The Hippocratic Dental Declaration

A commitment to our patients, our staff, our families and ultimately the nation in which we live.

Authored by:

Dr. Wilson Arnette

Dr. Jessica Bishop Funk

Dr. Kelly Cook

Dr. Alison Reid

Dr. Christopher E. Roberts

Dr. Thomas Tomlo

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The Hippocratic Dental Declaration

"The hardest thing to explain is the glaringly evident which everybody has decided not to see."

--Ayn Rand

We are a collection of practicing dentists that share a common concern about the handling of the COVID measures by the ADA. We have collaborated in the architecture and writing of this paper to demonstrate a deeply held conviction of presenting our profession as leaders, not followers. We are aware that a basic public health principle is explained as: " experience *has shown that communities faced with epidemics or other adverse events respond best and with the least anxiety when the normal social functioning of the community is least disrupted. Strong political and public health leadership to provide reassurance and to ensure that needed medical care services are provided are critical elements. If either is seen to be less than optimal, a manageable epidemic could move toward catastrophe.*" We have done the exact opposite in the treatment of our citizens and our patients. We are disappointed in the ADA's lack of evidence-based research on developing viral models only to observe a complete lockstep, follow the pandemic narrative, even if it conflicts with actual science and clinical observations.

We studied to be researchers, we trained to be clinicians and we have worked for many years developing practice models that serve our patients with excellent attention and care. We know the difference between research done well and studies of poor quality. We work, in real time, with live patients and do so carefully and safely for the benefit of the communities we serve, every day. Now we are approaching the entities we have trusted over the years because we are disturbed by *the lack of leadership* and a "follow at all cost" mindset that has led to playing a part in the pandemic of lies through which we have lived. We want to share our concerns before the future of our profession is forever damaged! Harmed by a lack of critical thought and scientific discovery through the classic model of respectful debate and discussion.

We are two years into this pandemic and we are no closer to normalcy. Normalcy in terms of days without masks and events without a vaccine card. Normalcy in terms of open, constructive academic and scientific debate without retribution. We are a profession with the foundational guidance of the Hippocratic Oath, that we took when we commenced our careers in patient care. This oath lays out specific guiding principles on how we are to care for our patients and the past two years has demonstrated a complete obfuscation of these principles. Our Hippocratic Dental Declaration is based on adherence to the following, a revised version of the original Hippocratic Oath, rewritten in 1964 by Dr. Louis Lasagna, Academic Dean at Tufts University School of Medicine (emphasis has been added):

Hippocratic Oath

I will respect the hard-won scientific gains of those physicians in whose steps I walk and gladly share such knowledge as is mine with those who are to follow.

I will apply for the benefit of the sick, all measures that are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is an art to medicine as well as a science, and that warmth, sympathy and understanding outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not", nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially, I must tread with care in matters of life and death. If it is given to me to save a life, all thanks. **But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play God**.

I will remember that I do not treat a fever chart or a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those of sound mind and body, as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Improper Use of Masks

"Of all the tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. Those who will torment us for our own good, will torment us without end, for they do so with the approval of their own conscience."

--C.S. Lewis

"Seriously people, STOP BUYING MASKS!"—tweeted then Surgeon General Jerome Adams on Feb 29, 2020. Two days later, Adams said, "Folks who don't know how to wear them properly tend to touch their faces a lot and actually can increase the spread of coronavirus." A month later, on March 30, WHO Health Emergencies Program executive director Mike Ryan said that "there is no specific evidence to suggest that wearing of masks by the mass population has any particular benefit." He added, "In fact there's some evidence to suggest the opposite." And then, about a week later everything we ever knew about the inadequacy of surgical and cloth masks was turned on its head and the general public was FORCED to cover their faces. Did the science change in that short period of time? Or did, unelected health officials just defy a basic public health principle. Public health measures are only enacted with credible, researched and vetted evidence of their overarching benefit and must not otherwise compromise public safety.

As a profession, we train annually on the proper use of a surgical mask. This use has very specific donning and dothing protocols to which we must adhere. Doing so improperly can lead to contamination of surfaces and the spreading of disease. Advocating for general public use with absolutely NO SCIENTIFIC evidence to support is both harmful and shameful. General mask use is done improperly by the average citizen and creates a false sense of security in high-risk populations. This can and has led to unnecessary COVID infections and a host of other mask related health issues. Additionally, to support the improper use of wearing masks by auxiliary staff as they answer phones, pull down their masks with their unclean hands to allow their voice to be properly heard to the person calling, demonstrates a complete lack of integrity for the proper use of PPE. It is disgraceful that our profession would sit back and defy years-worth of proper mask usage to put on a façade of safety to our patients.

In dentistry, we began wearing masks during the AIDS epidemic of the 1980's. We did so to block the transmission of blood and salivary borne droplets. We have NEVER worn masks to protect from annual cold/Flu season. Why? Because respiratory viruses are spread via aerosolized viral particles that a surgical mask cannot filter. Prior studies on Influenza gave us models to demonstrate that small aerosol nuclei are the predominant mode of transmission for a respiratory virus. These studies also provide that hand washing and mask wearing interventions did not substantially change the overall risk of infection for household contacts.

Not only did we have evidence that surgical masks did nothing to prevent the spread of Influenza, we also had studies that provided necessary data to demonstrate that cloth masks not only are ineffective but can also increase the chance of contracting an ILI (Influenza Like Illness). Caution against the use of cloth masks was advised due to moisture retention, poor filtration and reuse likely increased the risk of infection. Allowing/advocating for the use of cloth masks during seasonal or pandemic outbreaks of a respiratory virus have supporting evidence of their ineffectiveness and we obfuscated our duty of do no harm by not being honest with the public and the patients we serve.

A meta-analysis of non-pharmaceutical measures for pandemic influenza in non-healthcare settings did not find evidence to support a protective effort of personal protective or environmental measures in reducing transmission. They specifically mention that surgical type face masks were not effective in reducing laboratory confirmed influenza transmission, either worn by the infected person (source control) or by person in the general community. A more current, for Cochrane Reviews by Jefferson, et al that examines 13 of 14 RCTs (Randomized Controlled Trials), that are the gold standard for medical research, notes uncertainty about the effects of face masks and pooled results of randomized trials did not show a clear reduction in respiratory viral infection with the use of medical/surgical masks during Influenza season.

The CDC hosts on their website, "Science Brief", which highlights studies demonstrating that mask wearing reduces infections. This is to serve as the main public justification for its mask guidance and the CDC provide 15 studies, NONE of which are RCTs. These studies are strictly focused on observational evidence completed after COVID-19 began. In general, observational studies are not only of lower quality but are also more likely to be politicized to discover what one wants to find. Interestingly, the narrative on masks may be facing some difficulty in continuing to support as sources typically in line with the narrative are beginning to draw awareness to the lies and junk science being touted by the CDC. A recent article in the Atlantic, establishes that what Dr. Rochelle Wolensky is continuing to preach to American citizens is entirely unreliable. Even Dr. Wen of CNN has recently said 'cloth masks don't work'. Oddly enough, Dr. Rand Paul was deplatformed from YouTube for saying the exact same thing earlier this summer. Although it is not a novel concept that cloth masks produce little to no efficacy for containment of an airborne respiratory virus, it appears as though the media is only now becoming aware of this long-studied science.

As a profession, we are the leaders in infection control. Dentistry has seen one of the lowest incidences of spread from provider to patient or patient to provider. Unlike a medical office, we must unmask our patients and work on their open mouths a mere 18 inches from our own faces. We did not test our patients prior to dental procedures like medical facilities required of surgical patients. We may have asked questions and taken temperatures but we maintained our pre-pandemic level of care for our patients without incidence. This demonstrates our leadership in sterilization, sanitation and the PROPER USE OF PPE. It is inexcusable and unethical to think that a nondental citizens can be entrusted with properly using a face covering. We witnessed this first hand as patients presented for their appointments with masks that had obviously been worn for days, covered in make-up and dirt, stuffed into their pockets or purses and donned with dirty hands. It is an embarrassment to our profession that we did not openly discuss the science and confront the irrational mask mandates.

If the citations provided, regarding the lack of efficacy of facial coverings worn improperly by the public are insufficient, here is a *living document* of over 150 studies detailing the ineffectiveness and harms of what has been outlined above. An additional opinion paper on the psychological harms of masking the general public details the long-term impact on certain populations within our society.

Lack of Discussions about Health, Prevention and Early Treatment

"All truth passes through three stages. First, it is ridiculed. Second, it is violently opposed. Third, it is accepted as being self-evident."

--Arthur Schopenhauer

Our profession has prided itself on the discussions of prevention and early treatment as it pertains to dental disease. Although, it is out of our purview to treat patients for medical conditions, it should be in our best interest to advocate for our patients' general health and offer education when appropriate. A proper functioning immune system is well aided by Vitamin D, Vitamin C and Zinc supplementation. We learned these basic principles when we trained to become dentists because these same supplements play a role in proper gingival and dental health. There is profound evidence to prove what we have known for years. We could have been leaders out of this pandemic by being encouraged to talk to our patients about basic immune health advantages and advocating for our patients to have Vitamin D levels checked.

Never, in the history of medicine or dentistry, have we taken the approach of making a diagnosis and then sending a patient home with NO TREATMENT and advised only to return when they have declined to the point that they cannot breathe or are in tremendous pain. Early in the pandemic there were brave doctors who used the experience and knowledge gained over their careers in medical practice to treat sick COVID patients at the onset of symptoms. These doctors likely recalled the Hippocratic Oath that they took, as many were providing prevention protocols that work. ***I will prevent disease whenever I can, for prevention is preferable to cure.*** In this case, prevention meant offering specific mitigation strategies for the highest risk patients, the elderly. For the broader portion of society, prevention meant boosting patient immune system capabilities.

The doctors of FLCCC are just one group of many doctors that formed protocols for prevention and early treatment. In their prevention protocol they used the following items which have long been used to prevent viral infections and have extremely high safety profiles.

Vitamin D --The Unites States population has a severe deficiency of Vitamin D3, ranging from 41-82% based on age, demographic and race. Countries, such as Finland, have an incidence of deficiency less than 5%. This is impressive considering they are a country that is above 35 degrees latitude, a geographic marker for a lack of UV-B rays during the winter months. But Finland, through a public health measure, provides Vitamin D3 to their population by the fortification of foods and supplementation. Interestingly, Finland has recorded only 1500 deaths since January 2020 out of their population of 5.5 million. This is a population death rate of 0.027%. In comparison, the United States has a population of 330 million and we have experienced over 800,000 deaths in the same time period. This is a population

death rate of 0.24%, eleven times worse than Finland and there is sound evidence to point to at least one factor being Vitamin D deficiency.

