Below is a rush transcript of this American Thought Leaders episode from April 9, 2022. This transcript may not be in its final form and may be updated.

Jan Jekielek: Dr. Aaron Kheriaty, such a pleasure to have you back on American Thought Leaders.

Dr. Aaron Kheriaty: It's great to be here, Jan. I'm looking forward to our conversation.

Jan Jekielek: Likewise. We're in this time right now where COVID restrictions are being lifted throughout the nation at local state and even at the federal level, but it's not a uniform response by any means. You've been opposing these mandates on both scientific and unethical grounds and some of these other restrictions. Are we ever going to go back to normal? That's I think the question that a lot of people have on their minds right now.

Dr. Kheriaty: Yeah. That's a really important question, and you're right that a lot of the previous restrictions of 2020 and 2021 are now being abandoned in the face of overwhelming scientific evidence, especially after the recent omicron wave when many people still got infected with COVID despite all the things that we have done for the last two years to try to prevent the spread of the virus. The viruses still spread. Fortunately, most people did well, particularly with that variant, which was less lethal than delta and other previous variants.
So a majority of Americans have now been infected with COVID, vaccinated or unvaccinated. So I think there are a lot of jurisdictions that are recognizing that these continued stringent measures from stay-at-home orders to vaccine mandates or vaccine passports didn't really achieve their purpose and are no longer, if they ever were useful, and so they're being abandoned, but you're also correct that that tendency, that shift that we've seen in the last month or two is certainly not uniform across jurisdictions and across various institutions.
So my own previous employer, the University of California, as many other jurisdictions early this year, were abandoning vaccine mandates. They doubled down and put out a booster requirement for all employees, and they're not alone in that. Many public and private institutions are not only mandating the initial two-dose mRNA or one dose of the DNA vaccine, but they're now mandating a third booster dose in spite of all the evidence that show that the efficacy of boosters lasts even a shorter period of time than those original doses.

Really, we're deploying a vaccine that has become, in a sense, obsolete, right? It was designed to target the spike protein on the original Wuhan strain of the virus, and that's a strain that's no longer in circulation. If you look at the efficacy numbers for the mRNA vaccines like Pfizer and Moderna against omicron, the estimates were between zero to maybe 15% to 20% efficacy against omicron of the two-dose regimen.

If you give a third booster dose, you bumped that up to about 37% efficacy, but that was very short term that, again, lasts only about eight weeks, and that 37% peak efficacy is well below the 50% threshold that was required for FDA approval. So if we were to test the vaccines that we currently have available now against the current variance actually in circulation, they would not be FDA-approved. They would not even be authorized under the emergency use authorization.

So lot lots of places and institutions are shifting away from some of those more heavy-handed COVID policies, but many are not. There is buzz in the air about the next wave that's coming. There is chatter of about the possibility of redeploying lockdowns, which seems like it should be a relic of the past. That's so 2020. Aren't we beyond this idea of quarantining healthy people, but I think there's some public health officials, they're having a hard time accepting the failures of their own proposed policies, and they look at their toolbox and they see the same three or four tools that they've deployed throughout the pandemic, whether it's universal masking with cloth masks or surgical masks that are not effective at stopping an aerosolized respiratory virus or lockdowns quarantining healthy populations, which clearly did not work again. A majority probably north of 70% of Americans still got COVID in spite of almost a year of lockdowns and stay-at-home orders that had massive collateral damage.

So there seems to be this impulse to go back to the same three or four failed measures rather than pivoting and putting our resources toward a more focused protection, which you've talked to my colleague, Martin Kulldorff, about the focused protection approach of take the folks that are vulnerable, and we know who they are. They're mostly the elderly. That's ages, by far and away, the strongest risk factor for bad outcomes for COVID.

What more can be done to protect them? How do we treat this illness more effectively when people get sick to keep them out of the hospital, for example? Then for the rest of us, recognize that COVID is becoming endemic, and we're

going to see a seasonal pattern of recurrence, and that natural immunity after exposure to COVID is going to be our primary way out of the pandemic and toward a state in which we're living with this virus, but it's not anything that we need to be afraid of anymore.

So once you've already had COVID, we know now that you have a broad infection-induced natural immunity. That's quite effective over time and against new variants. Fortunately, we're seeing natural immunity hold up better over time in terms of efficacy than the vaccines have held up.

Will we go back to some of those old methods that didn't work? I fear that there are certain economic and even political forces that embraced those measures for reasons or with motivations that were other than public health. The welding of public health with digital technologies that allow for tracking and surveillance and the gathering of massive amounts of data, some of it quite private from citizens, public health combined with those digital technologies combined with the police powers of the state that are enforcing heavy-handed measures like lockdowns or vaccine mandates or a vaccine passport system.

I think that, what some have dubbed a biomedical security state kind of regime is probably here to stay unless people stand up and say, "These kinds of measures that we've tried over the last two years were ineffective. They were quite frankly an assault on many of our civil liberties, and we're not going to go down that road again. We're not going to redeploy those kinds of measures the next time there's something that is declared a public health crisis." These have become highly refined tools to treat a population as a kind of undifferentiated mass that I can shape and mold and direct according to my particular political or economic purposes.

So I mean, we could talk about lockdowns, for example. One of the things that happened during lockdowns was a massive transfer of wealth from the working class and the middle class, not just to the upper class, but to the upper class of the upper class, especially tech companies and big tech moguls.

Mr. Jekielek: The 0.01%.

Dr. Kheriaty: The 0.01%, exactly. I mean, we know that Amazon, which is headquartered in Seattle, lobbied West Coast states, Washington, Oregon, California, in favor of lockdowns. Why did they do that? During lockdowns, we

saw hundreds of thousands of small businesses, which is Amazon's competition, closed during the lockdowns, most of them not able to reopen, most of them that closed not able to get back on their feet. So I think if you want to know and want to understand why some of these political decisions or public health decisions were made, you can ask the very basic investigative question of, "Okay. Who benefits?" There's many ways to measure benefit. One of them is wealth, right? One of them are these economic shifts. Who benefited in terms of assuming powers that they didn't previously have? That's another important question that I think people need to ask as we do a postmortem on the pandemic and we do a retrospective analysis of what happened over the last two years.

