

Health Is Personal and Medicine Must be Personal Too

A new two-part public health strategy for this pandemic

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This article defines a more effective public health strategy for the current COVID pandemic. The core issue is that there is a huge array of reactions to both COVID infections and vaccines based on diverse biology, genetics and medical conditions of individuals. Missing from current policy is recognition and support of personalized medical methods.

First, medical history tells us the wisdom of *making the medicine fit the person*. This is the cornerstone of what is called personalized or individualized medicine. Good physicians also find the *combination* of drugs to best address an illness or disease. This contrasts with mass use of off-the-shelf, one-size-fits all drugs. Proposed here is an approach to tailor or fine tune medical solutions to individual biologic and genetic characteristics, and personal medical needs and circumstances.

As an example of how trying to get the public to accept a mass medicine is the case of seasonal flu vaccines. A large fraction of the public [does not take them](#). During the 2019-2020 season, 63.8% of children between six months and 17 years got a flu shot. Among adults, just 48.4% of people got flu shots.

Why is this? Because it is common knowledge that their efficacy rate is relatively low. [On average](#), people who get the flu shot are between 40% and 60% less likely to catch the virus than unvaccinated individuals. The truth is that the annual flu vaccine does not fit every individual. Even though there is little medical evidence that taking a flu vaccine poses significant health risks. But people know that the flu infection fatality rate is relatively low. Many individuals make a sensible risk/benefit analysis, concluding that there are insufficient benefits. Others, especially older people with serious medical conditions and possibly weak immune systems get annual flu shots. The public health system has allowed a personalized approach to seasonal flu vaccines.

And it turns out, based on government data, that low risk is also the case for the current COVID pandemic. For the vast majority of people getting coronavirus infection either means no symptoms or only mild ones not much different than the flu or a very bad cold, and which pass in relatively few days. Here is the [reported](#) truth about low coronavirus death risks for healthy people: “CDC showed that 94 % of the reported deaths had multiple comorbidities, thereby reducing the CDC’s numbers attributed strictly to COVID-19 to about 35,000 for all age groups.” This stands in contrast to the widely reported total of over 730,000 COVID related deaths. What this shows is the huge variations in how people respond to COVID infections because of their innate differences.

What COVID infected people do get is natural immunity to this virus that abundant medical research and clinical studies [have shown](#) is better than vaccine immunity. The latter declines in about six months, whereas natural immunity lasts longer and better defends against new variants.

Combination of medicines

Besides making the medicine fit the patient, is established clinical wisdom for using a *combination* of drugs. And often, in this pandemic, some doctors use a combination that includes more than several generic medicines and, especially in hospitals, government approved drugs. Also widely used are vitamins and supplements. The eminent Dr. Peter McCollough has been the leading proponent of using [individualized combinations](#) to treat and prevent COVID infection disease. All this is an alternative to the strategy of mass vaccination for everyone.

Today, anyone without too much work can find a host of combination protocols to treat and prevent COVID.

The missed opportunity discussed early in the pandemic

Between the early 2020 months of the pandemic and the roll out of mass vaccination in late 2020 there was interest in applying the personalized medicine approach to managing the pandemic.’

Consider what the Mayo Center for Individualized Medicine [said](#) for the COVID-19 response. The document detailed a number of initiatives Mayo was pursuing to address the pandemic by obtaining medical data that could lead to personalized pandemic solutions. This is what Mayo wanted to do:

“When COVID-19 spread across the U.S. in March 2020, the Mayo Clinic Center for Individualized Medicine urgently responded to accelerate research, development, translation and implementation of novel tests, lifesaving treatments and diagnostics. Now, collaborative teams of scientists are continuing to unravel the mysteries of the novel virus, including using advanced genetic sequencing technologies to investigate how the virus can infiltrate a person’s immune system and wreak havoc on organs, tissue and blood vessels, leaving some patients with long-term effects.”

A September 2020 [article](#) had the intriguing title “How to use precision medicine to personalize COVID-19 treatment according to the patient’s genes.” Here are excerpts:

“In recent years, a gene-centric approach to precision medicine has been promoted as the future of medicine. It underlies the massive effort funded by the U.S. National

Institutes of Health to collect over a million DNA samples under the [“All of Us”](#) initiative that began in 2015.

But the imagined future did not include COVID-19. In the rush to find a COVID-19 vaccine and effective therapies, precision medicine has been insignificant. Why is this? And what are its potential contributions?