Vitamin D deficiency co-exists in patient with COVID-19 and findings demonstrated some 79% of patients hospitalized with severe COVID-19 were also severely deficient in Vitamin D. The association of deficiency and severity of COVID-19 might do so through a variety of mechanisms. Adequate Vitamin D levels help in maintaining intact epithelial layers, reducing the survival and replication of viruses, reducing the production of pro-inflammatory cytokines, and increasing ACE2 concentrations. As of late 2020, the evidence of 14 observational studies offered evidence that serum 25-hydroxyvitamin D concentrations are inversely correlated with the incidence and severity of COVID-19. Combined, these studies generally satisfied Hill's criteria for causality in a biological system.

Studies from over a decade ago, demonstrated Vitamin D's critical role in modulating proper immune function by assisting the innate and adaptive immune response. Deficiency in Vitamin D is associated with increased susceptibility to infection. Therapeutic doses of Vitamin D showed that administration resulted in statistically significant (42%) decrease in the incidence of Influenza. Before antibiotics were discovered, Vitamin D was (unknowingly) used to treat tuberculosis. Patients were sent to sanatoriums where treatment included exposure to sunlight. Cod liver oil, a rich source of Vitamin D, was also used as a treatment of tuberculosis and in general to prevent infections.

Doctors prescribing and advocating Vitamin D were both silenced and censored. What is not going to age well for the medical/dental community is the compilation of data supporting the efforts of those who were disparaged for recommending the use of the most basic of supplements known for years to prevent and mitigate respiratory viral infections. A recent study found that with blood levels of Vitamin D3 at approximately 50 ng/mL, any excess mortality may have been prevented. These findings are supported not only by a large infection study, showing the same optimum but also by the natural levels observed in traditional people living in the region.

An additional study found that Vitamin D treatment shortened hospital stays and decreased mortality in COVID-19 cases, even in the existence of comorbidities. Vitamin D supplementation is effective on various target parameters. This link contains many, many additional studies pointing to favorable outcomes of patients with optimized Vitamin D levels. It is essential for COVID-19 treatment and yet we continue to not highlight this in our journal articles or advocate for patients to have blood serum levels checked.

Vitamin C—Vitamin C supplementation has been able to both prevent and treat respiratory infections. It supports epithelial barrier function against pathogens and promotes oxidative scavenging activity of the skin, thereby potentially protecting against environmental oxidative stress. In one study, up to 82% of patients who were critically ill with COVID and hospitalized were Vitamin C deficient. COVID-19 can have severe outcomes due to the inflammatory reaction that causes acute respiratory distress syndrome and multiple organ system failure. Several studies suggested that high-dose vitamin C reduced inflammatory reaction associated with sepsis and acute respiratory distress syndrome. High-dose vitamin C may also reduce the mortality and improve oxygen support status in patients with COVID-19 without adverse events.

Zinc--This is a key mineral that plays a vital role in our immune system's ability to ward off viral infections. It functions by aiding immune cell production, like T-cells and white bloods cells that help our bodies fight off disease. Zinc has been shown to reduce the severity and duration of viral infections such as the common cold. A deficiency in Zinc, has been shown to impair immune function.

Studies have shown that Zinc has the ability to inhibit SARS-CoV RNA polymerase. This finding would make zinc a potential antiviral agent for the coronavirus diseases. The use of hydroxychloroquine (discussed below) acts as an ionophore which means that it promotes cellular uptake of zinc. A mechanism which may increase the effectiveness of these compounds in inhibiting the replicative capacity of the virus.

Melatonin—Melatonin was first discovered in 1958 by Dr. Aaron Lerner, a dermatologist. He was able to isolate it from the pineal gland of a cow and the world soon learned of the many positive effects for our bodies, served by the production of melatonin. It is now known to have anti-inflammatory and anti-oxidative properties and antiviral effects. Melatonin has benefits of reducing inflammation and possibly curbing the cytokine storm caused by SARS CoV-2. In a preventative protocol, it can act as an agent that equips the body to better fight viral infection by decreasing ACE 2 receptor surface expression and decreasing viral replication. Two key studies have identified the role that melatonin plays in reducing the risk of a positive test for COVID-19 and lowering the incidence of severe symptoms.

Melatonin has been both proposed and explored as a treatment for various viral infections with mechanisms that cause an extreme immune-inflammatory response and oxidative stress. Melatonin may be able to attenuate some of these reactions. SARS CoV-2 enters the alveolar epithelial cells via ACE 2 receptor binding domain. Melatonin indirectly inhibits the coupling of the ACE2 with SARS CoV-2 by the inhibition of calmodulin (regulates the surface expression and retention of ACE2 in the plasma). Melatonin has been used safely in patients for many years and continued exploration of its benefits to COVID-19patients is critical.

Quercetin—Quercetin is a powerful immune booster and broad-spectrum antiviral. It was initially found to provide broad-spectrum protection against SARS coronaviruses in the aftermath of the initial SARS epidemic that occurred in 2003. Quercetin's anti-viral capacity has been attributed to several main mechanisms of action. It is able to inhibit a virus's ability to infect cells by transporting zinc across cellular membranes (known as an ionophore, this will be additionally covered below in reference to hydroxychloroquine). Quercetin inhibits replication of already infected cells and it inhibits platelet aggregation. Blood clotting is a well-known adverse event associated COVID-19 diagnosis.

Additionally, quercetin has been demonstrated to inhibit the SARS CoV-2 spike protein from interacting with human cells. It has also been demonstrated to inhibit SARS CoV-2 related cytokine production and help to regulate the basic functional properties of immune cells and suppress inflammatory pathways.

Ivermectin—Perhaps the greatest tragedy through the entire pandemic has been the complete obfuscation of pharmaceuticals with known safety and efficacy profiles being completely silenced and censored in the name of protecting the pharmaceutical industry. To establish the need for an Emergency

Use Authorization (EUA), there must be no known low-cost therapeutics of efficacy. The prevention of the use of Ivermectin will be a story for history books that will not shine favorably on our public health officials and the medical establishment.

Ivermectin won the Noble Prize in 2015 by the Nobel Committee for Physiology or Medicine, in its only award for treatments of infectious diseases for over six decades. It is a multifaceted drug deployed against some of the world's most devastating tropical diseases. Ivermectin has been used in humans for almost four decades and it is one of the World Health Organization's Essential Medicines. In the last decade, it has been studied for its anti-viral properties. Specifically when used to treat SARS CoV-2 infections, it is believed to be display competitive binding with SARS CoV-2 spike protein. It is likely non-epitope specific, possibly yielding full efficacy against emerging viral mutant strains

Developing new medications can take many years, therefore it is essential to identify existing drugs that can be repurposed against COVID-19 that already have well established safety profiles through decades of use. Ivermectin is commercially available and affordable. Meta-analysis of the efficacy of Ivermectin demonstrates that if it had been widely available and used for prevention and early treatment, there may have been a large reduction in COVID-19 deaths. Additional studies can be found at this database.

Hydroxychloroquine

Previously mentioned in this paper, is the need of the pharmaceutical industry to ignore the beneficial indications of certain nutraceuticals and pharmaceuticals. If COVID-19 could have been mitigated with proper prevention and early treatment protocols, there would have been no emergency to indicate the need for an EUA of a novel therapeutic with no long-term safety being heralded as a vaccine. Most abhorrent was the criminalization of science to effectively falsify studies to show poor treatment outcomes. What the Lancet produced against hydroxychloroquine is just one example of the capture medical journals experience.

Hydroxychloroquine (HCQ) was approved for medical use in the United States in 1955. Like Ivermectin, it is on the World Health Organization's List of Essential Medicines. HCQ functions as an antimalarial/anti-inflammatory drug that impairs endosomal transfer of virions within human cells. It is also a zinc ionophore that conveys zinc intracellularly to block the SARS CoV-2 RNA-dependent RNA polymerase, which is the core enzyme of the virus replication. The benefits of an ionophore as it relates to the treatment of a SARS like virus dates back as far as 2010. This paper, co-authored by UNC's own Ralph Baric, demonstrates the efficacy of Zinc ionophores in blocking viral replication. *Given their crucial function in the viral replicative cycle, RdRps are key targets for antiviral research. Increased intracellular Zn^{2+} concentrations are known to efficiently impair replication of a number of RNA viruses, e.g. by interfering with correct proteolytic processing of viral polyproteins.* (Baric et al.)

The American Journal of Medicine combined the use of Zinc, HCQ and Azithromycin for early COVID-19 outpatient treatment. Notably, the American Journal of Medicine published its findings after nearly a year of well publicized criticism of HCQ and only 3 months after the CDC and NIH recommended against HCQ for the treatment of COVID-19 patients. What is clear is that false publications, such as that produced by the Lancet, inaccurate and unreliable information promoted by Dr. Rochelle Wolensky and

the contradiction of the CDC and NIH conclusions relative to HCQ, do nothing but further undermine public confidence in the dictates of public health officials and governmental institutions. However, this is the direct result of not relying on science and common sense.

Meta-analysis of HCQ has demonstrated that the most serious outcomes were improved by a rate of 46-64% and potential 75% decrease in mortality when used for early treatment. This is the key to the benefit of HCQ, as a zinc ionophore, it decreases viral replication. The Lancet study utilized lethal doses given to patients who were already hospitalized. Those who understood the potential benefits of HCQ in early March 2020, knew that its benefit would be in prevention and early treatment, not after the body has been overcome by viral replication. In this meta-analysis, the authors also mentioned the tendency for North American studies to be 2.8 times more likely to report negative results as compared to the rest of the world. The probability that an ineffective treatment generated positive results from the 302 studies reviewed, is estimated to be 1 in 751 trillion.

Informed Consent

"I am a firm believer in the people. If given the truth, they can be depended upon to meet any national crisis. The great point is to bring them the real facts."

--Abraham Lincoln

Informed consent is fundamental in the practice of medicine and related disciplines of healthcare. It is essential for patients to make educated decisions about their personal health options. The principle of informed consent certainly springs from ancient times with The Hippocratic Oath as the oldest and most widely known treatise on medical ethics. This oath taken "to do no harm" by healthcare professionals is a rite of passage into the practice of medicine and is known throughout the world. The Revised Hippocratic Oath rewritten in 1964 by Dr. Louis Lasagna, Academic Dean at Tufts University School of Medicine is contained in our opening statements. The Classic Hippocratic Oath, prior to revision, can be read in our supplemental documentations.

