist but also as a husband, father, and grandfather. I'm also a COVID and lung COVID survivor, as many in this room are. In my opinion, we should not have politicized the public health response to SARS-CoV-2 and COVID-19.

This is a bipartisan issue and the physicians who are represented here are truly a bipartisan group. I'm not, although I've been characterized as a right wing proud boy. I've previously supported both President Obama and President Biden's campaigns. But the course of events has forced me to rethink a lot of my positions. And I think that's the case with many of my peers. In my opinion, many mistakes have been made. Many those have been covered here.

Now we need to look forward and base our management decisions on omicron and the current science, rather than looking backwards to data from earlier phases of the outbreak, involving virus strains, which are no longer circulating. I'm a physician and scientist with more than 30 years, have worked as a vaccinologist and clinical researcher focused on new vaccine technologies, drug repurposing, clinical research and regulatory affairs.

In fact, I have two major clinical trials currently ongoing with the support of the Defense Threat Reduction Agency, and the leadership of Lighthouse, which I serve as a consultant to. Early in my career, during the late 1980s, I had a series of discoveries which led to nine issued patents, which describe the original platform technologies upon which the current mRNA vaccines are based. I've spent my entire career focused on developing ways to protect people from infectious disease threats, including both naturally occurring and engineered pathogens.

Good case can be made that whether you agree with what I say or disagree, it's certainly valid that I should have a role in discussing the current data. Regarding the currently available mRNA and adenoviral vectored vaccines, the science is settled, it's not a political issue. These vaccines are designed for the original Wuhan strain but are mismatched for omicron. They do not prevent infection, viral replication or spread to others.

In other words, the vaccines are leaky, they have poor durability. And even if every man woman and child in the United States were vaccinated with these products, they cannot achieve herd immunity. Furthermore, they're not completely safe and the full nature of the risks remain uncharacterized. It usually takes us many years to fully understand the risks of vaccines and certainly new vaccine technologies.

If there is risk, there must be choice. Dr. Kheriaty has just shared the legislative and ethical background for that, nicely summarized. Informed consent based on full disclosures of risks is an absolute necessity for any medical procedure. You all know this. When you go to the doctor, if you have a medical procedure, you go to the surgeon, they describe the risks, benefits and allow you to make a choice.

This is particularly so in the case of products used under an emergency use authorization. In contrast, omicron is highly infectious, readily affects those who have been vaccinated, is generally associated with mild disease, and rarely, if ever, it causes death. Mandating these vaccines makes no sense and is completely inconsistent with the core principles of Western bioethics, developed since the Nuremberg trials and codified in federal law as the Federal Carbon Rule.

If I may quote, in May of 1995, Nelson Mandela said, "There can be no keener revelation of a society's soul than the way in which it treats its children." In my opinion, our public policies in managing this have had a particularly strong adverse effect on our children. And vaccine mandates for our children are completely unjustified at this point.

In closing, I always like to try to end on a positive note. Americans are good people. We're committed to the importance of integrity, human dignity, and community. The world still believes in the importance of the American experiment, of American ideals, and still looks to us to provide leadership during these difficult times. I believe in the vision of the United States.

In the vision of the shining city on the hill, and that vision of Camelot and I have faith that we will be able to overcome these difficulties as we have had all prior challenges. It's time to come together and move forward using fact-based reasoning, rather than outdated and politicized policies, which are not consistent with current scientific data. I thank you for your attention.

Senator Ron Johnson 25:06
Thank you, Dr. Malone. Our final in-person presenter is Dr. David Wiseman. Dr. Wiseman was a top research bio scientist at Johnson&Johnson and now runs his own product R&D business Focused on internal scarring and pain he established a patient group and co-founded the first integrated clinic.

His raw data analyzes reverse negative studies used to justify COVID policy for hydroxychloroquine and ivermectin. He has made 13 FDA, CDC or other government submissions on COVID and is the World Council for Health's coordinator for vaccine injury. I was certainly made aware of Dr. Wiseman from the email group but also from his presentations in front of federal health agencies. Dr. Wiseman.

Dr. David Wiseman 25:49
Thank you. Okay. Thank you, Senator, for your leadership, and for inviting me to this distinguished panel. So, my friend called me a week ago, he said, "Watch this new movie. It's called Don't Look Up." And I told him, "Listen, I don't need to look at this movie. I've been in this movie for the last two years." In the final scene, DiCaprio and Jennifer Lawrence try and just try to distract themselves from the inevitable by prattling on about coffee beans. It's not helping.

And DiCaprio observes, "We really did have everything, didn't we?" And that's where we are. We have the finest scientific institutions in the world. They had some problems, but they were still the finest - NIH, FDA, CDC. With almost 900,000 deaths, CDCs advisors are tired, confused and despondent. Boosting is "the Last Whack a Mole." Neither sustainable or smart. They're confused. We thought vaccines would return us to work. Now. The wounds of vaccine divisiveness will take years to heal.

My movie trailer is more upbeat. I call it look up a time to heal. Watch us discover data missing from an EUA revoking study that yields a 42% reduction in COVID with hydroxychloroquine. Watch us discover how a policy shaping paper in JAMA shows 56% COVID reduction with ivermectin. Who did it? Was it FDA? Perhaps it wasn't? If FDA can wade through molnupiravir and paxlavid potential spawners of dangerous variants, will they seize this Get Out of Jail Free card that we're giving them? Or will they be sucked through the vortex of the vaccine syringe onto planet omicron where two doses barely offer protections say Pfizer or even anti efficacy.

Were trying to boost maybe immunologically equivalent to heroin addiction with ever less benefit for ever greater risk of harm and increased all-cause mortality? How safety signals evaded detection? How was FDAs risk-benefit analysis for children off by up to 56 times. Why were key Pfizer, Jensen, or molnupiravir data not verified? The movie at this point glimpses hope when FDA and CDC acknowledge VAERS underreporting by five to seven times.

But it takes another twist. The vaccines are not what we think they are. They meet FDA's definition of gene therapeutics. They could need 15 year studies for cancer, autoimmune and other concerns. Perhaps Quasi vaccine better describes these novel vaccine-like drugs. FDA, say they contain nucleoside modified mRNA or Mod RNA.

Why aren't we using that term? Hidden in plain sight? These mod RNA quasi vaccines contain parts of human genes, not just the viral spike genes as popularly understood, and I have the papers here. Find out what we think they are doing there and how the vaccines are engineered to go outside of the arm where we were told the vaccines would stay.

We all want answers, none more so than those who suffer from vaccine injuries. Every vaccinated American should be concerned about what we call post COVID quasi vaccine syndrome or pCoQS. Possibly a medical and economic problem far greater than COVID. Is this the sequel? FDA says stop taking the horse drugs. I say stop feeding us the horse bleep. You can't keep this up.

America wants to see FDA listen not only to vaccine-injured patients, but also to scientists who started to figure out this months and months ago, establish ICD 10 and CPT codes, release the NIH study on injuries, fund research. And at this point, hot off the press, hot off my phone, we have an announcement, which I don't even know the senator knows about.

And that is Bree Dressen, who I'm, with your permission, going to ask to speak in a moment, has been trying to get hold of FDA and NIH, asking will they meet with scientists? And the answer appears to be yes. So finally, we're getting through. So, look up everyone. Look up FDA. It's time to heal. Thank you.

Senator Ron Johnson 30:50
Thank you, Dr. Wiseman. But let me ask staff do we have Dr. Bhattacharya's video cued up? Can we run that?

Dr. Christina Parks 31:00

I did not finish my testimony on vaccines. Should I do that now?

Senator Ron Johnson 31:04
Oh, sure.

Dr. Christina Parks 31:05
Because I was a little bit confused about where we were in the in the thing. So, I just want to stress again, that African Americans have many predisposing mutations that are very protective for malaria, we have betathalassemias, we have sickle cell trait, we have glucose six phosphate dehydrogenase. When their system is stressed, they lose their ability to carry oxygen effectively. One in 10 males of African descent has glucose six phosphate dehydrogenase deficiency.

It's sex linked. That means one in 10 could basically devolve when their system is highly stressed, either under COVID, or as a result of a vaccine. Do we screen for this at birth? No. Are hospitals ready to give a transfusion when someone does this? No, they don't even know what's happening. They just ignore the whole thing.

And so, in this light, my son is Ethiopian. And we know that Gregory Poland's data showing that people of African descent generate a much more vigorous immune response that could go hyper inflammatory in response to vaccines. That is some of the most significant, like statistically significant data I have ever seen. The p value is so low, it's got, you know, like negative numbers all behind it.

And so, he's supposed to get a vaccine. He's in New York City. He's like, "Mom, I can't do anything. I can't go to a restaurant; I can't do anything." So, we're in a horrific position where people of African descent are being mandated to get a COVID vaccine to stay employed, or participate in normal life, such as going to a restaurant, even though these products have not been optimized for the genetic profile.

Thus, African Americans are likely to be at significantly more risk of an adverse event than their European counterparts. Even worse, we're about to push this on our kids. Right? We know that in response to MMR, William Thompson at the CDC was a whistleblower that said, African American boys who got the MMR on time again, these are RNA vaccines. And we know again, RNA viral vaccines live viral vaccines, we have the data to show how they are affecting the immune system.

And that data showed that they were 2-3 times more likely to get an autism diagnosis, if they were vaccinated on time, right. William Thompson alleges they then shredded the data. It's 20 years later from the first study and we have not addressed the fact that not all of us are the same. And we need individualized medical care. These are not hard problems to solve. They're really not. We just need to use our brains. And we actually need to address the issue instead of making everything a one-size-all political nightmare.

Senator Ron Johnson 33:46

Thank you, Dr. Parks. Again, do we have Dr. Bhattacharya's video. Okay, we'll run that. And that will kind of conclude the opening statement part of the program. Then will be the free for all of a discussion, very free flowing. Dr. Urso?

Dr. Richard Urso 34:05
Senator, I want to just before we get on the questions, enter something into the record. I want to personally thank you. In the past, medical schools and conferences like this would take place, we'd debate on how to treat these kinds of diseases. And, you know, I.... It's kind of strange that this meeting has to take place in the US Senate.

You know, given the current state of affairs, that's where we are. But in the past, we would think that somehow the FDA, the CDC, the NIH, we would have basically maybe a message board exchange ideas. And I really want to reach out and say thank you for what you've done to Dr. McCullough and Dr. Risch who initially set all this up.

You know, the extreme censorship and attacks have led us to come to this place. And so, I wanted to just thank you for what you've done. You've really pushed this all forward. You know, as you know, you yourself have become a researcher and the scientist over the last few years. So, thank you very much.

Senator Ron Johnson 35:07
I appreciate that. Okay, thanks. So, again, what we'll do is we move to Dr. Jay Bhattacharya's description of... I think he'll probably be talking about the Great Barrington declaration to kind of wrap this all up. This is, from my standpoint, this is what might have been, this would have been certainly a second opinion of how to respond to COVID, which from my standpoint, would have been far more rational.

In my opening statement, I talked about our deaths per million, which are I think, over 2600 per million versus Sweden's 1500 per million. And I will point out that 1.8 million Swedish school children went to school, no masks, all the way through, and it may have changed, but last time, I heard not one of those 1.8 million children died of COVID. Now, again, Sweden was excoriated, criticized, you know, uncaring, you know, just an uncaring society.

Results, facts, truth matter. So, we'll listen to Dr. Bhattacharya and then we'll open up the discussion. I know there are people in the audience that have some questions, we'll call them. I can't really predict how this all goes. But I certainly appreciate the beginning. The opening statements here, I think, I think it's opened people's eyes.

And I don't see how anybody watching this today, and I think it'll be really reinforced during the discussion phase, I don't think anybody could question the credentials, the qualifications, the integrity of individuals that are sitting around this table again, this is just this is a fraction of other courageous people out there globally, trying to push back against, you know, the one-size-fits-all approach but let's start the video with Dr. Bhattacharya.

Dr. Jayanta Bhattacharya 37:11

Welcome everybody, my name is Professor Jay Bhattacharya. I'm a Professor of Medicine at Stanford University. And I'm pleased to be able to offer an alternative to the lockdown focused policies that we have followed throughout the pandemic. Those policies have not worked to stop the pandemic and have led to the deaths of hundreds of 1000s of people in United States and have created destruction and misery almost everywhere they have been tried.

As an alternative, I would suggest a plan that I authored with Sunetra Gupta, a professor of epidemiology at Oxford University, and Martin Kulldorf, a professor of epidemiology and biostatistics at Harvard University in October 2020. The basic outlines of that plan would work not just in this pandemic, but in many, many other pandemics. The plan relies on two basic scientific facts, completely undisputed.

First, that is that this pandemic, the disease in this pandemic, the virus in this pandemic, is not an equal opportunity virus. In fact, it harms people who are older at much higher rates than people who are younger, a thousandfold difference in the risk of mortality and severe disease from infection in this pandemic. A very large fraction of the population who have died from this virus are over the age of 65.

And almost 40% of the deaths in the United States that have occurred, have occurred in nursing home settings where older people with many comorbidities reside. The second scientific fact is that the lockdowns themselves are harmful to population health. The lockdowns have created a crisis in the mental health of the population in the United States and elsewhere.

In July of 2020, after only a short amount of lockdown, one in four young adults in the United States reported seriously considering suicide. It's also affected physical health, for instance, people who were... People, many people skipped cancer screening, many people skipped even treatment for heart attacks and diabetes.

All of these consequences, all of these effects on the use of preventative medical services will have long-term consequences on the health of the population. On children, the lockdown in many, many states lead to extended time away from school. And we know from an extensive literature that this leads to enormous damage to the health, long-term health, wealth and well-being of children, especially poor children were affected by this.

So, if you put these two facts together, what you have is a vulnerable population, an older vulnerable population who really do and did need protecting from the virus because they face such a high risk of death if were infected. At the same time, the rest of the population were harmed more by the lockdowns than they were by the virus itself.

The Great Barrington declaration, which is co-authored with Martin Kulldorf and Sunetra Gupta, then proposed to protect the vulnerable through a policy of focus protection, including a suite of strategies to protect older people living in nursing homes and older people and other vulnerable people living in the community at large.

Now, the lockdowns needed to be lifted then and the continuing restrictions on populations need to be restricted now, because they impose more harm than good. They do not stop the disease from spreading. As we can see, during this current wave, the disease spreads via regional and seasonal patterns.

We've maintained this very this illusion of control over the the path of this disease and attributed to basically regional and seasonal influences to our own actions, which actually have not particularly affected the path of the disease, while at same time, reached enormous harm on the population at large. So, lift the lockdowns and engage in extensive focus protection of vulnerable populations. Now, we wrote that in October of 2020.

Now we have even better tools to protect vulnerable populations than we did then. The vaccines while they do not stop disease spread, actually are quite good against severe disease, making sure that vulnerable older populations are vaccinated and protected against severe diseases is still quite important, not just the United States but around the world. Furthermore, we have better treatments, and we should be investing in research to continue to improve our treatments, and strategies to make sure that we have treatments available everywhere where someone vulnerable especially gets sick.

So, if you put these strategies together, our society can continue to function in a much more healthy way than we have functioned these past two years. While at same time working to protect older people. The strategies we followed, basically by ignoring the possibility of early treatment, by not focusing our efforts on the protection of vulnerable populations, and worst of all, these restrictions on human behavior on human connection, have wreaked enormous damage. And it's far past time that we stopped those policies and instead followed an alternate plan. Thank you for your time.

Senator Ron Johnson 42:55
So, Dr. Bhattacharya was joined by colleagues from Harvard and from Oxford and put together the Great Barrington declaration. I'm pretty sure they published that, and it was October 2020. We've since seen emails between Dr. Collins and Dr. Fauci, head of NIH and NIAID, basically, with a concerted effort to destroy reputation, destroy Dr. Bhattacharya and his co-authors.

Now, I'll ask the listening audience, does that sound like a crazy individual? Sounds to me like a highly-qualified, very reasonable person as we have in this... as we've assembled in this room. So, what we're going to move into next is the open discussion. I don't know where this is all going to go. There is so much information to cover.

There are so many topics to discuss. We're going to try and get as many of them discussed as possible. We've literally got this room till two o'clock PM, Eastern Time, we'll take up the time if we need to. When this group grew from three to six to however many we got now, I was highly concerned about overlapping of information, repeating of it. Now, some points need to be repeated. I don't think we've seen that here. And I really appreciate that.

I would, as we go forward, it's kind of a standard phrase United States Senate, what I call cattle call types of presentations, like you finally get up there and say, I know everything has been said that needs

to be said, I just haven't said it. So, try and resist that temptation. I've got a series of questions. I know you all submitted questions. I'm going to start going through mine because mine really come from the standpoint of just a non-medical professional, and also from my constituents who asked me the same questions.

So, we'll start there. But I really encourage all of you, if there's an important point that we're missing that is allied with a particular subject, but what I want to do is I want to try and group these things together. So, we're just not talking about early treatment on one hand, that hospital treatment. I'm going to go through this in an organized fashion based on Dr. McCullough's four pillars.

So, we'll start with the limiting spread, but just kind of the basics of the virus, what we know. But again, I want you to hop in, if you want to be recognized, just flip your name tag, and then I'll recognize that. Audience members can speak to my staff if you want, it's here at the table here. But audience members again, we want to keep all this succinct, and you know, doctors and professors that you know, also, keep your answers pretty succinct, so we can keep moving.

Somewhat organized, but not totally. Let me start with a question that's been on my mind that's never been answered adequately. When I got COVID, in September of 2020, I had no symptoms. The only reason I got tested is because I have contact with the public and I would do preemptive testing frequently. All of a sudden, on that one test, I was positive. So, I went home. Afraid, concerned.

I mean, I did the things, you know, things like my mouthwash, you know, something we never talked about here. Zycam, I hate to push, but that's what I did. Okay, I did the vitamin C's I did the zincs. I did all that stuff. I don't know if that helped or if I was just one of the lucky members of the public that was asymptomatic. Why we're so... Here's the question. Why were so many people that were tested positive for COVID asymptomatic? Dr. McCullough.

Dr. Peter McCullough 47:00
There's a tremendous spectrum of symptomatology in COVID-19 that there are determinants, including the individual, and Dr. Bhattacharya mentioned, age is a huge determinant of symptomatology from no symptoms at all, a younger type of senator all the way to extreme symptoms and death in the very elderly and frail. Part of that determinism is layered on to it comorbidities.

Dr. Parks went over this. Obesity amplifies the syndrome, diabetes, heart disease, kidney disease. So, the presence of other diseases amplifies symptomatology and consequences. And then leading research suggests that not everybody can actually get COVID-19. The CDC has always said about 15% of people can't get COVID-19 and it may be protective factors, such as their microbiome, the local organism content in the nasal pharynx and oral pharynx, plays a role.

It's contiguous to the microbiome in the gastrointestinal tract. One of the things we've learned that we can leverage on this is the use of nasal virucidal washes. You mentioned gargles. There are now 12 clinical trials using dilute povidone iodine or dilute hydrogen peroxide as an intentional, very thorough nasal wash and oral gargle, that dramatically reduces the percent positivity of PCR, it drops the intensity and duration of symptoms and improves outcomes, randomized trials included.

Dr. Richard Urso 48:31
Senator?

Senator Ron Johnson 48:32
Yeah, Dr. Urso.

Dr. Richard Urso 48:34
Your question sort of begs the answer to Does asymptomatic transmission occur? is basically what you're saying. You were asymptomatic at the time, okay? So, that has never been the driver of a pandemic, or an epidemic of any kind. Asymptomatic transmission has been used during this pandemic to create fear over and over.

Asymptomatic transmission, if you look at the studies that have been done, I think there's like seven or so basically, asymptomatic transmission is responsible for less than 1% of cases. What you do see and people who are asymptomatic, quote unquote, is when they convalesce at home, an interesting phenomenon sometimes occurs where the other family members and other close contacts also become asymptomatically, in a sense, they convert their T cells and you can measure their immunity.

But my point is that asymptomatic people, and I think this has been a fear for many in this country, that asymptomatic transmission is occurring. And so, I think the answer to that is it is not a driver of this pandemic, and it's been a driver of fear. And I think it's important to let that be known.

Senator Ron Johnson 49:54
So, one of the concerns or I think one of the things that we learned is, all the shutdowns drove people to confine themselves in their home and with a virus that spread through aspiration probably it was the... probably the worst response. I mean, is that basically true?

Dr. Peter McCullough 50:13
Let's have I would like to have Paul E. Alexander, just recognize your work and your scholarship and all the public health measures you've analyzed in your work.