Mr. Jekielek: Well, yeah, we definitely. That's interesting that you mentioned a postmortem, one thing that isn't talked about a lot. I've had a few people on the show mentioned it. It's just that these policies were just very different that were instituted, very different from past effective pandemic practice, right? So there is actually policy that exists that can be used that arguably given the failure that you described of these policies. You might want to go back to the things that actually worked in the past, right?

Dr. Kheriaty: Yeah. That's exactly tight. Pandemics are nothing new. At the beginning of COVID, we kept hearing that COVID was unprecedented. COVID was not unprecedented. Many of our responses to COVID were unprecedented, but the COVID-19 pandemic was very precedent. In fact, we have a pandemic, a worldwide pandemic once every 100 years, and this one came more or less right on schedule, about 100 years after the 1918 Spanish flu pandemic.

You can go back from the lepers of the Old Testament and the way in which they were quarantined by the Hebrew people that had religious significance, but it also had public health significance. You can look at the late Roman empire, the plague of Justinian that many historians believed contributed to the fall of the Roman empire. Most likely it was a smallpox epidemic at that time.

Human beings learned a about how to actually manage epidemics, how to manage these outbreaks of infectious disease. They figured out that you had to quarantine the sick. They figured out some things about distancing from those who were symptomatic, and the measures that were put in place over the centuries did save lives, right? What happened and what was unprecedented in 2020 was that for the first time in human history, for the first time in the history of any known society dealing with an outbreak of infectious illness, we quarantined healthy people, and

that was based on modeling that was catastrophic in terms of predicted number of COVID deaths modeling, for example, from the Imperial College of London, which very quickly was rendered null, was proven wrong by the facts on the ground. Even when we could see in retrospect that these models didn't work, we continued to double down and triple down on the same measures.

I remember when Governor Newsom had locked down initially, and then with the emergence of another wave, he locked down again a second time. At the time when that second lockdown occurred, I was working at the University of California. I had access to the daily hospital metrics from all five of the UC hospitals that are scattered throughout the state.

When we locked down again for the second time, the ventilator capacity in California, we were at about 15% to 20%, depending on the hospital, ventilator occupation. So 80% of our ventilators were still available for use. We didn't go into that second lockdown for the purpose of flattening the curve in order to not overwhelm hospitals, which was the original rationale that had been given to citizens here and in many other states as to why we had to do this. We're seeing now the accumulated fallout from that collateral harm, a spike in alcohol-related deaths that was just reported last week, a huge spike in drug overdose deaths. Viewers will probably recall that before the pandemic we had an opioid crisis, the worst drug crisis that we had ever seen in the United States in terms of morbidity and mortality and people dying from drug-related deaths. In the year 2000, there were less than 20,000 deaths by drug overdose, which is still a lot and still a tragedy, but by the year 2018, that number was 66,000. Last year, 100,000 Americans died of drug overdose, 100,000.

So we took a very serious public health problem, and by locking people down, we poured gasoline on that fire and did a lot of collateral damage in the process, and that number that is now available from the CDC and the Office of National Statistics is not a number that I hear people talking about. It's not a number that is being reported by most media outlets.

Mr. Jekielek: The collateral damage number or the opioid number?

Dr. Kheriaty: Well, specifically, the numbers about drug overdoses.

Mr. Jekielek: Because there's also been this discussion of excess death increasing, right?

Dr. Kheriaty: Right. That's another important issue that we're going to hopefully hear more about in the next year. This is a number that is very useful because you can't statistically game death counts, right? There's different ways to spin statistics, but one very helpful number to cut through all this statistical noise is what we call all cause mortality, how many total deaths were there in the United States during a given period of time, right? We can argue about what caused their death or was this with COVID or from COVID, and you can get into all kinds, but you can't argue with the fact that this person is dead and has a death certificate and was buried in the ground.

So all cause mortality is a useful shorthand metric for how are we doing in terms of public health. We have a base baseline number of people that we expect to every year, and that usually doesn't change very much year to year, but what we saw over the last year was a huge spike in that number with one life insurance company reporting that among 18 to 64-year-olds we saw 40% increase in all cause mortality last year, which was the year we were supposed to come out of the pandemic. It's the year we had the mass vaccination campaign and yet we saw 40% increase in all cause mortality in an age group that doesn't have high mortality rates, right?

Actuaries tell us that a 10% rise in all cause mortality is a once in 200-year catastrophic event. Even during World War II, we didn't see a 10% rise in all cause mortality in the United States. Last time we saw that was actually World War I and around the time of the Spanish flu.

Another important thing to understand is that most of those deaths were not due to COVID, right? So COVID accounted for some of that, but not for most of it, and it's going to take a lot of work to sort out what is going on there. Was this effects of the lockdowns? Was this vaccine adverse events that may have gone unreported or underreported? Was it probably more likely some combination of those things and other things that we still may need to tease out? This is a very pressing question that public health authorities need to contend with.

Mr. Jekielek: I mean, you're saying that 10% is one in 200 years. So this is, I mean, once in a millennium or something.

Dr. Kheriaty: Yes. It's catastrophic. It's a disastrous outcome for public health.

Mr. Jekielek: Well, I have to ask this then. So one of the things that you've been talking about recently, actually writing about is lifting these emergency acts that allow for governors to take control or, frankly, again, also at the federal level, at the state level, and local level. Some of these things are being lifted, but certainly not all, and at the federal level many haven't. Given what you're saying, I mean, it sounds like we are in an emergency, right?

Dr. Kheriaty: Well, we're certainly in a situation in which Americans are not healthy and something is going on that is producing catastrophically bad outcomes, but my suggestion is that our response to this virus and the measures that we took are what is inducing this problem. So if we're going to get a handle on it, we need to recognize that the things that we've done have not saved lives when it comes to COVID, have failed according to their own intentions and their own stated purposes.

