Dr. Peter McCullough interview with John Leake: [Full Transcript]

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"The full video has been transcribed, and while all of the information is incredibly helpful and insightful, I did highlight some pertinent topics that were discussed. I may try and provide an index as well, but at the moment using the ctrl-F function should help in order to find particular words that may be of interest.

Also thank you to all the doctors/scientists/researchers, etc. who have been brave enough to stand up for their patients and for humanity in general. Your bravery and integrity speaks volumes of your character and exemplifies what it means to be a strong, compassionate individual, especially in the midst of adversity and vitriol."

Dr. Peter McCullough Interview 5/19/2021 from John Leake on Vimeo

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On May 19, 2021 Dr. Peter McCullough was interviewed by author John Leake in Dallas, Texas on the subject of Dr. McCullough's treatment and research of Covid-19.

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@00:11: "I'm Dr. Peter McCullough, and I'm an Internist and Cardiologist and Academic Physician Professor of Medicine at Texas A & M College of Medicine on the Baylor Dallas Campus.

And, in February of 2020, like many physicians, I was really taken by storm with the news that a tremendously contagious virus was emanating out of Wuhan, China. And it looks like the United States was in the crosshairs.

When you heard the first reports of this novel respiratory illness headed our way, what were your initial thoughts about how to prepare for it?

@00:46: In the beginning, in my clinical practice, I really didn't have any viewpoint about prior viral pandemics. And some had mentioned prior influenza pandemics – if we go back to the 1300's – there was, you know, plagues that occurred across Europe. But point in fact, we were largely, and very quickly, thrown into emergency mode. And so what happened was a whole series of communications within health systems that really dealt with protection of the doctors and nurses. And Americans were introduced to a term called PPE, or Personal Protective Equipment, and most of our taskforce meetings and calls really didn't have to do with sick patients. It had to do with protection of the healthcare workers and doctors.

So, I got a sense early on that *fear, group fear,* was a major driver in behavioral response to the pandemic.

@01:45: My research endeavors and my research life before covid-19 centered on the interface between heart and kidney disease. I'm the President of the Cardiorenal Society of America. I'm considered the most published person on this topic in the world in history. I chair *many* FDA approved clinical trial data safety monitoring board – in fact I've probably seen and examined more drug safety trial data than any doctor in current American medicine. So I'm well-grounded in chronic disease epidemiology and randomized trials.

But for covid-19, our major viewpoint that we had early on, or at least for me with my prior cardiorenal collaborations were, was with Italian doctors. And so we were starting to email each other in terms of what is going on in the metro Milan area. In Milan, and then down to Sienna, in Tuscany, **and we quickly started to get an understanding that this illness was like a[n] upper respiratory infection, like a common cold. And for a majority of individuals it was like the common cold.**

However, in some individuals, it could progress to what we call the adult respiratory distress syndrome. Where there's an overwhelming attack against the lungs; patients lost their ability to breathe and exchange oxygen and carbon dioxide, and then required mechanical intubation. So this was unlike any common cold and it appeared to be very different than influenza. Influenza in elderly people can also cause the adult respiratory distress syndrome, but it's almost always because of a secondary bacterial infection – like staphylococcal infection.

So SARS CoV-2, the virus, and covid-19 appear to have these special features, and then within a few weeks we understood pretty clearly that the illness had 3 major biological features to it.

One was early viral replication, where the virus replicates exponentially as other viral infections do. And that it has a second phase where the immune system is tipped off into a very abnormal maladaptive pattern. So instead of the immune system defending the body, the immune system sends out signals that begin to damage organs, including the heart, the lungs, the kidneys, the brain… the blood system.

And then very importantly, the virus itself, through the spike protein, or the dangerous spicule on the surface of the ball of the virus, the spike protein itself caused coagulation or blood clotting. And a unique type of coagulation. It caused the red blood cells to stick together at the same time the platelet stick together. So this is a very different type of blood clotting that we would see with major blood clots in the arteries and veins – for instance, blood clots involved in stroke and heart attack, blood clots involved in major blood vessels in the legs – this was a different type of clotting.

And in fact the Italians courageously did some autopsies and found micro blood clots in the lungs, and so we understood in the end, the reason why the lungs fail, is not because the virus is there, it's because micro blood clots are there.

What were you seeing in the initial reports about Covid-19?

@05:11: The waves of reports in published medical literature originally emanated out of China, the early ones, and the public should understand that the typical publication cycle for an academic paper that's peer-reviewed and published, can be anywhere from 9 months to 2 years.

So, what happened was the publication cycles were too long to get any rapid information out. So immediately our system collapsed and it's what's called preprints. So publications would be submitted, papers would be submitted for publication, but the preprint would come out basically telling the world that the paper had not yet undergone peer-review, but we need to get this information out now because people need to understand what's going on.

So we had a wave from China originally, which was difficult to interpret, because of English writing, because the Chinese population is just so different in terms of its structure, and it was hard to make much out of what was coming out of China outside of it, and in some cases it could be fatal.

Italy was much more like the United States. That was the next big wave and we just collaborate more freely with the Italians. And what I had done is I reached out to what's called the Coracle Network in Italy as an American doctor and I freely said, "Listen, I am not a virologist, or an immunologist, but I can tell you every infectious disease doctor in America is completely subscribed to inpatient care of patients with covid-19. And there's nobody able to kind of think their way through what's going on in the pandemic."

And so what we learned relatively early is that this illness was clearly and strongly amenable to restratification or that baseline risks was very, very strong determinants, even more so than the virus itself for mortality. So what that meant is, the strongest determinant of mortality is age. And age itself is an underlying determinant or cause of death, if you will, in the general population. Then we start adding on the typical things that put people at risk for death of other causes: heart disease, lung disease, kidney disease, cancer, obesity, diabetes.

The interesting thing is that obesity appeared to be a super loaded factor. And so the virus seemed to really prey upon patients particularly who are obese. And there are some reasons for this, in terms of how the cytokines and immune factors are generated in response to the virus that could explain it.

@07:48: **But we understood *quickly*, that individuals under age 50, for example, with no major medical problems, could ride through this illness *very* easily.** And in fact, the Swedes figured this out very quickly and said, "You know what? We're not going to shut down. We can just, this is sufficiently understood, that we can simply protect the individuals at risk the best we can, the best that any protection measure can, and then we'll just have our economy and our schools move along in a usual fashion."

With the pandemic, what happened is there was a global shutdown on travel, and a global shutdown on academic meetings. So for the first time in my career we could no longer meet with our colleagues – in the United States, or overseas. And academic medicine, its lifeblood is meeting and interchange of ideas. And so for the first time we could not freely interchange ideas as a group.

In fact I recall a teleconference early on held by the National Institutes of Health, strictly actually by the Division of insulin- Diabetes and Kidney Disease, it was that institute that I'm aligned with in terms of clinical trials, and it was led by Dr. Robert Star, a terrific scientist, and as I recall there were hundreds of people on that call to just learn about what was going on in other centers.

And people were asking each other, *"Well what have you seen out at UCLA?"* / *"What have you seen at Baylor?"* / *"What have you seen at Harvard?"* And so we were literally just communicating to try to understand what in the world is going on with this virus. *"Who needs to be hospitalized?"* / *"What happens when they're hospitalized?"* / *"Who needs mechanical ventilation?"*

@09:33: All of these interactions had us settle on the idea that this was enormously amenable to restratification. **People under age 50 without any medical problems, unless they presented with severe symptoms, they were going to be fine. Honestly. It was going to be like a head cold.**

But over age 50, there became a real risk of hospitalization and death. And the two important endpoints, the two important endpoints, were hospitalization and death. You ask Americans, *"What are you afraid of? Are you afraid of getting a cold and being at home for a few days or a few weeks?"* / *"Nah. I'm afraid, I'm deathly afraid of being hospitalized and obviously afraid of dying."*

@10:09: **Why was the hospitalization so, so frightening? Because for the first time, patients would be hospitalized, they were put into isolation, they could never see their loved ones again. Those who died actually *never did* see their loved ones again.**

The workers were terrified. They were wearing personal protective equipment, they had very reduced visitation to patients in rooms, they started using telemedicine services where the poor patients were in, glass rooms, no one was coming in and seeing them. And the care that was offered was modest. Honestly it was supportive care until patients needed to go on respirators. **So to sit in the hospital on oxygen, *terrified*, day by day by day – no one being able to come in the room, not being able to see their family, these messages got out to other family members and it put America on watch, with extraordinary fear.**

Now over the last year, I've published, and I've managed to get this out despite the, our incredibly difficult publication cycles, I've published 40 peer-reviewed papers on covid-19. That may be more than anybody in America. One of my very first papers, the title of it, and the paper dealt with '*what are the important outcomes?*' That's hospitalization and death. And when I started to see that scoreboard come up on the major

media channels, where it listed positive cases and death, and all the Americans remember this, this was up there almost instantaneously, it came from Johns Hopkins, instantaneously, it was cases and deaths.

And I kind of wondered, how did they get that information so quickly? That was, amazing. We don't have death certifications and other things that are very rapid at all on who can be determining this. But at any rate, it was up there. And what I said was, I said, *"What really what we need to know is who's being hospitalized?"* Because if we can't figure out who's being hospitalized, and we can't figure out *where* the hospitalizations are occurring, we don't know where to allocate resources.

So I published a paper on this in the journal that I edit, *Reviews in Cardiovascular Medicine*, I immediately wanted to reach the American public; I published an op-ed in The Hill, which is a newsletter out of Washington, and I said, *"Listen. There's an* ***emergent*** *need, we need the hospitalizations."* And I screamed as loud as I could to the administration to say, *"Listen. Get an Executive Order to get the U.S. hospital census everyday so we can see what was going on."*

It never happened. We got an Executive Order to get the positive test results to come in from all the major laboratories, and through the hospital laboratories, because all the tests for the virus were under the emergency use authorization. So it was linked to an Executive Order. So the positive tests were just coming in to the Johns Hopkins Center, so we knew who was testing positive;

@13:00: There was no control over duplicates, by the way, so if a patient had one or two or three tests, unless the system had a way of actually filtering out these duplicates, those piled on, and it really didn't take into consideration who was sick and who wasn't sick.

