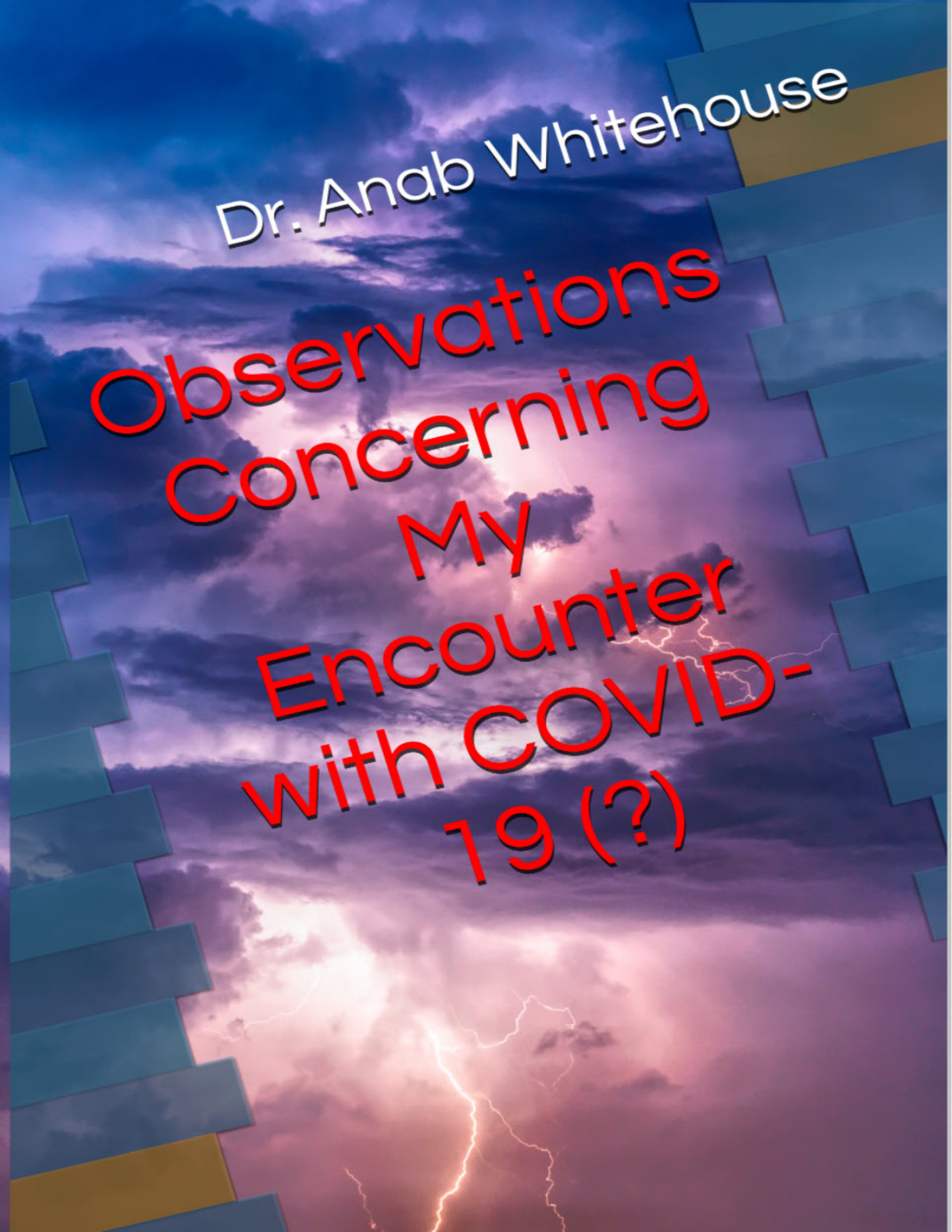
Dr. Anab Whitehouse
Observations Concerning My Encounter with COVID-19 (?)

Interrogative Imperative Institute

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A Very Brief Forward

For the last month, or so, I have been recovering from a fairly serious illness that began in late September 2021 and continued on throughout most of the month of October 2021. Many individuals -- whose understanding has been shaped and framed by sources that, for various reasons, cannot necessarily be trusted – might be likely to have assumed that the illness against which I have been struggling was nothing other than a manifestation of a viral infection caused by SARS-CoV-2. For reasons that will be made clear during the course of this book, such an assumption is not necessarily warranted.

This book has been written, for the most part, during my period of on-going recovery. It gives expression to a variety of observations that have been made concerning the whole COVID-19 narrative and what relevance, if any, that narrative has in relation to my recent bout of illness.

Introduction – Differential Diagnosis

Suppose a person has a slightly elevated temperature and/or chills, a bit of a cough, along with a certain amount of fatigue, as well as some sort of relatively minor or low-level respiratory disturbance or difficulty in breathing (e.g., one's breath catches occasionally). This person shows up in someone's examination room – whether at a community health center of some kind, a doctor's office, or at the emergency room of a hospital. How would a medical clinician go about trying to assist that individual?

The process of differential diagnosis that takes place in medical settings tends to give expression to a set of protocols for processing biological, physical, and historical information that has arisen in conjunction with a wide array of clinical experiences involving presenting symptoms of potential clients over a long period of time in different localities, both foreign and domestic. Moreover, such a diagnosis can be affected by when, where, and through whom such a methodological process takes place.

For example, the kind of medical training undergone by a given medical practitioner might impact or orient how that clinician goes about interpreting the aforementioned presenting symptoms. Moreover, the sort of "official" standard of care that governs how a medical facility tends to engage those sorts of symptoms could also affect how a clinician who is employed by such a facility might proceed as that medical practitioner works while operating under the guidance of such established – both informally and informally – standards of care.

Furthermore, when and where the aforementioned symptoms present themselves could play a role in shaping a clinician's decision. Thus, at one point in time and in one set of geographical circumstances, the symptoms might be attributed to being caused by some sort of infectious/contagious element that is believed to be active in a given location, while in other instances such symptoms could be attributed to the impact that various kinds of environmental toxins or poisons are known to be having on some people in a given geographical location.

Of course, one must also take into consideration the person who is presenting the previously noted set of symptoms. Part of the problem

associated with engaging in a process of differential diagnosis is to try to determine how a given set of symptoms might relate to a potential client both with respect to possible long-standing, chronic problems of health endemic to such an individual as well to try to discern what role, if any, the presenting symptoms might play in conjunction with whatever possible acute, contingent circumstances that could have arisen in that individual's life within a relatively short, recent temporal framework.

Differential diagnosis is part methodology and part art. The process is rooted in both empirical data but, as well, gives expression to elements of interpretation and, sometimes, intuition … elements of interpretation that some clinicians are much more gifted or talented at providing than are others. Subsequently (especially in Chapter 17), I will return to some of the problems that can emerge within the context of a process of differential diagnosis.

Naturally, there are a variety of tests and augmented forms of analysis (e.g., blood work ups, imaging techniques of various kinds, etc.) that often are used in conjunction with a given framework of differential diagnosis in order to try to either eliminate various possibilities or try to narrow down the set of considerations to be taken into account in order to reach a diagnosis that can be treated in one fashion rather than another. For instance, in today's medical environment, one of the tests that often is used in conjunction with the set of symptoms outlined at the beginning of this Introduction with respect to an individual who is being engaged through a process of differential diagnosis involves the so-called PCR test – that is, the Polymerase Chain Reaction protocol.

A little later on much more will be said of a critical nature concerning the whole PCR issue. However, for present purposes, let's assume that such a protocol is administered in order to either allegedly "confirm" or reject the idea that a person who has presented with the aforementioned set of symptoms is exhibiting signs of COVID-19.

<u>Chapter 1</u> – Disease, Somehow, Arrives At My Door – Some Context

My wife's place of work had established a set of guidelines for engaging possible cases of COVID-19. One of her fellow employees (along with at least one other individual who had some degree of oversight responsibilities concerning such potential breaches of established COVID-19 protocols) ignored those guidelines and, nevertheless, that employee came to work in some sort of sickened condition and, as a result, proceeded to share her existential condition with other individuals (including my wife) who had been present at work on that occasion.

A few days after the foregoing incident took place, my wife had been attending an art class that was being run by a prominent, state artist in another town an hour, or so, away, from our home. Following the art class, my wife received a call from her employer indicating that on a date when she had been at work, someone had tested positive for COVID-19 via a so-called PCR test, and, as a result, my wife withdrew from the art class that had been scheduled for the next day and went about the business of trying to determine whether, or not, she should quarantine at her home.

Her situation was complicated by the fact that she had a husband – namely, me. I had not been at her place of work when the aforementioned disregard of established COVID-19 protocol had transpired, but, nonetheless, if my wife had been exposed to something on that occasion, then, there could be some sort of likely probability associated with the foregoing incident that entailed the possibility that the nature of her exposure – whatever that might be – would become extended to me in some fashion as well.

My wife arranged to do a rapid-PCR test. The process came back with a positive result for – supposedly – the presence of the SARS-CoV-2 virus.

For reasons to be explored later, I did not go through the same sort of testing procedure as my wife. As far as I was concerned, my condition was whatever it was, and I would try to deal with whatever -- if anything -- that might arise in conjunction with that condition if and when it manifested in the future.

Within a few days following her positive test, my wife began to experience some symptoms. She had a persistent, but low-grade fever. She developed a cough and had a few respiratory issues that affected her breathing at times but nothing that seemed to be of a serious nature.

Subsequently, she lost her sense of smell. Although that sense of smell has – to a limited degree – returned, it still remains fairly impaired.

She had decided that, perhaps, it would be best if we slept in separate bedrooms. Although she still had not been given (and, actually, never received) any direction from her Human Resources Department concerning the issue of home-quarantining, she hoped that our relatively separate sleeping arrangements (she had her own bathroom as well) might reduce my exposure to whatever was taking place.

My wife's much more serious symptoms appeared a few days later. She was staying in an upstairs set of rooms, and I was staying on the ground floor.

At some point, I heard a series of quite-pronounced bumping noises in one of the rooms above me. It seemed to go on for a short period of time, as if there might be some sort of thrashing of a body on the floor.

I called out, but there was no immediate response. I went up the stairs and found her on the floor near one of the doorways to a smaller room.

She had been about to come down stairs, but, instead, she had collapsed just prior to moving to the stairs. She was somewhat dazed and not quite certain what had taken place, but, as I arrived, she was conscious and resting while also attempting to regain a sense of orientation with respect to her on-going condition.

If she had collapsed while trying to negotiate the stairs, the situation could have been far more problematic. Fortunately, this was not the case, but we decided that in view of what had taken place, she needed to stay downstairs for the remainder of her illness.

My wife is 61 years of age. She has some underlying conditions concerning various kinds of health issues, but, she is not only taking

medications for those challenges but, as well, she is trying to change the way she eats and exercises, and, as a result, recently received some very good test results concerning improvements in her condition of health.

Although my wife continued to have a low-grade fever, cough, some fatigue, as well as no sense of smell, she experienced no further deterioration of symptoms. Eventually, the fever broke, and she was left with just: A cough, a few breathing issues that, from time to time, asserted themselves but were of a manageable nature, and a continued absence of her ability to smell.

My symptoms were on a schedule that, approximately, was three to four days behind the ones that my wife had experienced. I am 77 years old and almost five years ago had died – several times -- from cardiac arrest before being revived electronically, given some stents, and, then, put in a medically-induced coma for a number of days before being brought back to consciousness and being provided with the opportunity to have a few more stents placed in me.

Somewhere along the line, I had learned that less than 20% percent of the people who went through the physical/biological trauma that I did survive. I further discovered that when individuals are placed in a medically-induced coma as I had been, fewer than 10% of those people are able to come back without experiencing some sort of neurological problems. By the Grace of God, not only did I survive, but, as well, there seemed to be no neurological deficits that appeared within me … although I am sure that there are those out there in the world who might question the accuracy of the latter claim.

Due to the powerful assortment of drugs that I had been given while in a coma, when I returned to consciousness, I went through a round of medication-induced madness. I had become convinced that the medical staff was conspiring to ship me off somewhere to another part of the world so that my organs could be harvested, but, eventually, this delusion began to wane, and a process of real recovery began to take place.

In any event, five years later – that is, present time (October - 2021) -- I had begun to encounter what was, in some ways, an even more challenging set of circumstances than had taken place when I almost died. Like my wife, I had developed a low-grade fever of some

kind, a low-level cough, a loss of my sense of smell, but something else, much more pernicious, began to occur.

For several nights I felt – in hard-to-describe phenomenological terms -- like I was engaged in a series of skirmishes with something or other. I experienced one kind of attack after another that, in some way, seemed to be directed toward my consciousness.

The attacks were not specific, but I could sense a certain degree of deterioration in my mental functioning. I couldn't think straight, and a circle of dullness seemed to have settled in to part of my mind.

During this period of time, I had tried to type a few e-mails to several individuals. However, my hand, eye, mind co-ordination were filling the attempted communications with all manner of errors, and no matter how many times I would try to slow down and concentrate and finish the very short e-mails, I would just make more and more mistakes.

Furthermore, I am Muslim, and, so, God willing, among other things, I try to say my daily prayers. Unfortunately, my mental condition was such that I couldn't remember what to do and was unable to repeat verses of the Qur'an that had been uttered by me for more than fifty years on a daily basis.

I went and got some typed copies of the prayers and tried to just follow along with the written words. I didn't succeed.

At some point, I collapsed to the floor and had lost all capacity to function. My wife was quite concerned, as I had been when she had collapsed previously in a room upstairs in the house.

Eventually, I was able to sit on the bed near where I had collapsed. My wife and I were going to try to move me to another room.

While trying to make such a transition, I would shift a few feet along the edge of the bed where I had been resting but had difficulty doing so. The progress for moving toward the other room was painfully difficult, both for me as well as my wife who was trying to help me.

The foregoing incident was followed by a period in which – although I was in a sitting position -- I just was completely absent. Subsequently, my wife informed me that my fingers were making

strange, uncoordinated movements … she could see that there seemed to be nobody of a conscious nature at home in my body.

Although I recovered from the foregoing condition within a matter of a few minutes, my condition was not good. Somehow, my wife helped me to get to the living room, and it was in that location that she began to administer to me in a manner that I believe is, to a great extent, responsible for my still being alive and kicking today.

Upon reading the foregoing account, some individuals might wonder why I wasn't taken to the hospital or why an ambulance wasn't called to transport me to such a facility. My wife was in a difficult situation because prior to anything of a problematic nature happening with respect to my health during the age of COVID, we had a conversation about various possibilities, and during this discussion I tried to explain to her why I was not prepared to go to the hospital.

Although my wife is not naïve about some of the problems that exist within the allopathic system of medicine that largely is in control of medical issues in America, nevertheless, she believes – from a practical point of view – that if certain kinds of health problems arise (e.g., a few years ago I had an umbilical hernia that needed to be surgically repaired, and this was done successfully), then, seemingly, what choice does one have for dealing with those sorts of emergencies other than to go to the people who supposedly are capable of dealing with those matters. Without wishing to deny some of the wisdom that is present in my wife's perspective concerning the idea of seeking assistance from medical practitioners when there might be a need to do so, nevertheless, prior to my current illness, I had been starting to explore a somewhat different approach to the idea of health than that which tends to be offered by much of allopathic medicine and notwithstanding whatever merits the allopathic approach to health and wellness might have, there were reasons why I wanted to go in a different direction.

For instance, about 13-14 years ago, I had several operations on my face to look after a squamous cell cancer that had developed. Mistakes were made by some of the medical practitioners who were involved in some of those treatments, and among those mistakes were the following: (1) the medical practitioner who performed the initial surgery said that it was unlikely that any cancer was present and felt

that no biopsy was necessary to confirm such a judgment, and it was only after my wife insisted that such a biopsy be performed that the discovery was made that cancer was still present; (2) a second surgery was performed by another medical practitioner at the health facility to which I was going but, for whatever reason, they were dragging their feet about reporting back to me concerning whether, or not, any traces of cancer were still present in the margins of the biopsy that had been taken at the time of the second surgery, and as a result, a friend of mine from another state who had been an emergency room physician for many years – including heading up the emergency services for a well-established hospital – offered to intervene and contact the medical practitioners who had been operating on me and try to induce them – which he did – to act in a more proactive way with respect to me case.

The foregoing set of incidents were among a series of such medical misadventures that transpired over the next ten years that sent me down a road of questioning concerning the manner in which medicine is often practiced in America. Another episode from the foregoing sort of series of events involved a severe, and rapidly moving allergic reaction that seemed to be spreading across my body as a result of one of the medications that had been prescribed for me following my heart attack.

