NATIONAL CITIZENS INQUIRY

Regina, SK **Day 3**

June 1, 2024

EVIDENCE

Witness 1: Dr. Pierre Kory
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Shawn Buckley
Commissioners, I'm going to formally open the June 1, 2024 hearings in Regina of the National Citizens Inquiry. Commissioners, for the record, my name is Shawn Buckley. I am lead counsel for the Commission. I am pleased to introduce our first witness who is attending virtually this morning, Dr. Pierre Kory. Dr. Kory, can you hear us? We'll ask you to speak just to make sure we can hear you.

Dr. Pierre Kory
Oh, I'm sorry. I was muted. Yes, I can hear you. Thank you.

Shawn Buckley
Yeah, I've been doing that for the last two days. We're very pleased to have you with us this morning. I'll ask if you can state your full name for the record, spelling your first name and spelling your last name.

Dr. Pierre Kory
My name is Pierre Kory. That's P-I-E-R-R-E. Last name is K-O-R-Y.

Shawn Buckley
And Dr. Kory, we swear our witnesses in. So I'm going to ask, do you swear to tell the truth, the whole truth, and nothing but the truth, so help you God?

Dr. Pierre Kory
I do.

Shawn Buckley
And I just want to introduce you to the commissioners. Now, we have entered your CV as Exhibit 207, so R-207 for the commissioners to review. But it's quite a lengthy CV, and I just want to go through some highlights so that the commissioners and those watching this morning understand who you are.

In 1996, you obtained a master's in health policy and administration. In 2002, you received a medical degree. In 2002 to 2005, you did a residency in internal medicine. In 2005 to 2008, you did a fellowship in pulmonary disease and critical care. You are the former Chief of Critical Care Service and Medical Director of Trauma and Life Support Centre at the University of Wisconsin. You have pioneered using ultrasound to diagnose critically ill patients. You have pioneered using hypothermia to treat post-cardiac arrest patients. In collaboration with Dr. Paul Marik, you pioneered the research and treatment of septic shock patients with high doses of intravenous vitamin C.

You were on the front line of COVID-19 hot spots. You led the ICU in New York City during their initial five-week surge. You went on to run COVID ICU units in Greenville, South Carolina. You were also doing this in Milwaukee and Wisconsin. You co-authored over ten influential papers on COVID-19. You are the President and Chief Medical Officer of the Frontline COVID-19 Critical Care alliance, referred to as FLCCC. It is an organization of critical care specialists who focus on the research and development of effective COVID-19 treatments and vaccine injury treatments.

You have written a book on ivermectin called *The War on Ivermectin*. You are likely the world expert on the use of ivermectin. You have 56 peer-reviewed journal publications. You have written several medical books. You have written several chapters in medical books. Now I understand that you have prepared a presentation for us on various topics that we've asked you to present on. I'm going to ask you to go into that, but I do hope you can tell us, before you launch into that, how you came to be—I'll say on the non-government side of the COVID narrative. Because you didn't start on that side.

Dr. Pierre Kory
Correct. When it was apparent that there was going to be a pandemic of a novel virus that was a pulmonary and critical care disease, and I was a pulmonary and critical care specialist—I mean, it was predominantly causing death through acute respiratory failure, which is one of my areas of expertise—I was 50 years old and I would consider that the peak of my career.

And I took it very seriously. I thought I needed to be all focused, needed to be on combating this and figuring out how to treat it. And I quickly became expert in numerous facets of the disease, along with my colleagues—I would say my mentor and friend, Paul Marik, who is one of the most published critical care specialists in the world, actually in the history of our specialty.

Myself and other colleagues, we started sharing papers, preprint servers, talking to doctors around the world. We talked to doctors in China and Italy, Seattle, New York. I have colleagues who run ICUs in New York. And when they got hit, I was on the phone with them every day. And I just immersed myself in everything COVID. I took it extremely seriously. And I testified for the first time in May of 2020 about the critical need to use corticosteroids in the hospital phase of the disease.

I did that at a time when every national and international healthcare organization recommended against their use. And that was the first time I went against, as you said, the narrative and the government's position. I did that in a Senate, in a United States Senate hearing, and I was quickly and roundly criticized for that, almost to the tune of malpractice. However, two months later, that became the standard of care worldwide, was the use of corticosteroids.

And as we continued to study disease, and particularly the therapeutics—that's essentially what we focused on—Paul and myself, we were watching all the trials data, looking to see when the data was sufficient to find a drug, any drug to apply in our protocols, We were building protocols at the time. And we found that the data for ivermectin was more than sufficient in October of 2020. And December of 2020 I testified about the critical need for ivermectin in the early phase of the disease. And the same thing happened, except much, much worse.

That started a war on ivermectin, because there is—and I'm going to end here—as I quickly came to discover, and I'll tell you about today, that triggered enormously powerful and financially-interested institutions and forces for whom ivermectin was very inconvenient to their interests. And I then had to witness the last three years of, as I said in my book, a war on ivermectin. And that was a disinformation war, and I'm happy to talk more about that.

Shawn Buckley
Yeah. No, I'll have you launch into your presentation. I just wanted the commissioners and those watching to understand. I mean, you got into this because as a critical care specialist, you were just trying to find out what is going to help patients. So you were just trying to figure out: How do you basically be of the best service possible to help patients facing the crisis that we were facing?

Dr. Pierre Kory
Correct.

Shawn Buckley
So I'll ask you to launch into your presentation.

Dr. Pierre Kory
Okay. So, actually, let me do share. I'm sorry, give me one moment.

Shawn Buckley
And we can see your screen.

Dr. Pierre Kory
Okay, thank you. So, as I said in my first opening statement about how that led to me to discover that there was a war on ivermectin, I would ask the audience to ask yourselves, who are these forces that would want to attack ivermectin? And it's my opinion that ivermectin was extremely inconvenient to those vaccine manufacturers, because a multi-billion—if you can almost go into the tens or even 100 billion—market for worldwide vaccines opened up, which promised incredible profits to some of the most powerful corporations on earth, if not one of the biggest industries on earth.

And it wasn't just the vaccines that ivermectin threatened. It was also these pipeline patented pharmaceuticals such as Paxlovid, molnupiravir, remdesivir, and monoclonal antibodies. And again, the combined markets for all of these wares are clearly over 100

billion if you look at worldwide. I mean, just in the U.S., we've spent somewhere between three or five billion. It's likely more at this point. So it is a massive financial market that ivermectin threatened. Because ivermectin is obviously, if the audience doesn't know, it's off-patent. It has numerous manufacturers around the world, and it's widely available, and it's extremely inexpensive. There are no major profits to be made off of ivermectin—not at all.

And I want to also call attention to the fact that the system in the United States, this is what's called a forest plot. I don't know if you can see my mouse, but there's a gray line to the right of all these green triangles. That gray line indicates zero effect of a medicine. Anything to the left shows that there's a positive benefit to the use of the medicine. The farther to the left it is, the more potent it is. So this is ordered in terms of potency, according to the summary data of all of the clinical trials done for each medicine.

And if you can see for ivermectin, which I put in under a block at the time that I made this slide, there's now over 100, but there was 93 controlled trials. Approximately 40 were randomized. The rest were observational control trials, which are extremely valid. And so you have these massive evidence bases, some smaller, some larger, for 47 different medications that are effective. I would argue that the audience has no idea that there's that many medicines that have been shown to be effective in clinical trials against COVID.

The other important part of this slide is I circle the only approved medicines in COVID. And it might be a little faint, but those circles, circle the price, the cost. And I find it remarkable if you look at all of the different costs of all of the different interventions—which range from zero, such as diet, to one dollar, five dollar, ten dollar—coincidentally, I find it odd that the United States only approves medicines that are over hundreds, if not thousands of dollars. There's not one cheap medicine on that list of approved medicines. And the only thing that was recommended, especially early on, was fever control with Tylenol. And that, unsurprisingly, increases mortality. It is an absolute myth that you should treat anything but the most severe refractory fevers.

Now, I've already laid out what happened, that ivermectin was very inconvenient to one of the most powerful industries on earth. And the focus of my talk is to talk about the disinformation campaign, or the war on ivermectin, that was launched when the data began to emerge that it was effective. I would say that myself, my colleagues, and Paul Marik, and the FLCCC alliance at that time were responsible for bringing forth and disseminating the evidence of efficacy around the world.

The problem that we came into is: As soon as we started doing that, really bad things started to happen to us and our careers. And the reason for that is that industries, not just the pharmaceutical industry, for years have developed tactics to counter science that's inconvenient to their interest. They know how to destroy inconvenient science. And the science we were bringing forth for ivermectin was extremely inconvenient.

Now, these tactics, it's called *A Disinformation Playbook*, from an article written by the Union of Concerned Scientists back in 2017, where they delineated the tactics that have been used for decades. This playbook was actually invented by the tobacco industry in the 1950s, when data began to emerge that cigarettes were causing cancer. And they actually hired a public relations firm. Remember, this war is actually fought using media and public relations. And they literally disseminate disinformation, which is information intended to deceive and/or harm. And meanwhile, what do they call folks like us, scientists who bring forth this evidence? We are labeled misinformationists. So it becomes a war of those labeled misinformationists against those that are spewing deceitful and false information.

The tactics they use are named after American football plays, for those of you not familiar with American football. And I would say the most powerful is the first one, called The Fake, where they conduct counterfeit science, and they try to publish it as legitimate research. They are actually highly successful at doing that. And they can do it for their own products. They can do fraudulent trials, such as with the vaccines, which I may get to later. And they could also do fraudulent trials to show that competing products don't work, such as ivermectin.

And I'm going to go through examples of this, because I had to witness this. You know, when I first testified in the United States Senate for the second time in December of 2020, and I brought forth all of the evidence around ivermectin, and I demanded that it be globally deployed worldwide, some countries listened. Many cities listened. There are numerous, almost just incredible examples of precipitous drops and deaths and cases when certain regions did that—all roundly dismissed by the media. But when I did that, suddenly we started to see these tactics being deployed against us.

And I didn't know what disinformation was at the time, nor that there was a playbook that industries followed. But within a few months of that testimony, I came across this article, and I would say it changed my life. It gave me an insight into what was happening in the world, because I couldn't make sense of it. I thought that the information I brought forth to the world through that Senate hearing would be welcomed. I didn't know that I would be championed or become a hero for it, but I certainly didn't think I would become a villain. And I was very quickly villainized throughout the world's media.

Again, this is inconvenient science, all of these competing medicines. But keep in mind how threatening ivermectin was. And the pharmaceutical industry is not stupid. They know their medicines. They know their drugs. They know their competitors. And they knew that ivermectin was a threat because the Nobel Prize winner, Satoshi Omura in Japan, he knew that there was ten years of in vitro data showing that it was a broad antiviral against RNA viruses. There was efficacy in the lab against Zika, West Nile, dengue, even influenza. And so he asked Merck early on that we should do a clinical trial. However, Merck answered, no.

Merck actually helped invent ivermectin, but they lost the patent protection from making obscene profits many decades ago. Not only did they refuse to do clinical trials, but they also did the most brazen thing. On the night of February 4, they posted on their website three brazenly false statements warning the world that there's no scientific basis that it might work, there's no evidence that it does work, and that they were worried about its safety. This is one of the safest drugs in the history of medicine, and you have a pharmaceutical company posting brazen lies without scientific authors, without any data.