Of modern history, nothing is more compelling to the importance of informed consent than the events of WWII that lead to and resulted in the Nuremberg Trials. These trials led to the creation of the Nuremberg Code which established ethical codes of conduct during human experimentation. Of the 10 codes of conduct, the first stated the voluntary consent of the human subject is absolutely essential. Of particular interest of the first code is the person involved should have "free power of choice, without…force, fraud, deceit, duress…or coercion; should have sufficient knowledge…of the subject matter involved; to enable an…enlightened decision. This means before a decision is made, it must be made known to the person "the nature, duration, and purpose of the experiment, all…hazards reasonably to be expected, and the effects upon his health or person." The Nuremberg Code can be found in our supplemental documentations.

The Hippocratic Oath and Nuremberg Code is reproduced and advised for all to review and reaffirm as we believe these principles of medicine are being violated by the response of our governments, medical establishments, and private industries to the COVID-19 pandemic. From the beginning of the experimental COVID-19 vaccine development to current day, informed consent to the public has been lacking. The term "vaccine" is used within this document to be consistent with the current verbiage of medical literature. But this can debated, as an appropriate term given the mechanisms of action of the mRNA products currently being administered as COVID-19 vaccines. Poor efficacy, failed prevention of transmission, and statements from industry itself to only "attenuate" symptoms also give credit that the current experimental COVID-19 "vaccine" is not a vaccine, but could be debated as gene therapy.

Currently, federal, state, and local governments have mandated experimental COVID-19 vaccines in various parts of the country. These mandates have consequences of loss of work or significant measures of indefinite testing and masking for those who choose not to receive an experimental COVID-19 vaccine. These tactics to increase vaccine uptake in the public are certainly coercive in nature and do not allow for personal choice, violating the first Nuremberg Code. Many persons, who otherwise would not choose to receive the experimental COVID-19 vaccine, have done so only to remain gainfully employed as they have to provide for themselves and family. This choice to take the experimental COVID-19 vaccine or lose your job, is highly unethical and is in essence, coercion. The option given in some instances to have the public test for COVID-19 weekly and to mask, wear a badge or a label, segregate unvaccinated or be

placed under restrictive measures as an alternative to receiving the experimental COVID-19 vaccine, is discriminatory and labels the person, and thus again, is coercive in nature. These measures label individuals of the public as “dissenters” and as possibly “infectious,” which leads to unwarranted abuse, shaming, or condemnation from fellow members of the public who have received the experimental COVID-19 vaccine. Many persons who otherwise would not choose to receive the experimental COVID-19 vaccine have only done so to avoid these discriminatory measures or to avoid retaliation from fellow coworkers, members of the public and leaders in our society. Certain political leaders, researchers, members of the medical establishment and the media have publicly disparaged those who have not chosen to receive an experimental COVID-19 vaccine. Such conduct only empowers members of the public to repeat such remarks or acts, leading to broad societal unrest and increasing pressure on those who choose not to receive the experimental COVID-19 vaccine. Again, persons deciding to take the experimental COVID-19 vaccines, under such circumstances, is coercive in nature and violates the first Nuremberg code.

A foundational component of our dental education and the actual practice of dentistry is the concept of “Informed Consent”. Informed Consent is a discussion or conversation where five important concepts must be covered: the nature of the procedure, the risks and benefits of the procedure, reasonable alternative treatments, risks and benefits of the alternative treatments, and assessment of the patient’s understanding of the previous four aspects.

“It is the obligation of the provider to make it clear that the patient is participating in the decision-making process and avoid making the patient feel forced to agree with the provider.”

To review these five aspects of Informed Consent as it applies to the current public health situation here in the United States:

Nature of the Procedure: Covid19 vaccine utilizes synthetic mRNA surrounded by lipid nanoparticles to enter the human cell and code for the spike protein. The human cell then presents the spike protein in the intact form on the cell surface to trigger B-cells and T-helper cells as well as a fragment on the MHC I and II molecules that trigger T-cell activation. This is a novel therapy that has never been used in humans and no long-term safety data exists for these products.

Risks and Benefits of the Procedure: COVID-19 vaccines do not prevent infection by SARS CoV-2 nor transmission of infectious virus. COVID-19 vaccines are believed to benefit individuals by generating the immune response described above and to decrease the severity of disease. There are risks associated with the COVID-19 vaccine that should be disclosed. Comirnaty is the FDA approved COVID-19 vaccine and Pfizer-BioNtech is the EUA vaccine. The FDA did state that these could be used interchangeably; however, there are some concerns that the two vaccines are legally distinct and therefore would have different liability ramifications. US Federal District Judge Allen Winsor ruled that they were NOT interchangeable.

In addition, the FDA insert for Comirnaty acknowledges that there was insufficient data to inform on the vaccine associated risks in pregnancy, lactating women, and individuals under 16 years of age.(Section 8.1, 8.2, and 8.4 respectively) There are side effects and adverse reactions including deaths recorded in VAERS demonstrating higher numbers than other vaccines. VAERS is a self-reported adverse reaction site and does not prove causality; however, health care personnel are required by law to document an adverse reaction that they are aware of and falsifying a report is a criminal offense. In addition, all reports are supposed to be verified. As a requirement of the 1986 National Childhood Vaccine Injury Act, vaccine manufacturers must maintain an accurate reporting system to document adverse events. The VAERS system was established in the early 90s to represent this required capture. In a report generated by Harvard Pilgrim Healthcare, Inc and funded by the CDC, it was found that VAERS has a likely capture of only 1% of vaccine adverse events.

As is the case with any new technology or medical treatment, research is ongoing about the mRNA COVID-19 vaccines and as data is being collected over time, additional safety signals are emerging. There are studies that indicate that the spike protein damages DNA damage repair. Other studies find the mRNA vaccines cause increased cardiac inflammatory markers. There are also reports of increased risk of vaccine induced acute cardiac events. Recently, Pfizer documents obtained via a FOIA request to the FDA indicate an increased number of side effects that had not been previously disclosed to the public. In addition, the FDA has requested an unusually extended period of time to fully disclose all the Pfizer documents utilized in approving the Comirnaty vaccine. The FDA has asked for 75 years to fully disclose all the data. BUT the FDA was able to 'thoroughly' review the data in 108 days prior to recommending Comirnaty for approval.

Pre-COVID-19 Vaccine Safety Concerns:

1. **Brand New Technology**--The COVID-19 vaccines are brand new technology that has never been used before in medicine. Vaccines are traditionally composed of a bacteria or virus that is not pathologic in nature (killed) and injected into a patient. Sometimes the vaccine may not contain the whole bacteria or virus but only a part (antigen) that is not pathologic. In each case, the body recognizes the foreign agent and produces an immune response. In this way, the patient mounts an immune response to the actual bacteria or virus when encountered in the wild. The COVID-9 vaccines do not contain any part of the SARS CoV-2 virus. The COVID-19 vaccines instead contain messenger Ribonucleic Acid (mRNA). This mRNA enters the cells and instructs the protein synthesizing machinery of cells to produce the spike protein of the SARS CoV-2 virus' surface. This pathologic protein is expressed by the cells which produces an immune response from the body. Ideally, the body will therefore produce an immune response to the actual SARS CoV-2 virus in the wild.
2. **Failed Prior Attempts at Coronavirus Vaccines**--Previous attempts at making vaccines for coronaviruses have failed. In animal studies, many animals died when the animals were tested with the live virus. Thus, the vaccines did not pass animal studies. For example, reference the studies listed here.
3. **No Independent Published Animal Studies**--Animal studies are critical in the development of new drugs or vaccines, in that pathologic or toxic effects can be evaluated before starting human

trials. Animal studies have not been independently conducted or published in peer reviewed medical journals for the Covid-19 vaccines.

4. **Possible Adverse Reactions**--One type of possible adverse reaction is called Antibody Dependent Enhancement (ADE) or immune enhancement. This process is where the antibodies produced actually enhance the infectious nature of the virus. When this happens and the animal encounters the virus in the wild, instead of being protected the animal develops severe infections and die. This type of reaction was proposed as a possible occurrence observed in animal studies on previous coronavirus vaccines. Researchers have and are continuing to warn for possible ADE events.
   For example, Wen Shi Lee, et al. writes in journal Nature Microbiology, "Antibody-dependent enhancement and SARS-CoV-2 vaccines and therapies," **in the conclusion, "ADE has been observed in SARS, MERS, and other human respiratory virus infections including RSV and measles, which suggests a real risk of ADE for SARS-CoV-2 vaccines and antibody-based interventions.** However, clinical data has not yet fully established a role for ADE in human COVID-19 pathology…Going forward, it will be crucial to evaluate animal and clinical datasets for signs of ADE…Ongoing animal and human clinical studies will provide important insights into the mechanisms of ADE in COVID-19. Such evidence is sorely needed to ensure product safety". Timothy Cardozo, et al. also evaluates if patients have been properly informed of this possible adverse reaction, which he states "**adequate patient comprehension of this risk is unlikely to occur, obviating truly informed consent by subjects in these trials."**

Safety Concerns with the Covid-19 Vaccines Post-vaccine campaign:

1. **VAERS Reports**-- VAERS stands for Vaccine Adverse Event Reporting System, which was established in 1986 as a result of the National Childhood Vaccine Injury Act passed by congress. The VAERS system is supposed to help identify potential vaccine injuries or problems with vaccines as the products are approved for public administration. The Pfizer / BioNTech Covid-19 vaccine was approved for EAU by the FDA on December 11, 2020. Moderna Covid-19 vaccine EAU was December 18, 2021 and Johnson and Johnson EAU was February 27, 2021. As of December 17th, 2021 the Covid-19 VAERS data as related by OpenVAERS contains the following reports for Covid-19 Vaccines:
   - Deaths: 20, 622
   - Hospitalizations: 108, 572
   - Myocarditis / Pericarditis: 19, 039
   - Heart Attacks: 10, 429
   - Severe Allergic Reactions: 35, 997
   - Bell's Palsy: 12, 317
   - Miscarriages: 3, 365
   - Total Reports: 983, 756

2. **Cardiovascular Reports**-- Myocarditis is inflammation of the heart muscle and pericarditis is inflammation of the outer lining of the heart. Myocarditis and pericarditis are two of the most well documented conditions associated with Covid-19 vaccine induced adverse events.