On the occasion of the aforementioned severe allergic reaction, the community health facility that I had been attending for a number of years was using a medical provider of some kind who, when that individual learned more about my condition nonetheless, refused to contact the cardiologists who had been looking after me since my heart attack. He claimed – in a rather unnecessarily aggressive and defensive manner – that it was too late in the day to do so, and, consequently, he had to be reminded by my wife (I was actually not in any condition to advocate for myself) that the cardiac facilities to which he was referring operated on a 24-hour basis of availability for emergencies and consultations concerning such matters.

Contact finally was made with the cardiologists by the individual who had been so resistant to offer medical assistance in conjunction with the on-going severe drug reaction. The matter was resolved when

one medication (the one to which I was allergic) was discontinued and another replacement pharmaceutical was introduced.

However, prior to going to the aforementioned community health facility, my wife and I had gone to the emergency services of a local, fairly prominent hospital. The practitioners there performed all manner of tests, charged all kinds of money, and, in the end, did exactly nothing for me – in fact, they never actually addressed the issue of the severe drug reaction that was taking place before their very eyes as a result of medications that had been prescribed for me just a few days before by the very same hospital to which the aforementioned emergency services were attached.

A few years later I read about the experiences of Dr. Susanne Humphries in connection with a hospital that was located only five minutes away from me. She was part of the nephrology department at that facility.

She indicated in her book *Rising from the Dead* that prior to 2009 she had never questioned the safety and efficacy of vaccines, and, as a result, she had been quite willing to administer them. 2009 was the year in which, according to some overly imaginative medical modelers and practitioners, the Swine Flu was going to kill millions of people around the world … something that didn't even remotely come close to happening.

For whatever reason, there was a shortage of the Swine Flu vaccine. Consequently, only those who were considered to be at risk were being given the vaccine.

At some point, Dr. Humphries saw a dialysis patient who seemed to be quite upset. When she asked the individual how long he had been on dialysis, he replied that his kidneys had been fine until he had gotten the flu vaccine.

She investigated the man's case. All of his medical records indicated that up until a month before he received his flu shot, his kidneys had been functioning normally.

From that point onward, she began to ask various patients who seemed to be caught up in strange case presentations concerning their kidneys about whether, or not, they had been vaccinated at any point leading up to whatever kidney problems they were encountering. She

discovered that there was a clear time relationship between receiving the flu vaccine shot and the emergence of their problems, and, subsequently, after some time had passed, she eventually did a video entitled "Honesty versus Policy" which provided an overview and commentary on the many cases of the foregoing sort that she had encountered.

In the meantime, Dr. Humphries decided that she should present some of her findings to the chief of medical staff for the hospital. She spoke to him about three patients who had received the flu shot who went on to develop kidney problems despite the fact that in the months prior to their difficulties emerging, there had been no history of kidney issues prior to receiving the flu vaccine.

The chief of the medical staff automatically responded that whatever was going on had nothing to do with the vaccine. He was of the opinion that those three individuals had contracted the flu and that the vaccines simply didn't have the necessary time to work.

Dr. Humphries found the answer unsatisfactory. None of the three patients had been exhibiting any symptoms of the flu prior to either receiving the flu injection or the development of kidney problems not long after receiving that jab.

According to Dr. Humphries, while it is true that, very rarely, an influenza infection can, by itself, give rise to a case of interstitial nephritis that leads to kidney shut down, nevertheless, in her many years of working as a nephrologists in large tertiary care facilities, she had never encountered such a case. She wondered about the likelihood of having encountered three such cases in which none of the individuals had shown signs of having flu, and, yet, each of them, despite having good kidney functioning prior to having receiving a flu vaccine, then, shortly thereafter, experience kidney failure.

What was an even more disturbing turn of events took place a short time following the foregoing set of circumstances. Dr. Humphries was admitting a patient of hers for a biopsy, and when she went to do the admitting order 45 minutes after her patient arrived, she discovered that her patient had been given a flu shot prior to Dr. Humphries arrival and that Dr. Humphries name was given as the individual who had ordered the flu shot despite the fact that she had not ordered the shot.

She asked a nurse about the situation. Dr. Humphries was apprised that if was now hospital policy for the pharmacist to put the name of the doctor for a patient as having ordered the flu shot as long as the patient had consented to receiving the shot.

Dr. Humphries found such a policy to be problematic for a number of reasons. To begin with, she hadn't ordered the shot, and she didn't like the fact that her name had been given as the individual who had authorized the shot when this was not the case.

Secondly, she also discovered that it was now policy for flu shots to be given to all newly admitted patients irrespective of whether such individuals were having a heart attack or undergoing a deterioration of condition due to a worsening form of cancer. There seemed to be no rhyme, nor reason, for doing so.

Finally, she objected to the policy on the ground that receiving such shots could make it more difficult for a physician to figure out what might be wrong with a patient. As such, a policy of giving flu shots patients that were being admitted to the hospital (and quite irrespective of their condition) had the capacity to interfere with the process of doing a differential diagnosis.

Dr. Humphries knew – from her own experience (prior to 2009), as well as from the experiences of other doctors with whom she talked – that most physicians had no idea what was in any given vaccine. Moreover, most doctors had no idea how such vaccines are made, nor did they understand the nature of the inflammatory response that the administering of those vaccines tend to set in motion, nor did they have any idea bout which facet of a person's immune system might be inflamed following a flu shot.

In the past, when she consulted on cases, she might have noted in conjunction with some case of kidney failure that what was taking place was due to the presence of a statin, or particular anti-biotic, or diuretic of some kind. Once such an observation was made, the medical practitioners for whom she was serving as a consultant would immediately discontinue whatever had been identified as the cause of the kidney failure that was taking place.

However, if she commented that a given instance of kidney failure was due to the administering of a flu vaccine, she was <u>always</u> met with

resistance. The automatic response was that the problem was never the vaccine despite the fact that over time, Dr. Humphries had worked out a system that allowed her to trace the deterioration of kidney function from slight, to impaired, to failing following the administering of a flu vaccine.

The hospital's medical executive meeting met to discuss the concerns that Sr. Humphries was voicing. She was not permitted to attend the meeting, and, later, she was issued a written notice that members of the nursing staff were becoming confused by Dr. Humphries directive to discontinue vaccinating her patients who were being admitted to the hospital and was told to follow hospital policy.

At some point she once again met with the chief of the hospital's medical staff. On this occasion, there also was an oncologist who was present as well.

She asked the chief why it only seemed to be her that grasped the nature of the problem with hospital policy concerning the automatic administering of flu vaccines to patients who were being admitted. Why had it suddenly become the "right" thing to do to subject incoming patients to a flu shot?

The oncologist who was present answered her question with two words. He said it was: "medical religion."

During the period in which the foregoing set of incidents occurred involving the possible relationship between flu shots and kidney problems, Dr. Humphries discovered the existence of VAERS (Vaccine Adverse Events Reporting System). Although the system had been in existence since 1986 and was intended to monitor reports of adverse events in conjunction with the administration of vaccines, she (and, as she later found out, many of her colleagues) either knew nothing about the system or, for whatever reason chose not to use it (apparently, for example, there were some unknown number of doctors and nurses who did not want to take the 20 minutes, or so, that was required to fill out the VAERS report).

As a result, many adverse events associated with vaccines were never reported or investigated, and, therefore, this reality pointed to the possibility that the potential damage caused by vaccines was being underreported. Such underreporting could mislead individuals like Dr.

Humphries' chief of the hospital's medical staff to be of the opinion that vaccines were safer than actually might be the case.

While I acknowledge and am persuaded by the case that Dr. Humphries puts forth in her book: *Rising from the Dead* concerning many facets of her critique of certain aspects of modern medicine -- and the foregoing material constitutes but a very small reflection of all that she has to say in that book about an array of topics – nonetheless, there is one item that is passed over in the foregoing account.

Hospital policy is that a doctor's name would be given as having ordered the flu shot irrespective of whether, or not, such a doctor actually had authorized the injection as long as the patient being admitted had given their consent to the shot. Now, if, as Dr. Humphries points out in her book, most doctors have no idea how vaccines are made, or what is in them, or how they tend to cause massive forms of inflammation following the process of injection, or what aspects of the immune system might be affected by such a shot, then, how is a patient supposed to give any kind of informed consent to such a process?

Such patients – or the individuals who have legal authority to make such decisions on their behalf-- are put in the same position as my wife had been placed when she was asked to make a decision when I was suspended somewhere between death and life following my heart attack and electrically charged revival. She was being asked to approve a medical plan for proceeding in my case despite the fact that the medical staff had done nothing to provide her with information about the pros and cons of such a procedure or whether there might be other alternative forms of treatment that were available or should be considered.

Yes, my condition was fragile, and, yes, for better or worse, a decision about where to go from there had to be made. However, my wife was not, then, placed in a situation in which she was being given an opportunity to make her decision based on informed consent because, through no fault of her own, she was not provided with such an opportunity. Instead, she was, in a sense, maneuvered into accepting the standard of care that the hospital had to offer without having the information and understanding that was necessary to negotiate all the nuances of that standard of care, and, as a result, there

was a form of medical abuse that was taking place not only with respect to my wife but in relation to me as well.

Similarly, there was a form of medical abuse taking place in conjunction with the aforementioned hospital policy discussed by Dr. Humphries in her book concerning the administering of flu shots to all individuals who were being admitted into the hospital as long as they consented to the injection. How could those patients – or their medical advocates – possibly be expected to know that which, according to Dr. Humphries, most doctors are not familiar with respect to vaccines? Whatever consent was being given by hospital patients with respect to flu shots was not likely to be of an informed nature, and, therefore, an important dimension of medical ethics appears to be missing from her hospital's policy concerning such matters.

There are other instances in my life involving medical misadventure similar to the foregoing that could have been mentioned. However, I would like to focus on what – for me -- was a very fundamental problem involving my treatment during my heart attack.

Earlier in our marriage, my wife and I had a few conversations about various possibilities that might arise in the form of some medical emergency. She knew that if there was a good likelihood that a medical treatment might severely incapacitate me, or leave me, in a vegetable-like state and that under such circumstances, I would prefer to be permitted to die.

Following my heart attack and near death experience, my wife now had to make some very difficult decisions under very trying emotional and psychological conditions about how – or whether – to proceed further. When asked what she wanted to do in conjunction with me, she related to the medical practitioners what I had told her in an earlier conversation about my not wanting to end up ensconced in a seriously debilitated and dysfunctional chronic condition.

The issue of stents was raised. The pros and cons of such a procedure were not explained to her, nor was she given any information about the possibility that there might be a variety of theories concerning the nature of the heart that exist and whether, or not, any of those options might be better suited to the chances of my

long-term survival without some sort of serious physical or cognitive impairment taking place.

Yes, my condition following the heart attack was tenuous and couldn't wait forever for a decision. Nonetheless, the medical practitioners attending to my case already had their own established standard of care for dealing with such situations, and, as a result, they didn't seem too interested in presenting possible alternative approaches for moving forward

In essence, my wife was being induced to make a decision about medical treatment without really being presented with an option that offered her anything approaching informed consent by the medical practitioners who were anxious to get going with their established standard of care for such situations. Consequently, she was left with little choice but to tell them to go ahead with the plan of treatment they were proposing.

The whole issue of stents is fraught with controversy. Some people swear by them, while others believe that they are not necessarily the best way to resolve whatever cardiac problems might exist, and the latter individuals often have a very different model of heart functioning than the medical practitioners who have committed themselves to the use of stents.

I remember watching one video some time ago about a person who, for medical reasons and based on an alternative theory of heart functioning, had tattooed on his chest words to the effect of: If you use stents, I will sue.' I don't know which, if any, of the different theories of heart functioning being alluded to are true, but I do believe that many medical practitioners are ensconced in their own worlds of understanding that mix together theory, clinical experience, and experimental data in ways that make sense to them – or the hospitals in which they work -- but which might not be correct, and, yet, which are used to engage in various forms of experimentation on their clients.

Sometimes, for whatever reasons, their experimentation seems to work out well. On other occasions, this is not the case.

Returning to my particular set of circumstances following my heart attack, there were several instances when one of the doctors

involved in my cardiac care indicated to my wife (by pointing to one side of his head) that one of the big unanswered questions concerning my prognosis (I still was in a medically induced coma at the time) was how all that was being done by medical practitioners in my case would affect my cognitive functioning later on. In other words, an indication was being given by the medical practitioner that there was a possibility that I might not be entirely neurologically intact after all was said and done – the very sort of thing about which I had been concerned and previously had communicated to my wife.

I do not hold my wife at fault in any of this. She had communicated with the medical practitioners in an honest and forthright manner, and she had conveyed to them my wishes on the matter, but, nonetheless, one or more individuals on the various medical teams that treated me that night decided to play God and decided that despite whatever risks there might be for some sort of neurological and cognitive impairment – whether severe or relatively marginal – nevertheless, the decision was made to proceed full steam ahead with their treatment.

Within a relatively short period of time following my being brought out of my medically induced coma – and, notwithstanding, a round of medication madness that had been given me thanks to all the potent drugs that had been pumped into me in order to keep me comatose -- I recovered my full cognitive faculties. However, in my opinion, this felicitous turn of events was due to God's Grace and not due to the brilliance of the individual or individuals who decided it was okay to gamble with my future cognitive condition.

Many people will say that it was modern medicine that made my full recovery possible. Therefore, kudos should be awarded all around to its practitioners!

Moreover, if I had come out of the ordeal with some sort of neurological or cognitive problems, many people might be of the opinion that, well, the doctors had done the best that they could, and, it was just a matter of my misfortune that their heroic efforts had gone unrewarded. Yet, meanwhile, if such neurological deficits had shown up, my wife and I would have been the ones who would have been left to deal with whatever the problematic health issues might be present in my life as a result of the decision of one or more medical practitioners to gamble with my life on the night that I nearly died. As

a result, I am not inclined to give the medical establishment a pass on their penchant for sometimes being willing – perhaps all too frequently being willing -- to experiment on, and take risks with, the lives and future health of their patients.

Furthermore, quite frankly, I don't see that kudos should be offered to the aforementioned medical team when it comes to my neurological/cognitive condition following my heart attack and medically induced coma. The doctors were waiting to see what damage, if any, had arisen from their manner of intervention, and, therefore, the fact that my neurological and cognitive functioning subsequently remained intact had little, or nothing, to do with what they did for me as much as it was a matter of what they were fortunate enough not to have done to me during my treatment.

The foregoing helps to provide a bit of a context for what comes next. Returning to the present day COVID-19 issues, my wife could see that my physical condition was very much compromised.

My wife doesn't know whether I am going to live or die. Consequently, she was inclined toward taking what she felt was an eminently pragmatic perspective and, as a result, felt that, perhaps, the best place for me might be in a hospital.

Chapter 2 -- Dr. Bryan Ardis Spills The Beans on Remdesivir

For the nearly two years of COVID-19 events prior to whatever is going on with me now, I had been doing a lot of research about standards of care and treatment protocols that had been taking place in hospitals across America. In conjunction with that research, I remember coming across several interviews involving Dr. Bryan Ardis, CEO of Ardis Labs. He had been addressing the topic of remdesivir, an alleged anti-viral drug which seems to have become part of the standard of care in many hospital settings for the treatment of what have been diagnosed as cases of COVID-19.

Remdesivir is described as an intravenous nucleotide of an adenosine analog. The theory underlying it has to do with the belief that the chemical binds to the viral RNA-dependent polymerase and, in the process, prevents viral replication by terminating the process of RNA transcription, but there is a huge empirical chasm between theory and actual clinical performance.

Dr. Ardis pointed out – and also referenced the papers that are cited by the NIH as, supposedly, medically justifying the use of remdesivir for COVID-19 diagnosed patients – that, initially, remdesivir had been one of four experimental drugs that were being tested in Africa as a possible treatment for Ebola. The results of those trials indicated that remdesivir was responsible for killing more Ebola patients than any of the other drugs that also were being tested in Africa at that time. In fact, the patient outcomes with respect to the use of remdesivir were so poor that the Safety Board which had oversight of the African trials took all of the patients off of remdesivir and placed those individuals on protocols involving the other three experimental trial drugs.

Despite the foregoing lethal history of remdesivir, the drug is now been identified by the FDA, the CDC, and the NIH as being the treatment of choice for allegedly severe cases of COVID-19 that show up in hospitals. And, yet, the drug has never been shown – either experimentally or clinically – to have any value in treating diseases of any kind.

According to Dr. Ardis, there are two studies involving remdesivir that are being touted by the NIH and CDC in an effort to establish some sort of credibility profile that supposedly justifies promoting use of

that drug to play a central role in shaping the standard of care in hospitals that is used during treatment of alleged cases of COVID-19. One of those two research studies refers back to the already-noted remdesivir trials in Africa – the ones in which remdesivir was found to cause more deaths than any of the other three trial drugs that were being studied in Africa in conjunction with Ebola. In other words, the NIH and the CDC seem to be trying to argue that the lethal record of remdesivir in Africa with respect to Ebola treatment is, now, somehow positive evidence for the efficacy of remdesivir for cases of COVID-19.

