Dear Dr. Hart September 27, 2021

Two of your recent writings about the COVID-19 crisis, “Special message from our President on the COVID-19 vaccine” (July 22) and another more extended “Notes From the President” (August 26) both on the LLUH news site seem somewhat misinformed, surprisingly shaming, socially divisive, and almost threatening to employees who are already apprehensive both about the pandemic and their employment.

Your most recent public comments (September 23) about the virus were embedded in a congratulatory, appreciation-focused review of how heroically the Loma Linda University Health work force performed during the construction of its 17-story new hospital, and all of that despite the ongoing crisis of the COVID-19 pandemic.

You noticed that at LLUH “We’re up to 95 percent of our doctors immunized, but only about 70 percent of the rest of our staff is immunized.” And then you shook your head about “a major fracture in our society. We’ve learned new words,” you noted, “the vaxers and the anti-vaxers. And we need to make more progress on this,” you insisted, because “It has created staff shortages. It has been a huge challenge for us in our healthcare world this year,” you complained, “A fracture, a fissure, a seismic fault line that has opened up in our society. And we must defeat COVID. We’ve got to get beyond this, folks. And I speak about a fracture.” The repetition emphasized your exasperation. “This is a fissure; this is a seismic fault line that has opened up inside our society that we need to figure out how to get beyond.”

Because your communications are so public, my response is an open letter to you intended to question your assessment of the COVID crisis, to expand perceptions, and to suggest how you might respond to the pandemic more constructively.

Lest I be found guilty of misrepresenting you, this correspondence contains the entire content of your July and August letters represented by indented blue type.

You and I share a considerable irony. We find ourselves the indirect beneficiaries of William Miller on whose infamous eisegesis SDA founders, Joseph Bates, James White, and Ellen Harmon doubled down to conceive a denomination which continuing growth depends on the selective obscurantism that permits it simultaneously to utilize the science of targeted proton-beam cancer therapy even as it insists on a world created in six 24-hour days less than 10,000 years ago. It is a church which teaches that the United States government is the shape shifting beast of Revelation 13 even as its flagship center of healing in 2009 and 2010 moved heaven

and earth to become an Accountable Care organization that could accept obscene amounts of money from that beast to treat so many patients of the optimistically named Inland Empire.

Another great (and wonderful) irony of life is that our shared faith heritage, founded on such fabulous assumptions, has nevertheless accomplished (and continues to accomplish) so much good in the world, and quite a bit of it over the past four or five decades at your prodding and direction.

Not so dissimilarly, the Church of Latter-Day Saints launched under even more ignominious circumstance nevertheless settled into a respectable, positive presence in the (mostly American) social-political landscape. So, SDA and LDS, each founded on visions have resulted in memberships of unusually good citizens who are in both cases exceptionally long-lived leavens to the entire societal lump.

I point out the ironic beginnings of the institution that has made possible so much of your life of doing good, because of what your recent writings imply about many who share our heritage and their expectation one day of heavy-handed government attempts to require their cooperation.

So much of your assessment of the pandemic leads you to expect employee compliance with government agency mandates and the "recommendations" of professional licensing entities—an authoritarian view of medicine and public health so at odds with LLUH's legacy (or the storied place generally of the physician in our culture) that I could not help doing my best to clarify some life and health and death issues for you and any reader who shares my perplexities.

You began your July 22 admonition this way.

A special message from our President on the COVID-19 vaccine

> As COVID cases rise across the country, the urgency for our own staff to get vaccinated increases, both for their own safety, as well as for children and others who are not yet vaccinated. As the CDC Director, Rochelle Walensky, recently said, "This is becoming a pandemic of the unvaccinated." The University of California is now requiring all students and faculty to be immunized by this fall.

My intention is to erode your seeming trust that "the science" is whatever the CDC or the FDA (and probably the NIH or WHO or even the AMA) is saying at any given time. I'd like to demonstrate to you with just a few examples that what those agencies promulgate is at crucial junctures unreliable, tendentious, and even self serving.

Your quote of the July 16 assertion from Dr. Walensky that "This is becoming a pandemic of the unvaccinated," provides the perfect example.

Not to just pick on the lady, Jeff Zients, White House COVID-19 response coordinator, said basically the same thing: "Unvaccinated Americans account for virtually all recent COVID-19 hospitalizations and deaths," he said. "Each COVID-19 death is tragic, and those happening now are even more tragic because they are preventable," he added.

If Walensky and Zients weren't enough, President Joe Biden made it perfectly clear:
On July 21, talking to CNN host Don Lemon in front of a Biden Townhall audience in Cincinnati the President said, "We have a pandemic for those who haven't gotten a vaccination. It's that basic, it's that simple. . . . If you're vaccinated, you're not going to be hospitalized; you're not going to die."

You quoted Walensky's statement because you wanted your readers to believe something about the Delta variant of the SARS-CoV-2, COVID-19—*that it is exclusively those who have not been vaccinated that are catching it.*

Just one week after the CDC director provided the quote you used to encourage the LLU family to get the jab, a *CDC Morbidity and Mortality Weekly Report* was posted online (July 30) as an MMWR Early Release. I hope you will see how radically at odds it is with what the CDC director and the White House took pains to announce so mistakenly a week earlier.

The CDC's July 30 MMWR Early Release stated:

> In July 2021, following multiple large public events in a Barnstable County, Massachusetts, town, 469 COVID-19 cases were identified among Massachusetts residents who had traveled to the town during July 3–17; 346 (74%) occurred in fully vaccinated persons. Testing identified the Delta variant in 90% of specimens from 133 patients. Cycle threshold values were similar among specimens from patients who were fully vaccinated and those who were not.

The same day (July 30) the *Washington Post* reported on the CDC report for general audiences and was comparatively candid: "A sobering scientific analysis published Friday found that three-quarters of the people infected during an explosive coronavirus outbreak fueled by the delta variant were fully vaccinated."

Beyond the fact that far more vaccinated were infected than unvaccinated, the *Post* noted that the CDC report "offers key evidence bolstering the hypothesis that vaccinated people can spread the more transmissible variant and may be a factor in the summer surge of infections."

Meanwhile, researchers at the University of Wisconsin–Madison, Public Health Madison & Dane County and Exact Sciences were memorializing corroborative findings as described by University of Wisconsin—News:

> Analysis of nearly 300 COVID-positive samples collected in Wisconsin between June 28 and July 24 showed no significant difference in "viral load" between 79 fully vaccinated people and 212 unvaccinated people. Both the vaccinated and unvaccinated study subjects had high viral loads at the time of their positive tests — levels shown in previous studies to be substantial enough to make them contagious to others.
>
> "This is what the CDC's study showed last week in a single outbreak, but we are seeing the same in a more distributed sample across our state," says Katarina Grande, co-author of the new study.

That was just the beginning of similarly compelling data from two more thoroughly vaccinated countries—Israel and England—that reinforce the same problem of a growing percentage of breakthrough cases that demonstrate the Delta variant has little regard for the mRNA jabs and that the inoculated who succumb to the variant are as contagious as the unvaccinated who acquire it.

With 78 percent of its citizens above twelve years of age vaccinated (mostly with Pfizer), Israel began delivering third (booster) doses of Pfizer's jab to its citizens 60 years and older because the recent rate of breakthrough cases of the Delta variant has been breathtaking. *Science* magazine (16 August 2021) sounded the alarm:

> [T]he effects of waning immunity may be beginning to show in Israelis vaccinated in early winter; a preprint published last month by physician Tal Patalon and colleagues at KSM, the research arm of MHS [Maccabi Healthcare Services], found that protection from COVID-19 infection during June and July dropped in proportion to the length of

> time since an individual was vaccinated. People vaccinated in January had a 2.26 times greater risk for a breakthrough infection than those vaccinated in April.
>
> Despite its unparalleled vaccination rates, "the country is now logging one of the world's highest infection rates, with nearly 650 new cases daily per million people. *More than half are in fully vaccinated people*, underscoring the extraordinary transmissibility of the Delta variant and stoking concerns that the benefits of vaccination ebb over time." [Italics added]
>
> What is clear is that "breakthrough" cases are not the rare events the term implies. As of 15 August, 514 Israelis were hospitalized with severe or critical COVID-19, a 31% increase from just 4 days earlier. Of the 514, 59% were fully vaccinated. . . . "There are so many breakthrough infections that they dominate and most of the hospitalized patients are actually vaccinated," says Uri Shalit, a bioinformatician at the Israel Institute of Technology (Technion) who has consulted on COVID-19 for the government.
>
> "[B]oosters are unlikely to tame a Delta surge on their own," says Dvir Aran, a biomedical data scientist at Technion.
>
> Aran's message for the United States and other wealthier nations considering boosters is stark: "Do not think that the boosters are the solution."

Ten days later (August 26) it was *Science* again reporting the findings of a preprint approved by the MHS (Maccabi Healthcare Services) Institutional Review Board (IRB) which concluded

> that natural immunity confers longer lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity.

England's experience parallels that of Israel.

An August 2021 report from Public Health England includes a table (pages 18, 19) entitled, "Attendance to emergency care and deaths of (1 February 2021 to 2 August 2021)." The table's figures indicate that From February 1 to August 2, the UK suffered 742 Delta deaths (a surprisingly small number).

What is astounding is that of those 742 deaths, 402 had been fully vaccinated. 79 had received one shot. Only 253 were unvaccinated.

Put another way, there were 402 deaths out of 47,008 COVID cases among *vaccinated* Brits; meanwhile there were 253 deaths from among 151,054 cases of *unvaccinated*.

Based on those figures, if you get Delta COVID-19 in England and you've been vaccinated, you are much more likely to die than if you were unvaccinated.

If you reside in England and want to live, why would you get a vaccine for COVID-19?

The same report on its page 3 summary says interestingly that "PCR cycle threshold (Ct) values from routinely undertaken tests in England show that Ct values (and by inference viral load) *are similar between individuals who are unvaccinated and vaccinated*." [my italics]

But the "pandemic of the unvaccinated" meme was loose, Dr. Hart, and you were contributing—I expect unwittingly—to its proliferation:

> The Association of American Medical Colleges (AAMC) told its members Friday [July 16] that medical schools and teaching hospitals should require their workers to get the COVID-19 vaccine. Our numbers of COVID admissions continues to increase in Loma Linda University Health Hospitals and throughout Southern California.

And riding the misleading implications of what the CDC had been saying about a pandemic of the unvaccinated, you brought the guilt.

> Our staff who cared for so many critical patients in the last surge feel that treating the willfully unvaccinated is demoralizing.
>
> While we recognize all the rumors and misinformation going around, we implore our own staff, our health professionals, to look at the evidence and protect themselves and each other as we prepare for what seems to be coming.