Multiple examples of severe myocarditis are documented in the medical literature, such as by Amanda K. Verma, et al. in *The New England Journal of Medicine* with the article, "Myocarditis after Covid-19 Vaccination." Verma documents two cases of myocarditis. One patient was with released with ejection fracture at 60%, and the other patient died 3 days after presentation. Lim documented as case where the patient, after 10 minutes of CPR, was saved by extracorporeal cardiopulmonary resuscitation (ECPR). Other cases are documented by Simone in *JAMA Internal Medicine* and Choi in *Journal of Korean Medical Science.*

Study Indicates Concern for Future Acute Coronary Syndrome (ACS)
Gundry, Steven R., "Abstract 10712: Observational Findings of PULS Cardiac Test Findings for Inflammatory Markers in Patients Receiving mRNA Vaccines," *Circulation,* November 8, 2021

- The PULS (Protein Unstable Lesion Signature) test measures the protein biomarkers that leak from cardiac lesions in blood vessel walls
- **The test generates a score predicting the 5-year risk (percent chance) of a new Acute Coronary Syndrome (ACS) called the PLUS Score**
- **Result: Before vaccination, the PULS score predicted a 11% chance that an ACS would happen in 5 years. After vaccination, the PULS score predicted a 25% chance that an ACS would happen in 5 years."**

Study Proposes one Mechanism of Action for Vascular Injury
Avolio, et al. illustrate the spike protein elicited signaling and functional alternation to pericytes in vitro**. "In conclusion, our findings suggest that the S protein may prompt pericyte dysfunction, potentially contributing to microvascular injury."**

Study Relates Potential Long-Term Consequences of Myocarditis on Cardiac Function
Tschope, et al. reference 210 patients that were treated for 2 years with standard heart failure medication. As seen in figure 1, 47% of the patient's ejection fracture did not return to normal.

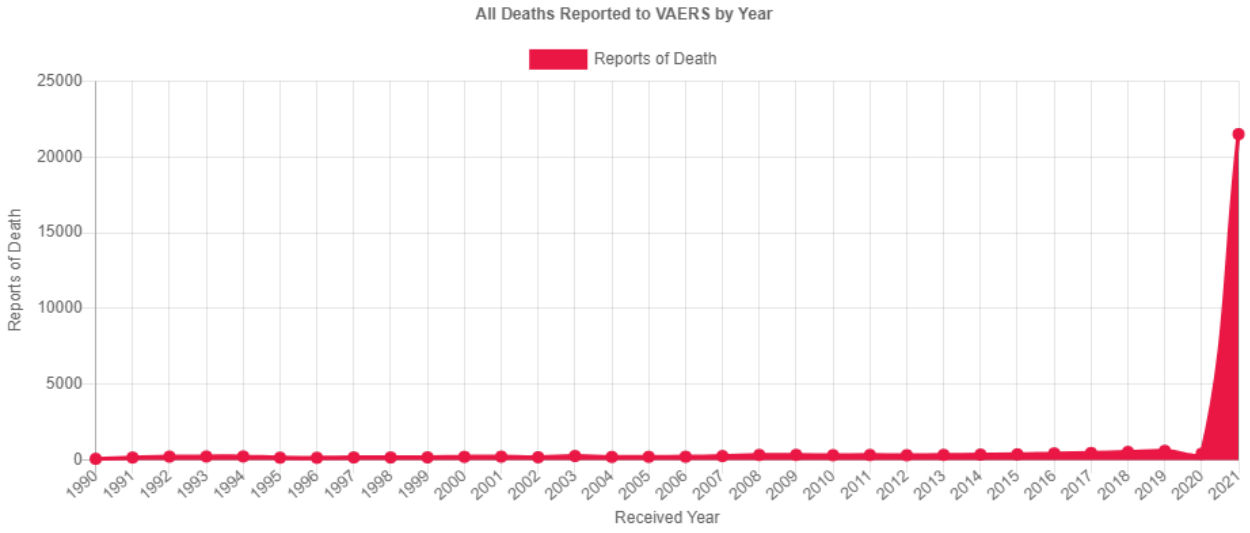
3. **Thrombosis and Thrombotic Thrombocytopenia (VITT)**--Vaccine induced Thrombotic Thrombocytopenia (VITT) has been reported with the vaccines. VITT is characterized by the presence of two conditions at the same time, thrombosis (blood clots) and thrombocytopenia (low platelets). Researchers such as Richard J. Perry in the journal*, The Lancet*, set out to describe the condition. They write "between April 1 and May 20, 2021, we received data on 99 patients…four patients were excluded…of the remaining 95 patients, 70 had VITT and 25 did not." Additionally, Salk researches have shown how the spike protein impairs endothelial function, confirming COVID-19 could be considered a vascular disease. The paper by Yuyang Lei, et al. published on April 30, 2021 in *Circulation Research*, demonstrates how the SARS CoV-2 virus damages and attacks the vascular system on a cellular level.
CDC no longer recommends the Johnson & Johnson Vaccine as of December 16, 2021 compared to the Pfizer or Moderna Vaccine due to the adverse event of thrombosis with thrombocytopenia syndrome (TTS).
Researches need to continue to investigate possible thrombosis, endothelial damage, VITT and the overall risks associated with the COVID-19 vaccines.

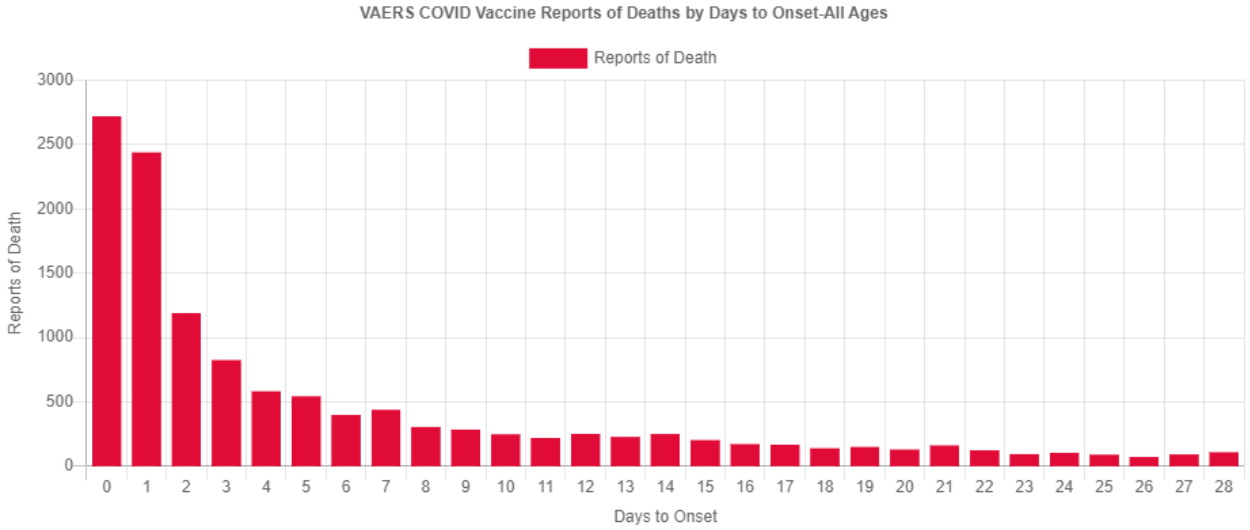
4. **Death**-- VAERS reports as related above

20, 622 deaths as of December 17, 2021

In the first graph below, one can see death reports in VAERS have significantly increased since the introduction of Covid-19 vaccines

The second graph relates that of the deaths reported for the Covid-19 vaccines, most are closely associated with the time of vaccine admiration





Pfizer Documents

Pfizer documents released on Nov 19, 2021 for a Freedom of Information Request (FOIA) that was filed by Attorney Aaron Siri on behalf of a group of scientists, academics, and researchers (Public Health and Medical Professionals for Transparency). These documents show that between Dec 1, 2020 and Feb 28, 2021 (roughly 2.5 months) a variety of adverse events were reported.

42, 086 case reports filed that contained 158, 983 serious adverse events
1223 were fatal
Among reported adverse events were some 25,957 cases of nervous system disorders, 17,283 musculoskeletal and connective tissue disorders, 14,096 gastrointestinal disorders, 8,848 respiratory, thoracic and mediastinal disorders, 8,476 skin and subcutaneous tissue disorders, and 4,610 infections and infestations.

While direct causality is unclear, the data from the Pfizer documents raise concerns about the safety of the vaccine. The sheer volume of reports is alarming, especially considering the growing body of data coming from the VAERS system.

Reference Pfizer document "5.3.6-postmarketing-experience"

Study on Quality of VAERS Data

McLachlan, Scott, et al. "Analysis of COVID-19 vaccine death reports from the Vaccine Adverse Events Reporting System (VAERS) Database," *ResearchGate,* June 2021.

The focus is to determine if the reports allow researchers to understand if the vaccine caused or contributed to the deaths and also to determine the quality of the reports since the public can submit reports. Source of the 250 analyzed reports: 67% were from a health service employee, 5% from a pharmaceutical employee, 28% from lay people. **Thus, nearly three-fourth of the reports were non-lay people reports.** Of 250 deaths the causation was found in 34 (14%) deaths, the vaccine could be ruled out as a cause. **Of 203 (81%) deaths, the vaccine may have been a factor in the cause**. **Of 13 (5%) deaths, the vaccine was most likely the cause.**

5. **Miscarriage--** Brock, Aleisha R. and Thronley, Simon, "Spontaneous Abortions and Polices on Covid-19 mRNA Vaccine Use During Pregnancy," *Science, Public Health Policy and the Law,* November 2021. Brock states an article used by the CDC to support vaccination during pregnancy gives a false reassurance "since the majority of the women in the calculation were exposed to the mRNA product after the outcome period was defined (20 weeks' gestation). **On re-analysis, Brock "indicates a cumulative incidence of spontaneous abortion 7 to 8 time higher than the original authors' results and the typical average for pregnancy loss during this time period."**

6. **Reactivation of Latent Infections**-- Muhie, Oumer A., et al., "Herpes Zoster Following Covaxin Receipt," *International Case Reports Journal*, December 1 2021. Varicella zoster virus (VZV) remains latent in dorsal root or cranial nerve ganglia after initial infection. Shingles is caused by reactivation of VZV, which can occur spontaneously or triggered by immunosuppression, trauma, stress, or fever. **Muhie writes "taking our case and the cases reported by other authors, one can draw a link between COVID-19 vaccine and reactivation of VZV and thus herpes zoster."** Other documented cases of shingles are here, here, and here.

7. **Nerve Injury Reports**-- Guillain-Barre Syndrome (GBS)
   Matarneh, Ahmad, et al. "COVID-19 vaccine causing Guillain-Barre syndrome, a rare potential side effect," *Clincal Case Reports,* September 2021. Documented case of 61-year-old man who developed GBS within 4 days of receiving the Moderna vaccine.
   CDC issued warning for GBS associated with the Johnson & Johnson vaccine in July 2021

   Bell's Palsy
   Burrows, Abigail, et al. "Sequential contralateral facial nerve palsies following COVID-19 vaccination first and second doses," *British Medical Journal*, June 3 2021. Burrows reports "single episodes of unilateral facial nerve palsies have been reported in clinical trials and in subsequent case reports." Additional medical literature reports Bell's Palsy here.