And on the right of this slide, I will show you what the clinical trials evidence base was on that day that they posted this on this website. And I will tell you the most shocking thing about this. The idea that a pharmaceutical company would spread a lie against competing medicine is not novel. But what was novel to me is to watch the media firestorm that erupted in favour of Merck. I had to watch headlines in major newspapers. I had to see the same lies spewing out of broadcasters mouths across the world's television screens on nightly news that Merck is warning against ivermectin, saying it doesn't work. And that lie was just repeated in this synchronous cacophony around the world. And it was very distressing to watch, because I knew it was a life saving drug. That's when the war started. And that was just soon after my testimony, but they'd already denied looking into research.

At the time, on that day, these were the trials for early treatment and prophylaxis. And that's what's truly remarkable, is that no one ever talks about the massive evidence base for its efficacy in preventing illness. It's far more effective than the vaccines back then, and even now. And early treatment at that time had a considerable base. Now it's much larger. Like I said, there's, I think, 103 controlled trials as of today.

This was, again, some time ago. This is when we were at 99. And again, if you look at most of the results, they are far to the left, showing very potent efficacy against death, hospitalization, time to recovery, and even cases. Yes, there are a few to the right which show that it didn't work or it was harmful for maybe a particular outcome. But those were very small numbers, and I will tell you, those were the ones that the world mostly focused on, rather ignoring the vast majority of the evidence base.

Now I want to talk about the most potent tactic that I saw being used to destroy evidence of efficacy. What happened was the largest trials, the most highly-funded trials in the world began to be conducted and then published. And what we noticed when they were published is we saw brazen, fraudulent manipulations against the ivermectin group when they compared it to controls, and they did the same thing over and over. And I have a chapter in my book called *The Big Six*, because at the time, those were the six largest trials. They were the only ones published in high-impact medical journals, and they were the only ones that launched PR campaigns, again, across the world's newspapers and television stations, which trumpeted these results that ivermectin was found ineffective.

Now first of all, ivermectin was not found ineffective in those trials in a number of cases, although they were presented as such. But you could see in those trials that ivermectin had little chance of being found effective. And why is that? They know how to design trials. They are expert at doing this. They can design a trial to show whatever they want. And I will tell you, the high impact medical journals are not a filter, they are not a safeguard for the publication of these trials. They sail to publication.

And I didn't know how brazen the corruption was at the level of medical journals prior to COVID. In fact, I used to venerate these medical journals. But when I saw what they were publishing and how they were allowing these brazen frauds to sail through, I have very little regard and I have actually a zero trust now in much of the published scientific literature.

So what they did is, first they conducted large trials in areas where ivermectin was ubiquitously available. It was over the counter in a number of these countries, and they were done in regions where the local governments were telling people to use ivermectin. And then they didn't put in much safeguards to exclude people who had been on ivermectin when they entered the trial, so it's very hard to show that ivermectin is more effective than ivermectin.

And then they repeatedly gave low doses. They invented a weight-limited dosing, such as if you were over 85 or 75 kg, you got the same dose as a 75 kilogram person. This is brazenly harmful, because ivermectin is a weight-based drug, You have to dose it according to weight. So they basically took the most obese patients and gave them particularly lower doses.

Then they also had this wide inclusion criteria to allow patients to enter a trial for early treatment trials up to 14 days from first symptoms. And then they tried to only enrol the most mild and youngest and healthiest. Because it's very hard to show efficacy of drug if most of your trial population will never go to the hospital. Then as a result of those things,

you need massive sample sizes to show efficacy when you do these above steps. But I will tell you, they failed at showing inefficacy. And I'm going to give you an example of what they did.

And this is an example of five of the largest six reviews and papers which claim to find ivermectin ineffective. Let's zero in on a couple of them. This is one of the largest and most publicized. This was done by the National Institutes of Health of the United States. ACTIV-6 was their series of research in COVID. And I want to emphasize that this is ACTIV-6. There was around 1, 2, 3, 4, 5—they waited years into the pandemic to do this trial. Every one of the first five rounds were patented, pricey pharmaceuticals. This is no accident. But this was really atrocious, what they did in this trial.

When you do a research trial, you need to submit a trial protocol which goes over exactly how you're going to execute and do your statistical analysis of the data. And it is considered basically research fraud, or I should say it's considered a violation of a research protocol, if you change the outcome that you're studying in the middle of the trial. And I will tell you, my theory is that they were seeing efficacy of ivermectin, and so they had to bury the evidence. So they changed the outcome.

And so if you look at this slide, the original trial protocol was to measure the outcomes at 14 days, which is how sick they were, how many were in the hospital, and how many deaths. And their original primary outcome was the clearance of symptoms, I believe, at 14 days. And in the middle of the trial, they change it to 28 days—for a viral syndrome, an early treatment trial. By 28 days, most everyone is largely better. If you look to the right, the way in which you prove efficacy is you have to set a statistical threshold. Their statistical threshold was anything above 0.95.

And if you see, ivermectin was statistically significantly superior at day 7, day 14—and lo and behold, coincidentally, that statistical significance disappeared, but not completely. What that posterior P means is that at day 28, ivermectin still was 74% more likely to be effective. That's what that means, that posterior P. And so it was showing efficacy all throughout, but the way they wrote this up is that it was ineffective because it didn't meet the 0.95 threshold—which is also misleading and I would argue, fraudulent.

The principal investigator of that trial also committed fraud in hydroxychloroquine. And I just want to make a quick mention that although I wrote a book called *The War on Ivermectin*, one of my colleagues, one of my deeply studied colleagues, could easily have written a book called The War on Hydroxychloroquine, because it was the same war swaying tactics that I went over earlier, and the same results as well.

Now, this one gets even worse. I just talked about ACTIV-6. Now let's go over to the UK and Oxford—right, Oxford University. This is a really good example of how and why they do these things. So this is the comparison of the trial designs for Merck's pricey molnupiravir on the left, and ivermectin on the right. And what is curious about this is that there's the same principal investigator.

And I would like the world, if there was still a functioning media, to interview Dr. Butler and ask him: "Why, with molnupiravir, did they set a limit that you could only enter the trial if you were within five days of symptoms, but with ivermectin, you allowed people to enter up until 14 [days]? And why, with molnupiravir, you only included elderly people or sicker young people, but with ivermectin, you included anyone over 18—you had no comorbidities or illness?" And then also, "Why in one case you would treat for five days and the other twice a day, and the other one you only do three days?"

And what I will tell you is, what he did with molnupiravir is truly a historic feat. Which if you look, they randomized 25,000 patients a median of two days from onset of symptoms, which is truly an impressive feat that takes incredible skill and effort and resources to do that. However, with ivermectin, they allowed up to 14 days from onset. Why would you randomize everyone within two days for molnupiravir, and [then] let people go up to 14 days?

And then the other thing is, with a lot of these patented pharmaceuticals, you hear about the results first from a press release and then you get to see the data, and it usually comes out very quickly after the trial ends. However, with ivermectin, these people sat on the results in the middle of a pandemic for 19 months without a peep, without anyone knowing what they found.

There's other anomalies. So for instance, in the middle of the trial they suddenly announced that they had run out of ivermectin—one of the most widely available medicines in the world. And a journalist called the supplier of ivermectin to that group in Oxford, and the supplier answered that: "We have no problems with supply." We have no idea why they suddenly announced that they'd run out of a med, which also would be a historic failure of any research trial is to run out of research medicine that you're studying.

Again, I talked about this massive delay between completion and publication, which is unprecedented if you look at—well, they're still sitting on their hydroxychloroquine trial results, so I shouldn't say unprecedented, because they've sat on those results now for over 1000 days. But with these repurposed drugs, they often take just immense amounts of time.

Now, the other things that they did is worse. So the long delay between registration and enrolment: When participants were filling out forms, they weren't hearing back from the trial until eleven and nine days later. These are two participants who showed their study enrolment papers and when they contacted the trial. So while they were slow walking the enrolment, they were also slow walking the medications.

With molnupiravir, they were getting the medication the next day, overnight. And with ivermectin, they first were allowing people to pick it up quickly, and then they removed that and forced everyone to get a delivery. But when they delivered it, again, molnupiravir was the next day, but with ivermectin, they did not require it to arrive there on the next day. And so you could see that these aren't just biases. These are overt, brazen tactics meant to do a trial to hide the evidence of efficacy.

And then they went even further, if you'll believe this—I mean, this is truly incredible actions that they took—but then they stopped being open every day. And so they only were open five days a week, so if you got sick late in the day on Thursday, you were never going to enrol or get any medicines until middle or the late of the next week. This is a list of the crimes. I'm not going to go over it. And if you think I can't make the story worse, I'm going to keep making it worse.

In the actual paper which was published— And I have to also put out another anomaly. All of the other big trials done by these august and respected institutions were published in high-impact medical journals. This particular trial, which was packed with the most brazen fraudulent actions, was published in the 7th most popular infectious disease journal, which I will guarantee you, no one but an infectious disease physician would ever read. They buried it in the medical literature, which is one of the most important and largest trials of ivermectin in the world for COVID—and Oxford buries it in a 7th ranked journal.

But here's what they found. They actually found a highly statistically significant result in favour of ivermectin, which is that patients were fully better two days earlier than if they weren't treated. That is a highly meaningful result to most people: to be better, fully better, back to work, whatever you want to do, two days more. So you would think that this appeared on headlines around the world. No, it did not.

They found many more results that were positive in favour of ivermectin in terms of Long COVID symptoms. So they were showing statistically significant reductions in Long COVID symptoms, as well as getting better quicker. These are even more in favour of ivermectin. But here's how it was published, and this has happened before in the medical literature. So despite all of that incredible data in the paper, I'm just going to read the conclusion in the abstract as it was published: "Ivermectin for COVID-19 is unlikely to provide clinically meaningful improvement in recovery, admissions, or longer-term outcomes." That is a brazen lie. Their data contradicts that statement, but that's how it was published.

So how could they have pulled that off? I'll show you. They invented a statistic called "probability of meaningfulness,"a statistic whose calculations I have no ability to understand or comprehend. But I will tell you, it has never been described before in the medical literature. I cannot find any example of this statistic called "probability of meaningfulness."

And here I'm showing that in the budesonide trial that Oxford also did, this is how it was published. There, they found a three-day improvement in full recovery. They did not include a probability of meaningfulness. But for ivermectin, they invented this new statistic. It clearly didn't meet whatever threshold they held, and that is how they supported that conclusion. That is a lie.

Other anomalies is that when this was published, you could find it nowhere. I looked for the results of the Principle trial. Any coverage of this Principle trial I could find nowhere on Google searches and, oddly, on their own website where they have the results of other medicines that they studied. So they studied numerous medicines in COVID—they didn't even put the results on their website.

Other things that they do, is that I have in my book documented many researchers around the world that I was collegial and part of a network with, who are writing to me that they couldn't publish their studies of ivermectin. So they would censor positive studies. They would selectively publish these fraudulent, negative studies that I already detailed to several of them, and then they would reject all positive studies. Some of them were very high quality studies from very esteemed professors that I list here, and yet they were getting rejected, rejected, rejected from anything but 3rd tier journals.

And then those of us who were successful in publishing in high profile or well-regarded journals suddenly found our papers retracted for unprecedented reasons and sometimes no reasons. And so these are some of the examples of the retractions. My own paper with my group and Paul was retracted even after passing full peer review. Three rounds of peer review from senior scientists—suddenly the journal decides to retract.