But as we have seen, it was the CDC and the President of the United States that were spreading "the rumors and misinformation going around" in their so very authoritative voices magnified by several networks, major newspapers, social media platforms, and internet technology behemoths. These very adamant but mistaken assertions greatly amplified the divisive message

and defamatory implication that the unvaccinated are either ignorant, paranoid, obstreperous, or malign.

At what venue were you assuming anyone under your administrative umbrella would go "to look at the evidence and protect themselves and each other as we prepare for what seems to be coming"?

You in particular, Dr. Hart, actually did not "recognize all the . . . misinformation going around," and consequently contributed unwittingly to that misperception among many in our Hill Beautiful community as you continued using the injured tone of a healthcare worker from out of state.

> As a nurse in Missouri recently commented, "I'm losing a little bit of faith in mankind. But you can't just not go to work."

The most important purpose for this writing is to demonstrate that much of the evidence you want us to limit ourselves to looking at is information prejudicially selected (filtered) and distributed by people with varying degrees of ignorance about specialty domains, often with strongly held biases, and even sometimes with mercenary political or personal financial interests. And those who attempt to circumvent the various filters find their efforts impeded by the censors at Google, Twitter, Youtube, Facebook, or even Amazon. And then if they manage to get to the bottom of particular issues or facts, their attempts to share what they discover are blocked, disrespected, or vilified.

Any effort to share the experience or findings of physicians who try to treat COVID-19 patients before hospitalization, before they are desperately ill, is censored, prejudicially fact-checked, or slimed by all the experts from Dr. Fauci to Stephen Colbert to Jimmy Kimmel to the brilliant women on The View. What isn't successfully blocked is met by censorship of anything that critiques the COVID vaccines or that suggests the efficacy of prehospitalization treatment of the virus. What isn't blocked is "Fact Checked" with prejudice and often mistakenly.

For nearly two years now most of the human race has attended a never-ending masquerade ball wearing face coverings to stop the Wuhan virus.

I wear them publicly to avoid conflict but feel foolish and a little dishonest doing it.

Research doesn't support masking in hardly any situation, especially driving your car alone with the windows up and the AC blasting. It is one of the funniest things you see around Southern California, but it is frightening to realize that the same people sit on juries.

Masks aren't condoms and they don't provide protection. Given the infinitesimally small dimensions of the viruses, they snicker at the sight of masks that to them have all the thread count of a volleyball net.

Because you have been a consultant to it, I might point out that the World Health Organization (WHO) agrees with me.

> At present there is only limited and inconsistent scientific evidence to support the effectiveness of masking of healthy people in the community to prevent infection with respiratory viruses, including SARS-CoV-2 (75). . . . The review concluded that wearing a mask may make little or no difference to the prevention of influenza-like illness . . . .

Sometime when you are bored, sample some recent studies on masks:

American Journal of Infection Control
Epidemiology and Infection
Influenza and Other Respiratory Viruses
CMAJ
Clinical Infectious Diseases

And beyond all of those sources, we have the video evidence that Goveror Gavin Newsome, House Speaker Nancy Pelosi, and San Francisco Mayor London Breed appear not to believe in the protection provided by masks.

The fact that our minders impose so many inconsistent mandates on small businesses but not gargantuan corporations, gyms but not stadiums, churches but not casinos, beaches but not protests—seems to imply some opaque agenda. What should the prejudicially importuned construe? That their political leaders are morons? Samuel Clemons could have told you that, but he's dead and we are no longer permitted to assign his pre-woke books or short stories for delicate students to read.

Most importantly, Dr. Hart, you make a huge mistake by imploring us "to look at the evidence" that you imagine will buttress your assumption/conclusion that the COVID-19 vaccines are our only salvation.

Some readers will recognize that you used that "nurse in Missouri" to express your own doubts about the judgment of that percent of humanity who are reluctant to take an mRNA jab. Then, after the guilting you offered the conditional gift of absolution.

> You can easily make an appointment for a vaccination through Employee Health Services to fit your schedule. Thank you for protecting yourself, your family, and our complete work force.

But it is that "implore[ing] our own staff, our health professionals, to look at the evidence and protect themselves and each other as we prepare for what seems to be coming" that is worrisome. If you are looking at the evidence, and all of your concerns and efforts are about saving lives, why hasn't Loma Linda Medical Center been an unusual hub of COVID healing through a blizzard of health education regarding those rather simple and inexpensive steps that anyone can take to improve their immunity to COVID and any other pathogen. *And thereby be less likely to get extremely sick and die if/when they contract it!*

All you would have to do is be faithful to your cultural heritage. You wouldn't even have to say where you got the impetus to suggest a particular brand of healthful living. Isn't that something proactive that any SDA healthcare institution might take the relatively inexpensive trouble to do?

Monoclonal antibodies

For the three angels' sake, it seems as though LLUH ought to make itself a center—like a small Florida—where the pre-hospitalized COVID infected (not yet needing oxygen) can count on being given monoclonal antibodies—about which there is no argument—from our Emergency Rooms, our Urgent Care centers, and our primary care physicians.

The State of Florida has established more than twelve centers offering free monoclonal antibody treatment to people sick with COVID-19 and considered to be high risk for severe illness or death. The monoclonal antibody treatment has shown to be effective against the more contagious delta variant that is now the predominant strain circulating in the United States.

Prodded politically no doubt by the initiative of Florida's Governor Ron De Santos when he established monoclonal antibody centers all over his state for any COVID-19 sufferers to access for free, Dr. Fauci recently touted (more than half a year late) the efficacy of monoclonal antibodies: "If taken early after testing positive, a person is far less likely to be hospitalized

from the disease, Fauci said. “So, bottom line is: This is a very effective intervention for COVID-19," Fauci said. "It is underutilized, and we recommend strongly that we utilize this to its fullest."

My understanding is that Inland Empire hospitals were sent stockpiles of the life-saving monoclonal antibodies from Eli Lilly and Regeneron early this year, but they sit shelved and largely unused. And there may be more and perhaps even better iterations of this life saving treatment on the way, such as Ronapreve and Sotrovimab.

In June 2021 the FDA approved Regeneron’s monoclonal antibodies for easy subcutaneous injection administration now at urgent care locations and even doctor’s offices, and at half the previous dose (1200mg rather than 2400mg) which was demonstrated to be just as effective.

You could save some lives!

But you may have waited too long. On September 3 the government Health and Human Services agency (HHS) inserted itself between physicians and hospitals who had been ordering directly Eli Lilly and Regeneron with a directive explained as due to increase demand for the life-saving product. Following Florida’s aggressive distribution and utilization of monoclonal antibodies, the HHES announced it was taking over distribution of the life-saving drugs “to help promote optimal and equitable use of the available supply of monoclonal antibodies while we continue efforts to procure additional product:

- Limiting immediate orders and shipment only to administration sites with HHSProtect accounts and current utilization reporting.
- Reviewing all orders for alignment with utilization, currently estimated at 70% of orders.”
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Does LLUH have an HHSProtect account, Dr. Hart? You shouldn’t have to in “the land of the free and the home of the brave.” But for the benefit of LLUH COVID-19 patients, I hope so. Here is the HHES State distribution table. If the former president was given monoclonal antibodies and rapidly recovered, what about the rest of us?

You imply, you hint, Dr. Hart, in your previous paragraph that anyone, everyone, has the opportunity to “look at the evidence.” Was that a rhetorical ploy? Or do you really believe the evidence is available where anyone can see it? If it is, how did you miss it?

I am perplexed that you do not have several capable faculty members and/or graduate students at the School of Public Health monitoring the latest COVID-19 numbers from all over the world and the most recently published, or pre-published studies related to the disease, its prevention, or its treatment as they provide you with regularly updated white paper summaries from which to speak and write knowledgably.

And if you believe in the free exchange of information and ideas that one would expect from a center devoted to health education and training why have there not been open symposia regarding various perspectives on the origins, prevention, and treatment of the virus? Loma Linda University has PhDs in the relevant sciences who no doubt have various views on the pertinent issues. But we haven't heard them exchanging perspectives at a campus forum. Why is it left to the Village SDA Church in Berrien Springs to host a "Coercion and Conscience" symposium of informed speakers August 20 and 21, including Peter McCullough, MD, MPH, and Roger Seheult, MD, a pulmonolgist from the Loma Linda community whose medical topics explained are presented on his MedCram Youtube channel.

Two of Berrien's Village Church videos were taken down by YouTube, leading to two strikes for its channel and a seven-day ban. To avoid further banning and losing their channel, they transferred the rest of the presentations to Rumble.

The last time LLU had a symposium on a controversial topic it was regarding free will. And of the two guest speakers and twelve panel members there was not one free will skeptic, much less a denier. Another example of the new obscurantism. Let's rehabilitate open discussion and the healthy stimulation of creativity and problem solving that candid dialogue by informed individuals can stimulate.

This new 21st century dive into anything but transparency understandably fertilizes the suspicions and fears of those who are isolated from alternate information and views. I'm loath to see you contribute to such an authoritarian ethos.

There is evidence that, standing alone, seems to affirm parts of your one note samba about vaccines, and there is evidence that assuredly challenges it. But the big media outlets television, cable, publications (print and online), and internet platforms of enormous reach have *openly conspired* (oxymoron alert) to tell just one story and to ignore, block, and trash counter evidence and narratives or make certain their evidence and rationale are not mentioned or platformed.

I construe from your well-intended advocacy of COVID-19 vaccines that the constant attempt to censor any information and rationale that does not support taking the jabs has succeeded. My most urgent purpose in this letter is to convince you that your sometimes credulous sounding advocacy for the vaccines is due to information you have not been able to access—information that you do not even realize exists. Your writings suggest no more knowledge and no less prejudice than you would acquire watching CNN.

It may be that you have not balanced the data from all sides—not because you might not like to, but because those who control our media and internet platforms have hidden or shouldered aside so much diversity of assessment and research. If I manage what I intend here, I hope to persuade you that your implicit trust in agencies such as the CDC and the FDA is naïve and misplaced.

Why would you trust the FDA?

A letter published February 2020 in *The Lancet* by twenty-seven scientist working in virology and related fields decried as "conspiracy theories" speculation that the Wuhan Lab was the origin of COVID-19. "We stand together to strongly condemn conspiracy theories suggesting that COVID-19 does not have a natural origin," they wrote.

The widely read letter discouraged early debate about the pandemic origins until evidence emerged that it was written by British zoologist Peter Daszak, head of EcoHealth Alliance, an American firm that was providing significant funding to the Wuhan Institute of Virology. Despite Daszak's declaration of no conflicts of interest at the time the letter was penned, *The Lancet* was forced to publish an addendum acknowledging his connection to EcoHealth Alliance and the scientist was removed from a UN-backed *Lancet* commission looking at the origins of the pandemic.

