VACCINES REVEALED

Episode 5
Transcript

Patrick: Welcome to vaccines revealed. I'm your host, Patrick Gentempo, and in episode five today, we have a large slate of people to present to you. What does a Cornell medical doctor graduate and an MIT senior scientist have in common? They're in today's episodes, as well as three other great presenters. Rather than me going through it all again, I want you to dig in, watch these interviews, and see where it takes you on this journey relative to the vaccine issue, which is so critical for everybody in the world to know and understand. Enjoy today's episode.

Speaker 2: So James, I actually looked at your website and I was incredibly impressed with all the information that you had written about the flu vaccine. It seems like you're incredibly knowledgeable about not only flu vaccine itself, in terms of how it's made, but the policies behind it and the politics around it, and some of the issues that went out around the flu vaccine, specifically the H1N1. Can you tell me, what got you involved, what got you interested in writing about the flu vaccine, reading about it, and researching it?

James: Sure. I wouldn't want to put myself out as an expert on how the flu vaccine is literally made in a laboratory. I think my expertise lies in sciences. I've just have always been good at understanding statistics and data. My original interest in the flu vaccine came from the idea that ... It was actually the H1N1 "scare." When I saw this huge panic that took place, where I live, and I'm sure it was North American-wide. It just struck me as being so illogical and overblown, that I decided to look into it. That's where my interest first started.

The issue of vaccination in general seems to come up a fair bit. I knew that it would be almost impossible to study that issue because we've got virtually all of the population already vaccinated and it would be almost impossible to convince anyone to do a proper controlled study. A controlled study would be that you have a control group that doesn't get vaccinated, you have a group that does get vaccinated, but most importantly, the most important variable in any study, is whether or not they get exposed to the virus. You have to

deliberately expose people to the virus to prove that the vaccine was efficacious in protection from the virus, and that's not going to happen. There's just not enough of an incident of those illnesses. We just don't have cases of polio and cases of measles around, so the argument could be whether or not the vaccines eradicated those things or not.

I don't think vaccine in general is an unreasonable stance. If you could prime the immune system of the body to develop antibodies against these illnesses, that makes quite a bit of biological sense to me. However, whether or not that makes sense as a hypothesis and whether or not there's actual enough data to show that that has occurred are two separate questions. For me, it was ... Well, it's very unbelievable to think that an entire world could have a policy that wasn't based upon some data of safety and effectiveness. It just seems almost, it's too big of a conspiracy to believe, I think, for most people, including myself.

I decided well, the neat thing as a scientist, the unique thing about the flu vaccine is that it changes every year. That means we can study the flu vaccine effectiveness next year, because it changes every year. In other words, we have a control group. If the entire population's already vaccinated against the measles, we have no control group because everybody's vaccinated against the measles. With the flu, it changes every year, so that allows us next year, we can do a great controlled study next year on whether or not the flu shot is effective against incidents of the flu, does it protect you against hospital admissions, does it protect you against transmission of the flu, and does it prevent death?

It's an easy thing to study, number one. Number two, because it changes every year, the vaccine actually changes every year, so that's another easy way to study it. The third thing for me that probably was the most important was that the flu vaccine for whatever reason is open to debate in the peer reviewed literature, which is where I spend my time. That's where I do my reading. For whatever reason, you are not going to be ostracized, you're not going to lose your research position.

It seems to be acceptable within the research community to question the data that's available for the flu vaccine, and that's really not true of the other vaccines. That may be because it's just really hard to study because I think if we were to be honest, we would say that because we can't really show because of the research design that vaccines ... We can't prove with a cause and effect type of research study design that they have worked, nor can we prove that they haven't. We just don't have the data to say they haven't worked.

I understand, if we look at the graph of incidence and we see that incidence rate is falling before any vaccination campaign was brought in, and we see that after the date of that vaccination campaign started, that the slope of that graph didn't change, I fully understand that. However, that's still not proof. It's still not evidence that it didn't have an effect or didn't do it, it's just certainly would give us reason to do more research into actually whether or not the claims that it did eradicate these illnesses is true. There's no more solid data against as there is for, because we just don't have the data. Studies have not been done.

As a scientist, I can't stand the idea of guessing, especially when it comes to healthcare policy. I just think it's my moral obligation as someone who's taken the hippocratic oath to make sure that I make my decisions based on evidence. It's really going to be almost impossible at this point to get the kind of evidence that I would require to make a statement yes or no about the other vaccines.

However, the flu shot is perfect, because the flu isn't deadly. Despite what they might tell you about the however number of deaths they say are caused by the flu, the fact of the matter is, and this is in the peer reviewed literature, as you know ... those deaths aren't caused by the flu, they're caused by pneumonia. Flu is not dangerous. I'd be willing to sign up for a study that they actually didn't give me or did give me the vaccine and they deliberately exposed me to the flu virus. I'm happy to be ... I bet we could get lots of people who would volunteer to do that study, and then the question's over, we can answer it.

The question that is so difficult to comprehend for people is this: has the whole thing been bought? The question is, is it possible that we've actually come to a place where we actually live in a society where the people we trust the most with our most important possession, which is the health of ourselves and our children, is it even possible that the whole thing has been bought? I think that's almost an impossibility to comprehend for most people. The other thing I like to point out is I don't believe that doctors have been bought. That, to me, says that there's doctors out there that have taken money to deliberately do the wrong thing or give the wrong advice, and I categorically except that. I'm sure there are exceptions in every profession, but I just refuse to accept that.

The question for me is not whether or not doctors have been bought, but whether or not policymakers have been bought, and that doctors have been sold. Medical doctors, for the 99.5 or 9 percent of them, aren't scientists. They don't have a graduate degree in science where they've actually ever conducted research or even learned how to conduct research or read research, so medical doctors have devoted their lives to helping people, no question, like all doctors in all the healthcare professions have. They're not in a position to evaluate policy. They're in a position to implement it.

I think the public doesn't understand the fact that there isn't anyone between them and the policy, and because we trust our doctors to say, based on this individual patient, I am going to make a decision that's best for this patient. That's not happening now. They're saying, based on policy, this is how I am going to treat this patient. We've kind of almost taken the doctor out of it, in many ways. Now what happens is, I believe that the medical doctors assume that those policies are being put into place based on valid evidence, and so they don't question policy. In fact, you would be in a very difficult position if you were a medical doctor and you did question policy. There's many examples of people who have been attacked, so I think they very rigorously not only implement policy, but defend it with the talking points that they're given from policy.

So, where does the policy come from? Well, the policy comes from government, and where does the government get their data? The government gets their data from the people who make the drugs or the vaccines. That, to me, is the biggest issue. I think the flu shot is the canary in the coal mine. The flu shot is the single greatest way we have the great litmus test, to determine whether or not our policymakers have been bought and whether our doctors are being sold. We know that the flu vaccine is now recommended for everybody over six months of age. They've made it mandatory for healthcare workers. They've claimed that the flu causes 30 to 50,000 deaths a year-

Speaker 2: 60,000-

James: Yeah, depending on what you read. They've claimed that the flu vaccine reduces mortality by 50 percent. They've claimed that it reduces the incidence of the flu anywhere ranging from zero to about 60 to 70 percent. The World Health Organization says 75%, they just put that statement out there with no data whatsoever to back it up.

Basically, the recommendation from the vaccine committee was that everybody over the age of 65 should get a flu vaccine. In just a ten year time frame, from 2000 to 2010, it went from people over the age of 65 to every single citizen over the age of six months and mandatory for healthcare workers. This policy has been distributed in a huge public information campaign. In a huge information campaign to the medical doctors themselves and the pharmacists and the nurses. The nurses and the doctors and the pharmacists have rigorously adopted this policy and vehemently defended it against anybody who questions it. This is a phenomenal example because if we find out that there isn't sufficient data to back up these flu recommendations ... If we find out that the statistics and the data that they're putting out there are spurious and have been deliberately manipulated, then all of the sudden now it becomes a possibility that this is going on in our system. If we don't have a way to show that it's a possibility, then I don't think anyone- doctors or patients- will ever really consider that such a thing could happen.

The thing that's so great about the flu shot then is that if we see this example, we see the data has been manipulated, we see the death rates have been exaggerated, we've seen the reduction of death rate exaggerated, we've seen the decrease in incidence or the effectiveness totally over exaggerated based on data, if we see them reporting relative difference instead of an absolute difference ... If we see all these things happening, then what that does is that creates that wedge od doubt for people that's required. When I say people, I don't just mean anyone who has an agenda to be anti-anything.

What I mean is, it creates an agenda if we can get the medical doctors who are very smart to look at this policy with a critical eye, which is really what the hippocratic oath says they must do. They don't take that oath to defend a policy. They take that oath to defend their patient. I truly believe that if they could see and just would take some time to look at the data on this flu shot, they would all of the sudden realize that they need to step up themselves as doctors and patient advocates to say we're going to demand better data for all of the policies. I think that's the most important part about it.

Very interesting when you bring up the idea of nurses in British Columbia because actually that was one of the great impetuses for me to actually go into the research and look at the flu vaccine because I know a nurse who was being told that her job was on the line if she wasn't going to do this. It just struck me as being so unfair, that they could have a policy in place like that without the data to support it. I'd known enough about the flu to realize, wait a minute, they don't have that kind of data, so I just decided to look into it and honestly, I would call it Flugate, almost like Watergate. The deeper I looked into it, this was not a conspiracy theorist issue, this was an issue that was being investigated by Ph.D researchers like Jefferson who writes for the Cochran Database. It was people who were in the national institutes of health who were Ph.Ds and MDs. There was all kinds of very credible researchers from very credible research labs or universities who were saying, wait a minute. If you actually look at

this data, what you find out is that it does not support the policy. It's not even close.

I think that's the key. I think we have now a great way to say: Is it possible that we could have something put in place to the point where it's mandatory and recommended for 300 million citizens in the United States that is based on no data? The first flu campaign was in 1957 to 1958 when they had a bad flu year, and so they came out the next year after that and said, We're going to recommend flu vaccines for everybody over the age of 65. There was not a single study to back that up that it was going to have any effect. In 1964, the vaccine committee came out and said, We are reiterating that campaign that everybody over the age of 65 should get vaccinated. Then they admitted 'although we have no data on efficacy.' Since 1980, there was about a 15% flu vaccine coverage rate. About 15% of the population got the flu vaccine. Because of their incredibly aggressive marketing campaign, both to the public and to doctors, by 2010, there was about an 85% coverage rate.

