Journal of American Physicians and Surgeons
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Skyline Printing Co., Inc.
Tucson, AZ

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www.jpands.org

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Tucson, AZ 85716

Journal of American Physicians and Surgeons (ISSN 1543-4826)
is published quarterly.

Correspondence

An Open Letter to the American Board of Medical Specialties and the Federation of State Medical Boards: the Destruction of Member Boards' Credibility

We condemn, in the strongest terms, the decision by several certification boards and/or medical boards, including the American Board of Internal Medicine (ABIM), the American Board of Pathology (ABP), the American Board of Family Medicine (ABFM), and others, to review the board certification of doctors Peter McCullough, Pierre Kory, Paul Marik, Ramin Oskoui, John Littell, Ryan Cole, Casey Delcoco, Elizabeth Laffay, and perhaps many others, on the frivolous grounds that they are spreading "medical misinformation." These actions against leading physicians, who have pioneered the development and deployment of treatment protocols against COVID-19, and who are now making similar efforts towards the treatment of patients who have been injured by the COVID-19 vaccines, threaten the right to life and the well-being of the American public.

Dr. Peter McCullough is an accomplished medical researcher with a powerful publication record[1] in the area of cardiorenal medicine. He is also one of the acknowledged experts on COVID-19, with more than 50 peer-reviewed research publications on the pandemic response to COVID-19. He is best known for the development of the early outpatient McCullough treatment protocol[2] for COVID-19. He has co-authored several more publications[3-7] with supporting evidence for the early outpatient treatment of COVID-19, and he has also published on COVID-19 vaccine safety.[8] In addition, he has successfully treated COVID-19 patients in clinical practice, and he is currently confronted with the need to treat patients that have been injured by the COVID-19 vaccines, which some have taken willingly and others under coercion by vaccine mandates. He has an encyclopedic knowledge of COVID-19 research, and he has meticulously cited the scientific literature in all of his public commentary. With his vast experience and expert knowledge, he is a national treasure and a resource that our public health agencies and medical boards have failed to consult throughout the pandemic.

Likewise, Dr. Pierre Kory, Dr. Paul Marik, and their FLCCC collaborators were monitoring the research literature from the beginning of the pandemic, and they were diligently making monthly white paper reports on the treatment of both COVID-19 outpatients and inpatients, based on their systematic literature review and their direct clinical experience. Their efforts culminated in the development of the MATH+ protocol[9,10] for treatment of hospitalized COVID-19 patients, the related I-PREVENT and I-CARE protocols[11,12] for prophylaxis and early outpatient treatment of COVID-19, and the I-RECOVER protocols for the treatment of long COVID syndrome[13] and COVID-19 vaccine injuries.[14]

Dr. Kory is an accomplished researcher with 56 peer-reviewed publications, of which 11 publications were focused on the treatment of COVID-19. His publication[15] explaining that COVID pneumonia was an organizing rather than a viral pneumonia was key in understanding the inflammatory phase of COVID. Dr. Kory is considered one of the world pioneers in the use of ultrasound by physicians in the diagnosis and treatment of critically ill patients. He is also one of the pioneers in the U.S. in the research, development, and teaching of performing therapeutic hypothermia to treat post-cardiac arrest patients. He has also pioneered, in collaboration with Dr. Paul Marik, the research and treatment of septic shock.

Dr. Marik has special knowledge and training in a diverse set of medical fields, with specific training in internal medicine, critical care, neurocritical care, pharmacology, anesthesia, nutrition, and tropical medicine and hygiene. Dr. Marik has written more than 500 peer-reviewed journal articles, 80 book chapters, and four critical-care books, and he is the senior editor of the only

published textbook[16] on COVID-19. He has already co-authored 18 papers on many therapeutic aspects of COVID-19. He has been cited more than 43,000 times in peer-reviewed publications and has an H-index of 77. He is the second most published critical care physician in the world ever, and is a world-renowned expert in the management of sepsis.