Mr. Jekielek: Hang on. Let me stop you for a second. Wait. They have not saved lives at all? I mean-

Dr. Kheriaty: Not overall.

Mr. Jekielek: Okay. So explain that to me.

Dr. Kheriaty: Well, look, in 2020, we locked down with the promise of slowing this spread of the virus long enough to get a safe and effective vaccine that was going to protect us, and we would've expected to see a sharp decline in COVID-related deaths if we had a safe and effective vaccine that was sterilizing, that prevented the spread of the virus, but that also prevented people with a vaccine from getting sick and dying.

We got a partially effective vaccine whose efficacy was quite short term, that didn't prevent infection and transmission. We actually had a lot more deaths from COVID in the United States in 2021 despite the mass vaccination campaign than we had in 2020 when there was no vaccines available.

So what we were told was going to happen and what I think everyone hoped was going to happen, it turns out it didn't play out according to that script. Does that mean absolutely everything that we did caused harm or that nothing that we did potentially saved lives? No. I would not want to make a statement that strong.

What I'm suggesting is that if you Google earth up and you look at the big picture, not this or that intervention, not this or that measure in this or that location because that gets very complicated.

So for example, a targeted use of vaccines for the elderly who are at high risk but not forcing vaccines on younger people who are not at high risk from COVID probably would've been a better strategy for overall health, right? Minimize potential vaccine-related injuries or side effects to people who don't really need the vaccine. Use the vaccine in a targeted way for people who are more likely to benefit, but that's not the approach that we took. We took a one size fits all approach, whether it was with lockdowns or the mass vaccination campaign or other COVID-related measures.

Okay. If you're going to take a one size fits all approach, you have to look at the overall outcomes and the overall health of the population as a whole, right? I think when we're not capable of stepping back and assessing in real time as things unfold and then changing course or pivoting our strategy as needed, then we're going to end up multiplying harms much longer than they needed to be.

Mr. Jekielek: So I had someone on the show recently who was arrested, probably for good reason actually, but it was under a 20-year long state of emergency in a different country, different situation, but the point is that states of emergency can hang around for quite a while, actually.

Dr. Kheriaty: They can. The Italian philosopher, Georgio Agamben, has written a lot about this, that really since the end of World War II, what he calls the state of exception or what we would typically refer to as a state of emergency in many supposedly democratized free, open Western nations, and many not so free nations, the states of exception or states of emergency have become the norm. So early on in the pandemic, probably for legitimate reasons, many governors and the federal government declared a state of emergency. The person at the federal level who's empowered to declare the state of emergency is the secretary of the Department of Health and Human Services, a man named Xavier Becerra, former attorney general of California. He's a man with no prior public health experience and no public health training, but he recommended to the president to declare the state of emergency, and he recommends periodically that the state of emergency be renewed and President Biden signed another letter renewing the state of emergency with no end date specified, so indefinite, essentially.

In my home state in California, here we're still under a state of emergency. So governors have assumed very enormous powers, probably even more power of control over the population than we see at the federal level. I think prior to COVID, a lot of people didn't pay a whole lot of attention. There was a lot of attention on national politics, but people paid less attention to who's my governor, this state versus that state governor. We've seen now how important that role is in terms of what happens to us in a time like this.

It's also shifted power into the hands of unelected public health officers, county public health officers, local public health officers, private individuals. A company's CEO can initiate a vaccine mandate and can make judgements about whether a medical exemption that was submitted by an employee signed by their physician will be accepted or not, right? Who gave this person the authority to do that and why should they have that authority?

So almost everything that was done during COVID was done under the legal pretense or with the ethical justification that while we're in the middle of a pandemic and this is an emergency and, therefore, ordinary rights of freedom of movement, freedom of assembly, even freedom of speech need to be suppressed for the sake of the greater good.

Now, are there emergencies in which certain rights might temporarily need to be bracketed? Probably. The problem with the way in which a state of emergency has been deployed during this pandemic is the threshold or the criteria for what counts as an emergency was never defined and still has not been defined, right? So when President Biden renewed the federal state of emergency last month, you can go online and read the letter that he signed to enact this.

The only statistics that he cites is a number of people who have supposedly died with COVID, the total death count, not deaths in recent weeks, not percentage of hospital beds that are occupied by COVID patients, not even projections over what might happen in the next month or two that requires that we keep this state of emergency.

Very few people asked any questions about this. We need to demand from our public officials clear criteria of what constitutes a public health emergency, criteria having to do with infrastructure or the healthcare system being overwhelmed or maxed out, criteria having to do with the risks to various segments of the population, whatever, to allow us to know both when there is an emergency and

when the governing authorities should invoke those extra constitutional, extra legal power, but it would also tell us when the emergency is over.

The people who are empowered to declare the state of emergency are also typically the people who assume additional powers during the state of emergency. Perhaps we give a governor authority short term to declare a 15-day or a 30-day state of emergency, but before long, there needs to be some either judicial review of the state of emergency or some legislative review for that state of emergency, right? The state Senate or the state assembly or the Congress at the federal level has to actually examine what's going on and cast a vote as to whether the state of emergency is going to continue.

Mr. Jekielek: You've outlined some things that I think people should do, but basically, are you telling me that unless US citizens do something, we're not going back to normal? Is that what you're suggesting?

Dr. Kheriaty: That's my prediction. I think this biomedical security state apparatus that has been put in place during the pandemic will remain in place and will be redeployed for other purposes. A good example to wrap your head around this is the idea of the vaccine passport. If you were to take people in 2018 and 2019 and say, "You need to download this app on the phone. Then you need to go out and take this novel medical intervention that was just basically recently invented, recently tested, recently rolled out, and then you've got to demonstrate, you got to show me your QR code verifying that you've done what you were told to do in order to get on a plane, get on a train, eat at a restaurant, gather in a public space for a public event," I think most Americans of all political persuasions would've said, "No way. This is an unacceptable intrusion on my privacy, on my bodily autonomy, on my freedom of movement, and my freedom of association." In the last two years, during the state of emergency and in a climate of fear, in a climate of having many of my ordinary rights taken from me, freedom of movement during the lockdowns, and then with the promise, this carrots and sticks of you can't go to work, you've got to work from home, maybe your small business is going to be shut down because you can't keep it afloat during the lockdowns, but if you do this thing, we're going to let you get back to normal or we're going to let you keep your job or whatever.