Over the time that the flu vaccine coverage rate went from 15% coverage to 85% coverage, the actual rate of incidence went up. The actual rate of mortality over the winter went up. That's a pretty powerful statement. If you add that to the fact of this incredible frailty bias, the research is very clear that the people who are most likely to die in the winter are the least likely to get vaccinated. There was a very good study that was published that said if we look at the people who actually receive the flu vaccine in the winter months, specifically looking at the elderly now, the people most likely to die from the flu ... they never die from the flu, they die from pneumonia. Not never, but so rarely.

They said that the people who actually got vaccinated, if you just remove the flu entirely from the picture and you looked at their state of health, the people who actually get vaccinated have on average a three to seven percent chance of death that winter. The people who didn't get vaccinated have about a 30% chance. Now you take that frailty bias, meaning that the frail people don't get vaccinated, so of course they die more, because they're more frail, and it looks like the

people who got vaccines didn't die because they got vaccinated, but that's not true. They had a much lower percent chance of death anyway. Then you add that to the fact that in the summer months, the same people have the same reduced mortality. Meaning that it can't be that they're not dying because of the flu, and they're not not dying because they got a flu vaccination, and why is that? Why? Because again, these healthier people are less likely to die in the summer and the winter.

Perhaps the most ridiculous of all is the fact that they report that they reduce all-cause mortality in the winter months by 50%. That means heart attack, cancer, hit by lightning ... They're literally claiming, and why is that? They have to claim that, because the fact of the matter is what they're finding out is these people, who are so much healthier that are getting vaccinated literally die at half the rate of the people who aren't getting vaccinated because these ones are so much sicker. That transfer, not just in winter, all year round. That's not my data. That's not me coming up with that. This is published in peer review.

People think, how can they say that they reduce death rate by 50%? Well the reason they say that, A, the frailty bias, and the other thing they do is they report relative versus absolute difference. That means in any given flu year, you'd have about 98% of the people who didn't get vaccinated would remain flu-free for the entire season. The people who do get vaccinated, 99% of them remain flu-free. What you're saying is there's an actual absolute difference of 1%, which is completely explained by the confounding factors of frailty bias or healthy user effect. Then, what they do is they say, well if 2% of people in the non-vaccinated group die or get the flu or whatever ... either incidence or mortality, and 1% of the people in the group that did get vaccinated die. So, unvaccinated 2%, vaccinated 1%, they say they reduce death by half.

Speaker 2: By 50%.

James: It's criminally misleading. That is criminally misleading. The problem is, they're misleading doctors. The doctors believe that if they give that vaccine, they are going to reduce the chance of death by 50%.

Speaker 2: By 50%.

James: They understand that flu is not dangerous, except for the people who are frail and very old, meaning the same thing, but some of them are also very sick. But they've now been convinced that if they vaccinate everybody in the community, that they will reduce the transmission of flu to the elderly. Even though it's not dangerous to these younger people, because everybody will admit that. What they're saying is, if we vaccinate everybody, especially healthcare workers, then we can reduce the incidence of the transmission of the flu to the sick and the weak ... Who, by the way, don't respond very well with the titer response to the vaccine anyway.

Here's the other confounding factor though. Vitamin D. They don't control for vitamin D, but what we know is that the level of vitamin D that you have in your blood is a hugely significant variable on whether or not you're going to get the flu. Why? The question to ask is why does the flu only come around in winter? The reason the flu is seasonal isn't because there aren't viruses around all the time. It's because that's when we have the least amount of exposure to sunlight, meaning we convert the least amount of vitamin D.

Why is vitamin D important? How does this come into it? There's receptors on your immune cells that actually require the attachment of vitamin D to produce what are called AMPs, or antimicrobial proteins. These antimicrobial proteins of your innate immune system, they are antivirals. They kill a flu virus. The most amazing thing to me, of all this, that's being overlooked is that we don't fight the flu with our humeral or our antibody system. Why? Because like the cold virus, the flu virus is different every year. Developing antibodies this year is not going to protect us next year. Antibodies are not the most logical biological defense against a virus that mutates or changes every year.

What's the most logical defense? It's to have a primed and ready cellular or innate immune response, so when you get exposed to this virus, it can go release these antimicrobial peptides and kill the virus. The British have been arguing this for years, saying it's not an antibody issue. There was a very interesting study in Canada where they actually looked at the incidence of the flu all year round. What they found out was the people who got the flu vaccine were less likely to die all year round, so it totally just blew apart this whole idea that it must be that they're dying less in winter from the flu because of the flu vaccine. No, it's a healthy user thing.

Speaker 2: It was the bias.

James: It's the bias.

Speaker 2: So, in addition to the Canadian ... The nurse's union in British Columbia, the national nurse's union in the United States as well as the SEI, which is a labor union and OSHA and NOSHA which are parts of the government, but they're actually occupational medical special ... right?

James: Yes.

Speaker 2: They're all against the mandated-

James: Correct-

Speaker 2: Flu vaccine for healthcare workers.

James: Correct.

Speaker 2: So there are a small body of, but a significant body of, physicians and nurses who don't want to ... who don't feel there's enough evidence. My question to you is what does it say if you've got administrators telling nurses and doctors that they're mandated to take a medical procedure when they themselves don't even want to take it?

James: It tells us that the medical doctors absolutely blindly believe what they're told. They believe that it's going to reduce mortality by fifty

percent. That's why they're fighting so vigorously to make sure these campaigns are out there. They believe that if we vaccinate everybody over six months of age, that it's going to reduce the transmission of flu to the weak and sick, who are dying by the tens of thousands, they think, because they're told, every year from the flu.

What this tells us without any shadow of a doubt ... What it tells us is that the medical doctors absolutely have complete faith in the people who are making the policy. That's dangerous. Who is in between? The people who are on this committee who decide who should get vaccinated, who's it going to be mandatory for and who it's not- who's between them and the medical doctors? Or even, let's go back further. Who is advising the government about the data about which vaccine should come down? It's the members of these committees. Fifteen-panel-

Speaker 2: And who are they?

James: Do they have any ties to the companies? I don't even want to go there. I know what the answer is but again, I hate to start with a conspiracy theory. I'd rather people trace that back. What I like to start with is look, how does the policy get implemented? What is the path?

The path is there's got to be some sort of research done. Who funds that research and who does it? Who interprets that research for a politician? The politicians aren't researchers, and they don't know, so nobody's interpreting that data who is independent from any of this stuff, for the politician. Then the politicians put in a policy which comes down to the medical officers. The medical officers aren't necessarily research experts, and they're not questioning the data because they think if it comes from there down, it must be trustworthy.

I respect that, I would see why they would do that. Then it comes down to the practitioners, the medical doctors themselves, who are injecting people with this stuff, and the pharmacists and the nurses. Who's in between the medical doctors and people telling them what

to do? Most importantly, who's in between the medical doctor who's going to recommend it and the patient?

My thing is, is that we don't want anybody between us and our doctors. We want to be able to rely on the fact that our doctors are never going to implement anything unless they're sure. They cannot be sure based on blind faith and a top-down policy. They must be sure based on the fact that they're willing to do some work to investigate.

Speaker 2: It sounds like we need somebody between us and the doctors.

James: I think we need to expose our doctors to the real data. I don't think we want a pharmaceutical rep or a policy person educating out medical doctors about the effectiveness or the efficacy of the data regarding these interventions. I think what we need is an independent body that says you must have no ties to any of these drugs or any of these vaccines. We must have an independent research body that will advise medical doctors.

Now here's the interesting thing. It's called the Cochrane Database, and if you look at Jefferson from Italy and these people who actually are independent researchers do systematic reviews of the literature. That's what that's for. What do they do when they come together? They say that there's no evidence that vaccinating healthcare workers or anybody else is going to make a difference, there is no evidence that it reduces death rate. There's no evidence that there is these death rates from the flu. If we just look at the data that's already been collected, we have enough information to already know that this policy that has been from top down and vigorously implemented and defended by medical doctors ... They've been sold a bill of goods. The medical doctors don't know that, but they're smart.

What I think we need to do is we need to get the medical doctors to take control of medicine.

Speaker 2: Well they would tell you that they're getting their information and their recommendations from the CDC advisory committees, and that those are physicians sitting on the committee. They blindly trust them to do the right thing and to do the work and to look at all the data.

James: What I would tell them is this. I have a full understanding of why you would have that opinion. That's why need to look at the flu vaccine. What I would say is, why don't we put that faith to the test? Why don't we use real, good science, and really good scientists, to put that faith to the test? If that faith that you put in, those recommendations for the flu shot, turns out to be false, what does that mean for you?

What I'm saying is: we can do it. It's easy. We can do the studies. Jefferson is crying for these studies. There's so many people crying for these studies and we can do it. We have a chance to put that faith, not only of the doctors and the CDC and the policymakers ... Not only do we have a chance to put their faith to the test, but we have a chance to put the patient's faith in their doctor to the test. Not because I want you to question the integrity of your doctor, but I want you to question the integrity of the information your doctor is being fed.

If we trace that up and we look at that stuff and say, wait a minute, how is it possible that this data got given to the doctor to implement that policy, let's trace that up. To the CDC. Let's trace the CDC and the data that they have, let's look at these 15 members on these panels and ask what kind of ties they have, but let's just start with the idea that says look, we can put that faith to the test. If it turns out that thew faith that you've had in that flu vaccine has been false, what does that tell you about the other policies that are coming down? This is our canary in the coal mine.

Speaker 2: I agree with you, but I know that the big argument after speaking to many, many physicians that are out in private practice ... that they blindly trust the CDC advisory committees, and that they don't have the time to do this.

James: I'm not asking the medical doctors to do the research. I'm asking the medical doctors to look at the research that's already been done. I'm not asking them to look at the abstract or the pamphlet that they get, I'm asking them to look at any of the data that I'm sure this documentary, I hope, will put all the references on there ... I'm asking them to look at the data, and then what I'm saying is, I'm asking them to demand a proper research study be done.

Speaker 2: I hope you get your way.

James: I do too because it's billions of dollars and there's a lot of people who could use that money spent in other areas-

Speaker 2: Other areas, and there's probably a lot of possible injury riding on this, right?

