Speaker 1 (00:00):

Now again though. Why do you think hydroxychloroquine was demonized? Why do you think that it was especially so early on in Australia? It, it can't be universal competence across the board. So one of the things that's interesting about IM Macin is it's not demonized worldwide. It's distributed widely in other countries and it's shown some effectiveness.

Speaker 2 (00:23):

Oh, absolutely. You know, I Mein now is a first line in Japan. It's attributed to crushing the curves in Mexico, uh, in Peru, absolutely crushed the curves in India. We've been in close communication with them. Ivermectin is an interesting, uh, drug, and I know you've reviewed it, uh, in depth on this show. Uh, so I'll leave it to experts like Dr. Corey and others, uh, there, but you, I use it every day in my practice. I have no problems with ivermectin. It's safe and effective. There's been a Nobel prize awarded, uh, you know, in 2015 for ivermectin, but hydroxychloroquine, I think worldwide is still the leading drug use to treat COVID 19, just because of it's of liability. Uh, you know, it's, it's, it's known dosing. The nice thing about the interesting thing between hydroxychloroquine and ivermectin is ivermectin has a range, inpatient and outpatient, and has a bigger effect size in general.

Speaker 2 (01:16):

Both of them have, uh, are still lacking the 20 to 40,000 patient clinical trial, uh, a singular drug. And I, I honestly don't think we'll ever get there there's by the way, we're in the multi-drug space. So we're never gonna go back to single drugs we're in the multi-drug environment. Uh, and, uh, so there are no large multi-drug trials even planned at this point in time. So we're, we're left with, uh, where we are signals of benefit, acceptable safety, but to finish a thought ICT and has a range of effect sizes that are gratifying inpatient and outpatient, um, diminishing efficacy later hydroxychloroquine has really no support on the inpatient side, outside the big Henry Ford study. So hydroxy is largely an outpatient drug. The advantages of hydroxychloroquine are stable dosing, 200 milligrams twice a day. We either go five, 10 or 30 days. We even have protocols where it's been done that way.

Speaker 2 (02:05):

Ivermectin, the dosing is 200, 400 or 600 micrograms per kilogram, and the dose intervals still are yet to be standardized or worked out. So it's interesting. So you see an entire range of doses in ivermectin, and we even clinically today, I don't know, do I go five days? Do I do 10 days? Do I do every other day? I don't know. We use the drugs and I'm comfortable with that. I can live with ambiguity in the setting of a crisis. The point is these are very safe and effective drugs. They useful drugs. I saw a trend you've asked me three times, so I'm gonna answer it. I saw a trend starting in April, may and June, where it became clear that any, anything we were doing to try to help patients with early treatment was receiving a chill. And the chill was coming through academic institutions through the medical literature.

Speaker 2 (02:55):

I think the capper was in June when there was a fraudulent paper published in Lancet on hydroxychloroquine between Harvard and a company called Sur surgi sphere. And this never happens lancets like the Newing England journal medicine of the world. I'm the editor of major journal. I run a journal. I know what it takes. There's there are editors, associate editors, reviewers. There is pinpoint accuracy. We check references, we check plagiarism, believe a tight world out there. They basically published a fraudulent paper on hydroxychloroquine in Lancet in 2020, around June. And they let it hang

up there for two weeks stating that hydroxychloroquine was associated with harm. When used in patients with COVID 19,

Speaker 1 (03:34):

Who made this study,

Speaker 2 (03:36):

It was between, uh, one investigator was at Harvard and it was by a company called surgi sphere that nobody knew what this company was. It turned out to be a company that literally just dissolved or went, went away, uh, without anybody understanding

Speaker 1 (03:49):

It was a company that was created specifically to do this

Speaker 2 (03:52):

