The Ugly Truth and Lies of the Medical Establishment & Big Pharma Exposed

By Jan Jekeilek – American Thought Leaders, Epoch Times

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I sit down with two leading cardiologists from two sides of the Atlantic, Dr. Peter McCullough and Dr. Aseem Malhotra, to understand how the COVID-19 vaccines impact the body, especially the heart.

"There has been a suggestion—and I think this is probably subterfuge from the PR industry of pharma—that mild COVID may be causing all the sudden cardiac deaths. And the evidence is just not there for that at all," says Malhotra. Once an outspoken advocate of the COVID-19 genetic vaccines, Malhotra changed his mind after the sudden death of his father compelled him to take a closer look at the data.

"Roughly 15 percent of people who have taken the vaccines are damaged by them," says McCullough, one of the most published cardiologists in America and the Chief Scientific Officer of The Wellness Company.

McCullough says the risk of adverse effects from the mRNA vaccines is particularly high for those who were previously infected with COVID-19**. "There are patients who are triple vaccinated, and then they get COVID. So they have a fourth exposure now of the spike protein. There is a cumulative risk here," he says.**

In this episode, the two doctors break down the data on the COVID-19 mRNA vaccines, bias in the scientific literature, and what people should do if they are concerned about their health.

FULL TRANSCRIPT

Jan Jekielek:

Dr. Aseem Malhotra, Dr. Peter McCullough, such a pleasure to have you on American Thought Leaders.

Dr. McCullough:

Thank you.

Dr. Malhotra:

Great to be here again.

Mr. Jekielek:

The topic of our episode today is going to be COVID-19 and the heart. We are sitting in front of two esteemed cardiologists from different backgrounds, from different countries, different medical systems, and we're going to find out what you think. Dr. McCullough, let's start with the basics of COVID-19 and the heart. And you can expand as far as you would like.

Dr. McCullough:

Looking back, there's been a published history of the coronaviruses, specifically the betacoronaviruses, and the heart. Ralph Baric at the University of North Carolina at Chapel Hill published in 1992 that he could create animal models with coronaviruses that would damage the heart and cause cardiomyopathy and heart failure. That was in 1992. So, it was well known that there were models, given enough of the virus in the right routes of administration, and the right experimental conditions, to cause this. The part of the virus that causes the heart damage is called the spike protein.

This was well known in 1992, well known ahead of the SARS-CoV-2 outbreak. When the SARS-CoV-2 outbreak occurred in the United States in 2000, within a few months, multiple entities were aware of this possibility. The U.S. military had a screening program for myocarditis with COVID, the respiratory illness, so did the Big Ten NCAA athletic league. And so, people were on alert to look for myocarditis in SARS-CoV-2, the respiratory infection.

Mr. Jekielek:

Dr. Malhotra, your thoughts.

Dr. Malhotra:

One of the things that became quite apparent early on in the pandemic is that the people who had risk factors for heart disease, who even also had underlying heart disease, were actually at higher risk for adverse outcomes from COVID-19. The issue with the heart and COVID isn't just about the vaccine, clearly, which we've discussed in detail before. It's about the fact that **one was also potentially in a worse off position from having a bad outcome from COVID if you had underlying heart disease.**

Mr. Jekielek:

Would that extend to potentially bad outcomes from the vaccine? Do we know that?

Dr. Malhotra:

It could be. Certainly the four bits of data that the WHO put out in terms of potential adverse effects from the vaccine were based upon COVID itself, animal studies on the vaccine, and the technology that was being used in previous harms from vaccines. But the fact that COVID itself was part of that as a problematic issue with the vaccine suggests that was just building on what we already knew with heart disease and COVID.

Mr. Jekielek:

The typical thing that we hear about is myocarditis, and we know that because that's probably the most developed of the cardiac issues when it comes to vaccination with these genetic vaccines. Why don't you just give me an overview?

Dr. Malhotra:

First and foremost, there's been a lot of debate about whether COVID increased myocarditis itself. The totality of the evidence, and I'm sure Peter will agree with me, doesn't suggest that compared to any other viruses it's particularly more prevalent. We'll talk about the vaccine in a second. **Myocarditis in general, viral myocarditis, pre-vaccine, is something we learn in medicine as a rule of third. A third of people are going to get worse and die when**

they get myocarditis, and it's essentially thought to be an autoimmune type of phenomenon.

It can happen to anybody. In fact, my elder brother died from viral myocarditis. Either a third will die and get very sick, a third will have impairment of the heart muscle pump function and will live with that for a long time but not die, and a third will be sick momentarily and then they will get back to normal. That's what we know about viral myocarditis.

With the COVID-19 myocarditis, it's a slightly different kettle of fish. In some ways, there are not obvious or apparent death rates from myocarditis that we see with viral myocarditis. But of the people admitted to hospital, MRI scans show that about 80 per cent of them are left with some kind of myocardial scar, which means that is potentially a problem moving forward as a substrate for arrhythmias, or even deterioration of heart muscle pump function over time.

Mr. Jekielek:

Are we just talking about the virus itself?

Dr. Malhotra:

No, sorry, this is with the vaccine.

Mr. Jekielek:

This is with the vaccine. Okay, great.

Dr. McCullough:

With the virus, if we just stay on the virus, there was a big paper that was published out of the Veterans Administration. They used ICD codes, but it was a huge study. **The first author, Xie, (X-I-E), showed that virtually every cardiovascular event that was serious enough to be in the hospital was elevated after a COVID infection.**

The risks were giant for those who were in the hospital with COVID. With outpatient COVID, the risks were much less, but they included traditional myocardial infarction, the

decompensation of heart failure, ventricular arrhythmias, atrial arrhythmias, and myocarditis.

Myocarditis in the inpatient studies is a problem because it's not adjudicated. And a blood test is commonly done in almost all hospitalized patients called troponin. Troponin is the most abundant protein in the human heart, and it's a reliable indicator of heart damage. But a troponin being elevated in COVID-19 respiratory illness doesn't establish a diagnosis of myocarditis, because it's elevated because of bacterial sepsis and other ICU conditions.