If precision medicine is the future of medicine, then its application to pandemics generally, and COVID-19 in particular, may yet prove to be highly significant. But its role so far has been limited. Precision medicine must consider more than just genetics. It requires an [integrative “omic” approach](#) that must collect information from multiple sources – beyond just genes – and at scales ranging from molecules to society.

The situation becomes yet more complicated for infectious diseases. Viruses and bacteria have their own genomes that interact in complex ways with the cells in the people they infect. The [genome of SARS-CoV-2 underlying COVID-19 has been extensively sequenced](#). Its mutations are identified and traced worldwide, helping epidemiologists understand the spread of the virus. However, the interactions between SARS-CoV-2 RNA and human DNA, and the effect on people of the virus’s mutations, remain unknown.”

...there is an opportunity to begin gathering the kinds of data that would allow for a more comprehensive precision medicine approach – one that is fully aware of the complex interactions between genomes and social behavior.

The NIH has [said](#):

“The National Institutes of Health’s All of Us Research Program has announced a significant increase in the COVID-19 data available in its precision medicine database, adding survey responses from more than 37,000 additional participants, and virus-related diagnosis and treatment data from the nearly 215,000 participant electronic health records (EHRs) that are currently available.”

The specialty germane to a personalized pandemic strategy is called pharmacogenomics. It is the study of the role of the genome in drug response. It combines pharmacology and genomics to discover how the genetic makeup of an individual affects their response to drugs, including vaccines.

It deals with the influence of acquired and inherited genetic variation on drug response in patients by correlating genetic factors of an individual with drug or vaccine absorption, distribution, metabolism and elimination. It deals with the effects of multiple genes on drug and vaccine response.

The central goal of pharmacogenomics is to develop rational means to optimize drug therapy, including vaccination, with respect to the patients’ genotype, to ensure maximum efficiency with minimal adverse effects.

By using pharmacogenomics, the goal is that pharmaceutical drug treatments, including vaccination, can replace or at least complement what is dubbed as the “one-drug-fits-all” approach. Pharmacogenomics also attempts to eliminate the trial-and-error method of prescribing, allowing physicians to take into consideration their patient’s genes, the

functionality of these genes, and how this may affect the efficacy of the patient's current or future treatments (and where applicable, provide an explanation for the failure of past treatments).

An August 2020 journal [article](#) was titled "Pharmacogenomics of COVID-19 therapies." Here are its optimistic views and findings:

"Pharmacogenomics may allow individualization of these drugs thereby improving efficacy and safety. ...Pharmacogenomics may help clinicians to choose proper first-line agents and initial dosing that would be most likely achieve adequate drug exposure among critically ill patients; those who cannot afford a failure of ineffective therapy. It is also important to minimize the risks of toxicity because COVID-19 particularly affects those with comorbidities on other drug therapies. ... We found evidence that several genetic variants may alter the pharmacokinetics of hydroxychloroquine, azithromycin, ribavirin, lopinavir/ritonavir and possibly tocilizumab, which hypothetically may affect clinical response and toxicity in the treatment of COVID-19. ... These data support the collection of DNA samples for pharmacogenomic studies of the hundreds of currently ongoing clinical trials of COVID-19 therapies. One of the biggest success stories in the field of pharmacogenomics was for a drug used to treat another, highly lethal, infectious disease: abacavir for HIV. ... In an acute illness such as COVID-19, pharmacogenetics would only be useful if the genetic test results were already available (i.e., pre-emptive pharmacogenetic testing) or rapidly available (i.e., point-of-care genetic testing). ... In the face of unprecedented challenges posed by the COVID-19 pandemic, collaborative efforts among the medical communities are more important than ever to improve the efficacy of these treatments and ensure safety. Some large national COVID-19 trials are evaluating pharmacogenomics, which will inform the role of pharmacogenomics markers for future clinical use."

A July 2020 NPR [show](#) was titled "Research On Personalized Medicine May Help COVID-19 Treatments." This was deemed newsworthy:

The nationwide [All of Us Research Program](#) aims to tailor medical treatments of all kinds, including treatments that may be developed for the new coronavirus. So far more than 271,000 people nationwide have signed up to share data with the initiative. All of Us started under President Barack Obama in 2018 and involves institutions across the country.