And then you see in the medical literature, in the high impact journals, you see these editorials just arrogantly dismissing and denigrating anyone who believed that ivermectin was effective. And they always use the same argument. Everyone who believes it's effective were later proven false by high quality, rigorous trials. Over and over again, you'll hear that

the largest, most high quality, rigorous trials showed it was ineffective. So, anyone who thinks it's effective is dumb, wrong, and doesn't understand science.

I just gave you guys examples that that is absolutely the opposite of what is true. Those supposedly high quality, rigorous trials are brazen frauds. And this has happened around numerous medicines over decades. So this is not a new phenomenon. These are not new tactics. I'm just trying to articulate and show you how they did this with ivermectin.

Now, outside of the medical literature, they did plenty of other things, so they go after researchers and institutions. And Dr. Andrew Hill from the University of Liverpool, who I used to be a colleague with and worked, he somehow was made to retract his own paper. He willingly retracted it, self-retracted it, and republished it as a negative review. The first one was astoundingly positive. It included 24 randomized controlled trials. And so what he did—and this is actually in the *New England Journal of Medicine*—is he started removing trials from his evidence base using invented categories.

So if you can't read it, that drop off from the trials in the red, he excluded potentially fraudulent studies. I would challenge anyone to define what a "potentially fraudulent study" is. It was not defined in the paper. Then he excluded high risk of bias studies, which is defined. That's fine, but that's actually not a typical action that you do. You actually include all trials, whether they have high or low risk of bias. But then—and this is where it gets almost laughable—he excluded studies with "some concerns."

Who knows what those "some concerns" are? But it allowed him to further disappear the statistical significance of his findings. And then that basically reversed everything. And basically this painted the narrative, which you saw throughout the media over the last few years, that all of the positive studies are fraudulent. Again, the world is upside down. The positive studies in the high impact journals were actually the ones that were fraudulent. But these that weren't published in high impact journals were made to appear fraudulent.

They also manipulate agencies. The WHO did very similar behaviour. What I find interesting about the ivermectin review by the World Health Organization—okay, the World Health Organization—is this you're looking at, what's called that forest plot, of just prevention trials. The WHO: How are they going to address this? There's not one negative trial. Several of them are randomized controlled trials. Several of them are quite large. And so it would be very hard to dissect or disappear this evidence base. And if you look, on average it's 82% improvement, but there's a number of studies where almost no one got COVID if they were taking ivermectin. This is really threatening to the other side.

So what did the WHO do about this? Very simple. This sentence appeared in their guideline: "While ivermectin is also being investigated for prophylaxis, this guideline only addresses its role in the treatment." So I would ask the audience to ask yourself, why would World Health Organization, a purported public health organization who has the world's public health as their primary purpose, why would they not look at the evidence base for an ubiquitously available, extremely safe, and highly effective preventative?

I think you all know the answer, but I'm going to say it anyway: This was the biggest threat to the global vaccine campaign, which made many dozens, if not $100 billion for the pharmaceutical industry—and so they just ignored it. And the evidence of regulatory capture by industry at the WHO over the last two decades is astounding, and I don't have time to go into it. But that is literally an organization that works solely and directly in the interests of the pharmaceutical industry.

And the evidence base that they were faced with, they just started excluding trials, just like Dr. Andrew Hill. Even though all those trials originally met their protocol for trials to look at, they excluded, excluded. But here's where it gets worse. Despite all the exclusions, in their own guideline they found that in the trials for ivermectin, the ivermectin groups had an 81% less chance of dying—and it was a statistically significant result.

So I would ask you to ask yourselves: "What did they do about this? How could they not recommend ivermectin when their own data that they had acquired showed that it reduced mortality by 81%?" Pretty simple. They wrote this. They actually did not recommend it because the GDG, the Guideline Development Group—and it pains me to read what they wrote in that document, because this is a crime, this is actually a crime against humanity—they wrote that they "inferred that almost all well-informed patients would want to receive ivermectin only in the context of a randomized controlled trial, given that the evidence left a very high degree of uncertainty."

Now what uncertainty is there? It was a statistically significant result. It was a large reduction in the most important outcome of any medicine, which was death. There are very few medicines in history that reduce your chances of death—maybe outside of antibiotics—of 81%. Well, what they did is they graded the quality of evidence. This is another trick that they do when they find inconvenient science. All you have to do is call it low quality and say it's not to be trusted. That's essentially what they did here.

But this is what they're really saying. This is how I understand it as just one human on this planet, is that they're telling me—and I'm going to consider myself a well-informed person—they're telling me that I would want to refuse to take ivermectin outside of a randomized trial.

Even if I were in bed breathing at 30 times a minute with advancing COVID on six litres of nasal cannula, and a doctor would come in and say, "You know, Mr. Kory, we have this medicine. It's called ivermectin. It's been around for decades. It's really safe. And the best available evidence shows that it might reduce your chances of dying by, like 81%. But you know, the WHO thinks that the trials evidence is of low quality." And I would say to that doctor—while breathing with advancing COVID and increasing oxygen requirements—I would say to that doctor, "I'm just not comfortable taking that unless it's in a well-studied, well-organized trial." This is absurd. This is a crime. But this is what they do.

Compare that to how they approved ivermectin for other diseases like scabies and strongyloidiasis: worldwide approval on minimal evidence bases when you compare it to ivermectin [for COVID].

And then the censorship in the media and the journals. Obviously, I hope you all know about Trusted News Initiative, but it's essentially the largest press corporations, media corporations in the world who combine together to censor information that is inconvenient to those with financial powers. Simply, that's the best description that I can do it. Our social media was censoring it. You posted about ivermectin, you got deplatformed, shadow banned from any one of the social media platforms. They were vicious: Facebook, YouTube, Twitter, LinkedIn, you name it.

And then we find out that our U.S. government paid a billion dollars to media corporations to run PR campaigns for the vaccine: "Safe and effective. Safe and effective. Get your vaccine. Unvaccinated people are bad." And so we were washed in false propaganda from the beginning, and it was paid for by our own governments. Bill Gates, the amount of money he gives to media organizations is astonishing: 24 million to NPR. Why would this purported

health philanthropist have to give so much money to for-profit media organizations? It makes no sense unless you know why he's doing it, which is he needs to control what the citizens on earth believe. He gives money all over the world, numerous countries, and the largest media corporations.

And what those media corporations did is in every article you saw, in mass media you saw the same statements uttered and quoted, with lettered doctors saying all sorts of absurd and false scientific statements like: "All of the studies were small. They were low quality. They were observational. They only work/showed efficacy in parasite countries. Ivermectin advocates promote it with religious fervor." And that's a form of censorship, because what they're doing is they're trying to denigrate and insult and make those advocates like myself appear uncredible.

Notice how they say ivermectin "advocates" and not ivermectin "experts." And why are they saying that I promote things with religious fervor. I'm a physician, I'm a clinician, I'm a scientist, I'm a researcher. It's not about religious beliefs. But yet they want to do that so that people don't listen to us, because they want to make those doctors who believe it works appear uncredible.

And then they make it seem like we want to have political careers. My entire medical career crashed and burned. I lost multiple jobs because of my supposed advocacy. It's absolutely horrible. And that is actually a tactic called The Blitz. And they've been doing this for years. Merck used to run a campaign with their Vioxx scandal. They would keep hit lists of doctors who were trying to bring forth the information about the toxicity and lethality of Vioxx, and they did that for years. And those who found that ivermectin was effective, if you just look at the FLCCC, our careers ended. Three of the five careers ended, in academics at least, with false accusations, medical board complaints, forcing to retire.

Umberto Meduri worked for the federal government in the VH [Veterans Health] Administration and we have, under very good confidence, knowledge that that call to force him to retire came from Washington to his hospital in Memphis, Tennessee. Flávio Cadegiani in Brazil, same thing. His advocacy for early treatment drugs: he was in court, I think, eleven different accusations in court. He was even falsely accused of crimes against humanity. This is what they call The Blitz.

I'm going to finish here and just talk about what I think was the penultimate battle in the war of ivermectin, what finished ivermectin for good—at least in terms of major knowledge of efficacy and widespread use. And this is what they really had to resort to. So what I call is this was the horse dewormer PR campaign.

And it began in August of 2021. It was triggered by data that came out of the pharmacy databases showing massive rise in ivermectin prescriptions. And the other side had to do something about this, because if it was continuing to be used at such a high rate, real world knowledge of its efficacy would spread like wildfire. Patients would be telling their friends, their colleagues, their families, "Hey, my doctor gave me ivermectin, and it worked." Doctors would be treating more and more patients, realizing that it was having amazing efficacy, telling their other doctors—and they couldn't let that knowledge spread.

So what did they do? They started a war. And the first shot in the war was in the lower right hand corner, when the FDA put out that historic tweet about: *You are not a horse, you are not a cow*. FDA starts making fun of a medicine, making it appear uncredible. Like, who would take a horse medicine, right? And that was August 19, 2021. This is after that pharmacy data came out.

Five days later, August 26, upper left hand corner, the CDC puts out a false advisory. They are trying to make it appear dangerous, right? So first it's uncredible, then it's dangerous. And that was investigated by investigative journalists, who found that it was inaccurate data on rises and controls, and it was actually inflated. It was like, I think, four calls increase, and they called it a 70% rise in calls to poison control centres. This is propaganda.

Remember what propaganda is. It's a story or a message to get you to think or act in a certain way. These are little messages and stories. They're trying to influence your thinking. So first it's a horse medicine: "It's uncredible. Stop using it, folks." Then it's a dangerous medicine, right? So they're sending little messages about danger. They know how to use media. They know how to use propaganda. And then if you look in the top right corner, September 1st, a few days left, and look how each action is spaced out by five days: boom, boom, boom. These are propaganda bombs.

Then you have some of the largest professional organizations in the country suddenly calling for the immediate cessation?—of prescribing, dispensing, and using, what I would think is fentanyl—but no, it's ivermectin. They're going after one of the safest drugs in history. This is absolutely terrifying that an industry this powerful can use these agencies and these organizations to spew propaganda at an average citizen in the United States.

That FDA action was finally reversed. The FDA was forced to admit through a settlement that they acted outside their regulatory authority, and because they knew they were going to lose the case. And I want to credit my colleagues, Mary Talley Bowden, Paul Marik, Robert Apter, who are the litigants in that lawsuit. And the FDA was forced to remove every single thing they've ever said about ivermectin on social media and on their website.

Then after those three actions by the agencies, then they brought in the real infantry and they launched the infantry, which is all of the world's media. Suddenly, you saw a PR campaign with the only thing that late night talk show host broadcasters would say is: "horse dewormer, horse dewormer, horse dewormer," again, "message, message, message" that no one would want to take a horse dewormer to treat. That is the most crazy idea. And that's why I was laughed at. Numerous late night hoax joked about it—and that was around the world.

And the prize for the most absurd propaganda goes to the Rolling Stone who put this article in. And let me just read the headline: *Gunshot Victims Left Waiting as Horse Dewormer Overdoses Overwhelm Oklahoma Hospitals*. I would like you to read that again. That is made, in my opinion, by a professional PR agency—an assassin of a PR agency. Because that was "Clippy." That went viral. Who would not click on that headline? It is so absurd, you have to read it. And the thing about that headline is it was 100% false.