The second of the two papers to which I alluded earlier that is being cited by the NIH and the CDC to "justify" the use of remdesivir in cases of hospitalized COVID-19 patients has to do with some work that, relatively recently, was conducted by a number of researchers from China This research was funded by Gilead, a pharmaceutical corporation, and, therefore, one might have to raise questions about the possible extent to which the researchers and their sponsors were involved in some sort or conflict of interest concerning the ultimate reliability of their study.

The study focused on 53 individuals. Those individuals had been identified or diagnosed as having COVID-19.

Twenty-three percent of the patients in the foregoing Chinese study who had been placed on some sort of remdesivir protocol suffered from acute kidney failure, hypotension, and septic shock. In addition, 80% of the patients who were receiving remdesivir were taken off the drug protocol because of a multiplicity of problematic side-effects that accompanied the use of that drug.

So, like the other study involving remdesivir's lethal impact on Ebola patients in Africa, the aforementioned Chinese study somehow has been magically transformed from: Giving expression to an empirically demonstrable medical liability, to being cited by the NIH and the CDC as a justification for using remdesivir as the treatment of choice for COVID-19 patients in hospitals. Obviously, there is a major disconnect between, on the one hand, the positive claims being made for remdesivir by the NIH and the CDC, and, on the other hand, the actual clinical experience of medical practitioners when using remdesivir either in the field or in experiments.

Dr. Ardis maintains that one of the reasons COVID-19 patients are dying in hospitals is not because of the presence of a supposedly lethal virus but, rather, is due to the problematic impact that the use of a lethal drug such as remdesivir is having on hospital patients. He goes on to cite the case of his own father-in-law who succumbed while in hospital due to the way Dr. Ardis believed that remdesivir undermined that patient's health.

Apparently, use of remdesivir leads, among other things, to the breakdown of kidney functioning. Once kidney functioning is destroyed, the lungs begin to fill up with fluids.

This presence of fluids in the lungs often was interpreted by various medical practitioners to mean that some form of secondary pneumonia had begun to emerge in such patients. However, Dr. Ardis indicates that the actual problem was not some form of secondary pneumonia but, rather, was giving expression to the presence of pulmonary edema which, within a relatively short period of time, would lead toward the cessation of life.

Oftentimes, at this point, as an alleged last desperate attempt to save the life of a COVID patient, the individuals suffering from pulmonary edema (rather than pneumonia) would be placed on a ventilator. For many of those patients, this became a death sentence because there was absolutely nothing that the ventilator could do to reverse the cycle of damage that had been set in motion by the use of remdesivir.

If the foregoing is true, then, the deaths of patients hospitalized with COVID were not necessarily due to COVID-19 per se. Instead, those deaths might have constituted strong empirical indications that a serious iatrogenic disorder existed in the hospitals where the foregoing protocol treatment was, and is, being observed. In other words, the process of medical treatment (involving remdesivir) constituted the hospital's standard of care for COVID-19 patients, and it was that treatment, rather than some viral contagion, that was the actual cause of death of such patients.

A similar, but much more devastating tragedy had asserted itself under the allegedly watchful eye of the NIH and the CDC beginning in the 1990s. AZT (azidothymidine -- which, theoretically, was believed to inhibit the process of reverse transcriptase supposedly used by HIV

to replicate itself) was the drug of choice for treating individuals who – through a deeply flawed process – were testing positive for HIV. Unfortunately, like remdesivir, the use of AZT treatments turned out to be what was killing thousands of individuals (in Africa and in the United States) rather than as a result of some unproven claim that HIV caused AIDS.

Fauci was well aware of the remdesivir debacle that had occurred during the Africa Ebola trials. He knew from those trials that remdesivir was both ineffective and highly toxic.

Nonetheless, on the basis of some 2017-2018 research of Ralph Baric involving bat cultures that had been obtained in certain Chinese caves and which were worked on at the Wuhan Institute under the supervision of two trusted confederates of Fauci, Baric maintained that he had conducted mouse studies in which remdesivir supposedly impeded the replication of a SARS virus. Given (as will be demonstrated in Chapters 7 through 12) that the SARS corona virus has never been properly isolated, one can't be really sure what was taking place in Baric's aforementioned mouse study.

Ralph Baric, the gain-of function guru at the University of North Carolina, was paid six million dollars by Fauci in conjunction with the foregoing research. As a result of that work, and putting aside remdesivir's horrific toxicity profile, Fauci believed, apparently that Baric's research findings were sufficiently promising as a possible therapeutic countermeasure with respect to corona virus that they (i.e., the research findings) warranted some sort of human trials.

Eventually, Fauci was able to corral 400 hospitalized patients and place them in his remdesivir trial. Although the study supposedly ran a placebo group, in point of fact, the people in that control group were given a toxic placebo instead of the required inert substance, and, therefore, the results of the trial were skewed by the presence of such a misleading "control" group.

In addition, another subterfuge that shaped the trial was the tendency to put people who were sicker in the control group while placing less sick individuals in the experimental group. Such a maneuver was likely to bias the outcome of the trial, and, yet, notwithstanding the foregoing sorts of perversions involving the scientific method, the people running the trial were unable to

demonstrate that remdesivir had any sort of constructive impact on the survival rate of people who supposedly were suffering from COVID-19.

One other methodologically illicit move made by the individuals who were running the remdesivir study for Fauci involved changing one of the protocols while the trial was still on-going. More specifically, the overseers of the study discontinued the original endpoint of the trial – namely, to lessen the number of people who died – and substituted a less stringent endpoint – namely, shortening the length of time a patient stayed in hospital.

However, even that underhanded tactic did not bring the positive results for remdesivir that the researchers sought. While the patients in the experimental group initially might have been released from hospital sooner than was the case for individuals in the control/false-placebo group, nonetheless, the people in the experimental group were having to be readmitted to the hospital at twice the rate as the patients in the control/false-placebo group, thereby indicating that many people in the experimental group were being released from hospital despite still being sick.

At this point, the result of Fauci's remdesivir trial had not been published. Nor had the results of that study been peer reviewed.

However, there was a Chinese study about which Fauci knew concerning remdesivir that had been completed, peer-reviewed, and published (*The Lancet*). Moreover, unlike Fauci's remdesivir study, the Chinese study was a randomized, double-blind trial that involved a true placebo group (i.e., the people in that group received an inert substance rather than remdesivir).

The Chinese research indicated that remdesivir neither helped people in the experimental group to stay alive longer than individuals in the control group, but, as well, remdesivir did not shorten the length of a patient's stay in the hospital when compared with members of the control group. Furthermore, the Chinese study revealed that remdesivir was as toxic as the African Ebola trials had shown it to be since more than twice as many patients in the Chinese experimental group (i.e., the group receiving remdesivir) encountered serious, debilitating health problems than did members who were in the control group (i.e., the individuals who received the placebo).

Rather than acknowledge that the available evidence indicated that remdesivir was an ineffective, toxic, and dangerous drug, Fauci doubled-down. He did this by using the opportunity afforded by a meeting in the White House with President Trump to announce the "good news" that: "The data shows that remdesivir has a clear-cut, significant, positive effect in diminishing the time to recovery," and, therefore, not only was remdesivir of benefit to COVID patients, but, as well, he felt it would be unethical not to remove the blind from his study and offer remdesivir to the false-placebo group, and, in addition, he intended to make remdesivir the new gold standard of care for hospitalized COVID patients.

In short, Fauci lied about what the data said concerning his own unpublished study, and, in addition, he hid the degree of toxicity that was entailed by remdesivir from the President and the American public. Moreover, Fauci remained silent about the Chinese study concerning remdesivir – a study which served to contradict everything that Fauci was, and was not, saying about the alleged benefits of remdesivir with respect to the treatment of COVID.

By becoming the new gold standard of care for hospitals – not through empirical evidence but via Fauci's unsubstantiated and false claims – hospitals could now be sued for not administering remdesivir to COVID patients. As the new gold standard of care for hospitals, a highly toxic and ineffective drug was going to be imposed on COVID patients.

The FDA approved remdesivir on October 22, 2020. However, three days prior to that approval, the W.H.O. published a research paper about the effect of remdesivir on more than 11,000 COVID-19 patients in over 400 hospitals in 30 countries.

The foregoing study indicated that remdesivir did not decrease morality among COVID-19 patients, nor did remdesivir reduce the length of hospital stays for such patients, and, as well, remdesivir did not decrease the need for the use of ventilators in severe cases of what had been diagnosed as COVID-19.

Obviously, the members of the FDA committee that approved remdesivir were derelict in their duty. They did not take into account the aforementioned Chinese study, nor did those FDA members make reference to the results of the W.H.O research that were published

prior to the FDA giving its approval to remdesivir, nor did the FDA committee members give proper consideration to the degree of toxicity that was inherent in remdesivir as documented in the original African Ebola trials.

Moreover, perhaps even more egregiously, the members of the FDA committee who approved remdesivir failed to do due diligence with respect to Fauci's own methodologically challenged study of remdesivir. Presumably, it was Fauci's study that was being favored by the FDA in reaching its decision to approve remdesivir, and, yet, anyone who was unbiased and read Fauci's remdesivir study would have realized that there was a rather stinky skunk in the experimental wood pile that was being foisted on the American people by the FDA committee members who approved remdesivir for hospital treatment of people supposedly suffering from COVID-19..

While the rights of patients and their advocates in hospital settings are supposed to have final authority over, for example, whether, or not, to accept whatever medical protocols have been set in place as the standard of care for such institutions (e.g., use of remdesivir in cases of COVID-19), there are indications that some hospitals in the United States are not necessarily respecting the rights of its patients, and, in the process are treating patients more like prisoners than individuals with preemptive legal rights. Thus, Dr. Elizabeth Lee Vliet has indicated that there cases have been reported cases (e.g., such as at Resurrection Hospital, a Catholic operated hospital) in which patients or the health advocates for such patients have specified that a given patient is not to be placed on a remdesivir protocol, and, yet, this directive is repeatedly ignored. In addition, in some hospitals, patients have been denied access to family members, clergy members, as well as even their own medical advocates who have power of attorney in matters of healthcare.

Given – as was pointed out by Dr. Ardis earlier in this chapter and as was indicated during the aforementioned Chinese study – that remdesivir damages both the kidney's and lungs, as well as mimics other problematic symptoms associated with COVID-19, one needs to ask the following question: Are hospitalized COVID-19 patients dying from COVID or are they dying from the use of remdesivir followed by ventilation? In other words, are the deaths in hospitals that are being

attributed to COVID a camouflage for the substantial role that iatrogenic dynamics might be playing in those deaths?

While reflecting upon the foregoing questions, one might keep in mind that for a number of months during 2020, America was one of the few countries in the world that was using remdesivir to treat hospitalized COVID-19 patients, and, yet, more Americans were supposedly dying from COVID-19 than non-Americans were dying – allegedly – from COVID-19 while being hospitalized in many other countries. Moreover, Brazil -- which had a COVID death toll that was second only to the death toll that occurred in the United States during 2020 – was one of the few other countries in the world that used remdesivir to treat hospitalized patients who had tested positive for COVID-19.

Chapter 3 – The Stand: How My Living Room Became a Medical Alamo

I have seen the images of isolated patients in hospitals, and read how the families and loved ones of those patients often were prevented from lending emotional, psychological, and other forms of support to those patients. In the process an array of people who actually could have helped patients – and hospitals – in a variety of ways were forced to comply with an iatrogenic set of forces that systematically undermined the health of both patients and the public health of the community.

The stated reasons for requiring everyone to follow the foregoing sorts of arbitrarily and capriciously constructed set of "public health" measures was supposedly to try to prevent the spread of some sort of contagious, viral outbreak. However, as will be critically explored just a little later, the so-called science on which all manner of public health and medical decisions were being made during the COVID-19 crisis was deeply flawed.

Notwithstanding all the problematic aspects associated with an iatrogenic system that ended up killing more people than any alleged virus, I know that hidden within the medical system are many very capable and caring medical practitioners. Nonetheless, quite frequently, those individuals were prevented from exercising their compassion and competence as a result of hospital administrative staffs that were ruled over by ignorant, financially incentivized board members who often lacked any semblance of common sense but, nevertheless, were the ones who were setting hospital policy.

I did not wish to become part of such a potentially inhumane system of medical care. As a result, I told my wife that we were going to make our stand in our own home because I did not trust what might be taking place in various hospitals or within so-called community health centers. I would rather die on my living room floor than subject myself to a medical system that, especially during the COVID crisis, seemed to have become quite pathological in its behavior toward human beings.

The foregoing desire to practice a concerted form of social and physical distancing with respect to many facets of the medical system was fueled considerably by the manner in which, very early on during

the COVID crisis, much of that system – especially hospitals -- had begun to advocate for and enforce alleged public health policies such as the use of masks, social distancing, as well as promote various kinds of pro-injection perspectives concerning different theories about mRNA- and DNA-based forms of genetic therapy … injections that were processed through a laughable system of experimental trials that were prematurely and improperly discontinued and, then, refashioned when the injections were framed through the elixir of problematic forms of statistical analysis, and, in the end, proved themselves incapable of protecting anyone or preventing people from passing on toxins to other individuals and, at best, were proclaimed to be capable of helping to attenuate a few of the more surface features of COVID-19, and, therefore, were incapable of dealing with any of the more serious possibilities associated with COVID-19.

As far as the issue of masks is concerned, one might note that the purported diameter of the SARS -CoV -2 virus is somewhere between .085 and .127 microns . On the other hand , the size of the mesh work in many forms of masks is .30 microns or larger , and , therefore , masks were like screen doors that were incapable of preventing such alleged viral agents from coming and going as they pleased., and, as a result, I lost a great deal of respect for, and trust in, many practitioners within the medical system . All too many of them were genuflecting blindly before an altar of medical abuse, and their unthinking compliance with such an arbitrary system became oppressive and unjustifiably authoritarian.

There are many, many studies that have been conducted (including the recently concluded Danish mask research involving COVID) indicating that masked individuals fare no better than unmasked individuals in many clinical settings. There were even a number of studies (conducted in Boston, I believe) that had been done in which medical practitioners working without masks were associated with medical outcomes that were superior to instances in which masks had been worn by medical practitioners in similar sorts of clinical conditions.

Notwithstanding the fact that real science – as opposed to junk science – actually shows that there is no reliable evidence indicating that masks protect people against, or prevent the transmission of,

possibly contagious elements, many people in the medical and public health communities insisted that masks were playing an instrumental role in stemming the spread of the alleged SARS-CoV-2 virus. There was no real evidence to back up such a claim, but the delusion to which those claims gave expression not only persisted but became entrenched and began to govern many facets of everyday life – from Education, to: Commerce, to politics, to family life.

The medical practitioners have tried to maintain all along that they were merely following the science. However, what they were actually following was an oppressive, fascistic, authoritarian form of medical religious evangelicalism that they were seeking to impose on one and all, and they didn't seem to care about the tremendous physical, emotional, psychological, political, economic, financial, educational, and spiritual damage that they were inflicting on society.

They were not advancing the cause of public health. They were advancing their own self-serving, self-righteous, control of others at all costs fanatical cult that entailed an array of unproven assumptions, dysfunctional biases, and unverifiable claims (more on this later).

At some point during my recent illness, I was sufficiency lucid to call a doctor friend of mine in another state. We had been friends for more than 20 years and, from time to time, he had been kind enough to help me – as best he could from a distance -- with some of my medical issues.

I described to him what had been taking place with both my wife, as well as me, and asked him if there was anything that could be done to help me. Prior to my current illness, I had had quite a few conversations with him about the whole COVID-19 scenario, and his approach to the issue was very different from the sort of medical, media, and government hysteria that seemed to be dominating much – but not necessarily all -- of the world's response to the COVID-19 phenomenon since January, or so, of 2020.

Based on earlier conversations with him about such issues, I knew that he had developed a protocol for treating individuals who were exhibiting certain kinds of symptoms that were being attributed to a viral infection known as COVID-19. The symptoms that were of interest to him however had little to do with people who might have a

mild persistent temperature, or some sort of cough, or were feeling a few aches and pains or who had a touch of fatigue.

Based on his own clinical experience, he noted that people with the foregoing sort of superficial set of symptoms often got better – whether treated or not – within a relatively short period of time. However, there were individuals who were coming to him (including some medical doctors who were reluctant to trust how they might be treated in a hospital setting) that were presenting a much more severe set of symptoms – usually of a chronic nature, but, on occasion, such symptoms showed up in an acute form (as was the case with my wife and I).

The severe symptoms manifested themselves in a variety of ways. Individuals often suffered from extreme, debilitating fatigue. Part and parcel of this fatigue problem involved problems with different facets of the way in which energy is generated, distributed, and utilized within the body, organs, cells, and mitochondria.