The literature, and there's some papers written on this, says that COVID-19 itself causes more myocarditis than the vaccine. **Those papers are not valid, because they're not adjudicated cases of hospitalized patients developing myocarditis.**

But here's something of interest on community outpatients. The Big Ten had a screening program. A paper by Daniels and colleagues published in JAMA looked for myocarditis in thousands of athletes, and 30 per cent of them got COVID. They found a handful of cases that would've met a definition by multiple testing, and there were no hospitalizations and deaths. And then, a paper by Joy and colleagues did very prospective cohorts, with detailed screening of patients who developed COVID, and no evidence of heart injury.

I agree with Dr. Malhotra, that with the respiratory illness as it all settles out, there is a risk for traditional cardiovascular events, because of this big inflammatory insult that the body gets with COVID respiratory illness. But this is a small, negligible risk of myocarditis with COVID, the respiratory infection, probably because the body doesn't get this massive exposure to the spike protein that it does with the vaccines.

Mr. Jekielek:

But once the disease is allowed to progress, and once someone is in the hospital, now we're seeing big issues. Is that right?

Dr. Malhotra:

Yes, absolutely. As Peter said, as to the cardiovascular event rates, certainly in the people with severe COVID—and we're going back in time to the ancestral strain really, because that's

what we saw at the very beginning, the Wuhan strain—it does seem to, through an inflammatory mechanism, increase cardiovascular events.

However, this is something we have known in cardiology anyway, with all sorts of infections. If you've got predisposition to cardiovascular disease, if you have an infection or pneumonia, it's going to exacerbate all these cardiovascular problems. It's going to increase the likelihood of plaque rupture and heart attacks, that kind of thing.

In that sense, it's not that new. The point that has been made more apparent recently is that there has been a suggestion, and this is probably **subterfuge from the PR industry of pharma, that mild COVID may be causing all these sudden cardiac deaths. The evidence is just not there for that at all, actually. People shouldn't be distracted by this false narrative that mild COVID may be causing a massive surge in cardiac arrests.**

Dr. McCullough:

There's a paper by Singer and colleagues that's notable. Again, Singer used this unadjudicated troponin elevation in the hospital by ICD codes, and **proclaimed that COVID-19, the respiratory illness, has a many-fold higher risk of myocarditis than taking a vaccine. Therefore, you should take a vaccine and risk myocarditis, in order to avoid myocarditis later on with the respiratory illness. That type of logic should be flawed to anybody listening to this. It's built on a house of cards. We never administer a product to cause a problem, to later on prevent a problem. It just doesn't work that way.**

With the vaccines, there's quite a history of myocarditis with the vaccines. The smallpox, monkeypox vaccine clearly causes myocarditis, well-published cases of myocarditis. Viral infections can cause it, parvovirus and others. In a paper from Arola and colleagues from Finland, published in one of the best cardiology journals before COVID, they established a rate. It's very important.

They studied everybody in the entire country, and they had very solid case identification. Four cases-per-million is the background rate of myocarditis before COVID. With the very first number of the CDC came out with, the CDC was dividing

safety events by the total number of people that took the vaccine, assuming other people didn't get it. That is a flawed statistical approach. But even doing that, the first CDC estimate was 62 cases-per-million, and then it rapidly escalated.

Tracy Høeg at UC Davis did different data analysis with 250 cases-per-million. Sharff at Kaiser Permanente found 527 cases-per-million. And now the two prospective cohort studies, Mansanguan and colleagues and Le Pessec and colleagues, two separate papers, when they finally do all the measurements before and after vaccination, Mansanguan was on the second shot of Pfizer in children age 13 to 18, Le Pessec was in healthcare workers on the third shot of messenger RNA vaccines, **they find together, their estimate now, 25,000 cases-per-million.**

Mr. Jekielek:

Has this basically accelerated as the vaccine rollout or the number of boosters, or how do you understand this?

Dr. Malhotra:

Yes. Myocarditis itself, absolutely. All cardiovascular conditions have gotten worse because of the vaccine. And anything and everything that can go wrong with the heart has gone wrong with the heart as a result of these mRNA vaccines. There's no doubt about it. That's why Peter and I both separately had essentially said if doctors are not aware of a possible diagnosis, they'll never diagnose it.

Unfortunately, many doctors, including cardiologists, are still not even conceiving of the possibility that the mRNA vaccine can cause these problems. But the list is there, it's endorsed by the WHO—cardiac arrhythmias, atrial fibrillation, heart attacks, myocarditis, and heart failure. I've managed all of these people in the community who have been vaccine injured. Their doctors have missed it, but I picked it up.

Mr. Jekielek:

Fascinating. Let's pause for a moment. I'm remembering this video that I watched that someone had put together online. You both came up with a particular phrase, which was "until proven otherwise." Some of the viewers might be familiar with this. I want to figure out,

what does it mean, number one? And two, did you both come up with it independently? And third, I'm going to ask you how you know each other and when you started talking to each other, because you've come to some similar conclusions.

Dr. Malhotra:

Yes. In terms of, "until proven otherwise," we came up with it independently. It was trying to capture people's attention, and for cardiologists and doctors to understand that these so-called unexplained events that were happening where it doesn't fit, in the case of a cardiac issue, then you have to include the side effect of the vaccine as part of your differential diagnosis.

It's trying to just shift the discussion. **Until you've got another clear explanation why someone suffered a sudden cardiac death, or had a heart attack or an arrhythmia problem, you have to consider it being the vaccine, until you've proven that there's another more likely cause.** And I'm sure Peter probably did the same thing. I can't remember, Peter, when we started actually speaking to each other.

Dr. McCullough:

It's been a while. He uses texting a lot. He's younger, so he's in the text generation. I have really a substantial experience on data safety and monitoring boards for the NIH, and for Big Pharma. I've done this for decades. When people are in a study, or it's in a post-marketing period in a brand-new drug, when someone dies within a few days, or certainly within 30 days of any new drug or injection, it is that drug until proven otherwise.