But the truth about the letter was even worse. Tenacious digging by the *London Daily Telegraph* revealed that twenty-six of the twenty-seven scientists who signed the letter had connections of varying significance to the Wuhan Virology Laboratory.

Under subsequent pressure, Daszak admitted that he wrote it and assembled his co-signers as a favor to Chinese colleagues in Wuhan.

Well before the Daszak letter for *Lancet* was submitted, an American virologist had written Fauci to say that the virus appeared to him manipulated. On January 31, 2020, Fauci received

an email from an NIH sponsored scientist Kristian Andersen telling him the virus looked potentially "engineered" and was "inconsistent with expectations from evolutionary theory."

But then *The Nation* reports the

> Virologist Who Told Fauci SARS-CoV-2 'Potentially Engineered' Just Deleted 5,000 Tweets.
> A California virologist who told Anthony Fauci that COVID-19 looks 'potentially engineered' and 'inconsistent with expectations from evolutionary theory' – only to later reverse course and publish a 'natural origin' paper 8 weeks later (before receiving a multi-million-dollar NIH grant) **has deleted more than 5,000 tweets**.

The Lancet's credibility problem was going to get worse along with that of the Food and Drug Administration.

The open conspiracy I'm alleging in this letter to you, Dr. Hart, may well have led to hundreds of thousands, of COVID-19 deaths.

To further undermine my faith in the FDA's integrity (and a reason you should not trust it either), early in the geographical perfusion of COVID-19 the FDA declared the uselessness and dangerousness of hydroxychloroquine (HCQ) as a treatment even for the early stages of the disease based on a *Lancet* article that was soon retracted. Despite *The Lancet* retraction, the FDA did not revise its judgment, and the use of HCQ was precluded even for physicians who wrote prescriptions for it, if the purpose was COVID-19 treatment. As an LLU employee, I repeatedly experienced this discrimination by LLUH physicians and its Meridian pharmacies in 2020. Because of party politics rather than scientific inquiry, it is not possible to estimate the efficacy of HCQ or the loss of lives this capricious treatment of an inexpensive and safe early treatment may have meant.

Also citing the *Lancet* article, The World Health Organization announced Monday that it's suspending a trial of hydroxychloroquine in treating COVID-19, saying fears of the drug's potential danger are causing it to "err on the side of caution."

As a much-travelled missionary physician you have to know that HCQ is only a long-time merciful relief to the suffering in areas dogged by malaria, especially in Africa and provided unreservedly by the Center for Health Promotion to travelers to malaria invested countries.

But it was President Trump's initial mention of HCQ and the chance it might be a very helpful inexpensive early treatment for COVID-19 that was the cue for the entire Fourth Estate to denigrate the possibility and yell down anyone who spoke in its defense. That foolishness should have badly damaged the credibility of both the *Lancet*, its peer reviewers, the FDA for not reversing its judgment, and the feckless press for not making an issue of the nonsense. (Yes, I know that QR elongation can be a threat to very old patients with seriously compromised hearts if they take HCQ in large doses for extended periods of time.)

I don't know for certain what efficacy hydroxychloroquine provides for early COVID-19 sufferers, especially when combined with doxycycline and substantial temporary consumption of zinc. But I know that the way its efficacy was determined—mostly by people who know nothing about medicine—was based on partisan politics, not evidence.

Meanwhile, Anthony Fauci was almost giddy as he spent several minutes in the Oval Office on April 29 describing Gilead's just concluded trials of Remdesivir that appeared to reduce the stay of hospitalized COVID-19 patients from fifteen to eleven days, even though it had no statistical outcome on mortality. And he concluded by saying that combined with other treatments going forward "I can guarantee as more people as more companies as more investigators get involved, it's gonna get better and better."

Well, it didn't. And it wasn't long (November 2020) before the World Health Organization (WHO) recommended against the use of Remdesivir. But American hospitals pay $390 per vial of remdesivir, which equates to $2,340 for a five-day course of the drug, using 6 vials for patients covered by Medicare, military or other government health insurance. The cost is closer to $3,120 for a five-day course of remdesivir at $520 per vial — when used to treat patients who have with private health insurance.[1] The IV infusion therapy requires a hospital setting, does not improve outcomes, and has the potential to seriously damage liver and kidney function.

So, Dr. Hart, would you explain to the LLUH family sometime the basis for your faith in the FDA? For the CDC? For the NIH? For the AMA? For the WHO? And why are you still using Remdesivir in your patient protocol for COVID-19?

It is no surprise that the drug companies might be coy about the negative aspects of their products, but it is disheartening when the putative protectors of the people (the administrative state), the fourth estate ("news" media), (aided and abetted by monopoly businesses (Amazon,

Walmart, Apple, CVSHealth), internet social media hegemonies (Facebook, WhatsApp, WeChat, Tumblr, Qzone, Instagram, Twitter, Youtube), and dominant telecom companies (in league with the Deep State) collaborate more and less formally to ban, deplatform, or demonetize, and in some cases destroy sources of information and opinion that is in any way critical of the CDC and FDA pronouncements. That is a relatively new and highly alarming collaboration.

Let me tell you just two short stories from the pandemic that demonstrate the fact that we are being ongoingly misled by a cabal of information sources that censor data that does not fit a jabs-only narrative as they feed us fear porn by day and by night.

Alex Berenson

Beginning in June 2020, former *New York Times* reporter Alex Berenson began self-publishing booklets entitled *Unreported Truths about Covid* that contain his accumulating investigatory deep dives into the pandemic—things like the history of lockdowns and whether they work; the way governments count and report COVID-19 deaths; the efficacy of masks and mask mandates, the risks and benefits of the new Covid vaccines etc. and always including direct links to the sources he is relying on, from the CDC, to the peer reviewed scientific journals, to the databases of government health statistics.

But then during the first week in June, 2020, Amazon's Direct Books refused to sell Berenson's booklets, and Amazon only backed down when Tesla and Space X billionaire Elon Musk tweeted

> "This is insane @JeffBezos," tagging the Amazon CEO. "Time to break up Amazon. Monopolies are wrong!"

Dr. Hart, I could not recommend to you more sincerely a close reading of Berenson's coverage of this viral scourge and societal responses to it, especially because of the totalitarian instincts it has evoked from ordinarily reasonable and independently minded people.

Nevertheless, just this August 29, 2021, Twitter announced it was permanently banning Berenson's account, saying that he had repeatedly violated the platform's rules. Berenson provided his readers the tweet that ended his Twitter account:

> "It doesn't stop infection. Or transmission. Don't think of it as a vaccine," the tweet read. "Think of it — at best — as a therapeutic with a limited window of efficacy and terrible side effect profile that must be dosed IN ADVANCE OF ILLNESS."

If you read that tweet carefully, Dr. Hart, could you more than quibble with it? I'd like to look at it with you more closely.

In Berenson's tweet we have four things known to be true but seldom reported by the advocacy news media in the effort to making lemmings of every human on earth as they search for the elusive herd immunity of which Dr. Fauci has made such a moving (growing) target.

> (1) The failure of mRNA vaccines to stop infection.
> (2) The failure of mRNA vaccines to stop transmission.
> (3) The reality that mRNA inoculations are "a therapeutic with a limited window of efficacy . . . that must be dosed "in advance of illness," and
> (4) The mRNA vaccines carry a "terrible side effect profile."

You might say it was never exactly claimed that the mRNA vaccines would stop infection, and you would be correct. *So why can't Berenson point it out?*

You might agree, if you are keeping up with the creep of the virus and its new variants (see links provided above), that the vaccinated are clearly and increasingly suffering breakthrough cases of COVID-19 and transmitting the virus to others.

If all that the mRNA vaccines do is make the infections less severe, then to call them a therapeutic rather than a vaccine is not unreasonable—especially because they do not qualify as vaccines under any rubric employed heretofore.

And, finally, the mRNA vaccines carry a "terrible side effect profile."

Berenson didn't say anything in that tweet about the *incidence* of the "terrible side effect[s]." But the difficulty in acquiring some idea what those numbers actually are *really is a scandal*, given that some of them result in death or in permanently debilitated victims.

Have you considered the side effect listings for the Pfizer jab? This is from the FDA which puts the best face possible on its warnings from a heading entitled "Myocarditis and Pericarditis":

> Myocardits and Pericarditis Postmarketing data demonstrate increased risks of myocarditis and pericarditis within 7 days following the second dose. The observed risk is higher among males under 40 years of age than among females and older males. The

> observed risk is highest in males 12 through 17 years of age. Although some cases required intensive care support, available data from short-term follow-up suggest that most individuals have had resolution of symptoms with conservative management. Information is not yet available about potential long-term sequelae.

Isn't that cause for pause, that the observed risk is highest among those least likely to be victimized by the virus? Nevertheless, we hear talk continually by Fauci and others of the need to get elementary and high school children vaccinated.

Although the FDA warning mentioned that "some cases required intensive care support," it doesn't mention the number of reported deaths.

A *British Medical Journal* preprint recently contributed to the myocarditis argument for not providing COVID-19 vaccines to young males saying, The risks appear to outweigh any benefits.

Alex Berenson's experience with censorship demonstrates what two monopoly platforms—Amazon and Twitter—have attempted to do or have done to one very gifted, independent, and relentless journalist. If that doesn't faze you, Dr. Hart, I write in vain.

I hope you will agree with me that it has never been the responsibility of the press to determine which scientific authorities are correct. In fact, the press I recall from my youth was skeptical of institutions and authority figures across the spectrum. Have they earned our trust since the days of Woodward and Bernstein? How astonishingly different was the mainstream media's response in 1971 to Daniel Ellsberg's release of classified "Pentagon Papers" to the *New York Times* which published them. Meanwhile, in 2010, an Army soldier, Chelsea Manning, gave 750,000 classified and sensitive military and diplomatic documents to Julian Assange who published them on his WikiLeaks website. Assange languishes interminably in prison un-championed by the press, while the man turned woman who stole the documents from his position of trust in the military had her 35-year Espionage Act conviction commuted by President Barack Obama.

With righteous indignation I can insist—and you should share my outrage—that monopoly platforms that deny users the opportunity to access an alternate viewpoint, especially in matters of life and death, are far more dangerous than the potential harm of whatever alleged misinformation Berenson might share, even if any of his work product is demonstrated to be mistaken.

Do you see yourself here, Dr. Hart, as on the side of Galileo or of Pope Urban?

So, that is evidence of an open conspiracy to support the efficacy and safety of the COVID-19 vaccines by some of the most powerful corporations. Elon Musk is a wonderful exception to the increasingly aligned political tendencies of the super-rich among the information maintenance and serving platforms and the news publishing moguls.

The crime of saving prisoners from COVID-19

My second story particularly ought to outrage you as a physician who holds precious the doctor/patient relationship and the primary life-saving mission of healthcare providers.

