



# Covid Early Intervention

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Dr. Lindsey Berkson

with

Peter A. McCullough, MD, MPH

Dr Berkson ([00:00:02](#)):

Welcome to the Best Health Radio Show. So when I worked with Dr. Jack Moncrief and his nephrology practice and his dialysis center, he would always say, "The kidneys drive the heart." He co-invented the home unit of dialysis. He brought organ transplantation to Austin. He even came up with the idea of telemedicine and signed the bill in with Bush. He's been one of my iconic heroes.

Dr Berkson ([00:00:30](#)):

So then I heard another physician that understands how kidneys intimately drive the heart. I heard him testify to the Texas Senate and I learned that he was an internist, a cardiologist, a professor of medicine at Texas A&M at the University School of Medicine at the Baylor Campus. His works, which are many, he has 1,000 articles published in various medical journals but one of his works included the interface between renal disease and cardiovascular illness. Well, that got my attention and his point-of-view got my attention.

Dr Berkson ([00:01:08](#)):

Dr. Peter McCullough, who's giving us some of his time on a Saturday, he's going to go running after this, he's an internationally recognized authority on the role of chronic kidney disease as a cardiologist, but he also is a co-editor of two medical journals. That's a big deal. He's always looking at the literature. He's always looking at the peer review science and he also, besides teaching, he sees patients. He's got his finger on the pulse of what's going on.

Dr Berkson ([00:01:36](#)):

He's the co-editor of reviews in cardiovascular medicine and he's an associate editor of the American Journal of Cardiology and Cardio Renal Medicine. Again, he's gotten a big, warm chambers of my heart starting to beat strong. But what I heard him focus on when he was testifying in front of the Texas Senate, which is brilliant and nobody else is talking about it, and thank you for coming on the show to talk about this, is early intervention. Not just the vaccines, what do we do for the patients that are diagnosed with COVID and then told to go home for two weeks and maybe they're getting much worse. What is the intervention? What are the docs saying that are really treating COVID? So welcome to the show Dr. Peter McCullough.

Dr. Peter McCullough ([00:02:21](#)):

Lindsey, thanks for having me. And the opinions I'll give today are my own and not necessarily those of my institutions or any organization. As you've mentioned, I've really been focused on heart and kidney disease my entire career. I'm the current president of the Cardio Renal Society of America. For two decades, I've had the chapter in the Bible of Cardiology, of Braunwald's Cardiology. I have really been focused on the data and the science through all of my career in internal medicine. I've chaired [inaudible 00:02:50] boards for several dozen clinical trials, been worldwide principle investigator. When COVID-19 hit, I saw a vacuum where our infectious disease doctors were completely consumed with inpatient care. It was all hands on deck for critically ill patients and it was the acutely sick patient at home that was really left without any attention.

Dr Berkson ([00:03:12](#)):

Why do you think this is? What's going on?

Dr. Peter McCullough ([00:03:15](#)):

I think initially there was a drain of resources. I was on a lot of these task forces and everything was focused on personal protective equipment and trying to reduce the spread. The principal of that that listeners should understand is that we always, always, always prioritize first the acutely sick patient. This is a principal we cannot deviate from. The acutely sick patient is our first and always our top focus and our top priority. That did occur in the hospital, and COVID-19 patients did receive top attention.

Dr. Peter McCullough ([00:03:52](#)):

Where I filled the gaps is for early outpatients because patients were given a diagnosis of COVID-19 and high-risk patients with what could have been a fatal diagnosis. In fact, it was fatal for now 575 million Americans and that was absolutely positively the top medical priority in America, was the acutely sick patient who just got their diagnosis and were going home with COVID-19. Average patient's at home for about two weeks before going to the hospital, so we had a two-week period to really focus our efforts.

Dr Berkson ([00:04:25](#)):

So, I was very struck by you saying, if you look back over what's been published over the last year, there's very little that's been published about early intervention and when you look at who are on the expert panels, there not... To give us guidelines of how to deal with COVID, they're not necessarily doctors who are treating COVID patients. Can you talk about that?

Dr. Peter McCullough ([00:04:49](#)):

Well our guidelines and the panels and the experts there are absolutely wonderful government agency officials, academic experts. They rightly so have a singular focus on inpatient medicine. So the Infectious Disease Society Of America, the National Institutes of Health. All the CDC recommendations and World Health Organization. They really do focus on inpatient care, as they should. But that is a void. It's been a year now, a void in terms of how do we care for patients who are sick early at home with COVID-19. We know early on, in all medical problems that emerge that we must use empiric treatment. We have to use our best clinical judgment and then later on, randomized trials come in and further refine our approach, and then far after that, guidelines come.

Dr. Peter McCullough ([00:05:39](#)):

So it's always empiric early treatment based on clinical judgment and an early assessment of the literature is looking for signals of benefit and acceptable safety with some principles. It's a fatal viral infection, so we know a single drug will not work. So any claim that a single drug cures COVID-19 can't be supported. Any claim that a single drug doesn't work, most of the time that doesn't have any support either. So we look for signals of benefit, no absolute conclusions, signals of benefit and acceptable safety and working multi-drug regimen. So that's where I filled the void. The very first publication that taught doctors how to treat COVID-19 at home, still the most frequently downloaded of all the papers from that journal was in the American Journal of Medicine, in the August 2020 issue. The follow-up paper that now had-

Dr Berkson ([00:06:28](#)):

Can you give the name so people can look this up? The name of the article?

Dr. Peter McCullough ([00:06:33](#)):

I'm the first author, so Peter McCullough, first author. Can search this in PubMed. The title of the paper is The Pathophysiological Basis and Rationale for Early Ambulatory Treatment of COVID-19. The most frequently downloaded paper from the American Journal of Medicine. It's probably received more citations than any paper in all of COVID because it hit such an important unmet need. At the time of that paper, there were 55,000 papers in the peer review literature all describing different aspects of epidemiology or contagion control or in-hospital care. But there wasn't a single paper that addressed how to treat a patient with COVID-19 at home. There were millions of patients. The follow up paper-

Dr Berkson ([00:07:13](#)):

Wait, you just pointed out that if you can treat them at home then they might not end up in the hospital. That's why early intervention is so critical.

Dr. Peter McCullough ([00:07:22](#)):

Right. So the rationale is very solid. So let me just finish on. So with the follow-up paper, which was published in Reviews in Cardiovascular Medicine Dedicated COVID Issue in December of 2020, that follow-up paper is titled... Again, I'm the first author, Peter McCullough. It's titled Sequential Multidrug Therapy For Early Ambulatory Treatment Of COVID-19 To Reduce Hospitalizations And Death. That paper has 57 authors including all the world's experts, all the ones who were treating patients of COVID-19 at home and filled the void. Because again, our expert panels and our government agencies were so focused on inpatient treatment. We really needed the outpatient medical scientists to contribute.

Dr. Peter McCullough ([00:08:05](#)):

So what we know, what came in over the last year is the reports from the very first innovator, Vladimir Zelenko, in New York City. He's the senior author on the December 2020 Guidance Document. Dr. Zelenko started with some early empiric regimens that involved some nutraceuticals-

Dr Berkson ([00:08:26](#)):

Can you mention what his regiments are?