The hospital the next day said that the doctor who was quoted in that article as saying that absurd headline hadn't worked for them for three months, and they hadn't seen one ivermectin overdose. But remember, a lie goes halfway around the world before the truth gets its pants on. The other thing about this is: look at the headline. Basically, you have to picture someone who is shot by a gun in the stomach, bleeding, trying to hold the blood back, and they're left waiting as ivermectin overdoses are rushed in, in gurneys. I mean, this is absolutely absurd that Rolling Stone would publish something like that.

Then I think I can play this for you. Can you hear the audio?

Shawn Buckley
We can.

Dr. Pierre Kory

> [Audio playing] —*reporting that their calls are spiking in places like Mississippi and Oklahoma because some Americans are trying to use an anti-parasite horse drug called ivermectin to treat coronavirus, to prevent contracting coronavirus. What would you tell someone who is considering taking that drug? Don't do it. There's no evidence whatsoever that that works. And it could potentially have toxicity, as you just mentioned, with people who have gone to poison control centres because they've taken the drug at a ridiculous dose and wind up getting sick. There's no clinical evidence that indicates that this works.*

I would just like to point out what the evidence base was on the day that they trotted out Dr. Anthony Fauci onto a national television prime time show to issue talking points. If you notice, he said it twice: "There's no clinical evidence that this works." This was the evidence base on that day. All of those green bars are positive results for ivermectin. There were 63 controlled trials, 31 randomized, and he goes out there and says a brazen scientific lie. And he also puts in a talking point about how dangerous it is.

Again, he is a master practitioner and participant in propaganda. And I'm finishing here. But this propaganda went around the world in headlines and major media periodicals. And by the way, that horse deworm PR campaign that I just ran through, if you see all of the timing—August 19, August 26, September 1, Dr. Anthony Fauci on August 29—I mean, this was a bombardment of propaganda. And it all led up to one month later the announcements of Merck's molnupiravir and Pfizer's Paxlovid in press releases that we have a life-saving drug coming. They had to clear the way to launch these drugs for their immense profits. And I'm going to stop there. Thank you.

Shawn Buckley
So, Dr. Kory, and that's just one of your presentations, am I right?

Dr. Pierre Kory
Yes. I have other topics.

Shawn Buckley
One thing that came to my mind as you were giving this presentation is, even when you were referring to the one trial that was published where they're trying to say it doesn't work, that there was an 81% reduction in mortality of COVID cases. And am I correct then that the other studies would show similar reductions in mortality?

Dr. Pierre Kory
So that was the WHO. That was a meta-analysis. So a meta-analysis is where they include a number of studies, and then they do a summary analysis of all of their data. And that's where in their collection of trials that they included—this is after excluding numerous trials with immense benefits—they included only a certain collection and then deemed them too low quality. But despite that, it was a statistically significant reduction in mortality, is what they found in that collection of trials.

Shawn Buckley
Right, of 81%. I'm just wondering, looking at all of the clinical evidence that you consider reasonable, is 81% reduction in mortality a figure you would settle on, or would the figure be higher or lower?

Dr. Pierre Kory
I would say that would be approximately correct. I think the efficacy depends on timing. If you were to distribute ivermectin to every household in the world that they could take upon first symptoms of COVID, I would say the efficacy in terms of death would be much, much higher. A lot of those trials vary in the timing of when they started that treatment. But 81% for a reasonably-timed and prescribed drug would be on the low end for me.

Shawn Buckley
Okay. And where I'm going with this is: I'm just trying to figure out then, because this is life and death. I mean, we're talking about a reduction in death by COVID. We had Dr. Tess Lawrie as a witness yesterday, and we watched clips from the Zoom call that she had taped with Dr. Hill. And she's saying in those clips—and this would just be the UK I think, the data—but literally we're talking about 15,000 people per day dying that could be saved, you know, most of them saved with ivermectin. What type of numbers would we be talking about in the United States of lives that could have been saved if ivermectin had been promoted instead of basically attacked?

Dr. Pierre Kory
You're talking the vast majority. I mean, we've had over a million deaths in this country alone. You're talking about in the many hundreds of thousands. But I would argue, I haven't testified about hydroxychloroquine. But remember, hydroxychloroquine was widely advocated for much earlier in the pandemic. Had that become the standard of care early on, like in the spring of 2020, I would say that almost all of them would have been avoided, because there was numerous other things that you could have done. But in both cases, yes, hundreds, hundreds of thousands of lives would have been saved.

Shawn Buckley
Right. And I'm thinking, I don't know if you're familiar with the work of Denis Rancourt.

Dr. Pierre Kory
Yes

Shawn Buckley
But I think he's worldwide indicating that there's excess mortality of around 17 million. And it seems that the main intervention that's changed is the vaccine, because he also does it temporally. So if we're talking 17 million deaths worldwide, if hydroxychloroquine and ivermectin, and my understanding is combination treatments can even be more effective, literally we didn't have to have most of these deaths at all.

Dr. Pierre Kory
Not at all. The ways in which this pandemic could have essentially been extinguished, and extinguished early on, are innumerable. And I would just argue that one of them would have been mass campaigns to check and replenish vitamin D levels. Vitamin D: I just would like to say one little thing. The way in which I discovered that article called *The Disinformation Playbook*, was because one of the world experts on vitamin D, who had been doing research on vitamin D for decades, wrote me an email one day. And it said, "Dear Dr. Kory, what they're doing to ivermectin, they've been doing to vitamin D for decades."

The vitamin D literature is so polluted with fraudulent trials showing that it doesn't work for anything. It's a massive threat, but to the pharmaceutical industry, that they have so many trials showing that vitamin D is a nonsense intervention, when actually it's extremely life saving. And had we treated the widespread pervasive vitamin D deficiency, particularly, I would argue in the U.S.—and I don't know what Canada's like, but you guys are pretty north of the equator; I would imagine, especially in the winter, vitamin D levels are quite low—had that been addressed, we would have had a very different landscape.

Shawn Buckley
Now, and I don't want you to be worried about the time, we're about 38 minutes before I want to turn you over to the commissioners. Can we address the shedding issue and then perhaps also the issue of side effects caused by the vaccine?

Dr. Pierre Kory
Yes, I'm happy to share my summary review of shedding. Let's see. Give me one second. I'm sorry, I'm just having—just give me 1 second. I don't know why it's not coming up, but I'll try one more time. Okay, here we go.

So I'm sure many people are not aware of the concept of shedding, but I will tell you that the FDA is. So the FDA, as far back as 2015, published a document called *Gene Product Shedding Studies*. And also in a similar European Medicine Agency's document, they also talk about shedding. So gene therapies—and a good example is the mRNA vaccines, right?—the definition is that they mediate their effects by transcription of genetic material. We inject them, genetic material, they transcribe it and they make a protein.

And so that's what these are. So what happens is the protein that the genetic material is programmed to produce, that protein can be shed through any number of ways. And so in their own document, they define shedding as the release of the gene therapy product by any or all routes: feces, secretions, skin, urine, saliva, fluids, and I would argue, even exhaled breath.

All gene therapy products that I have found have shedding on their inserts. So there's a product called Luxturna, which can go up to seven days in the secretions. Another one called Roctavian: in the semen for six months. That means the genetic material is producing that protein that's supposedly therapeutic, and it's going into the sperm for six months. Another gene therapy product was for a month in the feces. And so you have to be careful of the feces. And I would argue, I'm sure that the shedding was occurring in other fluids. If it's going into the semen for six months, you have to wonder why it's not in other routes.

Pfizer knew the risks of shedding. They had it in their own trial protocol that a number of exclusions—they didn't want people to enter the trial if they were exposed to vaccinated people. There's no other explanation for these exclusions. Even those breastfeeding or

having been exposed environmentally, they have it in their own trial. They're literally admitting that they were worried about shedding, as they should have been, because the FDA literally recommends shedding studies be done for all gene therapies.

The other problem, the other piece about shedding that you have to understand, is that the mRNA vaccine is a nanoparticle technology. So the mRNA is injected in these lipid nanoparticles. And the reason why, is the lipid nanoparticles can cross any physiologic barrier: They can cross the skin, the tissue, the lungs, and they can go through cell walls and any membranes. Now that's the synthetic nanoparticle. But we have a biologic counterpart, which is called an exosome. Exosomes are also tiny fatty sacs which circulate in our bodies, and they actually direct cell behaviour. They're almost hormonal in that they are parts of cell-to-cell communications.

Now, exosomes can take up any number of things, like nucleic acids, proteins, lipids. And what's been found is that exosomes can take up the spike protein. They're constantly produced and they are involved in intercellular communication, and they also can disseminate widely. You know, we were told that the gene material and the spike protein would only be produced locally. That's not true. The spike protein that was produced was then carried throughout the body in exosomes.

These exosomes can cross the placenta. They can go into breast milk. Again, this is why those other gene therapy products were shedding as well, and like I said, they can cross biological barriers. From one review paper, these ultrafine particles are capable of entering the body through skin, pores, debilitated tissues, injection, olfactory, respiratory, and intestinal. So exosomes, these tiny fatty sacs, they are ubiquitous and they can be excreted, and they can be absorbed by others.

And so the mechanisms of shedding, as I understand it, is that you need to disseminate the spike protein widely. It has to go either to the lungs or other places where we secrete or exhale. There would have to be sufficient concentration in those areas to then make someone else sick. And then once you excrete them from whatever orifice or manner, then they would have to be absorbed by someone close by. And in terms of pregnant women, they would have to either get to the baby through the placenta or through the breast milk.

Well, low and behold, we have evidence for all three of those mechanisms; [they] are actually a reality and they are scientifically proven to occur. A leaked EMA letter noted that mRNA is distributed widely. A Japanese document showed that the lipid nanoparticles go all over the body and they distribute to every organ. And even Australia's TGA evaluation report noted and revealed that the nanoparticles go everywhere. So spike protein can be produced everywhere in the body, and not just the arm.

The other thing is that spike protein has a particular affinity for the biological counterpart of nanoparticles, which is the exosomes—which is what exits the body. And we know that mRNA and spike protein can circulate in the body for wickedly long times. One study which ended after 187 days, in at least one study subject, found circulating spike protein in the blood—let alone the tissues, but in the blood. So they're produced widely, they're produced for long periods, and spike protein-coated exosomes can trigger an immune response in lung cells.

These are studies demonstrating vaccine product persistence. And then there's case reports of this dissemination. There's one actually published study of a man who died of a horrific encephalitis, brain inflammation. And on autopsy they found spike protein everywhere throughout the brain, the heart, the muscles. And then another autopsy series

by a German pathologist: He found that in the 50 autopsies where he was asked to stain for spike protein as a second opinion because families were strongly suspicious that their loved one died, he found disseminated spike in numerous organs and causing massive damage—particularly to blood vessels, which then led to the death of the patients. And I will tell you, it's standard protocol around the world to not look for the spike protein, which is another part of this multifaceted fraud.

Now the third condition is that the exosomes must be able to enter the body. The inhalational route presents the highest risks, and that's described in gene therapy and nanoparticle literature. When inhaled, specific sizes are efficiently deposited by diffusional mechanisms in all regions of the respiratory tract, so we know they can be absorbed. What's shocking is that in a 2023 study, they actually looked at children of vaccinated adults and they found that the children who hadn't been exposed to COVID, hadn't gotten COVID, suddenly they were showing antibodies to the spike protein.

