Exhibit 168

Dr. Peter McCullough, MD, MPH, Jun 27, 2022 Texas Senate HHS Testimony
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Dr. Peter McCullough

Madam Chairman, ladies and gentlemen, I am probably well known to the committee. I testified here on March 10, 2021. I'm a practicing internist and cardiologist in Dallas, Texas, and I'm an expert on COVID-19. I have 56 peer reviewed publications on the pandemic, particularly how to treat the infection and over 770 overall publications in the National Library of Medicine and well over a thousand overall medical communications. I've served on two dozen data safety monitoring boards for large pharmaceutical and device and in vitro diagnostic studies. And I consider myself both an expert on COVID as well as drug and device and biological agent safety. Here are my comments.

There has always been a duty to treat COVID-19. It started with the very first case as soon as we recognize that this was a potentially fatal infection. When a patient could have died of this infection at that moment and we understood it early based on risk stratification, based on age, medical problems and severity of symptoms upon presentation, there was a duty to treat that patient. Period. If a doctor did not treat that patient when a patient sought help, there was a duty to refer. From the very beginning there was a community of standard of care from the very beginning. It evolves over time. In many situations like this or in rare diseases the community steering of care may be one doctor in that community who's going to take on the challenge of treating that patient, but that becomes the community standard of care.

Early, there was use of a variety of drugs that became standard of care as evidenced by surges in use of these drugs and they included Hydroxychloroquine, Ivermectin, prednisone, budesonide. There were giant surges in use of these drugs as evidence that these were outpatient evolving standard of care. Now there's a surge of use in Paxlovid and a minor surge in molnupiravir. There has always been a community standard of care for early treatment.

Lesson learned from this committee. There's been 8 hours of testimony today. Not a single presenter could tell you what patients in these data sets received early treatment and what was their outcomes. Not a single presenter knew who had received early treatment and what was the degree of complexity of that early treatment. Lesson learned.

Next, pandemic get immediately an outpatient early treatment committee together. Their objective is to reduce the risk of hospitalization and death. That is the overall objective of this pandemic. Keep people out of the hospital and keep them alive. If they can get through this illness at home. That was your mission from the very beginning on early treatment. Fortunately, it's now been about 1400 studies. There have been hundreds and hundreds of randomized trials and we know that sequenced multidrug therapy that addresses viral replication, inflammation or cytokines storm and thrombosis is the approach in handling this. Dr. Proctor is here. He's published two very good studies right from the state of Texas, Vladimir Zelenko in New York, Doctor Raiout in France. All the data are cohesive that the early protocols very early had 85% reductions in the risk of hospitalization and death, Now with monoclonal antibodies, Paxlovid and others, I've testified under oath in the US. Senate on January 24, 2022. Based on my expert opinion, there is now a 95% risk reduction for death and hospitalization if early treatment is provided. Conversely, I've reviewed hundreds, if not thousands of reports of patients who are hospitalized and died. Hundreds, if not thousands of reports.

The outcome of hospitalization and death is a product of not receiving early treatment. Whether someone's vaccinated or not, the vaccination is irrelevant because the vaccination is not a treatment. What's relevant is, was the patient treated before the hospital? In every single case, in every single patient outcome that I can see, the reason why they're in the hospital is they received either zero outpatient treatment or they received inadequate treatment that was received too late. So a committee like this, lesson learned is always going to be about treating the next infectious disease early.

In terms of inpatient care and the overall landscape of what happened Timeline. I think the charge of the committee is pay attention to big developments. Pay attention to these. In May of 2020, there was a US. Senate hearing on the use of cortical steroids. Pay attention to that. That was a big you heard confusing testimony. There were some of these doctors didn't know if steroids worked or not. That was a landmark event where it was clear that steroids worked and it should have rapidly been instituted as a standard of care in the hospital.

Another giant development was I had published the first overall treatment protocol paper in a major medical journal August 7 of 2020. But rapidly after that in September of 2020, there already is a home treatment guide by the association of American Physician and Surgeons.

