TRANSCRIPT: Pierre Kory's Video Responses to My Questions About His Spring 2020 COVID-19 Experience

FEB 14, 2024

I transcribed the three videos Dr. Pierre Kory sent me in response to observations I made & questions I posed about his spring 2020 experiences with COVID-19 in Madison, Wisconsin, and New York City.

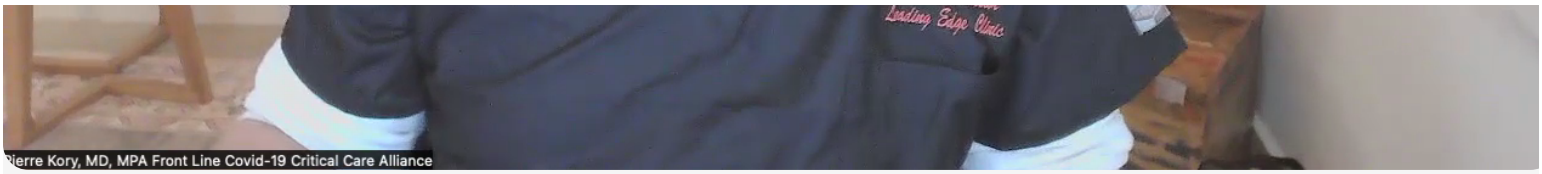
I used quotation marks to denote Dr. Kory reading from what I asked him. The topics ***bold typeface*** *is signposts for the reader that attempt to objectively summarize what Dr. Kory is addressing.*

My next post in this series will be an analysis of what Dr. Kory said. Insights and questions about the substance of his responses are welcome in the Comments.

Regarding English-language conventions, I tried to make choices that best reflected the tone, tempo, and style of the speaker.

Readers can email corrections or feedback about the transcript to WoodHouseSub@proton.me.

VIDEO 1



All right. So, since you wrote very nicely, I guess I have a few minutes, I'll take the time to answer these questions. Although, I gotta tell you I'm pretty exhausted with this topic and this discussion, but all right. You were nice. I'll try to be nice back. Cause you seem to honestly want to know more detailed information that's somehow gonna help you.

PREPARING FOR COVID. All right, so. Question number one. "Before the federal emergency, first four months of 2020" I was...preparing the hospital for an onslaught of COVID patients. Starting in, like, February. You know, when we started hearing reports of like New York and Seattle, um, I spent probably six weeks with administrative and clinical leadership developing processes and things about PPE and running IV tubing through the walls and externalizing ventilator controls [so] that we didn't have to go in and out of the rooms.

COVID PATIENTS, The first few patients started arriving in early April. I was heavily involved in evaluating and treating those patients. And like I said before, they were clotting like crazy, they were really hypoxic, um, really sick. We saw a lot of kidney failure. And like I said, lots of similar cat scans.

FLU SEASON. Then you asked me about the 2019 flu season. I don't pay attention to flu seasons. I'm an ICU doctor. I never see flu in the ICU. I mean, my *entire* career I've seen flu like four or five times. And I think three of the four were pregnant. So I don't know what a severe flu season - that's for epidemiologists and people out in the community. But in the ICU, there's no such thing as a flu season. I just don't see a lot of flu in the ICU.

EVALI/VAPING. EVALI cases. They were definitely reported in Wisconsin, generally in young kids. I mean I didn't see any - nobody in my ICU - I think, uh, actually my ex-wife is a ICU doctor, was on my service. I think she had one case of a kid on a vent from vaping. But I don't remember seeing any patients in the ICU with vaping. But I know there were a few of them that got quite sick around that time.

GUIDANCE FOR COVID PREP. "What/whose guidance were you following for preparing the hospital for COVID-19 patients?" Um, we were just using what we thought was the most efficient way to care for patients with a highly transmissible disease. We were making negative pressure rooms. We were cohorting. We made a COVID unit, which we repurposed. We tried to add beds. But there was no guidance for preparing. We were just getting ready for an onslaught of patients. I was on the phone every day with ICU directors in New York who were telling me how hammered they were getting. They were running out of ICU beds in rooms.