If this was in a regulatory dossier, it could even be something that's seemingly disconnected**. Believe it or not, in clinical trials, if someone's taking a drug and they have a car accident, it's attributed to the drug, because the drug may have made them dizzy or foggy or what have you.**

To be conservative, we actually put it on the new drug or the new injection or the new vaccine. That's just good regulatory science. When the deaths started to come in after the vaccine, unless we had something very obvious, a drug overdose of something else, a suicide attempt, or just something obvious…

Mr. Jekielek:

A very clear cause.

Dr. McCullough:

Yes. Or if there was an autopsy that said they died of a perforated appendix or something, it is the vaccine until proven otherwise. Then once we learned that the vaccine causes myocarditis in June of 2021, and the FDA said it causes myocarditis, the WHO anticipated this, and the NIH anticipated this. Then, the myocarditis cases started coming in, with the publication of fatal cases. If there are fatal cases, they undergo an autopsy, and the pathologists agree they died of fatal myocarditis.

Now it's in the peer-reviewed literature, 2021, New England Journal of Medicine, by Verma and colleagues from Washington University in St. Louis. We had Choi in Korea, Gill from Connecticut and Michigan and Minnesota, that trio published on two boys who died of Pfizer vaccine. **It's clear now in Circulation, our best cardiology research journal, with Patone and colleagues from the UK, there were 100 fatal cases where the UK doctors put fatal vaccine-induced myocarditis as the number one diagnosis on the death certificate.**

We have it now. The next person who dies out there, and there's no explanation, it is the vaccine, until the family comes out and tells us they didn't take the vaccine. With every family that remains silent, the assumption is they took the vaccine. Now, that **family is in a spiral of regret, remorse, and feeling guilty about what happened. That's probably what's going on. Families can clear this up. Anybody listening to this tape, if the families come out and say they did not take the vaccine, then we can take the spotlight off the vaccine.**

Mr. Jekielek:

It seems to make perfect sense as you're describing this right now, but I feel like I've been programmed to believe otherwise.

Dr. Malhotra:

Yes. The other thing to add in, which we haven't discussed yet as well, is the element of people almost accepting to some degree that these side effects, which they wrongly believe are rare, are acceptable. It's because they also have a false perception of benefit of the vaccine.

Here's one of the discussions I've even had with doctors who are, in normal circumstances, good critical thinkers, "Hold on a minute, Aseem. Haven't we ended the pandemic because of the vaccine? How about all these lives that are saved? How come COVID is not killing people anymore?"

No. COVID mutated independently of the vaccine. It's become milder. That's what happens to these viruses. Somebody asked me the question the other day, "If we didn't have the vaccine at all, would we be in a better or worse position than we are now?" The honest answer is we don't know, but I think we'd be better off if we didn't even have the vaccine at all. We would have had probably less harm to the population.

Mr. Jekielek:

Okay. That's a big statement. Why? What is the data that supports this?

Dr. Malhotra:

You go back to the very basics of the original randomized control trial. The vaccine showed you were more likely to have a serious—and this is in a healthier subgroup population, which were chosen by Pfizer and Moderna—you were more likely to suffer a serious adverse event from the vaccine than to be hospitalized with COVID. And that is during the original ancestral Wuhan strain. Think about that.

You've got the same effect of harm from the vaccine, and even in the worst possible wave, it was still more harmful. The virus has mutated to become less harmful, and you've still got the same level of harm with the vaccine. It's a no-brainer. You can make a very strong case that societies would have been much better off without this mRNA technology.

AstraZeneca, that was in effect suspended in the UK, even though it wasn't made public, they slowly phased it out. But

when you look at the Yellow Card reporting, and this is in a country of a population of 60 million, we had 1 million Yellow Card reports from AstraZeneca, which is just extraordinary. It was publicized in news reports as a rare clotting effect or a rare issue. We now know it wasn't rare at all. **These vaccines have had a hugely negative impact on society and on health. And of course, everything that's gone on with this has eroded trust in medicine as well.**

Mr. Jekielek:

Just to add to what you were saying, these vaccines were designed for this original variant. So basically, they would've been most efficacious, if they were efficacious, on those early variants than the ones today.

Dr. Malhotra:

Yes, absolutely. And another thing that we talk about are the psychopathic determinants of health. What was most criminal is telling people who had natural immunity to take the vaccine. Because some evidence suggests you were three times more likely to suffer a serious adverse event if you had COVID and then you took the vaccine, certainly within the first few months after it. It's beyond criminal. Let's just call it out for what it is.

Mr. Jekielek:

Let's talk about this. Natural immunity, since time immemorial, has been known to be effective. Basically, if you've had the disease, chances are that you're going to be in a much better situation with respect to disease. In many cases, you just won't get it anymore. You're immune. **So, what is the deal with natural immunity today?**

Dr. McCullough:

The biggest question I get from my patients is, "Doctor, if I get COVID, how can I avoid being hospitalized and dying?" Those are the two bad outcomes. Listen, if I can get through it at home, I'm good. The only factors that have been consistently related to reductions in hospitalization and death by risk is early treatment.

Every study looking at early treatment, it doesn't matter what drugs were tested, or what drugs in combination, they always take an edge off the illness and reduce the proclivity to be hospitalized. An analysis by [inaudible] and colleagues, a mathematical analysis, demonstrated that we actually knew that with a P value of less than 0.01, that forms of early treatment were stopping hospitalizations by December of 2020. Very important. There were multiple studies across the world. And then natural immunity.

Early on, the FDA and the vaccine manufacturers, when they were actually working on the registrational trials, they strictly excluded anybody who had previously had COVID, even suspected patients with COVID, they were excluded. They couldn't even receive a vaccine. Also, pregnant women and women of childbearing potential.

When we have exclusion criteria in clinical trials, the exclusions must be justified. The rationale to justify the exclusion was that they did not have an opportunity for benefit, but they had an opportunity for harm. A golden rule in medicine is, once people are excluded from the original randomized trials, we never immediately start applying this in practice.

In the first week of the U.S. vaccine program, we saw people who had already recovered from COVID were told they should take it, and our CDC, NIH, and FDA and hospital systems and others all agreed. This included pregnant women and women of childbearing potential.