At the end of this August, local and then national news began reporting the uproar surrounding a Washington County, Arkansas, prison physician, Dr. Rob Karas, triggered by a local justice of the peace who said a county employee told her the jail's medical provider was prescribing Ivermectin for inmates to treat and prevent Covid-19.

The ACLU immediately criticized the use of ivermectin in the jail as "medical experimentation" with an "unapproved treatment" for covid-19.

"No one—including incarcerated individuals—should be subject to medical experimentation," said Holly Dickson, executive director of the ACLU of Arkansas. "Sheriff Helder has a responsibility to provide food, shelter and safe, appropriate care to incarcerated people. The FDA has said that misuse of ivermectin for covid-19 can cause serious harm including seizures, comas, and even death. The detention center's failure to use safe and appropriate treatments for covid-19 . . . illustrates the larger systemic problem of mistreatment of detainees . . . even in the midst of a pandemic."

But the ACLU never complained about experimental vaccines being authorized for use on anyone eighteen years old and above.

"I am not in a position to dictate to my medical staff what they prescribe," Sheriff Helder said. "They have had a regimen of treatment since this began a year, year-and-a-half ago and it has worked well. When you talk about experimentation, I don't think that's fair."

The sheriff said he wasn't going to second-guess or override the decisions of the medical staff, adding that during the pandemic only one detainee has been hospitalized, briefly, for covid out of more than 400 who were treated.

Now the Arkansas Medical Board is investigating Dr. Karas who said he has prescribed the anti-parasitic drug "thousands" of times for treatment of Covid-19, including to inmates in an Arkansas jail.

A CNN report said the "FDA has been warning against the use of ivermectin for treatment of Covid-19 since March. The drug is used to treat parasitic infections, primarily in livestock, the news corporation argued disingenuously adding, the CDC recently cautioned about an increase in reports to poison centers of severe illness caused by the drug."

What an ignorant and prejudicially dishonest way to describe a near miraculous drug that has saved, and continues to save, the eyesight of mllions of Africans and Central and South Americans suffering from onchocerciasis (River Blindness) and lymphatic filariasis, important endemic diseases in Africa and South America.

CNN would need only to google Ivermectin to know that the drug is used to treat parasite infestations in humans that include head lice, scabies, river blindness and several others. (Here is a well-produced documentary on the History of ivermectin.)

Dr. Karas who has been the prison's contracted provider since 2015, said in an email he has used ivermectin himself and has had family members using the drug as well as advocating his employees who aren't vaccinated take it.

Karas said that he started to use ivermectin in the jail population in November on "high-risk patients over 40." He defended his practice saying no deaths have been reported due to Covid-19 out of the 531 cases in the jail.

"Do you want us to try and fight like we're at the beaches of Normandy? Or do you want me to tell what a lot of people do and say—Oh, go home and ride it out and go to the ER when your lips turn blue?" Karas asked.

You see what reason and truth are up against? Dr. Hart? This physician is not only trying to do no harm, he's trying to protect a population that is particularly vulnerable during a pandemic due to its confined proximity.

Think about it. A doctor shepherds a large prison population through the pandemic for a year and a half and loses no one; and only one, according to the sheriff is hospitalized; and what does he get but woe:

- The American Civil Liberties Union is threatening to sue Dr. Karas.
- The Arkansas Public Defender Commission is requesting records for information on the use of ivermectin in the jail.
- The American Medical Association is planning to investigate him.
- The American Medical Association, the American Pharmacists Association and the American Society of Health-System Pharmacists on Wednesday called for an immediate end to prescribing and using the drug to treat the coronavirus outside clinical trials.

Imagine if Dr. Karas had lost a prisoner while treating them with Ivermectin?!!! It would be reported that Ivermectin kills people. He'd be indicted and in solitary confinement awaiting trial.

Dr. Hart, wouldn't the normal human response to the success of Dr. Karas in treating a high-risk, disproportionately minority, tightly quartered prison population so successfully be extreme interest in his treatment protocol, and, further, to wonder if maybe 63 studies about the effectiveness of Ivermectin in treating patients with COVID-19 might be worth a glance?

Maybe, possibly, you, Dr. Hart, would be interested in the 26-page meta-analysis published in the most recent (July-August) American Journal of Therapeutics in which the authors write, **"**Corticosteroids have become an accepted standard of care in COVID-19, based on a single RCT of dexamethasone.[1]" "If a single RCT is sufficient for the adoption of dexamethasone, then *a fortiori* the evidence of 2 dozen RCTs supports the adoption of ivermectin," its authors do the logic. (For lay readers RCT stands for randomized controlled trial.)

But it is the authors' conclusions that make teeth grinding understandable:

> Given the evidence of efficacy, safety, low cost, and current death rates, ivermectin is likely to have an impact on health and economic outcomes of the pandemic across many countries. Ivermectin is not a new and experimental drug with an unknown safety profile. It is a WHO "Essential Medicine" already used in several different indications, in colossal cumulative volumes. . . .

> Ivermectin is likely to be an equitable, acceptable, and feasible global intervention against COVID-19. *Health professionals should strongly consider its use, in both treatment and prophylaxis.* [My italics added]

Nevertheless, the FDA was still insisting as of September 12, 2021,

> Currently available data do not show ivermectin is effective against COVID-19. Clinical trials assessing ivermectin tablets for the prevention or treatment of COVID-19 in people are ongoing.
>
> The FDA has not authorized or approved ivermectin for the treatment or prevention of COVID-19 in people or animals. Ivermectin has not been shown to be safe or effective for these indications. [What a calculatedly true statement. But it has been demonstrated safe for decades through billions of doses for other purposes.]

Ivermectin's original manufacturer, Merck, said in February that it had found no evidence that ivermectin is an effective treatment for patients with COVID-19.

> No scientific basis for a potential therapeutic effect against COVID-19 from pre-clinical studies; No meaningful evidence for clinical activity or clinical efficacy in patients with COVID-19 disease, and [dishonest sanctimony alert]; a concerning lack of safety data in the majority of studies.

How calculatingly disingenuous was that last sentence from Merck about "a concerning lack of safety data" when Merck itself, through the Bill and Melinda Gates foundation, has given literally billions of doses of ivermectin for use over the decades in other contexts.

That unsolicited opinion sounds rather self-serving, when you understand that Stromectol (ivermectin) is beyond its patent and sold generically now; and because Merck said in June that the US government agreed to pay about $1.2 billion for 1.7 million courses of its prospective COVID-19 treatment dubbed monupiravir, if it is proven to work and authorized by regulators. The company said it expected to file for US emergency use authorization of monupiravir in the second half of 2021 at the earliest.

During September's first week, there was indescribably irresponsible reporting from *Rolling Stone, Newsweek,* and the New York *Daily News* running with the claim that Oklahoma's rural hospitals were in danger of overflow with vaccine skeptics who were overdosing on

ivermectin horse deworming paste. Media spokespersons, including MSNBC's Rachel Maddow, tweeted about ivermectin overdoses straining Oklahoma hospitals.

According to a *Reason* report, The Associated Press recently announced that 70 percent of calls to Mississippi's poison hotline were from ivermectin overdoses. The actual figure was 2 percent.

Meanwhile, no hyperventilation about analysis of national databases that show acetaminophen-associated overdoses account for about 56,000 emergency room visits and 26,000 hospitalizations yearly, with 458 deaths each year from acetaminophen-associated overdoses, 100 of them unintentional." But the FDA warns ivermectin "not shown to be safe or effective . . . ."

Even as everybody from Jimmy Kimmel to Howard Stern was ridiculing the use of "horse dewormer" by a particular class of people to treat COVID-19, an entirely false narrative is promulgated everywhere about an inexpensive, unusually safe drug, Dr. Hart, that probably could have saved hundreds of thousands—maybe millions—of lives and a lot of stress on your hospital workers.

At least that is the opinion of some of your peers.

To exacerbate the problem, many pharmacies are refusing to fill prescriptions for ivermectin if the purpose is to treat COVID-19. So, people who are convinced it may help them not get the virus, or enhance their survival chances if they do, go to farm supply houses to get the product made for animals. And then they are ridiculed for using horse paste. And the ones who do a bad job of figuring out how to extract and consume a human dose from the animal intended product may sometimes goof and hurt themselves, to the sadistic joy of any number of press people and comedians.

Jane Orient, MD, executive director, American Association of Physicians and Surgeons (AAPS), wrote Gerald Harmon, MD, president, American Medical Association to put a fine point on the hypocrisy:

> Dear Dr. Harmon:
> The AMA has taken the startling and unprecedented position that American physicians should immediately stop prescribing, and pharmacists should stop honoring their prescriptions for ivermectin for COVID-19 patients. The AMA is thus contradicting the

professional judgment of a very large number of physicians, who are writing about 88,000 prescriptions per week. It also contradicts the Chairman of the Tokyo Medical Association, Haruo Ozaki, who recommended that all doctors in Japan immediately begin using Ivermectin to treat COVID.

AMA claims that ivermectin is dangerous and ineffective despite the safe prescription of billions of doses since 1981, and the mostly favorable results of 63 controlled studies in COVID-19.

AMA does not specify *any* recommended early treatments, but simply urges face masks, distancing, and vaccination.

Our members would appreciate clarification of the AMA's stand on the following questions:

- What are the criteria for advocating that pharmacists override the judgment of fully qualified physicians who are responsible for individual patients?
- What are the criteria for forbidding off-label use of long-approved drugs, which constitute at least 20 percent of all prescriptions?
- On what basis does AMA demand use only within a clinical trial for ivermectin, but call for virtually universal vaccination outside of controlled trials, despite FDA warnings of potential cardiac damage in healthy young patients, and no information about long-term effects?

We believe that these questions get to the heart of issues of physician and patient autonomy, as well as scientific principles such as the need for a control group in experiments.

We look forward to your response.

Sincerely yours,

Jane M. Orient, M.D., Executive Director

On what basis, Dr. Hart, does the AMA demand use only within a clinical trial for ivermectin while it called for virtually universal vaccination outside of controlled trials, despite FDA warnings of potential cardiac damage in healthy young patients, and no information about the consequences for babies in the womb, or long-term effects generally?

Dr. Hart, because it is the rule rather than the exception, this is a big problematic deal. When I googled "Ivermectin story" a couple of days ago, the first item that Google presented was an August 29, 2021, story in *Forbes* written like an op-ed by some tool named Joshua Cohen laughing at the drug and its users: "Bizarrely, in right-wing political circles, ivermectin has become increasingly popular as an antidote to Covid-19."

So, a 26-page meta-analysis of fifteen trials on Ivermectin by four PhDs and three physicians concludes, "The apparent safety and low cost suggests that ivermectin is likely to have a significant impact on the SARS-CoV-2 pandemic globally." But *Forbes*, sneering at right wingers and their horse paste is what anyone who searches Google or watches the networks will get.

