Adventists are for Health—Not the Herd

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The following blog is by Dr. Keith Colburn, a physician and expert in his field, who has submitted this paper to various outlets only to be rebuffed. We publish it with his permission, not merely for the science, but for the process of inquiry, and to stimulate reasoning, investigation, and the advancement of the principles of God's kingdom. —Timothy R. Jennings

Vaccines, while important, are not turning out to be the sum of what is needed to prevent COVID-19. And cheap, effective, at-home treatments are strangely spurned. Are lives being unnecessarily lost?

By Keith K. Colburn, MD, FACP, FACR

In our wellness oriented, whole-person care model, Adventists have long emphasized illness prevention and treatment using methods sometimes seen as out of step with mainstream medicine. In the larger picture, we have never been especially concerned to follow the pack or herd; one could even say our particular denomination prides itself on being careful *not* to reflexively accept groupthink.

During the COVID-19 pandemic and since vaccines became available, a great unmet need has emerged in at least two areas: 1) prevention and early treatment of breakthrough infections in persons already

vaccinated, as immunity wanes and variants arise; and 2) prevention and early treatment of COVID-19 in people who cannot take the vaccine for medical or religious reasons, as well as those who, irrespective of how much punishment or calumny is heaped on them, will never take the vaccine for reasons of their own. Each of these groups deserves compassion and consideration by the medical community, which has never before predicated its care on "correct" human behavior.

Much has been written on the role for a healthy lifestyle and natural supplements in human diseases, including COVID-19. While I heartily agree these can and do play a significant role, and my family and I include them in our own toolkit, my focus here will be different.

As a research scientist in the fields of immunology and rheumatology, professor of medicine and clinical practitioner of long standing, I have taken a special interest in the debate surrounding the potential use of repurposed medications to prevent and treat COVID-19.

I will not go into all the reasons I believe a good-enough scientific case has already been made for widespread use of certain repurposed drugs in this pandemic, nor the reasons I suspect for why they may have been prematurely dismissed while public discussion of them has been rendered *verboten*. Suffice it to say I have confidence in them, based on the most up-to-date databases of world-wide evidence currently available, coupled with my own experience in my practice.

The first of these drugs brought to wide attention was hydroxychloroquine (HCQ), which a number of physicians and physician-scientists found to be useful when given in combination with zinc. My specialty of rheumatology happens to be the primary specialty in which HCQ is used in the United States. Having used it over decades as a long-term therapy on thousands of our rheumatological patients, with very few problems, my colleagues and I knew immediately that the media framing of its dangers was vastly overstated, particularly with short term use. We grew even more perplexed when a large part of the United States' medical and scientific communities affirmed these overstatements of risk, to the extent that parallel studies claiming to show the serious dangers of HCQ were very hastily published in two of the most prestigious medical journals in the world—*The Lancet* and *New England Journal of Medicine*, only to require retraction when shown to be fraudulent.

But, by then, the damage had been done—few people in the public-at-large wanted to be enrolled in any study of a drug they'd heard was dangerous.

Then came ivermectin. This drug earned its two primary developers a Nobel Prize—not for its use in horses, but in humans. Millions of people in African countries and elsewhere have been spared the ravages of devastating parasitical and other diseases through its use. It is considered by the World Health Organization (WHO) to be one of the world's "essential" medications. After initial *in vitro* studies of ivermectin on SARS CoV-2 (COVID-19) appeared promising, this drug, like HCQ, has been widely studied in humans across the globe for the prevention and treatment of this novel virus. More and more information is coming out that puts ivermectin in a very positive light for the prevention and treatment of COVID-19, most likely also including its variant or mutant strains.

A few of the studies failed to show a significant benefit, it is true. And some studies have been recognized as sub-par. But so has the reporting on it, much of which has been highly disingenuous if not outright dishonest. I counted more than 30 headlines over just a few days recently that referred to ivermectin as "a veterinary medicine" or some variant of that. Even the FDA got into the act, ridiculing ivermectin as a horse dewormer in a stunningly contemptuous, juvenile post on its own Twitter site. Because of this bias, it has been extraordinarily difficult to locate fully trustworthy information on

ivermectin for COVID-19.