Dr. Peter McCullough ([00:08:28](#)):

Yeah, his early regimens were the use of zinc, vitamin D, vitamin C. The use of hydroxychloroquine and azithromycin, some supportive drugs and inhalers. He was the first one to demonstrate that even such modest treatment in high-risk patients with COVID-19 at home, compared to expected rates which are very easily calculable from the massive epidemiologic data. He published this with Dr. Roland Derwand from Germany in an infectious disease journal, shockingly, that there was approximately 85% reduction in hospitalization and death with early ambulatory treatment.

Dr. Peter McCullough ([00:09:09](#)):

When we came in in the fall, we worked with a very large practice in Dallas, Fort Worth area, Brian Proctor and his team of nurse practitioners and physician assistants, and they had kept very accurate statistics. Used an array of multi-drug programs. For very sick patients, they gave IV infusions. Again, it was nutraceuticals, the use of other hydroxychloroquine or now ivermectin, doxycycline or azithromycin, the use of inhaled budesonide, oral steroids, additional drugs as needed, including anticoagulants.

Dr. Peter McCullough ([00:09:44](#)):

These are the things that doctors were learning about in the hospital. Proctor and his team put together and compared to the age specific mortality of the three county region in Dallas Fort Worth and compared to expected hospitalization rates from the Cleveland Clinic calculator, again, Proctor showed in a large sample that there was an 85% reduction in hospitalization and death. So we knew from New York and Dallas, we had very strong data now, in the absence of randomized trials, we know they will come years later. But there are no randomized trials that are organizing four to six drugs to treat early ambulatory COVID-19. Those trials are not even planned. They're not forthcoming. So what we have-

Dr Berkson ([00:10:25](#)):

Can you talk about the issue with looking at one drug and then the Lancet article that really disses hydroxychloroquine and then it was retracted and all of the issues around the ivermectin. The World Health Organization just said they used a very different methodology than the Cochrane index usually uses and they came up saying it wasn't effective but it was as an isolated drug. Can you talk about... Most people don't understand what's behind this. So if you can clarify.

Dr. Peter McCullough ([00:10:53](#)):

I think the lay public as well as doctors were in such incredible fear and there was such suffering, it was natural to look for a single magic bullet. A single drug that was going to save us from COVID-19. So the first single bullet actually was commented on by Dr. Tony Fauci 15 years ago in the SARS one epidemic. Dr. Fauci mentioned chloroquine, hydroxychloroquine and how it could impair viral replication. And so, there was good support from the Chinese early on that boy this drug could be the miracle drug.

Dr Berkson ([00:11:31](#)):

And the [inaudible 00:11:34] study came out in April last year, right?

Dr. Peter McCullough ([00:11:37](#)):

Sure, Dr. [inaudible 00:11:38]. Hydroxychloroquine, to this day, is the most studied, the most utilized first line drug to treat COVID-19. But having said that, in the United States, we developed this hyper focus on a single drug which was a mistake. I knew from the beginning, as an internist cardiologist, it was going to take multiple drugs. Just like with HIV, just like with hepatitis C, just like with hepatitis B, we never treat viral infections with single drugs. And so, I was a bit worried that this whole fear driven cycle of events was going to lead to incorrect conclusions, politicization of things going on.

Dr. Peter McCullough ([00:12:17](#)):

And sure enough, what happened in really an unprecedented manner is once we started getting the early positive reports on hydroxychloroquine, a fabricated paper came in from a data source called Surgisphere. It had some prominent doctors on the author block, including a doctor from Harvard School of Medicine. And, in fact, that paper was a fully peer reviewed and accepted into Lancet and then published and hung up on Lancet for about two weeks. I can tell you, as a doctor, I knew instantaneously the paper was a fake.

Dr Berkson ([00:12:56](#)):

Because they gave... The dose was so high, is that it?

Dr. Peter McCullough ([00:12:59](#)):

No, it was a fake. They said they had data on 70,000 hospitalized cases with detailed information on what drugs they received and the average age in a database was in the 40s. What database existed worldwide that was hospitalizing people in their 40s and then it had detailed drug information? I knew from the very first minute that was published, it was a fake. Any doctor, and I tell you, as you introduced me, I'm the editor of two major journals. I'm the president of a major medical society. My name as an editor in a reviewer matters. The observation that Lancet considered one of the better journals in the world, no longer has that status by the way, but-

Dr Berkson ([00:13:49](#)):

Because of this event?

Dr. Peter McCullough ([00:13:51](#)):

Absolutely. That is a act of malfeasance. That means people in positions of authority, the reviewers and the associate editors, and the editors published a fraudulent paper. They either had a complete lapse in their understanding of data and their understanding of science and medicine. I don't believe that. I don't think they had a lapse. I think that they intentionally published a fraudulent paper and it looks that way. They published a fraudulent paper that had the purpose because it incorrectly concluded that hydroxychloroquine caused harm instead of benefit.

Dr. Peter McCullough ([00:14:30](#)):

It was intentionally published, it was obviously intentionally assembled as a paper, the author's intentionally did this and then the Lancet editors very intentionally published it and left it there for two weeks in order to frighten the world away from the use of hydroxychloroquine.

Dr Berkson ([00:14:49](#)):

Who benefits by that? Why would they do that? What's the conflict of interest behind this?

Dr. Peter McCullough ([00:14:57](#)):

My first observation is there was intent to do Worldwide harm. So by this method, the authors, the reviewers and the editors of Lancet intended to do harm is the only conclusion one can draw, because it's set out there in the public domain and was widely cited. It did do great harm. And then when it was retracted two weeks later, it was without any fanfare. The rejection was well, we couldn't validate the data and we rejected it. No sorry. No implications-

Dr Berkson ([00:15:31](#)):

That's amazing. When my mentor, [inaudible 00:15:33] had his paper in nature retracted, it was huge. It was like a media event. This should have been a media event.

Dr. Peter McCullough ([00:15:42](#)):

What it happened is, we had Junior FDA staffers, very inexperienced with data. They immediately put out warnings on hydroxychloroquine. We had NIH staffers. Again, very junior. None of these doctors or researchers had ever treated or handled a COVID-19 either clinically in research. [inaudible 00:16:04] dropped the NIH trial of hydroxychloroquine azithromycin. So that was America's only hope. They had 2000 patient trial, the NIH, the Allergy and Immunology Division had the sites funded, they had the drug.

They had all the binders. They had the research nurses. They were going to do a 2000 patients study with hydroxychloroquine azithromycin.

Dr. Peter McCullough ([00:16:26](#)):

A terrible blunder. They dropped the trial after 20 patients. Their statement was they couldn't find the patients with COVID-19 and we were overflowing with them. So I knew something... At that point in time something had gone very wrong. So that fraudulent paper in Lancet, the editorial decisions, how it has retracted, the FDA reaction, the NIH reaction, immediately world health statements, the world was thrown into confusion. Things were going pretty well and some countries never wavered... Greece said they never wavered. All Eastern Europe were using hydroxychloroquine.