Those breaches are breaches of regulatory science, breaches of medical ethics, and are completely off the rails. That was December 10th of 2020. At that moment, we knew things were off the rails. We had never done that before. We had never done that before. Papers by Raw, Krammer, and Mathioudakis clearly showed that if one had natural immunity, there was an explosion of risk afterwards, including going to the hospital. **One of the reasons why the adverse event profile is so bad on the vaccines, even way worse than the original trials, is because people with previous COVID have actually been taking these vaccines.**

Mr. Jekielek:

Yes. Let's look at that data. People that have had COVID and then took the vaccines, versus people who hadn't had COVID

and took the vaccines. You mentioned it was a three time increase.

Dr. Malhotra:

An almost threefold increase in systemic side effects. Yes. If you take the vaccine after having natural immunity. Absolutely.

Dr. McCullough:

Everything was worse. There's a paper from the UK, from Raw, I specifically remember that paper. Everything was worse. **The reactogenicity, the pain in the arm, lymph node swelling, fever, and events that landed people in the hospital were worse. Now, we have data from the V-safe data which is extraordinary. The CDC did not want to release that to the public. V-safe is a cell phone app where people were told, if you have side effects, fill it out on the cell phone app, in terms of something happened to you.**

10 million Americans did it. The CDC wanted to withhold it. They were forced under court order to release it to the NGO, ICAN, and the results are bombshell. 25 per cent of people who take the vaccine are incapacitated the next day. They can't go to work or school the day after. 7 to 8 per cent are hospitalized or go to the ER. This is the most toxic vaccine by the CDC data that we've ever seen in clinical medicine. My hunch is that a large number of those individuals previously had COVID.

I've mentioned this on national TV, and I've reported events through the VAERS system, a separate system, the Vaccine Adverse Event Reporting System. In the VAERS system, **there's no checkbox to indicate if they've previously had COVID. It is a massive oversight, when the data were clearly showing us recovered people were excluded from clinical trials. If they were going to have side effects with the vaccine, you'd think the CDC would at least want to capture that information, so they could mitigate risk with new recommendations.**

Mr. Jekielek:

How does this compare with the UK data?

Dr. Malhotra:

Yes, it's similar. For me, there is always going back to trying to make sense of this kind of behavior when the evidence is so clear. There was no precautionary principle applied. It still comes back to these regulatory bodies failing in their duty to protect the public from the excesses of and manipulations of industry who were there just wanting to mass vaccinate as many people as possible, irrespective of the consequences and irrespective of the harm.

People need to understand that. ***With the regulators in our country, the MHRA, and the FDA in the U.S., people don't realize that as long as they're captured by industry funding, they are not going to be independent. They're not rigorous, and they cannot be trusted. It's very simple. Let's just call it out for what it is. They have acted as essentially sock puppets or slaves to the psychopath. This is the only explanation, Jan, I have for this behavior. It's psychopathic.***

Mr. Jekielek:

We've talked your understanding of the psychopath or psychopathic entities in the past. Briefly, for the benefit of our audience who don't know about that conversation, please tell me what you mean.

Dr. Malhotra:

Sure. The evidence-based forensic psychologist, Robert Hare, was the preeminent expert in the original international definition for the DSM criteria for psychopath. He consistently describes that with pharmaceutical companies and many big corporations, the way they carry out their business is psychopathic. For example, callous, unconcerned for the safety of others, cunning, and deceiving others for profit. These several criteria they fulfill, which you would normally give as a definition of a psychopath in psychiatric definitions, are terms you can apply to these big corporations.

For me to try and explain this kind of behavior, many of the people that have been propagating misinformation on the COVID vaccines, who have been callous in terms of not regarding and understanding the safety concerns, are really slaves to the entity that's driving it,

and that entity is psychopathic. **For example, the FDA, effectively captured by industry as well, by promoting and not stopping this vaccine being rolled out when they knew there was significant harm, is behaving like a slave or a puppet to the psychopath.**

Mr. Jekielek:

It's still hard to fathom. Is it just simply this mania with making sure that every single person gets vaccinated, and it's just too complicated to test for natural immunity? Is that what you think?

Dr. Malhotra:

No, I don't think so. I can't see any rational reason for them doing it. I know this from direct conversations with people linked to the FDA. **One of the things that's been used is a surrogate marker of antibodies. But the FDA themselves in May 2021 on their website actually put out a statement saying the public and doctors need to understand that current SARS 2 COVID antibody tests do not give any indication of protection from or immunity to COVID-19, especially after receiving vaccination.**

They knew that it was essentially a useless marker. And yet, that's all they have used to justify the perpetuation of vaccines or use studies where they're showing slightly high antibody titers with people who had natural immunity and then had the vaccine. **It is the worst possible science.**

Dr. McCullough:

The term is called surrogate. A surrogate in the field of cardiology is actually a bad word. Surrogate means we trust something that's not a real clinical outcome, in hope that this is actually going to improve something meaningful, like reducing hospitalization and death. The FDA put out that warning, in fact I think it was in June of 2020 when they said, "We should not measure antibodies. Don't do it to try to assess for immunity. Don't try to do this."

And the antibody manufacturers were correct. If you actually read their package labels, it says the purpose of measuring this test is to ascertain prior infection. That's the whole reason to do it. The knowledge of prior infection is a very useful piece of information.

And we now know, there's a recent paper, one of the ones I quote the most, by Chin and colleagues, in the New England Journal of Medicine at the end of October 2022, with 59,000 prisoners and 17,000 staff, all in a closed setting. They know everybody who's getting COVID, they know everybody who's being hospitalized and died. If someone's had any prior version of COVID, and they now get the Omicron strain, there is zero risk of hospitalization and death.

Zero. It doesn't matter if you took a vaccine or not. The vaccine had no impact. Even with those where it was not clear if they had prior COVID, there were very, very low risks—very low risks across the board, and no difference whether or not someone took a vaccine. That's a massive sample size, but it gives reassurance. When people know they've had prior COVID, we can operate on that.