It is my educated opinion, after my own analysis of the studies done to date, that enough research of sufficient quality has been confirmatory in showing real benefit that this drug is worth trying on a large scale. Several developing countries have been using it for COVID-19 to remarkable effect. However one may wish to discredit and dismiss them, a significant number of highly-credentialed U. S. medical scientists and experts in relevant fields have determined, through their own clinical experience and meta-analysis of the existing research, that this drug has real promise in preventing and treating COVID-19. Yet ivermectin, too, has been inexplicably hounded out of public view and open discussion.

Since early last year, I have treated a number of patients diagnosed with COVID-19 with noteworthy success. I have used one or another of these widely-studied drugs together with associated supplements known to be safe in reasonable amounts, such as zinc (essential in the case of hydroxychloroquine), vitamin D3, vitamin C, and quercetin. I could relate several near-miraculous recoveries, along with surprisingly quick turn-arounds. There have been no deaths or even hospitalizations among the COVID-positive patients I have treated. This does not take into account the many more people my colleagues and I have placed on either HCQ or ivermectin prophylactically, with near–100% success.[1]

These stories would be dismissed as "anecdotal" by a wider scientific community that appears oddly bent on extinguishing any suggestion of the use of these drugs at all cost. Anecdotal evidence in science is not compelling—until it is, meaning a vast quantity of such stories in mostly one direction starts to look pretty persuasive. As a scientist, I have never been entirely dismissive of anecdotal evidence, since it is often the first step towards demonstrating efficacy. When I have achieved extraordinary success with something in my own practice, it becomes even harder to dismiss.

Further, while high quality randomized, double-blinded, placebo-controlled, peer-reviewed studies[2] are indeed the gold standard in medicine, there are times when exceptions are wise. During the AIDS crisis, for instance, many drugs were tried on patients before large-scale, gold-standard studies had been done. In a more whimsical example, I wouldn't wait to have the perfect placebo-controlled study on parachutes before I chose to use one in an emergency.[3] (Personally, I wouldn't want to see any placebo-controlled studies on parachutes, but that's me.)

The kind of clinical success with these repurposed drugs I and several physicians personally known to me have had in treating COVID-19 patients, some of them in desperate straits, cannot help but contribute to a practitioner's sense that he or she is on a worthwhile path. More than that, we know one would be contravening one's oath as a physician *not* to try such a thing in a given circumstance.

The degree of certainty needed before a drug is put into use in an emergency situation can reasonably be debated.[4] We know, from long years of use for other purposes, that HCQ and ivermectin are both exceedingly safe medications. Most prescription drugs in use today have worse safety profiles than either of these two drugs, and some have undergone little or no "gold-standard" study for certain purposes before use for that purpose by physicians. HCQ itself, initially developed for malaria and in long, distinguished service worldwide, was repurposed for several other conditions for which it remains useful today, such as rheumatoid arthritis, systemic lupus, Sjogren's syndrome, and certain forms of autoimmune vasculitis. A number of now well-accepted applications for medications were initially landed upon through use by doctors versed in a drug's mechanism of action who grew suspicious that it "might" work, and tried it.

We have a word for this type of legitimate, ethical physician use for conditions other than what a drug was originally tested and meant for: "off label." It is perhaps telling, or at least worthy of an eyebrow raise, that hydroxychloroquine is one of very few drugs to be effectively banned for off-label use for a particular condition—in this case, COVID-19—by any licensed physician. Ivermectin is another.

Compare the reaction of the United States and international medical regulatory agencies toward these two inexpensive drugs with their hurried, near-sycophantic reaction toward a far more expensive antiviral medication that ended up a treatment failure: Remdesivir.

Whatever else one may say about it, this is a historically singular if not highly disquieting moment in American medicine. While a questionable therapeutic drug and three vaccines are rushed into use under emergency authorizations, two extraordinarily safe drugs are shunned, censored, and "canceled," with stern warnings to physicians against off-label use in this one condition only—a use for which many decent, positive-outcome studies already exist.[5]

Not only are potentially useful drugs being ignored.[6] A group of people that deserves far more consideration than it has received is that of unvaccinated but recovered health care and other workers who have had the illness and thus have, by the best studies, much better immunity than those who have been vaccinated without having had the illness. It would appear these people deserve our heartfelt gratitude *and* a pass on the vaccine, not least because this society greatly needs them… but also because there is no reason to force them into taking a vaccine they may not want and for whom the risk-benefit calculation may well tip in favor of foregoing it.