I'm sure you start to get the picture, that we are ill-served by the government and its health agencies, mainstream media, the social media platforms, and the world's largest internet search engine.

Hart writing II

More recently, Dr. Hart (August 26), you wrote to us again more expansively and more exercised with the same concern that not enough of your employees are vaccinated for COVID-19.

> The degree of polarization around the COVID-19 vaccine today is not surprising. One perspective comes from those who are champions of individual rights, bolstered by what they read and hear about the dangers of the vaccine. On the other side are those who accept the reported science and believe vaccinations are the only solution to the pandemic.

I can't guess why you find it unsurprising, but I share your expectation of polarization given the near censoring and obfuscation of information regarding the efficacy and the kinds, the indeterminate number, and the severity of side effects suffered by populations who receive the several vaccines.

Without accepting your reduction of the dilemma to just two perspectives, I might just point out that I know people of varying sophistication and education who fear the jabs for reasons unrelated to the complexities of human rights. But far more telling is major polling from Carnegie Mellon University and the University of Pittsburgh indicating it is not by any means the champions of individual rights who are avoiding the jab. But more on that later.

Exemplars of what you request of your employees are not to be found at the White House. The President of the United States decrees a vaccine mandate on September 9, 2021, for federal employees—except for more than 600,000 postal workers (considered subcontractors) who are given the option to vaccinate or test weekly.

And then we learn that the Whitehouse has heretofore not required its staff to be vaccinated.

President Biden's September 9 announcement of a federal mandate for COVID-19 vaccines applies to employees of the executive branch — includes White House staff — and all federal agencies and members of the armed services. *But for some odd reason, the mandate does not apply to those who work for Congress or the federal court system.*

Are the congress and judiciary less important than the executive branch? No, it's about separation of powers.

And how interesting it was to see Dr. Anthony Fauci and Dr. Dr. Peter Marks, director of the FDA's Center for Biologics Evaluation and Research testifying in May that only about 60 percent of their employees were vaccinated. And who would be much more informed about the vaccines and related issues than employees of the CDC and the FDA?

Do you see why rational people can wonder whether their minders really believe in the vaccines or are just trying to enrich their wealthy donor friends who are somewhere in the vaccine funding daisy chain.

When you write with exasperation about unvaccinated LLUH employees, I might suggest that your exasperation is misplaced.

And I am nonplussed that a man of your training and experience appears to support the simplistic notion that "vaccinations are the only solution to the pandemic." Fortunately, as we have seen, and as we shall see, there are solutions to the pandemic; the puzzle is that you would be unaware of them.

Also, regarding "the reported science." Those of us who've lived long enough to acquire a little skepticism about the reporting sources can be forgiven their reluctance to join the herd—the lemmings they fear—for a variety of reasons, some with which you are familiar and some with which you no doubt are unfamiliar.

The rest of your letter seems to affirm only those "who accept the reported science and believe vaccinations are the only solution to the pandemic." Did you place the word "reported" in the sentence intentionally to avoid writing about "the science," as if it is settled, as is so often the claim by the dominant media messengers regarding vaccinations or the efficacy of masks or the uselessness of almost any form of pre-hospitalization treatment, whether repurposed medications or FDA approved?

> Those of us who have had the privilege of watching human nature for many years remember similar battles around compulsory use of seat belts, motorcycle helmets, fluoridation of water supplies, and various other public health mandates. Perhaps the most pertinent example is smoking.
>
> As long as your smoking was just a danger to you, we were willing to let you pursue your habit. But when research showed that second-hand smoke from you is damaging my health, the tide turned, and smoking bans were instituted in public places.

Do you have any idea how many people you trigger merely by the inartful, undiplomatic way you put that? "We were willing to let you." Wow! How generous of you to let me live my life as an adult with considerable agency unmolested by your dictates. That is the response many of us have to a sentence like that.

But what has made "we" insistent on lock-step obedience? Perhaps it is because you have been watching and listening for too long to that tendentiously selected "information" or "data"—"the science"—the media provide you so uniformly, from channel to channel to channel.

Your examples of behavior required, and behavior disallowed, by public mandate—and some examples you didn't mention—remind us of the slippery slope from which you write. No doubt Dr. Fauci has contributed significantly over the years to the kinds of misunderstandings your writings convey. (Remdesivir wasn't his first bad recommendation.) It was also Dr. Fauci who promulgated the myth of casual heterosexual HIV AIDS transmission. A recent article from The American Institute for Economic Research catalogs many of his past public gaffes.

And then there is your preferred analogy, the willingness to outlaw smoking in most contexts. You may as well have added peanut butter sandwiches precluded by law from school lunches. Meanwhile, we do not severely limit the consumption of alcohol, even though it results in a continuing epidemic of drunk drivers who kill innocent people, and the less immediately obvious scourge (over 50 percent alcohol-related) of spousal and child abuse, incest at loss of inhibition, and violent crime in general. (Much as I detest cigarette smoking, I'd much prefer my children smoked excessively than drank excessively. Tobacco kills older people; alcohol often deprives the young of so many years of life.)

Perhaps the more pertinent example is fluoride because it is something people are for all practical purposes forced to ingest and about which some debate lingers over its risk/benefit to consumers.

More relevant to this conversation, is the misapprehension your example reveals. Because as we are learning from Israel, England, Massachusetts, Wisconsin, it is becoming *decreasingly* clear that the unvaccinated are a greater source of COVID-19 spread than are those who have been vaccinated.

One of the factors that has discouraged many people from taking the mRNA jabs is that they had come to believe rightly or wrongly that the injection(s) would keep them from getting COVID-19. But then with the accumulation of breakthrough cases—and some of them severe and some ending with death—a bit of confidence in those who were pushing them on the public has diminished.

Also, the incomplete and waning protection of the vaccines enables those who are vaccinated to feel threatened and resentful of those who are not vaccinated and still somewhat more likely to become the contagious among us.

But you seem unaware of just how fungible and evolving the truth about the vaccines appears to be.

As we saw from accumulating numbers, the Delta variant in so many breakthrough cases of the vaccinated shows that the viral load they carry in their noses as potential spreaders is at least equal to the viral load carried in the nasal discharge of the unvaccinated COVID sufferer.

So, who is the greater danger to who? You have been trying to shame the unvaccinated into getting the jab as a way of being good citizens based very likely on your misunderstanding of an evolving reality. You must not pronounce on "the science" as if you know what it is. But you go on to lecture the unvaccinated on the basis of comparing risks that are very poorly established.

> That seems to be the crux of the controversy today. If someone wants to risk their health, and even life, by not being vaccinated, that is their right. But when their decision puts others at risk, it assumes a broader public health impact for all of us. That is what so many of our health professionals feel today, as we are now faced with caring for many unvaccinated patients who neglected or refused to be vaccinated.

There you are making claims more than a month after the CDC director was caught misstating the facts about "a pandemic of the unvaccinated." And you cite "what so many of our health professionals feel." I'd so much rather you cite peer review journals to support your judgment.

The most troubling part of your admonition is the presumption, the confidence from which you opine—about both the dangers posed by the unvaccinated (to who? The vaccinated for breakthrough cases?) and the solution you seem to think the vaccines represent.

> More than 90% of admitted patients and deaths at hospitals and throughout the country today are among this group. And their decision enables the virus to continue to spread, placing children and others at risk of the infection.

You seem unaware of Dr. Walensky's admission to the BBC that preliminary CDC findings suggest that unlike with the Alpha variant, vaccinated people infected with the Delta variant can carry high levels of the virus. (It was actually a University of Oxford study.) *"Infected vaccinated people can carry as much virus as infected unvaccinated people*," she said.

And in both your editorials you use the emotionally gratuitous phrase, "placing children and others at risk of the infection," like some teacher's union flak protecting their retirement benefits.

> The frustration and even anger from many of these working health professionals caring for ill and dying patients is increasingly being expressed.

What about the frustration and even anger from many patients with COVID-19 who are offered nothing by LLU urgent care or their primary care physician but the direction to return to the ER when their oxygen levels drop—when they can hardly breathe.

An LLUH employee of many years, a man of early middle age, a parent, went to LLU Advanced Urgent Care a few weeks ago having tested positive for COVID-19 five days earlier. He'd been suffering fever and lassitude and his wife, an LLUH healthcare worker, implored the consulting physician to give him monoclonal antibodies. When that request went nowhere she asked for ivermectin and got the same response including the assertion that there was no outpatient treatment for COVID-19. Two days later, the patient and his wife had another visit with LLU urgent care, and a different physician also refused strenuous requests for monoclonal antibodies or ivermectin and told the patient repeatedly to go home, take Tylenol, and he'd be fine. Now, a week into his illness, he went that same afternoon to an out of network physician

seeking help for his COVID symptoms, begging for monoclonal antibodies or ivermectin. The physician gave him a dose of ivermectin and a dexamethasone injection. Later that day his physician father gave him a budesonide inhaler and a double Z-Pak. But feeling worse the next day he returned to the Riverside physician for more ivermectin and another shot of dexamethasone. That evening his wife took him to LLUMC ER where after a workup it was determined, given his high fever and low oxygen levels, to admit him. The ER physician absolutely refused to keep the ivermectin going or to provide monoclonal antibodies. Instead, the treating personnel put him on a five-day regimen of IV infusion Remdesivir. On the sixth day his oxygen levels plummeted, and his heart stopped. It is very easy to wonder had the patient been provided monoclonal antibodies during his first or second urgent care visit whether he would be alive today.

During medical visits in the last year to LLUH clinicians, my requests for anticipatory or prophylaxis prescriptions for hydroxychloroquine, Ivermectin, or Symbicort, have been on occasion scoffed or merely denied—reluctantly in some cases. If early stage COVID patients who go to LLUH urgent care or ER were offered some home treatment regimen the fact that they receive no treatment might not seem quite so asinine. As you must know, there is disagreement among researchers, clinicians, and medical onlookers as to the efficacy of several repurposed drugs. Nevertheless, the claim they are dangerous is insulting to the fears and the intelligence of your potential patients.

> But what about all the dangers of the vaccine that are reported in our information-saturated society? I could try to chase down all the stories, from embedded microchips, to fertility threats, to long-term genetic alterations, to its experimental status (although Pfizer's vaccine is now approved by the FDA for general use). But I am afraid that suspicions are hard to change, as we all tend to look for evidence that bolsters our beliefs.

If only our culture was an information (rather than propaganda) saturated society.

You might like a study published last year in *Social Science Medicine* that blames "Conspiracy theories as barriers to controlling the spread of COVID-19 in the U.S."

> Although adopting preventive behaviors was predicted by political ideology and conservative media reliance, vaccination intentions were less related to political ideology. Mainstream television news use predicted adopting both preventive actions and vaccination.