Some individuals might also exhibit considerable respiratory distress in which they had a hunger for oxygen, but couldn't quite seem to get what they needed. Some of these people became cyanotic, and, yet, despite having low oxygen activity of some kind taking place within them, they did not become incoherent or comatose as usually is the case with such a cyanotic condition.

Another possible range of symptoms involved neurological impairment of various kinds. There also might be further symptoms involving the activity of blood, or the operation of hemoglobin, or the interaction between hemoglobin and oxygen.

A person might exhibit, in one form or another, all of the foregoing kinds of severe symptoms, or, maybe, only some of them. Moreover, whether those symptoms showed up in a chronic form or in some sort of acute manifestation, one was not talking about a relatively superficial and mild sort of physical condition that passed on its own – whether treated or not – within one or two weeks of the onset of misery.

Early on during the whole COVID scenario, my wife had purchased a pulse oximeter. When she began to have symptoms, she would test herself, but, instead of the sort of robust readings of 97 or 98 that

tended to present themselves under normal circumstances, she was going down into the low 90's.

She wasn't experiencing anything like a cyanotic condition. Nonetheless, her oximeter readings were clearly indicating that some form of persistent oxidative stress was taking place within her body.

My situation vis-à-vis the pulse oximeter was a little more complicated. My wife wanted to chart some of my readings, and, therefore, on a regular basis had been taking my temperature blood pressure, pulse, as well as any possible heart arrhythmias that might show up on limited number (and quality) of the testing instruments available to us, and consequently, she wanted to test me using the pulse oximeter.

I shied away from this. There were a number of reasons – good ones I thought -- for doing so.

My wife was already extremely stressed with respect to her concerns about both me as well as herself and our respective illnesses. I knew she was anxious concerning the issue of oxygen levels, and I knew that she had a guarded sort of trust – which I did not share -- in the ability of hospitals to help me if I were to get into serious difficulty.

For reasons previously noted, I did not believe that hospitals were going to be able to help me. I felt that it was more likely that if I were admitted to a hospital, the medical systems established standard of care – however flawed it might be – would begin to impose a set of medical protocols on me that might have a very good chance of killing me rather than helping me to become healthier.

Once both my wife and I had gone through the most severe phases of our respective neurological crashes, we had – as previously noted -- set up our COVID system of operations in the living room. Despite some degree of recovery from those severe forms of dysfunctional behavior, I was aware that I was continuing to have difficulty with focus and was completely unable to think deeply about anything for a sustained period of time.

For instance, just prior to my aforementioned neurological collapse, there was something of importance that I had promised to do for a Sufi friend of mine in Canada. Although the degree of difficulty of

that promised task was not extraordinarily complex, I knew that I was incapable of fulfilling that promise early on during my illness.

In fact, I was really not capable of moving from one room of our house to the next room just a few feet away where my computer was stationed. I looked at the daily paper a few times, but I had difficulty reading anything but headlines, and, although there were a few e-mails that I had wanted to write, my state of mind would not have been able to contend with engaging in such activity.

Some of the sounds that came from the television seemed quite assaultive. Even various color schemes that were used with different programs – especially news programs – also seemed assaultive and unpleasant.

Eventually, I found that old black-and-white Perry Mason television shows with the sound turned way down worked best for me. I found some sort of comfort in the presence of the show … it helped to keep me physically grounded in some hard to describe way just as watching television following my heart attack seemed to be able to do for me when I was in the hospital.

Recently, I learned from my wife that when I had my heart attack and was recovering in the hospital, some of the medical staff mentioned to her that they felt that my having the television on during recovery might not be in my best interests. The technology associated with the television was such that nobody else in the hospital room could hear what was being said on the television except me.

Once I had been brought out of my medically induced coma, gone through my bout of medication madness, and moved to a new, recently completed part of the hospital, I never went back to lying in bed. I slept in a recliner-like chair that was in the room, and when not snoozing, I would watch television – old comedy shows (mostly black and white) -- featuring Jackie Gleason, Lucille Ball, Andy Griffin, the Golden Girls, and a few others.

What the hospital staff who spoke to my wife about my television watching habits did not seem to understand is that I had a great need to feel existentially connected to life in a way that I could control. Watching television and living in that recliner chair was my way of doing that, and it offered me a form of comfort, familiarity, and

stability that could not be provided in any other way … as such, I felt that those television-related activities played an integral role in helping me to be able to become sufficiently stabilized to be able to leave the hospital and return home.

Recovery is about more than just receiving certain kinds of professional, medical attention. Whoever it was that spoke to my wife and questioned the wisdom of my watching television while in the hospital had a very limited understanding of the recovery process and, I feel, had failed to take into account that there are many emotional, psychological, social, and spiritual dynamics beyond the usual concerns of medical practitioners with biological functioning that might factor into whether any given instance of recovery will be successful or sustainable.

In any event, returning to the issue of the pulse oximeter, I didn't want there to be one more reading taken by my wife – especially with respect to the issue of oxygen – that might adversely exacerbate her already considerable degree of stress. Consequently, I told her not to take the reading.

Furthermore, although I realized that I was suffering from a certain degree of mental fog, I also knew that I was having absolutely no problem with breathing or with shortness of breath or with not being able to obtain sufficient oxygen, and, in fact, I sensed that my wife was having a bit more problems in this regard than I was since her cough was much worse than mine and, as well, there was a certain way that her breath seemed to catch sometimes when she was talking in a manner that, for the most part, I was not experiencing or was not experiencing to the same degree as she seemed to be.

There were a few times that I tried to test myself using the pulse oximeter, but the nature of my mental fog was such that I seemed to be getting nothing but some sort of error messages for the readout. Eventually, when my brain fog began to lift, I again tried to use the pulse oximeter.

The readings were in the mid-to-low 80s. There might have been one incident when the reading registered somewhere in the high 70s, some 20 points below what it should have been.

Nevertheless, if I restricted myself to reflecting on my actual physical condition of breathing, it was clear that despite whatever condition of oxidative stress I might be under, I was not gasping for air … I was not having difficulty breathing … I was not cyanotic. Consequently, I just decided to put the readings aside for the moment and bracket them with how my breathing was actually operating in real time.

After phoning my physician friend and running down through everything that had happened and seemed to be taking place, one of the first things he said to me is that most people in North America suffer from some form of adrenal insufficiency – sometimes only mildly, but in many other cases, much more severely -- due to the dysfunctional impact that the omnipresent electronic smog in which we are enveloped has upon different facets of our biological functioning. The smog is generated from the constant output of dirty electricity that is generated through cell phones, computers, various other kinds of electronic devices, satellites, different modes of, the process of generating electricity for industry and home uses, as well as for example, 3G, 4G, and 5G networks, Bluetooth devices, wireless technology, and so on.

Being bombarded constantly by an array of different forms of electronic smog introduces a wide variety of biologically and electrically stressful conditions into the bodies of many people – and some individuals are more sensitive to, or can become more sensitive to, the presence of this omnipresent electronic smog than other individuals. The foregoing stresses have the capacity to create havoc in, and render dysfunctional – to varying degrees -- many systems (neurological, respiratory, heart, blood, hemoglobin functioning, oxygenation, cellular, mitochondrial, and so on) through processes involving, among other things, oxidative stress of one kind or another. If this on-going electronically imposed stress cannot be managed, a person's system may begin to break down in various ways.

Adrenal insufficiency occurs when a person's adrenal glands do not generate a sufficient amount of steroid hormones -- such as cortisol or aldosterone – that, among other things, help regulate stress levels, sodium conservation, water retention, potassium secretion, and so on. While there might be a variety of conditions (for example,

Addison's disease, Cushing's syndrome) that give rise to adrenal insufficiency, the manner in which our electrically overcharged world interferes with the proper functioning of the adrenal glands has been well-established.

On the basis of what I had told him about what was happening with both my wife and myself, he indicated that, among other things, he felt my wife and I were both suffering from a serious case of adrenal insufficiency and, as a result, he was going to prescribe a course of hydrocortisone to try to help our adrenal glands to reset themselves and, hopefully, assist them to begin to function properly on their own. In addition, he began to list a series of supplements and nutritional resources that should be administered in a certain manner.

As much as my medical friend had reservations concerning many facets of the allopathic system that tends to rule over much of modern medicine in the United States, he indicated that one often knew the strengths and weaknesses of the many synthetic pharmaceuticals that tend to be prescribed in western medicine. However, he went to indicate that the whole world of supplemental medicine is overrun with an array of wild west snake-oil salespeople who are fairly ignorant about the quality, value, or proper uses of various kinds of supplements and, therefore, selecting appropriate sorts of high quality supplements can make a great deal of difference to the prospective health of a person who is consuming such materials.

My physician friend provided a list of materials, specific brand names, and a set of protocols concerning amounts, times, sequences, and so on that he felt would be important for my recovery process. My wife busied herself with ordering what was indicated, and most of what she ordered came during the next week or so.

Aside from the fact that it took a bit of time for ordered materials to arrive, we also ran into some difficulties in conjunction with getting started on the hydrocortisone regiment. Someone had died at the community health center where the pharmacy that we use is located, and, as a result, the center shut down for a day, or so. Consequently, we had to wait several days before the prescription my friend had written for us was able to be received, filled, and made available to us.

Among the many differences between the approach that my medical friend uses to engage issues of health and disease and the

allopathic system of medicine that tends to dominate Western medicine (and, remember, my friend had been trained within an allopathic oriented educational system and served as a first responder during 9/11 and had played a leading role in several emergency medical services in several states, as well as established a chain of urgent walk-in care units in a major metropolitan area, before selling that chain of urgent care facilities, and, then, setting up his own medical practice to implement his current way of engaging issues of health and disease), my friend believes that one of the most important functions that a doctor can offer is to find ways of helping people's bodies realize their innate potential for establishing and maintaining health. Rather than focusing – as does much of allopathic medicine -- on ways of intervening in the lives of people by prescribing this or that synthetically manufactured pharmaceutical as a way of trying to bring back, say, people's blood work within what are considered to be healthy parameters of operation, my friend often concentrates on helping individuals find ways to optimize the functioning of their inherent capacities for healthy living.

The protocols that were being given to me by my friend were all designed to help my body re-establish optimal ways of functioning. This began with the hydrocortisone prescription but extended out to, and enveloped, all of the other different parts of the protocol that he was proposing for treating my condition.

Because of the distance between us and because neither my wife nor I were in any condition to travel the hundreds of miles that separated us from my physician friend, there were certain aspects of his protocol that were unavailable to us. We accepted this and simply wanted to do whatever we could do with whatever might be accessible to us.

Three or four days later, all the materials that had been recommended or prescribed had arrived. We – or, perhaps, I should say that I – started to follow the protocol that had been given.

We had sufficient supplies of materials and medicines for both my wife and I. However, my wife was on certain medications and was worried about what complications might arise between what had been recommended and what she already was taking.

Moreover, for a number of reasons she also had some reservations of her own about taking hydrocortisone. Although my wife knew of my friend and had talked with him on the phone during the whole heart attack scenario as well as in conjunction with a few other health scares concerning me that had occurred, she had never actually met my friend and felt somewhat ambivalent about how to proceed.

She finally decided not to follow any of the protocol. However, she was resolute when it came to me and adhering to what my friend had been recommending.

In a sense, my wife plays the role of a sort of control group. Except, perhaps, with respect to her persistent attempts try to keep herself hydrated properly, my wife engaged in no treatment with respect to her on-going condition.

She didn't take ivermectin, hydroxychloroquine, or follow any of the protocols that many people were championing as early ways of successfully intervening in whatever was going on in the world of COVID and which, supposedly, would prevent them from becoming hospitalized. Gradually, she became healthy entirely independent of any kind of specialized forms of treatment as her body's natural potential for healthy functioning brought her back to a condition of stability.

My wife continued to have a cough. Moreover, sometimes, her breathing would catch as she talked.

Nevertheless, from the moment that all of the prescribed medicines, supplements, and other aspects of the medical protocol arrived at our home, my wife began to look after me full time even as she continued to recover from whatever had grabbed hold of her for a number of days. The story of her extraordinary care (which I will describe shortly) touches upon a related issue – namely, the fact that she had the opportunity (in terms of time, resources, as well as being able to work out various kinds of agreed-to arrangements with her place of work) to be able to act as my full-time health care worker.

There are many people in society who do not enjoy the same sort of conditions and resources with which to operate as did my wife during our recent 5-6 week long COVID crisis. She had money; she had

health insurance; she had been given time to look after me without losing access to paid employment or benefits.

How does a person without money, time or space manage to look after someone who is sick? Public health is about more than having hospitals, community health centers, and a bunch of politicians making policies.

Public health begins with creating conditions that enable families and neighborhoods to be able to look after their families and community members in good, as well as, difficult times. Public health has its roots in the strong foundations of families and neighborhoods.

Public health should not be reduced down to a process in which agencies that are removed from families and communities engage people through top-down enterprises that seek to impose, oftentimes, arbitrary policies on families and neighborhoods. Instead, the entire fabric of public health policies and activities should be dedicated to helping families and communities to be able to enhance their capacity to look after one another in constructive ways.

My wife was able to help me because she operated from within a framework that empowered her to be available to me in so many different ways when I was most in need of that sort of assistance. If this had not been the case, I have a hard time envisioning how I would have had been able to accomplish what needed to be done over the next four or five weeks.

Unfortunately, there are many people in America – and elsewhere in the world – that did not, and do not, have access to the same quality or quantity of resources that my wife was able to bring to bear on my care during my current illness. Oftentimes during the COVID crisis, people who were not advantaged in a manner that was similar to that of my wife concerning the issue of being available to offer care to her husband, tended to be sucked into the machinations of an out of control medical system … first showing up in emergency rooms, and, then, being admitted to hospital, and, then, being medically processed in a way that might begin with providing some sort of oxygen support, and, then, might move on to being treated with various lethal forms of anti-viral medications that often led to kidney failure, which in turn, would lead to the lungs being overrun with fluids, followed by the onset of pulmonary edema, ventilation, and, then, death.

Hospitals and nursing homes that pursued the foregoing sorts of treatment policies often became the killing fields of the COVID crisis. If there were statistics indicating that the number of excess deaths that were taking place was over and beyond usual sorts of death statistics, then, one might consider the iatrogenic role that such hospitals and nursing homes played in that dynamic dance of excess deaths.

People were not necessarily dying from COVID-19. However, they might have been dying because of the standard of care to which they were exposed within the medical system.

Returning to the issue of my on-going illness, the extent of my fatigue was such that, for the most part, I was unable to move about the house. By and large, I stayed ensconced in a recliner-like chair for the better part of a month.

I was not able to negotiate the thirty or forty feet (through several rooms) that separated the living room from the bathroom. Fortunately, my wife purchased a commode – the only one left in inventory – from a local store.

When necessary, and with a moderate degree of difficulty, I could move the few feet from my chair to the commode. Also, we had arranged several urinals which could be used while my wife slept in the recliner chair next to me, and since, from a very early stage in my disease process, my wife had insisted on making sure that I did not become dehydrated, she got me to begin to try to drink as much water as I could – which led to the urinals being used a lot, as if I was the source of some new body of undiscovered liquids.

When I had stayed in the hospital during my previous heart attack, both my wife and I had noted the properties of the ridiculous – if not dangerous -- urinals used in the hospital that were made from thin plastic forms that were very sharp in all the wrong places (as well as being relatively cheap to purchase) and were referred to, somewhat grudgingly, as the 'slice-o-matic', and I will leave the rest to the reader's imagination.

In the early hours of the day, my wife would begin her ministrations to me by getting my medicines, supplements, and nutritional supports ready for consumption. On my own, my condition was such that I wouldn't have been able to be able to purchase those

materials on line, or unpack them when they came, or arrange them in their appropriate order of consumption.

She fixed me breakfast – usually oatmeal with, sometimes, a piece of peanut butter toast. She made sure that I took all of my medications and supplements.

According to instructions that had been provided by my medical friend, a couple times a day she fixed a smoothie that contained spinach, carrots, as well as cuttings from beats, ginger, garlic, turmeric, and a few other ingredients. I couldn't have done any of this.

There were an endless line of used dishes, pots, pans, mixing containers, glasses, plates, and utensils that needed to be cleaned. She often did this three and four times a day, and on my own I wouldn't have been able to do it even once.

She fixed – from scratch – delicious concoctions of beef stew and chicken soup. I would have had a difficult time buttering a piece of bread – assuming that I could have found the energy to locate the bread and remove one of its slices.

She prepared other kinds of meals as well. For instance, my doctor friend had a way of categorizing people according to their nutritional tendencies, and, as a result, he adjudged me to be a certain kind of nutritional individual, and, thus, on that basis, recommended that she cook me certain dishes that might be most compatible with, and useful for, my eating style.

On a fairly continuous basis, she would have to go to the store to replenish the supplies that were being used every day by both of us. I could not have driven to the store or managed any of this.