Well, a lot of Americans went ahead and did that. What I'm trying to help people understand is, okay, you may not have minded verifying that you had been vaccinated in order to travel, but this has now become normalized. What if the

next thing that's demanded of you by the governing authorities or the public health authorities is something that you're not so inclined to do or that you're ambivalent about or that you want to wait a year and before you go ahead and take that step or you want to do a little more research or whatever or you believe you have a medical contraindication for? How are you going to feel about this passport system then?

This vaccine passport system gives an unprecedented level of surveillance, monitoring, and control to many different institutions, not just the government. Many people are given access to otherwise private and protected health information. You're showing to a perfect stranger a verification of a particular medical decision that you've made, perhaps under coercion or under duress, so that you could go and visit your grandparents who are dying or whatever. That's going to be used for other purposes, right?

There is going to be another public health crisis. There are social issues already in play that over the last year have been redefined as public health issues. Climate change would be one obvious example of something that five, 10 years ago was framed as an environmental issue, and it's been now reframed as a public health issue. I think this same infrastructure is probably going to be deployed to, again, try to control movements of the population.

Just a week or two ago, there were governing authorities in England that were advising people to I think it was work from home three days a week to deal with the oil and gas crisis created by the political situation with Russia and Ukraine. Many people have talked about how clean the air was during lockdowns and have proposed rolling lockdowns or periodic lockdowns as a way to try to deal with climate change.

Again, whether you think those things are a good idea or not a good idea, the important thing is to recognize that this welding of public health with digital technologies of surveillance and control and the police powers of the state allow for intrusions on our privacy, on our bodily autonomy that are unprecedented in history. I mean, the most controlling totalitarian regimes of the past could have only dreamed of having these tools at their disposal.

Mr. Jekielek: Well, we're in California, and we were discussing offline a whole suite of new legislation that speaks to exactly the kinds of things you're talking about like legislation that's actually being proposed, and I still have no idea if this

is something that can be passed, but let's just say there isn't a strong opposition in California.

Dr. Kheriaty: Right. So yeah, if you want to see which way the winds are blowing or you want to see which direction the sheep are moving, the bellwether state is probably California for some of these novel measures, and what I've described as the biomedical security state. If you look at these 10 bills that have been proposed in the California state legislature, it's a pretty clear sketch of what the next phase or the next step in this process will look like. So that includes bills that will, for example, lower the age of consent for vaccines to 12 years old so that parents are not consenting on behalf of their children for this medical intervention. They're not even perhaps notified that their child was vaccinated, intrusions into medical privacy.

So there's one bill that will allow the government and the medical board, which is appointed by the government, to basically search physicians' offices and physicians' records and to access patients' medical records without the patients' own consent. There are bills that involve an attempt to control the free speech of physicians and to muzzle any physicians who challenge the government's public health narrative or the government's public health recommendations. They will be labeled as giving misinformation and subjected to discipline by the medical board, which is a very serious thing for a physician. That's even more serious than losing your job. If I lose my job at a particular hospital, I can go and get a job at another hospital or start a private practice, but if I lose my medical license, that means I can't practice medicine at all. It would be like being disbarred as a lawyer.

Mr. Jekielek: Well, which seems paradoxical given how, I guess, wrong these large structures have been that you would think you would want to give a lot more room for physicians to try to understand the reality of the science and literature and the research that's being done and try to come up with good ways of dealing with the problem.

Dr. Kheriaty: Exactly. That's in fact how science progresses. That's the only way that science can progress and make progress and evolve is through a free and open exchange of information and data and a free and open discussion and debate about the upshot of that data or what does the data as a whole show. Real doctors do not talk about The Science, capital T, capital S, as though scientific information is one monolithic thing that's not subjected to dispute or debate. Science progresses by conjecture and refutation, by generating a hypothesis and by working to try to

verify or nullify that hypothesis by doing experiments and by gathering more information and by trying to analyze data.

So the idea that in something as complicated as a novel coronavirus that's impacting the population in ways dissimilar to anything that we had seen before, the idea that on the fly in real time certain people can figure out everything that's going on and are the last word in what's happening and how we ought to respond to it, quite frankly, is ludicrous.

Many of the people who were claiming to be the last word on the pandemic or the last word on science related to the pandemic, two, three, four months later were contradicting statements that they had said earlier. So they couldn't have been right in both instances, and maybe they were wrong in both instances as well. Maybe there's a third answer that's actually more correct.

So Americans should be very worried about any legislative attempt to muzzle scientists or physicians. I mean, I don't know of any American that would trust a physician who was not capable of speaking his mind, right or wrong. You can take or leave the judgment or the recommendation of your doctor. You can go and get multiple opinions, a second or a third opinion, but you want to know that your doctor is telling you what the doctor actually thinks and not just giving you a line that was dictated from above.

Mr. Jekielek: We've been shown, I think, the dangers of having a situation, and I guess you've already spoken a little bit about this, of precisely having this unilateral approach policy, this is how the policy works for everybody and the exceptions. Human bodies are complex. People's medical histories are complex. That's the reason you have a personal doctor, all this, right? Of course, these doctors certainly would want to look at CDC recommendations and everything else, right?

Dr. Kheriaty: One of the members of SAGE, which is the Scientific Advisory Group for the National Health Service in England, so they advise the English and the Scottish governments on health policy, one member of that group in an interview said very openly that prior to lockdowns, there was not meaningful modeling and debate of the potential downsides of lockdowns.

He said, "Anytime you have a new sort of initiative that you're going to roll out in public health, you're going to try to project the good that it will do, but you're also

going to take a look at downside side effects, potential collateral harms. You're going to model all that out as well, and then you're going to debate and weigh, and you have to make decisions based on imperfect information, but you at least have that conversation."