Dr. Ramin Oskoui advised the Trump administration on COVID-19 issues and testified before the U.S. Senate about COVID-19 treatment in November 2020. He has co-authored three research papers on the treatment of COVID-19. He was named 2015 Physician of the Year by Johns Hopkins Medicine Clinical Awards for Physicians and Care Teams, won the annual Patients' Choice Award many times, and was named a Top Doctor in the Washington, D.C.-Baltimore area by Castle Connolly and Washingtonian magazine. Dr. Oskoui has also received Compassionate Doctor Recognition and was named a 2014 Top 10 Doctor in the District of Columbia for cardiologists. He has expertise in diverse areas of cardiovascular medicine.

It has been recognized for more than a century that academic freedom, enabling researchers to publish and present to the public their findings without fear of institutional reprisal to their livelihood, is absolutely crucial, and has played an essential part in establishing the U.S. as the preeminent force in scientific research. Researchers like Dr. McCullough and Dr. Kory require academic freedom to conduct research and communicate their findings in their area of expertise to the public, without fear of institutional reprisal against their livelihood. The ill-conceived crusade against "medical misinformation" has now been aimed at destroying the academic freedom of some of the most experienced and qualified independent U.S. COVID-19 researchers. Individual medical researchers have the duty to publicly speak against any incorrect or outdated recommendations or decisions by our public health agencies and to hold them accountable, and more broadly to counter genuine medical misinformation. The public should be able to hear many perspectives from teams of medical doctors who may disagree and have different viewpoints on the current status of the research literature on the pandemic response.

At this time, treatment of COVID-19 and the safety and efficacy of the COVID-19 vaccines are continuing research areas. COVID-19 itself has been a moving target, with the emergence of new variants requiring updating of treatment protocols, continuing reconsideration of the balance of risks and benefits of COVID-19 vaccinations, and recalculation of our current status of herd immunity.

It is an unacceptable fallacy, based on circular reasoning, to use the opinions of public health agencies including the Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), National Institute of Health (NIH), and World Health Organization (WHO) to define what is or is not "medical misinformation," and then to use that fallacy to investigate the board certifications of the very researchers who are conducting the research that these public health agencies depend on to justify their recommendations. Researchers at the cutting edge of COVID-19 research are inevitably ahead of that curve in which, ideally, information flows from them to the agencies. But under current conditions, regulatory capture[17] and malfeasance[18] of these agencies, and the financial conflicts of interest caused by the regulators being the sponsors of the COVID-19 vaccine program have disqualified them from serving as neutral adjudicators of medical misinformation about the COVID-19 vaccines and the competing prophylactic and treatment options.

In the COVID-19 era, there are not as yet "well-established medical facts." Officially proclaimed viewpoints are constantly changing. The recurrent changes in mask guidance emanating from CDC are just one indication of confusion in the U.S. public health hierarchy. The often stated consensus that the COVID-19 vaccines are safe and effective, as if that was accepted medical certainty, is also contradicted by many different facts. The CDC has admitted in public statements that current COVID-19 vaccines do not prevent transmission, and has also admitted, in their booster recommendations, that benefit conferred by the COVID-19 vaccines is transient.

The CDC VAERS database[19] has shown substantial injuries and deaths associated with COVID-19 vaccination, which are temporally associated with the timing of vaccine dose[20] and occur at an increased rate with an increasing number of doses.[21] The mechanisms of action for vaccine injuries are known,[8,22] and a recent report[23] by the World Council for Health shows consistent findings of vaccine injuries and deaths across the CDC VAERS, WHO VigiAccess, EudraVigilance, and the UK Yellowcard databases, and has called for the recall of the COVID-19 vaccines. In a large number of European nations and Canada, the Moderna mRNA 1273 vaccine is discouraged for adolescents and young men. A recent publication[24] highlighted the dangers of post-vaccination myocarditis and pericarditis in France, which still allows the Moderna vaccine. Only in the U.S. is the Moderna mRNA1273 vaccine authorized for administration to tiny children and adolescents without question. Clearly, at this time the consensus of U.S. government health agencies is not accepted in other countries.