James: There's always a risk, and our problem is, we don't have the data. We don't have enough data on vaccine injuries because we don't have enough data on vaccines, period. I'm an advocate for evidence-based practice. What we have to understand is that a body of science by itself isn't evidence for what they're claiming, in terms of an outcome. The conducting of science isn't evidence-based care. They do conduct these studies, but how they interpret and report these studies is not valid and it's not ethical.

Speaker 2: It can be very misleading. No, I agree. I hope you get your way. I do. I think it sounds like a great plan. I'd love to see it implemented.

James: So would Jefferson, so would the people from the National Institute of Health. There's a lot of really good people out there who are really smart and have a lot of clout. I don't think they want anything more than to do a proper study. I do have faith in humanity. I do have faith. I don't think any medical doctor would want to be injecting people with something that there's no data for-

Speaker 2: Oh, I agree with you on that-

James: I don't believe in any medical ... So my point is, I don't think that we're going to solve this by people being anti-anything. I think we're

going to solve this by getting medical doctors to be pro-evidence. I think that's where my optimism lies, because I really do believe that those people out there do deeply care about their patients. I think it's them that we have to mobilize and get interested in this topic because as long as they believe that they already know the facts, they'll never change. If they understand what the actual data says, then I really believe that they will act as advocates of their patients. I do have faith in them.

Speaker 2: No, it's a good point, and the point is well taken that this is the one place in vaccine efficacy, safety issues, that you are allowed to actually talk about and have discussions without being called a crazy person, really. It does seem that there's room for people to debate the effectiveness and the adverse events regarding flu vaccine, versus all the other vaccines. I do hope that you're right, and I also agree that I think most physicians truly believe ... Physicians and nurses who give vaccines, who push the flu vaccine on their patients, really believe they're doing a good thing.

James: People doing the buying are the people who make the money from the implementation of the policy. I think if you trace that up, you'll find that there's an awful lot of evidence for that. One of the great things about the flu vaccine is that there are people willing out there, highly respected researchers, who are willing to debate this in the peer reviewed literature and to actually point out the fact that we have either spurious data or manipulated data or not enough data. It's a very difficult position to be in, because nobody wants to be the next Wakefield. Nobody wants to be the person standing up and saying something where you're going to have this incredible target put on you.

I think that's also one of the great reasons that the flu vaccine gives us the greatest hope to put this to the test-

Speaker 2: The Cochrane website itself has Power points on the flu vaccine, and of course, they've been ... The industry has put out articles negating, with ridiculous arguments in fact ... I don't know if you're aware of a more recent study that was supposedly was hanging its hat on

showing that the flu vaccine was effective, but the control group ... There was a bunch of healthcare workers who got the flu vaccine and the control group got 3 other vaccines, so instead of a placebo, they actually got a tetanus booster, the pneumococcal, and I think the meningococcal and then what they did was, they went back and took a survey 4 weeks later and said how many hours of fever did you have this month? Those in the placebo group had more hours of fever by 8. They had 8 hours of fever more than the group that received the flu vaccine, so therefore, they concluded that the flu vaccine was effective.

James: This is a great example. Forget the control group. What they didn't do in that study-

Speaker 2: They didn't even document flu-

James: Correct. They didn't even document who actually got the flu, and what we know for a fact, absolutely, unequivocally supported in the literature, is that most of the things that we would call the flu or have flu-like symptoms aren't caused by the actual influenza virus at all. There's a lot of viruses hanging around. That's just a great example that if someone can actually take that data and assume that that provides support for a policy of mandatory vaccination for healthcare workers, then thank you for making my point. There couldn't be a better example of the problem with the data.

Speaker 2: By the way, there's some states now with mandatory vaccination of all preschool children.

James: Because there's so much data.

Speaker 2: You know what the Cochrane showed below the age of six?

James: The Cochrane showed it from zero to death that there's no evidence. There's just no evidence, there's never been ... There's no controlled data on it. Even when they come out and say, Well, we reduced the flu by 60% or 50%, then it's a still relative instead of an absolute difference that they're reporting. Even Jefferson himself says you

have to vaccine 100 people to prevent one less flu symptom. That's not confirmed flu. Then if you take the frailty bias into that, it's just ... disappears. Imagine if you had another intervention and you said, I've got this great diet. If 100 people follow it, one of them will lose 5 pounds. It should be mandatory.

Speaker 2: That's a good example. I love that analogy.

James: It's ridiculous. By the way, a flu vaccine will `decrease all cause of mortality by 50%. We should give them to the soldiers so they don't die in war. We should give them to people who drive a car so they won't get in car accident and die. We should ... It's absolutely unequivocally absurd beyond belief, and yet, they're getting away with it.

Speaker 2: Is this going on in Canada too? Is the policy-

James: Yes it is. In fact, it's just coming around again where they're going to make it mandatory that if you don't ... Because the nurse's union won last year, but now they're saying if you don't get the flu vaccine, you have to get the mask. I want to make something really ... This is really important to me. What this does is it makes the people who get a flu vaccine believe that when they go in there and work with these people, that they've protected them, and they don't wear a mask. That's the tragedy.

If we actually want to be patient advocates here, everybody, what we have to understand is if that flu shot has got false data to back it up, it means that you're walking in there without a mask on because you believe that you're protecting those people and you're not. That's where this does the most harm for me.

Speaker 2: Hi Kelly.

Kelly: Hello!

Speaker 2: It's great to finally meet you.

Kelly: Likewise. A total pleasure.

Speaker 2: I'd love to discuss your latest blog entry, which was on flu vaccine and I believe flu vaccine and how it pertains to pregnant women.

Kelly: Yes.

Speaker 2: Pregnancy. So if you could talk about that a little bit, and maybe even back up and let me know how you came to write about this. Where are you coming from, from a medical aspect? What's your specialty, what kind of medicine are you practicing?

Kelly: Sure. I was trained as a conventional psychiatrist. I did a residency at Bellview and it was at that point that I recognized I really wanted to focus on women's health and I did a fellowship in psychosomatic medicine or consultation psychiatry, where we learn how to interact with other clinicians and their medical and surgical patients, including obstetrical patients, also known as pregnant women. I learned through, I think a fairly rigorous training, how to provide informed consent to these patients, or what I believed to be informed consent at the time, because often patients would either be considering a pregnancy or they would be pregnant, or postpartum and there would be a lot of questions about how to safely treat these women with medication during this time of special consideration, I guess.

I would sit down with them for several hours and go over all of the available data with regard to, let's say, the safety of Zoloft or Seroquel and pregnancy or lactation and it really helped me to understand that the patient was relying on me for this information. I was doing my best, I think better than most obstetricians who are reflexively prescribing these medications without that conversation, but in fact, it turned out to be somewhat inadequate, which is something I learned along my journey.

It also opened up a lot of doors for me because I began to look at these patients, these women, and I began to think about all of these other exposures they were encountering in their lives. In the water that they drink, in the air that they breathed, in the cream they put on their face every morning, in other medications they were taking, and even in the food that they were eating. I began to wonder, who's

consenting them for these exposures? Are they having an impact on this baby as well? It really busted wide open this paradigm for me of informed consent, particularly in pregnancy, although now it applies more globally.

I would start to recognize that I would have patients who would come in and we would be talking about their medication treatment, and they would sort of casually mention that they happen to be at the local CVS and they got a flu shot there while they were there. Or they stopped by their OB's before they came over to my office and the OB gave them a flu shot. Often, it wouldn't come up, and then I started to learn to ask for this information, which I felt was relevant if we're really concerned about outcomes, right?

I began to research it. I began to look into relative to an SSRI, what do we know about the flu vaccine in pregnancy? Do we have comparable information? We have 25,000 cases in the literature of SSRI exposure in pregnancy, and some would argue that that's totally inadequate information, but we have even less information that is viable, in terms of being clinically sound, top tier evidence in the population that's by necessity very hard to study when it comes to flu vaccination, and even less information about many of the so-called agivents in these vaccines, and it alarmed me. I began to dig deeper.

Speaker 2: So you were concerned, one, that there was no true informed consent or disclosure about what the real risks could be. Two, that possibly we don't even know what the real risks could be. It is a growing trend. When did you start seeing flu vaccine being given to pregnant women? This is certainly ... it's never been approved by the FDA for pregnancy.

Kelly: It was about in the past, I would say, two to three years. When I was in medical school, they were a contraindicated population. Something changed along the way where they became actually part of the classically indicated patient who was felt to benefit empirically, and really based on a lot of theory and a lot of assumptions and expectations for what this might do for them and also for them, their morbidity and mortality, and also for their

potentially for their child and protecting the pregnancy. Somewhere, there was a tipping point where this decision was made and it hasn't been an evidence-based decision, as far as I could dig up.

Speaker 2: I believe that initially, the flu vaccine was really recommended for an elderly population and that's changed 180 degrees, right? It's been recommended for all ages-

Kelly: For all people-

Speaker 2: All people, right! Do you know when that ... Is that evidence-based? Have you found evidence to show that that's of benefit, versus not of benefit?

Kelly: There's an alarming signal of harm around the flu vaccine in the literature, but in the general population, you don't have to look much further or dig much deeper than what doctors consider to be gold standard source of evidence, which is the Cochrane database. When I was in medical school and residency, this is where we turned for really more objective answers because there might be one review that claims one level of efficacy or outcome and another that claims something different, so we really need somebody objective to synthesize that information and the Cochrane database does a pretty good job at accomplishing that.

For several years, in both the pediatric population and the elderly population, and the population at large, they have demonstrated that there's a lack of efficacy. When we're confronting these questions and we know that the context for the questions is a lack of efficacy, then all of the potential risks are far more concerning. The precautionary principle of saying, okay, we have to have a very low threshold of recognizing that we need more information before we proceed. In the setting of a lack of efficacy, the precautionary principle should probably be enacted at the first sign of concern.

Speaker 2: Maybe even more importantly, in the setting of where the risks are unknown, because the safety studies aren't done. Then you really have to use the precautionary principle, because you cannot make a

risk-benefit assessment without knowing the risks. Certainly the Cochrane database on all their flu vaccine studies end with the same sentence, which is that the studies for safety need to be done, so you're onto something.

Kelly: Yes.

Speaker 2: How have your patients been hearing this message? How do you convey this message, one, and then how do they receive it? It's counter to the message they're hearing every day. They're walking by every CVS, every drugstore says come inside for your flu vaccine. How are they receiving this message?