Dr. Peter McCullough ([00:17:03](#)):

India, Pakistan, were using it. Russia, they never wavered. In the United States, we had doctors who had already had great experience with hydroxychloroquine. There were papers coming out. We had basically 1000s of papers in patients in observational studies using hydroxychloroquine as an outpatient, reduced hospitalization and death by about 50% in terms of association. We had all the early ambulatory trials which were halted early in a panic when they were assembled in a meta analysis by [inaudible 00:17:36]. There was a 24% reduction in new COVID cases, hospitalization and death.

Dr. Peter McCullough ([00:17:43](#)):

So all the signals were positive. Was it a cure? No. The effect size was about 25 to 50% reduction and that could have been amplified by selection bias. But there was no doubt about it. Hydroxychloroquine had a beneficial effect early on in reducing hospitalizations and death. Those who are-

Dr Berkson ([00:18:00](#)):

[inaudible 00:18:00] made people really nervous about its effect on the heart but did it turn out in that one study that they gave triple the amount of what would be not the normal dosage?

Dr. Peter McCullough ([00:18:09](#)):

Even if higher doses are used, hydroxychloroquine is like Nana histamine you get over the counter, it has a predictable prolongation of the Qt. It doesn't cause fatal arrhythmias. and there could be some rare circumstances where there'd be a safety event. Probably the biggest safety event people need to be aware of with hydroxychloroquine is acute hemolytic anemia with a G six PD deficiency in African Americans. That was completely overlooked by the medical media and the press. But importantly, the cardiac effects are well known. I can tell you as a cardiologist, on our very first paper, we had an electrophysiologist on our paper to give us the assurances that we could broadly use hydroxychloroquine. What had turned out as the QT prolongation, really long ones we were seeing in the hospital were due to the COVID illness itself.

Dr Berkson ([00:18:54](#)):

Looking at the EKG. Looking at the electrical beat of the heart.

Dr. Peter McCullough ([00:18:58](#)):

Right, so that signal was due to COVID itself. And so, on a paper from our organization that I'm the senior author [inaudible 00:19:06], it showed that in fact, we had a patient, a woman, a fatal case where

she had dramatic QT prolongation. She was in touch with hydroxychloroquine and in this week's issue of journal, the American Medical Association now the data comes out that the virus itself prolongs QT. It's not hydroxychloroquine-

Dr Berkson ([00:19:22](#)):

Oh, gosh. That's coming out this week. Thank you for sharing that.

Dr. Peter McCullough ([00:19:29](#)):

[inaudible 00:19:29] their paper. What we had with hydroxychloroquine though, to finish the story is the NIH had the [inaudible 00:19:34] trial, very small, randomized trial done and an impatient of 500 patients and there was another... Very small trial of 250 randomized patients. There were only two placebo controlled trials in hydroxychloroquine. The NIH trial and the Brazilian trial, they were given very late, a fraction of those patients already on the ventilator. Their hydroxychloroquine was neutral. It was just neutral compared to placebo. It didn't cause harm but it was neutral.

Dr. Peter McCullough ([00:20:00](#)):

So I concluded from that, hydroxychloroquine, very late, probably had little benefit. However early all we had was positive signals on the early side and even this week in one of the major journals was another early ambulatory trial, randomized trial, hydroxychloroquine. It was administratively stopped early in the panic because the day safety manager board thought maybe they already had an answer. And sure enough, when you look at the data, there's fewer deaths and hospitalizations and hydroxychloroquine. Every time there's a panic, the board stop the trial early. Every time a hydroxy is a winner by a few events and it doesn't meet a P value. This is a consistent story.

Dr Berkson ([00:20:43](#)):

So if you're treating a patient with COVID, and they just test positive, and they have comorbidities but they're not ill enough yet to go to the hospital, what is the mixture that you have found to be very effective for early intervention or what are the docs that are treating COVID sharing with each other?

Dr. Peter McCullough ([00:21:01](#)):

Well, the leading protocol currently update again is... I'm the first author, Reviews In Cardiovascular Medicine 2020. It's freely downloadloadable, Early Sequence Multi Drug Therapy and involves the following. First is risk stratification. The first thing we want to do is identify who needs to be treated under age 50, not presenting severe symptoms, no medical problems. Those people require no prescription medical treatment, just what we call a nutraceutical bundle is reasonable.

Dr. Peter McCullough ([00:21:29](#)):

The vitamins and supplements don't save people's lives, but they're thought to be helpful. They include vitamin D, vitamin C, quercetin and zinc. That's perfectly fine. Now high risk patients over age 50 or with medical problems or presenting with severe symptoms, the lead approach is to do an antibody infusion. A monoclonal antibody infusions. These are FDA, EUA approved so there should be no controversy here. They're made free and available to the US public.

Dr. Peter McCullough ([00:21:56](#)):

It takes a phone call for a doctor to arrange this. I rely on this in my practice every day. The current feature product is by Regeneron is called [inaudible 00:22:05]. It's hard to say but it's a combination product. It's infused over an hour, an hour of observation and patients go home. These products are sadly underutilized and the vast majority of patients hospitalized with sick COVID-19 were never offered an antibody infusion. So we have to get the message out. You probably have noticed in the popular media, there's no mention of the EUA antibody infusions.

Dr Berkson ([00:22:31](#)):

Well didn't Trump get that at that Walter Reed Hospital when he was ill? That was part of his cocktail.

Dr. Peter McCullough ([00:22:37](#)):

He did, so did Rudy Giuliani. I tell you, I rely on these in my practice. Had a conversation with a treating doctor who controls five urgent cares in New Jersey area, he infuses them every day. These products work, they're safe, they're effective and Americans should demand that we should never have a senior citizen go to an urgent care and be diagnosed with COVID-19 and be sent home without being offered an antibody infusion. I testified in the Texas Senate that this is unacceptable. That every patient getting a COVID-19 positive test result should get some information on how to get treatment-

Dr Berkson ([00:23:12](#)):

I love that right, please.

Dr. Peter McCullough ([00:23:14](#)):

And critically these monoclonal antibodies. I think our local no services and the major media are doing a giant disservice by not featuring the availability of these drugs. Why is the public being informed, the acutely sick public... We have 45 to 60,000 cases now at a baseline in the United States. Why is the public blinded to early treatment with these FDA approved effective products? This is a very-

Dr Berkson ([00:23:39](#)):

If people don't have that offer to them, what else do they have? Because most people aren't getting that offered to them. So what's next? What's more available?

Dr. Peter McCullough ([00:23:49](#)):

Well, whether they get the antibody infusion or not, most circumstances depending on the patient's risk factors or symptoms, for me I'm a cardiologist so all my patients have heart lung disease, kidney disease or cancer. So we're going to move into what's called two intracellular anti-infectives. These are drugs to reduce viral replication in damage to cells. So they include hydroxychloroquine with azithromycin or doxycycline. The antibiotics having modest effect on the virus but they also control for bacterial superinfection.