Senator Ron Johnson 50:24
Dr. Alexander, just kind of quick state your credentials. And...

Paul E. Alexander 50:29
Dr. Paul Alexander. My background is in evidence-based medicine. And I'm a clinical epidemiologist, I worked prior with WHO and PAHO in DC. And I also worked for Trump administration as a COVID advisor. So, I wanted to want to touch base on two things quickly, to support Dr. Marik.

That day that they released a study NIH on remdesivir, that morning, about 11 o'clock, there was a high level paper published in The Lancet by Wang et al. on remdesivir. And they found that there were 60% of adverse events in both groups, remdesivir group and placebo, and they stopped that trial early for

harms. So, when NIH released this study, in the afternoon, it was on the heels of a devastating study on remdesivir.

I wanted to put that on the record. Now, in terms of what Dr. Urso said, it's an excellent point, we've looked at the body of evidence on asymptomatic transmission. And we looked at all of these studies, and probably it is exceptionally rare, if at all it exists, probably at around 0.5%. It's very similar to the issue of recurrent infections. We've looked at the body of evidence across time. And we found that the idea of reinfections and recurrent infections is exceptionally rare.

If at all and is often an issue with a suboptimal interpretation of the PCR results, we would actually like to see at least a 90 day period between test one, test two. We want to see at least two tests, positive PCR or antigen tests or genomic sequencing. So, there are a lot of problems and what Dr. Urso said is absolutely correct.

The issue about asymptomatic transmission was used as a tool in this pandemic, to drive fear and to get the population to almost lockdown and fear. And you had 15 year old Johnny, who's at the prime of his life, hiding at home, thinking that he was at the same risk as 85 year old granny with three underlying medical conditions. And that has been a tragedy here, the fear in the population.

Senator Ron Johnson 52:44
Dr. Alexander, while you're at the table, because I know, in the email groups, you've done in the group, I would say, society a real service in looking at all the studies. And one of them, in particular, as you've pointed out all the studies on the effectiveness of natural immunity. What's baffled me, I think in May of 2020, either FDA or CDC recommended against testing for antibodies and prior to vaccination.

We'll get into vaccine injuries here later. I think one of the concerns and this was expressed, I know talking to you, Dr. McCullough, early on, that if you're... You know, with a flu vaccine, the first thing, and again, I'm just a layman, you go, and you get a vaccine, the first thing they ask you is are you sick today? We didn't do that with the with the COVID vaccines. So, can you just quickly talk about all the studies that talked about the benefit of natural immunity? And also, why it probably would have been a good idea, certainly in light of mandates, to at least test somebody for antibodies and recognize natural immunity in this response?

Paul E. Alexander 54:03
Thank you. That's an excellent question. I've done a lot of work with Dr. Risch and Dr. McCullough, people like Dr. Cole on natural immunity. We looked at all of the available evidence and science, we compared the effectiveness research as well as high level papers published for people like Dr. Marty McCurry out of Johns Hopkins.

And we put together about 150 pieces of evidence and we've found conclusively that natural immunity is not just equal to but far superior to vaccinal immunity. And I think there was dismissed perception from around the fall of 2020 to the beginning of 2021 when the vaccines were beginning to get to the completion phase and the rollout.

There were some studies put out there some small studies saying that look, your blood antibodies are waning, so, therefore, you're losing your immunity. But these public health officials at CDC and NIH, they knew better than that, they knew that they were misleading the public and they were misleading the government and the population.

They knew better than that, that your serum antibodies can win. But they knew that we had another compartment, your cellular immunity along with B cell immunity, T cell immunity, that was robust, potent, lifelong, durable. We had a study done around 2008-2009, published in CIDRAP, that looked at the persons who there were some persons still alive at about 95 years old from the Spanish flu, and they were infected.

And what the research showed is that those persons who were still alive, their blood still produced a cellular response, T cell immunity to Spanish flu, 90 years prior. That evidenced to us the robustness of the immunity. And the reality about it is that to be very specific, what we should have done was, in rolling out this vaccine program, and I have been an advocate, I questioned the vaccines only to be focused for high-risk groups, potentially 70 years and above, but across the board, no one else.

So, I want to put that on record. I'm not in support of these vaccines. I am in support of vaccines that are properly developed, with the proper duration of follow-up, with the proper safety testing. These vaccines have not... Children should never get these vaccines. But what we should have done, what we should have done was before anyone was given a vaccine, in conjunction with proper informed consent, which I argue globally has never even happened today. Informed consent has been abysmal.

But we should have done some serological testing for antibodies, or we also have a test availability to T detect test for cellular immunity, etc. And that has been a catastrophic failure. Because we've been vaccinating people who've already recovered from COVID. We have good studies by Kramer, by Matteo Dacus, by RA. And there are three additional ones that show if you layer vaccine immunity, antibodies on top of COVID recovered antibodies, you are at an increased risk of ending up in hospital.

Senator Ron Johnson 57:31
Okay, thank Dr. Alexander. And go to Dr. Malone first and Dr. Kheriaty, but I don't want to, you know, miss this question. Why was there the assumption on the part of federal health agencies that natural immunity wasn't worthwhile? But let's go to Dr. Malone, put his tag up first, and go Dr. Kheriaty.

Dr. Robert Malone 57:52
Okay, I'm going to punt on the why question. For some reason, they don't consult with me,

Dr Aaron Kheriaty 58:00
I'll try to answer the why question, Robert. So that's...

Dr. Robert Malone 58:03
Okay, you got that. So, I think I may be the only representative here from the virology and vaccinology community. And so, I'll do my best to address your original question. And I used to be at primate

research center, California Primate Research Center investigator very involved in vaccine development and challenge studies.

In answer to your question, why do we see this spectrum of disease, I agree that there's, it's clear that the preexisting conditions in the individual are crucial, and the dose of virus is also crucial. We know very well, in my community, that virtually any vaccine can be overwhelmed with a sufficiently large dose of pathogen. This is a complex dynamic interaction between the effectiveness of your natural immunity.

This is prior to infection, even prior to recovery. We, in our world, we talk about innate or natural immunity, it's kind of a different definition from what the public has now acquired. But in any case, we all have differences in our preexisting conditions. We all have a genetically diverse immune system, that's a good thing.

Because it means that a pathogen can't take all of us out because we're all different. Diversity is good in immune response. But specifically, regarding your question, the dose is crucial. And perhaps what happened was that you received a very small dose, you mounted at immune response, you generated a more indolent, slowly developing progression of infection, and your body handled it naturally, which is why you were asymptomatic You hardly even noticed it.

And so, I think we need to just keep in mind that there's complex dynamics here. It's the host, it's the pathogen, it's how much pathogen you get, t's your level of vitamin D, all at the same time. But I just wanted to kind of nail that down that the dose of the virus matters over. Oh, one last thing regarding the natural immunity, I've been traveling to Europe quite a bit.

And the Europeans are always a little gob smacked because in most European countries they do recognize natural immunity. And it's perplexing that the United States government with its massive public health infrastructure does not recognize the obvious where even small obscure European countries do. Over.

Part 3

Tue, 2/1 6:19PM • 56:11

SPEAKERS
Dr. Ryan Cole, Dr. Robert Malone, Dr. Harpal S. Mangat, Dr. Ben Marble, Dr. David Wiseman, Dr. Richard Urso, Senator Ron Johnson, Dr. Paul E. Marik, Dr. Christina Parks, Dr. Harvey Risch, Dr. Pierre Kory, Paul E. Alexander, Dr Aaron Kheriaty, Dr. Peter McCullough, From background, Steve Kirsch

Dr Aaron Kheriaty 00:00
So, the CDC and other public health agencies have given two reasons for avoiding acknowledging natural immunity in terms of their vaccine-related policy. So, I'll mention those two. And then I'll mention a third that I think is also operative. The first worry and I served on the Orange County Vaccine Taskforce, I helped the University of California develop our vaccine allocation policy, not the vaccine mandate.

They didn't consult their own bioethicists on that policy. But I was involved in vaccine rollout policy and ethical questions about who should get the vaccine first, when the supply of vaccine was insufficient to meet the initial demand. You remember, in the early days, you know, who gets in line first, who gets it first? One worry that public health officials have mentioned is, well, if we acknowledge that natural immunity is a reality, which of course it is.

And it's, it's been a... It's epidemiology and immunology 101, they're worried that people would go out and deliberately get COVID rather than getting the vaccine. But of course, the issue around acknowledging natural immunity is what about the people who already have had COVID? That's what we're talking about here, right.

And we can give people advice on, you know, avoiding infection and so forth. But ignoring all the folks that have already recovered from COVID is not a good public health policy. The second worry was, it was going to decrease the efficiency of a needle in every arm, right? If we have to ask people, who have they have had COVID, or have been bring medical records, or run a lab test to verify antibodies or T-cells that may slow down what we want to be a hyper-efficient process.

And of course, the response to that is don't put the burden of proof on the people responsible for giving the vaccines. Just simply put the burden of proof on the individual recipient of the vaccines, if they want to decline the vaccine, and cite natural immunity, then, you know, they can go get the test, they can go to the--

Senator Ron Johnson 01:59
Until they were mandated to get the vaccine.

Dr Aaron Kheriaty 02:02
Right. Well, so that's the issue. And I've been interested in this because my lawsuit against the University of California's mandate is precisely on behalf of people with natural immunity. The third reason that went unspoken, but I think is absolutely undeniable, is that acknowledging natural immunity would lead to the next very basic question how many people have it, and the fact that two years into the pandemic, we still do not know exactly how many Americans have had COVID is astonishing.

It's an astonishing failure of public health to do basic epidemiological research. The two most basic facts that every medical student learns first about every new illness that they learned about are incidence and prevalence. How many new cases and how many total cases over a given period of time, right? So, let's run population based randomly sampled T-cell testing or ongoing antibody testing to find out each month, how many Americans in what regions have already had COVID? Seems rather obvious.

Well, if we do that, we're going to find that, you know, prior to Omicron, it was probably over 50% by most estimates. After Omicron, many people are estimating 70% or more have had COVID. The public health establishment was afraid of those numbers because they would see it rightly or wrongly, as an admission of policy failure.

Why is that? Well, the lockdowns, the masks, the mass vaccination campaign, all of this was supposed to stop the spread of this virus. And yet, 70+ percent of Americans got Coronavirus anyways. Not exact... Not a smashing success. Exactly. Exactly. As part of my ancillary efforts surrounding my lawsuit, we also filed the CDC... a FOIA request to the CDC saying, "please show us one case of someone getting reinfected." And you know, we can debate about how common reinfections are with natural immunity.

My own view is that they're quite rare, maybe a little more common now with omicron, but always milder than the first case. Almost no cases of hospitalizations and death. So, one very important fact about natural immunity is that there has not been a single reported case of someone getting reinfected and subsequently transmitting the virus to others, which we know is not the case for vaccines. Vaccines don't offer, against COVID, that kind of sterilizing immunity.

So, we FOIA the CDC and said, "Please show us any evidence of someone with natural immunity getting reinfected and transmitting the virus to others." They couldn't come up with any data. We actually put that in our lawsuit the university's experts could not come up with a single counter example. It's very dangerous thing to say, right? Because almost nothing in medicine and science is 100%. You can always find outliers. But natural immunity. People with natural immunity are the safest people to be around. You're not going to get COVID from somebody who's already had COVID.

Senator Ron Johnson 05:16
So, I mean there are so many questions that pop in my head just as people are talking and we've already got the four name tags turned upside down. I have got to quickly ask this one though. And again, I'm not a medical researcher but as I was reading about this, it seems like prior to the

Coronavirus, there were already about three coronaviruses that would infect humans and cause a cold, right? Otherwise, is rhinoviruses. Is omicron... Is that just like one of those cold viruses now? Ryan, go ahead. Yeah, you can put it down right away.

Dr. Robert Malone 05:58
I was hoping that someone else would take that hot potato.

Senator Ron Johnson 06:02
Oh, is that?

Dr. Ryan Cole 06:02
Robert? Robert? I can take that. Like, this is an excellent question. We have a new virus right now. Omicron. It has nothing... If you look at your family tree and you see the funny uncle that really doesn't look like the family and maybe the milkman came along somewhere. That's what omicron is. Okay, he's not on the family tree, he probably actually snuck into the family somewhere. So, it doesn't branch off of the other variants.

Omicron has enough mutations, the backbone of it actually looks more like a pre-Wuhan virus from a genetic point of view. It is behaving like a common cold to the point of what Dr. Urso said earlier. It doesn't bind in the lungs like the previous variants did. It doesn't cause the degree of clotting that the scary earlier variants did. We have been blessed with almost a natural vaccine.

It is essentially... Now, if you had COVID and your COVID-recovered, you tend to get less disease with omicron symptomatologically. However, we are finding that those who have gotten the shots are getting omicron, the vaccines are negatively effective, meaning you're actually getting omicron at an enhanced higher rate.

Now, there's a reason for this. And this is basic immunology. If you get a shot in your arm, you don't have a tendency to... You... Everybody hears about antibodies, but there's a special kind in your tears, your nose, your mouth, called secretory IgA. It's little mops in your tears. If you've had a natural infection, you have high levels of secretory IgA, these little mops in your mucosal membranes. And that mops up virus quickly.

The virus from... I'm sorry, the response from the vaccine, you don't get this physiologically. So, we are seeing actually the vaccinated carry a high volume of virus because they don't have the secretory IgA. So, this false construct from our federal agencies that this is a pandemic and the unvaccinated are spreading is a pathophysiological lie.

The vaccinated are carrying high volumes in their nose, their tears, their mouth a virus, because the vaccine does not neutralize in that location of the body where the virus comes in. So, this is very important. This is why mandates are absolutely now moot, irrelevant, and out the window and need to go away worldwide like most of the world has done already. This is the funny uncle. This is not SARS-CoV-2 COVID-19. This is COVID-22 meh, you know.

Senator Ron Johnson 06:05
Okay, Dr. Cole.

Dr. Ryan Cole 07:48
So, it may not even be a variant of the coronavirus. This might be a naturally occurring may not even be a variant of the coronavirus. It's a coronavirus, no doubt.

Senator Ron Johnson 08:56
But not THE coronavirus.

Dr. Ryan Cole 08:58
It's essentially, it's going to be a more of a common cold. Like the other ones, you just correctly mentioned, that have circulated for decades and years that we've known in the human body. That's part of the reason why many of us didn't get very sick. Because we've had those common colds and that good T-cell innate immunity, the ability to say hey, I've had a lot of Corona common colds, my body can fight this off.

You're likely asymptomatic because as you travel the world you probably had some of those. So, yeah, again, this is that funny uncle that doesn't belong. This is a blessing to humanity, the frail, the fragile, the comorbid die of common colds everywhere every year, no matter what common cold it may be.

So, we still need to be cognizant of those things. Do some of the early treatments still work against this and make your symptoms less? Absolutely. Is your risk of death from this one far less? Absolutely. Is your risk from hospitalization from this less? Absolutely. Is South Africa opened backup? I've talked to my colleagues, they're like, absolutely. It's common cold. What a blessing. We're done. We need to do the same.

Senator Ron Johnson 10:12
Dr. Parks. And I want to talk. That was my first question. Okay.

Dr. Christina Parks 10:06
... something for omicron? I was going to address the PCR tests

Dr. Robert Malone 10:16
Yeah, I didn't want... I didn't want to get the way it was worded. Is this a separate beta coronavirus. But I wish to say, I've just come from Europe from the opportunity to spend time work with and learn with Dr. Geert Vanden Bossche, who has been the leading proponent worldwide of the position, which I gently suggest the senator and his colleagues really...

It merits paying attention to. One of the things about Omicron that's rather odd is that the data are showing that the vaccinated seem to be more prone to becoming infected by omicron and there may... or there is some indication in the data... This is, I'm going to voice this as my opinion based on the data that I've looked at, primary data from a number of countries. So, it's my opinion. There's evidence that omicron is associated with a higher risk of infection in the vaccinated population.

And that that increased risk is a function of the number of vaccine doses that one has received. Omicron we are truly blessed. As I said back before Christmas, that omicron has such low risk for severe disease and death. However, it's got a warning sign. And it's what Geert has been warning about and what the FDA has acknowledged in the original documents allowing the emergency use authorization, in which they told the pharmaceutical industry that they desired that the pharmaceutical industry would investigate the risks of antibody dependent enhancement, or vaccine enhanced disease.

What Geert has been warning us about, quite stridently, is if we continue to implement this universal vaccination policy rather than the position of the Great Barrington Declaration, which I've supported in multiple op eds in The Washington Times, among others. If we continue to pursue this universal vaccination strategy, in the face of the pandemic, particularly with omicron now, a much more highly infectious, highly replication competent virus, what we risk is the driving the virus through basic evolution to a state where it may be more pathogenic and more able to elude immune response.

So, in sum, I don't wish to scare, we've had enough fear porn, but if we continue to pursue universal vaccination, the high probability is that what we will continue to see is the evolution of additional escape mutants that are increasingly infectious and may well become more pathogenic. This policy of forced universal vaccination is absolutely contrary to all of our understanding about basic viral evolution. We are clearly seeing the development of escape mutants that are resistant to the vaccine. Omicron is not only resistant to the vaccine, but its effectivity seems to be facilitated by the vaccine. And in my opinion, this must stop for the sake of the world. Over.

Senator Ron Johnson 13:42
Again, Dr. Geert Vanden Bossche, right, he's South African. He wrote a letter to the World Health Organization, well before these vaccines were approved, warning about the vax... mass vaccination into the midst of a pandemic. And those warnings went unheeded, and I've always said too, and there's so much we don't know.

Dr. Robert Malone 14:08
Minor modification--

Senator Ron Johnson 14:09
It would indicate to you some caution.

Dr. Robert Malone 14:12
He's Belgian.

Senator Ron Johnson 14:13
I am sorry.

Dr. Robert Malone 14:13
But it's a small nuance. He's actually corresponded also with some of the, what I believe to be, the world's leading vaccinologist, and he asked me to not disclose the name. But a gentleman who is

headed major vaccine companies, highly respected, innovative individual who completely concurs that this is what we're doing.

Senator Ron Johnson 14:36
Okay, Dr. Parks. Again, we're veering in vaccines, which I know we'll get to and by the way, we have all kinds of questions online, which shows the interest, Five hours won't be enough time but let's try and stick to the, you know, kind of the--

Dr. Christina Parks 14:50
Right, I want to go back to your original question. So, it's possible that you had a false positive PCR test and I just want to dress the PCR test because many people don't really understand what it is. A PCR test amplifies the signal. And the PCR threshold, the number of cycles, each cycle amplifies the signal one, so we go from two to four to eight to 16 to 32.

And you get to the point where you have a lot of amplified viruses. So, you need to have that cycle set low enough that you're only getting virus, because if you have it set really high, if there's no virus there, it's going to amplify something. And you're just going to amplify garbage. And so, your false positive may have just amplified garbage when you have 40 cycles of PCR. And so, that's something that is really of concern, because we're having our athletes tested, where, you know, we have all this high, high mortality in our young people.

And we're kicking them out of sports because of false PCR tests, or possibly they had some fragment of the virus, again, parts of the virus, the virus has been destroyed by their innate strong immunity, right, our young people have very strong immunity, they blow that virus apart. They still have parts, but they're not infective. They get that positive PCR test. Now, they can't play sports, now everyone has to be quarantined, bla bla bla bla bla. So, this issue of the false PCR test really does need to be addressed.

Senator Ron Johnson 16:14
Thank you. Dr. Wiseman. Quick, again, I want to just try and keep this thing moving. There's so much ground to cover.

Dr. David Wiseman 16:22
Yeah, I just want to briefly pick up on natural immunity. And I want to point out two very important studies that show either 88% or 77% protection from natural immunity, and the studies were performed by Pfizer and Merck.

Senator Ron Johnson 16:37
Now, when you say natural immunity after COVID infection? By the way, I did have antibodies. So

Dr. David Wiseman 16:42
So, in the Pfizer study for... Oh, looking... The Pfizer study for the vaccine, excuse me, and the Merck study for the molnupirovir, they looked at people who were already zero prevalent at the time of the study. And when you compare those people, the placebo groups that were either yes, zero positive, or

no or zero negative, there was an 88 or 77% protection against COVID from Pfizer's own study and from Merck's own study. So, thank you, Pfizer, and thank you, Merck. 77, 88%. That's a very important thing. Dr. Alexander talked about 140 different studies that have shown-- Yeah, well, I think these are very important. I mean, yeah, there are 140, but I'd like to quote Pfizer and Merck. Thank you.

Senator Ron Johnson 17:36
Okay. That's for the information they do make available. Dr. Marik?