That conversation we didn't have. In many respects, we're still not able to have it. People who attempt to ask questions, attempt to do a retrospective analysis on the policies and, in some cases, the failure of the policies are still being vilified, are still being marginalized, are still being censored and suppressed on social media. This is not a good climate for advances and progress in science, medicine, and public health.

Mr. Jekielek: Why is this a norm? Why would that be an acceptable way to operate?

Dr. Kheriaty: I think it had to do with the public health approach that was decided and predetermined from the beginning, which involved instead of trying to educate the public, we took the approach of saying we have a behavioral outcome that we want to induce in the public, stay home to save lives, a needle in every arm, everyone wash their hands six times a day, mask up, whatever that behavioral outcome that was predetermined was. We're going to quietly shelf or set aside or even actively suppress information that might undermine that behavioral outcome.

So a responsible public health approach would be to say, "Because it's a rapidly evolving and complex situation and that the science around this is complex and subject to some degree of debate, we're going to try to take this complex information and simplify it enough that the ordinary person can understand it. Give people accurate information that's comprehensible to them so that they can make good and informed decisions for themselves and their families," but as I said, that's not the approach we took.

We said, "We want you to behave in a particular way and we're going to control the flow of information so that all the information you get pushes you in the direction of that behavior."

Well, one of the problems with that is that you're never able to debate or discuss that predetermined outcome, and is that something that we actually should be aiming for. Another problem with that is that it becomes obvious if you're getting

that behavior but not getting the results from that behavior that you want, it becomes obvious that that's not working and that there was information that was kept from us. That's a really good way to destroy the trust of the public in public health officials, in medicine, in the scientific establishment, right?

If people feel that potentially relevant information was kept from them, and it doesn't even necessarily have to be information that would've changed their mind or changed their behavior, but just relevant information was kept from them, they're not going to trust what you tell them the next time, that you tell them something.

Recently, even the New York Times reported a few weeks ago that the CDC has been deliberately keeping a lid on a lot of its data and not releasing the kind of data that it was releasing earlier in the pandemic in terms of cases, hospitalizations, and deaths, and the vaccinated versus the unvaccinated, and doing that in an age-stratified way so that we could see these numbers for different age groups.

The reason that the CDC spokesperson gave to the New York Times as to why they're basically suppressing data or not being transparent with their data is that, "If we were to show this data to the American public, we worry that that would increased vaccine hesitancy."

In some highly vaccinated regions, Israel, parts of the UK, Ontario, Canada, we've seen in the last few months the emergence of negative vaccine efficacy, of higher rates of COVID infection among those who are vaccinated. Does the CDC have numbers that are starting to show a similar trend? I don't know. They haven't let us see that. The only thing they've told us is we don't want you to see that information because it may change your mind on vaccines.

One of the problems that we see here, and one of the major reforms that I think is needed here is we take an agency like the CDC. They really have two functions. One is to gather data from all 50 states and collect and collate that data and release it to the public. Although, as I said before, now they're gathering the data but they're not necessarily releasing much of it.

On the other hand, based on that data, they also have this function of making recommendations, especially recommendations related to masking and social distancing and vaccines, and that has created this, I think, conflict of interest

within the CDC such that we're to the point now where rather than releasing the data that American taxpayers have paid for and, obviously, have the right to see and independent researchers have the right to scrutinize, they're keeping that information from the public because they think it may be harmful to some of the recommendations that they've made.

I think we need a stronger firewall between those two things. We need an agency that just gathers and releases data, and public health authorities, independent researchers, university-based researchers, everyone has access to that same data set. Then you have maybe a separate agency whose responsibility it is based on that data and based on any other available information to make policy recommendations, but when you conflate and confuse those two things, you end up in a situation in which you have the control of information.

Basically, giving people only the information that you want them to hear in order to do what you want them to do, that's basically a definition of propaganda. So we're almost set up in terms of how we've arranged things right now for public health agencies to serve as a propaganda arm for a particular political interest or a particular political agenda.

Mr. Jekielek: … or even a particular vision of health, a specific one, right?

Dr. Kheriaty: That's right.

Mr. Jekielek: Which should be subject to some kind of scrutiny. Now, just something, as you're talking, we're talking about profoundly different philosophies even of public health. Would you advocate for this radical transparency with information? Something that struck me here is that, for example, we had drastic when it comes to looking at COVID origins, this consortium of some amateurs, some professionals, many of them wanting to stay in cognito for a variety of reasons, just doing some incredible work trying to understand virus origins and things like that. So with a lot of data being available, you have this opportunity for people, for all sorts of people to try to debate, discuss, try to figure out what's actually happening, find things that others aren't finding. Would you advocate for this kind of radical information transparency or something else? I probably shouldn't call it radical because it's just information transparency, full information transparency, actually, just radical in the current context.

Dr. Kheriaty: Yeah, that's right. That was going to be my first remark is that the proposal actually isn't that radical. In fact, I think the pandemic response is an exception to a general trend in science that we've seen over the last few decades of a push toward data sharing, a push toward open access of information. Scientists have their own particular self-interest in protecting their data in certain cases, "I want to be the first out of the gate to publish this. I want to get credit for it." All of those human motivations operate in sciences as well, but there certainly has been a movement in much of the scientific community toward the sharing of data, certainly toward making your original dataset available to other researchers. That's a basic ethical norm now in published research so that other people can see, "Were we able to replicate your results with your original dataset?"