Of course, the study suffers from the same assumption you present: that what is real and actually true (its point of reference) is what mainstream news media are passing along from the pharmaceutical companies and government healthcare officialdom—pandemic by gaslight. So, it has little relevance for the overwhelming epistemological problem I am trying to convey in this letter.

Your preceding two paragraphs seem full of good advice for everyone. Confirmation bias is omnipresent, Dr. Hart, and you seem to suffer from it in your determination of which reports and sources are reliable. You presume (against so much history that I can't provide here) that the CDC, the FDA, and the WHO are reliable and trustworthy sources of information and direction. Their day-by-day announcements seem to have all the force of law with much of the medical community and are rarely second guessed.

The dangers you mention people fearing about the vaccines are mostly not the things that I have heard discussed or that are discussed by those who have worked to develop (or who have run trials on) the vaccines. And distressing vaccine-related outcomes are seldom reported in media that is easily accessible, such as from the director of the Pathological Institute of the University of Heidelberg, Peter Schirmacher, who performed 40 autopsies on post vaccine deaths. Are you acquainted with his report? Do you read German? But the Merkel administration quickly moved to respond to his "politically explosive" statement. According to the German Press Agency (dpa), the Paul Ehrlich Institute announced that Schirmacher's statements were "incomprehensible."

And that becomes the end of it.

Rather than deride your employees fears, especially the ones who may have minimal sophistication behind their jab reluctance, why not address real complications that are actually being reported even in mainstream platforms such as vaccine-induced thrombotic thrombocytopenia (VITT), strokes, pericarditis/myocarditis, Guillain–Barré syndrome, microscopic clotting, and herpes eruptions and suggest ways to determine the incidence of those side effects and to which of the several vaccines they adhere.

> In these situations, one needs to balance the data from all sides when seeking to make a wise decision. It is also important to check credentials and find trusted sources of information.

Good idea about balancing data. Where do you see that being done? How do you decide who to trust? We are in a uniquely obvious crisis of epistemology exacerbated by those who flagrantly de-platform experts whose writing or testimony disagrees with the CDC, FDA, NIH, etc. and by those who make their near-monopoly search engine radically skew search results on contested or politically sensitive topics.

What you have written to the LLUH family does not evidence your having accessed all sides by any reckoning, not I imagine because you might not like to, but because you apparently are hardly aware of research and data that calls into question the recommendations and mandates from authorizing entities.

If you were familiar with the Warp Speed compromised trials used to vet the vaccines, it might make you more wary. The fact that no pregnant women and very few senior citizens or comorbid individuals were included in the Pfizer trials prepared the trials to succeed.

For so much you seem unaware of I can only recommend to you as a starting point the clearly written and heavily sourced pamphlets of the much maligned Alex Berenson who happens to be an experienced reporter of healthcare and pharmaceutical issues. His candid writing on a complex topic is full of hyperlinks that take you directly to whatever is contested or supportive.

> As an old public health doctor who has worked in vaccination programs for 50 years, I have seen the incredible benefit of vaccines. We have eliminated smallpox, largely stamped out polio, and controlled measles, diphtheria, pertussis, tetanus, hepatitis A and B, and many other infectious diseases. Many of these are what we call live-attenuated vaccines, meaning the virus has been modified in the lab to largely eliminate its infectivity and danger but still retain enough characteristics of the virus to stimulate the production of antibodies. While there has been controversy around each of these in years past, they are all accepted now by the vast majority of people and have become required in this country for our children to attend school and health professionals to work in health care settings. Everyone has benefited from these vaccines.

The history of vaccines is not nearly that neat, but I can't recite more than examples here. You lived through the development of the polio vaccines and the manufacturing mistakes that in 1955 killed ten children and paralyzed to varying degrees, more than 200. Recipients of a vaccine developed in the early 1960s for respiratory syncytial virus, or RSV, the most common cause of bronchiolitis and pneumonia in children younger than one year of age developed an enhanced form of the disease. Dozens ended up hospitalized and two died. There still is no

vaccine for RSV. Also in the 1960s, a measles vaccine given to thousands of children caused many cases of atypical measles, was withdrawn and never revised. And then just three years ago the Philippines ended a school-based dengue fever vaccination program with a French product called Dengvaxia. It actually increased the risk that a child would contract a more severe form of the painful, mosquito-transmitted disease.

And if we expand our review to drugs developed to treat various maladies, we would need a book. But it is worth noting in this COVID-19 context that nothing but failure has met attempts to develop an HIV AIDS vaccine, and wretched decision making involving AZT as a treatment can be blamed to a considerable degree on Anthony Fauci. All of this and so much more prepares the public to be leery of promises that come with mandates, shaming, and judgments.

> But this one is different, they say. Yes, it is born out of the urgency of a rapidly spreading pandemic. We have benefited from an advanced understanding of how our immune system works and ways to use it more effectively against infections. We are also blessed with a delivery mechanism, mRNA, that was developed in 2005 and can now be used to stimulate antibody production and inhibit viral growth. These new vaccines use our own God-given defense mechanisms to target the spikes on the COVID-19 virus and inactivate it. The mRNA vaccines never enter the cell nucleus and cannot change our DNA. Like most vaccines, they are not 100% effective and do have minimal side effects. But the risk from the actual disease is many times greater than any risk from the vaccine, as shown in many studies and the 170 million Americans who have now received them.

Given the impotence of the Vaccine Adverse Events Reporting System (VAERS) for tracking, categorizing, and tabulating negative reactions to the COVID-19 jabs, your confident assertions about vaccine safety seems naively cavalier.

Healthcare workers who administer the shots or take care of a patient who presents at a doctor's office, an urgent care, ER, or hospital complaining of vaccine related symptoms are mandated by law to file a report to VAERS within a specified time frame. Of course, there are rules. The process is tedious and buggy. You may attempt your report online, or using a downloadable 5-page PDF.

Anybody except the dead can file a report. But only a masochist would bother. Clinicians would rather in many cases get home in time to tuck their child in for bed or disappear for dinner and some psychological relief with a spouse or friends, than spend another half hour or more filing a VAERS report.

So, as you can imagine, the dead and less serious cases often go unreported. And there is powerful anecdotal evidence that a lot of reporting goes undone.

Almost everything I see online rejects and reviles those who wish to report adverse effects of the vaccines. To get a sense of the experience of healthcare workers who feel they are kept from reporting to VAERS from their patient care positions or are bullied and silenced, **listen to the testimony of frontline workers.** My tendency to take them seriously is based on similar frustrations I have heard from LLUH healthcare workers directly.

It is reported that VAERS numbers this year for adverse reactions to the COVID-19 shots are twice the number of reported adverse reactions to all other vaccines over the past 30 years.

So many roads we might go down regarding the vaccines and cell physiology and RNA mutation rates and the unexpected perfusion of the spike proteins and the potential for ADE, and many things I know so little about.

But underreporting adverse events is not an abstruse technical issue, and it is particularly worrisome.

> **Watch a nurse and a doctor in an HHES hospital emergency room recently in angst-laden distress discuss being ordered not to report to VAERS dozens of cases of severe vaccination reactions.**

We can't resolve this issue here. The new obscurantism, the pandemic of censorship, precludes me from knowing the truth. I'm simply trying to explain to you why the vaccination resistors around you are not all right-wing wackos, or African Americans with Tuskeegee Institute PTSD, or Adventists obsessing on end time scenarios.

The vagaries of the numbers, Dr. Hart, you might understand, give the field to anecdotal reports. I could name here a number of people I know, some of them physicians, who have had and continue to have very disturbing changes to their physiology since taking the vaccines. But as a scientifically oriented modern man, I resist the temptation to generalize anything from small samples haphazardly selected.

But what seems almost bizarre is your statement that they "do have minimal side effects." Given the number of deaths and permanent disabilities that have been attached to the several

vaccines . . . are you denying all of that? Do you totally discount each of the thousands of deaths correlated temporally by the VAERS reporting system to the COVID-19 vaccines?

Of course, as you say, all "vaccines use our own God-given defense mechanisms" to target whatever pathogen is being addressed. But you go on to describe the mRNA vaccines—Pfizer, Moderna, and (in a different way) the Janssen Ad26.COV2.S COVID-19 vaccine, explaining what they don't do. But you ignore altogether a very real potential risk that the genomic geeks who developed the new vaccines were willing to gamble—antibody-dependent enhancement (ADE)

It is of concern to some of us that one of the scientists involved in the development of the mRNA delivery mechanism, Dr. Robert Malone, has been expressing his severe doubts about the wisdom of delivering these vaccinations in the middle of a pandemic. He believes the potential for ADE is real and if realized would be catastrophic. Dr. Malone took one of the vaccines and became quite ill but recovered, he says, with the help of ivermectin.

You will not find discussions with Dr. Malone on Youtube. And if you google him, you will get a collection of warnings, because the proponents of the new methodology only sing Home on the Range where "the skies are not cloudy all day."

Data from the study of SARS-CoV and other respiratory viruses suggest that anti-SARS-CoV-2 antibodies could exacerbate COVID-19 through antibody-dependent enhancement (ADE). Other scientific researchers supported by the NIH have condemned the failure of Pfizer in its informed consent disclosures to warn its 40,000 vaccine trial subjects of the potential for ADE.

> The specific and significant COVID-19 risk of ADE should have been and should be prominently and independently disclosed to research subjects currently in vaccine trials, as well as those being recruited for the trials and future patients after vaccine approval, in order to meet the medical ethics standard of patient comprehension for informed consent.

Does the informed consent you provide patients before giving them vaccines at the Center for Health Promotion warn of a specific and significant COVID-19 risk of ADE?

But perhaps the most apparent problem with the mRNA vaccines is how much more frequently RNA mutates than DNA. Because RNA mutates at a high frequency, we find ourselves in the globe-encompassing circumstance where self-selected virologists powered by massive amounts of so often tax payer money, policed by their own sensibilities, (or that of like-minded and not

disinterested colleagues), used the RNA dependent method to create putative vaccines that are delivered to billions of subjects in the middle of a pandemic leaving us hordes of noses (human petri dishes), that is, billions of peripatetic probosci, each of which has the potential when infected by COVID-19 to spin off the virus and any variants for roughly three weeks.

And the variants keep coming. Since Delta, MU and Eta, Iota, and Kappa have appeared and there are already two variants of the Delta variant in the US—creatively designated by the letters A and B. And no one knows if, or to what extent, the vaccines will provide immunity to them. As we have seen, the effectiveness of the mRNA vaccines appear to be waning in just a matter of months to the pathogen for which they were designed, not to mention their relative submission to the Delta variant.

And if the administrative state, and Dr. Fauci, and you, Dr. Hart, have your way, there will be only subjects in this grand, Brobdingnagian experiment.