When there is a physician group that publishes a home treatment guide, pay attention to that. Remember, the infectious disease side of America always had the first set of guidelines. And then the NIH, they still to this day do not have a comprehensive outpatient treatment guideline. That's the reason why AAPS filled in, Frontline Critical Care Network filled in, Truth or Health Foundation, Frontline doctors and others. When other physician organizations based on consensus and data fill in the gaps, pay attention to that. Very important.

When an organization puts out a negative position on a drug, a negative position. This is really important, and it's a worldwide organization. You must pay attention to this. November of 2020, the World Health Organization says, stop using, remdesivir stop it. It's bad. It doesn't work, and it's leading to more deaths, at least a kidney injury and liver injury. The immediate thing this committee should have done is who's using remdesivir in the state of Texas, and let's talk about it. Now, whether or not the NIH disagrees with who that's got to be vetted. But the question should have been asked. We needed to re examine this where Texans are going to be hurt by this drug. The World Health Organization European Society of Critical Care said yes. And that went on under this committee's watch. These are very important - lesson learned. Pay attention to the big developments.

We've covered monoclonal antibodies well enough. My second set of comments the COVID-19 vaccines. The COVID-19 vaccines went through clinical trials and had two months of observation. The standard regulatory guidance was 24 months for live attenuated killed or antigen based vaccines. These were genetic gene transfer technology vaccines. They're classified that by the FDA. They needed five years of observation. All that was thrown out. There was no carcinogenicity, no mutagenisity studies, there were no teratogenicity studies. So when they came out, they were and still are today emergency use authorized investigational which means the consent form says we don't know if these work or not, and we don't know if they're safe long term. The consent form still says that. Under your watch, vaccine mandates started happening in the state for investigational experimental products.

We knew by January 22 there was a problem because the US CDC Vaccine Adverse Event Reporting System had too many deaths that have already happened with a COVID-19 vaccine than they had from all the prior vaccines combined. January 22 of 2021, the warning bells came off and then nothing happened. We knew on January 29 thru Freedom Information now our US FDA and Center for Disease Control was supposed to be putting out monthly safety reports for America. No safety report. Lesson learned from this committee get a Vaccine Safety committee together. Get them together and start having a meet. If you're not seeing safety being provided at a federal level, remember it's safety, safety, safety. It would have been wonderful if these vaccines would have worked, but it was all about safety. We now know through court ordered documents, freedom of Information documents, Pfizer knew about 1223 deaths within 90 days of release of their vaccine. Pfizer knew about it. We don't know if the FDA knew about it. Nobody did anything. And the freight train continued.

Now fast forward as death started to occur, people started to get very uncomfortable. You saw all the pushbacks, protests, all kinds of worldwide feelings of great vaccine hesitancy because people were dying shortly after the vaccine. papers were published. 50% of the deaths occur within 48 hours, 80% within a week. We know the vaccines install the genetic material for the Wuhan spike protein that was manipulated in a biosecurity lab in Wuhan, China. There are now 1000 papers published on the spike protein and the vaccines 1000 that deal with vaccine injuries. And they're well characterized. And the FDA agrees. The vaccines cause blood clots, the vaccines cause heart damage. The vaccines cause neurologic damage. They also cause well characterized immunologic and hematologic system damage. This is in the peer reviewed literature. This is not equivocal. This is not a subject of controversy or debate. It's in our literature. There are now brand new diseases named after COVID-19 vaccine injuries.

As of June 17, 2022, our CDC VAERS system has certified 13 388 Americans who have died with the vaccine. Either they've taken it electively, or they were forced into it. That's 13,388 people who've lost their lives prematurely due to these vaccines. The vaccines qualify by the Bradford Hill criteria, which is an organized set of criteria on causality. They qualify as causing these deaths according to these epidemiological criteria. I'm a trained epidemiologist. I am an expert in applying these criteria on a more probable than not basis and almost certainly clear and convincing that these vaccines are causing death.

This month, the World Council for Health, which represents 70 bodies worldwide, has called for a global recall of all vaccines because worldwide, 40,000 deaths. That these safety databases across the world. 40,000. In the big ones VAERS, the Yellow Card system, the Vigisafe, and the Ujis system, 40000 deaths with the vaccines unacceptably high. Typical standard for any biologic product is 50 deaths. Pull it off the market. Something's gone wrong. 50, not 40,000.