NOT ONLY NEW YORK. And by the way, you guys keep looking at mortality data in New York as if mortality in New York was such a unique thing. Um, other cities got hit hard too. I don't know the mortality data. But I know clinically, on the ground...I mean, I had a fellow calling me in the middle of the night in like, I was still in Wisconsin. It was probably April, early April, in Detroit. And he was freaking out cause he had 50 people on ventilators he was trying to manage. They had just split a ventilator in the operating room cause they were down to their last vent. And he was trying all sorts of maneuvers on these patients and nothing was working. And was literally calling me for help. I yelled at him, "Put 'em on corticosteroids," um, which he did, over the objections of the infectious disease doctors. But um...Oh and Seattle got hit really hard. We were hearing stuff out of Seattle and New Orleans. I mean, a bunch of cities, the hospitals getting really hit hard.

EXPECTED & OBSERVED SURGE. Okay, B). "During the spring federal emergency,

you frantically prepared for the expected surge of patients. Why was the surge expected?" Cause they were surging everywhere else. We knew it was going to get to us at some point. New York, Seattle, Detroit, New Orleans. Like I was telling you, there was a number of cities and places that were getting hit. And also we were the main medical center in Wisconsin. If there was suddenly going to be a surge of cases in Wisconsin needing ventilators, we knew they were going to come to us.

"Was there a surge?" Actually, that's a fair question. So, I resigned - I left to go to New York April 27. And although we had a lot of, we had quite a number of patients in the hospital with COVID, I don't know if I would call it a surge. I mean, we definitely filled the ICU that we built for COVID. I think that was eight beds.And then we had a little, I think sometime during that month, we started to use the main ICU, which were trying to keep free of COVID. But I wouldn't call that a surge like I was hearing from my colleagues around the country. I would just say that we had a fair amount of COVID, but it wasn't a surge in Wisconsin. At least I don't think so. I left at the end of April though.

COVID SYMPTOMS. "*At what point in time did you begin seeing new patients presenting with symptoms that were new or unusual''?* You guys do *not* want to call it COVID; it's so funny. Yeah, I'm just going to answer the question. We saw them coming in with COVID - the typical classic COVID with the X-rays, the hypoxia, you know, all of it - the respiratory failure. LIke I said, I think that was the first week in April.

COVID TESTING IN HOSPITAL. I don't know when COVID testing began, but it began – we had, we were ready to test when we had our first patient. So, I remember the very first COVID patient coming in. I can't tell you the date. Might have been late March/early April. Um, but the first patient came in with the classic signs and symptoms of COVID tested positive and that was around that time.

"Were all patients who were admitted to the ED and/or as inpatients to the hospital in March and April tested for COVID-19?" The answer would be yes, because they had the tests ready and when they came in with the classic, you know, prodome of a viral illness and then developing hypoxic respiratory failure, yeah they were testing that.

[Pauses to read]

TAKING CARE OF COVID PATIENTS IN MADISON. So did I "attend to COVID patients as well"? Not as the prime–when you're asking about the early weeks, so a lo of those briefings were before our first COVID patient. We were just - it was new policies, protocols, what to do when they arrived. I was working with a therapeutist committee, coming up with a treatment protocol. I got IV Vitamin C on the protocol. But I was not on service taking care of COVID patients, but I was in the unit, with my colleagues, doing ultrasounds. I'm an ultrasound expert, so I was examining them. We were finding clots. I was doing lung ultrasounds. So I was heavily involved. My colleagues were presenting the cases to me and so, like, I knew the case. But I was no personally in charge.

NO SURGE IN MADISON. So, like I said, on question 7, it wasn't, like I wouldn't say it was a *surge*. It wasn't that bad. Like we handled it. We had a lot of backup people in place. And it didn't seem that bad, so I asked permission to leave because I wanted to go to New York.

MADISON PATIENT TYPES. "Whence the patients during the surge? Were they transferred from Nursing Homes?" No, they were coming from the community. I think some came from nursing homes. Most of them were coming from the community. Um "moved from within the hospital"? No, they were really coming from outside. And/or they were transferred. This is something else you have to understand is many places in Wisconsin, when they have a really sick patient, they get air-flighted to us at the

University of Wisconsin in Madison. I would say my ICU in my career there, approximately 50% of patients came from Madison and the rest came from the surrounding region. So when you're asking where they came from, I would say it's probably that same percentage but I don't know for sure. Might have been a little but more came from the region rather than Madison.

NO SURGE IN MADISON. Um, I definitely observed some deaths from COVID, but that was not...yeah...like I said, it wasn't a high number. I wouldn't say that we had a surge in Wisconsin. We were preparing for one. We were ready for one. We had a number of patients with COVID, but it wasn't–it did not, it was not similar to the stuff that I was hearing hitting the cities. Um...