Well, pardon me if I'm committed to science without an article to modify it—science the methodology, that is; and, as a consequence, I believe there should be a control group. And I insist on remaining in it, and I'm willing to forego the random selection and the double blindness.

That, Dr. Hart, is the essence of the reason for the resistance by a cautious, contemplative cohort to your insistence on making every member of the LLUH family part of this ill-conceived experiment to limit the spread and consequence of SARS-CoV-2.

Given your part in a hospital system founded on the basis of healthful living, dietary proscriptions, and preventive care, even diet, I'd think you would be inclined with your large platform to use your voice at least to advise our employees and our patients early in the disease that quercetin, zinc, vitamin D and C in temporarily elevated doses could help the body's immune system fight the virus. That maintaining normal or better blood levels of vitamin D is essential to immune health.

You would think that with nothing else to offer, that LLUH and the American public health entities might continually be health educating about immune supporting diets, supplements, and lifestyle, rather than threatening the employment of physicians who are concerned about the lives of their patients.

But there are other things to offer, most notably (because it is not being slimed by the mainstream media) those monoclonal antibodies.

> So how will this end? It is hard to say, though some believe this virus will continue to circulate through our society until everyone has either received the vaccine or had the infection. That would be a tragedy when we have such an effective tool and can avoid many needless deaths.

What is the "effective tool" that will keep the "tragedy" you just referred to from happening? The tragedy you describe as the "virus circulating through our society until everyone has either received the vaccine or had the infection"? What are you trying to say here? It sounds as though for you the "tragedy" and the "effective tool" are one.

I thought you wanted everyone vaccinated in the worst way? Now you say "it would be a tragedy." Up to this point you seemed to be saying that you want everyone to get vaccinated and that it is the fault of the vaccine resistors that we have so much death and so many exhausted healthcare workers.

So, what is the "effective tool" you mention, if not the vaccine? I'm befuddled.

As we documented above, the accumulating evidence suggests that reliance on vaccines is hope betrayed. Remember the results in England and Israel where the vaccinations are so widely used? Meanwhile, we may be approaching a breakthrough pandemic—a pandemic of the jabbed. Because the virus, aided by the prolonged and unrecognized mild cases of the vaccinated are farrowing variants like piglets.

Even the vaccinated could benefit by a prophylactic lifestyle and pre-hospitalization treatment if they get sick which they now frequently do.

Your faith in the rushed jab effort might be understandable, but what about those condemned to death because early treatment innovations are outlawed by bureaucratic fiat . . . even though there was no alternative, and even as the research stacks up supporting the efficacy of several repurposed drugs for different aspects of the disease and its symptoms (and treating physicians' experience accumulates).

Shouldn't the pathetic fails from the *Lancet*, and FDA in following them, affect the confidence of you and some of your LLU physicians in those sources?

Whether it has efficacy for early stage COVID or not, the idea that HCQ is dangerous is risible. And this is an example, Dr. Hart, in which you have to recognize the claim is gaslighting. You have spent too much time on the ground in countries that hand out HCQ almost like candy. You have probably taken it yourself as a prophylaxis against malaria. So, if people have doubts about what they now are being told, they often have cause.

Tell me why doctors were threatened and fired for trying to repurpose relatively harmless drugs like Hydroxychloroquine and Ivermectin for desperate patients when the authorities had nothing whatsoever to offer?

Why are innovative efforts to save lives so menaced by Big Brother? You know it is irrational and life and health damaging and it further weakens the trust of patients in institutions they look to for solutions.

And if this is all about saving lives, I ask again, why hasn't LLUH pushed those monoclonal antibodies from Regeneron or Eli Lilley that were demonstrated so effectively on the treatment of President Trump in October 2020 and approved in November by the FDA for general use in treating hospitals and clinics?

> It is unfortunate that many organizations, including hospitals, are having to resort to mandates to push up their vaccination coverage of employees. It seems that these mandates, especially from the government, only accelerate the suspicion about the vaccines. Some feel outside forces are seeking to control us.

What do you mean by outside forces? Evil angels? Satan? Or are you referring to unelected NGOs funded by billionaires to promote a variety of societal agendas in most cases without the approval of those whose lives they intend to improve. Some of them, like the Bill and Melinda Gate Foundation, seem well intended even if sometimes wildly misguided. Others, such as George Soros Open Society Foundations, sometimes appear malign and even misanthropic—whether interfering with elections or undermining a country's currency (the British Pound) or breaking the Bank of Thailand.

They arouse suspicion from so many, by their presumptuous planning for our futures—futures that imagine, like the John Lennon song, no heaven and no countries. That sort of imagining is rather a nonstarter for most people, like imagining no police. But you may have noticed for quite some time now that elected representatives, congressmen and senators, seldom do what

they promise. Seldom! Like in, rarely! Whether it's domestic policy or foreign. And they spend our money (taxes) about as carefully as Adventist hierarchs spend church members' tithes and offerings. (To get a little sense of that, read my granularly sourced book, *Who Watches? Who Cares?*)

So, explain to me now, Dr. Hart, from where derives your presumption of trust for government appointed American healthcare officials (CDC, FDA, NIH).

In all of this a fair amount of trust in pharmaceutical companies is necessary as well. For the most common of the jabs you are promoting we have to have considerable faith in Pfizer. But according to the *National Times Australia*, In the last twenty years, according to the 'violation tracker' section on *goodjobsfirst.org*, Pfizer has paid over $US 4.6 billion in fines for false claims, safety violations and many other offences as well as for having sold defective heart valves, misled regulators, settled a bribery scandal, and tested a dangerous drug on Nigerian children without consent from their parents in which eleven died and dozens were disabled.

It is shocking when you discover the carelessness, the shortcuts, and the calculated rule breaking by pharmaceutical developers that led to these billions of dollars in settlements and penalties. Consider the countless personal stories of ruin and death, as well as financial perfidy, these billions represent. And you think people are naïve or foolish or stupidly obstinate to have second thoughts about a new kind of "vaccine" that has been allowed to circumvent some of the usual safety hurdles ordinarily required to certify a drug? (The vaccines were not tested for use in pregnant women but are being given to them nevertheless.) And especially when we see the massive, coordinated effort to promote the jabs while simultaneously taking unprecedented efforts to keep some of the most informed but skeptical experts from having a voice in print, on air, or online. Whatever happened to your crap detector? Why are you suddenly so recklessly compliant in this one area of reality and so judgmental of those who are not?

One of so many human failings that lead to heartbreak is the tendency to project onto others our own relative decency. That's how the conman makes out and the politician. But I stutter. I wonder, Dr. Hart, if your own benevolent nature doesn't lead you to trust people who aren't quite like you. You have the drive but not the personal cupidity that infects the billionaires of pharmaceutical making.

We learned recently that the pandemic made possible the formation of nine new billionaires. But how did they make their money? It could not have been more wrong. You and I, American

taxpayers, paid for much of the research and development (much of the risk) to rush out these experiments, and you and I, American taxpayers, paid the pharmaceutical companies for billions of doses. That wanton self-serving circularity is inexcusable. And for these vaccines the government preemptively has absolved them of any responsibility for any consequent damages or death.

Social capital is risked, while private corporations and individuals profit. And here you are unwittingly, unintentionally shilling for them to your 16,000 employees.

Reluctance to get the vaccinations it turns out is mostly not for the reasons you have surmised or the people you expect.

That new study I mentioned from Carnegie Mellon University and the University of Pittsburgh shows that PHDs are the American cohort least likely to accept the jab(s). As reported by the *DailyMail.com* "Researchers surveyed just over five million US adults in an online survey, with 10,000 reporting that they were educated to PhD level."

During the first five months of 2021 the largest decrease in skepticism about getting the vaccine was among the least educated—those with a high school education or less. But as late as May reluctance among those with doctorates held constant.

"Those with PhDs were the only education groups without a decrease in hesitancy," the paper reported. The researchers attributed the "refusal or reluctance to be vaccinated" to "slowed vaccination uptake, potentially prolonging the pandemic."

I might add, Dr. Hart, that it is important to recall that the resistance of African Americans to the vaccine has a particularly wretched source of reluctance. The "Tuskegee Study of Untreated Syphilis in the Negro Male," an egregiously unethical experiment conducted by the US Public Health Service (precursor to CDC) was brought to an end by the Richard Nixon administration after 26 years under Democratic and 14 years under Republican administrations. It was the press that used to be suspicious of and investigate the powerful of both parties that brought the horror to light in 1972.

You continue:

> Others believe this is a fulfillment of prophecy or evidence of evil forces. But most of us accept that these mandates are apparently necessary to protect us from ourselves in these

> situations. This is very similar to what we have gone through with other public health measures when society determines the greater good requires the subjugation of individual rights, as sincerely held as they may be.

Prophecy interpretation or application is a particularly subjective art. But your second sentence is bewildering. A great quote comes to mind: "Truth is not concerned with how many it persuades."

Your third sentence about "public health measures when society determines the greater good requires the subjugation of individual rights" brings to mind 1919's eighteenth amendment by which society determined the greater good requires that individuals not produce or transport or sell "intoxicating liquors" and further subjugated individual rights with the Volstead Act that prohibited their consumption.

As wrongheaded as the 18th amendment may have been, at least it went through a laborious constitutionally mandated democratic process.

And then in 1932 society reversed itself. So much for societal wisdom and the tyranny of subjugation.

To follow your logic/language, society (US government through the PREP ACT of 2005) has determined the greater good requires a consequence-free zone for billionaires and healthcare providers—which basically means the seventh amendment rights of American citizens are set aside. We can't sue if you or the billionaires damage us with COVID-19 vaccines.

Have you considered the judgment of lawmakers seeing to it that the manufacturers of the vaccines (nine new billionaires this year among the jab makers) who are making billions from a disaster are not liable for any damages their product may inflict? And this given their history with vaccines and medications even when they were liable.

But what about laws against price gouging during a pandemic? On March 11, 2020, the World Health Organization (WHO) characterized the COVID-19 outbreak as a pandemic. Two days later, the US president declared a state of emergency in Proclamation No. 9994. Seems as though there had to be price gouging (or some other kind of corruption) for these guys to become billionaires from the vaccinations that we financed (through taxes), and then with your encouragement are basically forced to take and pay for again (through taxes).

Keep in mind that these vaccines were funded socially by American taxpayers and the profits were reaped individually by the owners and stockholders of Pfizer, Moderna, and Johnson and Johnson, etc. This is a game a lot of people would like to play.

The New York Times reports (September 22) that researchers are currently testing 105 vaccines in clinical trials on humans, and 35 have reached the final stages of testing. More than 75 preclinical vaccines are under active investigation in animals.

What does that tell you? It's like prospecting; and there is gold in them thar hills.