"This is an exciting opportunity for our participants to have a direct impact on COVID-19 research, watching how their participation in this historic effort is truly making a difference," said Dr. Elizabeth Burnside. "This focused initiative could be especially important for members of communities that are often underrepresented in health research and who may question the overall and personal benefit of research participation."

In sum, there was legitimate medical interest early in the pandemic to use personalized medicine, in which drugs and drug combinations are optimized for individuals or certain population demographics. The central goal is minimization of drug and vaccine toxicities and adverse reactions and deaths.

But one thing is now clear. The personalized approach to managing the COVID pandemic has not been aggressively pursued by public health agencies. They have placed their resources and hopes with mass vaccination, both encouraged, coerced and increasingly

mandated. The hope that we can vaccinate ourselves out of this pandemic has lost credibility.

In contrast, an alternative personalized approach, used by hundreds of physicians, based on generic medicines, vitamins and supplements have been more blocked than supported by the public health establishment as detailed in [Pandemic Blunder](#).

Proposed new public health strategy

Part One: Individuals decide either on their own or with the advice of their personal physician to be vaccinated for COVID. And to accept what government officials have decided are the best COVID medical solutions for outpatients and inpatients.

Part Two: Individuals choose a preferred medical professional who, on the basis of their education, training, experience and successful clinical results, offers alternatives to vaccination and government promoted medical solutions for outpatients and inpatients. The medical professional uses the patient's medical history, conditions, needs and unique personal biologic and genetic circumstances to reach the best personalized medical solution.

The new public health strategy is, therefore, twofold. Widely available vaccination becomes focused or finely tuned to meet the desires and needs of part of the population. Along with use of the second part there is no sacrifice of true public health protection in the pandemic.

Part Two of the strategy directly addresses the widespread resistance to COVID vaccination by some Americans.

This is a rational perspective consistent with the belief in medical freedom. If one believes that there are some certain medical benefits of COVID vaccines, then traditional medical practice supports use of them on an *individual* therapeutic basis. This is a free personal decision, perhaps in consultation with their physician to accept that COVID vaccine risks are outweighed by its benefits.

Risks and benefits may be based on personal research of available medical information on vaccines. Or on information from government agencies, often without advice from their doctor.

Not to be ignored is increasing negative information on COVID vaccines reaching the public. One recent example from a published medical research [article](#) is that "cost-benefit analysis showed very conservatively that there are five times the number of deaths attributable to each inoculation vs those attributable to COVID-19 in the most vulnerable 65+ demographic." From this same study: within "eight days post-inoculation (where day zero is the day of inoculation), sixty percent of all post-inoculation deaths are reported in VAERS." This study concluded: "It is unclear why this mass inoculation for all groups is being done, being allowed, and being promoted."

In seeking to implement the wisdom of fit the medicine to the person, requires accepting the science that no two people, medically, genetically and biologically speaking, are exactly the same; this cannot be disputed. This is why using pharmacogenomics has a role to play. Looking at average statistical vaccine outcomes ignores and disrespects individual biologics, medical conditions, concerns and needs. This is an overselling of vaccines.

Americans have always wanted to see themselves as unique individuals. This translates to medical actions. Mass vaccination for everyone ignores and devalues this traditional belief by Americans.

There are also legitimate concerns that giving *informed* consent to a shot has not been based on a full, easily understood presentation of data on risks for different kinds of people with various medical histories.

Those who are resisting vaccination have a right to question that government agencies have not strictly followed medical science, data and experience. For example, a vast literature concludes that stay-at-home mandates, lockdowns and masking have not been effective in controlling pandemic impacts.

And there is now considerable evidence that those who are vaccinated can get breakthrough infections and spread the virus. "We have data now through the first week of August from the Center for Medicaid and Medicare Services, showing that... over 60 percent of seniors over the age of 65 in the hospital with Covid have been vaccinated," noted the esteemed Dr. Peter McCullough recently.

This erodes the credibility of public health agencies and their medical authority and destroys public trust in federal agencies implementing pandemic policies.

The fallacy of only one medical solution

If the government would let some part of the public choose personalized treatment to deal with COVID infection and another part to choose vaccination (and other government actions) why is that not an acceptable public health policy? The two-part strategy will become increasingly important as the government promotes or mandates regular booster shots over months or years.