So when there is a global recall by an international organization, this committee ought to be having emergency meetings. What are we going to do? A worldwide body has called for these to pull off the market. They're still giving it. You just heard from the pharmacy director ahead of me. He's still giving them out. When there's a worldwide recall, there should be some committee meeting. So you have it down. I mean, you can tell something is going wrong here, that we're in trouble in terms of vaccine safety, dr. Malone has covered vaccine efficacy, which is largely waned. I will just tell you that the CDC told us, as of December 10, 2021, with the Omicron strain, 79% of people with Omicron were fully vaccinated. That is prima facie evidence that the vaccines have completely failed against Omicron variant. Now it's inverted.

Now the vast majority of people who are sick with COVID 19 and in the hospitals worldwide with the Omicron variant are fully vaccinated.

My final set of points.

Board question:
I have a quick question for you about when you talk about the worldwide reports and the worldwide rejection global recall, is Congress doing anything about it?

Dr. McCullough
To my knowledge, no US body has reacted to this worldwide call at all. So it's obviously a failure at the state level and at the national level. It's essentially an oblivion. It's an oblivion.

Final set of comments. Physician censorship and reprisal. It is clear now that in the area of Covid, that it's open season for censorship and reprisal, not just to physicians, but of nurses and patients and family members and others. And the censorship is because there is a global effort to mass vaccinate the population every six months, and anything that would deter from that is going to be censored. So if a family member has lost a loved one after the vaccine, that

event, if it's written somewhere, what have you, is censored We have widespread censorship in the medical literature now in social media, and even in oral presentations.

I presented here on May 10, 2021, five statements that I made here under oath are now subject to censorship and professional reprisal by the American Board of Internal Medicine. Every single statement I made just in my written remarks, in my prepared remarks, is cited. The American Board of Internal Medicine and the Texas Medical Board. They don't have a monopoly on the truth. No one holds medical truth. There are always two points of view on everything or more.

And so Senator Johnson has stepped in and called the American Board of Internal Medicine out to have a round table discussion on what's going on now is a giant sweep through the Federation of Medical Boards, through the American Board of Internal Medicine, Board of Family Medicine, et cetera. And to have an open conversation. They have not responded. In fact, they've doubled down and said they're joining forces with the American Medical Association again in an effort to inflict reprisal on physicians like myself, who are attempting to help patients through COVID-19 respond to the pandemic in terms of our patient care, our scholarship and our research, and also give patients a fair appraisal on a brand new set of experimental genetic vaccines, which for some patients now represents a mortal threat to them. And we must have certainly, a conversation about the risks and benefits.

So I think right now the most important thing that this committee can do is this committee probably ought to have a working group on censorship and reprisal at the professional level. Doctors, nurses, patients who under the watch of DHSS, is actually incurring the constitutional rights being stripped away from free speech. What is going on in this state to actually impair medical progress? Remember, medical progress will not happen unless there is a roundtable discussion on something. Several speakers a few minutes ago, he talked about a conversation between some doctors and a doctor who wanted to prescribe Ivromectin. That conversation, to me, didn't seem very fair, balanced. It seemed like a disciplinary conversation. There is no disciplinary conversations in a brand new novel Coronavirus. This is all about getting the patient better. The other thing I heard in that conversation is a very, very important act of censorship or violation of medical ethics is Dr. Bob Hall presented a case where a family member wanted a discussion about Ivermectin of a patient in the hospital.

There is a principle of medical active called shared decision making. When you're a patient in the hospital, you actually have a right to discuss what you want to have happen with your body. If you're taking a medicine as an outpatient and you want to take that as an inpatient, that's called medication reconciliation. You have that full right to do so. No doctor can lord over you and say, no, you can't have that medication. If you've had a fair, balanced discussion and the drugs, like Ivermectin hydroxychlorquine, are supported by hundreds and hundreds of clinical trials. They're in dozens of government guidelines elsewhere in the world as first line therapy. Any American, any Texan, has the right to receive these drugs in the hospital when they engage in a discussion with their doctor. And under no circumstances should any doctor refuse a patient shared decision making and their own personal autonomy. It's unethical, it's immoral, and from a clinical perspective, it's illegal. And don't let it happen on your watch. Those are my comments.