As a doctor, I get called all the time. "Dr. McCullough, I have COVID." My first question is, "Is this your first episode or a second or more episode?" "It's my second episode." Okay. I know that that patient has a negligible risk of hospitalization and death. I behave differently. When it's the first episode, it could be more severe.

But as Dr. Malhotra said, we're now in the Omicron era where we have very, very few serious cases. The current estimate right now is in the United States, and we've heard Rochelle Walensky say this, that there are 300 Americans "dying per day who are COVID positive." From our CDC data, we know that with 90 per cent of that something else is contributing to death, like a hip fracture, or pneumococcal pneumonia. They're just testing positive probably from a prior COVID infection months earlier, and 10 per cent really have adjudicated COVID.

Now, we're down to 30 deaths per day. 30 deaths per day. Let me give you an idea. In the United States, there are 2,000 cardiac deaths per day from heart attacks, heart failure, and fatal arrhythmias. So, for the last year, with COVID-19 in the Omicron era, there has been a negligible public health threat.

There are absolutely no criteria for President Biden to declare this to be a continued health emergency.

Mr. Jekielek:

Yes. That's interesting. Is that how you assess the death data now?

Dr. Malhotra:

Yes. Absolutely. It's very mild now. It's very, very mild. So, it's not an issue. It's not a public health issue. It shouldn't be. The pandemic is over. We're dealing with a cold. We're dealing with a cold. In fact, I got COVID early on this year. I'll be honest with you. Fine, I'm in my forties, and I've had worse colds. Effectively, by that stage, I was unvaccinated, because it was more than a year since I'd had two doses. People need to be told the truth. We need to stop scaring people.

Mr. Jekielek:

Some of the criticisms that I've heard about your respective work is that you both cherry pick your studies. You basically pick the studies that will give you the outcomes that you want. I would like each of you to respond to that criticism because it's a common one.

Dr. McCullough:

I have 60 peer reviewed publications on COVID-19. That's a pretty solid performance over the last three years. People have said, "Dr. McCullough, you're not an infectious disease specialist." I said, "I am now. I've done three years of dedicated study on this. I have studied my patients, I have received grants, I have investigational drug applications. I have done everything I could to apply my scholarship to this topic, and I'm all in on it."

We're at 300,000 papers on COVID-19. We're at 300,000. There is a clear-cut bias in the medical literature coming from the major publishers, Elsevier, Taylor & Francis, and others, all the way down to the editorial offices, to promote mass vaccination. We've seen a clear and present trend. For those reasons, we have

to look at less prominent journals and evaluate that data to see what's out there. We have to rely on the preprint literature right now.

What really matters are the data, it's tables and figures. I'm at the point now where I just ignore what the authors write. A typical paper on myocarditis, for instance, will start out like this. "COVID-19 vaccination has saved millions and millions of lives, and it's the most valuable thing that's ever come in human medicine. Now we want to describe all these fatal cases of myocarditis. Conclusion. This justifies COVID-19 vaccination." It doesn't. You're laughing because it doesn't add up right now. We just simply look at the data, and many times we have to look in the supplemental tables.

Mr. Jekielek:

I've read a number of these papers as you describe them right now, and I wonder if people aren't subversively putting good data into the system, while including those paragraphs at the beginning and the end, because it's the only way they can get them published in these journals. What do you think?

Dr. Malhotra:

Yes, absolutely. But to be honest, that's just cowardice as far as I'm concerned. Absolute and total cowardice. Let's call it out for what it is. The medical profession, the people who are doing that, they might as well be complicit in the problem, to be honest, if they're not being clear with what they want to say.

The second thing I would say, Jan, in terms of the cherry picking, is that I've been involved in this advocacy space for a long time. I've had attacks from the food industry, from pharma on statins, and that kind of thing. I'll quote a tweet from John Cleese, the comedian, in response to the accusations of cherry picking, which I haven't done. One of the old rules of the KGB is to accuse your enemy of exactly what you are doing.

Mr. Jekielek:

There's something called the ironclad law of woke projection. It reminds me of what you just said.

Dr. Malhotra:

Yes.

Dr. McCullough:

Jan, in medicine, if we take any major therapeutic, like a blood pressure lowering drug, or a certain class of cholesterol-lowering drugs, there will be papers written that say the risk of this drug far outweighs the benefits. There will be other papers that are written that say the benefits far outweigh the risks. It's a debate. It's a battle. And we go through this, we go to our meetings, and we revel in these debates.

With the COVID-19 vaccines, there isn't a single paper in the New England Journal of Medicine, JAMA, or Lancet, where the conclusion is, that the risk of the vaccines outweighs the benefits. There is an absence of balance in the literature. That tells me as a former editor, and as one of the most published people in the world in history in my area, that there is a deep-seated bias to only promote the vaccines in their peer reviewed literature. Because otherwise, we would have balance. We would have papers that come in and share a different viewpoint.

Dr. Malhotra:

Yes, and to come back to the cherry picking issue as well, what I try to do with my paper is just break it down. **What are the absolute benefits, and what are the absolute harms? I've not had a single rebuttal. I've had a few character assassination attempts in blogs. I've been involved in publications for a while, and there's not been anything effective in combating it. So for me, these accusations of cherry picking don't really stand up to scrutiny. And we're talking about very good level of data quality to make those conclusions.**

The other thing that was thrown out around there, and you may have heard this as well, Peter, **there was a paper not so long ago that made news headlines that claimed the vaccine has saved 20 million lives globally. It was the lowest quality level of evidence,**

extrapolations from a modeling study. It's basically bull. Let's just call it for what it is, bull. It's science fiction, it's marketing, and it's fraud.

Dr. McCullough:

Any paper that assumes the vaccines are beneficial and then multiplies at times large numbers is basically committing fraud. They're defrauding the readership. We should look at the data at hand. The letters to the editor, by the way, speak volumes. He's published part one and part two in a very well-respected journal, and the letters to the editor have not come in with any serious threats to validity.

When I published the very first paper on treatment in the American Journal of Medicine, and then the second one in Reviews in Cardiovascular Medicine, I watched the letters to the editor come in very carefully. Not a single one provided any threat. In fact, it was a wonderful discussion. I'd say, "I'm really glad you wrote this letter to the editor. Now here's even more data that we have to treat patients, and here's another." At the end I was inviting them to overcome their fear, and let's start treating patients. And those letters to the editor just went away.