Likely don't. I don't know. All I can tell is I looked at the data, Joe, and they had tens of thousands of people they claimed to wear hospitalized with COVID 19, fairly, uh, early in the pandemic. The average age of these people hospitalized was in the low forties. I looked at this paper in two seconds, like this doesn't make sense. We were hospitalizing people in their eighties, not in their forties. And so to me, it didn't, it didn't didn't look right. And then people started writing Lance it saying, listen, this doesn't look real. And they started receiving tons of emails and then Lance, it basically retracted it and said, we retracted it. No apologies, no explanation. I interpret that. And that, that occurred right before the FDA said don't use hydroxychloroquine. It almost looked like it was a step to basically try to bury hydroxychloroquine as a therapy, but

Speaker 1 (04:40):

Why this is what I still don't understand. What do you think is the motivation and why was it so

Speaker 2 (04:45):

Worldwide as a doctor? All I can tell you is the medical literature, as we are seeing it come about, there was once the discovery that the spike protein on the virus, the discovery in the medical literature, now that discovery we learned actually, or years before this was amenable to neutralization with vaccine induced antibodies. Once that became abundantly clear in the literature, there appeared to be almost a lock step developed where people said, Uhha, that's it, that's the solution. We're gonna vaccinate our way outta this problem. We don't even need to worry about how to treat the problem. We don't need to hear about drugs to treat the problem and the enthusiasm and the hubris for vaccination spread across academic medical centers all over the country.

Speaker 1 (05:32):

But what about the people that were currently sick and they were still waiting for the roll out of the vaccine. So if you're talking about August the vaccine, wasn't rolling out for another four and that's just for elderly people.

Speaker 2 (05:45):

I published an op-ed in August of 2020 in the hill, a Republican journal, uh, for, you know, Washington people and others, uh, in those circles. And the title of the op-ed was the great gamble of the COVID 19 vaccine development program. And what I saw is I saw a total shift on everything for the vaccines. Do you know, major clinical trials with hydroxychloroquine were dropped ivermectin. Things were dropped. Uh, we, we had, uh, programs for Fay VIR. The Canadians had a big thrust for fave Purvi dropped. I was the principal investigator overall for the Rema band program. That was a Japanese product. It was an anticoagulant antihistamine looked very promising. We had great preliminary data. We had bear that was gonna give us all the doses we needed to treat America. I was on calls between the ni age, uh, and the, um, FDA back and forth, back and forth.

Speaker 2 (06:41):

I couldn't get any traction in the summer at 2020. It was obvious. In fact, I remember one of the operation war speed officers telling me, listen, sorry. We have everything organized for, uh, the current program. I was also the assistive. I was this kind of second in charge of the Ilon program, which was a cellular based vaccine. That was a vaccine similar to the BCG vaccine, which is given for tuberculosis. We had noticed that regions that were vaccinated for tuberculosis, like Haiti and countries in central Africa, very little COVID. And so we had the idea, we got a, uh, a Dutch manufacturer to actually make this cellular based vaccine. We were gonna vaccinate healthcare workers, same thing, endless proposals between NIH and FDA got nowhere because it looked like it was already predecided that the current set of genetic vaccines were gonna move forward. There wasn't gonna be any discussion on early treatment.

Speaker 2 (07:32):

I thought it was a gamble I was faced with more and more of my patients getting sick with COVID 19. And what I told all over, I said, listen, I can't let the virus slaughter my patients. I'm not gonna do it. I said, there's gotta be something I could do early on. I used hydroxychloroquine other drugs in combination once a pure query, I give him great credit. His first contribution is actually, uh, steroids in the use of COVID 19. So we started using steroids once it was shown to us. Uh, we steroids the data started coming on anticoagulants, and that's how I put it together. I tell you, Joe, every single one of my high risk patients, I've always treated to prevent hospitalization and death of the 800,000 deaths that we are right now. I can tell you to a one they've received either no or inadequate early treatment.