She gave me a number of sponge baths. She provided new, dry undergarments when I would sweat during the night and wake up cold from the perspiration that had soaked my clothes.

She would keep a running tab on my temperature, blood pressure, pulse, and heart rhythms. She recorded this and, when appropriate, she forwarded the information to my medical friend.

For a long time, my wife had wanted to re-do our bedroom. Now, that we were living – or, at least, I was – in another part of the house, she arranged with her son and her son-in-law to: Take out a rug that was now long past its prime and likely to be the home to many unseen

critters; put in new flooring; painted the room, and cleaned out a bedroom closet that was so filled with this, that, and the other from days of old, and, as a result, probably contained secrets dating back to the American Revolution.

There were many mornings – around 5 or 6 in the A.M. – when we would just talk about life, spirituality, relationships, problems, COVID, health, the future, and various incidents in the past. She kept me company, and she was a constant source of support throughout this period.

There were numerous, unanticipated contingencies that arose each and every day. No one but she was in a position to look after those matters, and whenever she could, she would have to leave (making sure that I had a phone available to me) and do whatever might be required of her to keep things running smoothly.

She talked with people on the phone. She forwarded messages and e-mails to friends of mine in order to keep them apprised about what was happening.

She washed load after load of clothes. She made certain that I had whatever I needed in that department to keep me comfortable.

She changed the sheets and towels that were on my chair on a fairly regular basis. Early on, I was having considerable pain in my back on one side, and she purchased a heating pad to help me with that until the pain finally disappeared.

She could have slept in a bed while I stayed in the chair, but she didn't. Each and every night she went to sleep in the recliner beside mine so that she would be nearby in case I needed anything.

There were many times when – for various reasons -- I had considerable difficulty sleeping. There periods of extended time lasting across days, when I would not really get any sort of deep sleep. Instead, I would doze as I faded in and out of consciousness, and it was always a comfort to wake up with her by my side irrespective of whether or not she was awake.

Over time, I made some progress. I got stronger and felt more energetic – especially cognitively. As I progressed, there were a small set of expanding activities that began to occur and through which I not

only tried to assist my wife in various ways but, as well, tried to begin to take an active role in my own recovery.

I started to do exercises in the chair. In addition, I undertook a few breathing exercises that had been given to me by my physician friend.

I would stand up for short periods of time and try to move my body in different directions. I began to go for short walks around the kitchen – very limited at first, but, soon I tried to extend the journeys little by little.

On one occasion my wife accompanied me while I walked the 15-20 feet that separated the living room from our office, where my computer was. For a short period of time, I began to try to catch up with some of what had been missed over the last month, or so.

A few days later, I asked my wife for some paper and a pen, and began to work on a small project that, earlier, I had promised to do for a Sufi friend in Canada. A few days later, I asked her to help me finish the project and explained what I needed her to try to do, and she did all that was required … despite some frustrations associated with completing the project.

Several days after that, I asked my wife to get a certain book that had come in the mail. For the first time in three, or more, weeks, I was able to read, reflect, and make notes in the margins of that book.

On the physical side of things, progress was not without setbacks. For instance, when I finished my first round of hydrocortisone, my temperature – which had been normal for a number of days – shot up three or four degrees to about 102.6. My wife was concerned that, perhaps, there was some sort of low-grade something or other going on in my system that had caused the temperature spike.

I phoned my physician friend and brought him up to date on what had been taking place. He prescribed some Azithromycin which is a broad spectrum antibiotic that can be completed within a five day period just in case there might be some sort of inflammation taking place in my system, but he also decided to put me on a second round of hydrocortisone – this time dispensed through a tapered format -- because he was not certain if my Adrenal glands had been able to reset themselves.

Before the prescription arrived for the antibiotic, I had begun the tapered protocol involving hydrocortisone. The spike in temperature dropped shortly thereafter.

Today, I have finished the last part of the aforementioned protocol. A few days have passed since I had any hydrocortisone, and there has been no spike in temperature … hopefully this means that to some degree my adrenal system has been reset and has begun to function on its own.

In the meantime, my wife and I have taken a few short rides into the country side. In addition, I have begun to take a few laps around the backyard in an attempt to begin to regain some of the muscle tone that I lost while staying relatively stationary – intermixed with having to get up and down to look after various aspects of care -- for nearly a month.

All in all, I feel pretty good. We also have begun to make the transition into the newly refurbished bedroom.

The first night or two of trying this didn't last long because I just couldn't get to sleep in the bed, and, therefore, I went back out to the living room recliner. However, I hugged a pillow, turned on my left side and began to sleep – real sleep rather than just dozing -- for longer and longer periods of time.

The last several nights I have gone to our bedroom feeling tired and have had several long sleeps of a relatively normal nature. These were the first real, deep sleeps I had had since my ordeal had begun nearly a month earlier.

I'm still not completely recovered. My legs need more exercise, as does my respiratory system.

From time to time, I feel tired. I am hoping that this will begin to disappear as I engage in more physical activity.

I don't want to overdo things, but I don't want to under do them either. I'm not, yet. sure what the appropriate level of cautious pushing should be applied to the situation … but my activity levels are expanding, and I am beginning to take over some of the things that my wife has been doing for me all along which turns out to be a good thing because my wife must return to her normal work schedule starting this coming week.

In the interim, I continue on, for the most part, with the set of protocols that my physician friend had communicated to me. The protocols are designed to enable my body to be able have the opportunity to give expression to its inherent potential for establishing and maintaining a condition of health.

One change that my wife and I did decide to make has to do with the liposomal Vitamin C supplement that I had been taking several times a day during what seemed to be the worse days of my illness. We both had come across information indicating that too much Vitamin C in the system can, among other things, operate like a diuretic.

Although I had been able to have two or three very good night's sleep in our bed, nonetheless, on about the fourth day, I began to urinate a great deal – maybe once every hour, or so, through the night. While I was able to go back to sleep following each run to the bathroom, I knew that the sleep to which I returned was not necessarily deep or for very long.

The daily liposomal aspect of the protocol has been discontinued. The early returns indicate that the vitamin C issue might have been playing a major role in the excess amounts of urine that were being produced.

None of what my friend prescribed or recommended has anything to do with the many narratives that are being spun in the world of COVID events. He did not prescribe ivermectin, or hydroxychloroquine, remdesivir, other kinds of anti-viral agents, or propose that I become ventilated, and, yet, despite being slammed with something that caused my system to collapse (especially neurologically as well as in conjunction with the breakdown of different energy systems within my body that went on for an extended period of time), I seem to be on the road to recovery thanks to God's Grace as delivered through the assistance of my medical friend and the extraordinary compassion and caring activities of my wife.

When I had my cardiac arrest, the medical costs associated with reviving me, transporting me to another hospital, placing stents in my system, providing me with intensive care, placing me in a medically induced coma, and, then, later both bringing me out of that comatose condition as well as helping me to recover from the medication madness that was a function of the powerful drugs on which I had

been placed during the medically induced coma, and, finally, moving me to a special cardiac ward, and, performing a echocardiogram totaled – along with various kinds of residual costs here and there – more than a quarter million dollars for about a week's worth of care. Yes, there were many high-tech features that were embedded in the foregoing process as well as a lot or skilled dedicated medical personnel, and to a certain extent what I am about to say is like trying to compare apples and oranges, but the point still needs to be made – low tech and relatively devoid of the level of medical competence that was present during my stay at the hospital, nonetheless, my wife provided me with a level of care and competence during a medical crisis that was, in its own way, as impressive as – and, in some ways, superior to some of the care that I received during my hospital stay, and what she gave to me for a five week period – and not just a week -- was done for mere fractions of a penny on the dollar relative to the costs of my hospital stay … apples and oranges to be sure, but it does tend to induce one to begin reflecting on the whole issue of health, disease, and trying to determine what is the best way to organize, distribute, and utilize resources to establish health and resist disease – especially when it comes to issues of public health.

When I was in the hospital for my heart condition, the medical personnel along with the rest of hospital staff were professional people who were collectively committed to helping me regain some degree of health and to be able to return home. However, I also understand that my wife is committed to my wellbeing in a manner that falls well beyond the scope of how many hospitals operate.

Indeed, there is a very telling piece of data that is rooted in the foregoing differences of commitment to my well-being (namely, one that is professional and one that is personal). More specifically, iatrogenic factors are the third leading cause of deaths in the United States, and this on-going tragedy has enveloped the lives of millions of people across just the last few decades.

Chapter 4 – A Question of Etiology

There is more to the foregoing story of iatrogenic damage that is being perpetrated by various facets of the medical system, and it has to do with, among other things, all that has transpired in the realm of COVID during the last several years. Therefore, I am going to begin to critically explore the aspects of that story to which I am alluding and which were hinted at earlier during this on-going series of essays..

Let's return to the beginning of the present saga. While attending an art workshop in another town during a scheduled vacation, my wife was informed by her place of work that on a certain date she had been working with a number of people, one of whom, now, had tested positive for the alleged presence of COVID-19.

My wife had a pretty good idea concerning the identity of the person who might have tested positive. Despite COVID protocols that were clearly posted and which also had been communicated to everyone in the work place, the person who seemed to be at the center of the positive COVID test was someone who had come to work with a severe cough and a few other symptoms.

This individual had spent a certain amount of time around my wife within the work place. My wife had been annoyed because the person was obviously sick with something, and she was coughing on, among others, my wife. In the light of whatever that individual was visibly suffering from, that person was ignoring the established protocols for COVID work place policy and had refused to remain at home.

My wife began to feel a few slight symptoms of something a number of days following her notification of the work place situation involving a positive COVID test. A week, or so, later, she had a rapid PCR test and the results of that process registered positive for COVID.

Over the next week, my wife began to experience more symptoms. Eventually, as I noted previously, sone of those symptoms involved some kind of incident in which she collapsed to the floor in an upstairs hallway of our home.

Approximately four or five days after my wife began to experience symptoms – first of a nominal kind, and, then, of a much more serious nature – I began to follow suit. In many respects, my symptoms were similar to hers (low-grade temperature, cough, loss of smell), and like

my wife, my condition progressed to a neurological collapse of some kind, but whatever began to hit me (and I am nearly 17 years older than my wife and had nearly died from a heart attack four-plus years earlier) was of a much more severe nature.

My wife was sick with something, but she was able to function fairly well despite her condition. Within a fairly short period of time, I had become relatively incapacitated.

My mind was fogged in. I suffered from extreme fatigue and did not have the energy to walk even a few feet from one room to the next in our house. The pulse oximeter we had was registering readings in the low 80s and high seventies.

Given the foregoing, let's ask the following questions. (1) Were my wife and I both suffering from COVID-19? (2) How did whatever we had come about?

With respect to the first question above, how one goes about answering that question depends on certain contingencies. For example, my wife had taken a so-called rapid PCR test, and it had come back positive.

However, one could raise the question of whether the foregoing result might have been a false positive. In other words, although the test was positive, nonetheless, it was not necessarily an accurate reflection of what was going on inside of her body and, conceivably, she might not actually have been suffering from COVID-19 but, instead, from something else that had, yet, to be diagnosed.

I did not have a PCR test of any kind. Consequently, although some of my symptoms were very similar to those of my wife, there was no independent piece of evidence which was capable of confirming what the nature of my health problem might be or whether, or not, it was the same sort of condition as experienced by my wife – although of a more intense and debilitating nature.

As far as the second question noted above is concerned – namely, how did whatever we had or were going through come about – the knee-jerk response is to assume that someone at my wife's place of work had contracted COVID-19 through exposure to the alleged SARS-CoV-2 virus, tested positive for it, and, then, passed the problems onto my wife who, in turn, passed it on to me (assuming, of course, that

somewhere in my pre-illness travels, I had not contracted my health problem in some other fashion.)

However, the foregoing set of possibilities does not exhaust the options from which one might choose in order to pursue some sort of differential diagnosis concerning our respective conditions. If we put aside, for a moment, the issue of the PCR test (and, shortly, there will be much more to be said about this topic), we are left with a number of people associated with my wife's place of work who were sick or became sick within a relatively short period of time of one another.

While many people might assume that the foregoing pieces of evidence strongly suggest that some form of contagion process had been taking place, there are other ways of accounting for what might have transpired. For example, if a number of people are exposed to an environmental toxin or poison of some kind, one might anticipate that they would tend to show similar symptoms because, oftentimes (but not always) the manner in which one person's body responds to the presence of an environmental toxin is often fairly similar to what happens within the bodies of other individuals who also have been exposed to the same kind of environmental toxin.

The epidemiological pattern of spread doesn't tell one what is causing the spread of illness that is being observed. The spread of illness could be giving expression to some sort of infection profile, but that same spread of illness or symptoms might also be due to some kind of environmental poisoning. Therefore, one has to be careful not to presume that a cluster of cases necessarily means that one is witnessing some sort of infectious phenomena rather than being an indication that a form of environmental poisoning is taking place and that people are getting sick because of the presence of a toxin or poison in the environment rather than as a result of the presence of an infectious agent of some kind.

So, given the foregoing possibility, what sort of environmental poison or toxin might be capable of accounting for what took place with my wife, me, and, possibly, the other individual at my wife's place of work who also seemed to be sick with something or other? What about stress as an environmental poison or toxin?

The foregoing has some tricky aspects to it because stress is not a concrete object per se. Instead, stress not only gives expression to a

complex relationship between individuals and a given environment, but, in many respects, also varies from individual to individual in terms of how well, or poorly, any given individual is able to negotiate the process of experienced stress.

Nonetheless, one needs to keep the following considerations in mind. Since January, 2020, the world has been subjected to a non-stop set of conditions that are conducive to the experience of stress in virtually every human being on Earth.

Thus, the media has been engaging in non-stop fear mongering about COVID-related issues for the better part of two years. Fundamentally flawed models from the Imperial College in England, along with other such flawed models, have been hysterically promoted by people with massive conflicts of interest who are trying to convince the world that hundreds of thousands, if not millions, of people are going to die from the SARS-CoV-2 virus if the public does not bow down to whatever the medical system or government agencies recommend for engaging such an alleged crisis. Governments became arbitrarily, excessively, and oppressively authoritarian as they imposed mask mandates, instituted social distancing requirements, shut down some businesses (but allowed others to stay open), prevented people from earning a livelihood, abandoned the Bill of Rights, and began insisting – without adequate justification -- that they had the right to force people to participate in an experimental medical program without right to informed consent … which was in clear violation of the Nuremberg Code of Ethics concerning any form of medical experimentation. Many medical practitioners began to absent themselves from engaging in any kind of reasoned debate or from observing critically reflective forms of rigorous exploration concerning COVID-19 related issues, and, instead, began to try to impose their own set of unproven beliefs about various aspects of medicine, health, and disease onto everyone else like some sort of abusive, religious cult.

All of the foregoing themes give expression to a litany of environmental toxins that are experienced by individuals in the form of stress of one kind or another. Although each individual brings his, her or their own set of inclinations to the problem of dealing with the presence of stress (whether perceived or real), there can be no doubt that the environment – in the form of the media, the government, the

medical establishment, universities, corporations, research labs, hospitals, businesses, and so on – have been exuding values, themes, actions, topics, beliefs, policies, and so on that have created a context that is conducive to the experience of stress.

Stress is not just in the imagination of an individual. The political, legal, medical, educational, economic, corporate, financial, and media institutions are all busy, on a daily basis, of dumping various kinds of actions, policies, and beliefs into the environment that are toxic and poisonous in nature and which play key roles in helping to create an existential context that is conducive to the phenomenological experience of stress within individuals.

Throughout the COVID-19 crisis, my wife has been dealing with all manner of stresses in her place of work. Her job is very demanding under the best of circumstances, and the arbitrary changes that have been introduced into her place of work during COVID-19 have added many layers of frustration and degrees of difficulty to her job.

Considerable research into the phenomena of placebos and nocebos (the negative counterpart to placebos) has established that expectations and beliefs are capable of shaping the nature of one's experiences in any given set of circumstances. If someone believes that the SARS-CoV-2 virus is real, then, such a person might be inclined to experience – under the right set of circumstances – the presence of various kinds of symptoms that have been linked to, or associated with, COVID-19.

My wife knew about the low-grade temperature, cough, and loss of smell facets associated with the idea of COVID. She was not at all prepared for the neurological collapse that she subsequently experienced.

My wife was, and is, situated somewhat in an interstitial space between whether she believes that what has been taking place during COVID is due to a virus or involves something of an unknown nature. She feels fairly strongly that none of the so-called experts necessarily knows what they are talking about, and, yet, she is reluctant to summarily dismiss the idea that the SARs-CoV-2 virus exists or that it is capable of infecting people or being transmitted from one person to the next.

She had been very upset with the person at her place of work that had come to work ill despite COVID policies which had been established to discourage or prevent such reckless and inconsiderate behavior. Her distress not only concerned her worries about herself but also extended to me and whether or not her co-worker's actions had not only compromised my wife's health but might also end up compromising my health as well.