Dr. Peter McCullough ([00:24:20](#)):

The sinuses and the tracheal bronchial tree, they also cover super imposed infections which occur about two to 3% time from what's called mycoplasma or chlamydia, pneumonia infection. So doxycycline azithromycin is important. By the way we do this in asthma, COPD, outpatient URIs all the time. So the listeners should not be unfamiliar with doing this. Of course it should be done in COVID. So we use either hydroxychloroquine plus one of these antibiotics or ivermectin. Ivermectin does come on,

initially, with our first paper, there wasn't enough data for ivermectin to make the paper but it came in and we now have basically I believe a dozen prospective randomized trials. Way more than a dozen-

Dr Berkson ([00:25:08](#)):

We have definitive randomized trials showing reduction in fatality definitely.

Dr. Peter McCullough ([00:25:14](#)):

Right. 100% of them show an effect size about a 70% reduction in mortality. And again, we have the same problem now. So we had this really great body of data for ivermectin. And sure enough, a small randomized trial from South America lands in JAMA and is conclusive. Ivermectin is neutral, that doesn't have an effect on COVID-19.

Dr Berkson ([00:25:39](#)):

Do you think [inaudible 00:25:39] it is a solution, which is not how it's normally given and wasn't that trial sponsored by one of the J&J vaccine groups? I don't know if there's some of that conflict of interest on that.

Dr. Peter McCullough ([00:25:51](#)):

The trial is basically an invalid trial. Looks like both groups received ivermectin. Everything was wrong about the trial. It's so invalid that 120 leading scientists and doctors have written a letter to JAMA and asking them to retract it. Because we're back with the same thing with hydroxychloroquine. We have one paper that's trying to set back the entire field. We have a giant body of data supporting ivermectin. So how is ivermectin used in our approach?

Dr. Peter McCullough ([00:26:21](#)):

The original dose was 200 micrograms per kilogram. For most people that meant 12 milligram dosing. Now the belief is probably higher than that. 18 to 24 milligrams is what we have in our protocol. We have pharmacokinetic safety data up to 36 milligrams, for how many days? We don't know. Some programs use it for just three days and we stop it or every other day and stop it. So the-

Dr Berkson ([00:26:44](#)):

Do you get nausea at that level? Do you give it with [inaudible 00:26:47] or how is that?

Dr. Peter McCullough ([00:26:48](#)):

There's some nausea, there can be some skin rash, there can be some tingling or neurologic effects. So my practice pattern has been 18 to 24 milligrams once a day, every other day for three doses. That's very reasonable. Ivermectin, unlike hydroxychloroquine has completely positive data in the hospital. So you've heard of these famous cases of patients languishing in the hospital, the families demanding ivermectin, the doctors and administrators denying patients and then the families going to a judge and getting a court order and ordering them to get ivermectin. One case like that, humanitarian case is in New York. Now ivermectin we use for scabies. We use it in our dogs. It's used in veterinary applications. Medicine-

Dr Berkson ([00:27:34](#)):

We did a show on it. One of the people wrote in and said, "I requested ivermectin from my doctor and he said it will give me liver failure."

Dr. Peter McCullough ([00:27:42](#)):

And so what's happened is, there has been some veterinary use of ivermectin with some toxicity. So immediately that got into the popular media. Immediately, the FDA put a statement, don't use ivermectin. Didn't specify veterinary grade or prescription ivermectin. So the FDA has hung up these negative statements. There is currently an active statement by the US FDA saying do not use hydroxychloroquine across the board and another statement from the FDA saying do not use ivermectin across the board. Of course, the health systems have parroted this very negative stance on these two effective drugs.

Dr Berkson ([00:28:20](#)):

The World Health Organization said don't use it unless you're using it for a clinical trial. So now when a patient's listening to a show like this, hearing someone with your background, your CV, recommend these combination of drugs and then when they ask their docs, the docs say I'm not comfy writing a script for that because the World Health Organization, the FDA, they're saying no. So can you comment on what is going on behind the scenes that we're seeing... This is unprecedented, don't you think?

Dr. Peter McCullough ([00:28:48](#)):

Well, the listeners should understand that the FDA per year issues, hundreds if not 1000s of black box warnings and withdraws many products off the US market. So this is common for the FDA. FDA is in the business of giving warnings and doctors use their judgment. I can't tell you how many drugs I prescribe where it says warning. We prescribe steroids every day and warning this could cause diabetes. We prescribe inhalers for children with asthma and every single inhaler says may cause death.

Dr. Peter McCullough ([00:29:21](#)):

So FDA warnings are not the end all or be all to clinical medicine. The FDA doesn't treat patients and nor does the FDA or the NIH or CDC or WHO, nor do they have a fiduciary responsibilities. That means if a patient dies, those agencies don't have any responsibility to the patient, the doctor does. So the doctor is responsible for interpreting these warnings and understanding what they mean. But absolutely in no way is a doctor impaired from appropriately using these drugs to treat patients.

Dr. Peter McCullough ([00:29:52](#)):

So intercellular anti infectious, I've covered hydroxychloroquine, ivermectin. There's a third one outside the United States that in my view should have been brought in right away. It's the only oral antiviral that's actually regulatory approved to treat COVID-19 and that's favipiravir. That's a Japanese product. It's approved for use in about five countries outside the United States. Right on the box, it says indicated to treat COVID-19.

Dr. Peter McCullough ([00:30:19](#)):

Believe it or not, favipiravir is a direct oral polymerase inhibitor. It has the same exact function of remdesivir. So remdesivir, one of the reasons why it's controversial is it's given so late after the virus has left the body, but if we give favipiravir early upfront, it's assistive in clearing the virus from the body. Now again, it's not a cure, and its effect is modest but we use it in combination with other drugs. So

favipiravir is the third one. So in an ideal world, a doctor would choose hydroxy, ivermectin or favipiravir. Combine it with doxie or [inaudible 00:30:57]. That would be the intracellular anti infective.

Dr Berkson ([00:30:59](#)):

Can you explain that in terms of the stages of the disease. So you want something that's anti viral, then you want something that's anti inflammatory, then you want... Since this is also vascular tropic and clotting, you want something that's anti clotting. Can you talk about how the little recipe of putting these together addresses these different issues of COVID?

Dr. Peter McCullough ([00:31:20](#)):

Right, so we've been addressing the early viral replication phase which can last from, let's say, seven to 14 days. If a patient is at home for 14 days and they come in the hospital and they can't breathe, the data suggest... The viral replication is probably gone. So it'd be ridiculous to give remdesivir and expect an effect. It'd be ridiculous to give convalescent plasma and expect to get an effect because the virus has done its job. Now if a patient has a hot fever, nasal congestion and early symptoms, boy in the first day or so, the effects of hydroxychloroquine, ivermectin, favipiravir are tremendous.

Dr. Peter McCullough ([00:31:57](#)):

If we could give remdesivir, there tremendous. Monoclonal antibody infusions tremendous. convalescent plasma, this is all about any infection. We get a great effect when treating early. What's the problem? The second phase is really what's called cytokine storm. After so many days of this, there is tremendous immune disregulation. The doctors will recognize this because we see lymphocyte suppression on the CBC elevation in the overall white count. A high C reactive protein and riverside sedimentation rate. If we were to measure it, sky high levels of interleukin six, that's a signature COVID-19.