Likewise, substantial scientific evidence, which has been reviewed by Dr. Risch,[25] now supports the safety and efficacy of hydroxychloroquine-based multi-drug treatment protocols. It shows that they are safe and effective when used at the early stages of the illness. Additional evidence include Raoult's study[26] with more than 10,000 patients, as well as case series data[7] that meet the clear and convincing evidentiary standard. There is also supporting meta-analysis for India's hydroxychloroquine prophylaxis protocol,[27] and the underlying mechanism of action is well-known.[28]

Concerning the ivermectin-based multi-drug protocols, it is known that ivermectin has 20 mechanisms of action against COVID-19.[29] This alone is sufficient to justify physicians prescribing this medication off-label to treat COVID-19, given the excellent safety record of the medication. A recent review[30] of the research literature, including previous meta-analysis studies of ivermectin, shows that there is a clear signal of efficacy against COVID-19, and disentangles some of the controversies in the literature. Most notable is a recently published study[6] that has shown that, with a small cohort of severely ill patients, who refused hospitalization in spite of severe symptomatic presentation and severe hypoxia, a new innovative protocol based on a combination therapy of ivermectin, doxycycline, zinc, vitamin C, and vitamin D3, over a period of 10 days, prevented hospitalization and death, and resulted in improved oxygen levels within 24 hours of onset of treatment. The ACTIV-6 study,[31] proclaimed by the media to demonstrate ineffectiveness of ivermectin, actually

showed a large statistically significant benefit in a subgroup of patients with severe disease at onset of the trial. Likewise, the TOGETHER trial[32] has several methodological flaws,[33] but it tested a three-day low-dose ivermectin monotherapy against placebo, so its results are not informative about the multidrug ivermectin-based protocols used by practicing physicians.

Article 37 of the 2013 Helsinki Declaration[34] states:

> In the treatment of an individual patient, where proven interventions do not exist or other known interventions have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorised representative, may use an unproven intervention if in the physician's judgement it offers hope of saving life, re-establishing health or alleviating suffering. This intervention should subsequently be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information must be recorded and, where appropriate, made publicly available.

A minority of medical doctors in the U.S. as well as abroad, following article 37, were able to discover and use safe and effective treatment protocols against COVID-19, based on repurposed medications with acceptable safety. At the beginning of the pandemic, medical doctors received guidance from the NIH to refuse to treat COVID-19 outpatients, in direct violation of both article 37 as well as medical common sense. Both state and national medical boards have failed to support the minority of doctors who acted ethically, and saved countless lives by doing so, from adverse actions and professional reprisals.

On the contrary, this "medical misinformation" crusade by the medical boards has been aimed at intensifying the persecution of these hero doctors, including doctors Oskoui, Littell, Cole, Delcoco, Laffay, and perhaps many others who made available to the American public life-saving early outpatient treatment and prophylaxis options against COVID-19, suggesting an intent to make early outpatient treatment protocols unavailable to the American public. Public confidence in the medical boards themselves and the medical profession at large will be severely damaged when the public sees that medical boards are engaging in actions that intend to cut off the public's access to off-label life-saving treatment protocols, as has been done in other nations abroad, and to chill the free-speech rights of our medical doctors to question the safety and efficacy of novel and experimental medical interventions that are currently under research.

State and national medical boards have also failed to support medical ethics with respect to the COVID-19 vaccine mandates. Although some COVID-19 vaccines received provisional BLA approval under the labels *Comirnaty* and *Spikevax*, on questionable scientific grounds, the vaccine manufacturers are only making them available to the American public under the EUA labels. Consequently, all vaccine mandates are now clearly in direct violation of well-established medical ethics against coerced medical experimentation without informed consent. The long-held standard for informed consent requires full disclosure of the most current and accurate data regarding all potential risks, benefits, and alternatives to the COVID-19 mRNA vaccines. Both state and national medical boards have failed to take a stand against this blatant violation of medical ethics by the federal and state governments as well as some private employers. They have also failed to speak up in support of the long-held federal regulatory standard that considers any adverse event or death reported in temporal association with receipt of a novel or experimental therapy to be caused by the intervention until proven otherwise, which has been abandoned by U.S. federal and state agencies, which are now dismissing adverse-event reports as unrelated to the vaccines until proven otherwise.