So I think it's not a radical proposal to apply that to public health as well. I mean, it makes sense that more minds working on a problem will generate more creative and novel solutions. In the free play of ideas, we can see which ones work out best. I mean, the genius of the federalist system I think we saw playing out during the pandemic where there were at least a few states that acted as an exception to the general approach that most states took to the pandemic. Well, that's very useful because now you can compare their outcome and you can look at age-adjusted outcomes for Florida versus California and see that basically they got the same outcomes, even though California locked down and Florida stayed open, and Florida can demonstrate better public health outcomes in terms of mental health and the other collateral damage problems that we saw in states that locked down. Now, I've been battling also with the FDA for transparency. Several months ago, I along with my lawyer, Aaron Syria, I coordinated a group of scientists and physicians. We called ourselves Public Health and Medical Professionals for Transparency, which is a mouthful, but we filed a FOIA, a Freedom of Information Act to the FDA to get the Pfizer data, the Pfizer clinical trials data that was submitted to the FDA for approval of their vaccine, Comirnaty.
On the day in which that vaccine was approved, under federal law, FDA was required to release that information to the public. They have still not released the clinical trials data information. So we filed this request. The FDA came back and said, "We'll give you 500 pages a month because we don't have very many employees that can make photocopies," or whatever. If you do the math, it would've taken 75 years to get all the data that they reviewed in only 108 days. The judge, had a good judge in this case, said, "No. I don't think so. You need to get this data out in the next eight months."

Pfizer then intervened in this case and said, “We would like permission to redact the clinical trials data before it’s released,” which is not surprising that the company, the corporation who has financial interests at stake would try to intervene in that way. What was shocking and surprising was that the Department of Justice lawyers representing the FDA agreed with Pfizer and submitted a request to the court to allow Pfizer to redact their clinical trials data before it was released to the public.

Again, the judge declined that request and we’re starting to see some of the data from the Pfizer trial begin to roll out. Our organization is posting that online for independent researchers to evaluate and scrutinize and assess. We know that a corporation is going to act on its own self-interest, which may or may not align with the healthcare-related interests of Americans. That’s okay. We can deal with big pharma if we have trustworthy public health agencies to put the needs of Americans first and make sure that rigorous safety and efficacy testing was done before a new pharmaceutical product is released to the public.

What we have now, unfortunately, is a situation in which it seems that a lot of those public health agencies have been by the pharmaceutical industry itself. So the industry that they’re supposed to be regulating is actually more or less calling the shots when it comes to those public health agencies, and that’s a dangerous setup.

Mr. Jekielek: I can’t help but think about this essay that you wrote, The Anatomy of Coercion, this idea that in these incredibly let’s say developed bureaucracies that are these agencies now, they’re massive. It’s just a lot more difficult to pinpoint accountability, right? That’s an emergent property or perhaps by design. I don’t know, you tell me, but that’s fascinating and also, again, disturbing because you could say, “Well, that’s the CDCs fault,” but what actually went wrong and did someone make a bad decision or how do we deal with this?

Dr. Kheriaty: Yeah. So it’s a great question, and someone once quipped that a bureaucracy is an institution that exercises enormous power over you but with no locus of responsibility. I think many Americans have the familiar experience of going into a place like the local DMV and running into a government bureaucracy where they have to troubleshoot some anomaly. There’s some mistake that was made and they’re trying to figure out how to rectify or remedy it, and they keep going round in circles, and no one seems to be able to take responsibility to fix the

decision. It's not clear where I should go next to sort this issue out, and I feel like I'm stuck in this bureaucratic purgatory.

In many respects during the pandemic, I think what we see is that the DMV writ large on a statewide or a national or even a global scale where we have unaccountable bureaucracies that are exercising enormous and sometimes invasive powers over our life, but when we turn to try to seek redress or remedy, there's no one that seems to take responsibility for these very profound decisions, and I'll talk about how that plays out in terms of vaccine mandates.
So vaccine mandates such as the mandate that I was subjected to at the University of California that I'm challenging in federal court was made by the university, but if you go to the university and try to get into a scientific debate or argument about the mandate, what you get is, "Well, we're not making this rule. We're just basing this on the CDCs recommendation."

Okay. So maybe I should go to the CDC and try to get them to, let's say, acknowledge natural immunity as being equivalent to or superior to vaccine immunity, and the CDC's response is, "Well, we don't mandate anything. We don't make federal policy. We just give recommendations, and so maybe then you try to go to the pharmaceutical company that's making this product." Let's say you're injured by this product and you want to seek redress for that injury. Well, it turns out that under the Prep Act, pharmaceutical companies are shielded from all liability, not for medications that they release, but for vaccines that they release. So I can't seek redress for a vaccine-related injury from Pfizer if I'm harmed by their vaccine or from Moderna or Johnson & Johnson or whatever.

Okay. Well, previously, if someone was injured by a vaccine that's on the CDC schedule, they actually could go to the federal government in exchange for signing a nondisclosure agreement such that I'm never going to talk about the fact that I was injured by a vaccine. The government has historically compensated people some money to try to redress that injury, but that was done away with during COVID as well.

So no one, not the government that's making recommendations or in some cases mandating the vaccine nor the public or private institutions that are mandating the vaccine, nor the company that produces this product, nor anyone else seems to be responsible if things go south or if harm is done by these policies, and no one seems to be taking responsibility for these policies and their consequences.

Mr. Jekielek: The obvious thing, I keep wanting to go back to this, I guess, profound philosophical questions that I keep thinking about when I speak with you, when I speak with others on the same topic. I think people might have been more inclined if all these measures that were brought down in this heavy-handed way or actually worked. As we've been discussing, that actually hasn't been the case and it's, I guess, exposed, as I mentioned before, the fallacy of this kind of approach. It brings to mind just these fundamentally opposing approaches to dealing with the world, dealing with society, dealing perhaps even with reality itself. What are your thoughts here?

Dr. Kheriaty: So I think we can articulate this in terms of two fundamentally different ways of viewing the world, of understanding human knowledge and human society. So just to do a little bit of a deeper dive philosophically, if you go back to what I said about the public health approach where you begin with a behavioral outcome and then you control the flow of information to get that behavioral outcome, I contrasted that with a view of let's take complex information and try to make it readily accessible to everyone to allow people to make rationally informed decisions.