Dr. Paul E. Marik 17:39
Yes, to follow up on with your question.

Senator Ron Johnson 17:44
Yeah, like.

Dr. Paul E. Marik 17:45
To follow up in your question and what Dr. Urso and McCullough have said, the most important factor in determining progression of diseases symptoms is viral load. The viral load in your nose, or pharynx is really important. So, that's where the ace2 receptors are. That's where the virus replicates. Many factors affect the viral load.

As we heard, secretory IgA, but it kind of makes sense, if you know where the virus is, kill it where it is. Kill it. And we have oropharyngeal and nasal sprays that will kill the virus within five seconds. Why aren't we doing that? I travel with my own little nasal spray because I don't know when I'm going to be infected. I splash it in my nose. It is a simple, cost effective way to control the virus. Just squish this in your nose.

Senator Ron Johnson 18:38
You realize I was ridiculed for about 72 hour time period for just mentioning, potentially gargling. With some, you know, after these studies show that... You're treading on dangerous ground here. Dr. Marik.

Dr. Paul E. Marik 18:50
Yeah, I mean gargling is good, because it's good for your bad breath, anyway.

Senator Ron Johnson 18:54
That's why I said, What's... That's why I said, What's the worst outcome? You have fresher breath?

Dr. Paul E. Marik 18:58
Yeah.

Senator Ron Johnson 19:00
By the way, just that's the truth of all of these things you're talking about. All these cheap, generic repurposed drugs. We know their safety profile. Why not give them a try? That is what has boggled my mind. Why have doctors been so reluctant to practice medicine, but... Dr. Har... Dr. Risch?

Dr. Harvey Risch 19:19
I just want to respond to something that Dr. Malone said about the--

Senator Ron Johnson 19:23
Move closer.

Dr. Harvey Risch 19:24
...the... About the potential occurrence of a new and more pathogenic strain. That omicron has essentially pushed out all of Delta, according to the CDC surveys, that we're now seeing maybe 1000 cases of delta a day compared to the millions of omicron a day and it's going away threefold per week. Omicron appears to convey immunity to previous strains. And so, it's extremely unlikely that a new pathogenic variant would come out of any previous strain of COVID.

If one were to come out of omicron it's unlikely to be more seriously pathogenic because of the 50 mutations that it already has. It would have to essentially reverse mutate back into a more pathogenic variant, which seems at least relatively unlikely.

So, I think we're probably in pretty good grounds for expecting not to face a more pathogenic variant, but to just to face.... Omicron has already got dozens and dozens of its own variants now. And we're likely to see those circulating, and maybe more so next fall, but it's still very likely to remain a cold-like virus with all of its mutations.

Dr. Robert Malone 20:35
...is to God's ears. The... what... Essentially what Harvey is asserting is the thesis, that many of us have hoped for, that Omicron would function akin to a live attenuated infectious vaccine. And I share your hope.

Dr. Ryan Cole 20:54
And he's right, really quick as a science nerd. Because of that furin cleavage site, which we see in the laboratory setting and creating modifications of viruses for enhancement and function, that furin cleavage site isn't really being split and causing the S2 and S1 to split off in omicron. Again, it's more of a common cold, it's a blessing.

That's why we're not seeing all the effects and to Dr. Risch's point to Dr. Malone's point, absolutely right. We're seeing the behavior, giving back immunity. Hallelujah. The mandates are now unnecessary, because we have a new virus that really doesn't have the genetic potential to go bad.

Senator Ron Johnson 21:40
So, what you've witnessed is at least a slight disagreement between our experts here and that's, yeah, again, I wish we had truth and certainty, but there isn't. And so, the only way you're going to find truth, the scientific method is to be skeptical of question each other and discuss it, which has not been allowed. Before we move off the trying to stop the spread. And I do not want to spend much time on this.

I want one person to, you know, take this one up. The efficacy of masks. Can somebody... Somebody want to... Just, who's...

Dr Aaron Kheriaty 22:13
Paul Alexander?

Senator Ron Johnson 22:14
Paul? Oh, okay.

Dr. Christina Parks 22:16
Well, he's coming up, I'll just say--

Senator Ron Johnson 22:18
What are you a bunch of --

Dr. Christina Parks 22:19
if all those things fail, we have things like ivermectin and hydroxychloroquine that actually prevent the spread, right. So, even if we have a more infectious clone, if we start using these medications, then we can stop the spread.

Senator Ron Johnson 22:32
I see Steve Kirsch has stepped up the microphone to... He's got examples, I think, of masks that might work. But begin quickly because I don't want to spend much time on this. There are more important issues.

Paul E. Alexander 22:43
Two things quickly. I'll touch on masks and Steve will help me to reiterate something that Dr. Malone said about Dr. Geert Vanden Bossche. I think the key point he was making is, had we been using a vaccine that could sterilize the virus, that could stop transmission, we would not be in this situation whether or not the vaccine is needed. And the problem here is this vaccine does not stop infection, does not sterilize the virus, so it does not stop the transmission.

You can never ever get to population herd immunity 100% with these vaccines, impossible. Now, and there's also Dr. Malone mentioned the data. We have some brand new data from the UK and Scotland, this week, the third week of reporting for 2022, which demonstrates conclusively that the vaccine is driving, the second dose and the booster dose, is driving massive infections in the vaccinated and it is a big, big problem. In terms of masks and I know Steve will speak eloquently too.

We pull together 150 studies, published in a brownstone, and we could say this. When we looked at all of the comparative studies, there are just two RCTs, which is... One is a Danish mask study, and that had a problem to be published, that shows basically the masks are ineffective in terms of airborne infection. There was one RCT cluster randomized out of Bangladesh.

It went from zero effect to about a 13%, very modest reduction in risk. The body of evidence and I speak as an evidence based medicine specialist, the entire body of evidence tells us conclusively that the blue surgical masks that we've been using, and the white masks, the man-made masks are largely and highly ineffective. They do not stop transmission and every single place in America that we looked at, or the globe, where you impose a mask mandate, the actual infections increase.

Senator Ron Johnson 24:45
So, this was actually one instance where Dr. Fauci was right first. Before he decided to-- So, you know, Mr. Kirsch, just real quickly describe who you are, how you got involved in this and what point you want to make.

Steve Kirsch 24:59
Sure. My name Steve Kirsch, I used to be a high-tech executive. My company was shut down, I started the COVID-19 early treatment fund, was featured on 60 minutes for discovery of, or for the funding of Vox Amin, which has proven to be reduced death by 12, a factor of 12. And still, the NIH won't recommend it, for some reason. And I'm also the founder of the Vaccine Safety Research Foundation.

Senator Ron Johnson 25:29
Okay, you have a mask that you want to talk about.

Steve Kirsch 25:31
Yeah, so... So, there are only two randomized studies that have been done for masks and COVID. And they looked at cloth masks and surgical masks. And in both studies, there was zero effect. So, the most recent one was the Bangladesh study. And what we did is we got a hold of the original data set that was used for the paper, and we did the graphs.

There is no difference at all, between wearing a cloth mask and not wearing a cloth mask, the curves were identical. And they misrepresented it in the study as showing that it works. If you actually look at the data, and you plot the data, and you can get the data because it's publicly available, you will find that the curves are identical, there is no difference between the cloth mask and the surgical mask, or in between the cloth masks.

So, if you had a red cloth mask, it worked. If you had a purple cloth mask, it didn't work at all, and the surgical masks were in between the two. In other words, it's all statistical noise. These masks do not work at all. And the N95 masks are maybe slightly better, but only for a very short amount of time. If you're in a room with someone, for any amount of time, even with an N95, it's not going to work.

The only mask that is proven to work is the one they don't tell people about and that nobody wears. This is the only mask that works. So, this is called a P100 mask. It is 150 times more effective than an N95 mask. This is the only mask that has a chance of working. It's never been tested for the coronavirus, but it should be 150 times better than almost zero.

Senator Ron Johnson 27:30

I'm a little reluctant even here to talk about it, because I'm afraid the Biden administration just might allocate about $100 billion to send those out to everybody.

Steve Kirsch 27:41
But here's what it's like. So, you put this on like this, and then you strap it. And then you talk to people just like this. And this will filter it out it, but... but...

Senator Ron Johnson 27:56
I'm afraid I'm afraid they're going to require that for air flight, air travel. So....

Steve Kirsch 28:01
But one important thing is that this mask works only in one direction. It will work to protect you, but there is no filter on the outside, because if it was filtered on the outside, you wouldn't be able to breathe. So, it, it works. But it only works one way. And if they were really serious about protecting the American public, they would require everyone to wear this, in which case everyone would rebel, and we would have no mask mandate.

Senator Ron Johnson 28:32
And of course, we... So, one other point on masks. We don't have a psychiatrist, unless somebody wants to speak to this, but I think it's obvious, I don't think we really need... The harm done to our children in terms of development, speech. I mean, all these things have been written about widely. I mean, just even their oxygen levels.

Paul E. Alexander 28:53
Senator Johnson? There's one important study that actually ties everything up. It was the Swedish study by Ludvigsen. And he was cancelled because of this study. He looked at the 1.95, I think you mentioned it.

Senator Ron Johnson 29:08
1.8, I thought.

Paul E. Alexander 29:09
1.9 million sweet kids across the entire pandemic from zero to 16 years old, all in primary school, secondary school. And what they found was that they were zero deaths in Sweden in children. And what was critical about that study was that there were no lockdowns, there were no school closures, and they were no masks.

It was not even testing whether you had masks and it worked, there were no masks and there were zero deaths. And that was an actual seminal study. And thank you for mentioning it. Again, we've talked about the stratification of severe illness with COVID has been ignored. But Dr. Urso?

Dr. Richard Urso 29:48
You know, I just wanted to enter into the record, cleaning this up a little bit. Masks been looked at for three decades or so, and there's been randomized controlled trials. So, there's roughly, I don't know, 12

or so randomized controlled trials. There are zero randomized controlled trials that show masks stop the spread of respiratory disease. And that's including N95. And for everyone, N stands for non-oil resistant, 95 stands for 95% of airborne particles, of which all viruses fit through. So, I usually tell people that you know, wearing N95 also has not been shown in randomized controlled trials to be effective.

But more importantly, that the capsule on these viruses is an oil capsule. And I tell people, it's like pee in a pool, it goes right through, it doesn't stick to water, water molecules that it's an oil capsule virus. At the end of the day, the data is what it is. There's zero, repeat zero randomized control trials, at all, showing that masks stop spread of upper respiratory disease.

Senator Ron Johnson 30:44
So, let's move on to the second pillar, discuss early treatment a little bit more robustly. And I'm actually going to reward one of the... Like, we're getting all kinds of questions from Rumble, and I wish we can answer them all, but I've got one here from Sand Emmett says, My adult children, both fully vaccinated, got COVID, could not get treatment from doctors in Virginia, and they did not have mild cases.

This person asked, what is the definition of mild? What I want to talk about is... My first question, what... Because I've heard this from so many constituents, so many people I've talked to the get that test, start getting seriously ill. And they... Because NIH... Because, you know, I call them COVID guides literally have no recommendations. The only people... You got FLCC here, you've got the doctor McCullough's protocol, that's pretty much about it. What is a person supposed to do?

When it's very difficult to find doctors who will treat. If you have a doctor who will treat, it's very difficult to find a pharmacy that will fill some of these drugs. Some of them that haven't been poisoned, you can get but I mean, the big ones the ivermectin, hydroxychloroquine. It's very good... So, what is a person to do when they or a loved one gets COVID? So, can I just ask and so what the NIH recommendation is, and they've made public, We want to know what somebody's supposed to do like, do.

Dr. Paul E. Marik 32:24
Yeah, well, while the NIH tells you to go home, take fluids, take Tylenol, and you stay at home until you get blue, and you can't breathe. And then you go to hospital. And then they isolate you like a prisoner, give you remdesivir and dexamethasone and then you die.

That's the NIH recommendation. So, obviously, what we are saying, and Dr. McCullough has said this, and all we've said this is a treatable disease. COVID-19 is a treatable disease. But what's critical is timing. Because of this viral load, you treat early, you don't wait for the test. When patients have symptoms of COVID, you treat them like they have COVID And there are effective treatments to treat them.

Senator Ron Johnson 33:14
So, again, I understand that, but people can't find doctors like you. Okay? They just can't, so is it... Before they can find a doctor like you and hopefully there'll be more, I mean, I know some people are doing telemedicine and online, that type of thing. What are they supposed to do? I see somebody in the

back. Come on up and introduce yourself. By the way, this is a really important question. This is what people are.

Dr. Ben Marble 33:45
This is an important question. I'm Ben Marble, MD. I'm the founder of myfreedoctor.com So, we've delivered over 150,000 free doctor visits to America delivering early treatment, McCullough protocol, we've only lost four patients. We have a 99 point-- So, repeat that. So, you've treated through telemedicine? Yes.

Senator Ron Johnson 34:06
150,000 COVID patients.

Dr. Ben Marble 34:10
Yes, sir.

Senator Ron Johnson 34:12
What's your team?

Dr. Ben Marble 34:13
Yes, with the team. We have a team of volunteer free doctors that donate their time to help treat these patients that come to us. They go to myfreedoctor.com and they answer our questionnaires, we deliver the early treatment protocols to them as early as we can. And we have a 99.99% survival rate, so I believe myfreedoctor.com, the volunteer free doctor team, we have settled the science on this, early treatment works, period.

Senator Ron Johnson 34:39
Okay, so... Let me... So, I will repeat this. So, it's freedoctor--

Dr. Ben Marble 34:51
myfreedoctor.com And why, my--

Senator Ron Johnson 34:54
Okay, my... Okay. Can you tell me what... Tell us the cornucopia drugs you use? What is your basic protocol? Are you using...? What are--

Dr. Ben Marble 35:04
We're using the McCullough protocol, which is essentially the controversial drugs of course, ivermectin hydroxychloroquine. It also includes monoclonal antibodies, prednisone, budesonide, and several other prescription drugs that are low-cost, generic prescription drugs. And of course, we use the over the counter, vitamin D, vitamin C, zinc, quercetin.

Senator Ron Johnson 35:16
You mentioned budesonide together with Senator Paul and I'm sorry, I'm terrible with names, doctor in Texas. We sent information

From background 35:29
Dr. Barlett.

Senator Ron Johnson 35:31
Yeah. a study in England saying it was what percent effective? It is

From background 35:36
Over 80%.

Senator Ron Johnson 35:37
Over 80%. And again, we still don't recommend that. Dr. Kory. Thank you very much. Thanks. First of all, thanks for being a doctor. Thank you for providing that service.

Dr. Ben Marble 35:45
Thank you, sir.

Dr. Pierre Kory 35:48
Yeah, I just wanted this to second the applause to Dr. Marble and his service in this practice. Your question of how to treat this. It you know, in my opening statement, I called out the corruption, right? The corruption is because they don't want you to use off-label repurpose generic medicines. It does not provide profit to the system. And so that early treatment and its efficacy, and the availability is being suppressed.

What had happened in this country, and I have to call it out, is, again, I use the words absurdity and an obscenity. But these are crimes. You know what's going on in this country right now? Is that the CDC has been captured by the pharmaceutical industry, they sent out a memo in August of 2021. They sent out a similar memo back in the spring of 2020. Telling the nation's physicians and pharmacists not to use generic medicines.

We are now in a state in this country, where Senator Johnson asked the question, how can we get the average US citizen to treat or get treated? We have pharmacists across the land who are refusing, refusing to fill these because they've been manipulated and brainwashed into thinking that the FDA hasn't approved the use, as if that matters, off-label prescriptions. And prescribing has been going on for decades. It's encouraged when there are no effective treatments, yet I have to... When I try to treat my patients and Dr. Marble can attest to this, we have pharmacist who refuse to fill some of the safest and low cost medicines known in the history of medicine.

Dr. Marik talked about that. These are extremely safe, extremely low cost, they do not provide profit. The CDC has intervened and have manipulated the doctors. I need to make that message clear to all physicians in the land. These are highly effective medicines. They're not being used. The pharmacists are not filling, all the pharmacists in land, you have to understand that you are obstructing the good and sound conduct of medicine.

It has to stop. It has to stop; we have people dying. And you know, Dr. Marble's practice, the volume of patients that myfreedoctor.com has served is really almost miraculous, right. However, there also are other telehealth practices. And I don't want to you know, take away from Ben, but our non-profit organization, on our website, we have a button which says Find a provider, we've tried to collect as many telehealth providers that treat all states in the country and that is a resource.

We've done that as a public service. We are trying to let that message be known, because that message is being suppressed that this disease is treatable. There are providers that treat, but how to find them is hard. And I'm glad you asked this question, Senator Johnson, because it's absolutely... I mean, these... I keep calling it out. These are crimes against humanity. We have patients who are falling ill with a treatable disease, and they can't get treatment.

Senator Ron Johnson 39:05
So, but let me quick before I kind of asked my next question. You published in your website or in your sub stack what are these called again, what kind of...

Dr. Pierre Kory 39:16
Those are called novel, barely tested, highly profitable.

Senator Ron Johnson 39:19
I mean, that type of chart.

Dr. Pierre Kory 39:23
Okay, that chart is called the forest plot.

Senator Ron Johnson 39:25
So, this is a forest plot of all the different types of drugs, I know it's hard to see, all the different drugs that there has been some research on. And what was interesting about this chart is Dr. Kory circled the ones that are recommended by our health agencies. They all range from 700 bucks up to 3200. All the ones that are not recommended are the ones that are, you know, a couple bucks. Go figure.

Steve Kirsch 39:55
Senator, can I have a word on. So that website, by the way, that lists all of that that you just referred to is called C19early.com, and you can see a list of all of the treatments that are available to people. And so, if people cannot get treated by their doctor, they can look at that list, and they can take the things because a lot of the things on that list like vitamin D, NAC, even aspirin, these can all be gotten over the counter without a doctor prescription, and so if you can't get treated early with a doctor, you can use one of those.

Also, I want to mention the George Fareed and Brian Tyson, and acknowledge their work. George was going to be here today; he is unable to attend. But his protocol, he's treated over 7000 patients, not as many as Ben, but they're a small two-doctor practice, it's they treated over 7000 with zero deaths.

From background 40:51

It's 10,000 now.

Steve Kirsch 40:52
Okay, and they tried to reach out to the NIH in March of 2020, when this first started with their protocol, and they were ignored. And they tried reaching out again and again and they were ignored. And even today, their protocol is still ignored, even though there are zero deaths from anyone who got their treatment protocol. It's available on the web. They also have a book out now. But that's available to people if you can get a doctor to prescribe it.

And also, one final thing is fluvoxamine. And I know a little bit about fluvoxamine because I funded the, both the phase two and the phase three, trials on that. Now, trying to get a doctor to prescribe fluvoxamine for COVID is very difficult. But if you happen to be depressed when you've gotten COVID and you're depressed about it, you can go to your doctor and say, well, can I get some fluvoxamine for my depression?

Or maybe you have a handwashing, obsessive compulsive disease or maybe, you know, you're wearing masks or you're obsessively, you know, touching your nose, you can get a prescription for fluvoxamine for that obsession. And by the way, it might just cure your COVID as well, just fluvoxamine alone, 50 milligrams twice a day for 14 days.

Senator Ron Johnson 42:17
So, I think... So, we have Dr. Mangat, you wanted to say something.

Dr. Harpal S. Mangat 42:23
Just coming to your question from Virginia, I practice in Maryland, and it's a familiar problem seen from Virginia, that the Virginia pharmacists are difficult. And even my patients who live in Maryland, and work in Virginia face the same problem. But the key answer is to find a doctor who is going to treat you. And then that doctor is going to be cognizant that a lot of his scripts will not be prescribed.

Like I have patients in Virginia, I treat them to figure out where I can get the relevant drugs. And that often means independent pharmacists. So, you got to look this, stay away from the CVS. Costco ain't bad, and you just got to figure out who has it. And that's the key question and have your patient work with you to identify and find those places.

Senator Ron Johnson 43:18
So, by the way, that's where I've referred people, to doctors that actually treat. The first thing I'll say, is find a pharmacy that will actually fill the prescription and it's an independent one. But let me ask those of you who have utilized this cornucopia of cheap, generic, repurposed drugs, have any of your patients had an adverse reaction to ivermectin, hydroxychloroquine, I mean just, you know, budesonide, fluor, has any of you...