Kelly: Right. It's sort of surprising to me that that level of direct-to-consumer contact and advertising doesn't raise any flags for citizens and for patients, but it doesn't, I think. I had a patient just in my office yesterday and we were talking about the flu vaccine just very honestly, she said why would they recommend it to me if it was dangerous? We sort of tried to tie in some other parallel considerations, one of which was around genetically modified foods and other conversations that we've had, and she had a similar question: why would it be on the shelf if it was dangerous for me?

I think that for a lot of people, they look around and they say well, everybody's doing this and people are fine. The truth is, and if you're in medicine, whether you're in holistic medicine or allopathic, conventional medicine, you know that people are not fine. People are not fine, we have 1 in 6 children with chronic disease, we have basically redefined standards of sperm counts and childhood milestones, basically to meet what is essentially the devolving of our species. We know that we're sick with all manner of mysterious and complex illnesses, whether it's autoimmune disease or cancer or depression, all manner of inflammatory pathologies and diabetes, and we don't connect the dots.

I think the reason is because you have this very toxic soup. You've put in twelve to fifteen really bad ingredients like the spoiled meat and the herbs that have been sitting on the shelf for 100 years, and

the soup makes you sick, but you don't know which of those ingredients ... Maybe it was all of them, maybe it was one, maybe it was two ... So we have people taking toxic medications, exposed to toxic pharmaceutical products, we have people breathing toxic air, drinking toxic water, and then we have them swimming in this environment of endocrine disruptors and myriad industrial chemicals that have never been and probably never will be studied for safety, and they get sick, but they see it as ... I was fine, I was fine, I was fine, and then I got sick. In fact, it's this very difficult to quantify, cumulative process for most people. Then of course there are the acute adverse reactions, where it's very easy, hopefully, to connect to the trigger-

Speaker 2: You think!

Kelly: You would think. You would think. If it's not covered up.

Speaker 2: It's now just labeled temporal relationship, but not causation.

Kelly: Right, like Sudden Infant Death Syndrome.

Speaker 2: Or having a vaccination and then having a seizure that night and being dead the next day. Doesn't prove that the vaccine caused the seizure and the death, it's just temporally related.

Kelly: There's so many layers to the defensive rhetoric around not wanting to connect those dots, I think. This is something I spend a lot of my time just meditating about, trying to figure out why it is that people don't want this information. Why don't they have room for this information?

Speaker 2: It's interesting that most physicians look at these illnesses as, Oh, you've been fine for 35 years, 40 years, and then you came down with this disease, and don't think twice about what was in the equation leading up to that disease. If someone was clearly capable of living a life for 40 years, healthy without asthma, without MS, what changed? What's going on that that changed? I don't think that that's questioned. What's your experience in terms of dealing with

other physicians? The way you look at your patients very differently than the typical physician doing what you're doing, who has a primary care practice. What's the conversation that you're having with some of these other physicians?

Kelly: One of the areas where the rubber meets the road for me in this area is in the treatment of thyroid ... Probably 80 to 90 percent of my patients have mostly postpartum onset autoimmune thyroid conditions and it's something I'm very familiar with. I have recovered myself from that condition and so I have a vested interest in detecting it early. I often reference a very important paper, it was done mostly looking at lupus patients through a VA Hospital and identifying the predictive value of antibodies.

Just antibodies floating around, and how they do so, many many years in advance of "disease onset," and so this idea of why am I checking for their thyroid antibodies, who cares, it's not going to change treatment, they don't need to be treated, let's just watch and wait ... I try to argue this point with them, that actually, this is a point of important intervention and mostly, my interventions are around lifestyle medicine, looking at cleaning up their environment and their diet, and it works. I think that we're taught to put out fires, we're taught to suppress symptoms, so this notion of preventive medicine really comes down to screening and that's about the beginning and end of it.

I think for most physicians making this leap to thinking about individual risk factors is a very tall order. I think that's where universal recommendations like the flu vaccine for example, or if you want to broaden it to the vaccination program on the whole, as being the only universally recommended medical intervention probably in history of time, this is where we are experiencing our own uberous because the science is suggesting that epigenetics, that the expression of our genes, is such a complex and sophisticated dance. The 25,000 genes in the human species do not account for our complexity, that there's a lot going on between the genes themselves and the DNA and in their expression, and that that individual

difference from person to person is where medicine is really at right now, and looking at that individual biochemistry is essential.

If we're not doing that, if we're making one-size-fits-all recommendations, there's going to be collateral damage. There's going to be collateral damage on an individual level, and also on a societal level. This would apply even to using antibiotics liberally. We have to catch up. We have to push doctors to catch up with what basic bench science is suggesting is important, which is that different people bring different vulnerabilities. We don't know who the canary in the coal mine is going to be, so we need to think cautiously and think preventatively.

Speaker 2: I think many would argue with you, that the focus has been on genetics and money. Lots of money is going into looking at genetic basis for autism, genetic basis for MS, for all these diseases that you are saying are probably more associated with environmental triggers-

Kelly: Yes-

Speaker 2: So would you say to people who would rebut you by saying all this money, there's millions and millions of dollars going into looking at genetic differences ... Is that what you're saying needs to be done, or are you talking about something very different?

Kelly: I'm talking about something related but in fact very different, which is that looking for the gene, we really want it to be simple, right? We want there to be one gene for one disease and then one medicine for that disease, and we want this linear A to B to C sort of a model that we can all take to our offices. In fact, it's this very complex web of different factors interacting in very sophisticated ways. That is epigenetics. That is how in each individual, these environmental factors conspire to either promote the expression of problematic genes, or suppress their expression. That's a pretty big difference. It's a 1s or 0s type of thing in some case, but then it's also the collective, interactions of all those different genes. It's never going to be a gene being present or not, we already know what those diseases are. We're not talking about that.

We're talking about why are people so sick in the past 150 years. Why are they getting so much sicker, and it's not because we have evolved on a DNA level, as a species. We have the same genes that we've had for several million years, but in fact, we are getting sicker every day. I think, in my practice, I can see that I have patients who come in and their mom was depressed, and their mom's mom was depressed, and their uncle committed suicide, and they feel condemned. They feel condemned to a life of depression and they feel that they've been taught that the solution is in a pill. They've been taught that the solution is their correcting their serotonin imbalance. What they've learned essentially from commercials-

Speaker 2: Exactly from commercials-

Kelly: From direct-to-consumer. When they get better, without any medication and with really frankly basic modification of their exposures, I think it should be empowering to them where they can see how amazing it is to liberate themselves from what they thought was essentially a sentence. It's a different way of thinking about it.

Speaker 2: What you're describing is really ... You're saying that we're complex, adaptive systems. The neurological system is so complex, as is the immunological, and endocrinological ... They're very complex, and they adapt, and so there's all this domino effect going on. It's a wise way to treat your patients, it's a wise way to look at what's going on, but I do think that there is a push in the medical world to focus, not on the environmental triggers, not on disruption of our environment internally and externally, but really to focus on ... certain kids are autistic and it's got to be genetic. It's genetic, we're having an epidemic of genetic possibilities. It sounds like you're not buying that. You're saying-

Kelly: No.

Speaker 2: No, that's clearly not what's going on here.

Kelly: I think the reason that it's hard, I have a lot of friends who are wonderful people and they want to help their patients and they're

doing the best job they can do. They went into significant debt in their medical training, it's really quite a process of indentured servitude. Being a resident and a fellow and an intern, and I think they get to the end of that sometimes decade of training, and they say you can't take this away from me, this is what I learned to do. This is my expertise, and they feel very defensive about having that challenged. I think that the reason that I have been able to try to open my mind about some of these very big fundamental questions that are undermining to all of the training that I've ever had and paid for emotionally, mentally, and financially ... The reason that I'm open to it is because I have a different perspective and a different set of tools through my functional and holistic medicine training, and so I don't feel left naked, trying to bear the blast of this news.

I feel like, Mm-hmm (affirmative), that makes sense, and in fact, I can default to using lifestyle medicine with these patients. I think if you don't have alternative tools, you really refuse to give up the gun. It's too much to ask the average doctor to question the very foundation of what they've been taught.

Of course I think that, I hope that, most people are aware that in medical school and in medical training, we are not taught about nutrition and there's not much room for the assessment of the role of nutrition, exercise, and environmental toxic exposures in that training-

Speaker 2: That begs the next question, which is you trained in psychiatry, but you are not prescribing psychiatric or psychotropic medications, and I know that is the very foundation today, in this country, of psychiatric practice. What did you learn about these medications or their effects on your patients that helped you decide or pushed you to decide to leave them by the wayside and try other means?

Kelly: Bringing the awareness rhetoric and sort of investigative eye that I brought to assessing vaccine safety in my patients, it took a long time to bring that same eye to my own craft. Thinking about this with regard to psychiatry with something that happened ... actually several years after I began to see the connections of industrial

influence on cosmetics and women's products, on genetically engineered foods and pesticides, and psychiatry was sort of the last holdout.

Then I began to start to taper patients more off of medication in advance of their pregnancy, mostly because of their preference and because we were working on other things like their diet for example and other wellness interventions. Many of my patients felt empowered to consider that, whereas previous to that, I'd been unwittingly in the business of maintaining them on their medications for pregnancy because that's the general posture of people who are specialized in what's called perinatal psychiatry, is to really protect these patients and their right to treatment and to understand the safety data around that, what's available.

When I began to taper patients, it got very ugly and-

Speaker 2: Because?

Kelly: Because, in fact, it turns out that the body, when exposed to something like an SSRI for example, but this is true of probably any pharmaceutical intervention and particularly all psychiatric-

Speaker 2: When you say SSRI, you mean?

Kelly: Serotonin reuptake inhibitors, classic antidepressant like a Prozac or Zoloft.

When you start to take that, I think many people are led to believe that they're correcting a problem. They're correcting an imbalance, and we've been ... This notion, what's called the monoamine theory of psychiatry was born out of an observation in tuberculosis patients, of how they respond to a medication that may have interfered in a beneficial way with their brain chemicals in the monoamine class, and it's never been demonstrated in a human study that this is actually what depression is all about.

That doesn't surprise me, because depression is about the most vague syndrome you could ever come up with. It's like you can have

a toe that's hurting because somebody's standing on it, because you wrapped a string around it, or because there's infection in it. There's so many pathways to this symptom, really, that it's just almost like a dictionary definition that has been ... There's consensus that has come together around what the label means, but it in no way describes what is actually going on in the body on a physiological level. You take this medication that then creates a disturbance, it creates an imbalance, and it perturbs the system. The body and the brain adapt to that, and that process takes, we think, about two to three months, and then you go along with your life, and you're taking this medication, and you're maintaining that adaptation.