EARLY INTUBATION. So the doctors who wanted to push for early intubation, they were scared because, I would call it a rumor but there was like people were hearing that these patients would suddenly crash and I didn't think that was true. I didn't think pneumonitis would cause a sudden crash. Usually things that cause sudden crashes are like heart attacks and/or huge pulmonary emboli. And they ever did early intubation. They were proposing a protocol of early intubation and I argued strongly against that. I said we're going to follow the same indications that we had always, which is you make the judgment in terms of work of breathing. So we did not do early intubation at the University of Wisconsin - not that I was aware of.

TREATING PATIENTS IN MADISON. "Should this be taken to mean you were successful using these treatments with patients at UW?" So again, um, I know hospitals were using IV Vitamin C. Some of the - some of the ICU docs who were on service used it because it was on our protocol. Didn't last on our protocol very long, by the way. **UW RESIGNATION.** That's one of the reasons why I left University of Wisconsin is because the Dean got the Chair of Medicine to remove IV Vitamin C. So I wouldn't say I was using them *successfully*. And then I would add to that, my

colleagues Northwell Hospital System on Long Island, which is right outside New York City, they had a systemwide protocol using very high doses of IV Vitamin C. It really didn't do much in that first wave. I know the data now shows that it helped reduce pretty much every important adverse outcome. But back then they weren't seeing huge impacts from a high-dose IV Vitamin C.

REPORTS FROM NYC. "How did their reports compare to what you were seeing in Madison?" *Their reports*? I wasn't seeing anything in Madison. So I was calling them every day. I was like, "What's it like? What's going on?" Da da ta ta. And so they were telling me everything was going on. I was just busy preparing. So we really didn't match up in terms of the overwhelming massive surge."

NYC CALL FOR HELP. So, you want to, then number 1 under C, you want to see *emails* of those *solicitations*? I don't know that I have–I've actually had problems with my email archive. I've actually lost a lot of old emails. I'm sure I could get a colleague to find one if he searches. But, what, you don't believe us that these societies - the Society of Critical Care Medicine, American Colleague of Chest Physicians...you don't believe that they were sending out those emails? Well, they were.

WHY HE WENT TO NYC. Um, so the reason why I left...I will say I'm being a little disingenuous with why I left. It wasn't just humanitarian. It was more of a push/pull. I really wanted to go to New York and I felt like the situation in Madison was not out of control. I thought it was being managed well. **RESIGNATION FROM UW.** The second reason was, I had decided to end my career at University of Wisconsin and I was not going to continue my career there. So I knew I was resigning anyway. And one of the reasons why I resigned was because the Dean and the Chair of Medicine literally committed academic misconduct by reconvening the therapeutics committee and getting them to remove IV Vitamin C. Because, for whatever reason, academics, the system Docs, they hate vitamins and they don't want to be associated with vitamins.

And once I saw what they had done, I told my ex-wife, I said, "I'm done here. I'm just done with academics. I'm not gonna work for this chair." And so I left. And so I asked for permission. And I think they were probably happy to grant me permission to leave, cause not only the IV Vitamin C but we were fighting on other treatments. I was saying to doctors they should use anti-coagulation, they should use corticosteroids, and I was getting kinda pushback from them.

COMMUNICATION WITH SENATOR JOHNSON. "Did you and the Senator or Senator's staff communicate in late 2019 or in the first few months prior to the..." No, I've never met Senator Johnson before. The first time I ever talked to him or interacted with him was when I was in - I remember I was in the ICU in New York City and I was on morning rounds and I got a call from his Chief of Staff. Said that he wanted to talk to me. And I went back to my office and he and I had a chat and he told me that he wanted me to testify at the hearing a couple weeks later. So it was probably a week or two before that hearing is the first time I met him and talked to him.

[Pause]

STATE OF PATIENTS AT BETH ISRAEL HOSPITAL. I would say when I got to Beth Israel [Hospital in Manhattan], things were definitely on the downslope. The ICU I inherited was the first COVID ICU to fill. Most of the patients in the ICU had been on vents for a couple of weeks and they were pretty much non-rescuable. I mean they were really chronically, critically ill and dying. So I basically oversaw a fair amount of death. I mean I threw the kitchen sink at 'em and it didn't really work that late in the disease. I was involved with the first attempt at a lung transplant. I had one guy who wasn't intubated, he was on biPaP for about three and a half weeks, which I had never seen in my life before. I'd never seen someone on 100% full settings of biPaP for three and a half weeks. Never ever ever have seen that. And so I tried to get him a transplan and he – I did transfer him to a transplant center but unfortunately he died on arrival

because of, um, machine malfunction on the way.