Dr. Ryan Cole 43:46
No. I've treated 400 patients, not a single one's gone to the hospital, not a single one died. Half of those were elderly. comorbid, high-risk. The only thing that's happened as an adverse reaction is, I've lost a

third of my business because insurance contracts have pulled away from me for unprofessional conduct for using these dangerous drugs, ivermectin, for which my patients have had no adverse reactions. I've treated 500,000 patients or diagnosed 500,000 patients diagnostically in my career.

I've not had one single complaint against me. I have four complaints against licenses in four different states for saving lives. So, the adverse reaction from these drugs is being attacked for being a good doctor. That's the bad adverse reaction. And I know many of my colleagues on this panel as well.

Senator Ron Johnson 44:32
Okay, Dr. McCullough.

Dr. Peter McCullough 44:35
I just want to... I want to give a just a fair, balanced statement, and again, you can see this among doctors. I'm a cardiologist, so I manage some of the highest-risk of people in medicine. I have lost patients, and patients do die of COVID. And I can tell you to a one, the patients that I've lost, it's because we've gotten a late start on early treatment.

I've recently published a paper with Fazio and colleagues from Italy, we have shown the golden window to treat COVID-19 is the first 72 hours. And the patients that I have lost, and they've been very few, but if if people listen to this out here, they will recognize that it's a late start at treatment, that is, in a sense, the failure of early treatment.

If we start early, we have uniform successes. I've reviewed hundreds and hundreds of reports of hospitalized patients, and of those who've died of COVID-19. And in those reports, the clear observation is that determinants of hospitalization and death are the lack of early treatment.

Steve Kirsch 45:40
Yeah, I want to echo that. You know, as head of The COVID-19 Early Treatment Fund, we see early treatments from all kinds of different doctors. And what makes the difference is not which early treatment protocol you are on.

If you get treated early within that 72-hour window, nobody dies. It doesn't even matter what protocol you're on. If you get treated within those 72 hours, I have never heard of a single case of anyone dying.

Dr. Richard Urso 46:13
I want to address...

Senator Ron Johnson 46:14
Just really quick for my staff, can we do my censored chart? Is that available? If it is, put it up. Dr. Urso.

Dr. Richard Urso 46:22
I just want to... I want to kind of go off with what Dr. McCullough said. Really, we're looking at the risk-benef... The question begs the risk-benefit ratio, that's really what we're getting at. Is there a risk for these low, ivermectin, hydroxychloroquine?

I always tell people, you know, hydroxychloroquine has got so many side effects, like Dr. Parks talked about, lowers cholesterol, lowers hemoglobin and C, lowers the glucose, lowers insulin resistance, lowers D-dimer retroactive protein sed rate, decreases stroke, heart attack, pulmonary embolus, decreases chronic kidney disease. So, there are a lot of side effects associated with these drugs. So, that's one, I don't want to finish it there.

Dr. Ryan Cole 47:06
He's being very facetious; those are all benefits.

Dr. Richard Urso 47:09
There are now 96 clinical trials going on at clinicaltrials.gov for use of hydroxychloroquine in cancer, so solid tumors. So, if you go to clinicaltrials.gov, that's where you're going to see. So, these drugs have a lot of side effects. They're really, for the most part, wonder drugs, and they can cause side effects. Jokingly, I was being facetious earlier, but it can't cause GI side effects --

Senator Ron Johnson 47:31
You really need to point out how facetious you are being okay, now I'm dead serious about that.

Dr. Richard Urso 47:37
In case you didn't know, lowering the glucose and lowering the rate of stroke and heart attack is a good thing.

Senator Ron Johnson 47:44
Those are benefits, not side effects.

Dr. Richard Urso 47:45
The bottom line is that many of the drugs, like as erythromycin, have wonderful effects on so many levels, on inflammation, on viruses, on many things that you would... I've been using for 20 years for scarring. So, if you look at what we're prescribing, and you talk about the risk-benefit ratios, what we are prescribing is very, very low-risk drugs over and over.

And you can compare those that are, the ones that have been developed by by Pfizer and Merck, one is a molnupirovir, which is a nucleoside analog, and I want to go into this because I think it's important. These are not creative thoughts. These are old drugs from the 1950s that have been dressed up and put back out there.

And they are literally... They're going to kill viruses because viruses use the same machinery we do, but they'll also kill your mitochondria, they'll also kill your normal cells. They're actually not too bad at killing cancer cells, anything replicating quickly.

So, we are seeing the use of paxlovid, which is like a collegiate 2.0, so we are seeing drugs sort of being dressed up and repurposed. They are repurposing themselves and putting a price tag on. They are using repurposed drugs, with a higher price tag. Everyone needs to know that.

Senator Ron Johnson 48:54
They get to repattern them.

Dr. Richard Urso 48:56
In their own way. So, that is one of the issues with what we are seeing. These are not creative things. Remdesivir, that is not creative. Neither is molnupirovir. I cannot say that enough. It is not a creative thing. The drugs we are talking about are wonder drugs. They really are ivermectin, hydroxychloroquine, erythromycin, superheterodyne, Pepcid, there's a whole list I've got.

I won't go through them, but there's a lot of things we can use. They're incredibly safe. And you can save lives. We've had people save lives without hydroxychloroquine, ivermectin. This doctor from South Africa named Dr. Shetty, we all know, he saved over 7000 people without using any of those drugs.

Senator Ron Johnson 49:37
So, I guess my chart has been banned by my staff as well. But let me just quick summarize it for you because it just points out, in very stark terms, the safety profile of some of these repurposed drugs versus, you know, what we're seeing through the VAERS report with the vaccine.

Ivermectin, over 26 years, on average about 15 deaths per year reported and associated with it, and again VAERS and FAERS, this is FAERS, it does not prove causation. So, 15 deaths per year on average. Hydroxychloroquine 69 deaths per year, over 26 years.

The flu vaccine, about 77 deaths. I think it is. 77. Oh, it isn't. Oh, great. It wasn't banned. I'm not. I'm an accountant, I remember numbers. But take a look at remdesivir, it's over 1600 deaths since it got its emergency use authorization. And now, unfortunately, with the COVID vaccine 22,000 deaths reported on VAERS.

Again, we all recognize VAERS does not prove causation. But 30% of those 22,000 deaths occurred ND 0, 1, or 2. It certainly raises alarms to me. I don't understand why it hasn't raised alarms to the FDA. And so, what I... What I quick want to go back over to because it's on the same subject. Dr. Wiseman, one of the first things I really recognized in terms of things you'd done is your video you put together in terms of the advisory committee meeting on molnupirovir. And very quickly, it again, let's not get too far down in the weeds.

But that advisory committee barely recommended it, it was a vote 13 to 10. Can you just hit on...? And again, I personally hope that molnupirovir, facts of it work beautifully. I mean, anything, I will embrace anything, I am completely agnostic, when it comes to whatever drug will, in this pandemic. Vaccine, whatever, I don't care, I want this pandemic over.

I want people to live. But just talk a little bit about the molnupirovir in terms of that study. And if you've got something on pax, because I know you've also done some work on paxlovid too. But again, succinctly.

Dr. David Wiseman 51:51

Okay, so, thank you. I would encourage everyone to watch that Amback meeting. Amback was the... is the committee for the FDA that deals with antimicrobial drugs, because that, to me is the closest to any real discussion of safety and efficacy of any of the agents that we've been talking about. And what's remarkable to me is that it hasn't been repeated.

It wasn't repeated with paxlovid. And it wasn't pre-quelled with the vaccines. But in that meeting, you had very, very good discussion among top, top FDA toxicology people who expressed serious concerns about molnupirovir, and amazingly paxlovid didn't go through the same procedure afterwards. I won't--

Senator Ron Johnson 52:39
The concerns about molnupirovir were?

Dr. David Wiseman 52:41
Excuse me?

Senator Ron Johnson 52:41
The concerns about molnupirovir, were?

Dr. David Wiseman 52:43
Okay, so the main concern, the main concern on molnupirovir is that it's stated mechanism of action is to induce mutagenesis, is to make a storm of mutations so much that it discombobulates the, you know, the innocent --

Senator Ron Johnson 52:54
So, what could go wrong there?

Dr. David Wiseman 53:01
So, what could go--?

Senator Ron Johnson 53:01
And their solution, the solution of that problem which Merck was asked, and they had no answer for the solution was?

Dr. David Wiseman 53:11
Well, they didn't really have a solution. The solution was, well, we have to be very careful. We'll keep monitoring it. We'll make sure that variants don't come up, in fact. But what surprisingly, Senator, was that, and I've got the documents here--

Senator Ron Johnson 53:24
As I recall, as I recall, the solution was we're going to make sure that everybody stays quarantined on molnupirovir--

Dr. David Wiseman 53:30
Yeah.

Senator Ron Johnson 53:31
And they were going to take the full dose.

Dr. David Wiseman 53:33
Right, but you know, what, when you read the approval letter, which I happen to have here, I've got the approval letters for molnupirovir, paxlovid, and remdesivir--

Senator Ron Johnson 53:42
I don't want to take too much time.

Dr. David Wiseman 53:43
I'm not going to, but, surprisingly, all the safeguards that the committee members, even the ones who voted in favor of it, right, were saying this, many of them, the safeguards that they had, because the concern are we going to spawn dangerous mutations and that may even be the reason why we've got a funny uncle, who knows, because we've already got molnupirovir working on it.

Okay, but the concern is we may be spawning dangerous mutations. And there's all sorts of precautions, like you mentioned, and hardly any of them are mentioned in the molnupirovir approval letter. Paxlovid didn't have a committee member, has even more things that they mentioned in the paxlovid letter about mutations and resistance--

Senator Ron Johnson 54:25
Plus, it has to be taken with a drug that interacts with a bunch of common drugs. And it's got a long list of--

Dr. David Wiseman 54:29
Okay, that's a--

Senator Ron Johnson 54:31
... totally separate...

Dr. David Wiseman 54:32
Okay, that's another issue. So, but the main point, I think, I mean, many points, is that he you have absolute hypocrisy from the FDA. Here, they're wading through molnupirovir, paxlovid, with as you said, with a long list of adverse events, okay. And hydroxychloroquine and ivermectin and fluvoxamine, which are, you know, relatively innocuous.

You've seen... you've got the chart over there. Nothing, nothing. This is absolute hypocrisy. And so, that what's important about molnupirovir, it serves as a warning for all of us. That's what should have happened. They should have those discussions for the vaccines. They should have had the discussion for the paxlovid, and they should apply hydroxychloroquine through the same channels.

And we have data, Pierre and I co-authored a paper, we re-analyzed the key study that closed down hydroxychloroquine for post-exposure prophylaxis, we showed it was completely wrong. It was missing data, we found the missing data, 42% reduction. Not only that, the similar group that had an early treatment version of that study, they won't even supply us with those missing data.

We know the data is there, they won't even supply it to us. And so, those are the studies that close down hydroxychloroquine. Those are the ones FDA need to insist on getting those data. The New England Journal of Medicine need to insist on getting those data and those internal medicine need to insist on getting those data.

So, you talk about corruption and coercion and corruption of the peer-reviewed literature, and FDA. Here it is, right there. We've got the solution. FDA can get out of this tomorrow.

Part 4

Tue, 2/1 6:20PM • 54:37

SPEAKERS
Kyle Warner, Dr. Christina Parks, Dr. Ryan Cole, Dr. Robert Malone, Brianne Dressen, Dr. Peter McCullough, Dr. Richard Urso, Senator Ron Johnson, Dr. Paul E. Marik, Steve Kirsch, Dr. Harvey Risch, Dr. Pierre Kory, Dr Aaron Kheriaty, Dr. David Wiseman

Senator Ron Johnson 00:00
So, this is where I want to start transitioning into, Dr. McCullough, who we've talked to in the past, because you were calling for, you know, what they're called, these independent safety review panels or I mean, you've got the exact name for it. Talk about, as Dr. Wiseman just said, talk about what we didn't do in the approval process, in the safety surveillance, the follow up process. Talk about the steps we didn't take that we should have and what we ought to be doing moving forward.

Dr. Peter McCullough 00:29
In my comments, I will be regarding the COVID-19 vaccine, so Pfizer, Moderna, Johnson and Johnson. I have served on or chaired over two dozen data safety monitoring boards for NIH sponsored, in Big Pharma, sponsored clinical trials. I know data safety inside out, backwards and forwards. I've also been on critical event committees, and I've been on institutional review boards.

Those three bodies are essential. I'll repeat, a critical event committee to adjudicate a safety event, a data safety monitoring board to independently look at what is going on with a clinical program and when an investigational product has been administered, and then a human ethics board to understand and help protect the subjects in that study. We have an Office of Human Research Protections here in the United States, OHRP.

They are charged in protecting human subjects. Our COVID-19 vaccines that consent form indicates in every state in the United States that the vaccines are investigational or in research because they are under emergency use authorization. What did not happen is we did not have those three essential bodies of independent people installed.

We never had those-- By the way, they were installed and were utilized in the randomized clinical trials before they came to EUA approval. We also had the wrong bodies leading the vaccine program. Remember, the FDA is supposed to be the safety watchdog, the National Institutes of Health is the government research body, and the CDC is the outbreak investigation body.

Right now, the CDC and the FDA are the named sponsors of a vaccine program. If American can learn anything, we should never have the FDA and CDC be a sponsor of a public program in administering a product. It has been a giant and colossal mistake.

We should have had a separate body, a government body, be the sponsor of the vaccine program, the vaccine manufacturers can supply the products. And then we needed the separate data safety monitoring board, clinical event committee and human ethics committee. They're in oversight. And if this would have happened based on the emergence of unexplained deaths, I am testifying today that the program would have been shut down in February because of excess mortality.

Senator Ron Johnson 02:56
Dr. Kheriaty.

Dr Aaron Kheriaty 02:57
The NIH, specifically, the NAIAD division of the NIH co-owns the patent on the Moderna vaccine, and six members of the NAIAD get royalties from the profits into their personal pockets. Not to mention that the entire budget of that program--

Senator Ron Johnson 03:15
Are you sure of that?

Dr Aaron Kheriaty 03:16
I'm sure of that.

Senator Ron Johnson 03:17
Is that, is that--?

Dr Aaron Kheriaty 03:18
That's publicly available information. Four, four members get royalties.

Senator Ron Johnson 03:26
I know there's also an issue, not to, you know... There's also an issue of the people that on the panel for remdesivir had some kind of tie with Gilead, as well.

Dr Aaron Kheriaty 03:35
Rife with conflicts of interest. That would never be accepted in other settings. So, they are profiting and look, NIH, just for people out there that don't know where these agencies are situated in the federal government NIH, which has gotten involved in sponsoring the research, the studies for approval of the vaccines, FDA, which is the agency that that gives approval, and CDC, which is the agency that that makes recommendations on which subsequent mandates are based.

So, the CDC says, well, we don't mandate anything, we don't make federal policy, federal law, which is true, right. But all the mandates then look to the CDC recommendations as their justification. So, nobody ultimately takes responsibility for the mandates. There's no place where the buck stops. All of these are divisions of the same Department of Health and Human Services.

They all report to the same Secretary of the Department of Health and Human Services and the need for strict separation from those who are profiting from these products. Right, which is what we expect corporations to do. Of course, that's what they're, that's what they're about, but all the more need for careful structures to be put in place, such that the regulatory agencies are serving the interests of the American people.

Senator Ron Johnson 05:03
Then there's also a revolving door between the agencies and pharma.

Dr Aaron Kheriaty 05:06
Exactly.

Senator Ron Johnson 05:07
And I won't name any names, but we've seen it--

Dr Aaron Kheriaty 05:09
You can trace their careers as they rotate through these agencies into pharma and back.

Senator Ron Johnson 05:14
So, let me transition. Dr. McCullough talked about the CDC, NIH, FDA kind of not playing the roles we should have played. What about the health agencies, in general, dictating how doctors practice medicine, and how foreign that really should be, to how the structure is set up? And why is that? I mean, I realized, you know, $140 billion worth of grant money flowing through Dr. Fauci over decades. So, talk a little bit about what has happened to --

Dr Aaron Kheriaty 05:49
One more common--

Senator Ron Johnson 05:50
-- the establishment?

Dr Aaron Kheriaty 05:51
Yeah, yeah. I received a letter from the California State Medical Board, maybe six months ago. It went out to all physicians from the medical board saying, "Any physician in California who writes an inappropriate exemption for masks or other COVID-related measures, will have his medical license subjected to investigation and disciplinary action. " So, for a physician, just to help you to understand, this kind of threat hanging over your head is worse than the threat of getting fired.

If I get fired from a particular healthcare organization, I can go to another healthcare organization or go start a private practice. If I lose my medical license, I cannot practice medicine. Okay? That's how serious this is. The letter never defined what might constitute an appropriate or inappropriate mask mandate. So, I have no idea if I brought a mandate for a kid with a severe anxiety disorder that's worsened by the wearing of a mask, is that going to subject my medical license to disciplinary action?

Physicians in California interpreted the phrase "and other COVID-related measures" to include vaccines which had already been rolled out at that point. It has become de facto impossible to get a medical exemption for a COVID vaccine in the state of California. No physician will write them even when you have someone that has a contraindication listed on the CDC's list of contraindications to COVID vaccines.

I have a patient, who went to her rheumatologist specialist in her autoimmune condition. This specialist told this patient, "I don't think you should get the COVID vaccines given your age or low risk of COVID. And I think there's a good chance that these vaccines, based on the data that we have, could worsen your underlying medical condition." She turned to the same physician immediately afterwards and said, "Can you write me, therefore, a medical exemption? Because I need one for work.

There's a vaccine mandate at work." Same physician that just told her not to take the vaccine or recommended against it said, "No, I'm sorry, I can't read you a medical exemption because I'm afraid I might lose my license."

Dr. Peter McCullough 08:07
Are you telling me that patients who have known life-threatening contraindications --

Dr Aaron Kheriaty 08:13
That's right.

Dr. Peter McCullough 08:13
--to receive a COVID-19 vaccine indeed are not being given exemptions?

Dr Aaron Kheriaty 08:17
So, the medical boards are behaving very irresponsibly doing the bidding of governors who want to impose certain mandates, in this case, mask mandates or vaccine mandates. They're not serving the public good. In this case, they're certainly not serving the interests of patients. And they are, again in my entire 18 years of being a licensed physician, I and my colleagues have never ever received any kind of communication like this from the medical board. It's outlandish.

Dr. Ryan Cole 08:47
And to your point, Dr. Kheriaty, they never define. They threaten you, and it's this looming threat without definition. "You're spreading misinformation." Oh, do cite the papers in which I am, you know, spreading misinformation.

They will not define it. They will attack you. They will threaten you; they will put you in a state of fear and say, "you can only do what we say but don't save a life." And by the way, the vaccines are expired because omicron is here. And now they still want to mandate them. So, they threaten us and threaten us and threaten us and were hunted for caring and being compassionate and empathetic and wanting to help humanity.

Steve Kirsch 09:27

I want to correct one thing that Dr. Kheriaty said which is there is one physician in California who will write a medical exemption and a mask exemption. There is one physician.

Senator Ron Johnson 09:43
I wouldn't name him.

Steve Kirsch 09:46
Believe me he doesn't want to be named. But he is being investigated.

Senator Ron Johnson 09:51
Okay. So, a little ahead of schedule. I see Brianne Dressen has been somewhat the spokesperson for some of the individuals that have been experiencing injuries. So, Brianne, why don't you two introduce yourself, if for some reason you want to address this issue.

Brianne Dressen 10:09
Yeah, so, I'm Brianne Dressen. I--

Senator Ron Johnson 10:10
Get it close.

Brianne Dressen 10:12
I'm Brianne Dressen. I participated in the clinical trial for AstraZeneca here in the United States last November. I experienced an extreme reaction that has changed my life. Even though I am sitting here before you today, I feel like I'm being electrocuted 24/7 and I can eat about six things. And my body feels like it's made of glass. And--

Senator Ron Johnson 10:33
By the way, you were also paralyzed from the waist down, for a length...

Brianne Dressen 10:36
Yes, yes. So, I was hospitalized. I was paralyzed from the waist down. I was incontinent. And because of this and because I cried while I was in the ER, when my legs weren't working, I was diagnosed with anxiety. So, I was sent home with intensive physical and occupational therapy due to anxiety due to the COVID vaccine. So, yeah, but I was later able to go to the NIH and receive appropriate diagnosis after seven months, neuropathy, POTS, things that are not anxiety.

Kyle Warner 11:09
Yeah, and my name is Kyle Warner, I'm a professional athlete, mountain bike racer, and I was injured by the Pfizer vaccine with my second dose. I developed the heart inflammation, POTS, and then a little bit of mass cell activation syndrome, which has also made it so I have limited things I can eat without just a big inflammation cascade.