So we just had test positive, and then we had the deaths, which started to take on a cadence of trailing by about 4 weeks after the positive test cases. But that whole death ascertainment was a real mystery to Americans. And what I said, I think was around March or April, I basically made this statement relatively publicly. I said, *"Listen, there are two bad outcomes. Hospitalization and death. I'm going to put together a team of doctors, and figure out how to stop these hospitalizations and death."*

@13:50: I felt compelled, as an academic leader in medicine, if no one in the White House can say that, no one in the White House task force can say that, if no one in the FDA can say that, or the NIH or the CDC, and Americans were pouring into hospitals and dying, no one can make that courageous statement uniquely, and individually, and alone – ***I*** **made that statement.**

How did you conceptualize the problem of Covid-19 and how to deal with it?

@14:20: We had… as our country's leadership, an inability to frame the problem. The problem was, there was a virus, it was popping up in clusters in the United States. And in most people it was causing a cold, and they got through it just fine. And other people it was leading to hospitalization and death. But we couldn't frame the problem that the virus in some people causes hospitalization and death. Let's stop it! Let's stop the hospitalizations and death. Let's treat the virus.

We could not frame that problem. Our leaders couldn't frame the problem. I personally didn't have any problem framing the problem. It's a bad thing. If there was another form of pneumonia out there, I would've said the same thing. Another form of newly acquired asthma, another form of urogenital infection or gastrointestinal infection.

@15:17: Ebola had just been actually in Dallas, a few years earlier, and I think ebola hurt us in terms of our thinking. Because ebola was so terribly contagious and so quickly fatal, that the fear that ebola created in Dallas was extraordinary. I'll never forget it. Our medical center, one time I tried to get in one of the usual doors that I go into and there was a police officer there. I said, *"What's going on?"* **He goes,** *"We're here to block anybody with ebola from coming in our hospital. We're going to shunt them to Presbyterian Hospital*

north of us." **When do we "shunt" patients away from one hospital?… – The fear that ebola created because of this idea was terribly contagious and fatal quickly – I think set us on edge.**

And with SARS CoV-2 virus, what we learned is, the average person sits at home for two weeks! There's no immediate lethality to the virus. In fact we've got a long window of time to make a diagnosis, organize treatment, and prevent hospitalization and death. So SARS CoV-2 was very different from ebola.

But we look at other conditions where we readily accept the fact that somebody can fall ill at home, but if we start treatment early, with an infection, we can save the patient. That exists for community acquired pneumonias. It occurs for various forms of staph infection, including Staphylococcal toxic shock syndrome. It occurs for Diverticulitis and abdominal conditions. It occurs for skin infections, various forms of cellulitis, it occurs for meningitis.

@17:03: **And for instance, if someone had a form of meningitis, we wouldn't say,** *"Listen, sit at home for two weeks. And then if you're really really bad, and you're having seizures, and you can't even breathe anymore,* ***then*** *come in the hospital and we'll start treatment."*

So the different, unique aspect of the medical response to SARS CoV-2 and covid-19 was for the first time we had an infectious disease, where the medical community settled into a groupthink – and this was supported, by the NIH, the CDC, the FDA, the American Medical Association, all the medical societies, it was supported by these societies – (long pause) …to tell doctors, *"Don't touch this virus. Let patients stay at home. Let them get as sick as humanly possible, and then when they can't breathe anymore,* ***then*** *go to the hospital."*

In fact, it was shocking, October 8th (2020), when the National Institutes of Health came out with their first set of treatment guidelines, because prior to that, none of the societies had any treatment guidelines! They actually didn't tell doctors how to treat the illness. Now there was suggestions about what should be done in the hospital, but Americans cared about what was going on when they got sick at home.

And the first set of guidelines said, *"You get sick at home, don't do anything. Don't do anything. Come into the hospital when you really can't breathe." / "****Still*** *don't do anything, until a patient needs oxygen.* ***Then*** *start doing something."* **Like then actually give the first anti-viral drug, which was Remdesivir.**

Well that's 14 days after the virus had already started replicating! By that time the virus is long gone. When people can't breathe the problem is micro blood clotting in the lungs.

So the federal agencies – the CDC, the NIH and the FDA – were *enormously* inept in terms of perceiving what this problem was. *Incredibly* inept in applying any type of judgement or direction to doctors. And what had happened among the doctors was, *"We're so terribly frightened, we're not going to do anything unless we have the intellectual support from our associations, from our federal agencies, from our medical societies."*

And it was just the opposite of what medicine had always been. Medicine had always been, early innovation by doctors, empiric treatment, small studies, randomized trials and then sponsored large randomized trials, in that order. And then after large randomized trials, then guidelines bodies would then look at all those large randomized trials, make determinations of what should be done, and then those guidelines bodies would issue guidelines and then the federal agencies would file the guidelines.

That's exactly what we do for mammography, colonoscopy, treatment of myocardial infarction, treatment of pneumonia, it always started out with early empiricism, then getting to guidelines and agency's statements *years* later.

Why was there an assumption that nothing could be done to treat people in the early stages of Covid-19 infection?

@20:00: It was a dangerous assumption. To assume there's nothing that one can do for a fatal infection, is *enormous* blunder. It's a blunder by citizens. It's a blunder by health responders. And it's a *massive* blunder by agencies. Can you imagine, let's make an assumption. And could our assumption lead to the absolute worst possible outcome, which would be hospitalization and death. Or we could make another assumption. And say, *"You know what? It's treatable. We're going to try to treat it."*

Which dangerous – which assumption is more dangerous? ***Absolutely*** the dangerous assumption is to do nothing. The dangerous – you can take any example. Let's make an assumption on… traffic safety. You can assume that traffic safety rules and lines and stop signs and seat belts do something. Or you can assume they don't. Let's try. And let's have a free-for-all out on the streets right now and see what happens versus paying attention to some rules.

@21:00: We never make assumptions that are dangerous to people. And the thing that really worried me about this whole thing is this series of extraordinarily dangerous assumptions. Can you imagine a senior citizen who has heart and lung disease, recovered from cancer, has some kidney disease, is handed a diagnostic test result and says, *"Here. You have covid-19. Now you have your fatal diagnosis. Our recommendations, based on the assumption we can't do anything, is: go home, and wait it out. – And when that panic, and that fear, and that breathlessness, and fever, is **SO** overwhelming, when you can't bear it anymore! – **then**, go to the hospital."*

And how do people go to the hospital? They call family members. They contaminate all their family members. They call EMS. Uber drivers. Taxi drivers. Every hospitalization in America was a super spreader event.

So this "assumption" that there's nothing we could do, and giving somebody a fatal diagnosis, with *no* instructions, led to a *massive* amplification of cases. So what we could have assumed, and what I *did* assume, was that there are some principles we could adopt from other precedents.

For example, every form of pneumonia known to man does better if treated early. Even influenza. And that's the reason why, Tamiflu, as an example, and there's an analogous product, are FDA *approved* for the treatment of influenza. They have some partial effect. Now do we ever use Tamiflu alone? No! We typically combine it with other drugs to get patients through the illness. There are supportive respiratory drugs. There are forms of inhalers. What's called beta agonist inhalers and steroid inhalers. We use those liberally in forms of emphysema, pneumonia, asthma, allergic pneumonitis.

There's other things that we can do to help patients get through the syndrome. The inflammatory nature of this syndrome became very interesting. We understand that antihistamines, as an example, Montelukast, aspirin, steroids, corticosteroids, play an important role.

@23:17: If I had an asthmatic at home, I wouldn't say, *"Listen. Sit at home for two weeks until you **can't** breathe anymore and then go into the hospital."* **Are you kidding me? I'd put that asthmatic on inhalers, I probably would use some empiric antibiotics in that patient and then some steroids, and I'd prevent the hospitalization to the best I could.**

So I approached covid-19, respiratory illness, like any other with the following thought. And we pretty quickly put together our approach based on other precedents including influenza, including asthma, including bacterial pneumonia, as follows: that this was going to be amenable to restratification, those under age 50 who had no pulmonary symptoms, they could simply ride through the illness.

@23:59: We had data suggesting that nutritional deficiencies seemed to increase the risk for hospitalization and death. And so that's where the nutraceuticals came in early on, that there was supportive data – not curative – but supportive data for zinc, for vitamin D, vitamin C, and interestingly a polyphenol substance called quercetin. There was some others that were considered, including lysine, and N-acetyl cysteine, they became what we call the nutraceutical bundle.

So is it kind of reasonable to do that in patients? I would say yeah, if it's linked to mortality, we don't know anything else, there's no harm in these supplements, they're readily available, people can buy them. So we recommended the nutraceutical bundle for those under age 50, and really no medical treatment. That amounted to roughly of people getting ill at the time, probably 2/3 to 3/4 of patients really needing no treatment.

However, if someone below age 50 have medical problems, presented with severe symptoms, or over age 50 with medical problems, it became clear that the rates of hospitalization or death were greater than 1%, that was enough, greater than 1% – it's kind of the magic number in this whole equation, that's enough to do something. That's enough to do something.

We knew somebody at age 60, for instance, would face about an 18% chance of hospitalization and death. 18% chance, that's too high. In my field, cardiology, our guidelines say anything more than 5% is high risk. 1 to 5% is moderate, less than 1% is low risk. In general, for anything less than 1%, we don't go after it. So in this low risk group, we didn't go after it. But age over 50, young people presenting with severe symptoms, we went after it. So it was nutraceutical bundle.

What did we know next? The timeline was very interesting. We knew from SARS CoV-1, SARS 1, that's 80% similar to SARS CoV-2. We knew from studies dating back to 2006 that hydroxychloroquine, a drug that's used for lupus, used for rheumatoid arthritis, it's used for other rheumatologic conditions, including dry eyes, as well as malaria: safe, was effective in reducing the viral replication in SARS CoV-1, we knew that. And so the United States knew that.

@26:17: **In fact, that drug was stock-piled by the United States government, Australian governments, some European governments, the hydroxychloroquine was on boarded appropriately, and ready to rock and roll. In fact, many countries front-lined hydroxychloroquine for high risk patients and still do so today. People go to Athens, Greece, Rome, Italy, across all of eastern Europe, central and South America; hydroxychloroquine is the lead drug. India and East Asia, hydroxychloroquine is the lead drug. So hydroxychloroquine played a role.**

We also knew that by the summer, we knew that ivermectin played a role. This is an anti-parasitic drug used for scabies and other illnesses. Safe and effective.

So these drugs – how – the reason why they work against the virus is they get inside cells. A lot of antibiotics like penicillin doesn't get inside the cell. But these, what's called intracellular anti-infectives do. Japan, had an influenza drug that had the exact same activity as remdesivir – their first U.S. approved inpatient IV drug; that drug's called favipiravir. And the Japanese had data to suggest that favipiravir, like oral remdesivir, would play a role early on. And it was readily approved by 5 countries, FDA approved – FDA equivalent approved in those countries to treat covid-19.