ARRIVAL DATE IN NYC "What was your date of arrival in New York City?" No, I didn't go to any other hospitals. I believe it was April 27th. That totally makes sense to me. And when I got there, I probably got there the night before. I got there the night before and the next morning I went into the ICU.

ICU PATIENTS. Yes, and I took over my old ICU. Yes [pause] uh, "Did those 16 patients die?" Almost all of them died. I think a couple of 'em we managed to get somewhat better, where they got tracheostomies. So not all died. A few of them did get to stable enough where they went to like a vent floor in a vent facility. But most of them died. Yeah, I mean, these were the patients who were just not improving.

VISITOR POLICY No, the hospital did not allow family members to visit their loved ones. It was *all* on iPads and we had a team that scheduled meetings and so like every afternoon I was doing video iPad meetings.

DNRs. "Did you witness DNR orders being given for COVID patients unilaterally without third-party witnesses?" *Absolutely not. NEVER in my career* have I *EVER* done that. Um, and I did not see that being done. That's considered *highly* unethical and um uh, in fact, the opposite is true. We oftentimes are *forced* to do CPR on patients because the families won't agree to DNR. And there was definitely unnecessary CPR that were done on occasion.

[Pause]

SIMULATION THEORY All right, now I'm on number five. Yeah, I oversaw residents and fellows. I was the program director of the fellowship for three years. Um, "such details are relevant to the *theory* that NYC hospitals ran a live-exercise simulation [laughing] during the surge"...ahhhh...ran a live exercise...I cannot even discuss that.

It's *so* out there. It's so out there. I have no idea what you're asking me in [question] number five. It was some sort of *simulation*? This was a catastrophe. We were–these patients were so sick and dying and filling ICUs. I mean, the first ICU to fill is the main ICU. That's the one I took over. But there were other ICUs all over the hospitals. They had had to convert a number of wards into ICUs. Um, this was not a simulation.

MILITARY IN NYC HOSPITALS. "There was a military presence in some New York City–" No, I did not see any military.

DEPARTURE FROM NYC. "On what day did you depart New York?" Um...yeah. I can't remember if it was four weeks or five weeks. It might have been four and my memory says five. It was one of the two. So, I think I left—I think I was back in Madison by June. So it might have been four weeks. Yeah. I can't recall. Might've been just four weeks.

RESIGNATION FROM UW-MADISON. Oh, the resignation gets confusing because I resigned, I resigned, I can tell you the day I resigned. I resigned May 6th, 2020, on the morning of my Senate testimony. 'Cause I'll tell you why, cause my boss called me afterward 'cause he was *pissed* that I didn't tell him I was testifying in the Senate. 'Cause I did not alert anyone I was testifying in the Senate. So I resigned from UW in May, but I wasn't due to go back until the end of May and I had enough vacation saved up that my official resignation date was June 30th. So I informed them of my resignation on May 6th but my last paycheck and when I had to turn everything in was June 30th, if that's helpful to you guys.

Wow, you're really suspicious.

MAY 6th SENATE TESTIMONY/SENATOR JOHNSON. "When did you receive a request to testify at the May 6th meeting?" It was somewhere like a week to ten days beforehand.

"Were you given guidelines or parameters for your testimony?" No, not at all. I just had to submit my written statement. And I explained to Ron that, you know, corticosteroids were critical and no one was using them.

I don't know of any other [New York] city doctors who were called to testify. The reason why I was asked to testify is pretty simple. It's because Senator Johnson was really angry that um...that nobody was treating. There was no protocols - that no one was treating. And he came across our organization's website and he saw that I was the chief of critical care service at the major academic medical center in Wisconsin. So he called me. It wasn't so much me. It was the fact that we were treating. He wanted to hear more about people treating. So I don't think he needed to talk to other New York City doctors because he wasn't interested in that. He was interested in why we weren't treating and he wanted to hear about good treatments.

And yes, same question, number four. Best of my knowledge, it would be somewhere between April 26th and May 2nd.

Question Dr. Kory is referencing when he says "number five" below.

