


Why listen to an anesthesiologist in the middle of a pandemic?

Musings on how and why the medical community has lost its bearings...

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Last month, the mother of two teenage children filed a [lawsuit](#) in Superior Court for the District of Columbia against [Janine A. Rethy, M.D., M.P.H.](#) She had taken her children to the [KIDS Mobile Medical Clinic/Ronald McDonald Care Mobile](#) clinic for their annual physical exam.

According to [The Defender](#):

“The lawsuit alleges Rethy, director of the mobile clinic, held the children in the examination room longer than necessary for a regular check-up and vaccinated them against [COVID-19](#) over their objections and without consulting their mother

In order to attempt to obtain the children’s consent — which they are not legally able to provide without a parent or guardian — the doctor falsely informed the children the COVID-19 vaccine was mandatory for school attendance and told them they could not lawfully decline it if they wanted to attend school.”

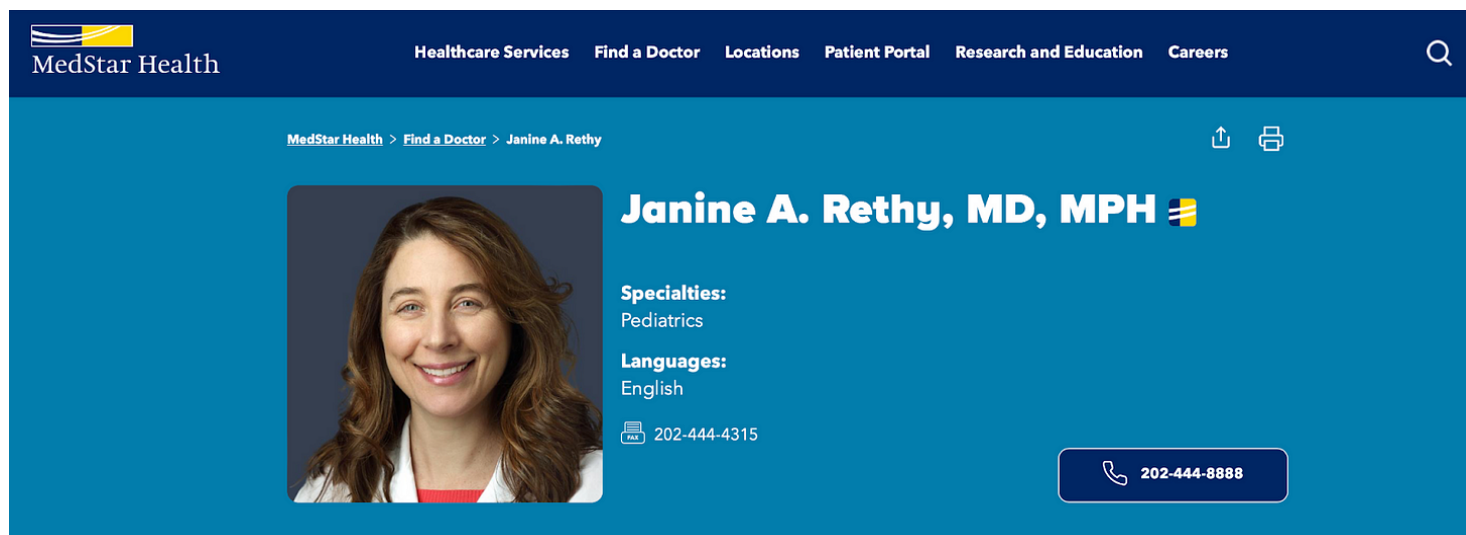
Rethy is a pediatrician, chief of community pediatrics at MedStar Georgetown University Hospital and Assistant Professor of Pediatrics at Georgetown University School of Medicine.

Two crucial aspects of the lawsuit are that the mother of the adolescent children was in a room next door, caring for another infant child. She was immediately available to offer her consent for the inoculations yet Rethy chose to administer the shots without consulting her first.

Secondly, when the elder child asked why the doctor was giving her the shot, Rethy explained that it was mandatory in order to attend school. This was untrue. Although D.C. public schools [imposed a vaccine mandate](#) for school children ages 12 and up for the 2022-2023 school year, the mandate was [retracted](#) on Aug. 26, a week before she allegedly

vaccinated the kids without consent.

