Exhibit 392

Why are hospitals spending so much on ineffective C-19 treatments?

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Why Are Hospitals Spending So Much On Ineffective C-19 Treatments?

By Pierre KoryFebruary 24, 2022

(Gilead Sciences via AP)

Remdesivir claimed the top spot for hospital drug spending in 2021, with sales earning Gilead $4.2 billion in the first nine months alone. The problem is that, at best, the drug doesn't work.

Despite some initial indication that Remdesivir might slightly reduce recovery time, the World Health Organization conducted a large-scale analysis that found it "had little or no effect on hospitalized patients with Covid-19, as indicated by overall mortality, initiation of ventilation, and duration of hospital stay." Unsurprisingly, the WHO recommended against using this drug to treat Covid-19 in November 2020 (and still does).

At worst, however, Remdesivir is harmful. A subsequent analysis of the agency's safety database found it likely caused kidney failure, and when independent trials (those not sponsored by a pharmaceutical company) are analyzed alone, there is a clear statistical trend to harm. WHO also warns that the drug may be associated with an increased reporting of liver problems.

How is it possible that an ineffective and potentially dangerous drug that is scarcely used throughout the world received more money from U.S. hospitals than any other drug?

The answer is because our drug approval system is broken. It's skewed towards expensive, patented, often marginally beneficial or unknowingly dangerous treatments produced by our pharmaceutical industry to the detriment of well-known, safe, cheap, generic drugs – and ultimately patients.

Look at this chart created by an independent researcher that displays the efficacy of all drugs and compounds that have been studied against Covid-19. The ones circled in red are the only medicines that have received FDA Emergency Use Authorization (EUA is essentially fast-track approval) in the U.S. Each authorized medicine commands an exorbitant price while all the low-cost, effective drugs remain unauthorized for treatment of Covid-19. It would be an astonishing coincidence if the price tags were unrelated to their FDA status.

Moreover, Remdesivir was approved based on a single, small trial with questionable results. This should never be the basis for approving a medicine for mass use – even during a public health emergency. The same thing has happened with monoclonal antibodies, Pfizer and Merck's antiviral pills, and, of course, the Covid-19 vaccines.

Even more troubling are reports that the FDA did not consult the Antimicrobial Drugs Advisory Committee in granting Remdesivir's EUA. But the committee consists of outside experts that the FDA has at the ready

precisely to weigh in on antiviral drug issues. It boggles the mind that the agency would authorize a drug without even consulting the very body that is supposed to advise it on such issues.

Compare these lightning-fast and flimsy approvals to the non-existent government response to mounting data that fluvoxamine is effective against Covid-19. The Journal of the American Medical Association and the Lancet have each published large, randomized trials to this effect, with the latter showing fluvoxamine reduced Covid-19 hospitalizations by two-thirds and deaths by over 90 percent.

The NIH review of the fluvoxamine studies unsurprisingly takes great care to highlight potential study biases while dismissing the importance of the outcome benefits found, while ignoring the limited benefit and far more glaring flaws in the Remdesivir study. Fluvoxamine already has full FDA approval. It is safe and inexpensive (a pill costs about $1). Given what we are seeing with the patented and expensive drugs like Remdesivir (a course costs about $2,400), perhaps fluvoxamine's small price tag is the problem.

As if this all weren't dispiriting enough, we have undoubtedly spent so much on Remdesivir because hospitals have a major financial incentive to administer it. The Centers for Medicare & Medicaid Services established a system that provides a 20% bonus to each hospital's bill to encourage them to use Remdesivir and other EUA approved high cost, patented medications.

The only way any of this will change is if we create an independent, well-funded government body dedicated to conducting fairly designed and transparent research studies of repurposed generic treatments. While we certainly must encourage innovation, we cannot afford to overlook cheap and effective solutions that are already at our disposal. But that clearly will not happen until we break the strangle-hold that pharmaceutical companies have on the approval process.

Physicians should support this reform. Under the current regime, they have been cowed into passive roles for fear of losing their jobs and even their medical licenses. Most follow hospital protocols – even when they call for treating with ineffective, expensive, and potentially unsafe drugs like Remdesivir – and ignore growing evidence from large trials that cheap, safe treatments like fluvoxamine could save their patients' lives.

If more physicians stood up against bad guidance based on a corrupt system, we could reclaim some of our autonomy and marshal the freedoms we once enjoyed, treating patients as we deem appropriate. That's how physicians practiced for centuries before we were sold out to the highest bidder.

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