Now in that paper, the researchers hypothesized that the parents' antibodies were being transferred to the children, presumably through the breath. But I've never heard of humoral immunity being transferred to children, otherwise I would be immune from every disease or virus that my parents had had. It doesn't happen. We know that it's the spike proteins that are being shed to those children and they're developing antibodies to the spike. We know that the mRNA is found in the milk at varying time points and it is packaged into breast milk extracellular vesicles. Extracellular vesicles, or EVs, are the same thing as exosomes.

Can baby absorb vaccine products? Well I would have thought that if a baby got it through breast milk that it would be destroyed by the acid in the stomach. But actually it's been shown in numerous papers that the encapsulated exosomes is protected from gastric juices and actually can enter the body through the intestinal wall.

And I give you a clinical example of that, is that in the post surveillance data for these, is that there were these breastfeeding catastrophes: central nervous system hemorrhages and strokes in babies who were breastfeeding—and they were removed. They were excluded from the post surveillance data. And this is literally the reasoning that Pfizer gave: "The two cases were determined to be non-contributory and are not included, since these two cases involved babies who were indirectly exposed to the vaccine through the breasts."

So if anyone wants to doubt that—"Shedding is not real"—you need to ask Pfizer why they admitted in their rationale for exclusion that the baby actually got the vaccine through breast milk. They're literally using that as a rationale.

Other neurological catastrophes: convulsions, strokes. I've never heard of this before. I've never heard a baby breastfeed and suddenly start seizing, outside of any other context of being ill. And again, they are excluding these from that post-surveillance database and they're using the reason is that, "Oh, it wasn't a vaccinated baby, they were only indirectly exposed through breast milk." It's absolutely absurd.

Anaphylaxis: Mother of twelve month-old boy received first dose of COVID-19 vaccine at 9:15 am. She breastfed her twelve month-old son three hours later, and while breastfeeding—and while breastfeeding—the child developed acute anaphylaxis. Again, a number of these respiratory failure after breastfeeding. I mean it shows that in certain women who are producing a lot of spike protein, that breast milk can be quite toxic. And these things are reported.

Skin exfoliation: This is a paper showing the massive amounts of menstrual abnormalities reported to VAERS, which is unprecedented. And the CDC has a threshold, a proportional reporting ratio, so a PRR. Per the CDC, anything over two—which is if there are reports that are two-fold more than the baseline reports for the flu vaccine—that is a trigger for a danger signal, and that should be investigated. So if you have twice as many COVID adverse events than the flu for any particular symptom, it should be investigated.

Well, in this paper, they showed that VAERS was showing in some cases near 10,000 the PRR for any menstrual abnormality compared to flu—miscarriages, you know, in the hundred. And so these are proportional reporting ratios that have never been described for any vaccine released. This shows you how toxic these vaccines are, particularly to the menstrual. And why is it so damaging menstrually? Why would a mother who got vaccinated have so many menstrual problems? And again, it's because of shedding. I believe this is the transplacental exosome transfer of spike protein which is toxic to children, not only through the breast milk.

And then we have collected well over 1000 reports that patients have written to myself on my Substack that I've collected that show numerous side effects, along with a colleague of mine who wrote a similar one. Now, there's also a paper which is still on preprint, and it will never be published, that paper, and I've talked to one of the authors, but it's the famous paper with Seligmann as the senior author, where they showed a consistent correlation between vaccine rollouts and mortality.

Now, there was an unnoticed fact in that trial which they also found, that in several countries, in U.S. and Europe, at a time when the adults were getting vaccinated in the rollout of the campaign, they noticed that unvaccinated young people who are not eligible for the vaccine, their excess mortality also rose for a period of 18 weeks. So I think that is indirect and very compelling data to show shedding, right? So the definition of a shedding event for me is—actually it's defined as the development of a typically-described adverse event of the vaccine by someone exposed to a vaccinated person. And so young people dying at increased rates as we're vaccinating older people would be a pretty good explanation for that.

Another group called My Cycle Story very early on: And I just want to mention menstrual irregularities is far and away the number one symptom of adverse events, not only in vaccinated women, but also in unvaccinated women. When the vaccines rolled out, many, many, many women noticed after years or even decades of normal cycles that they were developing menstrual abnormalities: amenorrhea, loss of period, heavy bleeding, irregular periods, prolonged periods. And this was censored on social media, dismissed as anecdotal. But the science is there for it. There's very good reasons as to why that was happening to those women.

And there's not only primary shedding, where you can be around a vaccinated person. But there's also secondary shedding that's been described, where a child comes home from school and the parents sense they start developing adverse events just from exposure to a child who's exposed to other children. And what I would say about shedding—now I'm going to the clinical aspect based on my expert observations as an expert who treats vaccine-injured patients, Long COVID patients, and who's collected a lot of these clinical reports—but the sensitivity to shedding varies. I would argue that most of us are not sensitive. It's generally kind of highly environmentally-sensitive people.

But I would also argue many people don't know that they'll get a certain symptom and not feel well. They don't know that it could very likely be because they were exposed to

someone that was shedding a lot of spike protein. But the descriptions that we've collected in the thousand, I mean, it's totally reproducible. People are just talking about the same things happening in the same situations or being around certain people. It's just too reproducible. Unless there's a conspiracy where they all got out there to produce these reports, it's impossible. And many of them are actually produced and written by researchers, doctors. And so like I said, it's mostly sensitive patients.

The characteristics are they tend to be more susceptible during booster rollouts or early on in the campaign, or someone recently vaccinated. But there are others who are sensitive to vaccinated people even far long after they've been vaccinated. Young and healthy people tend to shed more frequently, and it actually varies by the individual. So for instance, some people they would go to church and they'd be fine, but there were certain people at church that they felt that kind of made them ill, gave them dizziness or vertigo or nausea.

Most common by far is menstrual abnormalities. Decidual cast shedding, which is historically extremely rare when the entire lining of the uterus is shed, that has been described numerous times by women who weren't vaccinated whose husbands were. And this happened soon after the husband was vaccinated. Some of the anecdotes are extremely compelling and actually have led to divorces. There was one description where the woman, every time her husband came to bed she would get violently ill with headaches. And she actually could not physically be around her husband because she was so sensitive to the spike protein that he was shedding.

Headaches, tinnitus has been described. Nosebleeds, dizziness is also extremely common, and even brain fog. Less commonly is things like atrial fibrillation, peripheral neuropathy. But these have all been described by people who suddenly had close exposures to vaccinated people, and they never had these symptoms before. And the symptoms would develop in temporal associations of exposure as well as resolve, as those exposures removed or a few days would go by. But a lot of times these symptoms would occur repeatedly.

So for instance with seizures, there was one report of one man who, he went to numerous social events after which he would have a seizure. And in fact, he was one of the rare cases where we had a report of death. Although this happened a few times, he actually went to Thanksgiving dinner, and after that Thanksgiving dinner, he had refractory seizures and died. And so the patterns, the temporal associations, the reproducibility shows that there's immense clinical evidence that shedding is occurring. And I'll stop there.

Shawn Buckley
Dr. Kory, one thing that jumped out at me is: You were basically talking about a paper that isn't going to be published, so I assume just the authors are choosing not to continue to try and have it published. But where—

Dr. Pierre Kory
Mr. Buckley, I didn't mention this, but they told me that they had tried to publish in 30 journals and gave up for futility.

Shawn Buckley
Right. And you would have read it and you didn't see any difficulty with their methodology or anything, so this is likely just another case of censorship?

Dr. Pierre Kory
100%.

Shawn Buckley
Right. But the finding that you were talking about that I found interesting is: You were describing the vaccine has been rolled out for a specific age group, which didn't include people under the age of 18. And yet there appears to be data in more than one country that basically is indicating a rise in mortality for people under the age of 18, which correlates with the release of the vaccine and mortality in vaccinated people.

Dr. Pierre Kory
That correlation is there. The data shows it. And my sort of review of shedding, I would understand that to be emblematic or some supportive clinical evidence that's the mechanism as to which that is occurring. I believe it's because shedding is exposing unvaccinated children to vaccinated parents.

Shawn Buckley
Right. Now is there anything then that unvaccinated people should do or could do to help mitigate the effects of being around people that are shedding?

Dr. Pierre Kory
There are a number of things that we've seen the patients have reported are helpful. Not to belabor the fact, but ivermectin is one of them. We do also like some of the safe proteolytics that break down spike protein, like nattokinase, bromelain, NAC [N-Acetylcysteine], as some have shown. One woman reported that nicotine, she felt when she took nicotine she was less sensitive to shedding. But I want to make an additional point that it's not only the unvaccinated that are sensitive to shedding.

In my practice, I have numerous vaccine-injured patients. And I'll give you a really compelling clinical example, which is a patient told me at a visit a few months ago, he said, "Dr. Kory, you know, there's something weird happening." He says, "I can't go to grocery stores." He said, "I went to Trader Joe's a couple of times, and within ten minutes I feel terrible. All of my symptoms get worse." He has a lot of chronic symptoms. And then he added, "I was at a farmers market yesterday. It was really crowded, and the same thing happened. I felt really unwell." And I asked him, do you know why that is? And he had no idea.

I actually explained shedding to him, and I showed him the science behind shedding. Myself and my partner, we have numerous patients in our practice who have had to alter their social behaviours because they feel ill when they're around certain exposures or crowded areas, and they tend to keep to themselves now. I've had some who had to ask to work remotely from home. So this is real and being suppressed and/or it's just dismissed as ravings of a Looney Tune when we try to talk about it. But the science is there, the documents. The FDA knows this is happening. Pfizer knows it's happening. And so this is not an invention or a conspiracy theory.

Shawn Buckley
No. Just so I understand, you started one of your presentations with: Basically, the European EMA and the FDA both acknowledge that for these types of products, that shedding is a risk, and shedding should be investigated. And if I recall your evidence correctly, you also indicated that basically companies like Pfizer for the COVID vaccines were not required to do shedding studies. And yet Pfizer's own documents, they're excluding patients that literally have died or had poor outcomes from shedding, so they know shedding is happening. So the regulatory bodies normally would require these shedding studies.

And then you're sharing with us: Basically there's evidence of young people dying and the most obvious explanation—and we all know correlation doesn't mean causation—but at the same time, when we're talking about the death of young people, when the only change, the only intervention, and it perfectly tracks vaccine uptake and the death is happening, I mean, that is a serious outcome. So if that's caused by shedding, and if this shedding is real, we're really talking about significant negative health outcomes that people may not be aware of. People could be feeling sick and having no idea.

Dr. Pierre Kory
I totally agree. And you have to think the well-described excess mortality rippling across the world affecting nearly every highly-vaccinated country, based on that data, you'd have to hypothesize not only could it be driven by the vaccine itself, but also by secondary exposures to the vaccine by those who didn't get vaccinated.

Shawn Buckley
And there's some irony here. Because during the COVID experience we would hear things in the media like there's a pandemic of the unvaccinated. So basically the public messaging to force people to get vaccinated and to create this division between unvaccinated and vaccinated for several political reasons and to convince the unvaccinated to get vaccinated, we were being told, "Well the unvaccinated were public health risk." It appears, Dr. Kory, that actually the opposite is true, that we could now be experiencing a pandemic of the vaccinated.