What do you make of Dr. Rethy?



The screenshot shows a doctor's profile page for Janine A. Rethy, MD, MPH. The page features a dark blue header with the MedStar Health logo and navigation links: Healthcare Services, Find a Doctor, Locations, Patient Portal, Research and Education, and Careers. Below the header, a breadcrumb trail reads "MedStar Health > Find a Doctor > Janine A. Rethy". A portrait of Dr. Rethy is displayed on the left. To the right of the portrait, her name "Janine A. Rethy, MD, MPH" is shown in large white text. Below her name, her specialties are listed as "Pediatrics" and her languages as "English". A phone icon and the number "202-444-4315" are also present. At the bottom right of the profile section, there is a dark blue button with a white phone icon and the number "202-444-8888".

Obviously it has a lot to do with how you feel about the Covid “vaccine” and the apparent need to mandate its use to attend public school. Painting the doctor as misinformed and incompetent is different than describing her as a malintending operative of big Pharma.

On the other hand, if you believe the “shots” are safe and have saved countless lives from certain death from Covid-19, the doctor’s transgressions may not seem so horrid.

Rethy didn’t seek to harm the two minors in her office that day. To my knowledge, my medical school classmates chose to devote seven to eleven years of the prime of their life to the rigorous study of medicine and the art of caring for people because they wanted to help, not manipulate their fellow human beings. Aspiring pediatricians, I would venture to generalize, are even more heart-centered than the rest of us. The day we received our medical diplomas we publicly and ceremoniously vowed to do no harm.

Primum non nocere, “first and foremost, I will do no harm” is a massive commitment, and, as it turns out, nuanced. How does a doctor know that they are not causing harm? They don’t. What doctors are really promising is that “*given what I know*, I will act and advise my patients in ways that will not bring harm to them”. What we are really promising is that we

will not *intentionally* harm our patients, no more.

Medical training through the eyes of a skeptic

I was not a traditional medical student. The overwhelming majority of my classmates entered medical school directly after their undergraduate studies. When I matriculated at Baylor College of Medicine at the age of 27, I had already spent six years in the defense industry working on various research projects that were mathematically intensive.

I had helped build training simulators for crews of a highly sophisticated German tank, [the Leopard 2](#), using some of the most advanced computer generated graphics engines that had ever been built.

Later, I was lucky enough to participate in a project that used sophisticated acoustic data acquisition systems and computationally intensive signal processing engines in underwater surveillance systems for the Office of Naval Research. Just two years before walking into my first class in medical school I was drilling holes through ice floes to drop hydrophones into the ocean just a hundred miles from the North Pole.

Suddenly I was learning about the most complicated and elegant system on the surface of the planet, the human body. I was stunned by how seemingly confident the medical community was in their understanding of this miracle of nature. Very often I was the lone critic, and I generally kept my feelings to myself. Our instructors in medicine taught us what was known about it. It was a lot to learn, but to me, it was obvious that we were only scratching the surface. This was particularly apparent in our study of pharmacology, the mainstay of Western medical practice.

We learned about the mechanism of pharmaceutical agents and how they were intended to work. That made sense. But what about all of the known side effects? We could explain some but not all of them. We could explain why a given drug helped a person, but we really didn't have an explanation why the same drug failed another. It wasn't a big issue practically. There was almost always another medicine that we could try. But to me it spoke volumes of how much we didn't know.

Another obvious sign that we were groping around in the dark was the nature of drug trials, the means by which we establish the efficacy of a given pharmaceutical agent. If we needed

to administer a new drug to thousands of people and compare outcomes to an equally large group who received a sugar pill hoping to find a measurable difference, shouldn't that tell us that we don't know a lot more than we do? These "trials" seemed more like glorified "trials and errors".

These kinds of questions didn't seem to bother my fellow interns during my first year of training in Internal Medicine. Half way through my internship year I thought I was ready to call it quits. I called up a few of my contacts from engineering to see if they had any job openings. Then, a close friend from medical school suggested that I look into anesthesiology. "It's very quantitative", he explained, "you take care of one patient at a time and you get to give them your full attention."