So we had hydroxychloroquine, we had ivermectin, we have favipiravir, we combine it with either doxycycline or azithromycin, and those are antibiotics Americans know about. They get inside of cells, they're also intracellular anti-infectives, and they were slightly assistive in a couple ways. They cut down on some of the bacterial super infection that would occur in the sinuses or respiratory tract.

And we knew from some studies that there was about a 3% overlap between covid-19 and what's called atypical pneumonias. Which would be mycoplasma, chlamydia pneumoniae, and these would also be responsive to these. So quickly, hydroxyzine, azithro, ivermectin and doxy – these were common – favipiravir and doxy outside of the United States, became common intracellular anti-infectives.

But those alone didn't carry the day. Because what happened is the viral replication tipped off what's called cytokine storm, or the immune system going haywire. And so doctors early on in the hospitals started using steroids. And we had some confusing literature – are they hurting, are they helping? And the British helped out a lot with the study and inpatient study called *'the recovery trial'*. And the recovery trial picked an odd

corticosteroid, which was dexamethasone, in an odd dose, 6 milligrams a day. We typically use like 10 milligrams, 4 times a day. So an odd dose, but did show a small reduction in mortality.

And there was a meta-analysis published, looking at hydrocortisone, prednisone, it turned out any steroid worked, in some reasonable dose. So in the United States we quickly adopt using prednisone, which we use in asthma frequently. And then another trial in the UK was done called the *'stoic trial'* using inhaled budesonide.

@29:13: Now that was a very interesting development, because there was a maverick doctor, former military doctor, Richard Bartlett from west Texas. He even made the national news by saying, *"You know what? I think inhaled budesonide works."* **And he said this early in the spring. And he was on national news, he says,** *"I'm trying it. I'm a doctor, I'm trying to help my patients, I am using empiric treatment. I know there's no randomized trials."* **But he was doing the right thing. That's what American doctors ALL should have been doing, is trying to help their patients by taking empiric choices on drugs that make clinical sense, and he tried it! And indeed it worked. The British did the stoic trial, and sure enough, there was over an 80% reduction in hospitalization if we just used inhaled budesonide in outpatients with covid-19. So that made it on board.**

Montreal Heart Institute, one of the leading overall randomized control trial centers in the world, got funding from the National Institutes of Health, Gates Foundation, Canadian authorities, and tested a gout drug which works against the immune system, particularly works against the white blood cells and their ability to proliferate toxic granules and assemble microtubules, that drug is called colchicine. And so Americans would recognize this as a gout drug. **They carried out and conducted a prospector randomized trial, double blind for 30 days, the best quality trial done in all of covid-19, and they demonstrated that there was a marked reduction in hospitalization and deaths. So colchicine came on board.**

And so the last thing that we really had to look at was blood clotting. And to this day there has not been a single outpatient study of drugs to impair platelet aggregation or antithrombotics, however we can learn from inpatient studies and there's been very good analyses, they all agree, the use of full dose aspirin in the hospital is associated with reductions in mortality, and the use of full dose anticoagulation, whether that be injectable low molecular heparin, full heparinization, or we could even use oral anticoagulents as an outpatient, is associated with reductions in mortality.

So what I had been doing is I was working with the Italians, looking at how these concepts were coming together, and I published a paper in the *American Journal of Medicine* on August of 2020. And I have to tell you, when I looked at the literature through the spring, working with the Italians… (long pause)… there had been, by the time I submitted the paper on July 1st, there were 55,000 papers in the peer-review literature. Not a single one taught doctors how to put drugs in combination and treat the virus.

And it seems so odd to me. We knew this was a fatal viral infection; in fatal viral infections single drugs ***never work***! We knew this in HIV. We knew that we needed multiple drugs in HIV. We knew this for hepatitis C. We knew this for all the other fatal viral infections. We use drug combinations. Never single drugs. And the only thing we can do at that time is look at studies of single drugs, and find signals of benefit, acceptable safety, and then assemble them into regiments.

The clinical trials testing a 4 to 6 drug regiment… those haven't even been planned yet. I mean, the mortality rate would have been astronomical if somebody didn't step forward and have the courage to publish the concepts. And I guess that's what my role is in world's history for this.

@32:44: I published a paper called the *"Pathophysiologic Rationale for Early Ambulatory Treatment of Covid-19"*. **And it was published in the August issue of 2020 of the** *American Journal of Medicine*. **To this day, that's the most widely downloaded paper from that journal of all topics. And, it went viral. And… literally. It went viral because the world was thirsting for an approach to covid-19.**

Now, quickly after that was published I was managing all different types of communications regarding the paper; scientific and then also media related, and we have supportive data now coming in strong for ivermectin, for colchicine, for inhaled steroids, and Operation Warp Speed had delivered monoclonal antibodies directed against the spike protein, the pathogenic part of the virus. And they included a product from Lilly and another one from Regeneron.

So I needed to update the algorithm, and I put that together and published that in the journal that I edit *"Reviews in Cardiovascular Medicine"*, but with a separate issue and a separate unbiased editor that I didn't have influence on to make sure that was fully peer-reviewed and vetted, which it was, and that was published in *"Reviews in Cardiovascular Medicine"* in August of 2020.

@34:00: By that time there was a 100,000 papers in the literature, and outside of my first paper, there wasn't a single *other* paper that actually proposed a regiment or protocol to treat patients with covid-19. It was almost extraordinary, that we were over 9 months into a fatal pandemic influencing the world, and no one could come up with an original idea? Of how to put drugs in combination to treat the virus?

We didn't have the Harvard protocol, we didn't have the Johns Hopkins protocol, we didn't have UCLA, we didn't have a World Health protocol… So this was extraordinary, that all the firepower we had in academic medicine, couldn't – they just drew a blank. Matter of fact, if you look at these centers across the United States and across the world, they never opened up covid treatment centers. They didn't have outpatient covid treatment centers. They didn't attempt to study or help a single outpatient with covid-19.

Why were there not more doctors speaking out or offering solutions for early treatment of Covid-19?

@35:05: My contribution was… I think the ability to publish the ideas. [off camera: "OK."] This is very important. Others had the ideas. In fact, Vladimir Zelenko in New York City, an Orthodox Jew, stepped out of the box, he said, *"Listen. We need to treat this. We can use some drugs in combination… hydroxychloroquine, azithromycin, steroids, other drugs"*, and he started putting drugs in combination.

Richard Bartlett in west Texas, Brian Tyson and George Fareed, former NIH scientist George Fareed came out of retirement: they went to really the crucible of covid-19 down in California / Mexico border, and just opened up a clinic and had opened up a tent; people started walking up and they started treating them.

Didier Raoult in southern France said, *"Listen. We can treat this."* Him and a group of courageous French doctors opened up a large clinic in southern France and started treating patients.

We had Ivette [Yvette] Lozano in Dallas. She took her general practice building, on, by White Rock Lake, and turned it into a covid treatment center. She converted all her rooms to treating patients with covid. Oxygen concentrators and all the drugs – there's pictures of patients lining up on the side walk to receive treatment.

So it's interesting how the innovators were all independent, courageous doctors, and the academic medical centers drew a blank. They couldn't even pitch a tent to help people. And to me it was stunning that the academic medical centers, or even the large community centers, couldn't help a single outpatient. They couldn't even provide a patient brochure of what should be done. The CDC offered guidance like, *"Take some tylenol and if you get really sick go to the hospital."*

The response to a treatable outpatient problem, they gave us two weeks, of opportunity to do something; the lack of that anemic, the lack of that response was stunning. And it had to do, in my view, because of a whole timeline of events that put a chill on the attempts to treat covid-19. **The doctors and health systems and others, I think, in a relatively short order became actively *discouraged*, from treating covid-19.**

I can tell you, I never got an encouraging email or phone call saying, *"You know what? Do the best you can for your patients. Try to help them. These hospitalizations are terrible. Please. We support you in using your*

best judgement." **Or,** *"Here's a few suggested things you can do."* **I never got any of those emails from medical societies,** from others –

In fact, there was only one medical organization – just like there's, you know, a few courageous medical doctors – **there was one courageous medical organization, the *Association of American Physicians and Surgeons*, that saw what was going on. And interestingly that organization is an organization that represents *independent* doctors. Not those employed by hospitals, or big medical groups, or medical schools, but independent doctors. And they saw what was going on, and the first thing that they attacked was the stockpile of hydroxychloroquine.**

So what happened was, the U.S. had an ample supply of hydroxychloroquine. And the only issue was, start using it – and start putting it into combination with the other drugs to treat covid-19. It seemed terrific. And the first event in the timeline was the FDA emergency use authorization for hydroxychloroquine.

@38:34: So the listener should understand that an emergency use authorization would be for a brand new drug or product, where there is a great unmet need, there's not enough time to do all the testing, and that we would do an EUA for that. There's a government mechanism for that; it's under emergency circumstances. **That wouldn't apply to hydroxychloroquine. It was already fully FDA approved, it was out for 65 years, it was safe, we had used it in pregnancy, we knew all of its safety profile, doctors knew how to use hydroxychloroquine; I used it in my practice, it was just not a big deal. It didn't need a EUA.**

But so the EUA went out on hydroxychloroquine and said, you know, this EUA, with language, and it says *"restricting hydroxychloroquine to inpatient use"*. Okay. And so, one of the first big studies out of the block was done in thousands of patients out of Henry Ford. And it was great news! **That hydroxychloroquine was associated with a large reduction in mortality, *if* applied early. But the later it was applied in the hospital stay, it didn't look like – patients were too far gone.**

I wrote the response to that in several publications across the, across the United States. And one was an op-ed in The Hill. Cause as I saw this, I basically made the case that emergency use authorization was an effective restriction. It should be lifted and we should use hydroxychloroquine wide open. And then something *really* **terrible** happened. Keep in mind that the Henry Ford data was very positive, we had the EUA, the U.S. had stockpiled it…

The National Institutes of Health, the Allergy and Immunology branch, had commissioned a several thousand prospective, double blind randomized placebo controlled trial of hydroxychloroquine, and azithromycin in outpatients with covid-19. They had funded the trial. They got the drug supply. They got the placebos. They set up all the studies centers in the United States. We were all ready to go. That was in the spring. Terrific! Everything is coming together.