You know, number five, I'm just tired, I'm not gonna answer it. You guys are sitting in

your armchairs looking at data and coming up with theories that I have to try to explain to you why your theories don't make sense? I can't do it. I can't do it. You guys want to keep saying that I have some sort of confirmation bias. It's just – I can't do it.

I was not in the Beth Israel ICU "a month ago," but I was seeing patients in early April in Wisconsin.

TREATMENTS. "What specific therapies were you using that weren't working?" Well, was bombing 'em with steroids, anticoagulation, um...what else was I doing? No, it was too early for fluvoxamine. Whatever was on our MATH+ Protocol at that time. It was – I was doing high-dose vitamin C, corticosteroids, methylprednisolone , and IV thiamine. That was the *main* part of what I was doing. But it wasn't working that late in the disease.

REPORTS FROM NYC/SITUATION IN NYC. "What happened here...is that the initial surge caused so many terrible reports of patients being..." – all of my colleagues, half of 'em I trained! When I got there, they were exhausted! The stories they were telling me! You guy don't – ah! I'm getting so tired. I mean, *literally* we were building, they built out ICUs to take care of all the patients on ventilators. Then they had a floor which we called The Wild West. I've never seen that in my career in pulmonary medicine. It was an entire floor-long where *everybody* was breathless. They were breathing fast, they were on non-invasive ventilators or non-rebreather masks. And they were being monitored with a pulse ox. The pulse oxes were in the hallway so that the nurses and the doctors could see who was dropping and who was dropping severely. It was a bizarre monitored unit, like –and they called it The Wild West there. And so the fact that they had to do that and they had to put really–patients on the precipice of respiratory failure in a regular hospital ward, without ICU monitoring, shows you how stretched the resources were. But maybe that was a simulation exercise. I'm sorry if I'm getting, like, really [indecipherable]. I'm just tired. I think I have

to stop here. I have an interview. Maybe I'll continue later.

VIDEO 2

All right. Because I started this response, trying to give you guys the information you need. You have so many questions. I'll just continue. I think I'm on...I think I was on number nine.

TYPE OF PATIENT. "[In New York] Who were the patients that were coming to the hospital but not early enough? From where were they coming?" So, let me be clear about 'not early enough'. They were coming to the hospital – I don't necessarily know where they were–not necessarily nursing homes. I mean, I had patients...*many* non nursing home patients. I just remember a lot of fathers, 48 to 52 on vents.

LATE TREATMENT. Um, they probably almost came to the, almost all of them came to the emergency room - this is in New York City. But when I mean 'late enough' I mean that the ICU is late. Most of the patients were getting admitted, um, to the hospital wards. No treatment was being given. And then by the time they declined and went to the ICU, that's really late. I was trying to get hospitalists to start treating earlier, before the ICU, but with rare exception they weren't doing that. So, I don't know. Hopefully, that answers your question.

REMDESIVIR. "You endorsed the use of Remdesivir." Yeah. Remdesivir in the hospital is a joke of a drug. We, you know, it doesn't work that late. There's very little viral replication going on then. But it has a *profoundly* positive early outpatient treatment trial. And so it looks like it has high efficacy if given early in symptoms - not late in the hospital.

TYPE OF PATIENT: MADISON VS. NYC. "Are your spoken and written testimonies to the committee inclusive and representative of COVID patients you saw…?" Yes, they are. Uh, "You indicated you were using the MATH plus…with little success, which you attributed to your late arrival." Yes, it's true.

TYPE OF PATIENT. "Is it possible that the patients you saw were chronically ill patients that were transferred from nursing homes?" (laughs) No! I took care of taxi drivers and truck drivers. I remember I even had a patient that got transferred to us from the tent in Central Park. They had set-up, they needed more capacity and there were patients on vents in this tent in Central Park. One person got referred to me there. But they were not chronically ill patients. I mean, come on. I'm a doctor. I do this all day long. There was *all sort*s of patients coming in. There was no common theme. If–in fact, most of my memory is not of the elderly. Maybe the elderly died before they could get to the hospital. Most of them – I just remember 40s, 50s, 60s—even a couple of 30, people in their 30s.

