

# INTERNATIONAL OXIDATIVE MEDICINE ASSOCIATION

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## Position Statement of IOMA in the matter of James Shortt, MD

### Recitals:

There have been findings by Dr. Clay Nichols, a South Carolina forensic pathologist, that patient Katherine Bibeau died as a result of an intravenous infusion of hydrogen peroxide administered 4 days before her demise. The county coroner, Gary Watts, ruled the death a homicide. The national mass media has published these allegations and there is now hysteria over the use of intravenous hydrogen peroxide. Dr. Shortt has been cast as a reckless villain.

The International Oxidative Medicine Association (IOMA) is an international association of physicians who utilize very weak dilutions of hydrogen peroxide produced from without or within the body to produce certain clinically positive effects such as anti-viral, immune stimulation and tissue remodeling. IOMA has offered training programs to physicians for a decade on this therapy. Very weak, dilute solutions of intravenous hydrogen peroxide were first shown to be effective in fighting influenza in the Great Flu epidemic of 1917-18 and have been in continuous use by physicians since.

### IOMA investigation:

On Thursday October 7, 2004, Dr. James Shortt presented himself to a quorum of the IOMA Board of Directors including the entire teaching staff, and recounted the case. Specifically, he wanted to know if he violated accepted protocol, or could have been somehow responsible for the patient's demise. Mrs. Bibeau, 53, had a long history of Multiple Sclerosis (MS) and was on a downhill spiral when she initially came to Dr. Shortt. On March 10, 2004, Dr. Shortt administered a solution of dilute Hydrogen peroxide according to standard IOMA protocols. The patient had no ill effects and presented for an additional nutritional intravenous feeding (not H<sub>2</sub>O<sub>2</sub>) two days later on March 12. On March 14, she presented to the emergency room with suspected sepsis, disseminated intravascular coagulation (DIC) and died within hours. The pathology report states as cause of death:

"History of death following treatment with hydrogen peroxide. Terminal course consistent with systemic shock and DIC.....**Cardiac arrest due to systemic shock and DIC due to iatrogenic infusion of intravenous hydrogen peroxide**" The report went on to describe severe pathological findings of thromboses, organ necrosis and ecchymoses. We learned of additional critical information about this case not addressed or discussed by the official pathology report, coroner and available hospital records. Specifically, the patient had been taking the drug Copaxone and her sister, a nurse, had administered her last dose on March 13. Additionally, the patient foundered for hours in the emergency room of the admitting ER in serious condition. Multiple attempts were made to obtain an IV site including attempts at a femoral vein site. This failed and yielded tremendous bruising. She was eventually transferred to another ER. Eventually, a cut down was made

on a lower leg vein. The patient had a history of a seizure disorder and took Tegretol whenever she felt a seizure coming on. Evidently, in spite of shock and sepsis, she was lucid enough to reach into her purse and take a Tegretol only an hour before she was found dead. It is unclear if there was adequate monitoring of a gravely ill patient in the emergency room as well as competent handling.

Dr. Shortt most responsibly took an administration of IV fluids from the same bottles he used for the patient only days after learning of her death. In this manner he tested the purity of the materials on his own person. He suffered no ill effects. After determining that Dr. Shortt's peroxide administration to the patient did not deviate from our well-established protocols, we discussed the accusations that H<sub>2</sub>O<sub>2</sub> was the proximate cause. We are unaware anywhere of reports in the world literature of sepsis and/or DIC induced by IV H<sub>2</sub>O<sub>2</sub>. In fact, H<sub>2</sub>O<sub>2</sub> therapy has been reported as far back as 1920 in the Lancet to dramatically enhance recovery from grave infections.

Our investigation turned to the drug Copaxone, administered the day before. We were able to locate a warning letter addressed to the maker of the drug from the FDA several years ago (27 August 1998). In it, the manufacturer was warned about overstating claims of safety and efficacy. "*TMP has disseminated promotional materials containing false or misleading information about the safety, tolerability, and effectiveness of Copaxone....*"

Among this drug's listed "side effects" are extremely serious problems including but not limited to: multiple references to bleeding, metorrhagia, thrombosis, bruising, clotting problems, and infections. Sepsis has been reported in post marketing clinical experience.

The post mortem examination specifically lists DIC. DIC is a well-known complication of infection. With infection and clotting problems listed as potential hazards of this drug's use, the IOMA Board questions why the use of this drug and its known problems were not included in the pathology report. Additionally, Tegretol is a known liver toxin, and she had therapeutic blood levels. The possibility of drug interaction was not entertained at all.

The possibility of H<sub>2</sub>O<sub>2</sub> as a cause of sepsis is virtually zero. H<sub>2</sub>O<sub>2</sub> is a well-known and accepted agent that oxidizes and destroys bacteria. The only adverse effects we know of related to IV use of the type of dilute, very weak solution of hydrogen peroxide, include local sclerosing of the exposed vein and infrequent non-significant hemolysis. Yes, high doses of hydrogen peroxide have killed people but all of these cases involved dosages that were thousands of times greater than used clinically for the benefit of patients or used in the instant case. Further, hydrogen peroxide does not release *air emboli* as alleged by the pathologist. It releases *oxygen*, which is consumed by the body. In the extremely dilute concentrations used and slowly infused, we would expect any gaseous oxygen released to be picked up by the venous red cells immediately.

IOMA believes that investigators should look for horses before zebras. This patient was taking a parenteral drug (Copaxone) which has deadly serious adverse effects, and a drug

(Tegretol) known for its liver toxicity. In our opinion, the side effect profiles of both of these FDA approved drugs are more consistent with the demise of this patient than one very weak solution of hydrogen peroxide given three days prior to the use of the FDA approved drugs and her subsequent demise a day after the drug injection.

**Conclusions:**

1. The IOMA Board has not found a departure from the oxidative standard of care in Dr. Shortt's handling of this case.
2. We have no knowledge of any similar adverse effects of this therapy over 86 years of use in hundreds of thousands of treatments in the manner it was used.
3. A drug with listed adverse effects identical to the forensic findings was administered to the patient within a day of her demise.
4. It is more than reasonable to conclude that the proximate cause of this death was toxicity from the drug Copaxone, possibly in deleterious interaction with Tegretol.

**Additional conclusions** reached by board members, two of whom are either present or past members of state physician licensing boards:

1. That there exists the possibility of gross negligence in the conduct and findings of the forensic pathologist in not evaluating and addressing the patient's use and listed toxic effects of Copaxone and Tegretol.
2. That there exists the possibility of libel, slander and willful defamation of character in the written reports and press quotes of the forensic pathologist and coroner.
3. That the forensic pathologist may have willfully committed character assassination and wrongful professional accusation against a fellow licensed physician without due diligence, constituting professional misconduct.
4. That there exists the possibility of negligence in the multiple hospital emergency room evaluation and treatment of this patient.
5. That a safe and most inexpensive therapy that could save millions of lives in the expected event of another great flu epidemic, as it saved almost 50% of dying patients so treated in the 1917-18 epidemic, has been falsely smeared and castigated in a time of great need for solutions to untreatable infections.
6. That this death is yet another example of traditional medicine blaming an alternative practitioner for a death induced by (a) pharmaceutical(s).

Respectfully submitted for the board,

Robert Jay Rowen, MD, President