Speaker 2 (08:21):

All of them go look in a table of baseline, characteristics of hospitalized patients with COVID 19 and look at what they received before they came to the hospital. Zech in fact, there's one paper by I and colleagues. Uh, first name, last name is spelled IP. It was published from New Jersey early on. And in that paper back when there was a surge of hydroxychloroquine use in the spring of 20, 27% of people had received some pre-hospital hydroxychloroquine before they got to the hospital, they had improved survival, even some pre-hospital treatment really worked. So what happened is when we came up with our treatment protocols, a protocol that I mentioned, it sounds like describing, uh, what you received as a treatment. You basically received the McCull protocols now being copyrighted sequence multi-drug once the monoclonal antibodies came in, that became a building block in our program. And we can maybe show that MI multi-drug protocol all on the screen. If we can look at it. Um, the point is that, um, any pre-hospital treatment was associated with improved survival because we're taking an edge off I application reducing some of the inflammation, preventing some of the thrombosis. If we let this thing run for 14 days, Joe, the, the lungs are filling with blood clots. By the time the oxygen saturated goes

down, that's not the virus. The, the Italian showed us through autopsy studies, very courageous autopsy studies. The lungs are filled with micro blood clots.

Speaker 1 (09:45):

So in your opinion, if your protocol had been established and distributed worldwide, if people had recognized that this is a, a way to deal with early treatment, you think that the overall number of COVID deaths would've been significantly reduced.

Speaker 2 (10:03):

I testified in the us Senate, November 19th, 2020, I told Americans under oath that 50% of the lives at that time could have been saved. We were at about 250,000 deaths based on what I, I then testified on March 10th, 2021 in the Texas Senate sworn testimony. I upped that to 85% of the deaths could have been avoided. We know that because we carried out studies. We did one with Proctor here in, in Dallas, Fort worth, where we demonstrated that even the early primorial protocols beef for the mono Conal antibodies, when we use drugs in combination, we're associated with 85% reductions in hospitalizations and deaths compared to fair compared to our groups in for death, we use the TriCounty area and DFW averages, age adjusted. And for hospitalization, we use the Cleveland clinic calculator, which is a very precise estimate of the risk of hospitalization. Then simultaneously Dwin and Lanco showed that from Marron New York data, and then did weal showed it from Marai France. So we have three different areas showing early multi-drug therapy as an outpatient works substantially. And we've had a giant loss of life, a giant number millions and millions of unnecessary hospitalization. And it seemed to me, and I I've told Tucker Carlson and many others. It seems to me early on, there was an, an intentional, very comprehensive suppression of early treatment in order to promote fear, suffering, isolation, hospitalization, and death. And it seemed to be completely organized and intentional in order to create acceptance for, and then promote mass vaccination.

Speaker 1 (11:46):

So you believe this is a premeditated thing that they were doing. So they realized that in order to in get people enthusiastic about taking this vaccine the best way to do that was to not have a protocol for treatment.

Speaker 2 (12:02):

It's not just my idea. Now it's completely laid out by the book by Dr. Pam popper. The book recently published by Peter Bragen, uh, COVID 19, and the global predators. We either pre I wrote one of the, uh, introductions Dr. Le leaf Lee and Dr. Flaco Lasko wrote the other introductions. These books are basically nonfiction. They have a thousand citations in the Braham book showing how it was coordinated and plant. Now, Bobby Kennedy has his book out the real Anthony Fauci. Um, the most, uh, uh, mentioned physician in that book. I can tell you that if you wanna find the evidence that Madena was working on the vaccine before the virus ever emanated out of the lab, if you wanted to find the, the collusions and the operations between the gates foundation and Gavi and CEPI and Pfizer and Madena, and the vaccine manufacturers and the Wuhan lab and the national institutes of health and Ralph Barrack and university of North Carolina at chapel hill, and how all this was organized.

Speaker 2 (13:02):

If you wanna see the John's Hopkins planning seminar called the spars pandemic in 2017, where they had a symposium, people showed up, they wrote up their symposium findings, they published this, it

says it's gonna be a coronavirus. It's gonna be related to MERS and SARS. It's gonna come over here to the United States. It's gonna shut down cities and frighten people. There's gonna be confusion regarding a drug hydroxychloroquine or ivermectin, and we're gonna utilize all that in order to railroad the population into mass vaccination, it's laid out in the Johns Hopkins, spars pandemic training seminar. The only thing that got wrong was the year they said it was gonna be 20, 25. Instead it landed a few years early.