I've also asked my primary care physician for an exemption four times, she's not able to write me an exemption. I live in Boise, Idaho. And yeah, the St. Al's network there basically told her under no circumstance are you allowed to get an exemption. I'm worried about traveling for my job in the future.

I'm not going to get a booster because if I do, I'm worried I'll have an issue. And one of my questions to the panel, too, is, is there a standardized exemption form out there now where people who do get an exemption can travel around the world? Because if I show up at the Canadian border with just a doctor's note, will that be good enough?

Dr Aaron Kheriaty 12:04
We saw what happen in Australia, with the world's number one tennis player who had a medical exemption that was supposedly accepted by the Tennis Association that he was a part of, but the government, entirely and in a completely arbitrary fashion and to make an example out of this high-profile athlete, denied that same medical exemption.

So, unfortunately, there is not a uniform standard to acknowledge that some people should not get a particular intervention. There is no, there is no medication that is good for everyone all the time in all circumstances. It's an absurd notion.

Dr. Peter McCullough 12:54
And there's no product that's safe for everyone--

Dr Aaron Kheriaty 12:57
That's correct.

Dr. Peter McCullough 12:57
--at all times. And there were large numbers of individuals excluded from the clinical trials based upon concerns and appropriate concerns of safety, including pregnant women, women with childbearing potential who could not guarantee contraception, COVID-recovered, suspected COVID-recovered and those with positive serologies because the FDA and Pfizer, Moderna, Johnson&Johnson, outside the United States AstraZeneca, knew they knew that these individuals, the products would either not be safe or not be efficacious.

And the Institutional Review Boards and the FDA who reviewed these protocols also agreed. In order to exclude a group from a clinical trial the justification must be very strong. It is regulatory practice, in principle, always, that groups that are excluded from randomized registrational trials are always excluded and contraindicated from the administration of the product in clinical practice, particularly during the early adoption and early experience part of the program.

Without exception, we carry this forward. And the observation and the fact that the FDA and the CDC abrogated those regulatory principles and encourage actively and through many mechanisms, had others actually coerce individuals for whom the vaccine is unsafe to receive the vaccine and then incur fatal and non-fatal injuries is at this point in time, malfeasance. It's wrongdoing by those in positions of regulatory authority.

Dr Aaron Kheriaty 14:45
And there is no-- There is no stronger or clearer contraindication to a vaccine or a medication, then having already been harmed by it. So, being subjected to have to take something again that has already harmed you, in order to live, in order to travel, in order to work professionally, is criminal.

Kyle Warner 15:08
Yeah, that was one of my other questions.

Senator Ron Johnson 15:09
Kyle, really quick. And then Dr. Kory wants to say something

Dr Aaron Kheriaty 15:11
Insane.

Kyle Warner 15:13
That was just one of my questions too. Is it, you know, logical to think that if you've been harmed by the first dose, then you shouldn't get a second dose. And if you get the second dose, then you're harmed, will a booster potentially do more harm. And if you were on the seventh booster, would that potentially cause more harm?

Dr Aaron Kheriaty 15:28
Of course. You don't have to be a physician to know the answer to that question. A four-year-old knows the answer to that question.

Senator Ron Johnson 15:37
Doctor--

Dr. Richard Urso 15:37
I just want to partner off of what Dr. McCullough said. I don't think people realize that all these people who had COVID were excluded from the trials, all of them. So, we're going to take our 5-11 year olds that there's 20 million. That means 14, it was about half and half, it's probably more 60% who have had COVID already.

So, let's say 12 million have not had COVID. So, if those 12 million had the vaccine, and it was a perfect vaccine, it's 0.1 per 100,000, it might save 12 children. What's going to happen to the 16 million children who've already had the virus, who already have immunity, and we're going to subject them to something that wasn't even tested in that group. It's literally absurd. And that's the thing I would say, senator, is that we're not here about civil liberties and mandates.

We're here to save lives, and this group of people should be excluded. Absolutely. There's an Achilles heel to the program of natural immunity. Natural immunity denial should not be happening. It should be a major focus of what we're trying to do here because you are going to harm, I don't know how many children by force vaccinating 16 million children. It's absurd.

Senator Ron Johnson 16:49
So, we're going to... I'm going to get to medical necessity, quick with Dr. Kory, then I've got a--

Dr. Pierre Kory 16:54
I'm sorry to have to do this. I feel like a broken record. But I'm listening to my colleagues call out all of the inanities, the insanities, the absurdities. Okay, these departures of our policies, from what we know are to be scientific truths.

This thing is like denial of natural immunity. We have to understand why to sit here and point fingers and they're doing this wrong and that wrong? Why are they doing this? There could be multiple reasons, the simplest and most easily understandable and provable, is every vaccine, every of these, you know, these novel patented high-cost drugs, is profits. They're putting profits ahead of patients. You know, we can call attention to all of these policies, they are non-scientific.

They're failing at having scientific support, yet they're being carried out and they're being distributed across the country. And doctors and states and health departments are willingly accepting these without question, without critical thinking. And that's what I want us to be clear that we're calling attention to today. This is corruption, plain and simple. It's corruption.

Senator Ron Johnson 18:01
Sorry, I--

Dr. Christina Parks 18:02
I want to echo Dr. Kory's statement and say that it didn't start now. Many people have been fighting this corruption for many years. When they did the 1986 Vaccine Injury Act and said that manufacturers no longer have liability for any vaccine that's on the childhood schedule, the childhood schedule exploded.

Now, I'm not saying every vaccine is or isn't safe on that schedule. But I'm saying that's when they said we have the perfect business model. Every kid has to take these vaccines, if we put it on the schedule, and we have no liability. And so, the schedule exploded, and safety corners were cut, because we have no liability.

And suddenly, we started to see you have to have HPV for school, you have to have this for school, you have to have that for school. And so, this business model, the more they pushed it, the more they realized no one pushed back because of this sort of idea that vaccines were always, always a positive health intervention.

And so, now we've gotten to the point where the mass formation psychosis around vaccines always being a positive health intervention has gotten us here. And so, we have to look at that aspect. Why are they vaccinating our children? Because once it's on the vaccine, once it's on the childhood schedule, they are no longer liable for injury. So, they're going to get off that EUA, put it right on the childhood vaccine schedule, and then have no liability going forward.

Senator Ron Johnson 19:28
I'm going to try and do this in an organized process. And again, I love the free flowing discussion, but let me just enter a little bit of data into this. Because we hear, you know, infection fatality rates, and we hear these infant testimony small percentages. I turn those into numbers that I think are understandable and they're actually quite shocking.

Okay, this is this is CDCs numbers, and then John Ioannidis in Stanford, his numbers as well. They just got published. But again, we're talking about medical necessity in the stratification of the risk that we've completely ignored. And this puts in, I think, a sharp focus of why we shouldn't have ignored medical necessity, and the stratification of risk as it comes as it relates to COVID in general. So, according to CDC, the best numbers we have, if you're from 0-17 years of age, about 20 of you will die from COVID per million.

20 per million. 20, two zero. If you're older than 65, 90,000 of you may die from COVID per million. Okay, so, over the 65, 90,000 per million, versus 0-17, 20 per million, John Ioannidis's numbers are somewhat similar. As Stark, 0-19, different age categories, 0-19, about 13 deaths per million, over 70, 40,000 deaths. So, where should have our response been focused? With children? Should we even...? And let's face it, nobody, nobody can tell you the long-term safety profile of these vaccines, nobody. It's unknowable, because we haven't taken the time.

Nobody knows. Again, my banned chart would indicate, we ought to have a little concern. With that lack of knowledge, it probably would indicate you ought to use some caution. But we haven't. Before I... I just have to read you a quick little news story out of Vietnam. Just got this today. A ninth grader in the northern province of Futo, died Tuesday after getting her second Pfizer vaccine dose. The local medical center said Thursday.

The girl had gotten her first Pfizer dose on December 3, 2021. Afterwards, she experienced dizziness and had difficulty breathing. She was taken to medical center for treatment and later recovered. She had her second dose last Monday. Her mother told healthcare workers about the girl's side effects failing her first shot, but they asked her to get the second shot anyway.

Again, this is a ninth-grader. Doesn't have much risk from COVID, has a reaction to the first dose, but let's give him a second dose anyway. 20 minutes following the second shot, the girl experienced tightness in your chest, dizziness, difficulty in breathing and seizures. She received emergency treatment on the spot before being transferred to a district medical center. On arrival, she began to vomit blood, fell into a coma and her heart stopped.

Her family received news that she died Tuesday morning. Now, I guess this isn't evidence that a death might be related to the vaccine. But it certainly would concern me more than it's concerned Dr. Fauci Dr. Lewinsky. Dr. Collins, Dr. Woodcock, Dr. Marks, I know one of your favorites, Brianne. This is reality. This reality is being ignored by our by our federal health officials, by the legacy media, by big tech.

Dr. Robert Malone 23:25

Senator Johnson?

Senator Ron Johnson 23:27
I just wanted to get that out there. Dr. Marik?

Dr. Paul E. Marik 23:31
So sorry. So, 1000 times more likely to die from a bicycle than from COVID. So, I think it would be appropriate that the federal government ban all bicycles, because they are certainly more likely to kill you then COVID.

Senator Ron Johnson 23:52
Doctor Malone?

Dr. Robert Malone 23:57
Thank you, Senator. So, it's we all feel good when we say these anecdotes, and we, I appreciate the humor. We need humor to defend. But Senator Johnson, regarding... I'd like to touch on a couple of things. Regarding the age stratification, I had-- I was asked not to speak about this by Nancy Pelosi's office, but I had a meeting with them last fall. And I specifically asked that they asked the CDC to age stratify. And there was absolutely no action taken.

So, it's not as if the administration and the senior leadership in the House at least, was not aware of this issue of age stratification. Point number two, the issue of the vaccines and the vaccine mandates. The data are clear. The vaccines are not protecting from infection replication in the spread of omicron. And the data are relatively clear and emerging, that vaccination is enhancing the risk of infection, replication, disease and spread of omicron. There's no logic.

Senator Ron Johnson 25:14
Let me just quick stop you. Can you talk a little bit about the studies that have proven that? Because, you know, we've all been accused of misinformation, disinformation can you give--?

Dr Aaron Kheriaty 25:23
Yeah. The Ontario data, Robert, those lines crossed a couple of weeks ago. So, in Ontario-- Canada's a highly vaccinated region. Their public health data has shown for several weeks, higher numbers of omicron cases in the vaccinated as compared to the unvaccinated and the response to that was always, "Yeah, but a higher proportion of the population is vaccinated.

So, we would expect to see maybe more breakthrough cases." But just, I think about two weeks ago, if you look at cases per 100,000, so not total number of cases, but case rates, the vaccinated group was on a steeper incline, if you look at the curves. And those lines crossed about, what nine or 10 days ago, I think it was, where cases per 100,000 in Ontario, Canada, highly vaccinated region, are higher among the vaccinated than among the unvaccinated. I think it's an open and debatable question whether and to what extent the vaccines are still protecting against more severe symptoms. But in terms of cases, there's more cases now in higher--

Dr. Robert Malone 25:30
We-- Ontario is one example. There are multiple examples from Northern Europe. There are examples from Scotland in the United Kingdom. And now I'm being asked to consult with the President of Israel tonight regarding what they're seeing there where they've seen the third jab and the fourth jab are not helping.

Senator Ron Johnson 26:54
So, just, what would be the physiology? I realize you don't know this, but why would that be? Because I, again, being part of the doctors groups, I've heard doctors talk about this vaccine may misset your or inadequately set your immune system, and maybe make you more vulnerable. I mean, I think there is documented case that there's a spike in COVID cases right after the first dose, where maybe... You know, what's happening?

Dr. Robert Malone 27:20
So, Senator Johnson, you're exactly right. And we call this confounding variables. And it's very difficult because there's so many overlapping things. Dr. Risch can speak eloquently, I'm sure, about the challenges of confounding in these large datasets. And we always have to be very cautious. But what we're seeing is a risk profile. That is a function of the number of vaccine doses. So, you're seeing increased risk with one relative to none, and increased with two relative to one and with three relative to two.

Senator Ron Johnson 27:55
Why would that pass? Can you...? I told you guys to speculate--

Dr. Christina Parks 28:01
So, one reason might be is because when they gave the mRNA vaccines, which are a form of gene therapy, it induces a very inflammatory response. They wanted to tamp down on that to prevent hyper inflammation upon vaccination. And so, they modified the RNA in a way that changed the way that it interacts with our toll-like receptors.

Our toll-like receptors are receptors that we have, that basically take things like viruses, bacteria, and they coordinate an inflammatory response. And by coordinate, it's not a simple response, it's many different toll-like receptors integrating a large body of data and telling your body what to do. So, it's important that they are recognizing the right molecule, getting that danger signal, and integrating the response.

But we engineered these virus-like particles to tone down their response. And so, now we have basically, there was a paper that came out and maybe Dr. Cole has the reference for that, but that basically it's changing the whole way the immune system works. So, it's no longer as responsive to viruses. No longer has responses to bacteria and many other pathogens, because we've sort of like turned them off, or turn them down and we don't know how long that response--

Dr. Robert Malone 29:14
Your way dead in the weeds.

Dr. Peter McCullough 29:16
And that was Dr. Foss's study out of the Netherlands. So, there we are weakening our immune response chronically--

Dr. Robert Malone 29:23
There's four or five up--

Senator Ron Johnson 29:25
So, we may be seeing some disagreements, which is fine. Okay. I don't know.

Dr. Peter McCullough 29:28
I'm supporting her data.

Dr. Christina Parks 29:31
I mean, that's some new data. It's somewhat speculative, but that would explain some of the dose response if you keep turning off those toll-like receptors, and it would also some of the anecdotal evidence that there may be more cancers because that's a surveillance. You're turning off that--

Dr. Robert Malone 29:44
But if I may--

Senator Ron Johnson 29:45
So, again, we're trying to do this for a layman audience. And again, I'm trying to say... Now, this is... I did ask people to speculate and that's dangerous. I could be opening up a can of worms here, but I think this is an important discussion, but try and communicate it in a way that was...

Dr. Robert Malone 30:00
If I could have the floor for just a moment. Um, there's four or five different mechanisms, potential deep scientific mechanisms, that range from suppressing your immune system to changing the behavior of people that are interacting with their environment. There's a range of potential confounding variables.

And it's not... We don't need to go there right now, but the FDA, absolutely and my colleagues in vaccinology have long known that one of the great risks, one of the things that scares us most as vaccinologists is vaccine-enhanced disease. And there's a long history of vaccine-enhanced disease examples. Over time, respiratory syncytial virus is the one that's often cited by my fellow vaccinologists, but there's many others.

This is why we have to be careful in developing new vaccines. That's just one example of why we have to be so careful, and we have to be cautious about rolling them out in that we do the science. But in the case of vaccine-enhanced disease with coronavirus vaccines, this is a known complication. It's one of the reasons why I advise my group not to pursue vaccines.

When we got the call from Wuhan in January of 2020. Vaccine-enhanced diseases with coronaviruses has long been a problem. It has compromised every prior coronavirus vaccine development effort. It is including the veterinary ones. It's been overcome twice with license for veterinary vaccines and both of those are mucosal vaccines.

So, in short, this is a known problem. Many of us that are down in the trenches have been carefully monitoring for whether or not there are data emerging that suggests this problem might be occurring. And now we seem to be seeing clinical data that's consistent with that. But as Dr. Risch I'm sure will share, we have to be cautious because there are multiple confounding variables.

Dr. Harvey Risch 32:06
We all know actually the Public Health UK has actually published a statement about this in their week 42 weekly report that showed that people who've had COVID and then get vaccinated have lower levels of anti-nucleocapsid antibodies. And this means-- And since the vaccines don't address the nucleocapsid antigens, they only address the spike, it means that they're doing something that's damaging the immune response in a more general way than just what they do with a spike. And this is empirical data that Public Health UK has published.

So, we know that this is happening. It's not a theoretical issue about all of the niceties of laboratory biology and neurology of things that could happen. It's a real thing that's been really observed by their testing.

Dr. Richard Urso 32:59
And it's--

Senator Ron Johnson 33:00
Just real quick. This, by the way, is the kind of discussion that ought to be occurring within these advisory panels. Again, it's difficult for the general public to really understand because I didn't exactly know that--

Dr. David Wiseman 33:12
We have raised this in front of advisory panels. I've raised in front of the Israeli Ministry of Health, we've submitted papers, we've submitted written documents to CDC and FDA and all these issues, and all this stuff about negative efficacy--

Senator Ron Johnson 33:26
But they've been ignored.

Dr. Peter McCullough 33:27
But David, I want to point out that the CDC, and academic medical centers will say, and they will go to a home base, that they will say that the vaccines are associated with a reduction in hospitalization. And this will come up.

The CDC in the last few days said there's five more papers showing the vaccines, even with omicron, are associated with the reduction in hospitalization. But it's only in US hospitals. Not in South Africa, not in Germany, not in Denmark, not in the UK and not in Israel. Americans should be asking the question, why are the vaccines only working against hospitalization, but they don't work against binary cause of the respiratory illness or reduce spread? And they don't reduce mortality.

But why do they only reduce hospitalization? And by the way, they reduced hospitalization in most studies in the United States by 85%. How does that happen? That is basically academic fraud. And the reason why it is is because these hospitalizations are not adjudicated. They're not telling us why their patients are hospitalized. And we've had multiple officials come out and tell us that 40 to 60% of people coming to the hospital who test positive for covid are not there for COVID.

So, we have a trumped up set of numbers. And to make matters worse, our CDC has advised consistently that the unvaccinated get lots of testing and the vaccinated actually refrain from testing. So, the combination of not adjudicating hospitalizations and this asymmetric testing is creating a fraudulent data scheme in order to make the claim that the vaccinations are associated with reductions in hospitalizations when in fact they're not. And that's the reason why Israel is loaded with fully vaccinated people in the hospital for COVID-19. And so is Germany. And so is the United Kingdom and elsewhere in the United States.

Senator Ron Johnson 35:20
So, let me say, Dr. Kory. I was talking to Dr. Kory about this, who has some experience in hospitals. You're talking to me about the information system in hospitals as relates to vaccinated status. Can you kind of talk about that?

Dr. Pierre Kory 35:37
Yes. So, you know, this constant refrain that Dr. McCullough just pointed out to is that everyone in the hospitals is unvaccinated. I believe that is manipulated data. And it's done again, for the same purpose that I keep talking about. They want to vaccinate, vaccinate, vaccinate. Every vaccine brings profits. Now, how do they do that? In this country, when you log in to the most popular electronic health record, which is probably EPIC, and I've been in numbers of hospitals throughout the pandemic.

There are only two statuses of patient can have. They can either be vaccinated or they can be unknown. There is no category of unvaccinated, it's unknown. And it is my hypothesis. I cannot prove this. I believe that if you've been vaccinated within that hospital or hospital system, that vaccination record appears.

If you went to a Walgreens or Rite Aid or some private practice, I think it's highly likely it doesn't appear that you're vaccinated. I believe that they are artificially, with great purpose, they are hiding the fact that many people in American hospitals are vaccinated. Because Dr. McCullough just talked about why in the United States is the data here completely discordant from other countries and other health systems which are revealing the underlying granular public health data in a transparent fashion.

Dr. Richard Urso 36:58

Pierre, I have the answer here. Here's a paper. Here's a paper, I'm going to read the title of the paper, "The Food and Drug Administration bollocks, biologics, effectiveness and safety initiative facilitates detection of vaccine administration from unstructured data in medical records through natural language processing." Well, this is a paper from FDA that just came out in the last week or so.

They are saying that they've gone through, and they've said there's at least a 16% non-capture of people who were vaccinated but are being called unvaccinated. That is exactly what you're saying. FDA are admitting it.

Here's the paper. It's right over here. This is on the top of my list. What the consequence is of that that means all the data where they certainly got vaccinated here and unvaccinated here, you've got 16% who are in the wrong place. That means you've got a 32% imbalance is swinging the wrong way. FDA have just admitted that.

Steve Kirsch 37:54
I want to ask Peter a question.

Dr. Pierre Kory 37:56
I want to make one more point. That I am absolutely exhausted about hearing about vaccinated and unvaccinated. There's only one category you need to care about. It's untreated versus treated. Stop with the vaccinations.

Senator Ron Johnson 38:11
Okay. So, okay. So, because we mentioned hospitals, I can get us back on track to... Because we really jumped ahead to vaccines, and we got hours to talk about vaccine, vaccine efficacy, safety, that type of thing. I want to polish off hospital care, because I think it's extremely important. It's certainly, as I'm hearing from people some of those heart wrenching stories, I'm hearing where a loved ones in the hospital and the family's begging the hospital do more trying to save the person's life.