Dr Berkson ([00:32:34](#)):

Interleukin six is a real pro inflammatory cytokine taking a hammer to your tissues, right.

Dr. Peter McCullough ([00:32:38](#)):

Right, and that would be the rationale to even try with tocilizumab. What we've learned with this middle phase as outpatient is we have great support. So the stoic trial, using inhaled budesonide available in the United States is [inaudible 00:32:51]. 800 micrograms cumulatively in a day. Reduced hospitalizations and ER visits by 80% in a prospective randomized trial. This was pioneered by Dr. Richard Bartlett out in West Texas. I remember him being on the news and the media casting him as a [inaudible 00:33:08] salesman.

Dr Berkson ([00:33:09](#)):

His websites have been shut down. There's a big X, proverbial X over him when he's doing this really quality interventions which is so exasperating and it makes us distrustful of anything. Why are the good guys and people giving really effective protocols being silenced?

Dr. Peter McCullough ([00:33:27](#)):

Well listen, not everybody has been right. But I have to tell you, Richard Bandler was right. This one, I give credit to anybody who innovated. Vladimir's [inaudible 00:33:37] was right. Didier Rio was right.

Richard Bartlett was right. They were right where our leaders of the NIH and the CDC and the [inaudible 00:33:49] were wrong. Historians are going to be incredibly unkind to our agency leaders and the real heroes of COVID-19 are going to be people like Richard Bartlett, but let's continue the story on steroids.

Dr. Peter McCullough ([00:34:04](#)):

With steroids, we have a meta analysis published in JAMA. We have a multiple clinical trials. We even have outpatient experience from Brazil with a first author [inaudible 00:34:13]. There's about a 30% reduction in corticosteroids. What we've learned and my read on the data is oral steroids probably not administered too early on day five or any pulmonary symptoms and not at too high of a dose. So the first one we tried was dexamethasone. Was tried in the recovery trials. A poor choice of a steroid. It was more of a gluco cortico steroid. It was given in an odd dose, just once a day which we never do in clinical practice.

Dr. Peter McCullough ([00:34:37](#)):

So we have basically innovated and supported by the [inaudible 00:34:41]. We use prednisone which is a common oral steroid. We use it in asthma and allergic pneumonitis every day. Milligram per kilogram is currently in our protocol, my view is probably too high. My most common dose [inaudible 00:34:52] is about 40 milligrams for an average adult, five days with no taper. That covers the steroids, but importantly in the immune modulators class now was colchicine. Colchicine is-

Dr Berkson ([00:35:02](#)):

I was really excited for you to talk about this because in the olden days when it was legal, we used to give it IV for acute discogenic storm for severe back pain but then of course it would infiltrate. And if that happened... So we can't use it that way anymore, but it's a powerful anti inflammatory.

Dr. Peter McCullough ([00:35:20](#)):

Well, what we know about colchicine, the agencies have been clamoring for large prospective double blind, multicenter, randomized trials. Everybody's kind of, "Listen, I want that too. I want that handed to me on a silver platter." Well, you know what, Montreal Heart Institute with multiple sources of funding, including the National Institutes of Health, Canadian authorities, Gates Foundation and others, did the core Corona trial. Took outpatients with COVID-19 and then randomized them to Colchicine 0.6 milligrams, twice a day for three days and then 30 days thereafter versus placebo.

Dr. Peter McCullough ([00:35:55](#)):

And the primary outcome was hospitalization and death. Then quite a mysterious thing happened. This is [inaudible 00:36:02] Institute, one of the best clinical trials units in the United States, for no reason the trial was stopped early. And it was stopped early at approximately 4500 patients instead of 6000 patients. And then it turned out, out of the 4500, there was 4100 that were PCR positive since they recruited patients before some of the tests were done.

Dr. Peter McCullough ([00:36:24](#)):

So what we ended up with on the overall P value, it just misses statistical significance. So at the top line is so called a neutral trial. But among the 4100 or PCR positive, there's approximately a 45% reduction in mortality and there's a 25% reduction in death. So again, a signal of benefit and acceptable safety. So in my view, as a treating doctor who's interested in saving lives and preventing hospitalization, colchicine

gets added to my program. In fact, it was already added to the protocol I published in August of last year from the original GRECCO-19 trial from Greece.

Dr. Peter McCullough ([00:37:04](#)):

It was already good enough. Now we have corona making a compelling case. So the audience really needs to understand there's no reason not to use colchicine. In fact, I think it would really be misstep to avoid using colchicine in outpatients with COVID-19.

Dr Berkson ([00:37:21](#)):

So where are doctors coming together to share how they're treating and to share this effective recipe, these numbers of protocols? Why is it when so many people get tested positive, they're not hearing this or being offered these medications?

Dr. Peter McCullough ([00:37:36](#)):

Well, there's just one final segment to the treatment protocol and that's anti platelet, anti thrombotic drugs. What we learned from an important paper from a group from the UCLA Medical Center is that the virus markedly up regulates thromboxane production and that standard doses of aspirin are not going to be sufficient. So we're supported from inpatient studies. We need to use full dose aspirin. 325 milligrams a day for adults over 50. I continue this for 30 days, patients with atherosclerosis is my clinical practice to use for 90 days because the Japanese and others report about late strokes and heart attacks. [crosstalk 00:38:12].

Dr. Peter McCullough ([00:38:11](#)):

Aspirin is in the program. Now patients who have heart and lung disease or previous cancer we understand that thrombosis and blood clotting in the lungs, as well as the major blood vessels is a giant problem. Blood clotting a giant problem. And in fact, when the oxygen saturations are going down, that's probably not the virus, that's actually hemagglutination or blood clotting in the lungs. The patients at the highest risk beyond aspirin we use full dose, low molecular weight heparin, that would be an [inaudible 00:38:42] milligram per kilogram twice a day. To most people that's 80 milligrams twice a day and I have no hesitation in doing this as an outpatient, none.

Dr. Peter McCullough ([00:38:50](#)):

Or, using oral apixaban or another novel anticoagulant. And as an internist and cardiologist, I don't apologize to anybody about this. My responsibility is to the patient. When I testified to the US Senate and I showed the protocols and the data and the support for this. I told them, Listen, it's going to be years before we have large randomized trials. This idea that we should wait for large randomized trials and let people die is unconscionable.

Dr Berkson ([00:39:16](#)):

Randomized trials are usually looking at one actor. They're looking at one drug and he's saying that to be effective, like we do with many other illnesses, we use a number of drugs.

Dr. Peter McCullough ([00:39:26](#)):

We will have multi drug randomized trials. The National Health Service recently announced this. The NIH announced this. But they are years to come forward. The clinical trial protocols haven't even been

written yet let alone patient studied. Guidelines based on those clinical trials for outpatients are still years forward. This is a war. This is a crisis. I testified November 19. Basically I held the protocol up to the US Senate. My mask was hanging off one ear. I was a total mess and I told America I am doing this. I am doing this and I'm not asking for your permission. I'm doing this. I'm asking for your help.