CHRONICALLY ILL WITH COVID. "Along the same lines, a bit later in the interview you [said], 'When I was in New York, I saw nothing but - what I would say were patients chronically ill with COVID, I didn't see acute." Well, when I say, 'chronically ill with COVID,' they were so far advanced in the disease, they'd been sick for days to weeks, uh, and on ventilators. *Really* prolonged ventilator durations. And that was the unit that I took over. I mean, like I said, it was the first unit to fill. Many other units had been built since then. And a lot of the patients there were – had been admitted days to weeks before. I had *a couple* of new admissions. I should say I had a *handful* of new admissions that month, but most of them were just, were just the chronics on vents. Chronic *COVIDs* on vents. Chronic *severe COVID* on vents.

DISAPPEARANCE OF COVID PATIENTS IN NYC. "By the time I left New York, we had no new cases." Yeah, exactly. There were just no new COVIDs that I saw. "Does it strike you as odd that COVID cases in NYC hospitals simply disappeared in a city of —" You know, I don't know what to say is odd or not. I know they came in waves and I don't understand – I'm not an epidemiologist. You guys are asking me questions. I can just give you my clinical experience and then you guys can figure out how to explain the data.

NOVEL PATHOGEN/NOT FLU. Um, I really–but the "no new novel pathogen" is so bonkers and out there. That's the only thing that I think you guys *have* to admit you're wrong and come up with a new theory to explain what you can't figure out with the data, ok? But 'no new novel pathogen' is just bonkers. Bonkers. I mean, I'm *literally* an expert in acute respiratory failure. I've *never* seen a pathogen like that. Flu and vaping? It's just a joke. I can't tell the difference between flu and a novel pathogen? Like I told you, flu doesn't come into my ICU. Ever. Ever! When I ever, like, I told you - in my career, four or five cases of the flu and you guys are like, "this is an influenza-like illness." Yeah, this is nothing like influenza.

NEED FOR FORMAL INQUIRY/INVESTIGATION OF NYC HOSPITALS. "Do you think a formal inquiry of New York hospitals is warranted, if only on the basis of''? No–the hospitals, they just weren't being aggressive. They were doing supportive care only and that was the terrible thing that they did.

COVID DESIGNATION/UNIQUENESS. "Have you considered the possibility that COVID patient designation, as–" No! I could care less about the positive test. I took care of patients with negative tests who had COVID. You guys think that I'm like, you know, only a positive test determines COVID. These patients were reproducibly appearing in patterns and certain, um, distributions of abnormalities on the X-rays. I mean, it was *really* very reproducible the way they were presenting. They were getting severely ill. In fact, I think I put in one of my stor–Paul Marek saved some guy who had multiple negative tests, um, but was classic COVID and responded to MATH+ protocol Remember Paul was able to treat early. He treated right there in the emergency room hospital and before the ICU.

"...people were sick and dying from something else." They were dying from something else. You wanna call it COVID or not, I don't care what you call it. I don't care about the PCR test. The disease was severe, reproducible, and they were massive numbers of patients and they were filling and depleting ICU resources. I don't care what pathogen it was and what test it was. But the disease was absolutely reproducible.

NYC AS STAGED EVENT. Um "...was very severe and transmitted...the first wave... these are very strong words for a flu-like illness." (Laughs) "How confident are you that you were not observing a scene that was staged or set-up for you?" You guys! That question tells me to end this interview! I don't talk with—this is so bizarre. Staged?! Or set up for you? Patients come to me. They're diaphoretic, sweating, they have x-rays, and they're hypoxic. How is that staged? I mean, I've been taking care of patients my whole career. I was inundated trying to save patients' lives. Yes, it was all a

big stage. What is that question?

POINT RELEASE/BIOWEAPON. "*perplexed as to why responsible people would choose not to wear a mask…In your recent response…something as preposterous as deliberate widespread release in certain targeted cities and areas.*" I think on this question, I exhort you guys to read the [Robert F. Kennedy] book *Wuhan Cover-Up*. And read about the history of bioweapons development and testing. They *have been* spraying and exposing significant portions and communities in the United States to biological weapons for over 60 years. They've been doing this since the 1950s. So this idea that it could be a point-release or they attacked certain cities and released them is completely reasonable if you read that book. This to me was a bioweapon and this is what happened.

NEW YORK NOT UNIQUE. I don't care or know why New York got hit so hard. But you guys keep thinking that New York is so unique. My colleagues in Milwaukee got absolutely hammered. My colleagues in Detroit and Seattle and New Orleans. Like, I don't know what the data is for there but on the ground? Similar experiences were being related by numerous clinicians around the country. I mean, I was on these *huge* WhatsApp groups, with doctors all over the country. We were all seeing and saying the same thing. So why the data was so much an outlier, I don't know. But the reality was there were a lot of sick people entering hospitals with this disease.

