Guest Editorial

COVID vs. the Oath of Hippocrates

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Physicians who take the traditional Oath of Hippocrates promise to "prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone." This clause states that the physician's primary loyalty is to the patient, and the standard of care is the physician's best judgment. It is a stark contrast[1] to various other oaths, such as "A Modern Hippocratic Oath" by Dr. Louis Lasagna and the post-1980 American Medical Association Code of Ethics,[2] and to the Physician Charter.[3] The deconstruction of medical ethics by the "bioethics" movement has been chronicled by Jeffrey Hall Dobken, M.D., M.P.H., in a series of articles,[4-7] of which the most recent concerns COVID-19 restrictions.[8]

The American Medical Association, at its 2020 virtual interim meeting, stood for the primacy of "credible science and evidence," while giving lip service to delivering the "very best care to our patients." Physician and patient autonomy—the latter one of the fundamental principles of the Physician Charter—are implicitly canceled if they are claimed to involve the "anti-science bias and rhetoric" deplored by AMA President Susan Bailey, M.D.[9] AMA refused to rescind its language and opinion discouraging the use of hydroxychloroquine (HCQ) for COVID-19, although many members testified that historically, AMA is neutral on big and small pharma and is not a clinical care organization (McCullough PA, personal communication, Nov 17, 2020). As recommended by Reference Committee E, Resolution 509–Hydroxychloroquine and Combination Therapies—Off-Label Use was not adopted.

Resolution 509 stated: "RESOLVED, that our American Medical Association rescind its statement calling for physicians to stop prescribing hydroxychloroquine and chloroquine until sufficient evidence becomes available.... Implying that such treatment is inappropriate contradicts 17 AMA Policy H-120.988 that addresses off label prescriptions as appropriate in the judgement of the prescribing physician; (New HOD Policy),… and be it further RESOLVED, that our AMA reassure the patients whose physicians are prescribing hydroxychloroquine and combination therapies for their early-stage COVID-19 diagnosis by issuing an updated statement clarifying our support for a physician's ability to prescribe an FDA-approved medication for off label use, if it is in her/his best clinical judgment, with specific reference to the use of hydroxychloroquine and combination therapies for the treatment of the earliest stage of COVID-19…."

Reference Committee E stated: "Many commentors, including the BOT [Board of Trustees],…noted that since the release of the statement several well-designed studies have failed to find benefit in the use of hydroxychloroquine for treatment of COVID-19 in multiple settings. Several who testified also noted that it *would be an embarrassment to the AMA and call the credibility of the AMA into question* to rescind a statement that was evidence-based and accurate [emphasis added]."

The committee also stated that it "agrees with the need for physician autonomy, but also agrees with the BOT testimony that the AMA statement does not infringe on physician autonomy." AMA supports off-label use "when such use is based upon sound scientific evidence or sound medical opinion."

In the past, AMA has not weighed in on the appropriateness of a particular drug for a specific disease. Why has AMA broken away from its traditional policy to issue this unprecedented directive to physicians to *not prescribe just this one drug (HCQ)*.

Both physicians' and patients' autonomy was explicitly rejected by Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases (NIAID). He said that although the UK and the U.S. both have an independent spirit, "now is the time to do what you're told."[10]

The 'Right to Health Care'

Whatever the supposed "right to health care" means, the COVID-19 crisis has shown that it does not mean prompt access to the care of your choice. Dr. Stephen Smith writes that he reviewed the charts of every patient admitted with COVID to a single hospital in New Jersey in March or April who required mechanical ventilation. Of these 256 patients, at least 109 had sought medical attention a day or more before they were admitted. They were seen by their primary physician, at an urgent care center, or in an emergency room, and then discharged to home. This means that 42 percent of patients who subsequently were admitted and intubated for COVID were seen by a medical professional, and in all but three, COVID treatment was NOT given. Dr. Smith notes that this percentage is actually higher, since he did not include residents from skilled nursing facilities or subacute rehabilitation centers.[11]

As of this writing, the National Institutes of Health (NIH) COVID-19 Treatment Guidelines recommend *no* specific antiviral or immunomodulatory therapy if the patient is not hospitalized or is hospitalized but does not require supplemental oxygen therapy.[12] It is not possible to say how many patients are being refused treatment by physicians who adhere strictly to government protocols because they fear being fired, as Dr. Simone Gold was, or subjected to medical board investigations, as several physicians have reported to us. Most states have placed restrictions on the prescription of HCQ,[13] as have medical facilities. Once in hospital, patients' therapy is likely controlled by corporate protocols. Patients or family members report being denied alternate treatment such as corticosteroids if a patient declines remdesivir. AAPS past president Lee Merritt, M.D., reports successfully treating a patient who was immediately discharged with no outpatient therapy, despite her low oxygen saturation, when she declined remdesivir, the only NIH-recommended antiviral drug.