Then when you take the medication away, what happens? It's like if you were leaning on a piece of furniture and all the sudden, the furniture moved, you're going to fall on the ground. Or sometimes I describe it as a spring, like you're squeezing a spring really tight, and you let go, it's going to bounce all over the room. We have, what has been dubbed 'a relapse,' but I think the suggestion to many patients is, "Well this is your illness. It's coming back, so you do need that medication. We shouldn't have done that taper."

Speaker 2: Well, they're told they have a chemical imbalance, and that is just the expression of their chemical imbalance, rearing its head again.

Kelly: In fact, it's the expression of withdrawal from the medication that has disrupted their bodily functions. I would start to see patients who stopped sleeping entirely, were in a constant state of agitated anxiety, began having panic attacks, and they were started on this medication because they had a bad breakup with a boyfriend or sometimes for more severe depression, but never for these symptoms. The types of symptoms that they would have in the wake of taper were really novel, and they were medication-induced. It was what we call atrogenic, so it was doctor-induced pathology.

I really started to experience a concern that I have never encountered about what I had been doing to the patients that I had medicated for all these years, and how I never one time, in my history of training was ever taught to sit down with somebody and

say, "Before you fill this prescription, I want you to know that it may change your life forever, and it may be very difficult for you to live without this medication if you're taking it for more than 2 to 3 months."

Speaker 2: That would be a true informed consent.

Kelly: There's literature about the [inaudible 00:58:34] biology of discontinuation, this isn't just anecdotal observation-

Speaker 2: No, no, of course, and this is not happening. This conversation that you just mentioned, is a conversation that should and is not happening.

Kelly: Yes, yes.

Speaker 2: That's a great point.

Kelly: It's not happening, as far as I can understand because the data is corrupted and the data is manipulated and what reaches doctors in their training and what reaches doctors in their office, in terms of review papers and things that tend to make sense of all the studies that are going on are undermined by a system that is not really supporting outing the truth. That's something that I began to dig into. There are some thought leaders in this area. I began to read a lot of Dr. Healy and Dr. Irving Kirsch and Peter Bragen's work.

I remember that I read a book called Anatomy of an Epidemic by journalist Robert Whitaker, and I remember crying when I read it. I was very new to this concept, like I said, I really hadn't ... I wasn't shining this light on my own practice. It was very distressing to me that I had never heard one of the 16 studies that he discusses, in all of my training. Not to even have them dismissed or to have an attending physician tell me, Oh, well there was this WHO study that showed that outcomes are actually better if you don't medicate depressed patients in their index episode, but it's not a good study ... There wasn't even that level of knowledge or awareness of the work

that is out there that may be raising a signal of concern around the practice that is taking place.

Speaker 2: The people that you just mentioned, they've done amazing work and I know that there are a lot of people in the industry, including fellow psychiatrists who have really come down hard on them. What do you think about that?

Kelly: I understand it. I understand it because I was taught ... We were sort of taught these sound bytes. When a provocative study comes out, like a meta analysis like Fornier's or Kirsch's that suggests that these medications are not effective, they're not more effective than placebo, and when you unearth unpublished studies, which Kirsch did through the Freedom of Information Act ... When you unearth unpublished studies, even that marginal effect in severely depressed patients disappears. That marginal effect may even be accounted for by aspects of the medication, whether it's sedating properties or activating properties that are totally unrelated to its primary pharmacological action.

You're busting open the whole paradigm when you try to suggest that. The truth is that these doctors have spent so much of their time building truths and building their practice and building mastery. We all want to be really good at what we do. When you try to pull the rug out from under them, there's going to be resistance. I think they are ... I hear from my colleagues, my patients too, "You can't tell me this doesn't work, my patients are getting better."

Speaker 2: But at what price? The point I was making, though, Dr. Breggan and Dr. Healy have both been attacked personally. Not even just their work, they're attacked personally. Where do you think that's coming from, really, underneath it all? I understand what you're saying, so certain physicians might feel like the wool is being pulled out from underneath them and their whole world is being rocked, and not in a good way.

Kelly: Yes.

Speaker 2: Then to go and personally attack these physicians for doing good work. They're just trying to do good research. They're showing that this is the price we're paying. Maybe your patient gets some benefit in short term, but the long term is that their anxiety's worsened, their depression's worsened, there's an increase in suicidal ideology. Then they're personally attacked by psychiatric associations and some of these academies. Where do you think that's really coming from?

Kelly: I think we see that that happens really with a lot of different, what I would call thought leaders. If you look across different fields of research, you see that the people who have come out and questioned the paradigm are the ones who are suppressed, they're censored, and they're ridiculed. It's almost strategic. It's almost like some of the regulatory bodies like maybe the APA or the AMA or even the CDC, they disseminate these talking points and so people cling to them because they want it to be simple and they want to protect their status quo.

You start to hear these talking point bubbling up all over the world, really, and it's like this incredible echo chamber. It's an easy way to not have to deal with. It's sort of like if you walk by a homeless person on the street, and you know that's evidence of a bigger problem, a systemic problem, but it just feels like, Ugh, I hope somebody else is dealing with that. It's just more than I can manage and I don't have to deal with that personally, do I?

The reality is, let's just start with bringing awareness to the possibility. Just look that person in the eyes. Make eye contact, that's it. You don't have to give them a dollar, you don't have to help them, bring them to lunch. It's just about generating small openness and a little bit of awareness that there might be more to the story, and remaining ... We've been burned, as a society, when we have not remained open to the possibility that our assumptions have been based fundamentally on erroneous concepts and erroneous theory. This is a very important element of scientific progress, is knowing that the world may not be flat. It's that sort of idea.

Speaker 2: I think it's a perfect metaphor. In light of how Dr. Breggan and Dr. Healy have been treated and kind of vilified, I'm curious if you know anything about Dr. Wakefield and if so, what is your take on that?

Kelly: He's a strategic fall guy, and I think that my post-conventional training has been in functional medicine and it's almost an extension of naturopathic medicine. We focus on the importance of the gut, we focus on how that is really the seat of chronic pathology, whether it's in my field, whether it's mental illness, whether it's autoimmune, whether it's cancer ... The relevance of the gut as being the Achilles heel, essentially of many vulnerable individuals is a known fact of anybody who can connect the dots of human physiology. The level of vitriol that was brought to his life, and the effort, is so aggressive that it's suspect, right?

Similar things have happened to Sara Leeny and the genetic engineering realm and other people who have just suggested maybe we need to hold on a minute and get a little bit more information. Nobody should be threatened by that question, and maybe there isn't an appropriate one-size-fits-all because look at these vulnerable kids.

Sometimes I use this analogy with patients, it's like if the government asked us to pay $5,000 a month for terrorist insurance, everybody's got to put into the pot because we need to insure ourselves against the terrorists. You put in $5,000 every month ... To some people, that would be a massive hardship, and it would be disabling to them in a socioeconomic realm. For other people, they'd barely notice it. What if this mandated contribution was based on faulty intelligence? Then you'd really be caught with your pants down, if you had decimated the lives of all of these socioeconomically vulnerable people.

This idea of using a one-size-fits-all intervention and basing it on a lot of assumptions, expectations, and hand-waving research is dangerous. Maybe he's starting to help us understand why it might be dangerous, and he's just posing the question, but there should be something that the average citizen takes home about this and about

the nature of the attacks that he suffered. We don't get defensive or offensive to that extent if we're not trying to hide something.

Speaker 2: Methinks she does protest too much.

Kelly: Yes, exactly.

Speaker 2: Way out of proportion to a study with so few subjects that was just a suggestion. That's a great take on it. It's very helpful and I think that it's good to hear you say it.

Kelly: Yeah, thank you.

Speaker 6: If we're looking at vaccines, in part, we have to look at what's the germ theory? There's obviously some theoretical basis for how we get sick, or how germs adversely affect us and therefore the idea of vaccines come from that particular premise ... What is the overview of the germ theory as you see it?

Speaker 5: The beautiful and poetical thing about germ theory is that we're still actually in the theory part of the phase of understanding what germs are. What's happened over the course of especially the past 20 years, is a complete de-centering of the foundation of the concept that germs are the primary cause of diseases that we think are vaccine preventable. In other words, we think that viruses are pathogens whose job actually is to infect us and cause harm.

It's absurd because viruses actually hijack a pathway in the body which produces these little nano particles called exosomes, which actually are in the same range and size as viruses, which are extraordinarily small, infinitesimally small. The idea is that viruses are actually pieces of genetic information that are able to basically go from one body to another, carrying information which technically help these bodies evolve in space and time and share useful traits.

Viruses are being looked at very differently than what still today they are characterized as, these deadly agents of almost demonic energy, that all we can hope for is our immune systems don't exist, we need all these vaccines that will inoculate us with special powers to keep

these little microscopic invisible demons out of our body. It's very much like the middle ages or some other pre-scientific era where we're not dealing with science anymore.

Speaker 6: That's interesting, because you're right, the context for a virus, or the microbe world, in general, bacteria, but especially in this case for viruses, is exactly that- that they're something that need to be eradicated. As if they could be.

Speaker 5: Yes.

Speaker 6: The idea being that we've coexisted with these viruses for many, many years and like anything else, there's a balance to life and balance to the world, so now we're saying we can disrupt that balance and try to tilt it in our favor in some way. It starts with like ...

It's like saying the war on drugs. Drugs are in the culture. We have to have a war on drugs. I'm not making a statement about anti or pro drug whatever, but what I am saying is that-

Speaker 5: Yes-

Speaker 6: Forming that war on drugs and dumping enormous resources into it, where has it led? Are the drugs gone now? Did the war on drugs go ... So now we go to the microcosm of the microbe world, and we're saying we're going to have a war on viruses now, as if we could eradicate them.

Speaker 5: Thank you! Yes! That's the crazy thing that's happened in the past 20 years. Now we know that if you just look at the humane genome, the holy grail of molecular biology is the genome is the basis for what we are in all of the questions of medicine and disease would be answered. One interesting thing they found was that about 8% of our entire genome sequence is retroviral in origin. So a retrovirus is able to take its genetic information and insert it back into the cells of, say, a mammal. It can even get into the sperm or the egg germ line, which then forever is ... you can't eradicate it, it just keeps carried on forever. That's what's happened over the course of evolution, we've

been infected by an HIV-like retrovirus from another species and then over time, it's been incorporated into our genome and then used for very important things.