An interesting legal analysis by Carl H. Coleman,[35] who is clearly in favor of the official narrative promoted by NIH, FDA, and CDC, concludes that: "imposing disciplinary penalties on physicians for speech that takes place outside a physician-patient relationship would have dangerous policy implications and would almost certainly be unconstitutional," and notes that "disciplinary actions would be appropriate under one set of circumstances: if a board can establish that a physician has disseminated information that she knows to be false or with reckless disregard as to whether it is true."

It is not for the FSMB or specialty boards to enforce consensus orthodoxies. This is the death of medical progress. It creates a chilling effect, to the detriment of patients. Doctors who treat patients counter to so-called "official" positions risk litigation for bad results. Because of this threat, doctors would only do so with good evidence of benefit. Censorship of doctors for espousing public statements against consensus exceeds the authority granted to the boards by state governments to license their doctors. If the boards were just private organizations, there could be competing private boards, and doctors would choose which ones aligned with their viewpoints. But the boards are licensing agents of state governments, and limiting all contrary speech is overreach. Coleman's argument is that the boards only have jurisdiction when doctors make statements that they know are false or misleading. Just being against consensus per se is not sufficient. In light of the previously reviewed scientific evidence that supports adoption of early treatment protocols and the serious concerns about the safety of the COVID-19 vaccines, we are confident that Coleman's legal standard is not applicable to Dr. McCullough and his colleagues.

Arguments about the approaches to dealing with the COVID-19 scourge go in all directions, and all are only partially successful so far. The prevailing medical consensus has been constantly shifting about masking, composition of vaccines that offer protection against COVID-19, and even treatments such as monoclonal antibodies that have been authorized and then rescinded as the virus mutated. Physicians on all sides have arguments based on analysis of evidence, and all appear to strongly believe their positions. Open debate and discussion is the proper approach for sorting out these arguments. We have enduring confidence in the ability of the public to make personal decisions based on presentation of differing opinions. However, when those on one side abuse their positions of authority as medical board members to persecute and silence those on other side, with disregard or even contempt for the scientific evidence that supports the opposing side, and in doing so also undermine public trust in the medical profession, then one may ask whether it is these medical board members themselves who should be

disciplined for unprofessional conduct.

Certification of competence is a doctor's fundamental property right. It is untenable to attempt to remove fundamental property rights on the basis of statements taken out of context, media clips, interpretations, and hearsay. In the long run, we expect that any actions taken against Dr. McCullough, Dr. Kory, and their colleagues, combined with the failure of member medical boards to stand up for medical ethics, will destroy the credibility of your member boards. We also expect that future state and federal administrations, as well as congressional committees, will be curious and interested in investigating the real reasons for the persecution of our most exemplary and most ethical medical doctors and medical researchers. If the ABIM does not drop its threat against Dr. McCullough, the public demands an open meeting as requested by Sen. Ron Johnson (R-Wis.) to be attended by ABIM executives and their Credentials and Certification Committee with Dr. McCullough and other COVID-19 experts. This meeting should be a fair and balanced scientific review concerning early treatment of COVID-19, nonfatal and fatal COVID-19 vaccine serious adverse events, and vaccine efficacy concerning serious outcomes of COVID-19 hospitalization and death.

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[The complete letter and the list of more than 1,190 signatories are available at: http:/drelef.org/2022-open-letter-fsmb-abms/pmc-support-letter-final.pdf.]