My wife knew that a positive PCR result had been registered in conjunction with her workplace colleague. My wife also had taken her own test and that came back positive as well.

Whether the initial symptoms experienced by my wife were an indication that some sort of real form of biological inflammation was taking place within her, or whether those initial symptoms were a manifestation of, perhaps, a nocebo-like phenomenon in which my wife's expectations concerning what might transpire – symptom wise -- became something of a self-fulfilling prophecy is unknown. Her symptoms also could have been a response to the stresses – i.e., environmental toxins -- to which she had been exposed at work.

More importantly, however, the neurological breakdown that she experienced a week, or so, following the initial appearance of symptoms within her, can easily be accounted for as an indication that she was suffering from a substantial case of adrenal insufficiency and that her capacity to deal with the presence of different kinds of stresses in her life (many of them fostered by the environmental toxins that her work place and other facets of society were dumping into her life) had, momentarily become overwhelmed.

In other words, it is possible, that her neurological collapse was not due to the presence of a virus but was, instead, in direct response to the environmental stress toxins to which she had been exposed at work, as well as via life in general, for the better part of two years during the COVID crisis. For similar reasons, my initial onset of symptoms might have paralleled my wife's course of symptoms and been present because of various negative expectations that I might have had concerning the issue of COVID-19, but, like my wife, my neurological collapse and subsequent extreme fatigue might have been more a function of my condition of adrenal insufficiency (that is, my

loss of the ability to cope with certain kinds of environmental stress in a constructive fashion) than anything else.

There was at least one element present in my way of engaging certain facets of the COVID-19 crisis that was quite different from the perspective of my wife and could have played a role in my initial experience of symptoms. More specifically, I have come across a considerable amount of data indicating that those individuals who have been vaccinated seem to be able, at least under some circumstances, to transmit or shed molecular residues to others with whom they come in contact as a result of the materials that have been injected into them (or the subsequent production of, say, spike proteins as a function of those injections). Such injection-related residues might be expelled through breath, or touch or bodily fluids of one kind or another (for instance, sweat), and, thereby, released into the environment.

There have been thousands of disturbing reports concerning women who have not undergone the "jab" but who have had close contact with women who have opted to take the jab. The former individuals (the non-jabbed) often have experienced substantial changes to the way their menstrual cycles operate as an apparent result of contact with members of the jabbed group.

For instance, some women who seemed to be well into menopause began to have menstrual flows for the first time in years after coming into contact with individuals who had received the jab. Or, women whose period had been relatively mild and pain free began to have flows of considerable magnitude that went on for extended periods of time and also were accompanied by a great deal of pain.

Young males who had not received the jab and who, previously, had exhibited no tendency toward nose bleeds began to have nose bleeds after contact with individuals who had received the jab. Some doctors who were treating jabbed individuals for this or that issue indicated that they had begun to feel sick when interacting with members of the jabbed population.

There was also a fair amount of data to indicate that whatever might be sloughed off from COVID-injected individuals could be adversely affecting the pregnancies of women who had not received the jab. In some locales, the rate of miscarriages skyrocketed, and

many of those women indicated that the miscarriage took place after coming into contact with individuals who had received the jab.

None of the foregoing observations are definitive. There might be any number of other possibilities that could account for such reports, but one simply cannot ignore, out of hand, the foregoing sorts of data and presume that the idea of jabbed people releasing various kinds of toxins into the environment as a function of their jabbed status can be dismissed without further study.

I also recall watching a video about a young woman's experience -- I think her name was Ann -- who suffers from a condition known as CIRS or Chronic Inflammatory Response Syndrome. This disorder is apparently caused when somewhere during the process of living life the person inhales or ingests various inflammagens (an antigen or irritant of some kind that, among other things, elicits an inflammatory response) and biotoxins that are produced by certain kinds of bacteria, known as actinomycetes (which are classified as bacteria but have unique properties of their own), and moulds (molds).

Eventually, the foregoing encounter might lead to a subsequent multi-organ set of failures. Apparently, 25% of the population is genetically predisposed to being vulnerable to developing the aforementioned syndrome.

In any event, the young woman with CIRS in the video I watched noted something of considerable interest involving the issue of whether, or not, any sort of residue is being sloughed off by individuals who have received the jab. More specifically, she indicated part of her syndrome entails her body generating considerable inflammation and over-responding to the presence of toxins.

The young woman refers to herself as a "walking toxicity meter". She also indicates that her doctors seem to agree with her assessment of the situation.

If she goes into a building and encounters something of a toxic or poisonous nature during her stay in the building, she can tell (by the way in which her body responds) that there are toxins present in her vicinity, and, as a result, she becomes ill within seconds of such exposure.

The young woman indicated that she is most adversely affected by the presence of certain kinds of molds that release gasses that are filled with biotoxins. However, she also is adversely affected by the presence of heavy metal toxins.

She goes on to claim that she believes there is a new toxin present in the environment which also is capable of inducing her body to generate a substantial inflammatory response. She maintains that the new toxin is emanating from people who have been jabbed with one, or another, of the COVID-related genetic therapies that are being forced on people all over the world, and she indicates that every time she comes into contact with individuals who have received such jabs, she becomes ill, and, as a result, she cannot venture out into the public anymore without becoming ill from those sorts of contacts.

Among the symptoms that she reports from the foregoing kinds of encounters is that she develops a cough and she experiences brain fogs of varying degrees of severity. She also develops headaches, has difficulty with her memory, can't think straight, and her skin burns.

The young woman indicates that prior to the release of the COVID-related gene therapies she had been able to go into parks and open spaces without any sort of inflammatory response. However, once the COVID-related gene therapy began to be injected into more and more people, she is no longer able to go into such open-air parks without becoming ill, but adds that she does not get sick around those individuals who have not received the COVID-related jab.

Is the foregoing account merely a matter of someone's overly active imagination? Or, does it point in the direction of something that is much deeper and of a much more ominous nature?

I think it is interesting that the young woman with CIRS indicated during her video that among the symptoms she experienced after coming into contact with people who had received the COVID-related jab were: Inflammation, a cough, and some sort of brain fog.

Of course, the foregoing account might appear to be somewhat anecdotal, and, possibly, "iffy" in nature since it involves just the experiences of one person – experiences that have not been subjected to any sort of rigorous, scientific analysis. However, one can buttress, to some degree, the foregoing possibility with certain information that

has been reported by Karen Kingston, a pharmaceutical medical device analyst, concerning not only a portion of the contents in one of the Phase 1 trial design application submitted by Pfizer in conjunction with its proposed entry into the COVID-19 therapeutic (allegedly) sweepstakes, but, as well, the same topic (shedding) was discussed in an August 2015 FDA document exploring various analysis and design studies dealing with viral-based gene therapies.

More specifically, there is a section in the Pfizer drug design document covering the issue of 'exposure during pregnancy'. For instance, if a woman were to become pregnant after having sexual relations with her husband or boyfriend who, in turn, had previously interacted with a Phase 1 trial member via, say, skin contact or inhalation of such a participant's breath, then the woman who has been so exposed should report that incident to the Safety Board that has oversight for the Phase 1 gene therapy drug trial. Furthermore, if, subsequently, that woman has a miscarriage or if the fetus is born with some sort of birth defect or dies within one month of being born, then, whatever the nature of that tragic scenario might have been, this also must be reported to the aforementioned Safety Board for the gene therapy Phase 1 trial. Both of the foregoing provisions indicate that Pfizer was aware of the possibility that shedding of some kind might occur during the Phase 1 trial.

Furthermore, the FDA document which granted approval to Pfizer refers to shedding studies involving women who were pregnant and had been exposed (directly or indirectly) to someone who had been injected with the gene therapy mRNA materials. In addition, that same document mentions teratology issues – that is, issues pertaining to abnormal forms of development in organisms such as miscarriages, spontaneous abortions, and birth defects – as a result of pregnant women being exposed to someone who had been injected with the mRNA gene therapy concoction.

Karen Kingston goes on to report that an August 2021 CDC document containing material covering its weekly morbidity and mortality report has data which shows that starting in January 2021, there had been a substantial spike in, apparently, COVID-related hospitalizations among children between the ages of 1 and 4 (as well

as several other age groups). Previously, children in that age group had not shown any susceptibility to COVID-19.

However, the parents of many of those children were in the process of becoming vaccinated. Consequently, the aforementioned spike in COVID cases among the 1-4 year olds that required hospitalization could be a manifestation of the shedding phenomenon to which Pfizer alluded in its Phase 1 design document – and which was described previously.

In view of the foregoing considerations, one might at least raise the following question: Is it possible that COVID-like symptoms are not the result of viral activity but are, instead, a function of the toxins that some, or all, of the jabbed are releasing into the environment via the shedding phenomenon? In other words, is it possible that the presence of toxins shed from individuals who have been injected with the mRNA gene therapy might contribute to the emergence of illnesses among various groups of people … illnesses which are being attributed to a viral infection but actually might be due to toxic materials being shed from individuals who have been injected with the mRNA gene therapy shots that are being widely distributed among, if not imposed on, the public?

Although my wife is not completely convinced that the SARS-CoV-2 virus exists or that doctors necessarily understand what is transpiring with respect to the COVID crisis, she has tried to keep an open-mind about matters. As a result, she was prepared to interpret what was happening to us as a process of contagion that had, first, been passed on to her from someone at her place of work, and, then, was passed on to me.

For reasons that will be subsequently explored (see Chapters 7-12), I believe there is overwhelming evidence to indicate that the SARS-CoV-2 virus does <u>not</u> exist. Nevertheless, on the basis of a variety of data (such as the testimony of Karen Kingston and others), I remain open to the possibility that people who have been jabbed with one or another of the COVID-related gene therapies are sloughing off or shedding or transmitting something from such injections (or what that injection induces people's bodies to produce – e.g., the spike protein) and that such a residue constitutes an environmental poison or toxin which is capable of bringing the bodies of people exposed to it into a

stressed condition – with accompanying symptoms -- of one kind or another.

My wife was worried about the possibility that she might bring home a virus. I was worried that either she, or I, as a result of relatively incidental contact with one, or more individuals, from the jabbed community, might bring home some form of environmental toxin or poison that was being released into the community by those who had been jabbed and that, as a result, one might become sick through the presence of such toxins.

One might keep in mind that the emotions of others are transmitted into or shed into our lives on a regular basis and can have a problematic impact on our physical condition or state of health. In addition, someone else's beliefs can also be transmitted or sloughed off into our lives and, thereby, have a potential for adversely affecting our state of being or sense of wellness. Furthermore, words from other people enter into our lives on an almost continuous basis and, as such, sometimes constitute environmental toxins which affect our sense of psychological and/or physical well-being.

Quantum physics indicates that at least some of the particles that supposedly inhabit the universe seem to be capable of becoming entangled with one another to varying degrees. While the reality of such quantum entanglement has been experimentally demonstrated, what, if anything this might mean in conjunction with human entanglement or resonance with one another is a mystery. Nevertheless, as humans, we do have the capacity to resonate with, and become entangled in, the lives of our fellow human beings, and no one has, yet, completely charted out the extent to which the resonances that is occurring in one person might be capable of inducing similar sorts of resonances – whether constructive (e.g., health) or problematic (e.g., disease) -- in the lives of other people.

Irrespective of whether my wife is correct or I am correct or neither one of us is correct, the real issue before us becomes a matter of trying to determine the nature of the chain of causality that might have been at the heart of the more serious health problems (the neurological collapse that both my wife and I had experienced). Were our respective cases of adrenal insufficiency a product of viral dynamics or were other kinds of non-viral dynamics involved?

As previously noted, my physician friend had indicated to me during the early stages of my illness that almost all people living in North America – as well as in many other parts of the world -- suffer from some level of adrenal insufficiency. One of the specific forms of stress that he felt was being dumped upon people in North America came in the form of the electronic smog that envelops virtually everyone on a 24-hour, non-stop basis – something that has increased dramatically as a result of the thousands of new satellites that Elon Musk, as well as Jeff Bezos and others, have steadily been releasing into the atmosphere and which, to a large extent, since the end of August-2021, have been activated (meaning that human beings around the world are being exposed to massive clouds of satellite-generated electronic smog).

Not only do we have to deal with the many forms of toxic stress that have been generated during the COVID-19 crisis by an array of institutions, governments, corporations, universities, hospitals, and so on, but, as well, long before the COVID-19 crisis began, we had been under attack – unknowingly by many of us – by an all-out assault upon our biological integrity by a set of environmental toxins known as radio wave or EMF forms of poisoning.

If one considers the many possible ways in which the environmental stresses and toxins being generated during the COVID-19 crisis might combine with the stresses being generated through many different kinds of radio wave forms of environmental toxic poisoning, as well as other forms of environmental poisoning (e.g., glyphosates) the prospects are rather sobering with respect to the issue of adrenal insufficiency and its ramifications for either our long-term or even short-term health. The neurological collapses that my wife and I experienced – each in our own ways – might have had nothing to do with the presence of a virus and, possibly, might have had everything to do with the presence of an array of different kinds of environmental toxins that, among other things, were undermining – whether chronically or acutely – different facets of our biological integrity, starting with the issue of adrenal insufficiency.

Chapter 5 – What are Ivermectin and Hydroxychloroquine Curing? Just Asking ...

There have been many claims put forward in support of off-label use of drugs such as: ivermectin and hydroxychloroquine as ways to resolve the COVID crisis. Such claims often state that early use of those drugs could have saved thousands of lives.

However, whether rightly or wrongly, the use of those drugs was shut down by the CDC, the NIH, and a host of doctors and researchers (who, in one way or another, were beholden to, among others, the NIH as well as other government agencies and pharmaceutical companies) so that the federal government would be freed up to justify (at least on the surface) pursuing emergency use authorization of experimental gene therapy injections. In other words, as long as other, allegedly, effective, safe ways for treating COVID were available, the FDA could not assign an emergency authorization for experimental use of Pfizer, Moderna, or J and J, COVID injections. Consequently, in an exercise of Machiavellian power politics, the American government and a host of medical sycophants, who had huge conflicts of interest, engaged in an extended war designed to discredit and discourage the use of off-label drug such as ivermectin and hydroxychloroquine.

Relatively recently, there were reports from both India and Japan that their COVID crisis disappeared overnight when they decided to abandon the usual way of dealing with COVID-19 that had been proposed by WHO, CDC, and other medical or government agencies, and, instead, began using Ivermectin to treat COVID cases. However, one cannot really be certain what actually took place in those countries with respect to the nature of the health conditions that were being treated via ivermectin, or how serious any of those conditions were, or whether people might have recovered from whatever they had irrespective of whether, or not, they received ivermectin as long as they were kept at arm's length from the failed medical policies of the WHO, the CDC, the FDA, and the NIH in all matters COVID

There were medical practitioners who claimed that they had used such drugs to successfully treat COVID-19. Maybe this is true, and maybe it isn't.

One thing that I do know is that I have no idea what such medical practitioners were actually treating or what might have happened if

they refrained from using such drugs. My wife had experienced a severe neurological event in conjunction with something for which she had received a positive PCR, and, yet, while she took no special drugs or pharmaceuticals to counter her condition, nonetheless, she recovered.

Someone presents symptoms of a cough, a low-grade fever, as well as some aches and pains. The person is prescribed ivermectin or hydroxychloroquine, takes the drug, and, then, gets better.

Did the act of taking such drugs play a causal role in helping a person return to health? Unless one carefully examines the outcomes for individuals who, presumably, are sick in precisely the same way as the individual who was prescribed ivermectin or hydroxychloroquine but who are not given either of the foregoing drug treatments, one has no basis for concluding that the use of ivermectin or hydroxychloroquine is the reason why those people recovered from whatever ailment was affecting them.

As already noted, my wife recovered from whatever was ailing her without any treatment whatsoever. If the individuals in the experimental group (the ones who received a drug treatment) were to not have been given either of those drugs, would they also have recovered?

People have been getting sick for ages. They exhibit symptoms, and, then, they stay in bed or work their way through whatever symptoms they have with juice, chicken soup, rest, Vicks, decongestants, or pain relievers, and, then, their illness – whatever it might be – disappears, and they rejoin the human race in a host of normal activities.

Almost invariably – except for some individuals who might have been extremely vulnerable to whatever was transpiring -- the foregoing people would return to health. We might have many theories about why we believe those individuals recovered, but there is no proof that anything those ill people did actually was key to their recovery – although some of their medicinal actions might have helped to lessen some of their symptoms or help make the existential difficulties associated with living through their illness more tolerable.

Did any of the people who were given ivermectin or hydroxychloroquine actually have a severe case of something that has been labeled "COVID-19"? Do we know that whatever illness it is that they actually had, had been "cured" by the drug they were given?