@40:40: And then what happened was a fake paper was published in Lancet. A fake paper. Now Lancet, the listeners should understand that Lancet is like the *New England Journal of Medicine*. It's one of the most prestigious medical journals in the world. And when a paper is submitted, there are so many checks on validity: *"Where is the paper coming from? Where are the data coming from? Validating the data?"* Then it's sent out to peer reviewers who are independent. They check everything in the paper, they give comments about: *"Was this reported? Was that reported?"* What have you. So many checks on papers and then it comes back and then there's an editorial decision made on a paper, and then it's published. That's called peer-review. That ensures to the public that papers are not fake. It's very important. It ensures to the public that things are not falsified.

Well this paper had authors from Harvard, it came from a company called Surgisphere that no one really understood what this company was about. And the data was a large data set of inpatients with covid-19 from all over the world that had in depth drug exposure data. We didn't have that back then. You know, that was from December, January, February, this was just emergent. We didn't have this. The average age in that paper

was 49 years old. **And the paper implied that use of hydroxychloroquine was dangerous. And Lancet published this falsified paper.**

Somehow it fell through all the other peer-review, and how can they possibly publish it? And as soon as it came out, I knew in 2 seconds that it had to be wrong. We don't hospitalize people in their 40's. **And hydroxychloroquine, in fact, is associated with benefit, not harm.**

@42:24: This paper in Lancet, frightened the entire world. It was like a shockwave. And there was a whole series of reactions. People started publishing papers, *"Oh, hydroxychloroquine could be dangerous."* **All these academic doctors,** *"Case closed. Hydroxychloroquine doesn't work. Stop using it."* **Hospitals started pulling it off the formularies. It was extraordinary what happened with hydroxychloroquine. In fact, the USFDA put out language, that said,** *"Hydroxychloroquine shouldn't be used, **period**! We're canceling the EUA for inpatient use, and it shouldn't be used, period!"*

So that FDA language then went to the AMA. And the AMA says, *"Well don't use hydroxychloroquine, period. Inpatient, or outpatient."* **That went to the pharmacy boards. Pharmacy boards said,** *"Oh, doctors shouldn't be using this."* **So as doctors were treating patients in the community, prescribing hydroxychloroquine, next thing you know, patients would show up to the pharmacy and the pharmacist said,** *"Sorry, I can't dispense it. My board says that I can't."* **And then doctors licenses started to become threatened. And then, you know, then all of a sudden there was a cascade of events, hydroxychloroquine being the lead, that put a chilling effect on anybody's attempt to treat covid-19 as an outpatient.**

Why did the regulatory authorities and mainstream media tell the public that Hydroxychloroquine was dangerous and ineffective?

@43:40: Hydroxychloroquine, I think the fair statements are, it's the most studied and utilized therapeutic in the world for covid-19 to date. There are hundreds and hundreds of studies. And hydroxychloroquine was appropriately acquired and stockpiled by the U.S. government. **President Trump, who I personally think was very weak in the response, he could not articulate that hospitalizations and deaths were a serious problem. He could not assemble a team of doctors who were learning how to treat covid-19. Neither could the NIH, or the CDC, or FDA. We had gross failures from U.S. presidents and the major agencies.**

Can you imagine to this day, we still have not had a doctor in any position of authority in the United States, who's actually ever seen a patient with covid-19 and treated them. None! It is extraordinary what's happened. So how, President Trump mentioned hydroxychloroquine, let's try to give it a shot. And then immediately he was bashed down by his detractors. I thought it was a very weak statement to begin with. But he was bashed down. **And people have always held him up as, oh, it was Trump. If he hadn't mentioned hydroxychloroquine none of this would've happened.**

I disagree. I think, that there was an *enormous* effort to suppress early treatment, and hydroxychloroquine was initial lightning rod. Remember I mentioned that NIH trial? You know what they did after 20 patients? Disingenuously, they said they couldn't find covid-19 patients, and they shut down several thousand patient trial. They shut it down after 20 patients. That never happens! They purchased the placebo. They found the study centers. They had the binders. They had the nurses hired. They had everybody ready to treat Americans with hydroxychloroquine and azithromycin and they gave up after 20 patients. That was extraordinary.

@45:30: The false paper published in Lancet was extraordinary. We started to have an array of incredibly flawed papers publishing exaggerating cardiac effects of hydroxychloroquine. *"Oh, it could cause dangerous arrhythmias."* **There was one that I mentioned in my U.S. Senate testimony, it came from the Mayo clinic, it said hydroxychloroquine could cause a scar in the heart. They actually, they had a heart, and they showed a huge white scar. In fact, I ultimately hunted down that paper, hunted down the authors, and the publisher, and I demanded a retraction. Ultimately I got a conciliatory letter published saying,** *"You know what? We're*

sorry. It doesn't really cause a scar in the heart." **So people started to intentionally try to damage hydroxychloroquine so it would not be used in covid-19.**

Yet, other countries held with it steadfast. I mentioned all the countries to this day that use hydroxychloroquine. And now we have studies, for instance, a study from Iran, in 30,000 patients! A massive study. And they treat about 25% of people appropriately of hydroxychloroquine in combination with other drugs. And it has a massive reduction in mortality. So hydroxychloroquine was a mainstay, the prospective randomized trials, we just isolate on them, pre-hospital studies are all positive, now is it a game changer? No. I'd say it's about a 25% reduction in endpoints. But it's a very useful drug, to get started early. It's not a single drug, it wouldn't rely on it alone, but hydroxychloroquine itself, I think is a poster child for what happened.

You know, early on in this, I became of national attention. I received calls from the White House. I was contacted by the U.S. Senate. I became known on social media which I was never on social media before. I'm not an immunologist, I'm not a virologist, I'm not an infectious disease doctor. But I'm a good clinical doctor and I understand drugs. And I understand drug safety very well.

@47:24: Hydroxychloroquine had a signal benefit, acceptable safety. **I was contacted by doctors in Africa, that anonymously told me,** *"Dr. McCullough, there are some bad guys raiding the pharmacies at night, and they're coming in and burning the hydroxychloroquine."* **I said,** *"Who are these bad guys?"* **They said,** *"We don't know. But they look like they're some type of mercenaries or operatives."* **Mysteriously, the second largest hydroxychloroquine producing plant outside of Taipei burned to the ground.**

So… hydroxychloroquine, as a simple, safe and effective drug, to this day seems to be a poster child for worldwide comprehensive efforts to suppress early treatment.

And of interest, as the data came on with ivermectin, ivermectin became the next drug. Now of interest with ivermectin, there was an associated group that formed, called the Front – the Frontline Critical Care Consortium, the FLCCC – it was led by Pierre Kory; I identified him, and Dr. Paul Marik, I communicated with him, we had teleconferences, and I recommended Dr. Kory testify at the second U.S. Senate hearings in December. Also Dr. J.J. Rajter from Florida. Dr. Rajter had tried ivermectin in all of his sick patients in Florida hospitals and was enormously successful in reducing mortality, published his paper in CHEST, one of the best pulmonary journals, so I give him tremendous credit for that.

And so Dr. Kory and Dr. Rajter presented what became a very compelling case for ivermectin. If people were sufficiently turned off by hydroxychloroquine, we could focus on ivermectin. Dr. Tess Lawrie, who's considered one of the world's most prominent analysts in the UK, published – **and Dr. Andrew Hill as well, published incredible analyses demonstrating that ivermectin reduced mortality inpatient *and* outpatient. So a little different than hydroxychloroquine. Hydroxychloroquine takes a little time to work, and probably doesn't work at the very end of the illness, but ivermectin miraculously worked through the range of illness.**

And so the data started coming on for ivermectin and there was enough push power for emphasis on the National Institutes of Health guidelines where they made a specific statement regarding ivermectin. They said, *"You know what? We understand the data with ivermectin, we can't be for it, and we can't be against it."* It's the same statement that they made for the emergency use Regeneron and Lilly antibodies. The NIH said, *"We understand the data. We can't be for it or against it."* But at least we got a neutral statement out of them.

@50:07: Hydroxychloroquine still to this day has a series of negative statements on this, and doctors have literally had to fight for their medical licenses in order to prescribe hydroxychloroquine. One by one by one, all of those licenses have been restored. All of those state rulings have been overturned. All the medical societies have been overturned. And hydroxychloroquine is used today. Ivermectin is *widely* used today.

Both drugs, can not only treat the infection early, but they can prevent the – there's prophylactic studies – they can prevent, if patients take these drugs periodically, typically once a week or so, they can prevent covid-

19 from becoming an illness. They are preventive. In fact, I led one of the very early studies of hydroxychloroquine here in Dallas to protect our health care workers, that these drugs are about 90% effective. They are about as effective as the vaccines in preventing/acquiring covid-19.

When someone's ill, I never prescribe these drugs alone, but I prescribe them in what I call sequence multi-drug therapy. But that is the approach that independent doctors have taken in the United States. **And uniquely not a single academic medical center today, or community medical center today treats covid-19 patients as an outpatient with the goal of reducing hospitalizations and deaths. Why would these centers not want to help their patients?**

Why didn't more doctors resist the directives against providing early outpatient care for their patients?

@51:43: You know, doctors clearly have a groupthink, and doctors want intellectual support for what they do. That's the reason why we meet all the time, that's the reason why we go on rounds together, that's the reason why we have conferences every day. We want to intellectually support each other for making decisions on patients for the assurances we're making the right decisions.

And what happened was with the pandemic, all of our meetings were dissolved, we could not meet with each other anymore, there wasn't a chance to have much intellectual support. **And each doctor, one by one, had to make a decision. When the next patient called and said,** *"Listen. I'm sick with covid-19. Can you help me?"* **There was a binary choice. The choice was,** *"Nope. I'm not going to help you. Nothing works. There's nothing I can do. Just wait until you get hospitalized."* **or the answer could be,** *"You know what? Let me try."*

And what we found is that binary choice was the biopsy of who really had courage and who really had excellent clinical judgement. And doctors who were not confident in their clinical judgement quickly said, *"You know what? There's nothing you can do."* **And they got into that groupthink. And that could've been 90%+ of doctors had a.) a lack of clinical judgement, and a lack of courage. And what I found in this whole thing is those two things are rare. And for me, it was just very natural. It was very natural.**

My, my father was one of the first nursing home covid-19 patients in Dallas. He was the very first one at Presbyterian Village. He got covid-19, had pelvic fracture, he's flat on his back, **a scared PA says**, *"Your dad's got covid. He's in a unit. We don't know what's going to happen."* **His mortality being completely bedridden, with dementia, and now covid, I can tell you, he was facing an 80% mortality of just having covid just ravage him.**

So what did I do? Did I make that binary decision of doing nothing? Of course not! Of course not! If I could ever message any American doctor, or any doctor in the world right now, *"Have some courage, and trust your clinical judgement."* **I did. And that's what *real* doctors do. And I will *never* apologize for that.**

Of course my dad was treated with hydroxychloroquine. He was treated with azithromycin. He was treated with aspirin. We put him on lovenox, is a blood thinner. The full nutraceutical bundle. Zinc, vitamin C, vitamin D, quercetin, open the windows, get that virus aired out there. And he got really sick, as expected. He had dementia, his wishes were to not go to the hospital. Not go on a mechanical ventilator, we treated him right there. It took 60 days, and it was a long illness. But he survived. And that was early.