That sounded appealing. I also wasn't ready to throw away everything I learned over the previous five years. I decided to change residencies from Internal Medicine to anesthesiology.

During my interview at the University of Pennsylvania's Department of Anesthesia I had the great fortune of meeting Dr. Frank Murphy, the program's residency director at the time. He was very interested in my background and had taken the time to read my application and resume.

We sat down in his office and he asked me the obvious question, why did I want to be an anesthesiologist? I was honest. I told him that I hadn't a clue about the field. I was, in fact, questioning the practice of medicine altogether for the reasons I explained above.

Dr. Murphy was equally candid. He was the first doctor I had met that agreed with my critique. He stated it eloquently:

"Madhava, you have to understand something. In the physical sciences, you need to have six sig-figs of accuracy. In engineering, you need three sig-figs. In medicine, we are just trying to get the *sign* right."

"Sig-fig" means *significant figure*, a term that denotes the amount of confidence we have in a measurement. In other words, saying that a pencil is 5 inches long means something different than saying it is 5.0000 inches long. Science openly acknowledges the uncertainty in "facts". Every measurement comes with some level of inaccuracy. Scientifically speaking,

when the length of a pencil is given as 5 inches, we are really saying that its true length is closer to five inches than four or six. Saying it is 5.0000 inches long means that we are certain that it is within a thousandth of an inch of 5 inches long. In this example the last zero, at the ten thousandths place, always has inherent uncertainty.

He was echoing my frustration with medicine. He knew I was coming from a background where the precision and accuracy of measurements were essential to ensure that the finished product worked. He was openly acknowledging that it is nearly impossible to quantify anything when it comes to caring for human beings that come in all shapes, sizes, predispositions, genetic make ups and histories. We are just trying to help, not hurt. *The best we can do is get the sign right.* Frank became a great mentor to me.

The second pillar of ethical medical practice

Dr. Rethy, the pediatrician with the kind heart and smile was not intending to harm the two kids in her office. She wasn't breaking the Hippocratic Oath. However she ignored the second tenet of medicine, to obtain *informed consent* from their mother.

The reason why informed consent is so important is because there is so much uncertainty in medicine. What we know today is different from what was known yesterday. It's always changing. It's science after all. Ultimately people have their own relationship with uncertainty. That is why they are given the right to decide for themselves when medicine is practiced ethically.

Although Rethy would have presumably given the Covid shots to her own children, that does not mean that she had the authority to administer them to someone else's without their mother's consent.

The fact that there was no school mandate or that their mother was in the next room makes her actions particularly egregious; however her negligence stemmed from her inability or unwillingness to accept that we, as doctors, don't always get the sign right.

The medical community is abandoning this pillar of medicine more and more. Though doctors and nurses most often obtain written consent before administering the Covid jabs, are they obtaining *informed* consent? Few people on the planet know what is exactly in these things. We don't inform patients of all the possible side effects (that would take too