If so, what was the nature of the dynamic that saved the lives of those people? I have come across a number of theories that have been proposed as to why something like ivermectin or hydroxychloroquine might work, but I haven't encountered any experimental studies capable of proving that such theories are correct.

Did the use of those drugs actually save their lives? Or, is the foregoing statements concerning the value of ivermectin and hydroxychloroquine just a matter of making dramatic, but unproven, claims in an emotionally-laden situation fraught with stress and tension?

Vague claims have been made. None of those claims have necessarily been properly empirically verified in separate studies involving a comparison of experimental and control groups with respect to the use and effect of such drugs in conjunction with certain disease. Furthermore, we don't even know if the illnesses being – allegedly – treated through the use of ivermectin or hydroxychloroquine are all cut from the same cloth.

I am aware there is a considerable amount of clinical evidence which indicates that both ivermectin and hydroxychloroquine have excellent safety records, and, therefore, are well tolerated by most people when those drugs are administered in appropriate dosages. However, while appropriately using a drug for off-label purposes might, or might not, help a patient in a relatively low risk manner (no drug is completely free of risk), nonetheless, using those drugs in such a manner doesn't necessarily mean that a clinician understands the nature of a patient's disease or what is causing certain kinds of symptoms to appear.

Clinical use of off-label drugs is directed at treating symptoms that a medical clinician has not been able to successfully engage in any other way. One resorts to experimenting (and that is what is going on – experimentation) with off-label uses of a given drug or set of drugs because nothing else in one's medical arsenal seems to be working and because a doctor or clinician considers the risk/benefit safety profile

associated with such off-label drug usage to be of an acceptable nature so that one can try to help a patient/client without exposing that individual to any kind of additional, substantial risk.

However, generally speaking (and there are some exceptions), if a doctor is attempting to treat a patient or client in a prophylactic manner, then, the clinician is not necessarily recommending off-label use of a particular drug in order to try to reduce one or more symptoms. Rather, the doctor is pursuing such a course of action in the hope that an off-label use of a given drug will prevent certain kinds of symptoms from emerging at all.

Alternatively, of course, a person could be exhibiting a few minor symptoms (e.g., a cough, a low-grade fever, some aches and pains) which might, or might not, have anything to do with, say, COVID-19 (i.e., there are a lot of different illnesses that, at some point, might involve a cough, a low-grade fever, and some aches and pains). In such a situation, a doctor might administer an off-label use of a given drug as a prophylactic measure in order to try to prevent a potentially more serious progression of some sort of underlying disease from being able to establish itself.

If no such progression occurs after some off-label drug has been administered, then, one cannot be sure whether, or not, that drug was responsible for the absence of a more severe progression in illness. One only knows that, for whatever reason, nothing of a more serious nature developed, and because the off-label drug being used has – we are presuming -- a good safety record, the doctor likely feels that using such a drug was advisable even though there is no clear-cut proof that the drug would be, or was, effective.

Moreover, as indicated previously, if a patient/client continues to be symptom free, then, one cannot be certain that a prophylactic use of a particular drug is the reason why there is an absence of symptoms. A person might remain symptom free for many reasons that have nothing to do with whether a drug that has been administered is “the” reason why no symptoms have appeared.

For example, despite a drug being administered in order to try to prevent particular kinds of symptoms from being manifested in the near future, if a person doesn’t, subsequently, become exposed to some alleged contagion or environmental poison that plays a role in

symptom formation, then, there should be no, or little, expectation that various kinds of symptoms will arise, and, consequently, given that no symptoms actually do emerge, one cannot automatically conclude that the reason why there are no symptoms is due to the administration of a certain off-label drug. In addition, perhaps, an individual who is being given a drug for prophylactic purposes has an immune system or general biological terrain which is sufficiently healthy that even if that person were exposed to a contagion of some kind or were exposed to some sort of environmental toxin, nevertheless, the person might remain asymptomatic as a result of the healthy condition of that person's immune system or biological terrain in general and not necessarily because that individual has undergone a prophylactic protocol to prevent certain kinds of symptoms from arising.

Furthermore, not all off-label drug usage will necessarily be successful with everyone to whom a given drug is administered. For unknown reasons, some people might benefit from receiving a certain drug, while other individuals – also for largely unknown reasons – will not experience the same degree of benefit (if any at all) that has been manifested in other individuals to whom that same drug has been administered, and, therefore, in such prophylactic circumstances one doesn't necessarily know whether a given drug is, or is not, working. One only knows that people are remaining symptom free.

Finally, if one is considering non-prophylactic situations in which off-label drugs are being administered – that is circumstances in which someone is symptomatic and ill in some non-simple and serious fashion – one needs to separate two very different kinds of issues. More specifically, achieving clinical success with off-label uses of drugs is one thing, while determining the cause or causes of the symptoms which are being clinically treated tends to be quite another matter.

On the one hand, one wants to know whether administering various off-label drugs is associated with clinical success (e.g., either through a reduction in, or disappearance of, symptoms). Furthermore, there are ways to determine degrees of clinical success that are not dependent on running randomized, double-blind control studies (more on this toward the end of this chapter).

On the other hand, quite irrespective of whether, or not, an off-label use of a given drug is associated with clinical success in the

treatment of various kinds of serious symptoms (such as reducing them or removing them, or lessening the amount of time spent in hospital, or even saving someone's life), nonetheless, knowing how to treat a disease in the foregoing fashion is not necessarily the same thing as being able to understand or know the nature of the disease or state of pathology that underlies the symptoms that are being treated. Naturally, a physician might entertain theories about why a given off-label use works or has the clinical success that it does, but such theories require a form of evidence that goes beyond the sort of data that indicates whether, or not, an off-label use of a given drug has clinical merit.

For example, a physician might recommend using an off-label drug because the doctor believes that the drug has various kinds of anti-viral properties. However, if the underlying pathology were not viral in nature, then, even if using such a drug works, say, by reducing or removing symptoms, nevertheless, the clinician's theory concerning the nature of the mechanism that is responsible for such clinical success is incorrect (i.e., the anti-viral properties that he, she, or they) believe to be present in a given drug).

Just to consider one such possibility, reflect on the following concrete, real-world situation. Dr. Ryan Cole is a Board Certified Anatomical/Clinical Pathologist who works in Idaho and who was contacted by his brother as the latter individual was in route to an ER facility in another state.

Dr. Cole's brother had received a positive PCR test. In addition, his brother had a blood oxygen level of 86 (not good) and was experiencing both labored breathing and considerable pain in his chest.

Dr. Cole's brother also had some underlying conditions. Thus, not only was his brother overweight, but, in addition, his brother suffered from Type I diabetes.

Dr. Cole instructed his brother to go to a particular pharmacy in the latter's state where the doctor was going to phone in a prescription for ivermectin. Dr. Cole states: "Within six hours, my brother's chest pain was down to two out of ten due to the interferon effect of ivermectin."

The term "interferon" refers to a group of proteins that supposedly are manufactured and released in response to the presence of one, or another, virus. Apparently, Dr. Cole's foregoing statement seems to indicate that he believes the disease from which his brother was suffering is COVID-19, and, therefore, because – supposedly –there is a facet of ivermectin's dynamic potential which Dr. Cole believes is capable of offering some sort of anti-viral countermeasure to the presence of the corona virus, then, Dr. Cole believes that the act of taking ivermectin was responsible for reducing, among other things, the chest pain that his brother had been experiencing prior to taking the ivermectin.

Dr. Cole's brother had been given a PCR test which resulted in a positive designation. As will be discussed in the next chapter of the present book (as well as during Chapters 7-12), there is little, or no, evidence capable of validating the reliability of PCR tests as a way of reliably identifying the presence of the corona virus or any other virus. Consequently, notwithstanding the aforementioned positive PCR test, one cannot be sure that the reason for the pains in the chest of Dr. Cole's brother, or the reason for his brother's oxygen blood level of 86, or the reason for his brother's labored breathing was due to the presence of a virus. As Chapters 15 and 16 of the present book will explore, there are other possible mechanisms or disease processes that are capable of producing the symptoms being described by Dr. Cole and which have nothing to do with the presence of a virus. Therefore, the reason why Dr. Cole's brother experienced a marked cessation of pain in his chest might not have had anything to do with the interferon-like properties of ivermectin (assuming such properties actually exist) if the cause of his brother's symptoms were not viral in nature.

The interferon-like properties of ivermectin is a theory about how ivermectin might accomplish some of its apparent benefits. However, as things stand in the saga of Dr. Cole's brother, we do not have enough information to determine whether, or not, such interferon-like capability – if it actually exists – is the reason why his brother's chest pains went down substantially.

For instance, one might ask whether Dr. Cole's brother was having a panic attack in response to his positive PCR test. Did the chest pains

start before the test or did they arise after that test or did they become worse after getting the results back for the PCR test?

Is it possible that the reason why the chest pains of Dr. Cole's brother diminished is because the brother trusted and had faith in Dr. Cole's medical expertise? Is it possible that taking ivermectin (in conjunction with the brother's positive feeling about Dr. Cole's clinical competency) might have been comparable to receiving an ideational placebo through which the brother had been led to believe – by Dr. Cole and other individuals in the medical profession – that such a protocol might help improve the brother's physical condition, and, as a result, the brother's positive expectation concerning the potential of ivermectin to help resolve his physical problems might have played a more important role than any sort of palliative property of the drug in and of itself might have had?

None of the foregoing comments over the last several pages should be construed as an attempt to discredit the off-label use of ivermectin (or any other repurposed drug). There are thousands of cases like that of Dr. Cole's brother in which the use of ivermectin (or other off-label uses of repurposed drugs) has been followed by a reduction in, or cessation of, certain kinds of symptoms, and, therefore, one should think twice before trying to argue against, say, ivermectin's potential for offering some sort of benefit in various medical cases, and, yet, nevertheless, the foregoing sorts of clinical success actually say very little about why such success is possible or what underlying condition is being addressed by the process of administering ivermectin (or some other repurposed drug).

In his book *The Real Anthony Fauci*, Robert Kennedy, Jr. describes a 2021 paper that was published in *Medical Hypotheses* concerning two nursing homes in Spain that experimented with various forms of off-label or repurposed drugs during an alleged COVID-19 crisis. And, again, one should keep in mind that the nursing home residents were being experimented on quite irrespective of whatever constructive outcomes might have occurred in conjunction with such experimentation.

More specifically, during March and April of 2020, two nursing homes in Yepes, Toledo, Spain were allegedly struck by what was diagnosed as COVID-19 epidemic. The aforementioned article

indicates that 100% of the residents had contracted COVID-19 within three months. Furthermore, by the end of June 2020, 100% of the patients as well as half of the staff members of the nursing homes were said to be seropositive for COVID-19, and this status is interpreted as being evidence that those patients and staff members who were seropositive had both undergone a process of infection as well as recovered from those infections.

Putting aside, for the moment, the previously noted unreliability of the PCR test, one might also note that having a so-called seropositive test does not necessarily mean that a person either underwent a process of infection or recovered from that infection. First of all, if one has not been able to properly isolate, and, therefore, prove the existence of the SARS-CoV-2 virus (and as later chapters in this book will indicate, no one, yet, has done so), then, one cannot possibly know to what elevated antibody titers are serving as a response.

For example, long-term oxidative and nitrosative stress that was caused by psychic trauma surrounding what residents and staff have been led to believe is a dangerous, and potentially lethal COVID-19 viral epidemic that is running through the two nursing homes, and this source of stress over a number of months could have led to elevated antibody levels of a certain kind in both residents and staff members and, thereby, affect serological tests. If the SARS-CoV-2 virus does not exist – and there is considerable evidence to support such a possibility (see Chapters 7-12) – then there wouldn't, and couldn't, be any antibodies forming in conjunction with such non-existing viruses, and, therefore, when serological tests are interpreted as evidence that residents and staff members have both been infected by as well as have recovered from contact with SARS-Co-V-2 then such an interpretation might be on shaky empirical grounds.

The aforementioned *Medical Hypotheses* article indicates that no one in either of the two nursing home facilities died (although 28% of the residents in other Spanish nursing homes that did not engage in the use of off-label and repurposed drugs to fend off whatever was transpiring in those homes did die), and none of the residents or staff members in the two homes being studied had to be hospitalized, and none of the residents or staff members in those two facilities suffered any adverse reactions as a result of the off-label and repurposed drugs

that were used in the Spanish nursing homes. All of the foregoing outcomes indicate that the use of off-label and repurposed drugs in the two Spanish nursing homes not only did no harm but, in addition, might have done considerable good. Nevertheless, exactly why – and to whatever extent -- those drugs worked or the precise nature of the conditions being treated by such drugs was not actually known.

Among the many questions that might be raised in conjunction with the foregoing considerations are the following. Did the 28% of residents in other Spanish nursing homes die because they weren't treated with certain kinds of off-label or repurposed drugs, or did they die because they were treated with toxic antiviral medications – such as remdesivir – or did they die because they were put on ventilators that were improperly programmed, or, maybe, they died because they were subjected to some other iatrogenic set of mistakes, and, consequently, perhaps, if the residents in those other facilities had not been treated with any sort of "official" COVID-19 protocol, then, perhaps, the 28% death rate might have been lower – either by a little or, maybe, even by a lot?

Dr. Peter McCullough, an internist and cardiologist at Baylor University Medical Center, and who is, and was, a proponent of early intervention in alleged cases of COVID-19 has said:

"We could have dramatically reduced COVID fatalities and hospitalizations using early treatment protocols and repurposed drugs including ivermectin and hydroxychloroquine and many, many others. … The strategy from the outset should have been implementing protocols to stop hospitalizations through early treatment of Americans who tested positive for COVID but were still asymptomatic."

While keeping people out of hospitals might have been a good strategy simply because many of the diagnostic and treatment protocols being observed in hospitals were, and are, contributing to large numbers of iatrogenically caused deaths due to, among other things, the use of highly toxic drugs such as remdesivir as well as the improper use of ventilators nevertheless, Dr. McCullough's claim that "We could have dramatically reduced fatalities and hospitalizations using early treatment protocols and repurposed drugs including ivermectin and hydroxychloroquine" is inherently contrafactual. This

is because what he is saying should have been done from the outset, was not what actually happened.

Dr. McCullough's foregoing statement indicates that he accepts the PCR protocol as an accurate way of identifying people that, supposedly, harbor the corona virus. Yet, considerable evidence exists (see Chapters 7-12) to strongly suggest that the PCR test is completely unreliable and that, in many ways, the whole notion of a viral pandemic was driven by the frenzied, if not hysterical, use of such an unreliable process of testing in order to allegedly detect the presence of a virus – namely, SARS-CoV-2 -- that has never been properly isolated, shown to be infectious, or demonstrated to be lethal.

There was no good empirically-based reason for either using the PCR protocol as a process for determining someone's health status vis-à-vis viral contagion, nor was there any good evidence-based reason for supposing that the 6 patients who, during late 2019, had been identified by Chinese doctors in Wuhan as individuals who were suffering from some sort of idiopathic pneumonia (that is, a form of pneumonia whose cause was unknown) had contracted a virus. Instead, during middle-to-late January, 2020, Peter Drosten – a German researcher – and his colleagues imposed (with the help of the W.H.O.) a faulty PCR test on the world (as faulty – if not more so – than the wildly exaggerated and erroneous predictions of Neil Ferguson's Imperial College model of viral transmission and morbidity) that was the "fruit" of an alleged research paper (which one can read about in the next chapter of this book) that had not been peer reviewed, and when it was peer reviewed, its so-called research was shown to contain many egregious errors and problems. Unfortunately, by the time those research mistakes came to light through peer review, the clinical world had been overrun by an ill-advised stew of assumptions and presumptions that were unwarranted and concerned the idea that the reason why certain people were getting sick was due to the presence of a corona virus that allegedly was being detected by a faulty PCR protocol and, later on, by faulty serological tests.

On March 3, 2020, the Chinese published a new protocol for treating what was being called COVID-19 but which were, in effect, idiopathic cases of pneumonia. That protocol did not rely on the use of antiviral medications, but, instead, included a variety of minerals,

vitamins, steroids, anti-inflammatories, antihistamines, and compounds containing precursors for glutathione, as well as staples from traditional Chinese medicine that were all intended to stabilize as well as strengthen a person's immune system and/or to treat specific symptoms.

By focusing on treating symptoms and enhancing a person's immune system irrespective of whether, or not, one knows what is causing those symptoms, the alleged pandemic ended in China a little over a month later in April 2020. By focusing on PCR tests, remdesivir, and ventilators due to largely blind and empirically-challenged ideological commitments to questionable theories about PCR tests and the SARS-CoV-2 virus, the alleged pandemic in the West continues on, nearly two years later.