Dr. Peter McCullough ([00:40:07](#)):

And this is a very important message. That's probably the strongest statement that anybody ever made in COVID-19. I basically said in the spring publicly that hospitalizations and deaths were a terrible thing. I'm going to put together a team of doctors, we're going to figure out how to stop these hospitalizations in depth and then I did it. President Trump, President Biden, White House taskforce, NIH, CDC, none of them made that courageous statement.

Dr. Peter McCullough ([00:40:34](#)):

I can tell you this as a leader, if you can't identify the problem, you definitely can't find the solution. So of course Trump couldn't find the solution. He couldn't articulate the problem. Of course, Fauci can't find the solution. He can't even articulate the problem. So this is a global blunder that's happened. It's a multi level collapsing global blunder. It's a story of a large number of people who are confused. They've lost their way, they can't even see what the problem is. They can't focus on the sick patient. And on the other side of this story are the heroes. There are the innovators who figured out how to handle this.

Dr. Peter McCullough ([00:41:13](#)):

They organized, they are great networks. The Association of American Physicians and Surgeons has an entire web section on all the treating doctors, all the treating health systems. They have a home patient-

Dr Berkson ([00:41:28](#)):

Say that one more time. Say that one more time.

Dr. Peter McCullough ([00:41:30](#)):

There are two major sources for patients to access. One is the Association of American Physicians and Surgeons [aapsonline.org](http://aapsonline.org). They have all the educational CME webinars and other resources for doctors. They have a list of all the treating doctors by state, all the treating health systems by state. They have a patient guide telling patients step by step who needs treatment and how and why. Very importantly, when they can't access treatment, there are telemedicine services in the back.

Dr. Peter McCullough ([00:42:01](#)):

There's one featured telemedicine service that's completely free of charge to patients. Completely free of charge. It's a humanitarian effort. It's called [myfreedoctor.com](http://myfreedoctor.com), they can access this online, go through an assessment online by telemedicine and get medications called into their pharmacy ASAP. And I can tell you that this AAPS online guide has been downloaded and utilized in the second half of 2020 500,000 times. It's probably been passed around millions of times. The other major organization is called The Frontline COVID Treatment Consortium-

Dr Berkson ([00:42:41](#)):

[inaudible 00:42:41] the doctors from that group on here but please talk a little bit more about them.

Dr. Peter McCullough ([00:42:45](#)):

That group also has wonderful materials. It's common in medicine that we would have two groups. We'd have the AMA and the ACP or we'd have the ACC and HA. That's perfectly normal [inaudible 00:42:58] groups, okay? Because don't forget, we haven't been out even innovating and forming groups and we're collaborating at a high level to the best we can because we're trying to... We're busy with our practices and with our work, but these two resources provide America really relief. And thank goodness we have it in America where what happened towards the end of December was miraculous.

Dr. Peter McCullough ([00:43:23](#)):

I testified in the US Senate on November 19. I said the writing's on the wall. We're overflowing the hospitals. We're going to exceed our capacity and then the body bags are going to start to pile up outside. Our breaking point in US hospitals was estimated at 135,000 people hospitalized with COVID-19. The Washington Murray model had it right at 135. That was our breaking point. We pushed hard with Senator Ron Johnson. We had two sets of committee hearings. We push with AEPS, we push with FLCC. We went all out to fill this void for early outpatient treatment and lo and behold, at the end of December, new cases, hospitalizations and deaths began to plummet simultaneously.

Dr. Peter McCullough ([00:44:04](#)):

The only thing that can do that is an effect of early outpatient treatment. And so what I mean by that is when someone's treated at home, they actually extinguish the infection in the home. Other people get infected but it stops in the home when they receive early treatment. Early treatment, markedly shortens the period of time that someone's contagious. So we really reduce the spread and as long as someone doesn't panic and go out to the hospital and contaminate family members, contaminate EMS and Uber drivers, what have you, we markedly reduce spread with early treatment.

Dr. Peter McCullough ([00:44:33](#)):

That's what happened before the very first patient was ever fully vaccinated. So the early treatment has been the heroic story of COVID-19. If you can get this message out, it's very important. It's actually... United States, honestly, we haven't handled at this point in time. Sadly, the only patients being hospitalized and dying right now are those who receive no early treatment. If you look at those cases carefully. It's a shame. I was called last week by a doctor who I practiced with. He said oh his brother who lives in another city was hospitalized on the ventilator for two weeks.

Dr. Peter McCullough ([00:45:03](#)):

I said, "Did he get any early treatment?" They said no. And I said, "Well, there we go." And some of this is on the patient because he knew about early treatment. I said, "Well how come he didn't get early treatment?" He said, "Well it started out to be so mild." And I said, "It always starts out mild." That's the deceiving part of this illness. It always starts out mild. He goes, "He thought he was going to have a mild case." And then he realized 10 days into it, it wasn't going to be a mild case.

Dr. Peter McCullough ([00:45:30](#)):

So what I encourage patients, listen, over age 50, age is an incredible factor. Multiple comorbidities, just get early treatment even if it's mild and it will remain a mild illness. The only way to let this illness spin out of control is to not treat it and let it fester for two weeks at a time. So early treatment, absolutely positively the most positive story we have in the entire COVID-19 pandemic. It's a story of heroes and

leaders breaking through despite all the confusion and barriers and sadly, just north of us in Canada, patients are absolutely starved of any opportunity for early treatment.

Dr. Peter McCullough ([00:46:08](#)):

They're desperate in the United Kingdom, Northern EU, Australia, some South American countries, they've resorted to using veterinary great ivermectin because their health systems are absolutely blocking any hope of treatment to people sick with COVID-19. Conversely, other countries-

Dr Berkson ([00:46:25](#)):

Why would their health systems be blocking it? What's going on there?

Dr. Peter McCullough ([00:46:28](#)):

Well, let me just finish. Conversely, other systems have completely reversed. So Mexico City six months ago had COVID-19 hospitals with 1200 patients basically completely overwhelming their hospitals. Now they've gone to a full ivermectin based approach and they're handling the pandemic. Peru used ivermectin based approach. Had a new leadership come in, removed it and now is spinning out of control. Brazil's incredibly fragmented, some states using early treatment [inaudible 00:46:58] doing great. Others not, doing poorly. Italy really featured hydroxychloroquine after the Milano disaster did great. Again retracted hydroxychloroquine in the confusion, did poorly. Now they're right back to it in full treatment.

Dr. Peter McCullough ([00:47:13](#)):

Other countries went full ahead. So who wins and loses with COVID-19 is all about who adopts early treatment and who doesn't. The biggest crisis we have currently in the globe is in India. Which India is a-

Dr Berkson ([00:47:27](#)):

Tragedy.

Dr. Peter McCullough ([00:47:28](#)):

... Is a incredibly varied country. It has a caste system. It's not a free society in many ways. Enormous amounts of social confusion and families, people living on top of each other. I've been to India many times. It's not a country that honestly has its act together in many ways. They've been very fragmented on early treatment. They've been fragmented on immunization. And now, sure enough, they're having their time. When the virus sets up shop... Right now, the virus in a sense has moved out of North America, outside of Canada still a residual hotspot.