Dr. Pierre Kory
I believe that, yes, your statement is correct. The vaccinated do represent a risk to the unvaccinated via this shedding mechanism. That is totally clear. The science is absolutely convincing. Luckily, I believe the magnitude is not as much as it could be. I do think it's a minority who's sensitive, obviously, to shedding. So I am not sensitive. I travel everywhere.

But my deep concern is that based on the more recent information about DNA plasmid contamination, as well as now we know some of the contaminant DNA plasmid contaminants, there is evidence that it's integrating into cells. Although I don't have any short-term acute sensitivity to being exposed to a vaccinated person, what about if DNA plasmids are going into exosomes and they're actually affecting me? What is my long-term risk? And so the implications of this are vast and terrifying.

Shawn Buckley
I just want to make sure that the commissioners and those watching understand. You're now actually talking about unvaccinated people having foreign DNA being incorporated

into their body, so they could end up themselves making spike protein when they haven't been vaccinated, or they could be integrating into their genome foreign DNA with unknown consequences. Is that what you're referring to?

Dr. Pierre Kory
Well, I don't know. I don't have evidence that we are absorbing mRNA released from a vaccinated. We believe that it's the spike protein, predominantly. But I do hypothesize that we could be getting mRNA or DNA, and it could be functional, and it could integrate. That's more of a hypothesis, but it's a concern knowing that these things shed. We don't know exactly what's being shed. And I do want to put forth one more piece of evidence.

I know of a group that did a study where they exposed unvaccinated women to vaccinated women. And although I know the overall result, I don't know the methods, I don't know the size. They did not want to release that because they feared it would threaten their ability to publish. This was many months ago. I've checked in with them since. They have been unable to publish. They were very hopeful at one point. They were at a very late stage in the peer review process, but suddenly that peer review process stopped.

And this is another tactic that journals do. It's not reject or retract, but they sit on studies. And you're not allowed to submit an actively reviewed study to a different journal. That's considered to be a violation of the publishing ethics. And so they've captured that study. So I don't know that we'll ever see those results. But they've told me that they found that 70% of the women reported menstrual abnormalities after close exposure to vaccinated women. So that is the first trial I've ever heard of where someone actually studied shedding. Which is you're right, Pfizer should have done that. The FDA recommends that be done. But it wasn't done.

Shawn Buckley
Right. I'm thinking back to pregnancy consequences, and we had Dr. Thorp testifying yesterday about effects on pregnancy and fertility. And this would be of vaccinated people. But if it's true that 70% of women that are unvaccinated who spend time with vaccinated women have interruptions to their menstrual cycle, that could have huge consequences on fertility going forward.

Dr. Pierre Kory
Absolutely. And that is an area that I'm looking into, is the birth rates. Those are a bit delayed, but across Europe, there's been analyses showing precipitous drops in birth rates, timed with the vaccine campaign.

Shawn Buckley
Now I do want us to go into a different topic. And, Dr. Kory, it's just that a lot of the people that watch the National Citizens Inquiry, both live and after, is they don't typically follow people like you. And the idea, actually, that there are side effects from the vaccine might be new to them. So I'm wondering if you can share with us, because vaccine intake has dropped dramatically. And yet currently my understanding is we are seeing adverse reactions of a different type. And I'm wondering if you can speak to us about basically what you're seeing in your clinical practice and what the research is showing about the manifestation of new diseases and new conditions now that likely are attributed to the vaccines.

Dr. Pierre Kory
Yeah, so let me be clear on what I'm expert at, in terms of vaccine injury. So I would just tell you based on my expertise and my experience, really. I divide the side effects from the vaccine into what I call vaccine injuries, and then what I call post-vaccine injury syndrome or post-vaccine syndrome—injuries I consider to be kind of single organ problems and generally acute. So things like stroke, heart attack, Guillain Barre, even cancer, skin conditions, things like that, that people are reporting. Vertigo, tinnitus, dizziness, vision problems, those are generally single organ things.

My clinic and my experience: Those patients don't come to me. They're generally within the system. I have a private practice that's fee-based and I don't have an employer. So those that come to me are actually sick with a condition that I call Long Vax. It's the same thing as Long COVID. This is what I call Long COVID, because even Long COVID should be differentiated. People can have problems after COVID, but the syndrome that I see is not a new disease. It's been described for decades. It used to be called myalgic encephalitis, or chronic fatigue syndrome.

My practice is largely based on patients with Long COVID or Long Vax. And they come to me with the triad of these three symptoms. And these are chronically ill patients, most of them were vaccinated, obviously at this point, back in 2021. And they've done long slogs through the system trying to get care for these three symptoms, [of] which one is a new, inexorable, debilitating fatigue which is closely matched with something we call post-exertional malaise.

So patients who used to be fit with incredible endurance and exertional capabilities, suddenly— Like, in some of the worst case scenarios, one gentleman who used to run a full business and make a lot of money, he would walk to his mailbox, come back in the house, and have to lie down for 2 hours. So fatigue, post exertional malaise.

And then what we call brain fog, which is some amount of a cognitive deficit. In order of frequency, it goes from word-finding difficulties—so patients who's trying to speak, you know, "Hand me," then they want to say "cup," and they can't get the word for the cup or the pen.

Short-term memory: They're forgetting things that are told to them by their spouses, you know, the classic walking into the room, forgetting why they walked into the room. And also I have people reporting kind of little brain-foggy things that happen when driving. And that's just an aside, but we have immense data showing motor vehicle accidents have gone up in COVID to incredible amounts.

And then also sometimes confusion: inability to concentrate, focus. So you see cognitive deficits, fatigue and post-exertional malaise. So that's the core. Almost everyone has those three. Sometimes I'll see someone who doesn't have brain fog, but in general, the fatigue and post-exertional malaise is classic.

Now, that has traditionally been called ME/CFS [Myalgic Encephalomyelitis/Chronic Fatigue Syndrome]. And in a position paper by the Mayo Clinic in '21, they noted that ME/CFS was skyrocketing in this country. Obviously, they called it Long COVID. But here's the really important thing to understand. In my practice, 70% of my patients are Long Vax. It's the same disease. It's caused by the spike protein that is damaging and causing

numerous pathophysiologies in the body. But the vast majority, it started after the vaccine, not after COVID. So I would argue Long Vax is far more common than Long COVID.

Another difference is that on average, in my experience, Long Vax are sicker than Long COVID, with some pretty memorable exceptions. But on average, they're far sicker, more debilitated. They have far more frequent this kind of other side menu of symptoms. So after you talk about that triad of fatigue, post-exertion-related brain fog, the next most common is kind of a tie between dysautonomia—so rapid heart rates, low blood pressures. When people start to walk, suddenly notice their heart is beating at 140 minutes, there's no good control of the heart rate. They get up suddenly, they feel faint, the blood pressure drops.

And they also complain of immense amounts of sensory neuropathy—so suddenly these sensations of burning, tingling, pins and needles, numbness, pain. And that can be one of the more difficult symptoms to treat. But that's common. And then after that, we see GI [gastrointestinal] complaints, and then what I call is cranial symptoms, the most common probably being tinnitus. But then I have patients who develop headache syndromes. They have all these oddly-described headaches, vertigo obviously, vision problems, and even hearing problems. And then after that, maybe dermatological. So the symptom, burden, and variety is so vast.

And these patients are very common. These are the ones who come to me. They're actually disabled. And the thing about ME/CFS or Long COVID or Long Vax patients is that from that Mayo Clinic paper, they also say one of the most common descriptions of that disease is that they see numerous doctors, undergo vast amounts of diverse testing, and most of the testing is normal.

And so if you go to a system doctor with this variety of complaints and they start doing tests to figure out what it is, and the tests are all coming back normal, what do you think their diagnosis is that they render these poor patients with? Generally, "Oh, go to psychiatry. Maybe you just need a little physical therapy." Or they just send them to a neurologist, cardiologist, pulmonologist—they're just over referring.

And so these patients that have gone through these slogs through the system, no one's offering them treatment, just testing and referrals. They come to me rather desperate. And like I said, many are disabled. They cannot do anything anywhere near what they used to do. And some of them can't work. Many others cannot exercise. I mean, exercise is a worse thing for a Long COVID and Long Vax patient. It totally flares their symptoms, so they always have to pace and moderate. And their lives have been immensely damaged and changed.

Another feature—and this is where it gets really, really sad—from the Mayo Clinic paper, is they report that over the decades of study of ME/CFS, that only 5% ever return fully to their baseline premorbid functioning. And that is a devastating prognosis. I would say knowing the spike protein and what it does, I think our treatments are a little bit more effective than historically the ME/CFS that was caused by, like, Mono, EBV virus [Epstein-Barr Virus]—that's a very common trigger for ME/CFS—Giardia mycoplasma can do it. But we have a pretty good knowledge of the spike protein and what it does in terms of the pathophysiology.

And so I think our treatments are smarter and oftentimes much more effective than the case reports and series that I've read in the past of this disease. And so I'm a little bit more hopeful. But, you know, I've been in practice over two years, and although patients can come to us with 20% functioning, with some I've only got them to 40%. But I will tell you, a

patient who's operating at 20% and you get them to 40%, they are immensely grateful. But as a physician, I'm not happy. I see them as disabled at 40%. But we get many patients to 70%, 80%, 90%, but it's very hard to get someone fully off medicine and back to their completely fully-functioning former life.

Shawn Buckley
Dr. Kory, you just said you've been in practice two years. You mean you've had your private practice for two years, because we've gone through your extensive history before. Where can people access, like the FLCCC has treatment protocols? So for people watching that may be experiencing what you're describing, what resources are out there for them to access getting assessed and getting some professional advice?

Dr. Pierre Kory
Yeah, so the FLCCC—so flccc.net—has not only a protocol for vaccine injury, but also lists of providers who try to treat. I have a private practice where I do telehealth in all 50 states, and we do try to help Canadian patients through their physicians. Mine's called the Leading Edge Clinic. But [go to] the directory at FLCCC and it's called the I-RECOVER protocol. We have it for Long COVID and Long Vax. But the challenge with those protocols is that there are things that patients can access without a physician, but there are many things on there where you really need a physician.

I will tell you, it is such a complex disease, that although I know people who've tried some supplements, nutraceuticals, and have derived benefit, boy, I really think it needs an experienced physician—and there's very few out there. For instance, Long Vax is not even recommended. If you look at the state of this country and how it's responded, I mean, we have Long COVID clinics within many academic medical centres. And I will tell you, many patients have come to me after going to those clinics because their experience was testing, referrals, no help, no mitigation of their symptoms.

But there is no Long Vax centre. There is no centre for vaccine injury. No one is studying it. Even the research effort in this country, there was $1.2 billion devoted to studying Long COVID, and they haven't started any of the trials. They only have three that are ready, three that have been designed, one that's ready to enrol. This is as of a couple of months ago. That may have changed, but that first trial was studying Paxlovid, which is another brazen absurdity if you've listened to my lecture.

Paxlovid is an antiviral that has none of the mechanisms of these other drugs that we have in them. Paxlovid would have near nil chance at a benefit in a Long COVID patient, yet that's what they want to study. And I wonder why that is. And if my cynicism doesn't come through, obviously this is what our system is built on: rewarding industries to try to provide them opportunities to make obscene profits.