8. **Biodistribution**-- Pfizer biodistribution study obtained by Dr. Byram Bridle, a viral immunologist, as a result of a Freedom of Information Request made to the Japanese government for Pfizer data. Before study disclosure, the public was led to believe the spike protein stayed in the shoulder where injected. The biodistribution study obtained showed the lipid nanoparticles that promotes the uptake of mRNA into cells were circulated throughout the body. **Accumulation occurred in organs and tissues. Larger concentrations were in bone marrow, lymph nodes and ovaries. Potential long-term complications could exist such as leukemia, lymphomas, fertility issues**. Such effects will be harder to associate with Covid vaccines since most will not show until years later.

Effectiveness of COVID-19 Vaccines:

The narrative in the United States and countries around the world is that the continued surge of new Covid-19 cases is driven by areas with low vaccination rates. These researches investigate the relationship between the percentage of population fully vaccinated and new COVID-19 cases across 68 countries and 2947 US counties.

- Subramanian, S.V. and Kumar, Akhil, "Increases in Covid-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States," *European Journal of Epidemiology,* September 30, 2021.
  Results:
  - "The trend line suggests…**a positive association such that countries with higher percentage of population fully vaccinated have higher COVID-19 cases per 1 million people. Israel with over 60%...fully vaccinated had the highest COVID-19 cases per 1 million people."**
  - These findings are further shown in that Iceland and Portugal both have over 75% fully vaccinated and have more COVID-19 cases per 1 million people than countries such as Vietnam and South Africa that have around 10% vaccination.
  - In the US, for the top 5 counties that have the highest percentage of population fully vaccinated, the CDC identifies 4 of them as high transmission counties. Of 57 counties

that are “low” transmission by the CDC, 15 have percentage of population fully vaccinated below 20%.

Interpretation

- “**Sole reliance on vaccination as a primary strategy to mitigate COVID-19…needs to be re-examined.”**
- **“Other pharmacological and non-pharmacological interventions may need to be put into place…such course correction…becomes paramount with emerging scientific evidence on…effectiveness of the vaccines.”**
- For example, in Israel a report now shows the Pfizer vaccine effectives went from 96% in trial to 39%.
- “It is also emerging that immunity derived from the Pfizer-NioNTech vaccine may not be as strong as immunity acquired through recovery from COVID-19 virus.
- “A substantial decline in immunity from mRNA vaccines 6-months post immunization has also been reported.”
- Lastly, “the CDC reported an increase from 0.01 to 9% and 0 to 15.1% (between January to May 2021) in the rates of hospitalizations and deaths, respectively, amongst the fully vaccinated.”

Barnstable, Massachusetts

Morbidity and Mortality Weekly Report (MMWR) is released by the CDC as a series of reports for the “agency’s primary vehicle for scientific publication of timely, reliable, authoritative, accurate, objective, and useful public health information and recommendations.” The MMWR dated August 6, 2021 was released from the CDC containing the following, “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.” Thus, one can observe breakthrough infections as reported by CDC data concerning Barnstable, MA and the COVID-19 vaccines not being able to prevent infection of SARSCoV-2 as fully hoped for.

The Lancet

Gunter Kampf describes in the commentary, “Recent data, however, indicated in the UK that secondary attack rates among household contacts exposed to fully vaccinated index cases was similar to household contacts exposed to unvaccinated index cases (25% for vaccinated vs 23% for unvaccinated). 12 of 31 infections in fully vaccinated household contacts (39%) arose from fully vaccinated epidemiologically linked index cases…In Germany, the rate of symptomatic COVID-19 cases among the fully vaccinated…is reported weakly since 21 July 2021 and was 16.9% at that time among patients 60 years and older. This proportion…was 58.9% on 27 October 2021…a similar situation…described in the UK…Between week 39 and 42, a total of 100, 160 COVID-19 cases were reported…citizens of 60 years or older…89, 821 occurred among the fully vaccinated (89.7%), 3, 395 among the unvaccinated (3.4%)…**CDC identifies four of the top five counties with the highest percentage of fully vaccinated population (99.9-84.3%) as “high” transmission counties.” “Many decisionmakers assume that the vaccinated can be excluded as a**

source of transmission. It appears to be grossly negligent to ignore the vaccinated population as a possible and relevant source of transmission when deciding about health control measures."

Swedish Study

Nordstrom, Peter, et al. "Effectiveness of Covid-19 vaccinated against risk of symptomatic infection, hospitalization, and death up to 9 months: a Swedish total-population cohort study," *Covid Strategies,* October 29, 2021. (preprint)

- The investigators utilized Swedish nationwide registries to analyze data that included individuals vaccinated with at least one dose of any Covid-19 vaccines up to May 26, 2021. The investigators found the Covid-19 vaccines wane in effectiveness over time. For example, **Pfizer's vaccine started with 92% effectiveness but by month 4 waned to 47%. After 6 months, no effectiveness observed. Moderna's vaccine waned somewhat slower as it was 59% effective by 6 months.**

Natural Immunity vs. Vaccine Induced Immunity

Research is being conducted to show that natural immunity does occur when infected with SARS-CoV-2. Below is a sample of such research.

Le Bert, N., Tan, A.T., Kunasegaran, K. *et al.* "SARS-CoV-2-specific T cell immunity in cases of COVID-19 and SARS, and uninfected controls." *Nature*, July 15, 2020.

- These researchers studied "T cell responses against the structural (nucleocapsid (N) protein) and non-structural…regions of SARS-CoV-2 in individuals convalescing from COVID-19….in all of these individuals, **we found CD4 and CD8 T cells that recognized multiple regions of the N protein**. Next, we showed that patients who recovered from SARS possess long-lasting memory T Cells that are reactive to the N protein of SARS-CoV 17 years after the outbreak of SARS in 2003**. These T cells displayed robust cross-reactivity to the N protein of SARS-CoV-2."**

Le Bert, Nina, et al. "Highly functional virus-specific cellular immune response in asymptomatic SARS-CoV-2 infection," *Journal of Experimental Medicine,* March 1, 2021.

- These researches state **"asymptomatic SARS-CoV-2 infected individuals are not characterized by weak antiviral immunity; on the contrary, they mount a highly functional virus-specific cellular immune response."**

Israel, Ariel, et al. "Large-scale study of antibody titer decay following BNT162b2 mRNA vaccine or SARS-CoV-2 infection

- 2, 653 individuals fully vaccinated by 2 doses of vaccine and 4, 361 convalescent patients were included and were studied to determine the antibody titer levels over time
- **Conclusion: Individuals who received the Pfizer vaccine had higher initial levels of antibody titers, but had a much faster exponential decrease in antibody titers compared to unvaccinated individual**

Reasonable Alternative Treatments: the current method of diagnosing an individual with COVID-19 is via an antigen or molecular test. As with any diagnostic test, there is the risk of both false positives and false negatives. Neither the antigen nor the RT-PCR test can detect live virus nor determine a causal relationship between the virus fragments and the symptoms in the individual. In addition, the currently

used antigen and RT-PCR test do not have the ability to determine if an individual with a positive result is infectious.
"As things stand, a person who tests positive with any kind of test may or may not have an active infection with live virus, and may or may not be infectious."

In 2020, individuals with a positive COVID test were told there was no treatment; however, at this time that is no longer the case. There are many doctors who are actively treating patients with successful protocols using a combination of drug and supplement therapies. We would like to highlight the repurposed drug Ivermectin. Ivermectin has been unjustly censored by the media here in the United States but has been an FDA approved drug for decades. In the United States approximately 25% of all prescriptions filled per year are repurposed drugs that are used off label. Of note is the widespread use of Ivermectin in Japan instead of recommendation of a booster.

As previously discussed in this paper, a correlation between low Vitamin D and poor COVID-19 outcomes has been discussed and widely studied over the past 18 months. In addition, the negative effect of Vitamin D deficiency on our immune system's ability to fight off seasonal respiratory infections has been discussed for years. Recently, studies have been published concluding that monitoring and supplementing Vitamin D3 levels is critical in the treatment of COVID-19.

This link takes you to a "living document" that is updated regularly. All the treatments that have been used to treat COVID-19 are listed with the corresponding data such as the number of studies, the effectiveness, and the cost of the treatment.

Risks of Alternative Treatments: the safety profile for the repurposed drugs utilized in the FLCCC protocol, the AAPS protocol, and the C19early site are well documented and include populations that Pfizer did not include in their clinical trials; namely, pregnant and lactating women. For example, Hydroxychloroquine and Ivermectin are well tolerated medications.

Assessment of the Patient's Understanding of the Previous Aspects of Informed Consent: this component of Informed Consent necessitates a CONVERSATION between a health care provider and the patient where questions can be posed by the patient.

In conclusion, we are concerned that the Informed Consent conversation is not occurring sufficiently in our communities. Specifically, community members are not adequately informed about all aspects of the COVID situation such that the criterion for Informed Consent is NOT being met for any and all diagnostic tests, preventative treatment protocols, outpatient treatment protocols, hospital-based treatment protocols, and vaccines. Indeed, informed consent is intended to provide the opportunity to educate a patient on the treatment modalities available in order to obtain consent for the patient's choice. Informed consent does not, and cannot occur, when a treatment is mandated and imposed. We are concerned that members of our community do not have the freedom to choose the medical intervention for themselves and for their loved ones.

We hope medical practitioners and policy makers will reevaluate future COVID-19 policy and treatments, taking into account the concerns related above. Many highly trained medical practitioners are currently treating COVID-19 infected patients on an outpatient basis with great success using previously FDA cleared medications repurposed for the task at hand; making patients healthy again. It is interesting to see the low cost and historical safety profile of repurposed medications such as Ivermectin, Hydroxychloroquine and Povidone Iodine have been vilified while, the very high cost and lack of effectiveness of Remdesivir, Molnupiravir, Casirivimab, or Paxlovid have been applauded for use.

The FDA receives 45% of its budget from and the CDC receives 50% of its budget from the pharmaceutical industry, and the NIH holds multiple patents for vaccines. It is challenging to believe that these agencies can distance themselves from the fact that they receive funding from the very entity they are supposed to be regulating. The FDA, CDC, and NIH do not have the authority to tell physicians how to treat patients. Physicians should have the autonomy to treat patients utilizing their education and clinical experience utilizing appropriately prescribed FDA approved medications. It is our hope regulatory agencies, policy makers, and media outlets will give these practitioners the fair opportunity to share what they have learned with the public, and in essence, allow the doctor-patient relationship to flourish unimpeded by biases from researchers or the pharmaceutical industry.

Ethics

"The rights of every man are diminished when the rights of one man are threatened."

--John F Kennedy Jr

This section is focused on addressing the flaws in the ADA Ethics of Vaccination white paper.