Dr. Peter McCullough ([00:48:04](#)):

The virus now has settled into India and the next shoe to drop is going to be Southeast Asia, and watch out what happens in the Philippines and all of Southeast Asia. But right now in India, the epidemic curves are going straight up. They are higher right now than any prior point in the pandemic. You know when these curves go up-

Dr Berkson ([00:48:22](#)):

30% positivity rate.

Dr. Peter McCullough ([00:48:24](#)):

Right, when these curves go up, they stay up for three to six months. And they are going straight up right now. And so, what we are going to see, I think is clear, I've been there myself, their health system cannot handle this. It's now too late even for early treatment. It is out of control. I predict we're going to see a humanitarian crisis and a loss of life that will be unprecedented in India. It's unstoppable at this point in time.

Dr Berkson ([00:48:53](#)):

It's a tragedy. That has been such a great explanation of the critical importance of early intervention for COVID. And yes, there are treatments for COVID and the countries that are utilizing them are the ones that the patients are benefiting. Can you also... I know we have limited time left but you've talked about natural immunity being even better than getting immunity from a vaccine. You've made a comment that once you have COVID, you have immunity for life but the UCLA studies where they're tracking antibodies say that they go down every three months. Some people don't have antibodies after three to six months and some people do at the end of the year. So can you explain your position if you've already had COVID versus getting vaccinated? It's confusing for many of us.

Dr. Peter McCullough ([00:49:43](#)):

My opinion, what really counts is the clinical syndrome of getting sick with COVID-19, severe enough to warrant hospitalization. If we define that as a case, that as a case, that's a case of interest, not antibodies, not positive or negative tests, but a case of someone who has COVID-19, it's confirmed by nasal PCR test and hopefully validated with antigen testing or sequencing. If we have a real case, what we know with 111 million people in the world that had COVID-19, to each and every one of those people, it's just happened once. It's just a one time thing.

Dr. Peter McCullough ([00:50:22](#)):

There are about 100 cases published in the literature that said, well maybe somebody got it twice. When you look at those cases, on one of the occasions, a patient is really sick and they really have COVID-19 and the other time, it's probably just a false positive PCR test. It's not a real case. Believe me, it's at 100. So even if there are a rare bird of a recurrent infection, it is rare as hen's teeth. Now, there was a paper from Denmark, you alluded to one from UCLA, that have looked at antibody levels.

Dr. Peter McCullough ([00:50:52](#)):

Now antibody levels are ambient. We have all kinds of corona viruses that we get. So we are going to get ambient antibody levels. I'm personally one of them. So I had positive antibodies from a research essayed done at my hospital. I was a research subject in the summer but I wasn't sure if I got exposed to COVID-19 or not and then I got the real infection in the fall. So I'm a one time COVID patient. So I've had it one time. Probably the leading test to detect really has someone had COVID and is it done is called the T cell direct test.

Dr. Peter McCullough ([00:51:27](#)):

It's by a company called adaptive technologies. You can order this online. It's reviewed, go to Labcorp. They're all over America. Get your sample done. It uses next generation sequencing in order to identify minor chromosomal rearrangements in the human T cells that code for cell surface protein receptors. These chromosomal rearrangements are probably permanent. And so, we have data from T cell direct

that it's a reliable indicator, easily six to seven months out. But finishing this out, just like with SARS one, which is 80% similar to SARS two, the immunity appears to be robust, complete and durable.

Dr. Peter McCullough ([00:52:07](#)):

Very importantly. Someone didn't get SARS one over and over again. The lay person can think about this, if you could get COVID-19 over and over again, it would have kept sweeping through the nursing homes over and over again. The same seniors would have been on the ventilator five times by now because COVID-19 kept going in flares in nursing homes. When COVID-19 did, it affected different people. It didn't infect the same person over and over again. So there's no significant risk in my review of the literature that a patient could ever get COVID-19 over and over again.

Dr. Peter McCullough ([00:52:41](#)):

The immunity must be robust and durable and permanent. It must be. And so, it makes sense. And that's the reason why the US FDA and the vaccine manufacturers, I think they really understood this. And for that reason, they strictly excluded COVID recovered patients from the vaccine trials. They strictly excluded suspected COVID recovered patients. One of the vaccine trials strictly excluded anybody with antibodies because they knew that vaccination with limited immunity from just the spike protein antigen production, the vaccinations, the limited immunity that vaccine could provide would be of no benefit to a patient when COVID-19. In fact, may just cause harm.

Dr. Peter McCullough ([00:53:21](#)):

And now we have data that in fact that's true. So there's never been a single study done demonstrating benefit of vaccinating a COVID recovered patient or a suspected COVID patient or an antibody positive patient. Not a single study shows benefit and now the study is showing harm. That should really help clarify the vaccine need out there because there's been great confusion and there have been COVID recovery patients who have needlessly been vaccinated and it hasn't worked out well for them.

Dr Berkson ([00:53:50](#)):

So you're saying if you've already had COVID, you don't need to get the vaccine. Can you explain what you mean by some of the people who have had COVID and then gotten the vaccine, have had harm? Do you think that's linked to some of the clotting issues we're seeing post vaccination or what are you referring to?

Dr. Peter McCullough ([00:54:08](#)):

Well, in order to be conservative, again, the FDA and the vaccine manufacturers strictly excluded COVID recovered, suspected COVID recovered, women of childbearing age and pregnancy. And they excluded them for safety reasons and the idea that there was no opportunity for benefit.

Dr Berkson ([00:54:26](#)):

And those with autoimmune diseases, right? They were excluded too.

Dr. Peter McCullough ([00:54:30](#)):

Excluded. So when we follow the rules of regulatory science, we never apply a treatment to a group that was properly excluded from a clinical trial. In fact, exclusions have to be justified. They have to be justified to IRB's, they have to be justified-

Dr Berkson ([00:54:46](#)):

The ethics board for doing a trial, right.

Dr. Peter McCullough ([00:54:49](#)):

Right. So exclusions are really hard. That's a hard line in the sand. We would never treat a patient or vaccinate a patient who is excluded from a clinical trial. Never. That's never done. When they were released, the FDA and the CDC, I think to be conservative and to be cautionary and to... Because there was such a great public interest in vaccination said, you know what, these groups could receive the vaccine. They were permissive to that. And so, unknowingly people who had COVID-19 they thought, boy, maybe I can get it again even though nobody's really getting again, maybe I could and maybe all my friends are getting vaccinated. Maybe I should get vaccinated too.

Dr. Peter McCullough ([00:55:31](#)):

Well, we saw a paper come out of the United Kingdom from University of Manchester. And it turns out, about 2000 patients, 26% had previously had COVID and they were needlessly vaccinated and sure enough, there was two to three times the increased risk of safety events, including severe vaccine reactions. Things that required urgent care visits, office visits and hospitalizations. And again, there's no scientific evidence. There's no single study ever demonstrating benefit. No one in the world thinks that a recovery COVID patient could benefit from vaccines.