@54:44: **And that taught me that if I'm willing to do that for my father, I have a Hippocratic Oath, and I have a fiduciary responsibility to my patients. And I refuse to let my patients die of this illness. And when I testified at the U.S. Senate, I told the American people, I have always treated my high-risk patients. Always. And at the end of my opening statement, I held up the protocol, and I told the American people,** *"I'm not asking for permission to do this. I'm not. But I'm asking for your help."*

That's a very, very important statement. Because my patients were appropriately treated to the best of my ability. **And we have 600,000 dead Americans, that were *not* treated appropriately, and not treated to the best of the ability of their doctors. And that will go down in historical shame for our country. I think it is a travesty that we have 600,000 dead Americans, not – vast majority of them didn't get an ounce of treatment – in fact there were medical groups that adopted policies that they weren't even going to answer the calls of covid-19 patients, and they were *millions* of patients needlessly hospitalized.**

We had data that came in later from Dr. Zelenko in New York City, Dr. Proctor here in Dallas, who did the same exact thing, showing that our methods could reduce hospitalization and death by 85%. And I'm sorry, there are no prospective randomized trials of 4-6 drugs; there are none planned, so therefore, without any large trials, there are not going to be any guideline statements, and without any guideline statements, we'll never have any agency's support for this.

@56:33: But this is about courageous doctors saving Americans, and I would go farther than this. This is about courageous doctors saving the world. So now we have the Association of American Physicians and Surgeons. We have FLCC in the United States. We have 250 treating doctors. We have 4 national telemedicine services, 15 regional telemedicine services. We're treating 10-15 thousand patients a day.

Forget the U.S. government. Forget what anybody says about this. Americans are getting treatment. That once our message on early treatment came with two U.S. Senate hearings, headed by Senator Ron Johnson, the hospitals started clearing out in the end of December / early January, because early treatment markedly reduces spread and dramatically reduces hospitalization and death. It's the only thing that does that. The hospital doesn't save all the patients. I'd say the hospital honestly has a very modest impact on anything with covid-19. **It's all about early treatment. The hospitals started clearing out, the curves came way down in the United States. That's before anybody was fully vaccinated.**

And I testified in the Texas Senate on March 10th [2021], I said, *"Listen. we're at by standard CDC equations, we're at herd immunity!"* **By March 10th! No vaccine effect. That's actually just treating patients.** In Texas, we had 35 treatment centers, out protocols and methods work, and I have learned over time there are so many ways to treat the virus.

I've had a seminar with Dr. Shankara Chetty in South Africa, he said that hydroxychloroquine and ivermectin, just like in the United States, had become so politically charged, doctors were losing their license, in fact, some doctors were jailed in trying to help patients with covid-19. He gave up on them!

He's treated 4,000 patients, fewer than 10% got hydroxychloroquine or ivermectin, he treats them, he times the illness. He waits to day 8 and then he starts inhaled and oral steroids, he starts aspirin, other anti-inflammatories, Montelukast, and the high-risk patients he uses anticoagulants on the back-end. And he saved virtually everyone outside of a handful of patients – out of 4,000 sick patients in South Africa.

@58:34: So what I've learned about this virus is if doctors do anything, to try to help patients, they can reduce hospitalizations and death. And the only reason why this is such a horrible thing in American history is because doctors failed to act.

Why, when it came to Covid-19, did so many doctors agree to depart from longstanding medical practice in terms of seeking and formulating early outpatient treatments for their patients?

@58:56: The USFDA puts out thousands of drug warnings per year. In fact, Americans know this, cause they see a drug advertised on TV and it says, *"Warning: may cause death. And may cause – what have you."* So we get thousands of warnings per year. FDA recalls drugs, put black box warnings on drugs. Doctors still use these drugs. They understand the warnings. About 40% of drugs are used off the advertising labels. So once a drug is older it's original advertising label doesn't really apply, so we use drugs quote "off-label" all the time. That's common.

But what happened in covid-19, is because of the tremendous fear that settled in over our country. Whatever statements came out by the USFDA, the NIH, the CDC, started to take more weight than they ever would in the past. So if those agencies said something, like, *"Don't use hydroxychloroquine"*, **that emanated down through the AMA and each of the pharmacy boards where they actually denied patients hydroxychloroquine.**

In fact, there are probably patients who ***died*****, because the pharmacy did not dispense the hydroxychloroquine to patients. Or the ivermectin. There are doctors who started getting warning letters, stating – Dr. Richard Urso from Houston, and another doctor stepped out of his role like I did to treat the virus, got warning letters from the Texas Medical Board:** *"We're going to examine your license. We understand you're prescribing hydroxychloroquine, trying to help covid patients."* **Okay?**

These doctors, like Dr. Robin Armstrong, Dr. Robin Armstrong, in Texas, saved dozens of nursing home patients with hydroxychloroquine and azithromycin and steroids and blood thinners. The families think he's a hero; the Texas Medical Board tried to take away his license. And so he had to go through hearings and reviews and ultimately he was restored, although he was, his practice was just damaged, if not destroyed.

@1:00:50: **Emails started coming down through big medical organizations,** *"Don't use hydroxychloroquine."* **They later on came down and said,** *"Don't use ivermectin."* **In fact, there was, you know, flat out,** *"Don't do it!"* **We were getting official messages that basically said,** *"Don't take care of covid-19."* **These are codified in policies and emails by major medical organizations. And it went counter – can you imagine getting an email saying,** *"Don't treat pneumococcal pneumonia! Just let them die. Don't treat meningitis. Let them die."*

Can you ever – we've never seen this, this – the term that applies to what's going on is wrongdoing by those in positions of authority. It's called malfeasance. We don't put down a chilling negative message that's going to result in harm. We don't do that. We don't do that in a civil society. It happened from the NIH, the CDC, the FDA, major medical groups, these chilling messages.

@1:01:45: But at the same time you had AAPS saying, *"No, this is wrong. Treat patients."* **You had FLCC, a group that became very strong, saying,** *"No. Treat patients."* **In the UK, we had the BIRD group, that said,** *"You know what? Treat patients. Use ivermectin based protocols."* **We had PANDA developed in South Africa. We had the Covid Medical Network developed in Australia. We had Treatment Domiciliary developed in Italy.**

So listen, the counter argument to this, of *"no, we should treat the virus"*, that counter weight was there. And it's one of the reasons why you're talking to me today. You're not talking to some FDA official who basically wanted to throw cold or hot water at these, you're talking to me today because you're getting a sense of **truth**! You're getting a sense of reality. That this virus is treatable.

Everything that's we've done for this virus we've made it far worse. By not treating it, keeping patients in fear, isolation. We've done multiple things that have promoted hospitalization, and we've done multiple things that have actually promoted excess mortality. And it's a shameful time in America and in the world.

Where was the policy instructing doctors to NOT treat their patients coming from? Who was giving these orders?

@1:03:00: Under the dark cloud of fear, the medical administrations deferred to the FDA, the NIH and the CDC. Our three governmental agencies. They deferred to them. In fact, they will state, *"We're following the policy."*

So let's pick something less charged. Like wearing masks. How, you know, what sets the mask wearing policy? What the CDC says. Well they say this, let's follow it. Same thing is true. If the agencies say, *"Don't*

use hydroxychloroquine or ivermectin." – **in fact, that's what they say – that quickly gets down to medical administration, and they'll float out an email saying,** *"Don't do it."*

In fact, in a country, we can pick on it, Australia, they had the TGA. That's the equivalent of the FDA. They have a guidelines where they literally have dozens and dozens of negative statements. *"Don't do this."* / *"Don't do that."* / *"Don't do this."* / *"Don't do that."* Interestingly, none of these groups actually say *what to do*. So if you're to take any major hospital and ask them, *"What email, or what policy came down that told doctors what* ***to do****? You gave warnings on what* ***not to do****, but what did you tell them* ***to do*** *to take care of clinic patients with covid-19?"* Most of them would say, *"Nothing. We don't have -"*

In fact, I testified in the Texas Senate on this topic and within, on March 10th, and within 48 hours there was a draft legislation to at least give patients some information. Say, *"Listen, if the hospitals and doctors aren't going to do anything, we're going to give* ***you*** *some information. Here's some – when you get your positive test result, here is some information on what you can do. Here are the treatment protocols. Here are the EUA monoclonal antibodies."*

@1:04:42: **And again, if the hydroxychloroquine or ivermectin is controversial, okay. But what about the monoclonal antibodies? We haven't talked about these. These are high tech, they're produced by big pharma, it's big money, it was all NIH funded, they're emergency use authorized by the USFDA… How come America has no window to that? How come there's no updates on how we're doing with that? How come there's no 1-800 numbers? How sick patients can find out where these antibodies are?**

So it is a global suppression of early treatment, whether they're generic drugs or newly approved drugs. There is a global suppression on early treatment. Americans will know, they watch the TV every night, the initial dialogue was, *"We're scared. Wear a mask, go in lockdown, hand sanitizer…"* **Okay? Then there was some reports about terrible things going in the hospital, then the reports later on were,** *"Wait for a vaccine".*

There were never regular reports or updates from *any* local or national TV source that gave regular updates – *"This is what you should do when you get covid-19 at home. Here are the drugs that work. Here are the protocols. Here are the hotlines so you can get an antibody infusion."* Which is approved by the FDA! *"Here are the hotlines so you can get in research."* Research is important! There's still no hotline for Americans to get in covid-19 research. At a state or a federal level. Stunning! There's been no updates.