Choice is rational if, indeed, there are personalized treatment options other than vaccination that can be obtained from some medical professionals. Indeed, there is now a vast medical literature on treatment protocols not only to cure but also to prevent COVID infection. They are being used very successfully by hundreds of American physicians.

And some information reaching the public like the very successful use of the generic ivermectin in India and Indonesia reinforces the inclination of some people to seek alternative medical solutions. Also, that 100 to 200 members of Congress [have used](#) this generic.

Moreover, now there is also a vast medical literature, increasingly known to the public, supporting the strong effectiveness of natural immunity obtained through previous COVID infection. It is a rational personal decision to conclude that one's natural immunity is sufficient medical protection without taking on any vaccine risks. They have the right to seek a medical professional that agrees with that medical reality.

The only conceivable "loser" for this approach would be vaccine makers having a smaller market.

Physicians should have the freedom to advise their patients to either use a generic medicine treatment protocol or help document their natural immunity (with valid testing) to allow patients to embrace personalized medical action rather than be vaccinated.

In this two-part policy approach, of promoting a choice between personalized medical protection versus mass vaccination, the entire population could be fully protected without sacrificing medical freedom and without various forms of vaccine mandates. *Public* health does not require *total public* acceptance of one medical solution.

This strategy is consistent with what many physicians said early in the pandemic. Namely that vaccination should be targeted on those with the highest risks of serious COVID impacts, not the entire population. It is widely known by the public and accepted by the medical establishment that this pandemic does not pose a serious threat of either illness or death for people below the age of about 70, unless they have serious comorbidities or serious illnesses. Infection fatality rates for most of the public do not argue for vaccination.

Much of the public wants and deserves the choice to use something other than a vaccine shot to protect themselves. That choice becomes operational only if the government allows and supports medical professionals to offer their patients alternatives to vaccines.

Here is the ethical and medical truth: Protecting individual health trumps protecting public health *but is not antithetical to protecting public health*. Overly coercive public health actions, such as vaccine mandates, *are antithetical to protecting individual health for many people who fear even low probability negative reactions to vaccines*.

Here is the ultimate medical truth: *When all available medical science and means are fully used then the result is safely protecting public health without sacrificing medical freedom of both physicians and individuals*.

The current strategy has failed

As we approach two years of dealing with this pandemic there is abundant evidence that the emphasis on mass vaccination has largely failed. The US has the highest number of COVID deaths on the planet. Even now, after wide use of the mass vaccination approach, recent 2,000 daily deaths are related to COVID infection. Every week more people are counted as COVID deaths than the 3,000 people who died in the 9/11 disaster.

Not to be ignored is the widely cited journal [study](#) titled “Increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States.”

Breakthrough infections among the fully vaccinated are mounting. Because after about six months vaccines lose much of their effectiveness, especially against variants. And fully vaccinated people can and do carry and transmit the coronavirus.

If one wants first-hand accounts of how US physicians have documented their own negative impacts of COVID vaccines as well as those of their patients, then read a number of their [affidavits](#).

Conclusions

A new public health strategy that no longer adheres to single-minded mass vaccination can obtain broad public support. Now is the time to endorse and support personalized medicine applied to the pandemic.

Much of the public may not yet know this. But missing from the new CDC definition of

vaccine as of September 1, 2021 are these key phrases: “protecting the person from that disease” and “to produce immunity.” The new vaccine definition should reduce public confidence in current COVID vaccines. In fact, these changes reflect what is now known about the limitations of these vaccines. Fully vaccinated people can still get COVID disease and really do not have long lasting effective immunity to it.

Promoting choice is a far better public health approach than wide use of authoritarian pandemic controls that have devastated lives and produced mental stress and many collateral deaths.

On that last point, CDC has now recognized mood disorders put people at high risk for severe COVID cases. Compare pre-pandemic 2019 to 2020 when there were 53 million new cases of depression globally, a 28% increase, as reported in [The Lancet](#). Surely, promoting more medical choice for addressing COVID would help people stay both mentally and physically healthy.

Resistance to vaccine mandates should not be seen as unpatriotic or as creating harm for others. Supporting personalized medicine is a way to avoid negative impacts on the American economy because of rigid, inflexible vaccine mandates that compel many Americans to accept job loss that in many ways imperil public safety.

Lastly, staying alive and safe surely is the presumed goal of all people. We have more tools than vaccines to help people meet their goal. Now we need the public health establishment to let all the tools be freely chosen.

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