So the latter approach, which I would advocate for, is a traditional view of rationality which says all human beings, even if you're not an epidemiologist or a virologist, all human beings are still capable of and have the capacity for logic and reason and understanding, and that rationality is shared among us that there is something true out there about this virus or about the measures that we take to try to get a handle on this virus, and we have to do our best, fallible as we are, to try to discover that truth and conform ourselves to it, and our shared rationality is the thing that allows us to do that and allows us to have a meaningful discussion and debate and meaningful starting points from which to begin.

What we see now, however, is we don't see meaningful discussion and debate by and large in the public square or in public health. We see two cohorts of people talking past one another. I think what's happening is that you have that traditional view of rationality operating among a portion of the population.
Then you have a very what you might call an instrumental view of rationality among another portion of the population, which says that reason is not something shared, it's a tool that we use to do certain things or to accomplish certain things. It has an instrumental utility.

The truth is not something out there to be discovered. Truth is quite literally what we make or what we produce. A materialist understanding of the word, for example, Karl Marx's philosophy, would be a paradigmatic example of this way of thinking, where we don't actually have these independent thoughts. Our thoughts are just completely shaped by economic and social and underlying material conditions, right? Our thoughts are merely the foam on the top of the wave, but what's really happening is this material substrate of economic conditions and social conditions, and based on that, Marx said, "If you want to change people's minds, you don't argue with them philosophically," right? That's why he said the previous philosophers had sought to understand the world, but the point is to change it.

What he meant by that is the only way to change someone's mind is to change social conditions because that's what determines how you think, right? You think the way that you do, Jan, because you're a White male, Polish-American, who was born around this time and, of course, all those things are important, but the traditional view of rationality would say, "But yeah, you're also a human being who can think and deliberate and come to some understanding." Certainly, those things shape, to some degree, how you think, but they don't completely determine how you think, but on this instrumental view of rationality, the thing to do is actually to change the world and to create reality ourselves, and that's where you get this revolutionary elements in Marxism as well.

Americans are probably less influenced by Karl Marx and more influenced by our philosophical tradition of pragmatism, and pragmatism is like Marxism without the revolutionary component. It's truth is that which works, right? Again, it's not something out there that we need to discover. It's what we need to make by our own efforts.

So I think on this instrumental view of rationality debate is not seen as valuable, right? What's seen as valuable is changing people's minds so that they are moving in the right direction, this notion of the direction of history, what means to be ethical is to be on the train that's moving in the direction of history, in the direction of progress, in the direction of inevitable movement forward. If you're not on board that train, you're not worth talking to, right? You're not worth debating or deliberating with. You could just be steamrolled or you could just be discarded because you're obviously a bad person, right? You're obviously someone who's dangerous, whose opinions need to be suppressed or silent, which

is actually precisely what totalitarian regimes of the past did. They bought into this instrumental view of rationality, and debate and discussion were forbidden.
The political theorist, Eric Voegelin, said that the feature comment to all totalitarianisms is not concentration camps or men in Jack boots, as bad as those things are. He said the common feature of all totalitarian regimes is the inability to ask certain questions, and not to end on too much of an apocalyptic note, but I worry that we're starting to see that kind of tendency creep in, especially during this state of emergency where you were somehow deemed dangerous if you ask certain inconvenient questions.

We see also in the past that states of emergency that were prolonged paved the way even for totalitarian regimes. So anytime you mention the Nazis, people tend to freak out. So let me just say in advance, I'm not comparing either the current or the previous administration to the Nazis by mentioning this historical example. I mention it only to show that the prolonged invocation of a state of emergency can, under certain social conditions, lead in a totalitarian direction.

The Nazis governed for virtually the entirety of their existence under article 48 of the Weimar constitution, which allowed for the suspension of German laws during a time of emergency. People forget that Hitler was democratically elected. So how did this democratically elected chancellor in the late Weimar Republic assume power to the point where he could become the dictator of a totalitarian regime? Well, one of the legal mechanisms that paved the way for that was this invoking of a state of emergency, and the Nazis also used the language of public health to advance their agenda as well. If you look at the Nazi propaganda of the 1930s, you see that the Jews and other "undesirables" were often characterized and vilified and dehumanized as vectors of disease. They were dirty. They were carrying infectious agents that were going to infect the rest of the population.

So that's obviously a very extreme example of where this kind of thinking and where this instrumental view of rationality and where this legal mechanism of the state of emergency can take a society, but I think there are important lessons in history that we need to learn.

Another pre-totalitarian dictatorship that occurred earlier in Western history was the extreme elements of the French revolution, the Jacobin wing that took over and ushered in the reign of terror where people left and right were getting their heads lopped off by the guillotine. Many people don't remember the name of the

governing entity at that time. It was known as the committee on public safety, right?

So public health, public safety, several clear historical examples of the last few hundred years of Western history where this has been invoked in order to gain more invasive control over a population and more surveillance over a population in the name of health.

So I'm a physician. I care about health. I'm a public policy analyst. I care about public health. These are good things, but like anything else in society or in the public realm, they can be misdirected and they can be misused or they can be captured and commandeered for political or economic or other purposes.
So I think we have to be very careful because there is this urgent situation that we need to deal with. Okay. How do we make sure that those powers are not misused or abused? How do we make sure we unwind that as soon as possible to get back to a normal democratically, constitutionally functioning regime? Those are, I think, very, very important questions for Americans to look at over the next year or two.

Mr. Jekielek: So you've mentioned that you believe people need to play a role in seeing what you just described happened. To roll some of these things back, people need to voice their concerns somehow or participate. What are your suggestions because I imagine there's a number of our viewers would be interested in knowing that?

Dr. Kheriaty: Yeah. So I think studying what happened to German medicine would be a very instructive place to start. There were subtle shifts in German medicine that happened long before the Nazis came to power that made German medicine, German public health more prone to get onboard with the Nazis' disordered social program.

So starting around the early 1920s, there was the eugenics movement, which was imported from the United States and Great Britain. So that would be another thing for our viewers to study. Study the eugenics movement, not in Germany, which everyone knows about, but in the United States that resulted in the involuntary sterilization of 65,000 Americans in a majority of 34, I think, states had laws permitting this. The infamous Supreme Court case of Buck v. Bell, which relied on reasoning from the Jacobson case that allowed for involuntary vaccination in 1905 during a smallpox epidemic.