Dr. Peter McCullough ([00:56:05](#)):

I think a very important public health message is that COVID recovery patients can drive past the vaccination center. Please don't needlessly get vaccinated and cause harm to yourself. It's not worth it. This is something that should be cleaned up right away. There have been emergency letters going to the FDA saying this is an absolute blunder and oversight. Doctor [inaudible 00:56:29] who's from Harvard-

Dr Berkson ([00:56:33](#)):

I just interviewed him yesterday.

Dr. Peter McCullough ([00:56:35](#)):

Okay, so your listeners are familiar with him. He's got a very clear message. This is only going to do harm. There is a large fraction of COVID recovered patients who really have durable immunity. They can go to football games, go to church, in congregate settings. Honestly, sooner or later, America and the world's going to have to go back to work. Who's going to lead that? It's going to be the COVID recovery patients. I said for the Superbowl, they had sheepishly announced that they were going to let 100 vaccinated workers come into the Superbowl.

Dr. Peter McCullough ([00:57:04](#)):

I said what in the world? Why don't we fill up 80,000 people. Let's fill up every state with COVID recovered patients. Let them enjoy the game, show the world America's back. COVID recovered patients are going to lead America and the world back. We need to start prioritizing them. There's some discussions about even having vaccine passports like green passports. I said, listen, get the COVID recovered a gold star. Put them in first class. They're the least risk of anybody. COVID recovered patients can neither receive or transmit the virus.

Dr. Peter McCullough ([00:57:37](#)):

They're the best people to have on campus. I recently... Dr. [Nora 00:57:42] Chiasm has written, there's 80 universities that are trying to force vaccines onto the student population. Now keep in mind, there haven't been any major student outbreaks. There hasn't been any student to faculty transmission of any serious cases. And keep in mind, college age students have a very self limiting course of COVID-19. So they don't fall in a group where there would be much opportunity for risk and it could be, particularly those COVID recovered.

Dr. Peter McCullough ([00:58:08](#)):

And so, in my support of Dr. Nora Chiasm to the university presidents, I basically said listen, if you're going to keep track of something, keep that track of your COVID recovered patients. They are less risk than the vaccinated. Don't forget vaccine... Everyone agrees the vaccines don't provide perfect coverage and so a vaccinated person can clearly get COVID-19. They can transmit it to another vaccinated person. So the vaccinated patients are much higher risk than the COVID recovery patients. And so, our public health official-

Dr Berkson ([00:58:39](#)):

So natural immunity is stronger than immunity from a vaccine is what you're saying?

Dr. Peter McCullough ([00:58:43](#)):

Oh, absolutely. I think every single bit of scientific evidence supports if you had a chance, you'd rather be a naturally immune COVID recovered patient than a partially immune vaccinated patient. Even the vaccine manufacturers are saying, the immunity is pretty partial. It looks like it's not durable. Now we need to do booster shots in the fall. So you already see this signaling that the vaccine immunity is going to be very modest and limited.

Dr. Peter McCullough ([00:59:11](#)):

And it makes sense because the vaccine immunity is only directed against the wild type Wohan spike protein. That's in a sense, the antigen that the body makes. With any of the manufacturers, you're making a very limited stimulus which is the spike protein. It's pathogenic and that's reason why people have such symptoms with the vaccine. But importantly, it's a very limited immunity. There's no immunity to nucleocapsid, no immunity to the lipid [inaudible 00:59:42]. No immunity to the polymerases. There's a very limited cellular based immunity that we can see in terms of cellular assays. There may be no innate immunity form.

Dr. Peter McCullough ([00:59:52](#)):

So there's three levels of immunity. You get it all with a natural infection. The clinical data are reassuring. I mean, I personally have COVID. I was following this very carefully wondering gosh, am I going to get it over and over again? I'm already susceptible. We're now a year into this, more than a year into this. I personally am so relieved that I'm free of risk of COVID-19. I can go about my life. My wife and I aren't going to infect anybody else. We can shake hands and hug people. We wear masks and we follow the rules because people don't know we're COVID recovered.

Dr. Peter McCullough ([01:00:27](#)):

But I, in no way, have the fear I used to have. When I previously was susceptible to COVID, I was scared. I was afraid. COVID recovered patients can check the fear at the door and move on with their life. So much about what we've been talking about is about fear. Fear has driven so many of the giant blunders and the hardship and the avoidable death and hospitalization has been fear in doctors and nurses and health care officials. It's been fear in university presidents that are now taking something that's completely elective. That's stated in the consent form being investigational, where the manufacturers have already said, it's temporary at best and we need boosters. It's fear that's driving university presidents and administrators to in a sense make something that's elective mandatory.

Dr Berkson ([01:01:23](#)):

This is so good to hear. I had COVID a few months ago and I have a few really close friends that say, "Well, you can't come visit me until you get the vaccine." But I need to now send this... The link to this interview. Have them have peace of mind and accuracy of what's going on. There's so much diverse information out there. People are so confused as to exactly what to do. So this has been a very enlightening conversation. It's been a conversation to address fear because when fear drives actions, you never get the best outcomes.

Dr Berkson ([01:02:00](#)):

So thank you for enlightening us because nothing is as good as knowledge to really combat fear. Is there any final words that you want to say? We really appreciate you giving us this time. We know you're going to go out running. You're in your running suit even though you got the galaxy behind you. You are speaking to the galaxy. We do have people that listen to this in New Zealand, Australia, Canada, all around the world. Hopefully there's some people listening in India because we have a public health tragedy unfolding over there right now. Any final words Dr. McCulloh that you'd like to say? And thank you again for your time.

Dr. Peter McCullough ([01:02:34](#)):

The guiding principles to all the doctors listening is your clinical judgment reigns supreme. Your clinical judgment is far more important than what anybody says in the media. Far more important than any regulatory agency and your clinical experience with patients trust it. There are doctors who have dedicated everything they have in the last year, myself included, to handle this pandemic. Follow these doctors, they are the leaders in COVID-19, not bureaucrats, not regulatory doctors, not media doctors that haven't even seen a patient with COVID-19. It's the doctors who are really doing this.

Dr. Peter McCullough ([01:03:14](#)):

My second point is follow the peer reviewed literature. Please, if the peer review literature indicates that a COVID recovered patient has never been studied, never been studied and the literature indicates that harm is done when we vaccinate COVID recovered patients, follow the literature. Don't suggest that any COVID recovered patient should be vaccinated. We can avoid harm and we can do a lot of good by following the literature and using our clinical judgment. I'll let those be the final words.

Dr Berkson ([01:03:48](#)):

Thank you for coming from the clinical trenches as well as academia and combining the best of both worlds to enlarge and enlighten our perspective and turn the Titanic away from those icebergs in your life. So you have really great guidelines from this show. Thank you so much and may you have real good time with your workout today.

Dr. Peter McCullough ([01:04:09](#)):

Thank you.

Dr Berkson ([01:04:09](#)):

I hope I'm going to go hop in the canoe over on ladybird lake and have a good time outside too. Okay, thanks again. I really appreciate it and so does everybody who've been listening. Thank you so much for your work and your effort. Thank you Dr. McCulloh. Have a great Saturday. Bye, everybody.

Dr. Peter McCullough ([01:04:27](#)):

Great interview and have fun.

Dr Berkson ([01:04:28](#)):

Okay, bye bye.