Keep in mind that patients not only lack a "right to try" but

also a "right to know," as tech giants censor what they deem to be "misinformation." Hence patients may not be aware that they have been denied potentially life-saving therapy. AAPS requests for information about treatment experiences have reached only a small sample of patients. So far, we have received 176 written stories,[14] and 195 responses to a survey.[15] Of these, 24 percent said treatment outside a hospital was not available; nearly 10 percent believed that lack of out-patient treatment resulted in hospitalization, and 8 percent believed it resulted in death; 33 percent had trouble obtaining a prescription for HCQ; and 17 percent had difficulty filling a prescription for HCQ.

Because of COVID-19 restrictions, many Americans have not been able to receive care for other conditions. In Texas, for example, all "non-essential" surgery was forbidden, with a government agency defining "essential."[16] This was supposedly to reserve hospital capacity for an anticipated surge of COVID-19 cases, which usually did not arrive.

We have seen that by declaring an emergency, government can seize power to allocate resources, even those for which it does not pay, to its preferred purposes. Citizens thus have no right, but only a government-conferred privilege, to receive or to offer medical care.

Following the 'Science'

To the AMA, Dr. Fauci, and others who are attempting to block early home treatment, "science" is taken to mean the "gold standard" randomized control trial (RCT). This was the position of the Democrats' witness at the Nov 19 hearing before the Senate Committee on Homeland Security and Government Affairs on early COVID-19 treatment.[17] Ashish Jha, M.D., M.P.H., dean of the Brown University School of Public Health, focused on a few "high quality" studies of HCQ, which he considered to meet his academic standards and which failed to provide convincing evidence for the efficacy of HCQ.

Dr. Jha's own research concerns improving the quality and costs of healthcare systems with a specialized focus on how national policies, such as value-based payments and health information technology, impact care. He admitted during the hearing that he has never treated a COVID-19 patient.

Advocating early treatment were Peter McCullough, M.D., a widely published cardiologist at Baylor University; George Fareed, M.D., a family physician; and Harvey Risch, M.D., Ph.D., of the Yale School of Public Health. Dr. McCullough and Dr. Fareed have treated hundreds or thousands of COVID patients, and Dr. Risch has exhaustively reviewed the literature.

The growing number of studies of HCQ compiled on c19study.com has reached 187 (122 peer-reviewed) as of this writing, with 100 percent showing a favorable effect with early treatment. Dr. Risch explains that with current methods of adjusting measurements in nonrandomized trials to assure that groups are comparable, RCTs and their nonrandomized counterparts give identical results.[18]

Following the money is likely to reveal the source of what is called "the science." Dr. Jha's work is supported by NIH, the Bill & Melinda Gates Foundation, the Climate Change Solutions Fund, and the Commonwealth Fund. Gates is very heavily supporting vaccine research. Effective treatment would greatly decrease demand for vaccines. Many agencies of government, especially the Centers for Disease Control and Prevention (CDC)[19] and their officials, have pervasive conflicts of interest involving vaccine and pharmaceutical manufacturers, including Gilead Sciences, the maker of remdesivir.

The Double-Blind Double Standard

One of the most vocal advocates of the RCT—and *only* the RCT, Dr. Fauci became renowned for discovering the current standard-of-care treatment for Wegener's granulomatosis. The combination therapy of cyclophosphamide and steroids was accepted on the basis of a report on 18 patients,[20] who were treated, appropriately, without controls or placebos, and compared with historical controls. Ironically, HCQ is being investigated[21] as a milder potential therapy for the antineutrophil cytoplasmic antibody associated (ANCA) vasculitis in Wegener's.

During his tenure as effectively AIDS czar in 1987, Dr. Fauci refused to issue guidance to doctors about the prophylactic use of sulfamethoxazole/trimethoprim because of the lack of an RCT. NIH also refused to fund the trial. By the time a trial funded by activists was complete, 17,000 AIDS patients had died, perhaps needlessly, of pneumocystis pneumonia.[22] Dr. Fauci at the time was pushing to expand the use of extremely toxic zidovudine (AZT), an abandoned cancer drug, which was highly profitable for Burroughs Wellcome.[23]

Lockdowns, mask mandates, "social distancing," and 2-week quarantines of asymptomatic contacts are exempt from the need to satisfy the AMA's demand for "sufficient evidence… to conclusively illustrate that the harm associated with use outweighs benefit." Of course, blinding is not possible for such interventions, but randomization is. After multiple rejections, a report of an RCT of masking in Denmark finally appeared.[24] It showed no statistically significant difference in the occurrence of SARS-CoV-2 infection in the group told to wear masks (42 or 1.8%) and the control group (53 or 2.1%). The 95% confidence interval was compatible with a 46% reduction to a 23% *increase* in infection. Authors commented that there is an "absence of data suggesting serious adverse effects of masks."