Dr. Malhotra:

Another thing that's really important that we are also missing out on without the acknowledgement. We've got to remember; a lot of people aren't even walking. But we're running in terms of understanding vaccine injuries are real and they are common. Without even acknowledging that this exists as a major issue, we are losing out on dedicating time, resources, and research towards helping people who are genuinely vaccine injured. We are in complete dereliction of our duty as doctors by not acknowledging this is a problem. And the longer we go on, the worse the problem's going to get.

Mr. Jekielek:

Just to be clear, this data that we saw that you mentioned to me earlier, it was just like seven or eight out of 100 people who had taken the vaccine had a serious outcome. That's the number, right?

Dr. McCullough:

That's V-safe data.

Mr. Jekielek:

That is astounding. That is a whole different ball game.

Dr. McCullough:

Currently in the United States, 90 per cent of Americans are not taking any more vaccines. They're not taking any boosters. That's the CDC COVID tracker data. There's only a 10 per cent take rate now. Remember, the vaccines run out of any theoretical effectiveness after a few months. One has to keep taking boosters.

In terms of people taking boosters, we're down to about 10 per cent of Americans. So, how do 90 per cent of Americans, how did they know to stop taking vaccines? I don't think it's by watching CNN. This is where it's coming from. It's coming from the fact that 7 to 8 per cent of people end up in the ER or in urgent care, and then family members talk to each other.

There's a Zogby survey, a representative survey, that asked people about the vaccines. Two thirds of Americans in the Zogby survey said they took a vaccine. And they asked them, "What happened?" 15 per cent of people have some new medical problem that they're now seeking care after taking the vaccine. Those 15 per cent talk to other people. There's a Michigan State survey, 22 per cent of Americans know somebody who's either died or been seriously injured after a COVID-19 vaccination. That 22 per cent talks to other people. So, it's rare now that you would ever encounter anybody who says that they haven't heard something.

Dr. Malhotra:

Yes. That's a really interesting point, because prior to this, historically when it comes to side effects of drugs, people are more likely to trust the experiences of their friends and family to influence whether or not they take a drug than their doctor, when it comes to side effects. We're seeing this now with the vaccine.

Mr. Jekielek:

This has always been the case, you're saying.

Dr. Malhotra:

This is even pre-COVID vaccines. So, the truth is getting out. It's obviously there under the surface. There's clearly a disconnect now between what the government authorities are telling people to do and what's really happening. In the UK, every week I'm getting a message for the last several months from my general practice, my surgery where I'm a patient, to come and have the booster. Every week I'm getting a text message, come and have your booster. I'm just ignoring it.

And I'm a low-risk guy in his early forties. People are not turning up, people are not going. That's potentially a really bad situation. In some ways I'm glad, because people are being saved, but it's also not good where we are having a great disconnect now between what authorities are telling people to do, people who should be trusted in those roles and those guardianship roles, and the public ignoring that advice. What's going on with the trust?

Mr. Jekielek:

It's a complete breakdown of trust in public health. This type of trust is very hard to earn back, especially if the breakdown of trust is warranted, as you've been telling me today.

Dr. McCullough:

Can you imagine if things were different? Pfizer was approved December 10, 2020. Moderna was approved on December 18. J&J comes out in February. But you can imagine if early on when Pfizer knew about 1,223 deaths worldwide when their product was released? Can you imagine if Pfizer, after about 5, 10, 15, no more than 50 deaths said, "Wait a minute, we got to stop. We got to stop."

They probably knew about that even before Moderna came out and said, "We have to analyze these deaths. We're just going to pause the program, and let's analyze how people are dying after the vaccine." There could have been a deep investigation saying, "People who have polyethylene glycol allergies, and there's

anaphylactic deaths that are occurring right in front of us. There's reactogenic deaths or people dying with a fever and shortness of breath in nursing homes. There are people dying within a few days of heart inflammation, myocarditis. There are fatal blood clots." There could have been risk mitigation.

High quality science could have delivered an answer that. "For these groups here, this is unsafe, but we're going to continue with these other groups." And then, this idea of only applying the vaccine in the highest risk individuals. People have asked me, "Dr. McCullough, were you against the vaccines before they came out?" I said, "I published a cautionary paper regarding it in The Hill."

But what I said was, "Maybe 2.7 million Americans at the most should consider a vaccine initially." That would have been nursing home residents, nursing home workers, and very, very frail people. The patients in my practice who I know couldn't survive two hours of COVID. I have had patients in my practice die of COVID, those are the ones who should have potentially considered the risk of a vaccine.

But we saw it being widely applied to young people, and before you knew it, the newsreels were off of the senior citizens and they were onto children. There has been this incredible training of the public eye on children, even down to infants six months of age. It seems so out of proportion to risk. The risk has always been in the ultra-frail and elderly.

Dr. Malhotra:

Yes. So again, coming back to it, the only explanation, or the best explanation so far for this type of behavior is an entity, an organization that is not behaving in a moral or scientific way. They're behaving in a psychopathic way. That for me is the most likely explanation behind this behavior, until proven otherwise.

Dr. McCullough:

The thing that really worries me is, it's not just pharmaceutical marketing. It can't just be Pfizer, Moderna, J&J, AstraZeneca, and Novavax. It can't. The Department of Health and Human Services and the White House poured billions of dollars into an effort starting in April of 2021, four months into the campaign. It was called the COVID-19 Community Corps—billions of dollars.

It went to churches, community groups, medical societies like the American College of Pediatrics, the American College of Obstetrics and Gynecology, to the NFL, to the media companies, and all the Hollywood production. Hundreds and hundreds of entities received cumulatively billions of dollars. Why did HHS send money to the American College of Pediatrics before it ever came up for pediatric review? Think about that. Our government was basically monetarily preparing the American College of Pediatrics to be in line with pediatric vaccination before the studies were even done.