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We have before us the reality of a devastating and widespread illness for which mainstream medicine has, to date, *no* effective pre-clinical treatment to recommend other than vaccines.[7] As mentioned earlier, many reasonable people who are not generally opposed to mainstream medicine have serious reservations about taking this particular vaccine, and some significant number will likely continue to refuse. These people deserve consideration of their medical needs, as well. Place this situation alongside having exceptionally safe, inexpensive drugs like HCQ and ivermectin that have shown real promise, and it becomes baffling indeed as to why the Western medical and scientific communities have been so actively and vocally opposed to their use. Some countries have gone so far as to forbid and even criminalize their use for COVID-19 by licensed physicians, and we are perilously close to that situation here in the United States.

But my purpose in writing this piece is not to convince anyone to take a medication they're not comfortable taking, or which is not recommended by their own physician. My purpose is to show how a so-called "settled' question may not be all that settled, and from there to raise the question, why not air conflicting views on issues surrounding COVID-19, and let the chips fall where they may? Why would Facebook, YouTube and other media sites *want* to quash all discussion that does not go in the "correct" direction? Who or what is to decide what is the correct direction—or is "misinformation"—anyway? Science? But isn't it part of science to question continually, reassess assumptions, and welcome challenges in the spirit of free inquiry and the scientific process? Isn't the whole point of a free-speech society to allow speech not everyone agrees with, even speech that may appear offensive or patently untrue to some? Have we lost all confidence in the American people to think for themselves?

I hope we can agree that questioning the risk-benefit ratio of incessant masking of children or adults or whether taking a particular vaccine might, in fact, have serious, far-reaching adverse effects as yet
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unknown hardly compares to yelling 'fire' in a crowded theater. These are points upon which reasonable people, reading and listening for themselves, can disagree.[8] While it is true, for example, that association does not prove causation, it can't be totally insignificant that more than 9,000 deaths post-COVID vaccine have been reported into the VAERS official vaccine adverse-event reporting system.[9]

Scientists working from what is known as the scientific method have, at least until recently, been uncomfortable with the highly politicizable concept of "settled science." We do well to keep in mind that many things thought to be scientifically settled today will be discovered to have significant flaws or turn out to have been completely wrong tomorrow. This is just as one should expect in a healthy system where scientists, as well as the general public, are not only free but encouraged to openly question their own and others' assumptions. None of us would wish to live long in a society where that freedom has been abolished, whether judicially or through massive social pressure.

Whatever else one might say about COVID-19 and similarly charged issues, I do not think speaking about them publicly from various angles is an out-of-bounds exercise for physicians, scientists, and other experts in related fields within the SDA church. The church is not a scientific body having the authority to tell its members what to think or how to behave in a pandemic. Members with solid scientific credentials should be able to weigh in, and their views are likely to vary. The fact that we are in a public health emergency does not obviate the need to keep our minds open to minority views that may turn out to be correct. If we can't trust our members to listen to all sides and come to their own conclusions with the help of their own physicians, we have reached a very dark period in our history.

I believe Christ's approach would be to model a high regard for truth while remaining open to arguments that challenge our thinking, to accord liberty to people who hold varying opinions, and to treat with love and respect those with whom we disagree.

It is not only the scientific way. It is also the Enlightenment way so many of us treasure of open, respectful dialogue.

It might even be the Christian thing to do.

Footnotes

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[1] Preventatives and early, at-home therapeutics do not have to be alternatives to vaccines, but can be used in tandem. My wife and I have been vaccinated. But in light of the questionable duration of the vaccines and their efficacy against emerging variants, we and others we know continue to use ivermectin at regular intervals as "extra insurance." We have lived relatively normal lives the past two years, entirely without fear.

[2] A "randomized, double-blinded, placebo-controlled study" typically means one in which some participants are randomly selected to be given the actual medication under study, while others are given a placebo—meaning, in essence, nothing, in the form of an inert, look-alike substance. Neither is told what they got until the results of the study are known, nor do those who administer the treatments know which treatment they are administering.

As others have pointed out in parody, a double-blinded, placebo-controlled study on parachutes would

involve giving some jumpers parachutes in their backpacks, while others' backpacks would be equally weighted but otherwise empty—and none of the jumpers would know which sort of backpack they got until they jumped, and the results became manifest. Ridiculous, you say? Well, that is exactly why no such studies were ever done on parachutes before they were put into wide use, and why none may be needed in order to ethically recommend a certain, known-to-be-safe drug in an emergency when its usefulness is strongly suspected by many qualified physicians and physician-scientists, but has not yet been fully established.