Shawn Buckley
Thank you, Dr. Kory. I'm going to turn to the commissioners and see if they have any questions.

Commissioner Drysdale
Good morning, Dr. Kory. Mind if I have a couple of questions. I'm just trying to read my notes here in this darkened environment. In the conversation, you had talked to Mr.

Buckley about statistics concerning COVID deaths. And I was wondering, has anybody done estimates or studies as to the veracity of those reported COVID deaths?

And what I mean by that is, we've had a number of witnesses to this Commission who testified about how their—for instance, there was one that testified in Alberta last year. It was the doctor of a patient and the patient was a young boy and he was dying of brain cancer. And on his deathbed he'd already gone into a coma, if I recall. And they came in and swabbed him and he died the next day, and they said it was a COVID death.

And we also heard a testimony from a paramedic in Toronto who said there was a patient who jumped off an eight-story building and they swabbed what was left and they called it a COVID death. So when we start to think about what effect an intervention may have had, like ivermectin, how do we balance that with the numbers that have been reported and the veracity or the accuracy of those numbers, based on some of the information we've been hearing about how this or that was called COVID death?

Dr. Pierre Kory
Yeah, I think your point is absolutely fair. And I would like to say that is why I wasn't precise at giving a number, because I'm well aware that COVID deaths during much of the part of the pandemic were completely inflated. And there were incentives to do that. Any time there's incentives, that does guide human behaviour. And institutions had incentives to call things COVID deaths. So that's why I can't say for certain it's 700,000 [or] 800,000 would have been saved, but I do believe it's in the hundreds of thousands.

I would also like to add that I don't know if that behaviour has stopped in terms of calling a COVID death a COVID death, but we know Omicron is much milder. Many, many fewer people are entering hospital. COVID is not a major concern right now in terms as a cause of death. So that was then. Now we're in a different time point, and we have, I think you started talking about excess mortality. That's a different issue now. Now we're seeing excess mortality which cannot be blamed on COVID, and it's unexplained why we're seeing so much pervasive and large excess mortality.

And I argue that the answer is in the life insurance data in the United States. The group life insurance data is absolutely damning that the vaccines are the cause of the excess mortality. And the reason why is they provide very detailed excess mortality on all age groups. And the meteoric, unprecedented, historically unprecedented rises in death amongst numerous young age groups perfectly timed with the proliferation of vaccine mandates in this country, I find to be at minimum compelling, and more accurately, absolutely damning evidence that the vaccines are a huge driver of continued excess mortality. Now I changed the topic a little bit in my answer, but I did want to say that those are two different excess mortality discussions.

Commissioner Drysdale
Oh, absolutely. You know, I've had one of the experiences of my life here. We've been traveling across the country, and I get to speak to thousands and thousands of people. And as I was listening to your testimony, one of the things that occurred to me was it's a daily event for me, or perhaps many times daily, where someone comes up to me and they whisper in my ear: "You know, I take ivermectin."

And so my question to you then is: Do we have any statistics? And I would imagine they would be easy to obtain as to the use of ivermectin in United States or Canada. I mean, the

manufacturers must know they're producing 100% more or 200% more of it or 3% more of it. So do we have any idea how many people on their own are using ivermectin?

Dr. Pierre Kory
So that is not a question that I have researched or have data on, but I do have some insight into that. So Edenbridge Pharmaceuticals based in New Jersey, they make 99% of the FDA-approved product in the United States. Their sales were up many, many-fold at various points in the pandemic. I happened to be a little collegial with their CEO, and I talked to him maybe sometime in the past year. He said his sales of ivermectin went back to normal: pre-pandemic.

Now the reason for that is retail pharmacies, part of the war on ivermectin—I didn't go too much into it—but after that horse dewormer campaign and the FDA's tweet and the FDA's misleading statements they put on their website, you couldn't get ivermectin through retail pharmacies. I've recently heard, which I have not verified, that Jim Thorp—actually who apparently testified yesterday—he and his wife discovered pretty damning evidence that the financial incentives that the government gave these huge retail pharmacy chains literally implies that they put out directives. And we do have knowledge that pharmacists were told not to fill it.

So the retail pharmacy data nowhere would reflect the amount of ivermectin that is being distributed and used because, for instance, in my practice all the ivermectin that I prescribe, it all comes from independent compounding pharmacies. So that data wouldn't be found. And I would tell you, my network of colleagues who use or prescribe a lot of ivermectin were using compounding pharmacies. So I figured it's hard to find that data.

And then the unfortunate reality of this war on ivermectin with this political clamp down, the totalitarianism of this, you know, single protocols to treat COVID, is that many patients have resorted to using animal products. And I think that's a sad comment on our health systems. But I know, for instance, my colleagues in other countries, in South America, a lot of it was over the counter bought, you know, everywhere, but also many places were using animal products.

You know, after my ivermectin testimony, it was interesting. I was immediately asked to lecture by physicians, organizations, different groups, kind of around the world. So sharing the data on ivermectin, Paul and myself, Paul Marik, we gave a number of lectures in South Africa. And I don't know if it started like a civil war, but ivermectin was a major political issue after those lectures. And I remember there was even a television broadcast one weekend where they were interviewing farmers who said that the national supply of animal ivermectin had disappeared. They couldn't find it in veterinary stores and, like, there was a huge run on it.

So it's a long answer to say we have no idea how many people are taking ivermectin, having access to ivermectin. The other thing is, many people order it from India. It's a huge producer of ivermectin. You can get it cheaply, and if you can get it through the borders, because I think they look harder for ivermectin than fentanyl. That's obviously a joke, and I shouldn't be joking, but the way that these countries and the way these industries who control these countries have acted towards ivermectin, you know, people have had to resort to lots of things. But I know many who have ordered from India. So, anyway, long answer to say that you're absolutely right. I think many people probably are, but we would have no idea how to accurately estimate that.

Commissioner Drysdale
Well, you know, it's interesting. It's kind of like prohibition. When they brought in prohibition against the alcohol, particularly in the United States, these speakeasies showed up all over the place, and you never knew what the heck you were drinking because it was not regulated. And so that's what we're talking about here, that if people want a product, they will get the product. But the trouble is, it hasn't necessarily gone through proper regulatory channels, so you might be taking an actual veterinary product. I think that's what we're saying, is it not?

Dr. Pierre Kory
I think that's an excellent analogy.

Commissioner Drysdale
The other thing that I would like to talk to you about is: Just looking around, and I haven't got any direct evidence of this in the United States, but I can tell you in Canada that there are certain places, like in British Columbia, where the government has essentially legalized hard narcotic drugs. And they have these safe injection centres, and people can go there and inject themselves with whatever they inject themselves with these days. And yet the government's war on the distribution and use of ivermectin, which if I understand your testimony has a very safe profile, seems to be more effective than stopping something like fentanyl. How is that possible? How is it that we can stop a drug like ivermectin, but we can't stop fentanyl?

Dr. Pierre Kory
I only have one brief answer to that. It's because, in my opinion, the world has gone mad. The world has gone absolutely mad. And the reason, my belief for why it has gone mad is through unrelenting, very powerful, very coordinated propaganda and censorship.

It's getting our societies to behave in illogical, almost unconscionable and unimaginable ways. I mean, the absurdity of what you just described, which is absolutely accurate, makes very little sense. But I think the information that's directing people to behave, they're just behaving extremely illogically. And I think that's why I say the world has gone mad, and it's because of people are following information that's false, misleading, inaccurate, and unhelpful, and harmful, actually, to our citizens.

Commissioner Drysdale
Are you familiar or do you, off the top, know the orders of magnitude of the reported deaths by VAERS, for instance, on ivermectin, as compared to the amount of deaths reported for the COVID-19 vaccines?

Dr. Pierre Kory
I know VigiAccess, which is the WHO safety database, which is considered kind of the premier one in the world. Ivermectin data on adverse events has been collected since 1992. There have been 16 reported deaths over that time span of 30 years, a little over 30 years—sixteen reported deaths associated with ivermectin. I think the adverse events reported is in maybe the single digit thousands, or 16,000, maybe.

When you compare that to the vaccines in VigiAccess, there's—now I forgot, I had that number—but there's well over a million adverse events of the vaccines. And in deaths, it's in the 10-, 20-, 30,000 I think is in there now compared to ivermectin. And keep in mind, ivermectin over those 30 years: billions and billions of doses. At the beginning of the pandemic, it had been reported that 4.1 billion doses had been distributed in its history. And so the safety comparison, they are incomparable.

Now, I'll add another further comment on safety. There was a world scoping review, but done by one of the most famous and highly-regarded toxicologists named Jacques Descotes in France, who since passed. But he did this review in 2021, and in his review of all of the case reports, all of the literature, he concluded that not one single death had ever been caused by ivermectin—that those reports were all due to the reactions to the parasites that were infecting those patients. And they had a strong inflammatory reaction and died from that, but it was not— Because there's been massive, massive overdoses of accidental and intentional overdoses, and people have not succeeded in killing themselves with ivermectin. So I would argue it's one of the world's safest medicines.

Commissioner Drysdale
To my mind, one of the most chilling things that you testified to today—and I want to go through that with you just so that I understand—has to do with this phenomena called shedding, which I was surprised to hear you say that at least it was on the FDA website. I'm wondering whether it still is there.

But my question has to do with: We heard a lot of testimony, and we heard in public that, "Oh, you know what, if you get the needle, first it stays in your arm," and then we found out it doesn't. And they were all supposed to aspirate the needles, and they weren't. And then we heard it doesn't go anywhere else, and it does. Then we heard—and this is where I'm going with this on the shedding—we heard that, "Well, it only lasts in your body for a certain amount of time, very short period of time," and now we're hearing that it's longer than that.

But the part about shedding really bothers me. Because if this phenomenon, if what you're saying is correct, potentially you will never be free of the spike protein, because you'll get it from someone else as they continue to get boosters. And even though your body may or may not stop producing it, you get another dose of it when you go to grandma's for Christmas, or you go to the church, or you go to— Is that what we're talking about, that we may never be free of these spike proteins in our bodies? Is that the potential?

Dr. Pierre Kory
I think that is an accurate statement. I would just try to mitigate that statement in terms of magnitude of effect. Although yes, technically it's true that as long as these vaccines are continued to be used, I think we also need more data until how long someone can produce spike protein. Like I said in that one study, they found it circulating the blood up to 187 days, but that was only a small number. I think it was only one subject in a study of 20 patients.

So again, I think it's a small proportion that will continue to produce spike. But your question is: "Will we ever be free of it?" And I will argue absolutely not as long as this campaign with mRNA technology is continuing to be used for our vaccines. There absolutely should be a worldwide moratorium. I know we're coming closer to a few countries. There have been papers that were published that called for that based on just

shedding. But you know what happened to those papers? They were almost immediately retracted.

Commissioner Drysdale
You're right, and we found that on this side, I can tell you that September of 2023, this Commission recommended the cessation of the use of the mRNA vaccines in Canada. And I don't think that was carried by any of the mainstream or legacy media companies that I'm aware of. Are you aware of that? Did the CBC report on our recommendation to discontinue mRNA vaccines in Canada from September of last year?

Shawn Buckley
And Commissioner Drysdale, you're looking at me. I can advise you that I'm not aware at all. And the NCI administration does track what media is reporting on us. And to my knowledge, that was not reported by the mainstream media.