Mr. Jekielek:

It speaks to what you just said. And in the UK is it a similar reality? I don't know what the spending looked like, but it sounds from what I've read in that ballpark.

Dr. Malhotra:

Yes. Not the same kind of scale of the U.S., but the same sort of thing. Absolutely.

Mr. Jekielek:

Because there was this whole government effort to nudge the population and basically it used fear to elicit the behavior of taking vaccines. Is that what happened?

Dr. Malhotra:

Yes, it was. We were a little bit luckier in the sense that we didn't push or mandate it for everybody, at all. In fact the closest we came, which was unprecedented in the UK, was this initial announcement mandating it for

NHS staff, even though it went against traditional British Medical Association policy, but we overturned that. So that's a good thing. But this level of coercion should never have happened.

Mr. Jekielek:

But what about the vaccination rates? How do they compare, the U.S. to the UK?

Dr. Malhotra:

Still pretty high. Still very high.

Mr. Jekielek:

It's interesting to see.

Dr. Malhotra:

They've gone down massively, though, in the last six months to nine months. In fact, we're actually seeing, which is more concerning, that other safe, traditional vaccines like MMR, the uptake is down there. There is clearly good evidence of decreasing trust, and that's not good at all. It's not good at all.

Mr. Jekielek:

We started talking about COVID-19 and the heart, and vaccination related to the heart. We talked about myocarditis and about heart disease. What are the other effects that exist?

Dr. Malhotra:

Yes. Electrical disturbances of the heart are quite common. I've been managing people who, for no clear reason, are having conditions like atrial fibrillation, irregular heartbeat, non-sustained ventricular tachycardia, which could potentially be fatal if it becomes sustained ventricular tachycardia. A number of patients have cardiomyopathy, a condition affecting the heart muscle's ability to pump blood around the body.

There was a lady in her fifties, I wrote about her, who was very fit and well, and developed progressive breathlessness after a few

months of having the vaccine. She wasn't unwell enough to go to hospital, but she didn't feel right, and a heart scan showed that her heart muscle was severely impaired in terms of its ability to pump. Awful. And again, she didn't have COVID. The most likely explanation was a vaccine.

Unfortunately, anything and everything that can go wrong with the heart is being caused by the mRNA vaccines. Many people are not aware. There are people coming to me where, as a doctor, I make a diagnosis for the likely cause. They have risk factors for atrial fibrillation and whatever, but they haven't got any of that. The clear common denominator is they've had the Pfizer vaccine. It's a real problem. It's massive. It's huge. And most people don't know about it. That's the worst part. Most people are not getting diagnosed. They don't realize that the vaccine is causing them a problem.

Mr. Jekielek:

I just want to reiterate also that we discussed earlier how, because this is a yet untested product, you have to assume that's involved.

Dr. Malhotra:

Absolutely.

Dr. McCullough:

In a real hierarchy of safety, cardiovascular safety is typically number one on the list of being very cautious. In the paper by [inaudible] and colleagues from Bangkok, Thailand, with the first prospective cohort study of children ages 13 to 18 with the second shot of Pfizer, 29 per cent had cardiovascular symptoms. 29 per cent of the kids, when they carefully assessed, had cardiovascular symptoms. 2.3 per cent had bona fide myocarditis. Two children hospitalized. That's out of 333 children. So this gives you an idea. Usually with 333 children, that's not going to be enough to even find a signal. In fact, the signal was quite loud.

There are some signature syndromes with the COVID-19 vaccines. One of them is what's called POTS, postural orthostatic tachycardia syndrome. People feel their heart rate being elevated inappropriately at times, and blood pressure

being labile. There was a paper published in the journal Hypertension, one of our best circulation family of journals, showing skyrocketing of blood pressure in some people who received the vaccine, to the point where it could put them at risk of stroke.

And then, [inaudible] and colleagues published in JAMA a paper from three small Nordic countries, and it's stunning. There were 7,750 intracranial hemorrhages or blood clots within 28 days of taking the vaccine. And in those countries, it's Pfizer, Moderna, and AstraZeneca. They strictly excluded anybody who had COVID during this time period. This is a stunning number. There were thousands of neurologically devastated people within 28 days of taking the vaccine, with hypertension playing a role.

I'll tell you another one. Aortic dissection. It's been well described now that the major blood tube in the body, with this surge of blood pressure can actually rip. This has been published in the peer reviewed literature. Dr. Malhotra mentioned all the different arrhythmias, including young people with atrial fibrillation who shouldn't have it. There's been a study of people with defibrillators in. A defibrillator is great because you can actually measure what's going in the heart before and afterwards, and sure enough, there is a burst of ventricular tachycardia and other arrhythmias with the vaccine. This is undeniable.

This big broad brush of cardiovascular disease falls into the area of thromboembolic disease and blood clots. This was a big feature in that recent documentary about sudden death. With blood clots, and the FDA agrees, and the peer-reviewed literature is loaded with every permutation of blood clots possible—intracranial hemorrhages, deep venous thrombosis going in lungs, and pulmonary embolism. We've heard about ESPN, my favorite collage announcer Herb Kirkstreit, and our favorite weatherman, Al Roker. Deion Sanders had an arterial emboli syndrome.

These are public figures now. Hailey Bieber has had a thromboembolic event. These are public figures now, where they've either come out and said they've taken the vaccine, or we have enough information to suggest they probably did. They certainly

have not refuted they didn't take the vaccine, and have had these blood clotting events, both on the arterial and the venous side.

What I'm finding out in my practice, and the literature supports this, if somebody has a family history of a tendency towards blood clotting or they themselves have a tendency, then watch out. Any other factor that promotes blood clotting like supplemental estrogen, birth control pills, immobilization, smoking, all of those up the risks that someone who takes a vaccine is going to get a blood clot. The alacrity that we need to have in clinical medicine is extraordinary.

In my practice, I've seen two blood clots that have occurred in the arm. There's a common syndrome called thoracic outlet obstruction syndrome in athletes, and so a blood clot can form in the arm because of some stasis and flow. The second-best golfer in the world, Nelly Korda, had blood clot in her arm. She needs to have surgery. She said she took the vaccine, and sent out a cryptic message, "Well, I think I know what caused this," but didn't come right out and say it.