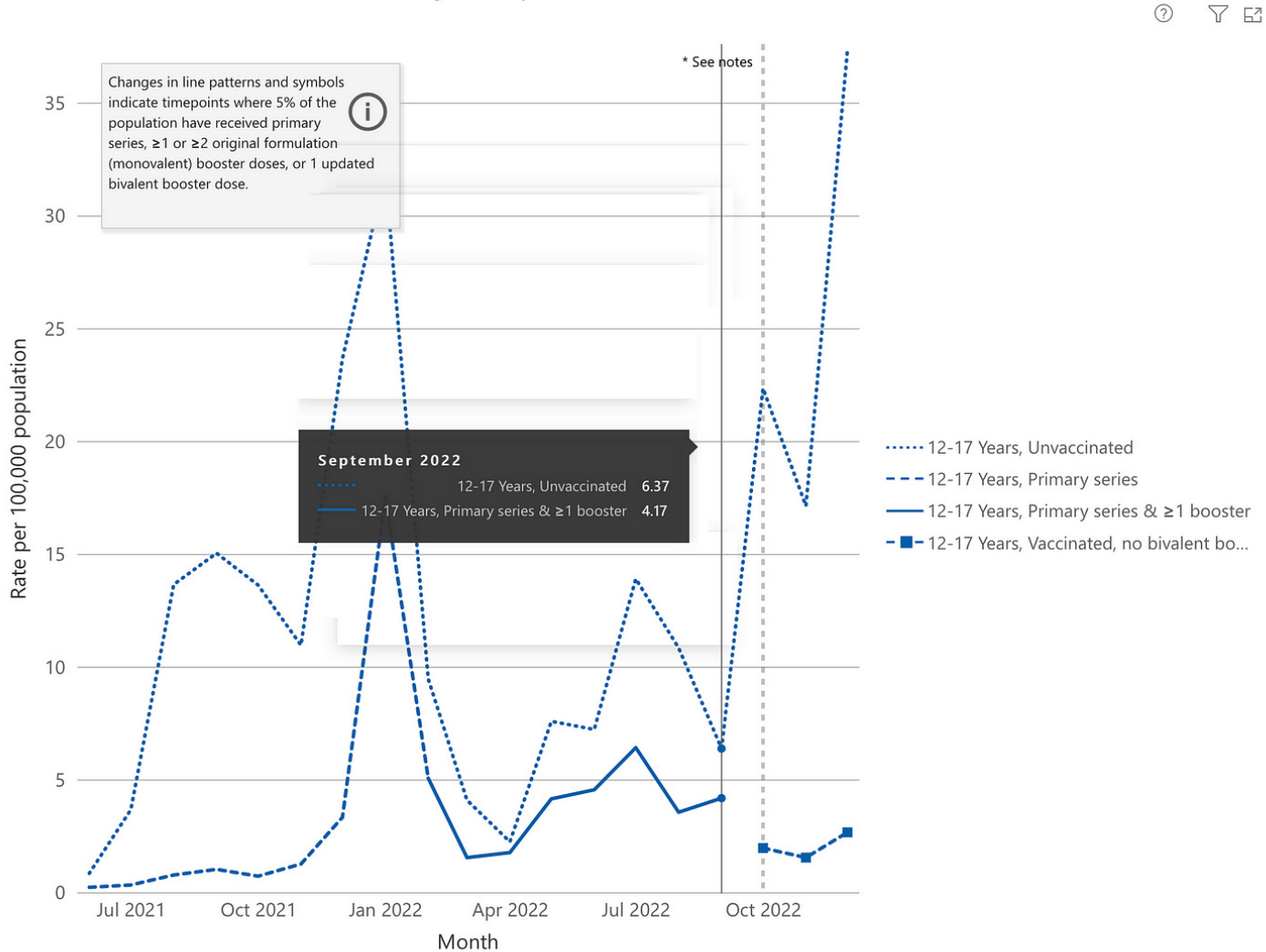
much of our precious time). We, in most cases, don't even explain the most important metric of a preventative therapy like a vaccine: the number needed to vaccinate (NNV).

I have asked many of my colleagues in medicine whether they know the NNV of the Pfizer formulation. None have known the answer to these essential questions: How many people need to be vaccinated to prevent a single case of non-serious symptomatic Covid? Answer: about 120. Covid-19 hospitalization? 2,500. Covid-19 death? 21,000.

When I ask them why they don't know their answer is simple, "I don't have time to read the trial data. I have to go with the CDC, and they recommend it for everyone."

Note: the NNVs above are calculated from Pfizer's published trial data. In September 2022, around the time of the incident in Dr. Rethy's clinic, CDC's Covid-NET data shows:

Monthly Rates of COVID-19-Associated Hospitalization by Vaccination Status and Age Group, June 2021 - December 2022



These data were posted on February 9, 2023, and reflect hospitalizations through December 2022.

*Notes: Data for October 2022 are not available for all age groups. Data are presented for the first complete month when 14 days passed since at least 5% of the age group-specific population of the COVID-NET surveillance catchment area have received an updated (bivalent) COVID-19 booster dose. For October 2022, that standard (14 days passed since at least 5% of the population received an updated booster dose) was only met for adults ages 65 years and older. Data for adults ages 18–64 years met the standard beginning in November 2022. Data for children and adolescents ages 5–17 years will be added once it meets this standard. Refer to Footnotes for additional details.