For example, the placenta has retroviral DNA indicative that it wouldn't even exist, we wouldn't even be mammals, if we hadn't been infected by that particular type of virus which conferred a set of genetic information essential for evolution. Our brains like plasticity and development, the encephalization phase of evolution took ... about two million years ago, there was a sudden almost exponential increase in brain size. Now they believe, again, that there was a type of virus that was introduced into our species that enabled that sudden shift and change. That's just the retroviruses, which of course we've been told HIV, for example, is the most deadly virus that's ever been discovered, but retroviruses are fundamentally are benign and useful in evolution.

About 36% of the human genome is retroposones, which are viral-like elements that jump around the genome and help to create this miracle that we are. Then you go out into the microbiome, which is a vast community of viruses, bacteria, fungi, and you find that the viruses in our body are so prevalent and contribute so much information that they eclipse the contribution of our sacred human species germ line cells and their DNA.

The idea is that viruses are what we are, so how could we possibly section out one of literally millions of viruses and say, this thing is what causes disease, not the pesticides I'm being sprayed with, the GMO food that's suppressing my immunity, the fact I have not had enough sunlight, the stress that I live with ... None of that. It's this little invisible particle. Even though I'm composed primarily of viruses, that is going to kill me if I don't vaccinate with this particular vaccine against it. It is the most absurd intellectually bankrupt view that could possibly ever exist in this day and age.

Speaker 6: If we shift the lens that we look through, and say there are some bad viruses that people die from, we look at the natural order of things and say, You know what? If you're alive, you're at risk. There's risk to

life for many reasons. You could walk out on the street and get hit by a bus. Maybe you're going to be susceptible, so the question is how do you create the most amount of health assurance?

You're walking down saying, I want to limit my risk, one of the questions then, you gotta say, Okay, am I better off trying to support my body in a positive way, like you said with proper nutrition, with sunlight, and all the things that we know that can really amp up our immune system and do that for my children, or are we better off injecting mutated viruses with these varying toxic substances that are integrated into them bypassing what evolution has given me all these years, directly into the system and then shock the system into a response ... What feels like the bigger risk to me or the bigger risk to my children? That's what I think people really need to look at.

If you can look at the varying theoretical constructs or you look at the varying models saying, here's the vaccination model based on a war against these viruses, these dark lords of the world that we are under attack from, or do you say that you were born to be healthy, not born to be sick, and if you support what creates health, that you have a better probability of having a long healthy life. Which path do you choose? That's what I think should be put in front of a parent before they determine whether they want to vaccinate their kids.

Speaker 5: Absolutely. We've seen just in the past five, ten years, the broad acceptance of the concept of probiotics. Bacteria, germs, that we need to be healthy. There's even something called prebiotics, things that feed those bacteria. People now see that in their yogurt, it could be inulin, whatever. There's actually now something called previrotics, or substances that feed viruses, because the role of viruses in our health and in actually mediating what's called the genotype-phenotype relationship in the immune system is so important that theoretically all these viruses that we've been told are deadly or could cause cancer, like Epstein-Barr, they're called latent or slow viruses and most Americans have a variety of these. A whole number of herpes viruses, for example, they are now discovering that when those viruses are not present, let's say, in an animal model,

that those animals are at much greater risk for developing types of tumors or types of deadly infections.

Technically, viruses are now being re-contextualized as being essential for our health and it's within this sort of awareness that germs, so to speak, as pathogens that are there to kill us are actually helpful. The vaccine agenda today and all the propaganda and all the rhetoric about vaccine preventable diseases and immune compliance, it just doesn't make any sense anymore. It's not evidence based on the most fundamental level of biology.

Speaker 6: I think we can at least conclude that there's more than one rational view of germ theory and the role that viruses, bacteria, microbes, play in life ... in the support of life.

Speaker 5: Absolutely. There are exceptions where, because in large part, vaccine development ... The very viruses that we thought were deadly that we then tried to create a weaker version of, ended up becoming more dangerous because of that. A good example is the oral polio vaccine that is in India. Basically what's been shown is that because they came up with a bivalent form, this was several years ago, to replace the older form that was causing a lot of problems. They found that it actually led to potentially 47,500 Indian children experiencing polio paralysis. The discovery was that the vaccine form of it was far more deadly than the actual wild-type form that was in circulation since the beginning of time.

We have inadvertently created what I would call an apotheosis, or reification of the very germ theory that we now know doesn't even make sense. There is an exception which is that technically our fear of germs has created an entire global system that has actually ended up weaponizing them to the degree where there now are exceptions. Some of these vaccine-virus strains are actually deadly when the natural form would have been beneficial. It's a highly ironic situation, so I'm not saying that all viruses are good now, or there's no exceptions, or when the immune system isn't susceptible from being damaged and deprived of nutrients, that a virus exposure couldn't result in harm or death ...

It isn't the virus per say, because that's the interesting thing in biology as you know. Viruses are known to have no internal driver. They cannot go and infect something because they're passive. They are in between living and dead, according to classification. How can we possibly attribute this vast image of death and destruction to something that isn't even living, that actually uses to produce the viral particle, the very proteins and lipids from the host cell ... So as it buds out the surface of these cells they're infecting, they steal the contents of that cell and are as much human as they are viral.

In other words, you cannot even say viruses exist because they are a byproduct of the fusion of a living cell with those particular viral genes.

Speaker 6: In the end, I think when people are trying to make decisions, I think it's not so simplistic a picture, saying these microbes are bad, they're out to get you, et cetera. We share this planet, as living beings, and we've shared this planet for millennia with these microbes that are around us, and I think we should be a whole lot more cautious around disturbing the balance of what took all these years to create.

Speaker 5: Absolutely, yeah.

Speaker 6: One thing that I don't hear people talking about very much is that the ingredients that are in vaccines, from a moralistic standpoint to certain sub points of our culture, they're very adverse to them, but they don't even know that they're injecting things into themselves, so can you speak to that a little bit?

Speaker 5: Absolutely. One thing that is sort of hidden out in plain sight is the use of what are called diploid cell lines, which is a scientific way of describing aborted fetal cells that were intentionally harvested for the purposes of creating vaccine seed stock for the entire schedule. These cells are not immortalized to the point where they could produce infinite amounts of vaccines, so they have to go and reharvest ... Actually, take a life, in order to create these vaccines, so that is a big problem because many of us with a denomination, it could be Christianity, it could be your own personal belief ... Don't

believe that is a good thing to do, nor a healthy thing. In fact, some would argue that it borders on cannibalism, to inject a diploid cell line vaccine into your child.

Unfortunately, there's a carve out, I believe, in popular consciousness, when it comes to these issues, some folks are willing to protest in front of abortion clinics, rightfully so. They're willing to do quite a lot to fight this type of presumable immoral acts, but when it comes to vaccines, because it's cloaked in science, scientism, the new religion, they believe that it's not even an issue or they don't know about it.

Speaker 6: They might not know about it, and even if somebody were pro-choice in their own personal beliefs, that doesn't mean they necessarily want these things injected into their bodies or the bodies of their children because it's another step even further. For certain people, it's a non-starter just on its face. For other people, even if they're a pro-choice advocate, they still might have a moral aversion to going to that use of fetal tissue.

Speaker 5: Absolutely, and also, let's say you're vegan and you're even offended when a friend wears leather. Yet, you're having your children participate in the vaccine schedule, where they're getting literally a dozen plus aborted cell line vaccines injected into their child, or let's say you're a non-GMO activist, which I happen to be. You realize that many of the products on the market, for example, HPV vaccine is a genetically modified organism, or that they're actually breeding into plants for edible vaccines or biologic als human DNA sequences like lactoferin, hemoglobin, into foods that may be used in the future, and then you're consuming those which is like a form of cannibalism, it's pro-GMO, it's obviously not vegan, you can't recall these gene sequences once they're out in the biosphere, either, so there's no choice anymore for anyone. This is a big part of why the vaccine agenda, hidden in many ways as it is behind biomedical language ...

There's a responsibility again, for informed consent. For people to know that they could very well be violating their most dearly held beliefs by participating in the vaccine schedule.

Speaker 6: I think that is something that I've heard many different views on considerations for people when getting vaccinated or why to vaccinate or not vaccinate, et cetera. That's one I don't really hear people talking about and I think it's very critical because these are deeply held beliefs, freedom of religion, freedom of belief. I don't try to tell other people what they should think or how they should conclude, but what I do know is that if you have created a conclusion, you have a deeply held belief, and yet you are sort of hoodwinked over what's in the vaccine formulas themselves-

Speaker 5: Yes-

Speaker 6: I think people need to question if it matters to you-

Speaker 5: Yes-

Speaker 6: If this is something that's important to you from a spiritual level-

Speaker 5: Yes, yes-

Speaker 6: I think you have to ask those questions too, you cannot just put that stuff aside because it happens to be a government mandate. There's freedom of religion in this country.

Speaker 5: Absolutely, and I feel that it's a medical-ethical responsibility of the medical establishment and pro-vaccine advocates to inform all participants that they may very well be violating their religious beliefs by participating, so that's another element of what's going on that clearly is not being addressed.

Speaker 6: It's called full disclosure, right? I mean, if I go eat at a restaurant, the vegan dishes have a V with a circle around them, or gluten free has a GF with a circle around it, et cetera. Non-GMO, et cetera, but when it comes to actually injecting something into your body-

Speaker 5: Yes-

Speaker 6: Don't you think you want to know what the ingredients are before you put it inside?

Speaker 5: I'm not an advocate of vaccination, but I would love for there to be a choice in the public for a green vaccine, a vegan vaccine, a non-GMO vaccine. That's great. It's only going to be better as far as reducing risk, but that's not being offered, and that is fundamentally an example again, where there is not real transparency. There is deep collusion, I believe, and profit is still primarily the motive behind this agenda.

Gary: This chart shows the number of deaths reported to VAERS, this Vaccine Adverse Event Reporting Season, during each influenza, flu season, from 1990 onward. You see that there's hardly any zero reports, then one report in '93 to '94. One in 1998, and these were after a flu vaccine given to a pregnant woman.

Speaker 8: Okay, so that's what we're looking at. We're looking at fetal deaths as in from women who had been pregnant and received the influenza vaccine, so that's what these reports are-

Gary: That's correct.