For my patient who had it, it was an emergency. She had to have her first rib removed and then we physically get out the clot, but the arm is not the same. I can tell you, these cardiovascular syndromes are real. We're both cardiologists. This is right in our wheelhouse. And I'm not having anybody come up to me and give me any other explanation outside of the fact that indeed it's due to the vaccines. The literature agrees, the regulatory agencies agree, and at this point in time these injuries and problems don't stop until the vaccines stop.

Dr. Malhotra:

Yes. And what's the conclusion from this? I recently got a text message from a very well-known cardiologist in the UK who doesn't want to be named. He summarizes everything Peter just said. In his view, he said, "We are dealing probably with the biggest crime against humanity since World War II.

Mr. Jekielek:

As we finish up, I want to do a couple of things here. You just mentioned a crime against humanity. That's some of the strongest language you can possibly have. I want to get you to reiterate for me what the real risk is to people who have taken these genetic vaccines, who might feel concerned, and what they can do personally. Then also, we'll round that out with what we need to do as a society to move forward.

Dr. Malhotra:

First and foremost, people should be reassured that most of these issues appear to be apparent in the first few weeks to months after taking the vaccine. I would say one exception to this is corona artery disease. For example, my father had a sudden cardiac death six months after the second dose. We've seen case studies explaining vaccines can even do that several months later. **The acceleration of coronary artery disease is definitely one thing which may be more long term, and we may see more and more heart attacks play out over the next few years because of that.**

Having said that, as a cardiologist that focuses on heart disease reversal, this is a great opportunity for people to really get themselves in shape. That means eating properly, cutting out ultra-processed foods and low quality carbs and sugar, getting moderate exercise, and getting stress levels in check. Optimizing one's health through lifestyle is going to be a good antidote to reduce a risk of complications from the vaccine. That's what I would say for sure.

And then, we need to think about a campaign. Was it Nancy Reagan who launched this Just Say No campaign against drugs in the '80s? We need to have a Just Say No campaign to drug companies and their excesses, certainly in terms of what needs to happen on a political and government level. First and foremost, it should be the end of drug companies testing their own products and holding onto the raw data.

That should never happen ever, ever again. We should never allow this situation to ever happen again. FDA should not be taking money from industry. They need

to be independent of industry funding. Party political donations should not come from Big Pharma. Governments cannot do their job properly if they're taking money from pharma, when it comes to the health of the population. It's a no-brainer.

I believe in true democracy, Jan. Any person, any citizen, any good citizen you may ask in the United States or the UK or Europe, or whatever else, and if you put this to them, all of them, 99 per cent of those people would agree that these links, these cozy relationships with pharma and regulators and government shouldn't exist. That means you need to change the law through democratic means.

Dr. McCullough:

You remember the Big Tobacco settlement, in the end when there's finally a recognition that smoking caused all these problems, the tobacco industry had to pay, and a lot of that payment went to research. We should have a vaccine settlement where there's a massive amount of money that comes back from the vaccine manufacturers, as well as the HHS who actually promoted this, to fund vaccine injury research. We need strategies for screening, detection, diagnosis, prognosis, management.

We need an approach, an agreed upon approach, for the serious syndromes, the cardiovascular, neurologic, immunologic syndromes. We need a complete overhaul of the peer-reviewed literature. We can't have vaccine injury papers being blocked from publication. How can doctors possibly learn to manage them if we can't publish a paper on how to manage vaccine-induced myocarditis or vaccine-induced thrombotic thrombocytopenic purpura?

We need this immediate about-face, and an understanding that the vaccines themselves have caused a public health crisis. A public health crisis. The V-safe data, and the Zogby survey are consistent. Roughly 15 per cent of people who have taken the vaccines are damaged by them. With most of them, the damage starts early, within the first few days. Some of these syndromes extend. And I would say the one

wildcard that I've seen in my clinical practice is subsequent COVID infection.

There are patients who are triple vaccinated and then they get COVID, so they have a fourth exposure now of the spike protein, and then here we go. That recently happened with Al Roker, the weatherman, and he's in the hospital with blood clots. I've seen this in my practice where it's been 18 months since someone's taken a vaccine, but they end up with blood clots, pulmonary emboli. What's happened in between? They've gotten COVID because the vaccines don't work, and so they end up getting COVID on top of it.

With the vaccines, the farther we get away from the vaccines in time, the better we can manage what's going on. If people continue to take shots every six months, we're in trouble. There is a cumulative risk here, where we could get deep into it. There are blood clots that we can't dissolve with blood thinners. There's heart damage that we can't recover, we can't get it back.

My fear is that COVID is still out there. The vaccines haven't ended the pandemic. The fact is that vaccinated people are getting COVID, then taking more vaccines. And we've seen public figures, we've seen President Biden, Walensky, Fauci, Bill Gates and others who have had COVID, they've had shots, and they still keep taking more shots.

When Anderson Cooper and Bill Gates got together, I'll never forget when Anderson asked Gates, he goes, "Hey Bill, we got COVID. You took three shots. I've taken two or three shots. Should we take more shots?" And Gates says, "We got to be safe, we should take more shots."

I would say, as a cardiologist, "No. Stop taking more shots. You've already taken an enormous risk." Remember, people who've taken one, two, or three shots and nothing's happened, doesn't mean they're

risk-free. That fourth shot can be the one that precipitates a cardiovascular event.

Dr. Malhotra:

Peter makes a very good point. There is an accumulative risk. One of the things is, we don't want to scare people too much, but what we need to tell them is just say no right now. Make sure they tell everybody, their kids, their family, their parents, do not take any more of these shots. It's all risk and no benefit.

Mr. Jekielek:

Dr. Aseem Malhotra and Dr. Peter McCullough, it's such a pleasure to have you on.

Dr. McCullough:

Thank you.

Dr. Malhotra:

Thank you.

Mr. Jekielek:

Thank you all for joining Dr. Aseem Malhotra and Dr. Peter McCullough and me on this episode of American Thought Leaders. I'm your host, Jan Jekielek.