@1:06:11: **When I've dealt with multiple congressional and senate offices I said,** *"Listen. Weekly updates to the American people, so that they know what to do so they're not so in fear when they're getting these results. Weekly updates! Through all public channels. Weekly updates on treatment. And then monthly updates to the guidelines."* **We have** ***none*** **of that! We are over a year of this, and the Americans have been absolutely let down by the government agencies, by the media! The media – why wouldn't it come in to any local broadcasters thought process to give their listeners an update on early treatment? It's a stunning oblivion.**

Given that most medications are advertised as having possibly dangerous side effects, why did regulators categorically dismiss early outpatient therapies for Covid-19, including FDA-approved Hydroxychloroquine, on the grounds of having possible dangerous side effects?

@1:07:06: For products to actually be officially advertised, they have to have somebody who's going to pay for the ad, which is a drug company, and they have to be FDA-approved. And they actually have to have an FDA advertising label. And because of the monoclonal antibodies, as an example, don't have an advertising label, they can't be – Lilly and Regeneron – can't go out and advertise for them. But because they're EUA, from a public health messaging perspective, they should be equally featured as vaccines.

Now vaccines are emergency use authorized; all we hear about is vaccines, morning, noon and night. Why do we hear – why do we hear a ***massive*** **messaging about vaccines? Americans ought to think about this.**

Why are vaccines featured, by, the CDC, the NIH, and FDA, morning, noon and night, by the media, morning, noon and night? By every medical center, morning, noon and night?

I can tell you as a doctor in a medical center, all our emails are about vaccination. Why are they featured in every single public health communication? Needles in all the arms? In fact, shockingly, in the Dallas area, in October, this is long before the vaccine trials were *ever* completed, if you were to call CVS or Walgreens, the answering machine would say, *"We're proud to offer the covid-19 vaccine when it comes available."*

@1:08:32: We have never advertised for a product before it comes available. In fact, it's *against* U.S. laws regarding drugs and biological products. So things started to go off the rails very early on, and it seems like there was a playbook. The playbook was to suppress any hope of treatment; a complete oblivion to treatment, through all the entities we've mentioned and at the same time prepare the population for mass vaccination. These two are very tightly linked.

And now with mass vaccination, we have seen things we have never seen. Advertising the vaccine before it's even available. Massive messaging for the vaccine, far out of proportion to treatment. **You have two EUA products, one you never hear about, Americans would – are starved of these monoclonal antibodies – in fact, they're grossly underused. They could've saved probably tens of thousands, if not hundreds of thousands of lives. And they're being squashed. The Lilly and Regeneron products have been squashed. But the Pfizer, Moderna, and J&J products are being massively promoted and advertised.**

Americans ought to be… kind of… wondering, why is that happening? Why are we de-focusing on the sick patient and focusing on well people? All the messaging about contagion control and vaccines are about well people. Why can we not focus on the sick covid patient? That was my message to the Department and Health Human Services in Texas.

But it goes further than that. It goes further than that. The vaccine registrational trials strictly excluded pregnant women, women of child-bearing potential, covid recovered patients, patients who had prior covid antibodies. Strictly excluded them. By regulatory science, if all the registrational trials excluded a group of patients, we would never use that product in that group once it gets on the market. Never! Never! We never violate that. Why? Cause we don't know if it's going to work, and we don't know if it's going to be safe. We *never* do that. There's another level.

@1:10:42: With pregnant women are a special group in research and medicinal products. It's very important for Americans to know this. In pregnant women, for vaccination, we *only* vaccinate with safe, inactive products. Inactive flu, tetanus, diphtheria and pertussis. That's it. We would never inject a biologically active substance in a pregnant woman's body. That could be dangerous. Never! And with the vaccines, as soon as they came out, the CDC, FDA, media, everybody said, *"Vaccinate them. Vaccinate them."*

Given our longstanding acceptance of vaccines for diphtheria, tetanus, polio and measles, how is the development and deployment of Covid vaccines a departure from previous vaccine development and safety review?

@1:11:30: Well, the USA – **the USFDA regulatory guidance on vaccines**, and their have been modern vaccines. You don't have to pick the old ones. I mean, we have modern vaccines, shingles vaccines, hepatitis-B, meningococcal vaccines, **demand a minimum of 2 years of safety data. 2 years.** By regulatory – in fact, they said it kind of written in, codified into the regulatory rules for the manufacturers.

That was all thrown out. And said, *"Two months. For covid, two months."* So two months of observational data. This idea, that we can vaccinate people that were not even tested, in the trials, that has never been done before. We have never just thrown a vaccine at somebody without having any data. None.

So the very first pregnant woman that was vaccinated here in the United States, it was done with no knowledge of safety, and no knowledge of efficacy. And the argument that we've heard, the argument that we've heard, is, *"Well, covid-19 is a bad illness. 600,000 people have died. The vaccine could help them. We should give it a shot. Come on. We should just give it a shot."*

Well that 600,000 died, I've already told you 85% of that was preventable with early treatment, which was *actively* suppressed and squashed. And not only that, is if this vaccine can help them, the vaccine better be safe. It better be safe. And my comments on the vaccine are safety, safety, safety. Let's see it. Let's see it. And Americans ought to – just like the Americans should have been getting weekly updates on treatment innovations, Americans should have been getting weekly updates on vaccine safety. Very important. Weekly updates from our federal officials on safety. Super important.

@1:13:22: **Those two things are probably the two largest acts of malfeasance in all of medical regulatory history. It'll go down in history of malfeasance. Wrongdoing by those of authority. How come there was no updates on treatment and no promotion of early treatment to reduce hospitalization and death? And now when we release the vaccine, why are there no safety updates?** Why are there no attempts for risk mitigation in terms of making the vaccine program safer? How do we have all these vaccines? How do we know that we can vaccinate pregnant women?

We know because of years and years and years of safety data. **Before a vaccine is ever been injected into a pregnant woman, it's probably been tested for decades before we try it in a pregnant woman. We would never out of the box take a brand new technology that's never been tested before, ever – and we know that the vaccine technology produces the dangerous spike protein, it produces the Wuhan spike protein, the spicule on the ball of the virus itself, which damages blood vessels and causes blood clotting. And all of them do. We would never unleash that into a pregnant woman's body.**

@1:14:31: **Americans have to understand, something is *very* wrong, what's going on. What's going on now in the world, these are examples, are clear cut examples, of wrongdoing that is at such a high level. The groupthink is in the wrong direction in such a consistence and overwhelming way, that people are being harmed in, in extraordinary fashion.**

How did you go public with your findings about early outpatient therapies for preventing hospitalization and death? How was it received?

@1:15:05: Well when I published the first paper in the American Journal of Medicine and taught doctors how to treat covid-19, and that could've been somebody else – if Dr. Zelenko had the publication power, he could've done it. Or Dr. Proctor could have done it. Or Dr. Didier Raoult could have done it. Or Brian Fareed – er – Brian Tyson or George Fareed. It turned out that I was the person who had sufficient academic authority to do this. Okay. And I have authority. I take complete responsibility for doing this. I did it uniquely, the only person in the world to do this.

Others actually may have been trying. And those papers may have been suppressed by editors. They probably were. Because we found suppression of early treatment literature all over. It became impossible to publish papers, it was really hard. I may have just been the strongest and the most courageous doctor in the world to do that. But I did it, and the feedback I was getting was tremendous. It was like, *"Of course. This makes sense. I'm so glad this, this got into the literature."* It came out in the electronic print in August, and then it came into hard print in January. When it hit January it landed in all the medical libraries in the world, that's when things *really* heated up.

And, I do have to tell you, that I got letters to the editor that came into the American Journal of Medicine and Joe – Dr. Joe Alpert, out of Arizona is the editor, Joe has let every one of those letters come to me for a

response. The tenor of the letters is quite interesting. And they've come from Duke University, they've come from McGill, from the Nash University in Australia, they've come from Brazil.

@1:16:44: The tenor of the letters is, *"Dr. McCullough, you can't do this. You can't treat covid-19 patients."* **… (long pause) And it's the most interesting – my response is,** *"Doctor. Please have courage. Let's, let's do away with therapeutic nihilism. Let's join together and treat covid-19 patients compassionately to reduce hospitalization and death. And we can do this, and I can do it, and we even have some more supportive data."* **So every time they say,** *"Oh, this drug doesn't work!"* **And I'll say,** *"Well here's 5 more studies that* do."

Hydroxychloroquine – and we're up to hundreds of studies that shows that it works. Ivermectin – hundreds of studies. Steroids – dozens of studies. Anticoagulants – at least a dozen studies. We are so well supported in the concepts of treating covid-19 that every time one of these letters comes in, I have a little fun with it, because the position of strength is enormous. My thoughts, and my positions, and my statements over time are becoming progressively stronger, and progressively more powerful.

@1:17:50: And the detractors sense that. This – the feeling of fear, intellectual fear, from my adversaries, is palpable. I feel it everyday. And when that first paper came out in the American Journal of Medicine, my daughter said, *"Daddy, why don't you make a youtube video?"* I said, *"No, I don't want to do social media. That's for kids. I just, I don't have time for this."*

She taught me how to do it, it was powerpoint. I literally just recorded my face down in the lower corner, I wore a tie, 4 slides, saying, *"Listen. It's Americans. It's Italians. We looked at safety. We looked at efficacy. We looked at all the available data. We think this is the best way to put together the drugs."* **We had 4 slides on this. It got up on youtube. It went absolutely viral. Went absolutely viral.**

And… then I got a message. It said, *"You violated terms of the community."* **and it was struck down. Then I got a call from the U.S. Senate. So I told you, I knew something was going on. Because, you know, I've never been called by the White House before. I've never been called by the Senate before. People in Washington were following this. They were stakeholders, in Washington who, in a sense, knew that something was going wrong here. That this, this viral infection could be treated.**

But they were kind of waiting for someone in the academic community to step forward and literally say, *"It can be treated!"* I was the first one to say, *"We can treat this! We can do this!"* It's very important to be able to make this statement, *"We can do it."* Based on what? Based on my judgement. Based on my judgement. Supported by the available science, but more importantly, based on my judgement.