Commissioner Drysdale
I have another question, Dr. Kory, with regard to one of the things that occurs to me when I'm listening to your testimony: is the huge variation in effects, in side effects and deaths, et cetera. Now I understand that the population that we're talking about is an extremely varied population, even between brother and sister, or brother and brother, or husband and wife. But we've also heard significant testimony about the presence of quality control issues with these vaccines.

We've heard that there is foreign DNA in them because they never cleaned it out properly. We heard of testimony of segregation within a lot. We've heard of foreign materials in them, leftover DNA or strands of DNA or RNA in them. How can we get an understandable picture of something with this level of complexity? Even when the main instigator, or potentially main instigator is so variable within itself, how will we ever know the answer?

Dr. Pierre Kory
In the current state of science and society, we cannot know the answer. Science isn't functioning. I don't think it's functioned for several decades in terms of objectivity, transparency, confidence. But there are innumerable scientific questions that need to be asked, researched, and answered around this mRNA technology and the vaccines. There's no appetite or incentive to do that.

You know, those who control the institutions of science, for instance, they control all the journals, they control the funding research agencies, they control the regulatory agencies. In such a world where the industry has near complete control of those institutions of science, there's no appetite, push, or incentive. In fact, most of their behaviours are in covering it up and not investigating.

So those of us who are really fighting for our patients, trying to answer questions so that we can help our patients, you know, we're doing that with one hand tied behind our back and a blindfold over our eyes. And it's a really an unfortunate state of the world, but we're going to keep trying as best we can. But I appreciate your question. I think my answer is it should be deeply saddening to anyone who's listening.

Commissioner Drysdale
You know, the other thing that occurred to me in listening to your testimony and listening to testimony that we heard, I think it was yesterday, and that is that one of the recognized side effects of the vaccine is a COVID-19 infection. As a matter of fact, CDC has announced that on their website probably six months ago.

So if people continue to get the COVID-19 vaccine, this is a self-perpetuating pandemic, is it not? And when people who were unvaccinated were accused of being a risk to the vaccinated, if you get a vaccination and one of the key symptoms is a COVID-19 [infection], it's kind of the opposite of what we were being told, is it not? The unvaccinated are at risk by the vaccinated, and we have a self-perpetuating pandemic.

Dr. Pierre Kory
I mean, I'm going to say a short answer and a long. The mRNA platform, but in particular the mRNA vaccines, is the most toxic and lethal intervention in my mind in history—a medical intervention. The way you talked about, it is the opposite. If you noticed in my lecture, particularly on ivermectin, what was deemed as truth and disseminated as truth is actually the opposite of what is true. And so there are a lot of opposites. And remember, that is what propaganda is: it's trying to present a reality that is not true. And the propaganda around these vaccines have been immense.

What's so disturbing is how much it was contrary to the truth. They weren't just a little wrong or moderately wrong, they were like 100% absolutely false. And so when you talk about these vaccines, this safe and effective mantra, and the fact that it reduces—Remember: "It reduces your chances of infection 90%, 70%, 50%. Ah, never mind, it reduces hospitalizations. Nah, it reduces death," right?—that all of those things have been directly proven true. And I will tell you in particular, the opposite of what is true is the thing that they held on to the most for so long, which they were shouting from the rooftop—and still do, right?

This is still a major prevailing narrative: is that the vaccines reduce hospitalizations and death. And I will argue not only their papers, [but] many analyses showing that that is false—and from the more transparent public health agencies around the world. Like at one point, Australia and the UK were actually dangerously transparent. Why do I say dangerously? Dangerous to them.

And I think it was even Ireland: they stopped releasing vaccination status data because it was so bad. It was showing the opposite of what they were claiming. But the other problem is in the U.S., actually, the data seems to suggest that it does reduce hospitalizations and death. However, this is the catch: there was a systematic miscategorization of vaccination status in the U.S.. You cannot believe the hospitalization data in the U.S., and I was directly a witness to this.

And I've talked to many nurses. The most prevailing electronic medical records system in the country, which is made by a company named Epic: every vaccine that anyone else ever gets, if you bring in your card, it gets logged into the actual vaccination record of that patient. It's an actual record, has all the dates, you know, as you've probably seen vaccination records before. But for some reason, with the COVID vaccine, it didn't go into the record. It went into the nursing note. The only people who were documented as COVID vaccinated were those who received the vaccine within the hospital system that they were attending.

And we all know most everyone got vaccinated at Walgreens, CVS, Rite Aid—I'm sure you guys have those companies in Canada—or vaccination centres. So very few people enter the hospital with "vaccinated" as their status. And the CDC weaponized that. They constantly showed data showing that the hospitals were full of the unvaccinated, when the opposite is true. And I just saw evidence come out about a week ago, the same thing happened in the UK. A group of my colleagues actually published a study in which they analyzed the vaccination status, and they found damning evidence of systematic mischaracterization.

So just going back to your point of the belief about the vaccine being nearly the polar opposite is truly astonishing. It really is. Like I said, it's not that they were a little inaccurate or a little misleading or overstated, they were saying the opposite of the truth.

Commissioner Drysdale
My last question is probably the most difficult, and that is: One of the themes that has come out in the last 26 days of testimony that we've had is that fraud, lies, accusations of lies, the complete abandonment of the fundamental principles of medicine—informed consent, do no harm, sanctity of doctor patient relationship—and as people are waking up, we see people going to ivermectin speakeasies, for a better term. They're not going to the medical system anymore. We see the rise in all kinds of other alternative treatments.

How will we ever restore the trust and reliance between the patient and the doctor when it has so fundamentally been attacked by not just the practitioners, but even the Colleges of Physicians and Surgeons, the FDA, or Health Canada, for whom I always thought was there to protect the patient. How are we going to heal this system and this tear in our society?

Dr. Pierre Kory
So, you know, that is a very challenging question. I could answer two ways, but I'm going to go with this one. I actually think the only way forward is for that trust to erode further. It has to be near complete, pervasive, and damning so that a new system can rise in its place so that it's constructed to fortify itself for the way our system's been captured. I mean, the behaviour of the medical system in COVID was truly unconscionable.

And again, I'm going back to the same theme. The propaganda emanating from the agency leaders' mouths, agencies and medical journals, they were lying to doctors, and they were lying to doctors who believed in those institutions. And so, you know, I'm going back to my phrase earlier that the world went mad. However, those that understand this, that understand how bad it was in COVID, and that those agencies and institutions were weaponized for profit and not patients' healths, everyone needs to understand that. Our politicians need to understand that, our physicians, our medical students need to understand that we are under immense industry capture of our healthcare institutions. And there's no soft fixes to that. I think that there needs to be almost, I don't know, a revolt, a rebellion.

But those forces are so powerful. In the United States, the biggest lobby is the pharmaceutical industry. They spend $660,000 per member of our congress, which is two to three times the budget of the coal and gas industry. All of the high profile medical journals in the world literally make immense profits. They're highly profitable businesses, by the way, and it all is derived from the pharmaceutical industry. Our world's media, one of the biggest advertisers is the pharmaceutical industry. And so, you know, until we

somehow have a mass rebellion against that industry and its capture—and you need a critical mass of people.

And I think, maybe I'm going to finish on a positive note and a rather respectful and admiring note for the work that the National Citizens Inquiry is doing. But I think the answer is more things like this. Inform the public, inform the citizens of what's really going on, because you can't fight an invisible war or a war that people don't even know we're at war. We don't even know that we are being targeted and our health and our systems are being attacked and corrupted, and I just think we need to disseminate that knowledge.

I will tell you that prior to COVID, I had that faith and trust in institutions. I venerated those journals. I thought only the best science and scientists were published in those journals. I literally started this pandemic thinking that Dr. Fauci was a sympathetic guy in a tough spot with a lot of critics, trying to do the best he could. And none of those things were true.

And so I've been awakened, and I'm aware of what's really going on. And as a longtime educator and teacher, I've committed myself to continue to educate those that need education. I mean, I just want to make people aware so that they can make those decisions. And, you know, part of your question is like, yes, they're seeking outside the system alternative therapies. I think that's good. I think that's good. I think more people should know to do that and know that they should be very skeptical of what's in that system.

And I hate saying this, but they should be very skeptical of what a system physician tells them, because unless those physicians wake up to the corruption, they are going to be tools of the pharmaceutical industry, and they are going to spew lies that they are told from their very trusted journals. Again, I probably repeat myself, but I think the answer is spreading more awareness and education of what the true state of things are.

Commissioner Drysdale
Well, I did say that was my last question, but you've brought up something that I can't help but ask about, and that is: You know, in the investigations that we've done, every time we've lifted up a rock or every time we've looked into something, we've found corruption.

And we have been focused on what happened in COVID-19: you know, the vaccines, the treatment people were getting in hospitals. Is it not reasonable for people to make the assumption that this corruption is in all aspects of their healthcare system? I mean, is it believable that the pharma industry has only corrupted those things that had to do with COVID, or is it more likely that they have corrupted every aspect of this system?

Dr. Pierre Kory
I think it would be hard to describe the scope, scale, and history of that corruption. It did not start in 2020, not by any stretch of the imagination. Just in my own specialty, no one would ever hear of this drug. But there was a drug called Xigris, manufactured by Eli Lilly. And when I started training in my specialty in 2005, Eli Lilly had put together a national— It was a drug used for sepsis in the ICU, and it was a powerful anticoagulant, like a blood thinner and anti inflammatory. That's at least how I thought it was working. It was $5,000 a dose.

They put together a national campaign for sepsis awareness, for which they had an answer, right? This $5,000 a day drug. They put out a fraudulent trial showing that it reduced mortality, and they got almost every ICU doctor in the country to use it. I will want to give

credit to my mentor, who I was training under that time. I never once prescribed that drug, even at a time where it was ubiquitous and standard in ICU's around this country, making billions for that company. And it later was found that it increased mortality.

There are innumerable stories of similar drugs and strategies. Statins are nearly worthless for what they're purported to be used for. Vioxx killed many. The benefits of chemotherapy and radiation are vastly overstated. I don't even think I'd have the time to answer the amount of fraud. I mean, our system is not built for the patient's health. It's built for profit. And that's a really sad state. And it didn't happen yesterday.

I mean, the history of doctors who found treatments that were not profitable to the pharmaceutical industry—and what happened to them, particularly around cancer and other diseases? They get destroyed, their careers get blown up. And I think I'm standing here before you as one of them, just for trying to educate the global public about the fact that there was a highly effective treatment for COVID. I lost numerous jobs and, you know, was forced out, media hit jobs, attacked, medical board complaints, you name it. But this is what happens.

And so, yeah, I think to your question, it would encompass every specialty, every medicine. I think we need to be highly suspect, skeptical. Do your own research. And I know that's something they tell you not to do, right? But I would try to do as vast and as diverse a review of different sources. And you have to decide who's the most credible. But be very skeptical of official and expert sources because, I'm sorry, they've been captured, and they oftentimes don't know they've been captured. I used to believe things in medicine that were not true, and I believed them because I trusted those who told me they were true.

Commissioner Drysdale
Thank you, Dr. Kory. Anybody else? Nobody? Nobody else.

Shawn Buckley
Dr. Kory, those being the questions from the commissioners on behalf of the National Citizens Inquiry, I sincerely thank you for coming and giving evidence today. Your evidence has been very helpful.

Dr. Pierre Kory
Thank you. It's an honour.