And they are just being told, "You know, your loved one, there's not much hope, you know, get ready for the worst," and they just won't do anything. So, I want to strike the question out. What freedoms do you give up when you get admitted to the hospital? And is this a new phenomenon or has this always been true? Because it seems like when you hear, you know, Dr. Kory's aware of this because he's involved in the lawsuits of families taking hospitals to court, administer you know, one of the unnamable drugs and even under court order, the hospitals won't do it.

And the people just die. I am the champion, I am the author, I'm the champion of Right to Try Legislation, which gives patients and their doctors the right to try an unapproved drug. And yet, Americans haven't been able to access fully-approved drugs with decades of safety profile. What has gone off the rail here? But so, again, I want you hospitalist here, you know, the people that actually, probably misusing the term.

Has this always been the case? Have you always lost all your freedom? Turn yourself over the hospital and you have no rights, and you can't even sometimes get checked out. I know, Dr. McCullough, you

were just involved in case of shipping somebody from... Shipping. Sending somebody from, a manufacturer, somebody from Minnesota down to, I guess it was Dr. Varone. Let's--

Dr. Peter McCullough 40:19
As an ethicist about right patient--

Dr Aaron Kheriaty 40:23
Physicians have always appropriately been granted discretionary latitude to exercise their own medical judgment. There are treatment recommendations from medical societies, from CDC, from all kinds of different sources, that we can take into account when treating our patients. But every patient is a new textbook.

Every patient is unique human being, that has unique factors, that only we and the patient really understand with sufficient depth to make difficult medical judgments. And this is the first time in my career, I think the other clinical physicians in the in the room would agree, where I've worried about is somebody going to be looking over my shoulder asking me why I've prescribed fluvoxamine for this indication, rather than that indication? I prescribe it for depression, no problem. Are you giving this to treat COVID? Why should it matter to you? So, introducing--

Senator Ron Johnson 41:22
So, you're saying this the first time in your medical--

Dr Aaron Kheriaty 41:24
In the last two years.

Senator Ron Johnson 41:25
Is that? Is that true?

Dr Aaron Kheriaty 41:27
The last two years. Now, there are things that hospital administrators do that have annoyed physicians for years. But the kind of hamstringing of physicians in terms of doing what we believe to be the right and best and good for this vulnerable patient in front of me right now. That is my only responsibility as a physician. This patient who has placed their trust in me as their physician to do what is best for them. And not be acting as the agent of a social program, or a state program, or any other interest that could compromise. So,--

Senator Ron Johnson 42:12
So, talk about the historic role of these agencies, in the relationship to doctors and how did that change. And let's leave the pharmaceutical companies after these things out of the equation here.

Dr Aaron Kheriaty 42:23
They are advisory and the CDC is not the nation's super doctor. And I'm going to scandalize a lot of people by saying the CDC is not a medical organization. It's a public health organization focused on infectious disease spread. And they can do modeling, they can do epidemiology, they can give,

obviously recommendations on that issue. But in terms of how to best treat this particular patient in front of me, they're not the experts. The CDC published a list of contraindications to vaccines that has been taken by healthcare institutions to be complete and definitive. The CDC never meant and would openly acknowledge this is not a comprehensive list of reasons to avoid the vaccine. But--

Senator Ron Johnson 43:12
Isn't it true that health agencies should be...? They should be working for the doctors; they should be providing you information. They shouldn't be dictating.

Dr Aaron Kheriaty 43:23
And they should--

Senator Ron Johnson 43:23
They're supportive of your--

Dr Aaron Kheriaty 43:25
Yes. And that's a two way street. They should be listening to doctors, the doctors on the front lines that see firsthand what's going on, that gain valuable clinical experience, as things that were tested in highly controlled settings, with smaller numbers of patients are put out to broader numbers of patients.

These agencies need that feedback from frontline physicians. So, it has to be a relationship of mutuality, and ultimately, all the work has to be for the benefit of the patient. Economic, financial and other perverse incentives and other interests cannot play a role in these deliberations.

Senator Ron Johnson 44:03
Dr. Marik?

Dr. Paul E. Marik 44:05
Yeah, so, I can address this personally, because this is a personal issue for me. So, just to make the point that what's happening now is completely unprecedented in the history of medicine, and across the world. We have the federal government, we have state agencies, and hospitals, telling doctors how to practice medicine.

They are interfering with the sacred patient-physician relationship. They are telling doctors to be doctors. So, I can tell you what happened to me. So, I was using our protocol to treat critically ill patients in the ICU with a whole host of repurposed drugs. I then... This is a memo. This is a memo sent to the entire health care system, but they targeted me personally.

And what did this memo say? This said I can use remdesivir, and then I will quote there was an added section "do not endorse section which includes medications that may cause harm and efficacy is not supported in peer-reviewed, published RCTs. These medications will not be verified or dispensed for the prevention or treatment of COVID. This list includes ivermectin, bicalutamide, etopsicide, fluvoxamine, dutasteride, and finasteride" and then just to stick it to me, they added ascorbic acid.

Dr Aaron Kheriaty 44:56
Otherwise known as vitamin C.

Dr. Paul E. Marik 45:38
The system was effectively preventing me treating my patients according to my best clinical judgment. And then how did this progress? I object it, so the first week I was in the ICU, I don't know what to do. What was I to do, my hands were tied? As a clinician for the first time in my entire career, I could not be a doctor. I could not treat patients the way I had to be to treat patients. I had seven COVID patients, including a 31 year old woman.

I was not allowed to treat these people. I had to stand by idly. I had to stand by idly, watching these people die. I then tried to sue the system. And you know what they did? They did something called peer sham review. It is a disgusting and evil concept. They then accused me of seven most outrageous crimes that I had committed, and that I was such a severe threat to the safety of patients, they immediately suspended my hospital privileges, because I possessed and posed such an outright threat to these patients.

Ignoring the fact that under my care, the mortality was 50% those of my colleagues. I then went on through the sham peer review. I went to a kangaroo court where they continued this. And the end result was I lost my hospital privilege and was reported to the National Practitioner Data Bank. So, here I was standing up for patients' rights. And this hospital, this evil hospital ended my medical career. So, that's what they do. It's an outright outrage. It's evil to the core.

Dr. David Wiseman 47:45
Why? Why did they do that?

Dr. Peter McCullough 47:48
Just one second, Dr. Marik. Did any of those cases that you were reviewed on, were they non-COVID cases? Were they pneumococcal pneumonia cases or staff sepsis, where you used a broad range of your clinical ?

Dr. Paul E. Marik 48:02
These were all patients with COVID.

Dr. Peter McCullough 48:04
So, it was specific to COVID. Not any other condition where you would use your broad range of clinical skills. It was only on COVID--

Dr. Paul E. Marik 48:13
Absolutely.

Dr. Peter McCullough 48:14

--that was the review was applied. And it was applied in a way that was basically expressing and advising therapeutic nihilism, which means, for the American public, therapeutic nihilism means the denial of treatment in patients in need.

Dr. Paul E. Marik 48:31
This is the document, which was sent to the entire health care system, which is the COVID-19 comprehensive treatment guideline, which specifically was targeted at me, preventing me from prescribing safe, effective, off-label drugs. It's unprecedented in the history of medicine. The hospital is telling me how to practice medicine. They are denying me the right to use safe and effective drugs and lying because they collectively--

Dr. Peter McCullough 49:05
Who can use safe, effective, off-label drugs for other conditions outside COVID?

Dr. Paul E. Marik 49:12
Absolutely. If this was pneumococcal pneumonia, this wouldn't be an issue. This is specifically for COVID.

Senator Ron Johnson 49:18
So, let me ask the question. How has the hospital treatment of patients advanced, improved over the last two years?

Dr. Paul E. Marik 49:28
Sorry to continue. So it's a terrible thing for me to say, I'm an intensivist. I've worked in the ICU for 35 years. Hospitals have become dangerous places for sick people. Patients must do whatever they can to avoid the hospital. When they are imprisoned in a hospital, they are denied their rights. They are not allowed a patient advocate.

Their family are denied access to the patient. They are prisoners in the system. They have no rights, and they get the treatment dictated by the hospital. They are dangerous places for sick people. And that, for me as a physician practicing hospital medicine for 40 years, saddens me to the core.

Dr Aaron Kheriaty 50:15
Yeah, there's two-- There have been two advances. One is, they many hospitals are finally using steroids and sometimes sufficiently-dosed steroids against COVID. In the beginning, they wouldn't even do that even though it's clearly an inflammatory condition in the long when it gets to that phase of the illness. The other advance that was made in the hospital is intubated patients get turned over on their stomach. Proned position patients apparently did better on ventilators, those who--

Senator Ron Johnson 50:48
That was actually really discovered very early on, correct?

Dr Aaron Kheriaty 50:51

And they were discovered very early on. That's right. Another thing that patients in the hospitals and their families were denied was the basic human good of burying the dead. I don't know if folks are aware of this. But in the early days of the pandemic, a theoretical risk that maybe a corpse, maybe might somehow, even though it contradicted all known science on respiratory viruses, somehow still spread COVID.

This was a very weird paranoid thought, that caused many health departments with the support of the CDC, to refuse to give the body back to the family. The bodies were incinerated, basically. And they would give you the ashes whether or not you wanted a burial or not. One of the most painful conversations I had in the hospital, as the head of the ethics committee, I had a lot of conversations with families whose loved ones were dying of COVID.

And this was a case of a patient irretrievably, at that point, dying of COVID The family had finally come to accept that difficult reality that patient wasn't going to survive the hospitalization. And then they asked about to help for funeral arrangements. And the social worker told them, "No, I'm sorry. You know, we can't give your loved one back to you.

We can't give the remains back to you because the health department won't allow it." So, this theoretical, nonsensical risk that obviously turned out to be false anyway, was placed above that basic human good of burying the dead. No sane society in the history of humankind since the days of Antigone has ever done this to people.

Senator Ron Johnson 52:40
So, again, I want to just kind of do the timeline. Early on, there was so much we didn't know and that was... We were all... Well, Dr. Urso is shaking his hand. But... But again--

Dr. Richard Urso 52:50
No, that's not true, Senator. We knew early on we had treatment early on from the very first day in March. That's as fabricated lights, it's scientific fraud to say that. There was treatment for inflammation, there was treatment for blood clotting, there was even treatment that we could try for the virus. There's treatment for respiratory demise.

It was definitely an option. Until as we went on, as he just talked, and I don't want to interrupt, but just let me kind of cover on this. The virus, respiratory viruses are gone in 5-7 days. To say that this corpse can contain this respiratory virus, you know, a month or two later is ridiculous. So, it's been a fraud from the beginning. And I don't understand why but to go to just one more quick thing. The NIH, the CDC and the FDA are not involved in medical education.

We went through a residency, a medical school residency program. We have colleagues, mentors, people that we rely on. I've seen 300,000 patients, I've never called the FDA, the NIH or the CDC one time for advice. It's not who we call. So, to have them dictate our medical practices has to stop. It should not ever have been done.

We've got to find a way to fight back. The public knows that hospitals are dangerous places, like Dr. Marik said, and we've got to reinvent the wheel, basically, because our current system is the corporate practice of medicine telling doctors what to do when we already know what to do. There's a nuance and we know it. Each and every patient has a slight potential thing that we might do differently and if we don't do that, we are not good doctors.

Part 5

Tue, 2/1 6:21PM • 1:06:44

SPEAKERS
Dr. Christina Parks, Dr. Ryan Cole, Atty. Tom Renz, Leigh Dundas, Dr. Robert Malone, Brianne Dressen, Dr. Peter McCullough, Dr. Richard Urso, Senator Ron Johnson, From background, Nicole Sirotek, Dr. Pierre Kory, Dr Aaron Kheriaty, Dr. David Wiseman, Jennifer Bridges

Senator Ron Johnson 00:00
So, what I want to know, is this completely a new phenomenon where the federal health agencies are really dictating how doctors...? Or was this a slow--?

Dr. Richard Urso 00:12
So, historically, just a quick history, I'll let Pierre talk, but the quick history is, historically, I was very closely aligned with the hospitals. And it was more like hospitals and doctors were... The CEOs of two major hospital systems were very good friends of mine in Houston. One was my next door neighbor, and one was a good friend from medical school.

Bottom line is, we were with the hospitals. It felt like a partnership. And we kind of felt like the insurers were the other side of things, like we were kind of us against them. But the hospitals started pulling together, they started building these big organizations, and now they are the most powerful entity in medical care for us. And so, we have to deal with them.

Senator Ron Johnson 00:53
So, it started this creep started with the consolidation of these hospitals--

Dr. Richard Urso 00:57
Correct.

Senator Ron Johnson 00:58
And they decided, you know, this is how we're going to throw out of hospital chain, here are the protocols we're going to follow. And this was cost driven. This was a cheaper way to do this. a more efficient, effective way.

Dr. Pierre Kory 01:08
Can I speak to that for a second? Because I want to say that prior to COVID, I did see some of this starting to happen. I was a clinical leader in a major US institution and academic medical center. And I started to hear these echoes of standardized, standardized, so it's this push for standardization.

Now, the problem with that is that a patient is not a car. You know, hospitals are not factories. Dr. Kheriaty spoke very eloquently about that, that beautiful mystery of a patient and the phase of disease and illness, and in all their host of comorbidities and predilections and medicines. It's a very complex problem that we have to solve. There is no standard solution.

That push towards standardization that was beginning before COVID, hyper-accelerated into some sort of totalitarian top-down control of the practice of medicine. Dr. Marik just spoke about it. The autonomy, the freedom, the liberty to make decisions, using your decades of expertise and experience was removed. You were told to use this drug at this dose for this duration.

I've never seen that happening. It's unprecedented. And I have to call out one particular point, is if you want to talk about hospital medicine, how far we've advanced. My strongly held expert opinion, as someone who has been treating COVID in hospitals and ICUs, for now almost two years, is that the proximate cause of death of nearly everyone in the hospital is the severe, persistent and pervasive underdosing of corticosteroids.

The standard NIH recommended guideline dose is dexamethasone at the dose of six milligrams a day. That dose is less than I give my 80 year old patients with emphysema who are wheezing. These are patients on ventilators, whited out lungs with almost no gas exchange capacity left, and we're giving them anemic and pathetic doses of steroids and they die.

They die and they die. And they keep coming into my ICU. And I look at their record of what they were treated with in the hospital. And they're stuck on this anemic dose of steroids. So, why would that happen? Why would that happen? Why aren't doctors thinking and saying they're sicker and escalating doses? I don't know why.

It's this totalitarianism. And I also, again, senator, forgive me, I'm going to call out the C word again, the corruption because it is my strongly held belief as an expert, that this dose that was tested in a major trial and which made corticosteroids the standard of care worldwide. And I also want to, I also want to give praise to Senator Johnson.

You know, Senator Johnson invited me to give testimony in the Senate in May of 2020. And I remember my first conversation with him when he reached out and he was so enthusiastic about hearing about the work that Dr. Marik and myself were doing that we're putting out protocols, and we're trying to treat this disease.

You know, and he said he couldn't understand why the system wasn't reacting, in what way the entire system was in reacting the way we were. And I remember he told me, because, you know, I want the doctors to take their gloves off, and they're not. They were sitting idly by the bedside, institutions were paralyzed, waiting for randomized control trials to be done. And then finally, a randomized control.

So, and at that time, I testified to the world that corticosteroids were critical in the treatment of this disease. Nothing happened until a trial came out eight weeks later and proved the lifesaving properties for corticosteroids. But that dose that was tested, was ridiculous. It was the lowest dose and the dose

that's being used, helps the few and fails the many. We now have almost a dozen trials testing higher doses of different drugs. We know we have lots of evidence to show that methyl prednisone, which is another corticosteroid is far superior to dexamethasone.

We know that higher doses of that work better yet that system just chugs on. And so, it's my belief, that low dose was tested for one reason, one reason only, I think it was a corrupt exercise. And I'll tell you why. And this corruption has now been well described.

They fix trials, they can design trials to fail to disprove the use of cheap medicines, and they can make things appear that they don't work. I believe that that low dose, which is perpetrated and propagated worldwide in the care of the COVID patient, was held artificially low, so that they could leave room for much more expensive and novel and patented cytokine blockers.

So, they can enforce the use of more expensive and profitable medicine. And again, I'm just going to keep doing it all day until the people listen, until we understand we can upend the system. It's a corrupt exercise. The practice of medicine has been corrupted. It's been co-opted and corrupted.

Dr. Peter McCullough 06:05
And, Pierre, the mortality in the six milligram prednisone dose in the recovery trial was 22%. Unacceptably high. The idea that we are going to take six milligrams of dexamethasone and hold it out with a standard of a 22% mortality rate from a single trial is malfeasance. It's medical malfeasance. Any good doctor would use the principles of use of corticosteroids and find a more appropriate dose as Dr. Marik and Kory--

Dr Aaron Kheriaty 06:36
Senator Johnson, it's very important on the why question to look at the way in which the CMS, Medicare, Medicaid payment structures have created perverse incentives for hospitals and hospital administrators looking at those reimbursements. The way in which a COVID hospitalization was paid more than someone with the exact same problem, exact same symptoms than another hospitalization.

So, I go treat a 22 year old woman who's in the hospital for suicidality, and a positive COVID test. And so she's an isolation, has zero COVID symptoms, that she shouldn't be on the medicine floor. She should be on the psychiatric ward. But the hospital is getting paid a lot more for that hospitalization simply because she had a positive PCR test. The same perverse incentives are working in terms of the novel drugs like remdesivir, that were ran through the approval process.

Once Medicare, once they go through the approval, and Medicare decides they're going to pay for them that becomes "standard of care." Third-party payers, the private insurance companies will follow suit. So, Medicare really sort of sets the table and sets the rules by which the hospitals operate financially, and the other third-party payers that reimburse the hospital's follow suit. So, until we can look at the CMS issues and follow the funding, I think we're going to be left scratching our heads wondering why are these institutions behaving this way?

Senator Ron Johnson 08:21

Okay, so, I didn't know how this was going to go. And we have the room for five hours. And I thought that might be overkill. It's not even close to enough time. It's not and we haven't even really got to vaccine efficacy, safety, some of those issues. To close out this hospital thing. The history of the fear is real. Now, I remember the Chinese responders in their moon suits and everybody with PPE, and I'm saying that wasn't unreasonable.

We didn't know. I mean, maybe some people were more enlightened, they knew. But I guess what I've always thought, I need to point out, you had a nice cushy job in Wisconsin, you know, beautiful, probably about three blowsy or something like that and then started and you went you went to New York, the hotspot, because you had the courage and compassion to treat patients.

I guess I've always put my faith and I've listened a little closer to the doctors that actually treated patients and a whole lot didn't. Which is why I asked you and an ophthalmologist or a pediatrician that wasn't able to come here today. Also, listen to the nurses who are the heroes. All these, all these people are the heroes of COVID. And now, because of the mandates, a lot of them, let's face it, a lot of them got sick.

Dr. Freed's sick got COVID Because he had the courage and compassion to treat. They've recovered from COVID. They're now treating vaccine injured. There is no way they are going to get the vaccine. They will not do it. And yet now we're pushing these mandates, even though, we know the vaccine doesn't prevent either infection or transmission. And we're still pushing it, doing a great deal of harm to our healthcare system.

Exacerbating the healthcare shortage. Dr. Kory pointed out, I guess, we have a nurse that would like to say a few words. Can you come up and introduce yourself? And we also have a doctor here with a coat on that. Now, that's the gentlemen that looks a little bit like Dr. Malone. So, please introduce yourself and tell us your story. And then we have to get to some of the vaccine injuries and some of the because Go ahead.

Jennifer Bridges 10:40
Yes, my name is Jennifer Bridges, I'm an... I'm still a nurse, but I was fired from Houston Methodist. I'm the one you might have seen all over the news. We were the first one mandated with the COVID shot. So, I blew it up on the national media. We have a huge state and federal lawsuit because we don't want to be guinea pigs.

We saw for ourselves in the hospital, people coming in with adverse reactions after getting the Pfizer shot. And the crazy thing is, is let me tell you a couple things about Methodist Hospital down in Houston, Texas. When they first started with COVID, I did that COVID unit on and off the whole time till they fired me in June, right? They started the first two months with hydroxychloroquine. They actually used it in the hospital.

Then they cut it back really quick, switched it to remdesivir, and all these other expensive drugs. And we're like why? And we would ask these doctors. No one could give us a reason. They just said, well,

the hospital policy changed. But they didn't know why. And you know, most of those doctors in that hospital would not even go in those COVID rooms.