And so, I ended up contracting covid-19 myself. In October. My wife came home with it. She got sick. Before I knew it, I got sick. It got into my lungs. I was in approved protocols. I quickly got into a protocol; it's hard, but I was able to find a protocol. I was on hydroxychloroquine, azithromycin, nutraceutical bundle, per the protocol; I later on needed steroids cause of lung involvement. **But I wanted to show America that you could get covid-19 and have some medical problems, which I do, and be able to get through it without being hospitalized.**

@1:19:56: So on treatment day 6, illness day 8, beautiful sunny day in Dallas, Texas, I went out, far away from anybody else, and I went jogging. And I was really short of breath. And I tell you, I'm a pretty strong runner. I was short of breath cause of the covid involvement in my lungs. But I ran all the way to a park. **I made a video in the park, and then I made it all the way home. And I had fun with it. I, in fact I played that Eminem music that said, the recovery video. If any of you watch Eminem, and it said,** *"I'm not afraid."* **and I just, you know, video of myself, I said,** *"I'm not afraid of covid-19."* **I had that video. That video was struck down. And then ultimately had to get restored.**

Now wait a minute. Youtube is playing a role here. In addition to all the other stakeholders in suppressing any early treatment. In fact, the early treatment doctors started to become scrubbed from twitter, from youtube, from social media, and then ultimately youtube came out with a very clear message. They

said, *"Listen. We are only going to have information that is in line with the CDC, NIH, and FDA. Which say, do nothing. And everything else is going to be considered misleading. And we're making the judgement. It's our call, on what's misleading and what's not."*

But if it's – it's pretty easy to be in line with the CDC, NIH and FDA because they say to do nothing! So if the social media platform is to just do nothing for early treatment and suppress early treatment, which it is, the major media is to suppress early treatment.

@1:21:32: So I still go back and say, *"Who's responsible?"* **I'd say the government agencies. In this period of crisis, if we're going to revert to our government agencies, and our task force, and if our presidents can't be wise enough to even choose doctors who have ever even seen a patient and know how to treat it, if they're not wise enough to pick doctors who can treat covid-19, we'll never have agencies that say we can treat covid-19, and if we don't have agencies to do that, then nothing else is going to follow.**

If the doctors and people we pick, have never seen covid-19, they're scared of it, they don't know how to treat it, and the only thing they can comment on is wearing masks and social distancing and vaccination – that's all that America's going to have. **So America's response to covid-19, the official response, has basically been to well people.** *"Wear a mask." "Get vaccinated."* **And America has offered nothing to the sick person. And when they get in the hospital, we haven't seen much feature on that. The drugs are pretty weak. Remdesivir, convalescent plasma, tocilizumab, steroids, anticoagulants, you don't hear much about it. And it's, it's honestly too late.**

Recently a Harvard group, the stop covid group, had published those sick enough to get in the ICU, the 28 day mortality is 38%. Unacceptably high. Going into hospital's a nightmare. I get desperate calls all over the United States. Thank goodness for the major telemedicine and regional telemedicine networks. They've basically have taken over. They're the real heroes of the covid-19 pandemic. Hospitals are empty now. **Hospitals here in Dallas used to have 200, 300 patients at a time. Now they've got… 10? 5? The other day in Texas we hit 0 deaths. Zero?**

So, early treatment is going to be one of the great, great stories that historians… and they'll reach out to Ben Marble who started myfreedoctor.com. Ben Marble, that, that whole telemedicine is run strictly by charity. People donate money, and they get patients their drugs. And they prescribe hydroxychloroquine, ivermectin, steroids and other drugs. Put them into combination, they follow protocols. Terrific. They're seeing thousands of patients by telemedicine everyday.

@1:23:44: So Americans are getting treated. And so word is out! People talk to each other. Americans, it's interesting. They understand that the media and the agencies are not leveling with them. They understand that.

I did a seminar early on because I had treated a very prominent African-American minister here in Dallas. And him and his wife were sick. He didn't tell me about his wife. And she was testing negative. She wasn't a patient of mine. He got what's called sequence multi-drug therapy, he got really sick, he's got heart failure, diabetes, emphysema, obesity, kidney disease – survives at home, sick for about 10 days – I'm not saying the drug therapy is perfect, but I saved him from being hospitalized or dying.

His wife, no treatment, hospitalized, diagnosed late, was in the hospital for 5 weeks. Came home on oxygen; that virus ravaged her lung. It was awful. They had the same illness. And so he became activated; he said, *"Dr. McCullough, can you do a webinar for African-American churches nationwide?"* **I did a webinar, and I presented my approach. And you know what the comments were? They said,** *"Dr. McCullough, we knew, we knew the government was lying to us. We knew this was treatable. We knew it all along."* **People know this.**

Are more doctors finally learning to overcome the regulatory and institutional suppression of outpatient Covid-19 therapies?

@1:25:06: It's the individual finding its way. There are practices that have come on. I've gotten calls in Dallas, *"Dr. McCullough, can you share your protocols? We want to do this."* The treating doctors really have interdigitated. And we informally called, formed a group called C19, where we get about 4-5 email updates a day, of really critical updates on treatment. It is international. We have former heads of state involved in C19, we have Nobel Prize winners involved in C19, hundreds and hundreds of American doctors.

There now is a published list of treating doctors in the United States; 250 across all 50 states. Texas has 35 of them. So Americans are finding their way despite suppression of early treatment. It's one of the great stories.

@1:25:56: And I'll never forget when I testified in the Texas senate, on March 10th, myself and Dr. Richard Urso, another leading early treating doctor in Houston, the chairwoman of the committee at one of the side conversations said, *"Yeah, my husband got covid-19, and he got really sick. And I'm so glad he got early treatment. We found a doctor that was willing to prescribe ivermectin and other drugs."*

And I didn't throw out the zinger in front of the Texas media, but I felt like saying, *"You know, do you have to be a chairperson of the Department of Health and Human Services to get some treatment? What about these poor people in south Dallas, San Antonio and Houston, what about people who are not so privileged?"*

Do you know that 85% of some of our patients hospitalized here are black or Hispanic? Who's helping them out? We should be having early treatment centers; they've been *denied* treatment. It's heartbreaking. Hispanics and African-Americans have double the – have double the mortality that of caucasians.

As a doctor confronted with sick people who need treatment NOW, how do you evaluate what therapies are effective in order to help your patients NOW instead of waiting for the publication of largescale studies?

@1:27:07: We have actually a law in America. It's called the 21st Century Cures Act. And what this says, is that the FDA and doctors and others trying to do decide on treatment, evaluate the totality of information, including that little anecdote about your mom and the caretaker, as well as case series, large prospective cohort studies, retrospective cohort studies, hospital studies, outpatient studies, and then large prospective randomized double-blind placebo controlled trials.

But in a virus, single drugs themselves are very difficult to prove. Like, if we require that for HIV we'd have no treatment. HIV we quickly realized we need 3 or 4 or 5 drugs. Everyone understands this. With covid-19, I never thought a single drug was going to work. Hydroxychloroquine. No, not alone. But in combination.

And it was that thinking, it takes kind of superior thinking, that somehow doctors just lost their ability to think. Think a cancer doctor would say, *"Oh, there's one pill that cures cancer."* Never. It's always combination cancer therapy. So, with this, with hydroxychloroquine, we're now at the stage obviously, we have hundreds and hundreds trials. We even have large randomized trials. I've published a doctorate with Joe Ladapo, only prospective randomized control trials show benefit.

So at every level we meet the evidence grade to use hydroxychloroquine. At every level, we meet the evidence grade to use ivermectin. Not so much evidence, but good enough, and the monoclonal antibodies. We have the same for steroids.

@1:28:38: The biggest and best trial in all of covid-19 is ColCorona. I mentioned it with colchicine. Shockingly, ColCorona, the best trial, 4,000 patients, double-blind randomized placebo control trial. The best quality that exists, rejected by New England Journal of Medicine, rejected by JAMA, rejected by Lancet.

There is a global suppression on any early treatment. I want the listeners to understand how global this is. If we were to go north into Canada, doctors are *threatened* that their licenses will be examined or taken away if they attempt to treat an outpatient with covid-19. They are told this, in Canada. In northern EU, the same is true. Dr. Didier Raoult, who is trying to innovate with hydroxychloroquine and azithromycin in France, in periods of time has been under degrees of threat of arrest or partial arrest or house arrest.

Okay? Almost as if we're back in the Dark Ages. In Australia, in April, they put on the books **in Queensland, Australia, a doctor who tries to help a patient with hydroxychloroquine could be penalized up and to the point of going into jail for 6 months for helping. In South Africa they *put* some doctors in jail for trying to help patients with ivermectin!**

Listen! The powers that are out there that want to suppress early treatment, and cause as much fear, suffering, and hospitalization and death, are not by happenstance. These are *powerful* forces that have created such fear among doctors; people are fearful they're going to lose their careers, their livelihood, their medical license, people are afraid of going to jail. In just helping their fellow man get through covid-19.

This is extraordinary. Historians should go look through the course of time. **You know the very first doctor, who tried to help a polio patient, survived polio? With the iron lung machine? Which became really a staple ICU device? Was thrown off medical staff. Throw him off staff!**

Can you offer any investigative leads to researchers trying to discover WHY early outpatient therapies for Covid-19 have been suppressed?

@1:30:57: I'd look very carefully at the work, building upon other investigative reporters. So Dr. Peter Breggin has a book called *"Covid-19 and The Global Predators: We are the Prey"*. And it has a living document, he's already pre-released the manuscript, and he's releasing updates. Now he's older and he's kind of worried the story won't get out, at his age. But I believe he's up to 900 documents. The whole story is not put together. But it is substantial and shows the interconnections of the stakeholders involved.

Dr. Nicholas Wade, who is featured on a recent Tucker Carlson is an investigative reporter, he has assembled quite a story. And then Whitney Webb, who is a young investigative reporter, has published some striking things.

All three of these, and as well as many more are linking to important concepts. The suppression of early treatment, and even probably the soft attenuation of in-hospital treatment, to make the problem worse than what it is. Many methods to make the case count look higher than what it is, make the mortality numbers look worse than what they are, many methods to create the reaction out of proportion to the realities. So lockdowns, fears, economic suffering, what have you. All of these things making the pandemic way worse than what it is.

Okay? To, to have that occur. More fear, suffering, hospitalization and death, loneliness, lockdown… in order to promote mass vaccination. These two are tightly linked. *"Now mass vaccination **AT ALL COSTS**! The world **must** be mass vaccinated."*

@1:33:00: And human beings on Earth ought to understand, at this point in time, what we're seeing is unprecedented.

It became known, the virus was going to be amenable to a vaccine, somewhere around April or May. At that point in time, therapy was suppressed, everything – nothing can be published. Everything, the fake Lancet paper, ***squashed*** treatment, and then prepared the population for vaccination. Once the vaccines come out, they're short-tracked, there's all kinds of enthusiasm regarding it, you know, needles in all the arms, trucks rolling, Americans cheering. And then the mass vaccination program starts off.