REFERENCES

1. Google Scholar. Profile of Peter A McCullough, MD, MPH. Available at: https://scholar.google.com/citations?user=LzqEaOkAAAAJ&hl=en. Accessed Jun 26, 2022.
2. McCullough PA, Alexander PE, Armstrong R, et al. Multifaceted highly targeted sequential multidrug treatment of early ambulatory high-risk SARS-CoV-2 infection (COVID-19). *Rev Cardiovasc Med* 2020;21(4):517-530.
3. Procter BC, Ross C, Pickard V, et al. Clinical outcomes after early ambulatory multidrug therapy for high-risk SARS-CoV-2 (COVID-19) infection. *Rev Cardiovasc Med* 2020;21(4):611-614.
4. Procter BC, Ross C, Pickard V, et al. Early ambulatory multidrug therapy reduces hospitalization and death in high-risk patients with SARS-CoV-2 (COVID-19). *Int J Innov Res Med Sci* 2021;6:219-221.
5. Alexander PE, Armstrong R, Fareed G, et al. Early multidrug outpatient treatment of SARS-CoV-2 infection (COVID-19) and reduced mortality among nursing home residents. *Med Hypotheses* 2021;153:110622.
6. Hazan S, Dave S, Gunaratne AW, et al. Effectiveness of ivermectin-based multidrug therapy in severely hypoxic, ambulatory COVID-19 patients [published online ahead of print Jun 13, 2022]. *Future Microbiol*. doi: 10.2217/fmb-2022-0014.
7. Gkioulekas E, McCullough PA, Zelenko V. Statistical analysis methods applied to early outpatient COVID-19 treatment case series data. COVID 2022;2(8):1139-1182.
8. Seneff S, Nigh G, Kyriakopoulos AM, McCullough PA. Innate immune suppression by SARS-CoV-2 mRNA vaccinations: the role of G-quadruplexes, exosomes and microRNAs. *Food Chem Toxicol* 2022;164:113008.
9. Marik PE, Kory P, Varon J, Iglesias J, Meduri GU. MATH+ protocol for the treatment of SARS-CoV-2 infection: the scientific rationale. *Expert Rev Anti Infect Ther* 2021;19(2):129-135.
10. Kory P, Meduri GU, Iglesias J, et al. MATH+ multimodal hospital treatment protocol for COVID-19 infection: clinical and scientific rationale. *J Clin Med Res* 2022;14(2):53-79.
11. Front Line COVID-19 Critical Care Alliance. I-PREVENT: COVID Protection Protocol. Available at: https://COVID19criticalcare.com/COVID-19-protocols/i-prevent-COVID-protection-protocol/. Accessed Jun 26, 2022.
12. Front Line COVID-19 Critical Care Alliance. I-CARE: Early COVID Treatment. Available at: https://COVID19criticalcare.com/COVID-19-protocols/i-care-early-COVID-treatment/. Accessed Jun 26, 2022.
13. Front Line COVID-19 Critical Care Alliance. I-RECOVER Long COVID Treatment. Available at: https://COVID19criticalcare.com/COVID-19-protocols/i-recover-long-COVID-treatment/. Accessed Jun 26, 2022.
14. Front Line COVID-19 Critical Care Alliance. I-RECOVER: Post-Vaccine Treatment. Available at: https://COVID19criticalcare.com/COVID-19-protocols/i-recover-post-vaccine-treatment/. Accessed Jun 26, 2022.
15. Kory P, Kanne JP. SARS-CoV-2 organising pneumonia: 'Has there been a widespread failure to identify and treat this prevalent condition in COVID-19?' *BMJ Open Respir Res* 2020:7:e000724.
16. Varon J, Iglesias J, Marik PE, de Souza C. Challenges in the pandemic: a multidisciplinary approach. Thieme; 2021. Available at: https://www.thieme.in/Challenges-in-the-Pandemic. Accessed Aug 22, 2022.
17. Breggin P, Breggin G. *COVID-19 and the Global Predators: We Are the Prey*. Lake Edge Press; 2021.
18. Hatfill S. The intentional destruction of the national pandemic plan. *J Am Phys Surg* 2021;26:74-76.