Speaker 8: Okay, got it.

Gary: In the early years, there was low vaccine coverage. Only mothers that were high risk were vaccinated, and there were very low reports shown here. When we get to 2009-2010, the coverage did increase, but what happened was, this was the pandemic year, 2009-2010. Two influenza vaccines were administered to pregnant women, sometimes at the same time. There was the H1N1 pandemic flu vaccine and the seasonal, trivalent, inactivated flu vaccine. We have this huge spike in fetal deaths.

What's interesting, the CDC commissioned Dr. Morrow and others to do a study of influenza vaccine safety. We see this spike here. When Dr. Morrow was preparing a paper that he published, he had access to this data but he cut off his study at the 2008-2009, and in his study, the total number of fetal deaths over the 19 flu seasons was 23 deaths, total. It computed to 1.9 fetal losses per 1 million vaccinated women. People saw the 2009 that his paper went from

1990 to 2009, appears in the title of the paper. Many medical personnel, physicians, obstetricians, gynecologists thought he was including the pandemic year, because the paper came out in 2010 after the pandemic flu season, but it's stopped short of the spike.

There was a four times increase in distribution of the vaccine to pregnant women and so we would expect maybe a four times increase from the previous year to the next year, but the increase was over 4000% in reported cases. Dr. Morrow and his associates attributed this large increase to a Weber-like effect. That's an effect when a new drug or vaccine is introduced to the market, they expect over reporting ... We could show that the reports to VAERS were just elevated on fetal losses. Other adverse effects were not elevated, so it could be proven that this effect here, this spike, was far greater than you could attribute to a new product coming to the market.

Speaker 8: So you're saying that that spike was just during the H1N1 season and the other VAERS reports didn't come in higher numbers from that vaccine, just the fetal loss.

Gary: Right. Other reports such as anaphylactic shock, we used as a control, only increased ten percent. What we explained was that this spike was due to an overdose of thimerosal because both the seasonal vaccine and the pandemic H1N1 vaccine could both contain thimerosal, this mercury preservative.

Speaker 8: That's really scary. They're pushing this vaccine on all pregnant women, and now with a few other vaccines, so that's very scary news.

Gary: Yes. Now, obviously the CDC noted that, so they subsequently in the next year removed the pandemic vaccine as a second vaccine and incorporated the H1N1 virus into the trivalent, or seasonal, vaccine. Instead of three seasonal vaccines, there were two seasonal strains and the H1N1 and that brought the rate back down.

Speaker 8: Interesting. So they knew this happened. Clearly.

Gary: Yes. Now also, at about this time, there was a big campaign that was to market flu vaccine so when Morrow came out with his paper in 2010 October showing the 19 previous flu seasons, the media actually thought that the pandemic flu season was safe. It was advertised as completely safe.

Speaker 8: You know this data, and you've got children, you've got daughters, you said three daughters. Would you recommend a flu shot to a pregnant woman?

Gary: Actually, I'd like to read a statement that it was contained in the various manufacturer's insert for the H1N1 pandemic vaccine. "It is also not known whether these vaccines can cause fetal harm when administered to pregnant women or can effect reproduction capacity."

What has happened in more recent times is a manufacturer, Glaxo-Smith-Kline actually did a test in animals. They tested rats and injected them with the influenza vaccine, but rats don't get the flu, so their test came out that the vaccine was safe. The FDA said they considered no difference between the seasonal vaccine without thimerosal or the seasonal vaccine with thimerosal. They regarded both as safe, so Glaxo-Smith-Kline did not run the test with the thimerosal version.

Speaker 8: What do you think about the flu vaccine in general?

Gary: I have in my notes here two reports that really summarize my final position on it. One is by Cowling and Fang, et al, and it's called Increased Risk of Non-Influenza Respiratory Virus Infections Associated With the Receipt of Inactivated Influenza Vaccine. This came out in Clinical Infectious Disease Journal in 2012. What it shows is, it's the only double blind, placebo-controlled study that was conducted for 250 days of follow-up, a long term study-

Speaker 8: A long term study-

Gary: And it showed there was a 4 times increase in the risk of non-influenza respiratory virus infections. Those are sometimes categorized as flu-like viruses, too-

Speaker 8: They're counted as flu-

Gary: Right, and so basically, there's another supporting study. Vaccine Effectiveness Against Laboratory-Confirmed Influenza in Healthy Young Children, a Case Controlled Study. That study supports also an increase in non-influenza respiratory virus infections. So really, the reality is, giving the influenza vaccine actually contributes to more infections-

Speaker 8: Yes, so Gary, what I'm wondering is, because you work for the CDC, you did work really for the health department via the CDC-

Gary: Yes-

Speaker 8: You did a lot of interesting work for them and you vaccinated your children and you came in as a scientist believing everything was above board. That was years ago. Now, where you're sitting, what's your view on the recommended vaccine schedule? What do you think about it?

Gary: Well, it's interesting you mentioned that because I did do a study that involved infant mortality rates. I looked at the top nations that had the lowest infant mortality rates and what it showed was the countries that vaccinated the most had the highest infant mortality rate. It's just the opposite of what you would expect. The countries that vaccinated least were maybe three cases per thousand, infant mortality- the child died by the age of one. Where in the US, it approaches six or seven cases per thousand, and the US vaccinates the most.

Speaker 8: Did you have to adjust for poverty or hunger? Were there adjustments that you had to make?

Gary: What we found was a very high correlation, and in our original article, you have limited space, but there were ten factors that

another researcher adjusted for, and the correlation still remained at 62% which is considered high. Then, I and another colleague, Neil C. Miller, investigated 20 years of vaccine adverse event reporting system, the VAERS database. We tallied the number of doses that each child received, and the children that received the most doses of vaccine on any one doctor's visit had the greater risk of hospitalization or death.

Speaker 8: Wow, I think other people have done that study. I've seen that, unless it was all your work, I've seen it, and it's very scary. Again, I'm going to ask you. What is your personal belief now? Would you want your grandchildren vaccinated?

Gary: Each vaccine has to be evaluated on its own merits. From what I've studied, the hepatitis B does damage to the liver upon delivery. Also, it is not as effective as it has been promoted. Then there's an HPV vaccine for women, they advertise one less will have cervical cancer, but really, one teen has died every month from that vaccine.

Speaker 8: They're giving it to boys, too.

Gary: Yes. If science actually listened to the data that is prevalent and already available, I feel 50% perhaps of common illnesses could be eliminated because we know the effect that ... the harmful effects of the protocols that we're using. What is happening is the pharmaceutical industry along with the legal profession, the FDA, the CDC, the monitoring refuse to document the negative, what I call the deleterious cases that exist.

When you evaluate only the positives and leave out the negative, you always have a success story, but it's an unbalanced cost-risk benefit. You see the healthcare situation as we have it today: extremely high medical costs to treat one problem like varicella. You get rid of chickenpox, but now you need a second dose. Now you need a shingles vaccine to boost adults. So you're in a cycle of disease and treatment.

It was really a sad state of affairs for scientists or researchers that want to do objective research. They're almost always forced, if they're going to get paid, to follow the precepts and goals that other superiors have created. What's interesting is what we see are experiments being conducted and people know the results, they're purposely using rats that don't get influenza to show safety. They're looking at the measles component of the MMR vaccine. They find it in the gut, but they'll look in other places, claiming, Oh, we didn't find anything. They structure in a very methodical way, a study that appears on the surface scientific, but the methodology, the concept, it's already known that they're going to find an optimistic answer to support their drug.

People get too focused on the greed of the situation. The varicella vaccine goes to 4 million children at over $70 a dose and I just feel that with the positive bias on the studies, some physicians think ... Oh, I'm really doing what is in the best interest of the children, all the science supports it. They're not getting the full story. Even my own supervisors agreed that the basic mechanism when you eliminate chicken pox, you increase shingles, but they knew Goldman, that will take twenty years to become manifest, so by then Merck or whatever manufacturer markets their product, gets reimbursed for research and they have an element of success until so many legal issues start to be pending, then they have to do an adjustment.

As an ethical person, I feel really that there's nothing I can do. I've done all I can by reporting honestly what data shows, and so hopefully it will accumulate with future data of other researchers, and they are accumulating over time. People are starting to see the toxicological studies where mercury goes off the chart when you do a toxicological study of some of these children with autism. They've been mercury poisoned. Granted, there is partly a genetic component, but there is a component that the vaccines trigger these problems. Mitochondrial disorders and others.

We need much more independent research. It's certainly possible in this computer age to track the adverse outcomes much more than using a passive VAERS database that can get 1/100th, or one case out

of a hundred that exist. With improved data collection, with the independent structure, you can get to the root cause of disease and the real cost and risk benefits and I think you could eliminate perhaps 50% of the health costs that we see today.

Just to exemplify that, children are given the chicken pox vaccine. Then they need now, a booster, but without the chicken pox in the natural environment, shingles in adults goes up, so now they have a shingles vaccine to give the adults the boost they were getting for free. So you have this cycle of treatment and disease that could be eliminated.

Speaker 8: Stephanie, thank you very much for letting me come into your office.

Stephanie: I'm delighted to do this.

Speaker 8: Can you start off by telling me who you are, where you are, and what type of position you have where you are, and what kind of work that you do?

Stephanie: My name is Stephanie [Zaniff 01:42:59] and I'm a senior research scientist at MIT, where I have been for all of my adult life. Undergraduate, graduate school, and then staying on as a researcher for the rest of my life. My research is in computer science. I'm at the computer science and artificial intelligence laboratory at MIT. My research is in computer science, but I have an undergraduate degree in biology with a PhD in computer science and I have been over the last six years, switching back to biology, combining it with computer science, to use computer science techniques to help me understand biology and to form connections between health and environmental toxins.

I've been studying autism, really really wanted to get to the bottom of autism. I could see that the rates were going up and up and up, and six years ago, when I also started studying the statins, I also started studying vaccines because I figured vaccines ... a lot of people have said vaccines might be related, there's the mercury ... So I looked at the VAERS database, the vaccine adverse event reporting

system, and very powerful to use VAERS database and use exactly the same procedures that we used for the statin drugs on the vaccines.

We discovered all kinds of interesting things. Again, you go back to the literature, you study the literature. It's always a combination of looking at the data in some database and relating it to the data literature, and using the same computer science techniques on both sets of data to interpret the biology behind the things that you're seeing from the analysis.