Masks might have an effect by one mechanism precisely because they are not completely effective at screening out all infectious virions. Monica Gandhi, M.D., M.P.H., and George W. Rutherford, M.D., of the University of California at San Francisco, proposed that by reducing the viral inoculum, universal masking might be considered a form of "variolation," reducing the severity of disease while permitting immunity to develop.[25] This idea was criticized in letters to the editor. Brosseau et al. write: "Cloth face coverings have no specified performance criteria and are in no way equivalent to vaccines, for which efficacy and safety must be shown before they can be widely distributed."[26]

CDC Director Robert Redfield, M.D., said at a Senate Appropriations Committee hearing that: "I might even go so far as to say that this face mask is more guaranteed to protect me against COVID than when I take a COVID vaccine. Because the immunogenicity may be 70%, and if I don't get an immune response, the vaccine's not going to protect me. This face mask will."[27] Such a statement will not be subjected to an RCT.

A difficulty with double-blind trials of a vaccine with a true (saline) placebo is that lack of side effects such as pain at the

injection site may convince subjects that they had received the placebo, effectively unblinding the study. These subjects may be more likely to report mild symptoms to the site manager, resulting in an overestimate of vaccine effectiveness, according to a Petition to Stay the Phase III trial of the Pfizer COVID-19 vaccine filed by Dr. Sing Han Lee.[28]

If a vaccine is tested against a "placebo" that contains all the excipients and adjuvants, or a different reactogenic vaccine such as Menactra, then it may have a very high incidence of adverse effects that are still not significantly greater than "placebo."

"Standard therapy" for COVID-19 is generally not defined, but it too is exempt from the RCT demand. Most commonly, patients may be advised to take acetaminophen (paracetamol) for symptom relief. How safe is this? In influenza and other fever-inducing illnesses, antipyretics can increase severity and duration of illness due to the immune-suppressing effects of such products, and the important role fever plays in reducing viral replication, writes James Lyons-Weiler, Ph.D.[29] In one study, aspirin and acetaminophen use in rhinovirus infection was associated with suppression of serum neutralizing antibody response, increased nasal symptoms, a rise in circulating monocytes, and longer duration of virus shedding. The reduction of viremia via the innate and cellular immune responses leading to fever is underappreciated in public health policy, Lyons-Weiler states. The use of medicines to reduce fever in people with mild illness will prevent the reduction of viremia and increase the likelihood of community transmission. Acetaminophen also depletes glutathione, which is critically needed during times of viral infection, he adds.[29]

A 'Safe and Effective Vaccine'

The research protocols that have been released by leading vaccine manufacturers are not designed to show whether the vaccines prevent transmission, hospitalizations, or deaths, but only whether they reduce symptoms, writes William Haseltine.[30] Of course, they cannot stop the pandemic unless they do halt transmission. Is vaccination more or less effective than pre-exposure or post-exposure prophylaxis (PreP or PEP), modeled on protocols for HIV/AIDS? A trial with a head-to-head comparison would be needed.

How safe are the vaccines? It is of course impossible to rule out long-term complications when testing has lasted only a few months. The most important is the effect on fertility, which would require years to manifest. The published protocols do not mention how this will be monitored. This is especially concerning when governments are apparently determined to vaccinate most of the world's population over a very short period.

Section 13.1 of the package insert for many vaccines states that the vaccine ***"has not been evaluated for carcinogenic or mutagenic potential, or for impairment of fertility"*** [emphasis added]. Examples include: Menquadfi®, Infarix®, Rotarix®, Bexsero®, Flumist®, Zostavax®, and M-M-R®-II.

Should this not be included in the informed consent form?

AAPS Resources

AAPS is not a research organization, and we do not advocate specific therapies. Many promising approaches are mentioned in our newsletter and Journal. Our *Guide to Home-Based Treatment*, freely available on our home page,[31] features the peer-reviewed, published algorithm developed by Peter McCullough, M.D., and many American and Italian colleagues. This and other early treatment and prevention protocols, lists of physicians offering early treatment, and links to study compilations are available at c19protocols.com. Physicians need to use their own best judgment and provide treatment personalized for their individual patients.

Literature concerning masks is curated by our past president Marilyn Singleton, M.D., J.D., at aapsonline.org/maskfacts. Many articles, commentaries, and legal and regulatory summaries are compiled at bit.ly/coronavirusarticles.

AAPS has a Limited legal Consultation Service and a Committee to Combat Sham Peer Review available to members.

Conclusion

The Oath of Hippocrates states: "I will preserve the purity of my life and my art," and "in every house where I come I will enter only for the good of my patients."

The Hippocratic physician must not be corrupted by conflicts of interest or be subservient to governmental, academic, or corporate interests that place a political agenda, financial gain, prestige, career advancement, or ideology above doing what the physician judges to be best for each patient.

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