We hereby submit that dentists should not provide vaccinations to the community. This should remain the primary responsibility of the patient's healthcare provider. The cavalier approach to mass vaccination of any kind needs more discussion and borders on malpractice. Dentists are not trained in vaccination administration, intervals, complications, dosing, etc. If dentists were to become vaccine providers, they should receive annual training and testing on all vaccines. Patients often come to dentists and have no medical care providers. Who will treat the patient if they have an adverse reaction? Will the dental patients begin to assume that dentists are the medical provider? It is ironic that the ADA states that the basis for recognition of dental specialties is to "protect the public, nurture the art and science of dentistry and improve the quality of care." Each dental specialty is carefully guarded against intrusion from non-specialists and, yet, the ADA supports the insertion of dentists into the arena of vaccination without any training on administration or adverse reactions. This does not appear compatible with protecting the public or improving the quality of care.

We agree with the mission statement offered by The Council on Ethics, Bylaws and Judicial Affairs (CEBJA), an ADA agency, whereby "the ADA agency dedicated to enhancing the ethical conscience of dentists by promoting the highest moral, ethical and professional standards in the provision of dental care to the public." In reading the Ethics of Vaccination, we believe only one side of each issue has been presented; therefore, the paper fails to adhere to the CEBJA's mission statement. We recommend that the ethics statement offer a broader scope of the ethical considerations which in turn will allow for a greater debate and encourage better scientific studies.

Relevant to this discussion is understanding the definitions utilized throughout the ADA paper. We argue that relevant definitions are partially applied. Also there exists a current controversary about changes to definitions in attempts to justify mass vaccination. Notably the ADA has conformed to these new definitions in support of its conclusions. In Appendix A, we have provided definitions that have guided our discussion. Appendix A includes the definitions for medical autonomy, non-maleficence, beneficence, justice and veracity. Appendix B includes several examples of definition changes from three different sources written at different points in time. The terms included are ethics, immunity, vaccine, vaccination, and misinform.

The Introduction

"Vaccination is designed to protect not only the person inoculated but also to protect the public through 'herd immunity'. When enough people are vaccinated against a certain disease, the germs can't travel as easily from person to person – the entire community is less likely to get disease." We agree. Bearing this definition in mind, we encourage the ADA to change the definition of the COVID-19 vaccine to the "COVID-19 therapeutic." A therapeutic is defined as "of or relating to the medical treatment of a disease or condition." This vaccine does not confer immunity as originally hoped; therefore, it is not a vaccine. We also believe herd immunity should include natural immunity.

We ask that you retract that section in the parenthetical statement “especially vaccine-preventable diseases including COVID-19”. The efficacy of the COVID-19 vaccines was thought to be greater than 95% relative risk reduction and a less than 1% absolute risk reduction; however, the efficacy has dropped in many cases to below 50%. The COVID-19 vaccine may lessen symptoms, but it does not prevent transmission or acquisition of the virus. Outbreaks with COVID-19 have recently occurred on cruise ships and military vessels where all people were vaccinated. This emphasizes the point that the current COVID-19 vaccine is mislabeled and should properly be called a therapeutic for the Alpha and Delta SARS CoV-2 virus.

Autonomy

We believe a dentist’s responsibility is to educate the patient about the problems that exist and the different options for treatment in order for the patient to determine, without the doctor’s bias, his or her own care. In order to make an autonomous decision the dentist must provide all aspects of informed consent as indicated on Page 3 “information about the risks, benefits, and alternatives to vaccination must be provided.” We agree. If a dentist were to administer vaccines, they should be able to explain to the patient what is in the vaccine, how it works, possible adverse reactions and treatment alternatives; then, the patient can make an autonomous decision about the vaccine.

We believe that respect for patient autonomy, a foundational principle in medical ethics, guided by the process of informed consent through which, it is hoped, patients’ wishes are acknowledged and executed.

1. **Risks**--Patients should receive a comprehensive list of the risks and adverse reactions. When advising patients on COVID-19 vaccinations patients should know that the likelihood of developing an adverse reaction to the vaccine is greater than the mortality from COVID-19 disease. Evidence of different risks can be found here, here , here and here. Comorbidities should be discussed. Additionally, the patient should be aware that the data may be skewed because underreporting of adverse reactions and overreporting of COVID-19 deaths. We take issue with the ethical violations of false reporting.

   In order for the patient to be properly informed, the dentist should advise the patient that all the ingredients in the vaccine are not known and that Pfizer has 75 years to publish the study and the associated adverse reactions. Would this be okay in the dental profession regarding the materials and drugs we use? We are required to maintain Material Safety Data Sheets on every material/drug. Should dentists not be required to keep a list of the vaccine ingredients on file in the office in the advent of an adverse reaction?
2. **Benefits**--The benefit of this vaccine is its potential to stimulate an immune response in the form of antibodies to a designated isotope on the spike protein. When exposed to the virus, if the vaccine is successful, the symptoms may be lessened or avoided entirely. This vaccine does not guarantee that a person will respond to another variant or prevent them from getting infected. This is unlike traditional vaccines and natural immunity where antibodies are created to multiple regions on the pathogen thus offering broader immunity. Natural immunity can occur with or without the presence of antibodies. As a human race we have survived thousands

of years with only natural immunity. A retrospective study evaluated over 49,000 patients and found that those with reported prior infections have a less than 1% re-infection rate. In making an autonomous decision, the patient should understand that the vaccine benefits the individual only and is dependent on its effectiveness against the current variant.

3. **Alternatives**--There are known alternatives to preventing COVID-19. Preventative measures, in the way of diet, exercise and supplements with Vitamin D, Vitamin C, and Zinc, have been sparse, if present at all, in the Public Health messaging. Please see the treatment protocol developed by many physicians including one of the foremost physicians and researchers in this area, Dr. Peter McCullough. The CDC's website listed Ivermectin as the 2nd recommended treatment but it has been suspiciously removed, a PDF of this document, dated 11/29/21, is included. Again, natural Immunity must be considered, to ignore this as an option is to disregard this God-given system in its entirety. It is discriminatory. Tests exists to detect natural immunity and this should be discussed; from antibody test to T-cell (T-Detect) test. A living document exists of 141 studies on natural immunity.

Nonmaleficence

In regard to the statement, "the dentist's primary obligations include keeping knowledge and skills current,'" we agree. We argue, however, that the majority of dental professionals are not current with the COVID-19 vaccine studies including the risks, benefits and alternatives to the vaccine. Dentists did not go to school to understand vaccine/drug interaction. Who will train them? What quality controls will be put in place? More importantly, will this detract from providing dental care that is sorely needed? This responsibility should be stay with their physician.

Beneficence

"Mass vaccinations protect the public at large by reducing the prevalence and thus the risk of transmission to others." We disagree. The statement should be corrected to say it protects the individual only. Our question is if COVID-19 vaccination decreases prevalence and risk of transmission then why we are still wearing masks, why are we using an old vaccine made to the Alpha variant, why are we requiring boosters? We strongly disagree with the CDC changing the definition of immunity. This is the equivalent of achieving an outcome in a scientific study then changing the question. Patients should be informed of the definition changes. In September of 2021, in an effort to cover for the lack of immunity offered by the mRNA vaccine (therapeutic), the CDC changed the definition of a vaccine to remove the words "produce immunity" and changed "to protect against." With this changed definition, arguably beneficence has been eliminated.

An unspoken problem with mass vaccinations is the psychological impact. The individual's anxiety arising from getting an adverse reaction must not be downplayed. If beneficence encompasses patient's welfare, then loss of bodily autonomy must be considered. To dismiss this is to dismiss the psychological component of the health and welfare of patients. People are aware that childhood deaths have increased and all-cause deaths have increased. Part of applying beneficence is understanding AND respecting the patients value system, which is highly individual and dependent on a patient's personal

preferences. If they do not value or believe in the vaccine and are forced to receive it, this encroaches on the patient psychology, again beneficence has been eliminated.

Regarding patients not wanting to get a vaccine from a dentist and the dentist's responsibility to the patient, "The dental practitioner still has an opportunity and, in some instances, perhaps a duty, to educate the patient on the safety, efficacy, and urgency of vaccination which benefits the patient and public at large." We find this statement somewhat of a joke in using the language in "some instances." This should read at all times the dentist has the obligation to educate the patient and this includes discussing both positives and negatives. This also includes the problems with mass vaccinations. We believe at all times the dentist should disclose the financial incentives from vaccinating patients and if he/she is part of any research behind the treatment or administration of the vaccine.

Justice

We find this statement irrelevant at this time "With other, less pervasive diseases or those with less morbidity and mortality, the need may be less urgent which, in turn, would affect the ethics of the participating in the program or not." It should be eliminated. We strongly believe that no dentist should deny care to any patient or those bringing the patient based on their vaccine status. We strongly believe that no person should be denied employment based on vaccine status. Employees can waive their rights to Hep B vaccine or a flu vaccine, both of which are more efficacious. Why do we want to violate these liberties especially when treatment is available?

In this section, we believe measles should not be compared to the SARS CoV-2 because it implies to the patient that the vaccines are alike and they are not. One confers immunity and one offers protection. To falsely claim this confuses patients, arguably this should not be considered as part of the justice argument. In regard to this principle "actively seek allies throughout society on specific activities that will improve access to care for all." We have found that unless "you" support the COVID-19 vaccine there is no justice. No discussions on nutraceuticals and therapeutics have been allowed by big pharma, big government and big business. Where is the justice in not giving patients access and education to these options? Third world countries have better access and more success to alternative treatments than we do in the United States.

Veracity

We vehemently agree with the ADA statement regarding dentists' "duty to communicate truthfully". What is the dentist's ethical obligation if patients and/or staff refuse vaccination, including ethical responsibilities to patients/staff who cannot become vaccinated?" Because the COVID-19 vaccine is under an EUA, no one can mandate this trial vaccine. Period. In good conscience, how can a single doctor, politician, public health official or person of authority mandate this, especially when these companies have no liability. The unscrupulous funding and kick-backs between big government, big pharma and big business needs to be challenged. The history should be known. Do we want our small business dental model consumed by these groups? We will no longer be able to communicate with the patients honestly as we as seeing what is happening in medicine.

The TRUTH is that mandating this vaccine violates our Constitutional Rights. This violates the Nuremburg Code (see below). The Nuremberg Code states that no human will be subjected to a medical treatment, experimental or otherwise, without informed consent and his/her expressed will. This violates the Hippocratic Oath – above all do no harm. Why is Pfizer not held to these same codes of ethics? Do they take the Hippocratic Oath? The oath is patient centered. If Pfizer truly has patients' best interest in mind, they would disclose their entire study immediately. In the name of good science, what is there to hide? They've made billions, are they truly concerned with patent infringement? Where is the humanitarian concern with this? Instead, "they" allowed big pharma 55 years to disclose over 390,000 pages, which has been extended to 75 years. Why? This far exceeds the statute of limitation laws. Where is there truth?