There was maybe two that would. They would stand outside, make us dress up head to toe and go in with an iPad. So, the only form of communication those doctors would have in Houston Methodist with the COVID patients was through an iPad. So, literally, we go in there, they'd be talking to him. Never assess the lungs, never look at him, nothing, go to discharge him. I would come back out and be like, "No, have you listened to them? They can't breathe." Like the wheezing is horrible.

They had no clue. They weren't even looking at that. And to address when it... Sorry. I'm like, I got a little emotional back here. I've been there, I've done the whole shebang, right. Even I was the first one at Methodist that they asked to do window visits. Because when these COVID patients were dying, and they never did this with anybody else dying, family was not allowed to come in to say goodbye. They couldn't hold their hand.

They were left alone in these rooms. I was asked, because I was one of the most compassionate nurses they had there, will you do these window visits? They would escort family into the cafeteria windows, I would go there sweating my butt off for almost an hour and a half, two hours just to put the phone by that loved one's ear, so they could say goodbye. I would stay in there as long as I could and other nurses, they wouldn't want to do it.

They'd be like, "No, it gets too hot," or "I don't have time for that." And the things you would hear were just insane to me. And I'm like I don't care about, you know, what's going on with me. This is way more important. And I would stay in there with them listening, you know, to these families say goodbye. They'd even be on the window with another cell phone and go like this so they could say goodbye. And yeah, I would love to talk to you later.

I have so much information for you that I have right before I got fired and I tried the wait way. I didn't go to the media at first. I actually had a meeting with my CEO and CNO at Methodist in Baytown, David Bernard and Becky Chalupa. They caught me going around with my little petition to say, you know, if people agreed with our stance not to force us against our will. Somebody told them I was doing that.

They called me into this meeting, where they sat me down, they threatened me, they told me I had to stop. They could fire me over this because I was soliciting. And I told them, I said, "Well, what if I went to the public? What if I went to other hospitals?" What do you think they would say? He looked me in the face, and he said, "I strongly advise you against that." And he even told me 100% compliance was more important than my individual autonomy as a nurse.

And that is a huge, huge slap in the face. And then after I got so public, basically, other doctors, whistleblowers were coming to me to share information. So, I've seen text messages, I've seen emails where Methodist Hospital threaten their doctors. You cannot sign medical exemptions. You cannot talk about; you cannot report adverse reactions to these vaccines. And then if you do and if somebody was actually brave enough to do that on writing, there were other people higher up to erase those.

Those were not to be allowed on record. I have the proof and I have the people that have shown me these things.

Senator Ron Johnson 15:00
By the way, I can confirm everything you're telling me. I've heard countless times from other nurses. And I just want anybody listening, our healthcare system suffers because you're not in it anymore. And hundreds of people like you are no longer in it because they were fired by these vaccine mandates. I also want a little thought experiment here. Can you imagine...

I mean, what you just described, I mean, let's face it, the inhumanity, the cruelty, just the heartbreaking examples of what happened during COVID. Can you imagine, if we, one, would have risk-stratified our outlook on this, if we would have embraced early treatment so that we realized very early on, you don't have to die from COVID This could be no worse. This could be no worse than flu or colds. Can you imagine what our society would look like had we treated that way?

Jennifer Bridges 16:04
There would be so many more people alive right now and not dead.

Senator Ron Johnson 16:08
And we maybe wouldn't have a million adverse events,

From background 16:12
We wouldn't be here.

Senator Ron Johnson 16:13
Maybe 22,000 deaths. We really can't tell. In our closing minutes here, okay, I've got to have Brianne Dressen talk about why the vaccine injured are in the exact same position as you, treating doctors, are. Or the problem that we've had through early treatment where the the CDC, the NIH, the COVID gods won't acknowledge these repurposed, cheap, generic drugs, and how harmful that's been to our response. But in the same thing, Bree, talk about why it's so important that people acknowledge just the possibility that your injury might have been caused by a vaccine. Talk about why that's so important.

Brianne Dressen 17:06
Well, the reason that's so important is because if we can't see the problem, we're not going to be able to address it. And it's so strange hearing all of your complaints, because what we have seen firsthand, it just is woven into every one of your experiences. It is incredible what we've, you know, we're running parallel. But it's actually it's like you said, it's the same problem when it comes down to it.

So, you have these agencies that have politicized the medical system. It's violated the patient to physician trust. And it's left us out on alert, because we have nothing. And so, for an example of that is I've been fighting with Janet Woodcock at the FDA, for the betterment of seven, eight months now. I've told her about the issues with the clinical trials, I've told her about the fact that I myself, I am a preschool teacher, just to let you know, I'm not qualified as a medical professional whatsoever.

But I have Ivy League physicians referring sick vaccine-injured patients to me for medical care. So, if that in itself doesn't tell Janet Woodcock, that the system is broken, I don't know what will. But the other, sorry...

Senator Ron Johnson 18:23
Well, I was going to... Talk about how doctors won't treat you until the NIH, CDC and FDA acknowledge the fact that these things, they just all think here--

Brianne Dressen 18:35
We don't exist. I mean--

Senator Ron Johnson 18:37
But you're also crazy, right?

Brianne Dressen 18:39
Yeah, I mean, you know, over 80% of us are misdiagnosed with anxiety initially, and then months down the road, we get appropriate diagnoses. And that's when we are able to find doctors that are actually willing to go against the directive, because like these physicians were discussing, their licenses have been threatened. And because their licenses have been threatened, we cannot get medical care. They are afraid to treat us.

We have had patients who are severely injured and are dying, who cannot get in the door to get seen by physicians because physicians are afraid of the word COVID vaccine. So instead, what they're doing is they've made us, like Kyle Warner and myself, and our membership of over 12,000 COVID vaccine-injured. We are ground zero to take care of the COVID vaccine-injured when we have highly qualified practitioners across the globe that have been silenced and threatened if they even so much as see us for what's going on.

Senator Ron Johnson 19:39
We also have to point out that your support groups on your Facebook groups that literally week from our first event where you were--

Brianne Dressen 19:48
Within 24 hours.

Senator Ron Johnson 19:49
They so these are the groups that allow you to stay in contact with people that are suicidal and have you... I know, you know, tragically a number of people who've committed suicide. What did Facebook do to your groups?

Brianne Dressen 20:00
Oh, they pulled us apart. So, right now, our Facebook groups were flexing, and Facebook and a couple of other social media groups were flexing between 22,000 members and 32,000 members any given

day. But they find us, and they pick us apart. And then we have to reboot and hope that everybody can find us again.

And so, these people do not have appropriate medical resources, because those doors have been closed by the NIH and the FDA and the CDC. And the FDA, and the CDC and the NIH know that this is happening to us. And they're still not doing anything to help remedy the situation, which it would be very simple for them to say, "Hey, I'm going to issue a communication through the American Medical Association, to tell the physicians, your license will not be pulled for review, if you address or acknowledge a COVID vaccine injury."

Senator Ron Johnson 20:52
So, one thing we have to do, and again, I barely scratched the surface of my list, I mean. First of all, we have to do something else like this again.

From background 21:03
Yeah.

Senator Ron Johnson 21:04
What we have to do is, we have to speculate. And you decide amongst yourselves doctors in terms who's best to theorize what's happening. What is causing these vaccine injuries? Dr. McCullough, I mean, you certainly understand about myocarditis.

Dr. Peter McCullough 21:25
The vaccines, all the vaccines in use in the United States, and predominantly across the world, use genetic technologies that harness the body's own cells to produce the protein on the surface of the virus, the spike protein, which is acknowledged to be dangerous.

This is the first time in human medicine, that we have an uncontrolled exposure for an uncontrolled duration and quantity in the human body, in a mosaic of cells. And to make matters worse, the vehicle that carries these genetic products into the human body goes into vital organs. And it's unprecedented that we've ever exposed a single human, let alone hundreds of millions of people, to this form of technology.

And I published an op-ed before these were ever released, saying it was a gamble. I knew it was a gamble. I knew based as a clinician, and one expert in clinical trials and safety, that this had a dangerous mechanism of action. It's biologically dangerous. And we have seen a large signal on safety. Unprecedented numbers of deaths and non-fatal injuries after exposure. We see unprecedented non-fatal injuries in the same data system.

And then when we look outside, and we look in the Yellow Card system, in the UK, we say the same thing. And we look in the EUGER system in the EU is do the same thing. We have just fulfilled the Bradford Hill tenets of causality. Meaning, I am telling you as an epidemiologist, the vaccines are causing these fatal and non-fatal events to a large degree and many of those skilled around the table, I'm sure would agree.

Senator Ron Johnson 23:18
Okay, so that transitions perfectly. Kyle, I'm going to have to actually ask you to give up your seat for Mr. Tom Renz. I got contacted by Attorney Tom Renz over the weekend, who represents some whistleblowers within the Department of Defense. In time, you cannot, you don't have much time at all, okay? He showed me his data, or he showed me the data that is being extracted from what is the name of this database?

Atty. Tom Renz 23:44
DMed.

Senator Ron Johnson 23:45
Pardon?

Atty. Tom Renz 23:45
It's DMed. It's the Defense Medical Database. And I'm going to just kind of cut to the punchline, because we just don't have very much time at all. But this data, so these are whistleblowers who have been extracting data out of the Defense Department database, they have noticed a very alarming increase in instances of certain conditions compared to a five-year average. You know, in like a 10 times number in some cases.

They also have evidence that with myocarditis, the data has been doctored already, because they did a search inquiry in August, that showed a certain level of myocarditis. I think it was like 20 times higher. 28 times higher? Something like that. But now, in January, it's only a couple 100 times. Or I mean, it's two times higher. So, there appears to be doctoring of the data.

Now, my staff has already sent... This morning, we sent a record preservation letter to the Department of Defense to try and protect this data. But, Tom, why don't you just quickly, because we have other things I do want to get to here, please, tell me. Apparently one of the whistleblowers is brave enough to come forward and give a name.

Or I would not have allowed you to come to-- Yes, senator. So, we've got three whistleblowers who have given me permission, at this point, to share their name. Lieutenant Colonel Dr. Teresa Long, DO, MPH, Dr. Samuel Sigoloff and Lieutenant Colonel Dr. Peter Chambers, DO and flight surgeon. All three of them have given me this data. I've declarations from all three, the state is under penalty. This is under penalty of perjury.

We intend to submit this to the courts. We have substantial data showing that we saw, for example, miscarriages increased by 300% over the five-year average almost. We saw almost 300% increase in cancer over the five-year average. Cancer is not being talked about except for by Dr. Ryan Cole. Thank you, doctor. We saw, this one's amazing. Neurological, so neurological issues, which would affect our pilots over 1,000% increase, a 1000.

Senator Ron Johnson 26:04

10 times. That's 10 times rate and obviously that rose--

Atty. Tom Renz 26:07
83,000 per year. I'm so, 82,000 per year to 863,000 in one year. Our soldiers are being experimented on, injured and sometimes possibly killed. Dr. Kory, thank you so much for your stance on the corruption. That's precisely what it is. They know this and, senator, when these doctors are attacked, not necessarily the people in this room, I'm not giving names, they call me. I'm the one dealing with the medical boards.

I'm the one watching the witch hunt. I'm the one fighting them off and I'm the one telling them where to go. I'm going to keep doing that. Senator, we also have, let me give you this last thing and then I'll shut up and get out of your way. 09/28/2021, Project Salus, weekly report. Project Salus is a defense department initiative, where they report and they take all this data that doesn't exist, supposedly, and they give it to the CDC.

They're watching these vaccines. On that date and around that date, I have numerous instances where Fauci and that entire crew were saying, "It's a crisis of the unvaxxed, it's 99% unvaxxed in the hospital." In Project Salus in the weekly report, the DoD document says specifically 71% of new cases are in the fully vaxxed and 60% of hospitalizations are in the fully vaxxed. This is corruption at the highest level. We need investigations.

The secretary of defense needs to investigate it, the CDC needs to investigate it. And thank you so much, senator, for having the courage to stand against the special interest. So, again, the Department of Defense-- Thank you. The Department of Defense, the Biden administration is on notice. They must preserve these records, and this must be investigated. Okay? Absolutely. Thank you so much, Senator. Thank you.

Senator Ron Johnson 28:09
So, the increase in cancer is something I've been hearing about for months. And quite honestly, I've told people that are reporting this to me, "I don't think the public's quite ready for that yet." Okay? But you've just raised this issue apparently. Dr. Cole, you're aware of this. Can you talk a little bit about that? Because this is frightening.

Dr. Ryan Cole 28:29
Thank you, senator. And this is a challenge in terms of aggregating data. I saw a signal early on of certain viral conditions. Dr. Parks pointed out mechanisms. I noticed certain viruses increasing while these same T-cells, immune cells, keep cancers in check.

So, I do about 40,000 biopsies a year. I'm busy pathologist, and I thought, "Gosh, I'm seeing more of this type of cancer and this type of cancer and this type of cancer." And so, I've tried to talk to other laboratories and aggregate a bigger dataset, which, obviously, these federal datasets are a very easy way to see that signal.

Obviously, I've been canceled. I've been ridiculed, I've been maligned, etc., for saying so, but I've been observing it. And I can't deny an observation. That's how science happens initially through observation, then we confirm through hypothesis, experiment and data. So yes, we're seeing it and now, when we travel with these groups and summits, I have oncologist, I have radiation oncologist, "I am seeing an uptick in cancers.

I'm seeing these odd stable cancers take off like wildfires." After the vaccines, it is happening. We need federal funding. The NIH isn't looking at this. Getting a grant to look at anything related to the vaccines is next to impossible because they're perfect, safe and effective. So, it's happening. My data is anecdotal, my observational group is significant. But we need additional studies to happen and thank you to Tom for digging into what's actually happening.

Senator Ron Johnson 29:59
I think we have some additional nurses. And by the way, that's where I was getting the safety signal from. Nurses from across the country are contacting me about the vaccine mandates, that type of things, talking, you know, telling me why they're not going to get the vaccine because they're seeing this. These patients that their cancers are in remission, then, you know, all of a sudden, boom, you know, they are blossoming again. Doctors are quickly--

Dr. Richard Urso 30:20
I've got a question I want to Dr. Cole to address. Ryan, you know that the experimental data on the genome in p53 and BRCA, can you explain that to everyone?

Dr. Ryan Cole 30:32
Yeah, really quick. So, we have genes in our body, we have mechanisms in our body, we have bad cells in our body every day. Our body says, "Oh, I can kill that, knock it off, you know, shakes hands with every cells. You're gone, you're gone. You're a bad cell." There are genes, there are suppressor genes p53.

It's the guardian of our genome. There's another breast cancer gene, BRCA gene, we know that the spike protein binds to the receptors for these genes and can activate them. That is a mechanism of the spike protein. So, putting the spike protein in the human body via a gene shot that is completely investigational. These are not approved, and to mandate something that's investigational that can bind to cancer, promoting, so--

Dr. Christina Parks 31:21
I'd like to just clarify and take that a step forward, because... What p53 does is it checks your DNA before it replicates, and it makes sure that it's fixed. So p53 is the one tumor suppressor gene that is most tied to cancer because once there's a mutation in p53, the mutation rate just skyrockets. And you're going to develop enough mutations that that cancer is going to have a much more likelihood of becoming metastatic.

Dr. Ryan Cole 31:49
Absolutely correct.

Dr. Christina Parks 31:49
So, p53 is the central tumor suppressor. Now, do we know for sure that the spike protein is binding it and inactivating it so that it cannot make sure that your DNA is replicated effectively and and without any errors? No, but that's why we should have tested these for cancer causing potential before we started giving them to our kids.

Dr. Ryan Cole 32:11
There are some confirmatory--

Dr. Richard Urso 32:14
I'll put it into the record. Paper by Jiang and Mei--

Dr. Ryan Cole 32:17
Yes.

Dr. Richard Urso 32:18
--where that goes into this data, SARS–CoV–2 spike impairs DNA damage repair.

Dr. Ryan Cole 32:24
Thank you.

Dr. David Wiseman 32:24
Yeah, one of the key points is that we still don't officially know what the structure of these so-called vaccines are. I mean, we do have some information now, that's been published by a Nobel Laureate group from Stanford, looking at the sequence from discards and comparing it with a PENS, and there are what are called untranslated regions.

Has anyone ever heard this word untranslated region? Anyone? Yes, a few people. Okay. Everyone has been told that the RNA in there is just RNA that's making the spike protein that's going to make your nice little cute little vaccine just like those mumps and polio vaccines that we've all had as children. No, wrong.

There are untranslated regions. And I'm going to read you what they are. There are three human gene sequences in those untranslated regions. One of them, we think, I'm working with a group of molecular biologists and genomics, one of them that we think is targeting the mitochondria. I'll tell you what that gene sequence is.

It is a, where is it, the three prime untranslated region comprises two sequence elements derived from the immunoterminal enhancer split ASMRNA and the mitochondrial encoded 12 is ribosomal RNA to confirm RNA stability and high total protein expression. That's what the WHO document says. Now, if that's true, if that's true, that could mean, we don't know, we need to find out, that could mean that the expression of the spike protein is actually being suppressed, partly at least, in ribosomal in mitochondria ribosomal.

Dr Aaron Kheriaty 33:56
This is so wrong.

Dr. David Wiseman 33:58
Mitochondria ribosomal-- That means it could be a kamikaze--

Senator Ron Johnson 34:03
Dr. Wiseman, listen. You're certainly letting us know you're qualified, but I don't know what you're talking about.

Dr. David Wiseman 34:08
What I'm talking about, senator, is, in every single drug in the packaging insert, you see a chemical structure. Do you not? There is a chemical structure. We need to know the exact chemical structure, the exact sequence of the RNAs and the DNAs in these vaccines. Okay, they are being withheld from us.

FDA needs to show us what those structures are. They need to explain what the pseudo uridine is doing. They need to explain this paper from Sahin, who is the founder of BioNTech, in 2019, no, excuse me, 2014, they talk about non-natural nucleosides. What are those non-natural nucleosides doing? He talks about the toxicity of them, the pseudo uridine. None of that is being discussed. None of that.

Dr. Christina Parks 34:53
So, I want to clarify a little bit there.

Senator Ron Johnson 34:55
I agree with you. We need a lot more information.

Dr. Christina Parks 34:57
I want to clarify because people have said these are mRNA vaccines. mRNA only always goes to protein, and we can't do anything. First, we know that people have reverse transcriptase. Yes, it can make DNA. Yes, it can go back into the DNA. But there's something else about RNA. RNA can make little hairpin loops.

RNA can regulate your DNA. So, when you put an mRNA vaccine or RNA into your body, it can get in, and it can be alternately spliced combined to your DNA, and it can regulate it. For positive or for negative, it can change your gene expression.

And there's stuff in there that can do that either intentionally or unintentionally and we don't know. It's completely unethical, because we are just beginning to understand RNA silencing where these RNA molecules regulate our DNA. So, that makes it completely unethical to use this technology.

Dr. Peter McCullough 35:46

We have to get on to... There are great unknowns with respect to the vaccines, their mechanism of action, and disease categories, like cancer.

But there is a disease category upon which the FDA, the CDC, and all stakeholders agree that the vaccines cause and that's myocarditis or heart inflammation. Now, I will tell you as a cardiologist, it is crystal clear that these vaccines cause myocarditis Dr. Parks has already quoted the paper by Avolio that has shown, beyond a shadow of a doubt, the vaccines cause myocarditis.

The FDA indicates for Pfizer, Moderna that they cause myocarditis. We now have over 200 papers in the peer-reviewed literature on myocarditis, sadly showing the rates of myocarditis are far in excess of what the CDC ever imagined. We've identified that boys have a predilection for this far more than girls, the maximum age group, the peak age group is aged 18-24, so it's actually the college age.

The risk extends up to age 50. And I can tell you that in this age group, it is clear, the risks of the vaccines are far greater than the risks of COVID-19. In the Respiratory Illness, two papers, one by Tracy Hogue at UC Davis, one by Ron Kossoff, that these papers have been presented at the FDA meetings, they have not been challenged as analyses.

And there are now fatal cases of myocarditis published by Washington University in St. Louis by Burma, and by Choi from South Korea. More fatal cases accrue. There is the father of a boy here in this room who's died of myocarditis. One death is too many. One. One. We have 21,000 cases of myocarditis and climbing in the United States that the CDC has verified.