LLU's motto is, "To make man whole," and its mission is to "further the healing ministry of Jesus Christ," not to help create new pharmaceutical billionaires by only fighting COVID with jabs.

We have a legacy of whole person care, and, Dr. Hart, this vaccine-only strategy doesn't even remind me of Loma Linda's ethos.

> We have been here before, and it usually takes a decade for any new measure to be fully accepted. My hope and prayer is that logic and understanding will prevail, and our class warfare can end as we seek to protect each other. Until we do, COVID-19 infections and deaths will continue to ravage the world.
>
> Sincerely,

So, the employees who resist the jabs have a failure of logic and understanding. Did you really intend in closing to insult a significant number of your sixteen thousand employees?

And what does any of this have to do with class warfare? Your enigmatic prayer seems unattached to "logic and understanding." Maybe your next writing will flesh that out

My closing thoughts assume that ultimately your vexation is about lives, their health and safety. But if lives are what matter, your singular focus on vaccines is inexplicable, especially with your background as a Seventh-day Adventist and as a health educator.

The monoclonal antibodies sit on the shelf. I hear rumors that Ivermectin has gotten some use at LLUH; at least I know some of your care providers have prescribed it on the down low.

I find myself resenting the ubiquitous, pell-mell, monomaniacal, incongruous pursuit of vaccines to the exclusion of—even defamatory rejection of—life saving treatments in the service of agendas about which we are left to surmise.

You talk about this essential goal of everyone vaccinated. But what does that accomplish if there are breakthrough cases everywhere all of the time. Massachusetts cases, Israeli cases, British and Vietnamese cases, Wisconsin cases. And the vaccinated who become low-grade infected aren't sure even that they are sick, but they are just as contagious. And you write about the unvaccinated as *a special problem*!?

Perhaps over time you come to take it for granted, but it is people whose support for the Adventist health message and preventive health education that have given you the opportunity to help people all over the world. People who you have persuaded and enabled to serve in all parts of the globe are many of them motivated by the beliefs that brought this center of healing into existence. Even people who accept Ellen White's insistence that the reason we have hospitals "is to prepare a people to stand true to Him during the investigative judgment" (Ellen G. White, "Instructions to Men in Positions of Responsibility," MS-154-02 [October 24, 1902], pp. 4, 7). People who believe that the shape shifting beast of Revelation 13 is the United States government. People who you have persuaded and enabled to serve in all parts of the globe are many of them motivated by the beliefs that brought this center of healing into existence.

Yet you dismiss the fears real or imagined of large populations and threaten their right to independent actions concerning their own health and their own bodies that you misguidedly say is a danger to who? Others who have not been vaccinated? Because we know the vaccinated are spreaders, perhaps super spreaders. So much is not at all settled.

You appear to aid and abet the drive to obtain herd immunity not only against the virus, but against the availability of data that fosters doubt about the efficacy and safety of the mRNA vaccines. In all of that you would drive roughshod over human freedoms, rights—if it is in an emergency and in the effort to save lives.

You may recall the insight of C. S. Lewis on this point:

> Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at

some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience.

Physicians and nurses in your immediate orbit have significant reservations about the vaccines. The basis of their reservations are very unsettled science, and the fear that some "science" is politically driven.

We can see now that there was a reason that the CDC, FDA, and Congress initiated a moratorium in 2014 on gain of function research that was being conducted in the US, and which is why Dr. Fauci's testimony in congressional hearings particularly under questioning by Dr. Rand Paul seem so disingenuous. How can you "pause" doing something he says was never done.

On January 9, 2017, the Obama Administration re-authorized funding for the creation of SARS gain of function research. "Adoption of these recommendations will satisfy the requirements for lifting the current moratorium on certain life sciences research that could enhance a pathogen's virulence and/or transmissibility to produce a potential pandemic pathogen (an enhanced PPP)."

To learn how much Pentagon funding for this kind of research went to Peter Dazsak's EcoHealth Alliance click here.

But here you are now, Dr. Hart, dividing us into sheep and goats, based on whether we have faith in any of the vaccines that were rushed at "Warp Speed" to the public. Sheep and goats. It is a very Adventist meme, but not a good one to goad people into.

The offhanded mention of "class warfare" at the end of your second writing reminds us of the disaster that is CRT. And Rawanda proves that people can be tribal and racist regardless of melanin levels. We are all tribal by nature. No need to bring it into medicine or into an already fraught conversation about the pandemic. Our job is to wrestle continually to disentangle the tribal tendency from our lives in every context.

When Remdesivir, hydroxychloroquine, and one or two other drugs were mentioned by then President Trump as possible panaceas, he was parroting what he was hearing from the physicians advising him. But it was monoclonal antibodies given him at Walter Reed Hospital in October that took him from sick to well within 72 hours. Why does LLUH not provide

monoclonal antibodies to its patients when they come to our ER our urgent care facilities or consult with our primary care physicians, rather than sending them home to see if their oxygen levels drop and their illness becomes desperate? Or, as the prison doctor says, "their lips turn blue."

Imagine what Hippocrates would think if he were alive today. You will know that the Declaration of Geneva was adopted by the General Assembly of the World Medical Association at Geneva in 1948, as a revision of the hoary Hippocratic Oath that expresses the Oath's ethical commitments in a contemporary manner.

It is troubling to notice from the reproduction below that your recent writings and approach to COVID care are not entirely consistent with that Oath. I have selected five affirmations from thirteen of what is now called a pledge. Quotes from the pledge are in blue; my next line comments are in italicized black.

AS A MEMBER OF THE MEDICAL PROFESSION:
THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

not society.

I WILL RESPECT the autonomy and dignity of my patient; including her individual rights*;*

Individual rights underlined by me.

I WILL PRACTICE my profession with conscience and dignity and in accordance with good medical practice;

which includes earliest possible intervention.

I WILL FOSTER the honour and noble traditions of the medical profession;

not the varying mandates of the CDC and FDA.

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

Your second letter seems to advocate the opposite.

Dr. Hart, I want to wind up these lamentations on a positive note. If you've gotten this far, you'll love the peroration and its constructive recommendations.

First, take every CD or DVD of that same self-congratulatory, gag-me-with-a-spoon "many strengths one mission" radio spot that has been running on Inland Empire radio stations for the past decade and replace it with something that will make people think you care about them.

Tell them that during this maddening and sometimes scary pandemic there are things they can do—besides take the needle—that will increase their odds of fighting off any variant of the virus. It's as though Rip van Wrinkle is running the LLU Office of Marketing. Surely you as an old health educator will appreciate an approach like this.

Instead of "many strengths one mission," tell them . . .

> You can improve your chances and fortify your immune system—with or without the jab—by minimizing the jelly rolls, the ice cream, the candy, and the emptiest of carbohydrates (fries, Cheetos, potato chips, French toast, etcetera). Pig out mostly on protein (meat or meatless) and healthy fat and fresh vegetables for a while (fruit is okay too). Drink water, most any kind of tea, even milk rather than sodas and adult beverages. Not only will you fortify yourself against that gain-of-function virus but in just a few days you'll feel better, think better, and even look better.
>
> That's the best advice your friends at Loma Linda University Hospital can give you. If the virus still gets you, come see us; we'll be ready with some monoclonal antibodies. Just don't wait too long.

Another version might point out that . . .

> Sometimes on this radio station we tell you how, with better eating and drinking habits, you can really improve your chances against that venal virus we've all been wrestling with. To improve your odds even more, make certain you take 5,000 international units of Vitamin D every day (or get regular, significant exposure to sunlight), take 25-40 mg daily in zinc supplements, and five- or six-hundred milligrams of Quercetin from your local or online supplements store to help that zinc take the fight to the interior of your cells where it can do its virus fighting job.
>
> And, just in case, we'll have some monoclonal antibodies ready for you here at Loma Linda University Medical Center if you get sick. For sure don't try to tough it out. Come see us at our brand-new medical center before the virus pulls you down.

Second, Stop with the scolding One-note Samba. It remains a fun song by the great Brazilian composer Antonio Carlos Jobim. But it is unbecoming of a physician/educator running a small hospital system and healthcare education university to appear so narrowly fixed in his thinking. And it certainly is not healthy for the purposes for which Loma Linda University was founded.

Third. I want you to make certain that your hospitals and clinics have access to as much monoclonal antibodies as the federal government will permit. Keep in mind, you do not need dedicated IV infusion space to provide it to patients, although with that shiny new, 17 story hospital, you can spare the space. You can give the COVID-killing antibodies by subcutaneous injection now. And do not forget that the dose required has just be reduced by half. The same exact materials delivered either way.

Fourth. Let your employees and your public know that the monoclonal antibodies are available if you are diagnosed with COVID-19, whether you have a break-through case or have not been vaccinated. And let them know they need to access this remedy early in their illness at one of your urgent care facilities. (Better yet, set up one or two dedicated locations as you have done with drive-up COVID-19 testing.)

Fifth. Inform all LLUH healthcare providers (especially primary care physicians) of the above and encourage them to tell anyone who is ill or knows someone who is ill what their COVID options are at Loma Linda University Healthcare. This is about saving lives, right?

Sixth. While you may encourage the public that vaccinations are available and free, if people present or test ill with COVID-19 to any of your facilities (urgent care, ER, doctor's office) and the monoclonal antibodies are being rationed by the federal government on some woke, intersectional priority, you will be failing your Hippocratic oath if you do not offer them a therapeutic cocktail of ivermectin, doxycycline (or azithromycin), plus . . . Leaving patients with nothing is unconscionable.

Seventh. If you can't make yourself do six, send the helpless patients here:
https://covid19criticalcare.com
FLCCC Alliance

Finally. When you project your own decency, your own expectation of truth telling, onto the people who address you from high office, you must expect to be misled.

Remember, Dr. Hart, as Steven Pinker said of the kerfuffle at Harvard over Lawrence Summers: "This is a university not a madrassa." For a long time, our scientific advancements have been driven by an ethos that assumed a Fichtean demolition derby for ideas—a thesis, an antithesis, and a synthesis—you know, the dialectic method.

But thesis without antithesis is dogma, and it leads nowhere but down. You've got to quit killing Johann Fichte.

Dr. Hart, for the sake of so many you impact, you do need to get your knee off of Fichte's neck and rehabilitate the heuristic dialectic. We need to hear competing points of view before we devise mandates for how others should live. And our default instinct must be to let others decide for themselves.

It was liberty and justice that got us this far.

There is more perspective in this letter than mine. Jan Hackleman, RN, MFT, has perused the literature and provided thoughtful medical and psychological insights. Because she believes in whole person care, you may recall that in 2010 Jan idled her counseling private practice to half time for a year while she helped set up a Wholistic Medicine Clinic in your Center for Health Promotion. She joins me in wishing you all the best.

Sincerely,

Doug Hackleman, MA