Opposing the Mandate

We strongly object to mandates of any kind. If we do not have the freedom and freewill to determine what happens to and with our bodies, we are no different than a caged animal. What we put in our bodies is our choice! French fries are bad for you, wine is bad for you, marijuana is bad for you, multiple sex partners are bad for you; all of these have potential long-term negative sequelae, but we do not mandate that people stop using these items or change their behavior. Arguably these behaviors burden our health system more and over a longer time and some of these behaviors can be harmful to others. Where does mandating stop? Who decides what we do with our bodies?

In the case of medical mandates, medical decisions should be discussed exclusively within the doctor-patient relationship. Increasingly, hospitals, administrators, insurance companies and government are exerting more influence and control over how physicians treat patients. The unprecedented erosion of the doctor-patient relationship should cause all of us to pause and question what it means to be a doctor. If the doctor is prohibited from confidentially treating patients as deemed appropriate, then should not those who are interfering with this private discussion be subject to the same training or lawsuits as the doctor?

In preventing a doctor from treating a patient, the hospitals and the associated administrators, the parties creating the government mandates, the insurance and the pharmaceutical companies and any other entity influencing patient care should be held accountable. "They" all are acting as the doctor and interfering with this very private relationship thereby undermining the autonomy in making a medical decision based on ALL unbiased information presented.

In the case of the vaccine, informed consent is negated because the four elements are not fully satisfied; thus, doctors are forced to breach their ethical obligation to present all evidence. These discussions lack full transparency of likelihood of adverse events from the vaccine as compared to the likelihood of recovery from the virus. Another element that cripples the argument is that doctors are not able to offer off label therapeutics without fear of loss of license. Humans thought the world was flat before learning they were wrong. Humans thought the sun rotated around the earth before learning they were wrong. Humans thought the COVID-19 vaccine would confer immunity before learning they were wrong. Let's elevate the discussion and allow for multiple perspectives. Let's let the doctor and the patient decide what is right for him/her.

Furthermore, mandating vaccines violates body autonomy. The destruction of bodily autonomy is a harm in and of itself. The harm at this junction constitutes both the psychological harm, in the form of vaccination under duress, as well as a spiritual harm. The resultant psychological anguish and spiritual violation precedes the final blow, the recognized physical harm from the potential and unknown short and long-term adverse reactions.

One may argue the physical harm from the vaccine, if minor, is treatable but living with a lifelong anxiety from "what have I done with my body" is not treatable; therefore, takes away our freedom to live with unaltered bodies. The vaccine mandate is an irreversible, coercive policy imposed by non-doctors and violates our sense of self and being. As for the spiritual harm, only the individual is privy to his/her sincerely held beliefs and how this vaccine violates them. By injecting a man-made pathogen into our bodies, we are denying our bodies the use of its natural defense system. Forced vaccination is unconscionable! Having to make a moral decision to support your family or take the falsely labeled and poorly studied vaccine violates bodily autonomy and therefore our freedom and freewill. Arguably there is no choice, we are but slaves to those in power.

The duress from this medical coercion has yet to be acknowledged and validated. Those who are unvaccinated are not putting others at greater risk. But those forcing others to get vaccinated are the creators of a new form of mental health crisis that must be discussed. When will "they" take responsibility for this NEW mental health tragedy? Both the unvaccinated and vaccinated carry the virus and can infect others. This is a fact! Taking away one person's freedom (the right not to be vaccinated) in favor of another's (the perceived right to mandate vaccinations for the good of the public health) is a value constructed on false narratives and poor science. This does not bode well for future freedoms. This creates a class stratification as it pertains to the value levels of freedom; therefore, is discriminatory. The mandatory vaccination discriminates against the natural biological response; it does not allow for natural immunity to be recognized.

The risk of illness from SARS CoV-2 is real, the risks from vaccine harm is real, the risks of loss of bodily autonomy, thus self-worth, is real. Whose risk is greater? The individual should decide the risk they are willing to take.

The argument that dentists must be vaccinated because we are in a healthcare setting and have an ethical obligation to our patients is a failed and flawed argument. How can we boast about having little to no transmissions to our patients, staff and family during 2020 when the vaccine was not available and now turn around and say we must be vaccinated? This negates our success in management of airborne diseases. Arguably, all medical professions should use the dental profession as an example, we did not have outbreaks in dental offices when SARS CoV-1, H1N1, and HIV were pandemics. We can and should be leaders in this environment.

Lockdown or Liberty

"Those who can give up essential liberty to obtain a little temporary safety, deserve neither liberty nor safety."

--Benjamin Franklin

To understand our collective objection to the lockdowns, restrictions, and the forced closure of schools, businesses, and houses of worship over the course of the pandemic, one must look at these actions through the eyes of our nation's founding fathers. They understood that this nation could and would succeed when freedom reigned and abuses from those in leadership were stymied, by only allowing a limited government. They would, just as we do now, consider these actions to be abuses of power, because government officials, particularly those who are unelected, effectively removed the individual's right to all the promises guaranteed by the Constitution of the United States. Indeed, the restrictions and interventions now imposed upon the citizens of this Country are akin and parallel to the very grievances so eloquently catalogued in the Declaration of Independence. The threat and issuance of mandates by the federal government and restrictions on individual freedom is precisely the focus of concerns raised by the founders of this nation in the Federalist Papers.

These documents laid the foundation for what would be an experiment of how a common man could prosper if given equal footing and equal guarantees of individual rights. That experiment led to the building up of the greatest nation this earth has ever witnessed. A common man could become uncommonly successful because he was unleashed, unchained, and free to do as he pleased to better his own station in life. Conversely, we see how progress and individual success is stifled when the government usurps the power and rights given to individuals. This nation is a Constitutional Republic, a democratic government, but not a democracy. Majority rule cannot, and should not, overrule the guarantee of individual rights. However, throughout the pandemic, we have seen and have been negatively affected by excessive, unnecessary, ineffective, and illegal abuses of power by government officials at the local, state, and federal levels. We have gone from a nation of citizens, to a nation of subjects, under totalitarian rule.

Thomas Jefferson, when writing the reasons for declaring independence from England, penned the words that laid the foundation for individual rights… **"We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are Life, Liberty and the pursuit of Happiness."** These rights belong to men, not governments or government officials! Thomas Jefferson listed abuses of power by **"the present King of Great Britain" (King George)… "declaring themselves invested with power"**, **"erected a multitude of New Offices, and sent hither swarms of Officers to harass our people, and eat out their substance"**, and then said we should resist when he wrote **"when a long train of abuses and usurpations, pursuing invariably the same Object evinces a design to reduce them under absolute Despotism, it is their right, it is their duty, to throw off such Government."** Thomas Jefferson was addressing King George of England, but we could change the name and list our government leaders here as well. History is repeating itself.

As healthcare providers, business owners, and licensed professionals, we are obligated to the patients whom we serve, our families for whom we provide, and those who lead our profession and licensing boards (as agents of the government). The first two obligations go hand in hand and we understand that one enhances the other, mutually. The last obligation, to our profession and licensing boards, must not go against the obligations to our patients, to our families, and it must not diminish or do away with our individual autonomy. If the obligation to our profession and licensing board does any of those, it must be thrown off as a matter of duty and virtue. With lockdowns, restrictions, and the forced closure of our businesses, our patients suffered from lack of care, our families suffered from lack of income and stability, and our profession suffered (and is suffering) from lack of credibility because our leaders have not stepped up to refute the junk science and abuses of power that have negatively affected us, the people they claim to represent. We are now stepping up, as a group of healthcare providers, to resist and **"throw off such Government"** as Thomas Jefferson penned in the Declaration of Independence.

While we are not calling for a revolution to overthrow the government, we are calling for a recognition of the abuses of power that have negatively affected all of us during the course of the pandemic, and which continue with unlawful mandates and personal restrictions. We are also calling for a repeal of all Executive Orders and power grabs that have succeeded to trample the individual rights guaranteed to us as citizens. These unlawful power grabs, enacted under **"Emergency Use Authority"** to **"protect"** us, have a tendency to live on in perpetuity if we, the people, do not stand up and fight for the rights that have been taken away from us. John Adams wrote that **"Liberty, once lost, is lost forever."** We are standing in the gap, united, to secure the rights and freedoms that are guaranteed us, to ensure that our liberty is maintained and not lost to be forgotten, for ourselves and for those who will come after us. It is our duty, honor, and obligation to do this in order to **"secure the Blessings of Liberty to ourselves and Our Posterity"** as written in the Preamble to the United States Constitution.

Conclusion

"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

--Margaret Mead

In conclusion, as we have known for years, prevention and early treatment are key to any human condition. Ample research, readily available to contradict the narrative, was available to speak truth and offer proper education to our patients and our families. Specifically, we know that the replication of a respiratory virus can lead to a series of deleterious impacts on the human body. Recommending historically well-known and studied therapeutics to our patients could have been an active role we, as dentists, were playing to benefit our patients and the society at large. The ADA could have encouraged the simple use of Vitamin C, D, Zinc and Quercetin, over the counter therapeutics with excellent safety profiles. We could have been instructed to recommend serum Vitamin D3 blood levels to our patients by their providers as an effort to minimize severe disease. Instead, the ADA was silent! The organization we pay to lead and offer optimal care to our patients spoke not a word as we erased historical knowledge and advocated for the useless wearing of a cloth mask to our patients.

Meanwhile the ADA supported the stay-at-home efforts that will take years to understand the full scope of the harms caused by keeping kids out of school and not socializing with their peers. We have been encouraged to promote a novel therapy with no long-term safety data (which will not be disclosed for 75 years), produced by companies shielded from all liability and completely obfuscating our duty to provide informed consent. For those of us in this field since the AIDS epidemic, we are watching the ADA turn its back on ethical treatment practices and standing by while doctors refuse to treat those who have exercised their right to informed consent and remain unvaccinated for a myriad of reasons that have been discussed in our paper.

History will judge this to be medicine/dentistry's darkest hour. There is ample evidence for the ADA to provide its constituents well rounded research and change the trajectory of our profession. Will we be known for the prevention of true scientific discovery and an accomplice to the medical establishment's worst atrocities in our lifetime? Or will the ADA consider the ever-growing number of dentists that understand the medical freedom movement and change course to preserve the integrity of the institution amongst dental professionals and the society we serve.