19. OpenVAERS. The OpenVAERS Project. Available at: https://openvaers.com/index.php. Accessed Jun 26, 2022.
20. Rose J. A report on the US Vaccine Adverse Events Reporting System (VAERS) of the COVID-19 messenger ribonucleic acid (mRNA) biologicals. *Sci Pub Health Pol Law* 2021;2:59-80.
21. OpenVAERS. VAERS COVID Vaccine Myo/Pericarditis Reports. Available at: https://openvaers.com/COVID-data/myo-pericarditis. Accessed Jun 26, 2022.
22. Seneff S, Nigh G. Worse than the disease? Reviewing some possible unintended consequences of the mRNA Vaccines against COVID-19. *Int J Vaccine Theor Pract Res* 2021;2(1);38-79. Available at: https://ijvtpr.com/index.php/IJVTPR/article/view/23. Accessed Aug 24, 2022.
23. World Council for Health. COVID-19 Vaccine Pharmacovigilance Report; updated Aug 4, 2022. Available at: https://worldcouncilforhealth.org/resources/COVID-19-vaccine-pharmacovigilance-report/. Accessed Aug 4, 2022.
24. Le Vu S, Bertrand M, Jabagi MJ. Age and sex-specific risks of myocarditis and pericarditis following COVID-19 messenger RNA vaccines. *Nat Commun* 2022;13:3633.
25. Risch HA. Hydroxychloroquine in early treatment of high-risk COVID-19 outpatients: efficacy and safety evidence. Sixth version. Available at: https://earlyCOVIDcare.org/wp-content/uploads/2021/09/Evidence-Brief-Risch-v6.pdf. Accessed Jun 17, 2021.
26. Million M, Lagier J-C, Tissot-DuPont H, et al. Early treatment with hydroxychloroquine and azithromycin in 10,429 COVID-19 outpatients: a monocentric retrospective cohort study. *Rev Cardiovasc Med* 2021;22:1063-1072.
27. Stricker RB, Fesler MC. Hydroxychloroquine pre-exposure prophylaxis for COVID-19 in healthcare workers from India: a meta-analysis. *J Infect Public Health* 2021;14:1161-1163.
28. Derwand R, Scholz M. Does zinc supplementation enhance the clinical efficacy of chloroquine/hydroxychloroquine to win today's battle against COVID-19? *Med Hypotheses* 2020;142:109815.
29. Zaidi AK, Dehgani-Mobaraki P. The mechanisms of action of ivermectin against SARS-CoV-2-an extensive review. *J Antibiot* 2022;75(2):60-71.
30. Santin AD, Scheim DE, McCullough PA, et al. Ivermectin: a multifaceted drug of Nobel prize-honoured distinction with indicated efficacy against a new global scourge, COVID-19. *New Microbes New Infect* 2021;43:100924.
31. Accelerating COVID-19 Therapeutic Interventions and Vaccines (ACTIV)-6 Study Group, Naggie S. Ivermectin for treatment of mild-to-moderate COVID-19 in the outpatient setting: a decentralized, placebo-controlled, randomized, platform clinical trial. medRxiv; Aug 11, 2022. doi: 10.1101/2022.06.10.22276252.
32. Reis G, Silva EASM, Silva DCM, et al. Effect of early treatment with ivermectin among patients with COVID-19. *N Engl J Med* 2022;386:1721-1731.
33. COVIDAnalysis. COVID-19 treatment studies for Ivermectin: TOGETHER trial. Available at: https://c19ivermectin.com/togetherivm.html. Accessed Jun 26, 2022.
34. World Medical Association, World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. *JAMA* 2013;310(20);2191-2194.
35. Coleman CH. Physicians who disseminate medical misinformation: testing the constitutional limits of professional disciplinary action (November 11, 2021). *20 First Amend Law Rev* 2022; 113. Seton Hall Public Law Research Paper Forthcoming. Available at: https://ssrn.com/abstract=3925250. Accessed Jun 26, 2022.