POINT-RELEASE THEORY & FEDERAL OFFICIALS. Um…"You seem…there was a point-release of SARS.." No, I haven't shared my concerns with federal officials. I have no evidence for that. I just think that's the only…it's a reasonable hypothesis and if you look at the Wuhan– And, by the way, have I shared my concerns with – you know how many concerns I've been sharing with the world, in op-eds? I've written like 18 op-eds on *numerous* concerns. Nobody gives this [indecipherable]. The federal government is captured. I'm not gonna run to the federal government and present a hypothesis

that I have no data to support. And they don't even listen to all the data that I am providing.

GLOBAL PANDEMIC? "If there was such a release, do you think it changes the WHO's March 11, 2020 pandemic declaration (or your view thereof)?" Yeah, it it uh...does it change my view? Yes, I mean, I don't know what to make of this. I don't know why it happened. I don't know why it transmitted that way, why it spiked in certain places. Um, but ahhh...it was becoming a problem in numerous areas of the world and and..in my...yeah...I think it was reasonable to call it an emergency, cause it was an emergency. I mean, we were getting overwhelmed.

SEVERITY/THREAT OF CORONAVIRUS/ALT CAUSES. "Do you think your early impressions of the severity and threat of the COVID-19 – and the transmission – were warranted?" (Pauses) So "If this perception was driven largely by what you observed in New York, have you considered that what you saw has alternate explanations that don't involve a spreading coronavirus?" No. Period. End of story. No. This was *clearly* an infectious illness that was transmitted from person to person. Uh, and that's it. That's all I'm gonna say. This does not change anything. Why it spiked, why it came in waves, why there were so many different variants, why there was different morbidities mortalities. I don't have great answers to that.

OMICRON/VARIANTS. I am concerned about that Japanese paper that suggests that all of the Omicron variants are not naturally evolved. That they all must've come out of laboratories. So I don't know if some kind of sociopath just keeps releasing these variants. I don't know why they're releasing *less* dangerous variants. I have no idea. I don't have all the answers. **VAPING/FLU/NOVELTY.** But this idea that it was a huge vaping explosion, or it was flu and I don't know what flu is and I'm mistaking everything for the flu. That's the only thing that I can't handle anymore and I'm done talking about this. You guys can do whatever you want. Take my information in the way you need it.

But what I'm *really* worried about is that you guys will never admit that this was a nove pathogen, even though it was. You'll keep going on with your theories. And I wish you the best of luck but this is all I can devote to this question. Thanks.

VIDEO 3

LONG COVID/LONG VAX. Also, one other thought – and you guys are ignoring this, but…the novelty of this pathogen is, I think, also equally best-evidenced in terms of the *huge* rates of long COVID, which is - although it's a new name, it's an old disease. It's called MECFS from myalgic encephalitis chronic fatigue syndrome. The three pillars of that diagnosis is fatigue, post-exertion fatigue, and brain fog or cognitive deficits. I literally left Madison and I have a practice which treats nothing but Long COVID and Long Vax.

Actually, Long Vax is far more common than Long COVID. But the Long COVIDs, I mean, they're still equally - or almost equally - the vaccine injured are much sicker, generally on average, sicker than the Long COVIDs. But Long COVIDs are wicked. I mean, I have literally a practice full of them.

And, although MECFS used to occur - you know, it's generally associated with mononucleosis - uh, the rates at which you saw does not even compare to COVID. This thing is wicked. I have so many disabled patients. I have an entire practice. I have a partner. We work full-time. I have an employed NP and we have an entire practice with the same syndrome. And that's *all* I do for a living now and it's wickedly complex to treat. Trying to find different therapies to work in patients is oftentimes really challenging. A lot of times it's not-so-challenging.

Um, but it's literally, it shows you just how toxic this pathogen was. I mean, I mean look at the disability rolls. Probably, it's mostly driven by the vaccines, but I mean we've added 3 million to the disabilities rolls in the last three years. And that started spiking, think, a little bit before the vaccines. But mostly driven by the vaccines but...I mean this thing, this thing is wicked. And I'm still dealing with the fallout. That's all I do is try to figure out how to help these patients today that have had COVID and they're still sick. And I don't remember clinics for Long Flu. I don't remem–or Long Vape. You guys gotta get off that theory.

Bye.