Resources

Opening

https://www.aier.org/wp-content/uploads/2020/05/10.1.1.552.1109.pdf

Masks

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https://ashmedai.substack.com/p/facemasks-are-not-an-inconvenience?token=eyJ1c2VyX2lkIjo0ODIwNjE2NCwicG9zdF9pZCI6NDU3NjQyOTMsIl8iOiJOMWQ1VilsImlhdCI6MTY0MDgwNTcyOCwiZXhwIjoxNjQwODA5MzI4LCJpc3MiOiJwdWItNDcxNjY1Iiwic3ViIjoicG9zdC1yZWFjdGlvbiJ9._TMKIoe5c4uvW-KKuv7_4VwfTNaQArYcWQP5n0CcEzU

Early Treatment

Vitamin D

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https://www.mdpi.com/2072-6643/12/11/3361/htm

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https://www.mdpi.com/2072-6643/13/10/3596/htm

https://pubmed.ncbi.nlm.nih.gov/34836309/

https://www.grassrootshealth.net/blog/review-vitamin-d-immune-health/#covid

Vitamin C

https://pubmed.ncbi.nlm.nih.gov/29099763/

https://pubmed.ncbi.nlm.nih.gov/33638944/

Zinc

https://www.frontiersin.org/articles/10.3389/fimmu.2020.01736/full

Melatonin

https://www.chronobiology.com/melatonin-chronobiology/melatonin-history/

https://journals.plos.org/plosbiology/article?id=10.1371/journal.pbio.3000970

https://www.sciencedirect.com/science/article/pii/S1201971221007980

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Quercetin

https://journals.asm.org/doi/10.1128/JVI.78.20.11334-11339.2004

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Ivermectin

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https://journals.plos.org/plospathogens/article?id=10.1371/journal.ppat.1001176

https://principia-scientific.com/the-american-journal-of-medicine-now-recommends-hcq-for-covid19/

https://hcqmeta.com/

Informed Consent

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https://globalcovidsummit.org/news/watch-talks-from-leading-physicians-at-the-florida-covid-summit

https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8481107/

https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(21)00258-1/fulltext?s=08#%20

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https://www.ahajournals.org/doi/10.1161/circ.144.suppl_1.10712

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https://phmpt.org/wp-content/uploads/2021/11/5.3.6-postmarketing-experience.pdf

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https://pubmed.ncbi.nlm.nih.gov/15507655/

https://www.nature.com/articles/s41564-020-00789-5

https://pubmed.ncbi.nlm.nih.gov/33113270/

https://pubmed.ncbi.nlm.nih.gov/34443589/

https://pubmed.ncbi.nlm.nih.gov/32785649/

https://brownstone.org/articles/pcr-tests-and-the-rise-of-disease-panic/

https://www.bmj.com/content/371/bmj.m4851

https://covid19criticalcare.com/covid-19-protocols/

https://aapsonline.org/covidpatientguide/

https://journals.lww.com/americantherapeutics/fulltext/2021/06000/review_of_the_emerging_evidenc

https://freewestmedia.com/2021/11/03/japan-sees-huge-drop-in-cases-after-it-switches-to-ivermectin/

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Ethics

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https://childrenshealthdefense.org/fauci_info/

The Nuremberg Code

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to

exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved, as to enable him to make an understanding and enlightened decision. This latter element requires that, before the acceptance of an affirmative decision by the experimental subject, there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person, which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.
3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study, that the anticipated results will justify the performance of the experiment.
4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
5. No experiment should be conducted, where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.
6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.
8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.
9. During the course of the experiment, the human subject should be at liberty to bring the experiment to an end, if he has reached the physical or mental state, where continuation of the experiment seemed to him to be impossible.
10. During the course of the experiment, the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgement required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

[“Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10”, Vol. 2, pp. 181-182. Washington, D.C.: U.S. Government Printing Office, 1949.]

Appendix A

Autonomy

The right of patients to make decisions about their medical care without their health care provider trying to influence the decision. Patient autonomy does allow for health care providers to educate the patient but does not allow the health care provider to make the decision for the patient.

Nonmaleficence

A term in medical ethics that derives from the ancient maxim primum non nocere, which, translated from the Latin, means first, do no harm. The principle of nonmaleficence directs physicians to do no harm to patients. Physicians must refrain from providing ineffective treatments or acting with malice toward patients.

Beneficence

Requires healthcare professionals to take actions that benefit others, providing for their good. It requires compassion and understanding of the patient's value system: determination of "good" is highly individual and dependent on each person's preferences.

Justice

In the context of medical ethics - is the principle that when weighing up if something is ethical or not, we have to think about whether it's compatible with the law, the patient's rights, and if it's fair and balanced

Veracity

As defined as being honest and telling the truth and is related to the principle of autonomy. It is the basis of the trust relationship established between a patient and a health care provider. Patients are expected to be truthful about their medical information.

APPENDIX B

Below is a list of definitions from different dictionaries and different time periods. For comparison, the textbook definitions from the American Heritage Dictionary were compared to the online definitions, as December 2021, of both the American Heritage Dictionary and the Merriam-Webster dictionary. The issue with online dictionaries is that no clearly defined time is identified when the definition is changed

or updated vs a book which shows the original publication date and copyright. Of interest, is how the Merriam-Webster online dictionary has changed the definitions to fit the narrative to conform with that of mainstream media. We challenge both the ethics of this and accuracy of the definitions.

Ethics (The American Heritage Dictionary) 1985

1. A principle of right or good conduct
2. A system of moral principles or values
3. The study of the general nature of morals and of the specific moral choices to be made by the individual in his relationship with others
4. The rules or standards governing the conduct of the members of a profession

Ethics (The American Heritage Dictionary) online 2021

1. A set of principles of right conduct.
2. A theory or a system of moral values: An ethic of service is at war with a craving for gain(Gregg Easterbrook).
3. ethics (used with a sing. verb) The study of the general nature of morals and of the specific
4. moral choices to be made by a person; moral philosophy.
5. ethics (used with a sing. or pl. verb) The rules or standards governing the conduct of a person or the members of a profession: medical ethics.

Ethics (Meriam-Webster Online Definitions) 2021

1. plural in form but singular or plural in construction: the discipline dealing with what is good and bad and with moral duty and obligation
2. a set of moral principles: a theory or system of moral values the present-day materialistic ethican old-fashioned work ethic—often used in plural but singular or plural in construction of elaborate ethics

Immune (The American Heritage Dictionary) 1985

1. Exempt or not affected or responsive
2. Having immunity

Immune (The American Heritage Dictionary) online 2021

1. (a)Not subject to an obligation imposed on others; exempt: immune from being eliminated in a contest.
1. (b) Having legal immunity: immune from taxation.
2. Not affected by a given influence; unresponsive: immune to persuasion.
3. Of or relating to immunity or an immune response.
4. Having resistance to a specific pathogen.
5. Having or producing sensitized antibodies or lymphocytes that react to specific antigens: immune serum.

Immune (Meriam-Webster Online Definitions) online 2021

1. not susceptible or responsive immune to all pleas especially: having a high degree of resistance to a disease immune to diphtheria
2. a. produced by, involved in, or concerned with immunity or an immune response immune agglutinins immune globulins
   b: having or producing antibodies or lymphocytes capable of reacting with a specific antigen an immune serum

Misinform (The American Heritage Dictionary) 1985

1. To give wrong or inaccurate information to

Misinform (The American Heritage Dictionary) online 2021

1. To provide with incorrect information.

Misinform (Meriam-Webster Online Definitions) online 2021

1. To give incorrect or misleading information to (someone): to inform (someone) wrongly

Vaccination (The American Heritage Dictionary) 1985

1. Inoculation with a vaccine in order to produce immunity to a disease, such as smallpox
2. A scar left on the skin by vaccinating

Vaccination (The American Heritage Dictionary) online 2021

1. Inoculation with a vaccine in order to protect against a particular disease.
2. A scar left on the skin by vaccinating.

Vaccination (Meriam-Webster Online Definitions) online 2021

1. the act of vaccinating

2. the scar left by vaccinating**.** Examples of vaccination in a Sentence. Recent Examples on the Web. That means continuing to push for higher vaccination rates, abiding by social-distancing

guidelines and wearing masks, among other measures, said WHO Regional Emergency Director Dr. Babatunde Olowokure

Vaccine (The American Heritage Dictionary) 1985

1. A suspension of attenuated or killed microorganisms, as of viruses or bacteria, incapable of inducing severe infection but capable when inoculated of counteracting the unmodified species
2. A vaccine prepared from the cowpox virus and inoculated against smallpox

Vaccine (The American Heritage Dictionary) online 2021

1. A preparation of a weakened or killed pathogen, such as a bacterium or virus, or of a portion of the pathogen's structure, that is administered to prevent or treat infection by the pathogen and that functions by stimulating the production of an immune response.
2. A preparation from the cowpox virus that protects against smallpox when administered to an individual.

Vaccine (Meriam-Webster Online Definitions) online 2021

1. a preparation that is administered (as by injection) to stimulate the body's immune response against a specific infectious agent or disease: such as
2. an antigenic preparation of a typically inactivated or attenuated pathogenic agent (such as a bacterium or virus) or one of its components or products (such as a protein or toxin)a trivalent influenza vaccine, oral polio vaccine. Many vaccines are made from the virus itself, either weakened or killed, which will induce antibodies to bind and kill a live virus. Measles vaccines are just that, weakened (or attenuated) measles viruses.— Ann Finkbeiner et al. A tetanus toxoid-containing vaccine might be recommended for wound management in a pregnant woman if [greater than or equal to] 5 years have elapsed.— Mark Sawyer et al. In addition the subunit used in a vaccine must be carefully chosen, because not all components of a pathogen represent beneficial immunological targets.— Thomas J. Matthews and Dani P. Bolognesi
3. a preparation of genetic material (such as a strand of synthesized messenger RNA) that is used by the cells of the body to produce an antigenic substance (such as a fragment of virus spike protein). Modernas coronavirus vaccine works by injecting a small piece of mRNA from the coronavirus that codes for the virus; spike protein. … mRNA vaccine spurs the body to produce the spike protein internally. That, in turn, triggers an immune response.—Susie Neilson et al. The revolutionary messenger RNA vaccines that are now available have been over a decade in development. … Messenger RNA enters the cell cytoplasm and produces protein from the spike of the Covid-19 virus.— Thomas F. Cozza Viral vector vaccines, another recent type of vaccine, are similar to DNA and RNA vaccines, but the virus genetic information is housed in an attenuated virus (unrelated to the disease-causing virus) that helps to promote host cell fusion and entry.— Priya Kaur

   NOTE: Vaccines may contain adjuvants (such as aluminum hydroxide) designed to enhance the strength and duration of the bodies immune response.

4. a preparation or immunotherapy that is used to stimulate the body's immune response against noninfectious substances, agents, or diseases. The U.S. Army is also testing a ricin vaccine and has reported success in mice.— Sue Goetinck Ambrose. Many of the most promising new cancer vaccines use dendritic cells to train the immune system to recognize tumor cells.— Patrick Barry