[3] Once a person understands what "placebo-controlled" means, the usefulness of the parachute analogy to giving one of these repurposed drugs in an emergency *versus* not giving it when it's known to be safe and very possibly effective really does become clear. It may even be compelling. We are not talking about willy-nilly sampling the drugs in your grandmother's medicine cabinet. We are talking about allowing widespread physician trialing outside of "official" trials of safe, cheap, extensively-studied drugs (tested also for COVID-19) such as HCQ and ivermectin in a "dire emergency" situation.

In other words, what's the harm of letting physicians all over the world prescribe HCQ or ivermectin to people for COVID-19 all they want, using their professional judgment, so long as supplies keep up and there is an adequate reserve for those needing it for other purposes—and then reporting the results they see? There is little question manufacture of these drugs could be ramped up at least as easily as new vaccines are rolled out, with far less expense.

[4] We might carefully add, not only some drugs, but some *vaccines* have historically been pressed forward in emergency situations on not-yet-perfect, not-yet-fully-conclusive evidence. Once they are in wide use, it is thought, many more things can be learned, and at a much faster pace. If this logic makes sense with vaccines, why wouldn't it make sense with preventatives and treatments?

[5] Don't let anyone tell you the "best" studies on HCQ and ivermectin have already been done, and they conclusively show these drugs to be unsafe or ineffective in treating COVID-19. This is simply not true. That, or its opposite, may turn out to be true some months or years down the line, but we are not there yet, in my professional opinion.

[6] A further drug being repurposed for treatment in COVID-19 is fluvoxamine, commonly used to treat OCD (Obsessive-Compulsive Disorder) and better known under the brand name of Luvox. (This ought not be confused with a similar-sounding generic drug, fluoxetine, commonly known as Prozac). It remains to be seen whether fluvoxamine, too, will be pushed out of public discourse and stigmatized unjustly.

[7] It has been argued that availability and promotion of these cheap, repurposed drugs might lessen the eagerness of some to get vaccinated. But this disregards the fact that vaccine efficacy is known to wane and that vaccines do not preclude breakthrough infections which can, however rarely, result in serious illness and even death. Meanwhile, one suspects that those making this argument are unlikely to come out, for the same reason, against two pre-hospital therapeutics not yet approved in the US but already media-celebrated, Merck's molnupiravir and Pfizer's ritonavir (Paxlovid), which are both vastly more expensive than ivermectin and will not be available to all who need them for some time.

[8] Jim Geraghty writes an astute post in the *National Review* about all those New York nurses being fired for not getting the COVID vaccine:

> It's tough to argue that these remaining unvaccinated health-care workers are nutjobs who don't know anything about human health; it is what they do for a living… [Rather] it is likely that most of the unvaccinated health-care workers are just plain wary — in part because they're probably used to watching vaccines being developed over a ten- to 15-year span. Others probably resent some government or professional authority telling them that they have no choice but to get one of these particular vaccines.

He continues:

> The remaining unvaccinated…point out that **the average survival rate for the unvaccinated [who contract COVID-19] is higher than 98 percent and is considerably higher for the young and healthy**, and [they] are not reassured by the exhortations of a governor who goes to a church in Brooklyn and declares, "I need you to be my apostles." (Say, who is the governor in this metaphor again?) **And that's not even getting into the people who have natural immunity from a past infection.**

[9] Here's a question one might ponder: How many deaths, out of the 9,000+ reported as "associated" with the COVID-19 vaccines, has the CDC fully investigated? Who knows? I haven't been able to find out. How many has the CDC acknowledged as being caused by one of the COVID vaccines? We do know the answer to that: Three. Three out of 9,000. That means 99.97% of the reported deaths after vaccine are thus far not acknowledged to have been caused by any of the vaccines. Almost sounds like a Soviet-era election result, does it not?

And again, why should people who can show they've had the illness be required to get vaccinated in order to travel, keep their job, etc.? It seems nobody in favor of "vaccines for all" can answer this question.

Let me emphasize, I am not against the vaccine. People who need it and want it ought to get it. I only raise what I believe to be legitimate questions.

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