Vaccinating and boosting 100,000 adolescents between the ages of 12-17 would save 2.2 hospitalizations per month (Covid hospitalizations in vaccinated but not boosted have not been reported after February 2022). The NNV to prevent a single hospitalization per month is thus approximately 45,000. The CDC is not publishing Covid-19 deaths in this age group as there are too few to make meaningful comparisons.

Is it worth vaccinating 45 thousand young people to prevent a single Covid-19 hospitalization per month? That depends on the risk. Unlike the memes and PSAs spewed from the CDC assuring us that the benefit far outweighs any risk associated with these products, let us look at the best data we have, the adolescent trial results [published in the NEJM](#) (Table S2):

Table S2. Participants 12–15-years-old and 16–25-years-old reporting at least 1 adverse event from dose 1 through 1 month after dose 2

Adverse event	BNT162b2		Placebo	
	12–15 years old (N*=1131) n† (%)	16–25 years old (N*=536) n† (%)	12–15 years old (N*=1129) n† (%)	16–25 years old (N*=561) n† (%)
Any event	68 (6.0)	58 (10.8)	67 (5.9)	45 (8.0)
Related‡	33 (2.9)	33 (6.2)	21 (1.9)	12 (2.1)
Severe	7 (0.6)	9 (1.7)	2 (0.2)	3 (0.5)
Life-threatening	1 (0.1)	0	1 (0.1)	0
Any serious adverse event	4 (0.4)	2 (0.4)	1 (0.1)	2 (0.4)
Related‡	0	0	0	0
Severe	2 (0.2)	2 (0.4)	0	1 (0.2)
Life-threatening	0	0	1 (0.1)	0
Any adverse event leading to discontinuation	2 (0.2)	1 (0.2)	0	2 (0.4)
Related‡	1 (0.1)	1 (0.2)	0	0
Severe	1 (0.1)	1 (0.2)	0	0
Life-threatening	1 (0.1)	0	0	0
Death	0	0	0	0

Results are for the reactogenicity subset of the safety population, which included all participants in the 12–15 years old group and a subset of participants in the 16–25 years old group.

*Number of participants in the specified group. This value is the denominator for the percentage calculations.

†Number of participants reporting ≥1 occurrence of the specified event category. For ‘any event’, n=the number of participants reporting ≥1 occurrence of any event.

‡Assessed by the investigator as related to investigational product.

0.4% of vaccine recipients in both the 12-15 and 16-25 year old cohorts had a serious adverse event during the trial that occurred within one month of getting their second dose. This means four in every thousand adolescents in the vaccine arm of the trial suffered a serious event. Given the respective hospitalization rates in September 2022, the trial predicts that *in order to prevent a single Covid-19 hospitalization, 180 adolescents will suffer a*

serious adverse event in the same period of time.

Knowing these numbers, would pediatricians like Rethy continue to encourage vaccination? Maybe. But would they go so far as to inject a child without obtaining consent from their mother in the next room because they feel that any parent who didn't vaccinate their child really shouldn't have any say in the matter?

We aren't obtaining informed consent; that fact is unassailable. And in this case, even uninformed consent. That is why this case against Dr. Rethy is so important. It's not simply about punishing a lone doctor for breaking their own code of ethics. It's about compelling doctors to do their own research, something that they encourage their patients to do too.

As the medical community slowly accepts that "mistakes were made" because "we didn't know then what we know now", calls for pandemic amnesty will become more common. Those injured by these vaccines will never be compensated by a system that indemnifies the manufacturers from liability. Apologies from those who claim that they were only following guidelines will likely never come either. However, there is no question that during these last two years, informed consent was rarely obtained, if ever.

More wisdom from Dr. Murphy

Anesthesiology is sometimes described as a practice of medicine that is 99% pure boredom and 1% sheer terror. This is because when properly monitored and treated, most patients do quite well under anesthesia. Administering anesthesia can get rote. We only have a handful of drugs in our arsenal and we know very well how patients respond to them. However when things go wrong, they can go wrong quickly, and there is often very little time to intervene. That's the sheer terror part.

These days, most anesthesiologists oversee multiple surgeries that are underway at the same time. A different Certified Registered Nurse Anesthetist (CRNA) is dedicated to each separate patient under a single anesthesiologist's direction. I have a deep respect for CRNAs and their skills and judgment. However, when something unexpected happens, it's always better to have more than one provider in the room.