And then before we know it, you know, we're vaccinating pregnant women. Why are we doing that? That can't be safe. Now we're going to vaccinate covid recovered patients. Wait a minute! They have complete and robust permanent immunity. No one's ever challenged the immunity of a covid recovered patient. Why are we vaccinating them? And then it keeps going and going.

At first we vaccinated high-risk people. I didn't really understand vaccinating young health care workers, because they weren't at risk. There were never any hospital outbreaks in the United States. The only thing that was clear, nursing home workers gave it to nursing home patients. We knew that. So nursing home workers should have been vaccinated. And then maybe high-risk people and we should call it a day.

@1:34:16: I always estimated maybe 20 million people need to be vaccinated. But that didn't seem to satisfy the vaccine stakeholders. Which are: Pfizer, Moderna, J&J, AstraZeneca, and any others that come forward, the CDC, the FDA and the NIH. And the White House. *Massive* vaccine stakeholders. You can throw in Gates Foundation. World Health Organization. You can throw those in as well. *Massive* stakeholders. And they wanted *every body* to be vaccinated. Without exception! No one will escape the needle.

We've actually never had this before. And the vaccine process is extraordinary. There's a consent form. It says this is investigational. *"We don't know if it's going to work. There's only 2 months of data. The side effects could be a sore arm all the way to death. And we don't know. Sign here. We need your identifying information. We need a barcode on the vial. We need you identified. And now you're in the database. You're vaccinated."*

And so this mass vaccination is extraordinarily concerning. We never vaccinate into the middle of a pandemic. Never. We've never had an effective vaccine for respiratory virus, including influenza – it's only modestly effective. We knew from the published data that the attack rates in placebo and the vaccine arms were less than 1%. So we know that the vaccine can have a less than 1% effect in the population.

Why would it be any different than the clinical trials? We knew from the clinical trials that it didn't stop covid-19, so people can get covid-19 anyway. What would be this incredible drive to vaccinate everybody?

And now, oh my Lord, now the vaccine within a few months has been completely weaponized. Now there's travel is related to the vaccine. People can't go to school without the vaccine. People are losing their jobs without the vaccine.

@1:36:02: Believe me, there is something very, *very* potent in this vaccine. It should be disturbing to everybody. The word "vaccine" ought to be the most disturbing word that they have seen.

Now we have 12 year old children who are told they can decide on their own, whether or not they can take a vaccine.

So, you know, about 70% of my patients are vaccinated. I'm very pro-vaccine, I've taken all the vaccines myself – about 70%, and they're all vaccinated in December, January and February. **But as we sit here today, in May, we have over 4,000 vaccine related deaths, and over 10,000 hospitalizations.**

The limit! To shut down a program! Is about 25-50 deaths. Swine flu, 1976, 25 deaths, they shut down the programs. It's not safe. The whole – all the vaccines in the United States per year, would [dialogue unclear] gets reported in the database, is about 200. And we're talking about vaccinating probably, probably, you know, 500 million injections.

@1:37:03: Here, in the United States, at a 100 million people vaccinated, this is far and away the most lethal, toxic, biologic agent ever injected into a human body in American history. And it's going strong. With no mention of safety by our officials. With wild enthusiasm by our hospitals and hospital administrators. With doctors supporting it. Doctors are saying now, they won't see patients in their waiting room without the vaccine.

This problem, covid-19, was actually from the very beginning, that's what Whitney Webb said, she goes *"Covid-19 is actually about the vaccine. It's not about the virus. It's about the vaccine."*

Why has there been such a relentless focus on mass vaccination as the ONLY way back to normalcy?

@1:37:50: **I think it's about what the vaccine means. And Whitney Webb gets credit for this, back in April she said,** *"Ah ha! I figured this out. This is what globalists have been waiting for. They've been waiting for a way of marking people."* **That you get a vaccine, you're marked in the database. And this can be used for trade, for commerce, for behavior modification, all different purposes.**

And you see it right here in Dallas. They have announced, you know, you can't go to a Dallas Maverick's game unless you're vaccinated. You've had people say, listen, you have passports. You had colleges today announce that they're not going to give any credit to natural immunity.

Every scientist in the world knows that the natural immunity is *way* better than the vaccine immunity.

If it's about covid, why don't we have covid recovered go to the Maverick's game? Why don't we have covid recovered people freely go to college? Why do we have to have faulty vaccine immunity be the priority? And have natural immunity not count?

See, these types of things make me think that Whitney Webb is correct. This is actually about marking. The vaccine is a way of marking people; it's a way of starting to assert efforts to create compliance, behavior control – don't forget the vaccine is just the starter. Now there's going to be updates, there's going to be boosters, they're already prepping people for this. There's going to be more – the vaccine manufacturers are all linked. They're all uniquely indemnified.

What medical product is there indemnification, where if something happens to you, you don't have any recourse? You know, woman gets vaccinated, pregnant woman, she has no maternal fetal rights. Something happens to her or her baby, she's out of luck. This is extraordinary what Americans are doing. It's absolutely extraordinary what's being thrust upon us now.

Are we entering a Brave New World in which a person who elects NOT to get vaccinated will be punished through nonjudicial means by being forbidden to work, travel, and attend important public events?

@1:39:45: **I think this whole pandemic, from the beginning, was *about* the vaccine. So I think all roads lead to the vaccine. And what it means. There are already places in southeast Asia and Europe, they are laying the groundwork for compulsory vaccination. I mean, compulsory. That means somebody pins you down to the ground and puts a needle in you. That's how bad stakeholders want vaccination.**

Listen. It's not of cost. You don't have to pay for it. It's all provided. There are people, or stakeholders, they do want a needle in every arm. This "needle in every arm" is a very important moniker. Why? Why do you want a needle in arm?

Let's take covid recovered. Can't get the virus. Can't receive it. It has nothing – Why would they ever want a needle in the arm of a covid recovered patient? Why? Three studies show higher safety events.

See, the tension that Americans are feeling right now, as they're trying to keep their jobs and go to work, is they know they can die of the vaccine! That's the problem. If the vaccine was like water, and you just got it and no side effects, who wouldn't take it? Say, hey, I'll comply. They got my social security number anyway in a database. I'm already marked. I'll just get marked.

@1:40:56: **But no, there's something very unique about this vaccine. It's something about injecting something into a body, that is so important to stakeholders, that it doesn't matter. Kids 12 years old told they can make their own decision on this?! And it could be their fatal decision? Think about that! North Carolina just passed that. Oh, kids 12 years old can make, can decide on their own.**

There are 4, over 4,000 dead Americans, there's over 10,000 dead people in Europe, that die on days 1, 2 and 3 after the vaccine. Why, are we pushing this in a way where people's jobs and their education, and their livelihood decide on a decision that's potentially fatal? The tension – you can cut it with a knife!

There are parents who say, *"Listen. I want my kid to go to college this year but I don't want to lose him to the vaccine."* **They know what's going on. The internet is full of these cases. Blood clots, strokes, immediate death.**

Now I'm fortunate. I have not directly lost a patient to the vaccine. I told you. Most got vaccinated in January – December, January and February. Based on the safety data now, I can no longer recommend it. I can't recommend it. It's past all the thresholds to being a safe product. It's not a safe product. None of them are. It's not just Johnson & Johnson. In fact, more of the safety events in the United States have occurred with Moderna and Pfizer.

There are now papers, written by prominent scientists, calling for a worldwide halt in the program. There are prominent virologists, many of them, including Nobel Prize Winners, who have said, listen. If we vaccinate people and we create a very narrow, incomplete library of immunity – which what the vaccine is. The vaccines are all targeted to the original Wuhan spike protein. Which is long gone. That's extinct. Patients are getting vaccinated to something that doesn't even exist anymore. That Wuhan spike protein is gone.

We're hoping the immunity covers the other variants. But that narrow immunity is a setup. It's just like giving everybody a narrow spectrum antibiotic. If you did that, what would happen? We'd grow up superbugs.

There are warnings out there saying, *"Don't do this! Don't vaccinate the entire world. All we're going to do is set ourselves up for a superbug that's going to really wipe out populations."*

So for many reasons, the vaccine, indiscriminate vaccination, is a *horrendous* idea, it's a horrendous *bioweapon* that's been thrust onto the public. And it's going to cause great personal harm, which it already has. Thousands of people have lost their lives. I've never lost a direct patient, but I've had my patients lose their family members – lots of them!

I've filled out a safety report on a patient who developed blood clots after one of the Pfizer or Moderna vaccines, and I'm telling you, it took half an hour to do it, there was many pages, and each page said: *"Warning. Federal offense. Punishable by severe fines and penalties if I falsified a report."* All those ***thousands*** of Americans that have died with the vaccine and hospitalizations in the database, I think are ***real***. And they are far beyond anything we've ever seen. And as a doctor, and as a public citizen, I am extraordinarily concerned about the vaccine.

The vaccine center right down the street here is empty. I drive past it everyday. Americans know, they're talking to each other, the vaccine's not safe. And now the effort is, the vaccine stakeholders want kids without parental guidance, and now they want to be in the church. Americans, and people worldwide, should be extraordinarily alarmed.

Has any agency or individual tried to silence you through threats or other forms of intimidation?

@1:44:24: My personal situation, professional situation, is a position of strength. And those who have attempted in any way to pressure, coerce, or threaten me with reprisal have paid an extraordinary price.

And I think that's an important message, to get out there. **There is a position of strength, of based on principles of compassionate care, and of the Hippocratic Oath, and of the fiduciary relationship that a doctor has to a patient, and a prominent doctor has to a population, that supercedes all of those other ill intents. And what I say is,** *"Bring 'em on."*

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Dr. McCullough is an internist, cardiologist, epidemiologist, and Professor of Medicine at Texas A & M College of Medicine, Dallas, TX USA. Since the outset of the pandemic, Dr. McCullough has been a leader in the medical response to the COVID-19 disaster and has published "Pathophysiological Basis and Rationale for Early Outpatient Treatment of SARS-CoV-2 (COVID-19) Infection" the first synthesis of sequenced multidrug treatment of ambulatory patients infected with SARS-CoV-2 in the American Journal of Medicine and subsequently updated in Reviews in Cardiovascular Medicine. He has 40 peer-reviewed publications on the infection and has commented extensively on the medical response to the COVID-19 crisis in The Hill and on FOX NEWS Channel. On November 19, 2020, Dr. McCullough testified in the US Senate Committee on Homeland Security and Governmental Affairs and throughout 2021 in the Texas Senate Committee on Health and Human Services, Colorado General Assembly, and New Hampshire Senate concerning many aspects of the pandemic response.