One was too many. Under no circumstances, under any circumstances, should a young person ever receive one of these vaccines. Let alone ever be pressured to receive a vaccine, let alone ever be mandated to take a vaccine. This is crystal clear. The FDA agrees. There can be no controversy over this. There can be no normalizing of this, to say that it's mild or it's transitory--

Senator Ron Johnson 38:24
Talk about that because there... Is myocarditis mild?

Dr. Peter McCullough 38:28
I'm telling you as a specialist, myocarditis is not mild. There are papers by Shower, and by now by Trang at University of Utah, Salt Lake, where they do MRI on these individuals with suspected myocarditis. 100% are having heart damage.

100%. We have a paper by Tschöpe and colleagues looking at the outcome of individuals prior to COVID in this age group with myocarditis. 13% will have permanent heart injury. 32% never actually get up to normal. They don't get back to normal.

We are seeing unprecedented numbers of athletes dying on the field in Europe, unprecedented. Of these cardiac arrests, half of them don't come back. We now have a report out of the heart group in the UK, where actuarial mortality for those under age 15 mortality in the UK is higher than expected.

Senator Ron Johnson 39:26
Which are--

Dr. Richard Urso 39:27
Dr. Malone?

Senator Ron Johnson 39:28
Just quick going back in rounds.

Dr. Richard Urso 39:30
I wonder if Dr. Malone could follow up on that.

Atty. Tom Renz 39:32
Just really quick, because we're talking about myocarditis. What concerns me so much about the whistleblower report there is this is the only vaccine injury that the CDC, FDA are acknowledging. And you combine that with the fact that there's at least suspicions that the Defense Department is doctoring with the data in their database, affecting myocarditis. I mean, I'm sorry, that just gets my suspicion antenna... And the recommendations and the mandates are ignoring the FDA warnings.

Leigh Dundas 40:07
I would contend, senator, that there is not just a suspicion. In August, when the report was run on acute myocarditis in the DoD website, there were 1239 cases. And now when you run it, it's down to 307. In January of 2022, there were 176 cases. And magically, they are now down to 17. There is a word for that, it's not suspicious.

We have in the military, the single best data set that exists because we have baselines in there. And acute disease across all categories, in the preceding years, five years, leading up to the vaccination year, was 1.7 million. They introduced and mandated a COVID-19 vaccine for our US military when they had only lost 12 service members total to the disease. And in the 10 months of 2021 after that, it jumped from 1.7 million all diseases to darn near 22 million.

That was a 20 million increase. We need to not be calling this suspicious. With all due respect, we need to be asking hard questions of the DoD. And I will close by saying, they are charged, at least in part, with protecting the sanctity and welfare of the brave men and women who are defending this country. And right now, these numbers indicate something is drastically wrong. And I know of only one reason that databases roll math backward.

Senator Ron Johnson 41:33
So, who are you? Identify yourself.

Leigh Dundas 41:34
I will listen to them. We will take their transcribed interviews; we will gather their data. And again, I put the Defense Department on notice, they must preserve these records, so we can investigate. Sorry, my name is Leigh Dundas. I'm a human rights attorney that's working with Tom Renz on the

whistleblower issue in the military. I would ask that Congress, listen to these whistleblowers, put their testimony on record. These are brave men and women of very high rank in the US military. Because not just do we, Congress in this building need to hear about it, the world needs to hear about what is going on, Thank you.

Senator Ron Johnson 41:52
By the way, I just got a... I have to show you. This is what we get when I investigate. I mean, this isn't to do this. But this is after a couple of years trying to get information out of another agency. And we finally get the information and it's all redacted. Because this is how the administration, you know, the federal government, the agencies comply with congressional oversight.

Atty. Tom Renz 42:35
We're glad to share with you, senator, because we have quite a bit of those that aren't blanked out. And we also want to tell you, listen, the side effects, the only one that they're recognizing, that's an outright lie. I've got the Pfizer documents. Pfizer said, in their FOIA documents that they released, they said, we're looking for these side effects.

The FDA said, we're looking for these documents. We've got their documents showing what they're looking for. They're not sharing it with the American people, because they're covering this up. Corruption was the word of the day. And I think it needs to be reiterated. So, somebody really quick, in their testimony talked about what the drug companies were supposed to turn over when they made application. Dr. Kheriaty.

Dr Aaron Kheriaty 43:15
That was our--

Senator Ron Johnson 43:16
Talk about that specifically. I mean--

Dr Aaron Kheriaty 43:18
Okay, so. So, on the day in which the Pfizer vaccine was authorized under federal regulatory law, that data had to be made public to the American people. By data I mean the clinical trials data, that Pfizer submits to the FDA that the FDA then reviews and decides whether or not we're going to give--

Senator Ron Johnson 43:39
Why wasn't it?

Dr Aaron Kheriaty 43:42
Well--

Senator Ron Johnson 43:42
Was there a waiver granted by FDA?

Dr Aaron Kheriaty 43:44

No, no, what they said was, you know, we have a lot of FOIA requests. And they didn't deny that they had to release it eventually, because that would have obviously contradicted federal law. So, what they said instead was like, you know, even though we have a budget of $6 billion, I think it is, you know, we only have a handful of employees to handle these FOIA requests. And you know, they have to make a lot of photocopies of these documents. [unintelligible]

Atty. Tom Renz 44:13
Now, judges ordered to release not at 500 pages--

Dr Aaron Kheriaty 44:16
Eight months.

Senator Ron Johnson 44:17
Yeah, we'll get that sooner. I did, again we're running out of time, I did want to talk about some of the other revelations. You mentioned FOIA. The FOIA under for Japanese regulators show that these vaccines are not staying in the muscle as we were kind of all led to believe, it hasn't--

Dr Aaron Kheriaty 44:33
Animal studies from--

Senator Ron Johnson 44:34
--it's by distributing. We know the nano lipid particle. And it also goes through some of these very difficult permeable barriers, for example, the brain or--

Dr. Richard Urso 44:46
Yeah, I want to ask Dr. Malone that question. I worked with lipid nanoparticles in for chemotherapy. They are like garlic, they go everywhere. They can slip through a door crack; they go through very tight junctions. That's what they do. That's why when I first saw the technology, I knew was going to end up in the brain because that's one of the things they were doing was trying to find lipid nanoparticles to carry chemotherapy.

Senator Ron Johnson 45:06
I got concerned about it getting into the brain.

Dr. Richard Urso 45:09
Well, that was the actual original design for lipid nanoparticles, to be used in chemotherapy, because in order to direct chemotherapy to the brain, it's very difficult. So, they were kind of using lipid nanoparticles to do it. The problem was lipid nanoparticles went into ovaries, bone marrow, or adrenal glands and other tissues.

So, it's still being worked on, studies are still being done. But I was going to ask Dr. Malone, because Dr. McCullough had just talked about the fact that he has concerns. Do you have concerns for this vaccine and children knowing that it's going into the brain, the bone marrow, the adrenals, and all these other organs?

Dr. Robert Malone 45:45
So, the answer is yes, I've said that repeatedly. I've put out a four-minute clip in which I talk about the damage and risk to children in brain, heart, coagulopathy, reproductive systems, and immune systems. That resulted in direct attack from the Israeli Ministry of Health on my personal reputation. Multiple fact-checkers denying it, but the data are incontrovertible. But to your point, Richard, and Jill and I can attest, you know, I do have some credibility here, because I did create this technology. I do know, in detail. I can--

Senator Ron Johnson 46:29
But you don't work for the CDC, NIH, FDA?

Dr. Robert Malone 46:32
No, no, I actually work for the DoD from time to time. So, I do know about the untranslated regions, why they're there. I do understand explicitly in detail about reverse transcriptase and what it can do, etc. But I can tell you that we moved off of trying to develop further these mRNA and DNA complexes based on our work in non-human primates and in mice.

We spent years, with both commercial funding and various public funding, not NIH, trying to advance this technology. Many, many different ketonic lipid formulations, compounds tested, screened for toxicity. We could never overcome the hyperinflammatory characteristics of these poly nucleotide catalytic lipid complexes, we could never get there.

Now, the Curico and Weissman assertion is, you know, it's inside baseball. I brought Katy Curico into this, like a decade after I'd made the basic discoveries. They assert that the inclusion of the pseudo uridine reduces the inflammatory response, but the data show that that is a marginal decrease. And the data also show, from their competitor, it's important to remember that they are BioNTech, Katy's a vice president.

So, their competitor in Germany has shown very good immune response without the pseudo uridine, so you're right. Pseudo uridine is a synthetic compound. The logic is that incorporation of pseudo uridine reduces the inflammatory response. But the inflammatory response is still there. And to your point, Richard, we are clearly seeing not only specific effects associated with spike protein, but nonspecific effects associated with lipo-nano complexes.

How do we know that? Because Moderna gave us a presentation to their stockholders recently, where they rolled out their Phase One data on their influenza vaccine candidates that are using the same technology platform. So, no spike protein associated influenza antigens in their hands at the 100 microgram dose, which is the dose that's used in the emergency use authorized vaccines, 90% of the subjects had adverse events compared to 30% in the placebo group.

This is phase one data. Now, that data has not been disclosed publicly, it was only disclosed to their stockholders. But what it clearly demonstrates is that the kelenic lipid RNA complexes have intrinsic toxicity above and beyond just that associated with the spike. So, when we get into these arguments

about is it spike, is it the lipids, bla, bla, bla, it's both, okay? We have a tendency to get binary. It's either this or that. No, it can be both. Regarding the data package from Japan that Byron Bridle first acquired, and then I think I was the first after that.

People often get confused about this, but senator, this is the thing that worries me among the most. Is that that limited data that was not produced to any quality standard that any clinical trial, you know, precursor non-clinical data package I've ever seen would be allowed to be used. What the FDA and the regulatory authorities all over the world allowed was for Pfizer to collect data involving unrelated RNAs, other candidates amalgamated together and submitted as a package.

And in those data, which are not, according to good laboratory practices, they did demonstrate that these lipid nanoparticles go all over the body, just as Richard is saying. And oddly, they seem to differentially go to ovaries and bone marrow, but ovaries relative to testes. And it's important, everybody kind of latches on to this and they say, Oh, they're spike protein in the ovaries. No, that's not what they measured.

They didn't ever measure spike protein. What they measured was the lipid component, the synthetic lipids, which is the other thing you didn't mention in this cocktail, okay? These synthetic lipids go to ovaries. Who cares? Well, when your child is born, when your daughter is born, she has all the eggs she's ever going to have in her ovaries.

And we do know that, and the CDC now finally acknowledges after women all over the world complaining about their altered menses and getting... I mean, I felt like I was in the mid-20th century. It was attributed to hysteria much as your own story. These alterations in menstruation were believed to represent hysterical women. The CDC is now acknowledging it.

The thing is that the ovary drives menstruation. As Ryan will, I'm sure, attest. Hormonally the ovary drives menstruation. When we're seeing altered menstrual cycles, we're seeing the phenomena of postmenopausal women starting to bleed. That's a hallmark that something's going on in the ovaries. And we know that these lipids are going to the ovaries. We know that these are synthetic, abnormal fats that insert into membranes and change the charge of cell surfaces.

That's all true. So, all we have is this trail of breadcrumbs. And unfortunately, apparently, the FDA made a determination that they would treat these products using their standard checklist approach for a standard vaccine. And they did not use the checklist that they would use for gene therapy. And furthermore, they didn't make any special accommodation for the novel nature of this technology which has not been previously characterized.

And so, what we end up with, is the FDA making a decision to move forward with a data package that's grossly inadequate, that doesn't meet any standards at all, that are at the norms in my industry that I've been trained on, and that is overlooking known problems.

And then when patients are coming, women in particular, and complaining about these reproductive effects, they're being subjected to the same kind of character assassination and ridicule that we all get routinely from our friends, Mark Zuckerberg and all.

So, senator, I do, in terms of the pediatric, as somebody who is intimately familiar with this technology. I'm not too worried about the untranslated regions, but that's a formal possibility and absolutely should have been investigated. And the FDA has been grossly derelict in not following through on these things. But beyond that, we have a clear trail of breadcrumbs about reproductive toxicity that's not being followed up.

And I am concerned about our children. I'm concerned about all of those affects, brain, heart, blood coagulation, reproductive system, immunologic system, and furthermore, they're not at risk for this virus. Why are we doing this? And mandating these vaccines for children just breaks my heart.

Senator Ron Johnson 54:25
We really need to wrap up.

Nicole Sirotek 54:27
Senator, if I may--

Senator Ron Johnson 54:29
I'm going to get to you. Those of you who know me realize my first child was born with translucent great arteries. And I love doctors, I love nurses so much because they saved your life. The skill of surgeons was unbelievable, they re-baffled the upper chamber of her heart, so her heart operates backwards today.

So, I entered this with just a deep respect for the phenomenon that is our healthcare system, for the doctors, all of your training. One thing I definitely noticed, though, is as much as I valued the skill, it was the care game of the nurses that, you know, I saw minute by minute. So, I kind of want to wrap this up. We have very limited time. So, please introduce yourself, tell your story, then we will wrap this up.

Nicole Sirotek 55:16
Thank you, senator, for giving me an uninterrupted opportunity to represent the harm that is coming to the patients in the American hospitals and the lack of early intervention. My name is Nicole Sirotek, I'm a registered nurse. I've been a registered nurse for over a decade. My specialty is critical care, trauma and flight.

Since the start of the COVID pandemic, I've actually been rebranded, I guess you can say, as a leading expert in early intervention strategies executed on a large mass scale using the FLCC protocol, as well as ventilator or COVID patient ventilator protective strategies to optimize COVID patients on the ventilators. My story actually begins back in May of 2020. I was one of the original nurses that went to NYC to help with the COVID pandemic.

Because as we remember, they needed nurses. And most importantly, they needed ventilators. Well, I was the whole package, a flight nurse that can manage ventilators. And when I arrived there, the gross negligence and the medical, you know, malfeasance that happened in there and the complete medical mismanagement of these patients, is what has led us to the situation that we're in right now.

The pandemic and the hysteria that was created from poor public health measures and poor execution of appropriate early intervention strategies and the handicapping of medical professionals doing their job has led to where we are right now and into the crisis situation that we are in. I will use several key case studies that will represent larger, descriptive statistical information for what I'm going to speak of.

But when I was in New York, and what continues to happen today, is that many of them are not dying from COVID. Now what many people don't know about me is that I'm actually a master's prepared biochemist and I have worked extensively with the HIV virus tracking genetic mutation. So, I feel very comfortable going toe to toe with some of these doctors here, although I am not a doctor, I'm just a nurse. But what we saw on these frontlines, we knew what was happening.

And when we asked for the ibuprofen, they said, "No, it was contraindicated." When we asked like, "Why aren't we giving them steroids?" "Oh, well, it's not we're just following orders." Following orders has led to the sheer number of deaths that has occurred in these hospitals. I didn't see a single patient die of COVID. I've seen substantial number of patients die of negligence and medical malfeasance. When I was on the frontlines of New York, I'm unfortunately known globally viral as the nurse that was in the break room sobbing, saying that they were murdering my patients.

The pharmaceutical companies had gone into those hospitals and decided to practice, I guess you can say, on the minorities, on the disadvantaged, on the marginalized populations that we know that we had no advocates for. Because the very agencies that should have been protecting them were closed, because we were sheltering in place.

Now, when I was there, and I saw that the pharmaceutical companies were rolling out remdesivir onto the patients, I tried to get ahold of the IRBs, I tried to get a hold of my appropriate chain of command, I tried CMS, I tried Department of Health, and they rolled out remdesivir onto a substantial number of patients for which we all saw it was killing the patients.

And now, it's the FDA-approved drug that is continuing to kill patients in the United States. As nurses, we've collected a statistical or descriptive amount of information that you may not get from the doctors, because for more they do quantitative data, we do qualitative data with a humanistic phenomenological approach in nursing research. And so, we've collected the data from all of these patients across the country from which we have been helping patients.

Because I formed the organization, American Frontline Nurses on the advocacy network, so nurses could advocate for these patients. And all of this data pool shows that as these patients get remdesivir, they have a less than 25% chance of survival, if they get more than two doses.

Now, they're rolling it out on children as well, and into the nursing homes or skilled nursing facilities as early intervention, when as Dr. Pierre Kory and Dr. Marik have already demonstrated that there are cost-effective medications out there and we are going to see the amplification of death across our country. And we haven't even touched on the vaccines for which all of our expert panels have already very well described that situation.

So, I won't touch on that, since many of them are by far superior to me than even I could ever hope to be. But I can tell you that two days ago, I flew out my first 10 year old with a heart attack and I had to fight the doctor in the ER because he's like 10-year-olds don't have heart attacks.

And I argued back and forth for 30 minutes to force his hand to get an EKG to find out that he had almost a complete STEMI, which is ST Elevated Myocardial Infarction, for which you could see it lit up on the 12 lead EKG. And he's like, "Well, that's not possible." And I'm like, "Well, he was just vaccinated yesterday, it is very much possible.

" At any given time, people are getting a hold of me and the nurse advocates at American Frontline Nurses to help advocate because as you've seen, there is victim shaming that it... Oh, it's anxiety, Oh, it's this. But in actuality, if they put down that it was a vaccine injury, the physician, the corporation, the hospital, the clinic, they actually won't get reimbursed, so it gets labeled as anxiety, or neuropathy or Guillain-Barré syndrome, when in actuality, it's very realistically a vaccine injury. No, I'm not... Even though I founded American Frontline Nurses, I've traveled extensively to South America, India and South Africa, working in hot zones, stopping the spread of the virus, and working with early intervention. And nowhere in those countries, in developing nations, do I see these issues that we see here in the United States. It's actually... I'm a very proud American citizen.

I come from a family of immigrants. And my mother told me that the United States is the best country in the world, though granted, I am biased being an American. And our level of health care has been deteriorated to substandard third-world nation health care. Whereas I tell people, you are better off in South America in a field hospital than you are in level one trauma designer hospitals in the United States. As nurses, we are getting reports across the country from our American Frontline Nurses, about patients not getting food.

Patients not getting water. How come a patient hasn't been fed in nine days? Why do I need to get a court order to force a hospital to feed a person who isn't intubated and who's literally telling you they would like food? Oh, well, you can't take your BiPAP mask off. Well, that's what us nurses are for. We're going to help you take that off and we're going to help you eat. But we're not allowed to. If you know if they're on a ventilator, they're not getting basic standards of care. I've had patients that haven't been bathed, haven't been fed, haven't been given water, haven't been turned. And if you ask me, this isn't a hospital, this is a concentration camp.

Absolutely, it is. Nowhere in the United States, do we isolate people for hundreds of hours at a time with no human contact. It's not even allowed in the prisons. You are not allowed to isolate a prisoner for beyond a certain sensitive amount of time. Because it is, again, it is horrible for their mental health, and is considered inhumane. However, in these hospitals, now we're allowed to isolate patients from their

families for days, and you have to say goodbye to them over an iPhone, as Jennifer Bridges has just demonstrated to us, or she has to shuttle people in to see.

And personally, I was fired for sneaking a Hispanic family in to say the last rights to their family. And so, thank you, Senator Johnson, for giving nurses the opportunity to come and represent our patients. Because as you can see, we're not often thought of as leading professionals, though we are the missing link between the doctors and the patients. So, thank you so much for this time.

Senator Ron Johnson 1:03:32
Thank you for being a nurse. So, I'm hoping everybody that view this today recognizes the qualification. Qualifications of the individuals that spoke here today. Now, again, there's disagreement between people in this room. The viewpoints expressed for those of those individuals expressing it.

But these are real world experiences, from people that are on the front lines, that are treating patients. And is different from probably anything you've heard, unless you've been following these people in the media, trying to break through trying to convey the American public and provide the information that I think we all need. That we all deserve.

Now, you know, my antenna is always up because I'm getting accused of spreading this misinformation all the time. So, I can imagine how the news media is going to treat so much of this. They're going to pick little phrases out and they're going to pick it apart and they're going to try and marginalize this entire event. All I can ask is the viewers to share this.

Tell your friends. I know this was long. This is a five-hour-long panel, and we didn't even scratch the surface of what we need to discuss. This shouldn't have been necessary. As our information grew, as we became better and better educated, less ignorant about the Coronavirus, COVID, the COVID vaccines, this should have been made public every step along the way.

But it wasn't. So again, I'm just asking the viewing public to have an open mind. Respect these individuals who have paid a significant price, professionally, reputationally. These are highly qualified individuals. They speak from experience. We've got to fix this problem. We can't let this continue. We can't let it happen in the future. So again, thank all of you for coming. Thank you for being doctors for being nurses, for being academicians, for being medical researchers. And thank all of you for viewing this. Share this with your friends. God bless you all.