When I am unexpectedly and urgently summoned into an operating room I always remember another priceless piece of advice Dr. Murphy offered me early in my training.

How did he teach a young doctor to prepare for the unexpected, especially when a patient's life is in imminent threat? Said Murphy (elegantly once again):

“[in those situations] Remember, *don't just do something, stand there.*”

Murphy was pointing to a mistake commonly made by medical professionals in these situations. People, including doctors, have the tendency to act without appraising the situation carefully. He wasn't advising us to do nothing. Action is required, but *which* action? He was imploring us to listen, look, feel, check and confirm before deciding what was appropriate. After taking action, reassess. Acting on inaccurate information can be worse than not acting at all.

The medical community has succumbed to the idea that doing something is far better than doing nothing. “Don't just stand there, do *something!*”. That something was, of course, pushing the Covid-19 vaccines, which had not been approved nor properly tested for safety. Moreover, their spurious efficacy was calculated for a very brief period of observation.

Symptomatic Covid-19 Infection

Median period of observation = 2 months but...
 17,411 people observed for 2,214 person years = 6 weeks
 1/2 of each group observed < mean of 4 weeks

Table 2. Vaccine Efficacy against Covid-19 at Least 7 days after the Second Dose.*

Efficacy End Point	BNT162b2		Placebo		Vaccine Efficacy, % (95% Credible Interval)‡	Posterior Probability (Vaccine Efficacy >30%)§
	No. of Cases	Surveillance Time (n)†	No. of Cases	Surveillance Time (n)†		
Covid-19 occurrence at least 7 days after the second dose in participants without evidence of infection	8	2.214 (17,411)	162	2.222 (17,511)	95.0 (90.3–97.6)	>0.9999
Covid-19 occurrence at least 7 days after the second dose in participants with and those without evidence of infection	9	2.332 (18,559)	169	2.345 (18,708)	94.6 (89.9–97.3)	>0.9999

* The total population without baseline infection was 36,523; total population including those with and those without prior evidence of infection was 40,137.
 † The surveillance time is the total time in 1000 person-years for the given end point across all participants within each group at risk for the end point. The time period for Covid-19 case accrual is from 7 days after the second dose to the end of the surveillance period.
 ‡ The credible interval for vaccine efficacy was calculated with the use of a beta-binomial model with prior beta (0.700102, 1) adjusted for the surveillance time.
 § Posterior probability was calculated with the use of a beta-binomial model with prior beta (0.700102, 1) adjusted for the surveillance time.

The table above is from the published results of the Pfizer/BioNTech Covid-19 vaccine trial that demonstrates a purported 95% efficacy in preventing symptomatic infection. In the

text of the [paper published in the NEJM](#), the *median* period of observation was stated to be two months. However, we can calculate that the *mean* time of observation was only six weeks. This means that *half of the participants were observed for an average of under four weeks at the most.*

Taken as it stands, the results indicate a remarkable efficacy against Covid-19 for a short period. But, these numbers only include participants that not only had survivable infection, they fully recovered without needing hospitalization.

Did this warrant their use in the so-called Covid-19 emergency? The vaccine was 95% effective in preventing no more than a sore throat, cough or fever. Though impressive, the vaccine efficacy would have had little bearing in “flattening the curve”. Moreover, nobody had any idea what the long term detrimental effects of this therapy would be. Nevertheless, the vaccines were pushed as the only possible solution in what was arguably not a crisis at the time they became available.

That Covid-19 is “bad” doesn’t mean that Covid-19 vaccines are “good”. This should be self-evident, especially to a physician. However, when looks of astonishment appeared on the faces of my colleagues when I suggested that we didn’t know enough about their safety, I was forced to accept the fact that they had abandoned their own sense-making ability. “But, but, people are *dying!*”

Yes. I am quite familiar with the phenomenon. But sometimes just doing something, anything, isn’t the best course of action.

28 Comments



Write a comment...



Randall Thomas Mar 14 ❤️ Liked by Madhava Setty

Wow. That's the kind of thinking I used to imagine all doctors engaged in. Sadly, Covid has