Speaker 8: So you're saying you're looking at one database, which is patient-generated, again, the VAERS reporting system is a national reporting system, but it's generated from patients adverse events from the vaccination, correct?

Stephanie: Yes. Right.

Speaker 8: Then you're saying that you compare that to the data that you can find in the research on the vaccines or on the Roundup or on the statins, whatever it is-

Stephanie: Even on the symptoms that you're seeing from the vaccines. With the vaccines, for example, we related it to of course, autism, and others have shown this too. For example, we found 0.001 as a P value for the likelihood of this distribution occurring by chance, which means that it's extremely unlikely that it's occurring by chance, and looking at the relationship between the hepatitis B vaccine and autism.

Speaker 8: Many factions of the government say it's a genetic epidemic-

Stephanie: I know, and I find that very frustrating because they're spending so much money. Even here at MIT, a lot of money is being spent on the genetic aspects of autism, looking for the genes that might be causing autism, which I think is really ... We may learn something, we are learning something from the genetics because you're finding out

which genes are being hurt by the environment, is what you're finding.

Speaker 8: So which genes may be activated or suppressed or altered from environmental triggers-

Stephanie: Exactly, yes, and then I think the environmental triggers will actually cause the genes to mutate as an attempt to try to find some other way to work, that's going to work better than the way it is now, because in the context of this environment, that gene isn't working properly. It's being disrupted, and those genes being affected are the ones that are under siege by the environment. That's helpful because that's actually one way that you can point to sulfate. I got to sulfate both from the statin drugs and from the vaccines.

It was really interesting that I was studying autism and I was studying heart disease and the two studies merged into the same story, which was sulfate.

Speaker 8: How does the sulfate fit into the vaccine and the autism story? You don't have to go into all the minutiae in terms of the [crosstalk 01:46:31]

Stephanie: The aluminum. What we found was aluminum. Mercury was phased out around 2000 and then they said they autism rates didn't go down, so clearly mercury's not the problem. They dismissed it. This was the wrong way to interpret it because at the same time as the mercury was phased down, aluminum was phased up-

Speaker 8: But Mercury wasn't really phased [crosstalk 01:46:52]

Stephanie: No, and now they're all about flu vaccine which is driving me nuts. Flu vaccine for young children, flu vaccine for pregnant women, I think this is insane.

It was really interesting because we took the set of vaccines after 2000 and then we took all the vaccines before 2000, again, get this age match distribution. Same thing we did with the statin drugs, exactly the same, and you find symptoms that show up with much

higher probability after 2000. These were cellulitis, seizures, infection, death. These were all showing up much more frequently after 2000 than before 2000.

Now if you take all the vaccines over the whole database, and you do the same thing but you say all the vaccines that contain aluminum and all the ones that don't, and you compare those two sets, you find exactly the same set of symptoms that are occurring more frequently after 2000 are also occurring more frequently in the aluminum-containing vaccines over the entire database.

Speaker 8: Aluminum is considered [GRAS 01:47:51] by the governmental health agencies, meaning generally [crosstalk 01:47:57] ... They're generally considered safe, so-

Stephanie: Three key things that I've identified are really devastating in a modern environment for the very reason that they're considered safe: aluminum, statin drugs, and glyphosate. Glyphosate is Roundup. These are all accepted as somehow okay. Aluminum, you think of aluminum pots and pans, aluminum foil, it's like around everyone. People don't think of aluminum as being toxic, but aluminum is extremely toxic. Especially if you inject it. You get past all the barriers, because your body is able to keep most of it out, if you get it through your gut, but when it's injected under your skin, you have no control. All of it is going to get in, and again, depending upon how much sulfate you have available, if you don't have enough sulfate, the aluminum will make its way to your brain. That's going to cause things like autism.

Speaker 8: Are there other ingredients in vaccines that might reduce sulphate or open-

Stephanie: Mercury, for example, for sure.

Speaker 8: Are there vaccines with mercury and aluminum-

Stephanie: Yes, exactly, mercury and aluminum are in Gardasil. Gardasil is an incredible vaccine. We looked at Gardasil and compared it to all the

other vaccines, same age match distribution, and Gardasil was the worst thing we had ever seen, in terms of the symptoms that were showing up. Coma, death of course, spontaneous abortion or stillbirth of an 8 month pregnancy, seizures of course, many things that correlate with aluminum but also additional things like the coma and unconsciousness that-

Speaker 8: A lot of unconsciousness.

Stephanie: Yes, very much so. Really terrifying. I was really shocked when I saw what Gardasil was showing up, compared to age match distribution of all other vaccines.

Speaker 8: If you could talk about the findings on the VAERS reports on Gardasil specifically, what stands out in your mind the most from these adverse events from Gardasil, in terms of being larger or greater amounts from all other vaccines?

Stephanie: Yes, Gardasil has an amazing list of reactions that stand out with high probability compared to other vaccines. They include some very serious things like coma and unconsciousness, as well as death and death of the child. You get a person who's pregnant getting a Gardasil vaccine and having a spontaneous abortion, or an 8th month term stillbirth.

Speaker 8: When you're reading this, what's going through your mind? You're reading about the studies and you're seeing all these stats?

Stephanie: I know. Disbelief is one thing. I don't understand how the government can be promoting so enthusiastically, not just for girls, but for boys ... They're trying to extend it to be practically everybody it seems like, a serious toxin, that's causing great grief and heartache to people who are being exposed to it.

Speaker 8: Let me ask you specifically about the deaths. Have you found, when you've looked at the data, post-Gardasil, because many people say, especially the industry says that that many children die, 2 out of a thousand or 2 out of two thousand, girls between that age die

anyway ... Have you found groupings of deaths? Have the deaths been ... Does it make sense that all the deaths in the placebo and the control group died evenly over the period that we're looking at, or were there unusual things about the deaths? Was there something that stuck out that you were convinced, these deaths were from the vaccine?

Stephanie: Both what they died of, and one thing they died of was suicide, and one of the things that aluminum has is depression. Aluminum is strongly associated with depression. So it makes sense that they would die of suicide, and suicide within a few days of the vaccine was happening repeatedly in these data.

Speaker 8: Within a few days?

Stephanie: Within a few days of the vaccine.

Speaker 8: So all the suicides, they weren't spread out over the year or two years, all within a few days?

Stephanie: I think pretty much all the suicides were ... I would have to go check, but most of them for sure were within a few days of the vaccine. I think the vaccine just makes them so incredibly depressed that they cannot cope.

Speaker 8: Right, you cannot imagine volunteering for a trial when you're blaming it off on yourself.

Stephanie: Of course, if you get accidents, like a car accident. That's going to be because you had a coma. You would think, if they're going to cause coma and unconsciousness, you don't want to be driving, you know? That's possible.

Speaker 8: So like a fainting spell?

Stephanie: Yes, exactly.

Speaker 8: Or seizure.

Stephanie: Yes, seizures too, that's right. These are all things that would disrupt driving.

Speaker 8: So were the rest of the deaths aside from the suicides, were they all around the same time, were they early on? Were they so many days out?

Stephanie: Most of them were soon after the vaccine, some of them were long after, but you do have a complex ... Once you have this, your body gets into this mode where the sulfate's deficient, it can take some time for that to develop into a crisis. It doesn't mean just because it happened several months later, that it wasn't because of it.

I don't, in fact, believe in vaccines, period. I think at this point in my life, I would say that no one should be getting any vaccine. I had to get to that point over time.

Speaker 8: How long did it take you to get ... That's a really extreme position-

Stephanie: It is an extreme position and at first, you would say well, polio, smallpox, those are really bad things and we should just ... very fine vaccines that we have all had. I have come to appreciate that biology ... We live in a symbiotic relationship with all the other species, and all of them, even the pathogens, are doing something good for us.

This is something I'm really excited about lately that I've learned about the flu vaccine. I'm actually going to be giving some slides on that in November. I'm giving a whole day seminar in November. One of the topics will be the flu virus, and what's really interesting about that virus is that it goes into the muscle cells and it reprograms them to basically hand over their sulfate to the flu virus. Then the cell releases those viruses and they carry the sulfate on their backs and they deliver it to the blood, so what's happening is the flu virus is rescuing the blood from a meltdown.

When you look at it that way, you think, Oh my goodness, the ... When you get sick with the flu, it's actually helping you out.

Speaker 8: Are there other people, I mean, are you alone in this venture or are you-

Stephanie: I have come across a few websites where people have toyed with that same idea, which was very pleasing to me to see that, but I can't ... but no, it's very few. Very few.

Speaker 8: Well certainly anti-industry, I mean it's ... it kind of disrupts the notion that we need more and more drugs, and newer and newer generations of antibiotics and more pesticide. If it really were a part of the ecosystem, we should be balancing the ecosystem-

Stephanie: We should be-

Speaker 8: There's no room for these high tech chemical solutions.

Stephanie: No, we should be pro-life rather than anti-life, and I think this is what we're going to finally realize. I just hope it won't be too late because it's very disturbing where we're headed right now. I sort of see no end in sight, and I cannot imagine what it's going to be like in 20 or 30 years.

Patrick: Well I hope you enjoyed the abundant information that we presented to you today. Tomorrow is another spectacular day. We have part 2 with my interview with Dr. Brian Hooker. If you saw part 1, you're probably on the edge of your seat, waiting to see what he's going to say next. I'm really looking forward to bringing that to you.

Tomorrow is also another very unique day because for the first time, we're going to be showing a film in its entirety. This is an event. This is a worldwide premiere of the film Vaccine Syndrome by Oscar-nominated filmmaker, Scott Miller. If you know anyone who's in the military or a first responder, this isn't a maybe, this is a must. They have to see this. If someone you know has family members that are in the military or are first responders, they need to see this information too. This is a very powerful and riveting film that we're going to be showing for the first time ... ever, that anybody is going

to see this film in its entirety, through Vaccines Revealed, and that's a part of tomorrow's episode.

Now I know that there has been, since we started Vaccines Revealed, with episode one, an enormous amount of content, and not everybody can see everything along the way. In addition, there are people who want to own this content, and you can own this content. On this page, you can see that we have silver and gold packages. We had a very sincere goal to make this affordable to anyone, so we have a variety of packages in the silver and gold category that you can look at and own for yourself and have this as a repository of information that you can use for the rest of your life.

Check out what we have to offer. Support us in this mission by owning this content and let's do something in the world that can really change what's wrong relative to this vaccine issue. I look forward to seeing you tomorrow.