This 1927 case of Buck v. Bell, the Supreme Court ruled in favor of the state of Virginia allowing them to involuntarily sterilize this young woman, Carrie Buck, who was diagnosed with congenital feeble mindedness, which was a loose category back then as it is now. The opinion was written by Justice Oliver Wendell Holmes Jr., very famous American jurist.

He said, "The principal that allows for forced vaccination is 'wide enough to cover the cutting of the fallopian tubes.'" Then the infamous line three generations of imbeciles are enough, right? So there was this social program that was tied to medicine and public health trying to improve the stock by controlled breeding. It resulted in involuntary sterilization of "mentally and physically defective" people, and poor people, and minorities disproportionately represented in the US.

Well, Germany was influenced by this, but they took it a step further. They took it in the direction not just of involuntary sterilization, but of outright non-voluntary euthanasia. There was a book published by a psychiatrist and a lawyer, Hoche and Binding in 1922 on the destruction of the German word was Lebensunwertes Leben, life unworthy of life, where they advocated that disabled individuals should be allowed to be euthanized by the state with or without their consent or their guardian's consent.

The German medical community embraced this. Why did they embrace it? Well, there was a subtle shift away from a traditional hippocratic ethic, where German physicians said, "My responsibility is to the sick patient in front of me, the vulnerable person who because of an illness requires my help, and I need to everything in my power to try to heal them and to try to minimize any harms to them." That's traditional hippocratic medicine.

Physicians became convinced starting in the 1920s that their responsibility was not to the sick individual patient, but to the health of the social organism as a whole. So there was this metaphor of the German people, the Volk, as being healthy or sick as a whole, this social health became the aim of medicine.

So if you have a social organism that has a "cancer" on it, well, what does a doctor do with a cancer? He carves it out in order to make the whole better. Well, certain people, certain individuals in society started being characterized as a cancer on the body politic or a drain on the social or economic or health resources of the whole. That was a subtle shift that occurred long before the Nazis came to power, and because doctors had begun to see themselves not as agents of the health of the sick

patient but as agents of the health of the social organism, when the state's social program became misdirected and disordered, physicians went along with it very readily and embraced it.

So the first people who were gassed in Nazi, Germany were not Jews or other ethnic minorities in concentration camps. They were mentally disabled patients in psychiatric hospitals in Germany. That's where the first gas chambers were located under the T4 euthanasia program. Physicians were signing off on and endorsing every one of those deaths. 45% of physicians joined the Nazi party, even though it was not a requirement to be in the profession. It might help you to advance in academic medicine or whatever. We can compare that to only 10% of teachers in Germany who joined the Nazi party.

So what happened to German medicine, which was backwards and barbaric? German medicine in the early 20th century was considered the best in the world, and German medical schools and medical institutions were considered the most advanced in the world. So Germany was a leader in medicine and public health prior to the Nazis coming to power.

What was it about the medical and public health system that started to veer off course, and is there a temptation in other societies to start moving in that direction? If you want to see the ultimate consequences of where that goes, study what happened to Germany in the early 20th century.

Mr. Jekielek: It's very difficult to hear you talking about this, frankly, as I'm listening. What about in terms of concrete things that people can do right now that are looking to see the state of emergency ended, that are looking to basically go back to something that resembles normal?

Dr. Kheriaty: So I think on next steps, people need to demand from our government to end the state of emergency, and along with some other scholars at the Ethics and Public Policy Center where I work, we submitted a letter to Secretary Becerra at HHS and to President Biden demanding that the state of emergency at the federal level be rescinded. I think we need to do that at the state level as well.

The second thing people need to do is to demand and take back, in a sense, their right of informed consent and their right of informed refusal. So what happened in the wake of the Nazi disaster? We had the Nuremberg trials and about a dozen

physicians were tried at Nuremberg for crimes against humanity, for engaging in research experimentation on prisoners in the concentration camps without their consent.

What came out of the Nuremberg trials when it came to science and medicine was the Nuremberg code, and I'd recommend that our viewers go and read the Nuremberg code. It's not complicated to understand. There's about 10 provisions. It's less than a page long. It's a quick read, but the first and most important thing that was articulated in the Nuremberg code was the doctrine of informed consent, which formed the foundation of all biomedical research and the foundation of clinical ethics in the second half of the 20th century that was cast aside when people's right of informed consent and right of informed refusal for a medical intervention was refused with vaccine mandates and vaccine passports.

People in California and other states that are facing the legislation that we talked about that would advance this biomedical surveillance security agenda can begin pushing back by getting involved in grassroots efforts. I'd recommend people go to the Unity Project, the Unity Project's website, where I serve as their chief ethics advisor, and they'll find all kinds of helpful resources there for California and states outside of California to oppose this kind of legislation and to help raise awareness among their circle of contacts of this kind of legislation.

So I think Americans have, in many cases, passively accepted with the spirit of civic responsibility and goodwill. I've done what the authorities told me to do, and it hasn't worked out so well for me or for my family. I think it's time again for us to regain a sense of active civic engagement that we cannot outsource our rationality and common sense to experts. Okay. I'll listen to the experts on epidemiology or on virology or whatever because that's out outside of my area of expertise, but I will not relinquish to so-called experts my ability to spot a logical contradiction, my ability to see that things aren't adding up or these things are not making sense.

So I would encourage Americans to kind of wake up from a sleepwalking state in which they may have bracketed a lot of these judgments and start trusting your own instincts, start trusting your own judgment again, start demanding clearer answers from our governing authorities and public health authorities about exactly what it was that happened to us over the last few months.

I think unless people become more actively engaged in these decisions, then those who have particular interests that are advanced by this agenda will continue pushing forward, and there will be a new real manufactured public health crisis that will continue to advance this agenda. So passivity is not a good option at this point.

Mr. Jekielek: Well, Dr. Aaron Kheriaty, it's such a pleasure to have you on the show again.

Dr. Kheriaty: Thank you.