If Drosten's problematic PCR test had never been imposed (with the assistance of W.H.O. and the CDC) on much of the world and if clinicians had treated some of the cases that were coming to them as being idiopathic in nature, and, as a result, began to engage patients according to their actual symptoms and health needs (e.g., having a healthy immune system) rather than according to unproven theories concerning alleged viral contagion, one wonders what would have happened during the last several years in, say, America. This too, like Dr. McCullough's earlier statement, is a contrafactual issue, but, nonetheless, one can see that in such circumstances, only those who were sick would be treated, while people who were not getting sick would have been spared such arbitrary policies as mandated: Masking, social distancing, lockdowns, economic collapse, the loss of civil liberties, as well as a rush – at warp speed --to produce injectable forms of gene therapy which appear to be responsible for thousands of unnecessary deaths and injuries.

Peter McCullough's aforementioned contrafactual statement would have had people who were asymptomatic being tested and, if positive, treated in a manner that would have kept them out of the killing fields that existed in many hospitals. However, if the PCR test is worthless – and it is – then there would have been no need to treat asymptomatic people with anything … whether off-label and repurposed or not.

Dr. McCullough and the previously mentioned Dr. Cole, like many other well-meaning doctors in the United States, bought into the reliability of the PCR test when there were many good reasons for not doing so, and, as well, such individuals also bought into the reliability of the theory of virology in which the fictional SARS-CoV-2 entity was immersed when there are many good reasons for not doing so. Although there are substantial differences in the modes of treatment being recommended by, on the one hand, doctors such as Peter McCullough or Dr. Cole (and I tend to be in favor of their approach to treatment in the case of idiopathic symptomology), and, on the other hand, the oppressive, ideologically driven, and arbitrary forms of treatment that were, and are, being pushed by the CDC, FDA, NIH, NIAID, many governments, as well as many doctors, hospitals, academic institutions, and research facilities that have huge financial and ethical conflicts of interest involving pharmaceutical companies and individuals such as Bill Gates, the fact of the matter is that both sides of the foregoing clinical divide are each operating under the presumption that the PCR test is reliable and that a virus – namely, SARS-CoV-2 – is the cause of the symptoms and pathology that both sides of the clinical divide are seeking to treat (each in its own way) and which both sides seem to expect that the rest of the world needs to accept as being true.

While the clinical side of Dr. McCullough's perspective is – at least for me -- far more preferable to the clinical side of the perspective of, say, the: CDC, FDA, NIH, or NIAID when it comes to the issue of COVID-19, nevertheless, both sides of the foregoing issue are making assumptions concerning issues of causality that are both questionable and problematic, and, therefore, both sides of the foregoing clinical issue concerning modes of treatment in conjunction with COVID-19 bear responsibility for unnecessarily entangling the rest of the world in unsustainable theories concerning PCR tests and viruses.

The clinical results generated through the sorts of treatment protocols being proposed by Dr. McCullough and others have proven to be largely successful. However, the clinical results generated through the sorts of treatment protocols being proposed by the: CDC, FDA, NIH, NIAID, various state governments, and numerous corporations have not been proven to be successful – that is,

mandated, arbitrary policies of: Masking, social distancing, lockdowns, and gene therapy injections have not been successful and cannot be proven to have been successful.

Nonetheless, putting issues of clinical success aside for the moment, neither of the two foregoing perspectives can offer a sustainable, scientific causal explanation that accounts for either the nature of the pathologies being treated – successfully or otherwise – nor can they offer any sustainable scientific causal explanation for why the successful forms of treatment are successful to whatever extent that this is the case. If the SARS-CoV-2 virus does not exist (and there is not one research paper that can demonstrate that it does exist, or that it is infectious, or that it is lethal), then, the reason why the protocols of Dr. McCullough, Dr. Cole, and other like-minded individuals work has nothing to do with whatever antiviral properties are believed to be present in such protocols, and, as a result, one must look to other biological mechanisms for why those kinds of treatment protocols are successful to whatever degree is the case.

Furthermore, if one jettisons the PCR test (because one cannot demonstrate that such a protocol is able to uniquely identify a fragment of an alleged virus that is both infectious and lethal -- namely, SARS-CoV-2), and if one jettisons serological tests (because if there is no corona virus exists outside of a computer algorithm, then, antibodies will not form in response to a non-existent antigen and, therefore, the presence of an elevated level of antibodies in a blood sample are likely to mean something other than constituting the foregoing sort of response … for example, a response to some sort of environmental stressor other than a virus), then, really, all one is left with is an idiopathic form of pathology. Irrespective of the fact that ivermectin, hydroxychloroquine and other off-label and repurposed drugs may be associated with successful clinical outcomes when treating such idiopathic maladies, one does not necessarily know what the cause is of the symptoms that one is treating. One only knows whether a given mode of off-label or repurposed drug use seems to have led to a successful outcome.

Some people (e.g., Dr. Harvey Risch of Yale University) have argued that when one has overwhelming evidence from multiple, independent sources, that off-label and repurposed uses of certain

drugs are repeatedly associated with successful outcomes in conjunction with a given set of symptoms and are able to do so without causing safety issues or adverse events in the recipients when such drugs are properly administered, then there is no need to engage in the so-called gold standard of scientific methodology – that is, a randomized, double blind, placebo control study. For example, in 2014, the Cochrane Collaboration (a coalition of 30,000 scientists who offer independent forms of scientific analysis concerning the efficacy and safety of drugs) performed a meta-analysis of 10,000 research articles involving observational studies of clinical uses of various drug protocols and came to the conclusion that such studies are equal in predictive capabilities to randomized, placebo-controlled trials.

One can accept the foregoing idea that there are reliable ways of identifying successful forms of clinical treatment which are not a function of randomized, placebo-controlled trials. Nevertheless, while the aforementioned ways or methods of identifying successful forms of clinical treatment might be able to achieve clinical success of one degree or another, those "ways" do not necessarily shed any light on the nature of the underlying condition that is being successfully treated or why such treatments are successful.

Consequently, there is a reason for why the present chapter bears the title that it does. More specifically, notwithstanding the fact ivermectin and hydroxychloroquine (as well as other off-label and repurposed drugs) have been shown to be associated with successful treatment outcomes that carry a low safety risk, nonetheless, one still can raise the following issue: What are ivermectin and hydroxychloroquine actually treating? … Just asking.

Chapter 6 – Drosten's PCR Test and His Other Arbitrary Inventions

On October 29, 2021 an article appeared in the Australian National Review. The title of the article is: "Coronavirus Scandal Breaking in Merkel's Germany. False Positives and the Drosten PCR Test", and the article was written by William Engdahl.

The so-called Drosten PCR test was the alleged brain child of Christian Drosten. The test played a central role in advancing the policies of WHO, the CDC, the FDA, and the NIH with respect to many of their COVID policies – including lockdowns, the wearing of masks, social distancing, as well as the concerted, authoritarian march toward introducing gene therapy and passport mandates world-wide that were intended to control the movements of everyone in society according to the likes and dislikes of fascist governments, corporations, and various medical practitioners (a variation on the method of digitalized social credit scores that were, and are being, used to oppress people in China).

On January 20th, 2020, the journal *Eurosurveillance* (a department within the EU Center for Disease Control) published an article entitled: "Detection of 2019 Novel Coronavirus (2019-nCOV) by Real-time RT-PCR"

The paper was a collaboration involving the alleged work of Christian Drosten along with a number of his colleagues from the Berlin Virology Institute at Charité Hospital, as well as the head of a small biotech company located in Berlin. The paper claimed to have established a procedure which was capable of determining whether, or not, someone contained within them the virus that was supposedly at the heart of the initial Wuhan outbreak of illness in 2019. Interestingly enough, the Drosten paper also noted that the researchers whose work was being given expression through that article didn't have access to the actual virus which their test was supposed to be able to detect (more on this shortly).

Instead of basing their test on the specific properties of the SARS-CoV-2 virus (assuming it actually existed), the Drosten group used a surrogate marker for purposes of identification – namely, the 2003 SARS virus. However, this just raises the same sorts of questions all over again.

More specifically, if one does not have access to the SARS-CoV-2 virus, then, why should one suppose that claiming to have access to the 2003 SARS virus is – methodologically speaking -- any more sustainable? Surely, one can ask: Has anyone successfully been able to isolate and purify the alleged 2003 SARS virus, or is that virus just another entry into the theoretical sweepstakes that is being operated by virologists?

Moreover, despite the similarity in names, one still does not know what the nature of the relationship is between the base pairs that supposedly – if they actually exist – have a unique sequence with respect to 2003 SARS and how this differs from the sequence of base pairs that supposedly – if they actually exist – have a unique sequence in conjunction with SARS-CoV-2.

Furthermore, if the alleged detection-test -- which, allegedly, had been developed by Drosten et. al. – had been based on various, supposedly, synthetic fragments that, allegedly, had been derived from the structure of 2003 SARS, why should one accept – without independent confirmation of any kind – that what Drosten was proposing as a test would be capable of detecting the presence of SARS-COV-2? There is a lack of clarity concerning the nature of the relationship between 2003 SARS and SarsCoV-2 in much of what the Drosten paper asserts and claims.

Immediately – even perhaps sooner than immediately since there is evidence indicating that the paper was acknowledged and endorsed by WHO before the article had even been released for publication – the paper received the endorsement of the Director General of WHO, Tedros Adhanom Ghebreyesus. This marked the beginning of the time when the Drosten PCR test became the so-called gold standard for detecting whether, or not, someone supposedly had the SARS-CoV-2 virus.

The foregoing Corman-Drosten paper – as it is sometimes referred to – was submitted to *Eurosurveillance* on January 21st, 2020, accepted for publication by *Eurosurveillance* on January 22nd, 2020, and subsequently published on-line during January 23rd, 2020.

There is no evidence indicating that – according to usual standards of scientific publishing – the foregoing paper ever went through a process of critical, peer review. However, on November 27, 2020 --

some 10 months, or so, after the release of the Corman-Drosten paper – a group of 27 well-regarded microbiologists, virologists, and other scientists from related disciplines did engage in a critical review of the Corman-Drosten paper, and as a result of their review, indicated that the Drosten article should be removed from *Eurosurveillance* list of publications.

Among other problems, the foregoing group of 27 scientists and researchers indicated that both Christian Drosten, along with one of his co-authors – namely, Dr. Chantal Reusken – had failed to inform potential readers of their paper that they were both board members of the *Eurosurveillance* journal. Not only had their paper not undergone any sort of peer review process, but Drosten and Reusken appeared to be using their insider status at *Eurosurveillance* to have the paper accepted and published (without peer review) – an obvious conflict of interest that threatens the credibility of scientific journalism.

Another issue that was raised by the aforementioned 27-member peer review group had to do with the considerable degree of disconnect between the paper and what actually was taking place in real time during the paper's release. More specifically, why was the Corman-Drosten article recommending use of a RT-PCR test as a world-wide standard during a time when only 6 cases had been detected in Wuhan that might have some sort of SARS-CoV-2 related disease connection? Even more pointedly, why had the WHO been so anxious to acknowledge and endorse such a perspective even before that paper had been released to the public for publication and despite the fact that there were no more than 6 cases existing at that time for which the test – assuming it to have been valid and reliable – might be applicable.

Quite a few months ago, I remember listening to a very informative discussion on "*The Infectious Myth Podcast*" between the late David Crowe and Stephen Bustin (his PhD is in molecular genetics and was granted by Trinity College in Dublin) who is an expert in all aspects of what is known as 'Quantitative PCR". In fact Stephen Bustin is one of the founders and developers of the MIQE Guidelines that are used for reporting QPCR and digital PCR results.

Q (quantitative) PCR concerns real time dynamics to which various editions of quantitative PCR give expression. In addition, there

is something that is known as RT-PCR which focuses on the use of Reverse Transcriptase processes in conjunction with PCR.

During the interview, Dr. Bustin indicated that the properties and characteristics of Real Time – PCR dynamics are the ones that are defined by the MIKE Guidelines. He contrasts the forgoing sort of dynamics with the end point assays that are done when one runs an appropriate form of gel, then observes, in real time, the nature of the florescence that arises in conjunction with that gel as a function of the PCR amplification process, and then, plots the progress of such growth by measuring the degree of florescence that is being manifested over time.

The MIKE Guidelines focus on issues and problems that take place prior to engaging in the end-point florescence process. The monitoring of the degree of florescence that might be present as an indication of the amount of amplification that is taking place is a separate issue.

Another distinction of importance involves the terms “probe” and “primer”. A probe is used to help detect the character of the target in some original sample of RNA, whereas a primer tends to delimit the portion of the DNA that is being replicated during the PCR stage of the process.

Dr. Bustin noted during the interview that one can get a PCR reaction without benefit of a probe, and, as such, the primers are sufficient for generating a PCR product that can be detected with certain kinds of non-specific dyes. However, he goes on to indicate that the probe can serve as a sort of insurance policy that permits one to have confidence that whatever result emerges from the PCR process, it constitutes a real result which cannot be dismissed as a misleading artifact that might arise in cases where a non-specific dye might have attached itself to something that gave an erroneous sort of replication but, instead, probes can actually be tied to the product in which one is interested.

Probes tend to be optional. Dr. Bustin suggests that for a diagnostic assay, one often would be likely to use a probe, but one might not always use a probe in research settings because probes add to the cost of the assay.

At this point the David Crowe-Stephen Bustin discussion moved on to the issue of some of the many problems that surround being able to secure reliable replication of results within the scope of Quantitative PCR dynamics that occur when being assessed through the MIKE Guidelines. Dr. Bustin noted that there are many, many factors that can affect the sorts of numbers one gets when one carries out any given RT-PCR.

For instance, he indicates that one will arrive at very different quantitative outcomes depending on a variety of factors. Among these factors are: How one goes about preparing one's sample; which enzymes are used in the process; what protocols are used; as well as the methods one employs in order to interpret the data generated by the RT-PCR process.

One very important point that was noted early on by Dr. Bustin during the foregoing interview is the following. Although various sequencing issues do arise when one is engaged in techniques involving RT-PCR within the context of the MIKE Guidelines, nonetheless, the MIKE Guidelines do not cover issues and problems that involve procedures for determining what the genetic sequence might be or should be for a particular instance of bacterium or some alleged virus or other form of microorganism.

One could go on exploring a litany of possible idiosyncrasies and problems that surround the process of Quantitative PCR, but enough has been said in the foregoing to help give emphasis to the crucial issue that is at the heart of so-called PCR testing. Unless one's probe and/or primer can be shown to be capable of identifying some facet of the SARS-CoV-2 genetic sequence that is unique to SARS-CoV-2 and helps differentiate it from all other viral sequences, then, really, a PCR test begins at no beginning and works toward no end.

If tests of some kind are to be used to identify the presence of a specific kind of virus, then that test – whatever its nature – must be capable of reliably and credibly being able to disclose or discern the presence of such viral uniqueness. If the test cannot accomplish this, then, the test is useless.

The issue of unique identification has nothing to do with the number of rounds of amplification that take place during the PCR process. The probe and primer that are used must be capable of

demonstrating that the RNA or DNA remnant for which one is searching in a given sample can not only be identified as representing, or giving expression to, a particular kind of species (for example, a coronavirus of some kind) but as well, such a sequence must be capable of being specifically tied to a unique genetic sequence within the SARS-COV-2 genome that indicates that the viral agent in question is, in fact, novel.

Returning to the issue of the previously mentioned Corman-Drosten paper, one of the many problems that the aforementioned group of 27 scientists who performed a peer review of the Corman-Drosten article discovered is the following set of ambiguities. Drosten et al. presented a number of unspecified primer and probe sequences in their article that, supposedly, were to be used by laboratories for identifying who did, and did not have – allegedly – COVID-19.

Due to the lack of specificity in those primer and probe sequences, one had no basis for identifying a sequence that could be shown to be unique to SARS-CoV-2. Labs could have used any one of the six, or so, primer and probe sequences that had been indicated for a testing process, but no one would be able to demonstrate that any of those sequences had anything to do with the SARS-CoV-2 genomic sequence … garbage in, and garbage out.

If one looks into the research background of Christian Drosten, one finds as many disturbing research mistakes as exist in the background of Neil Ferguson of Imperial College, a epidemiologist and professor of mathematical biology, who came up with a model for the alleged lethality of SARS-CoV-2 that were wildly inaccurate, Ferguson had committed many similar kinds of mistakes of modeling.

For example, during the Mad Cow crisis that captivated England in 2001, Ferguson's model indicated that 150,000 people would die and, as a result recommended that millions of animals be slaughtered. Ultimately, only 200 people died, and because Tony Blair accepted Ferguson's recommendation based on the aforementioned inflated model, the farming community in England was devastated for years to come.

Ferguson was again at his inflationary – and completely inaccurate -- best when he generated a model for the 2005 Bird Flu that claimed 200 million people might die from that form of influenza. The actual

number of deaths attributed to the alleged epidemic involved just a few hundred individuals.

In 2009, Ferguson came up with a model that predicted that at least 65,000 people would die from the Swine Flu. The actual number of deaths was in the order of 500 people

Drosten made the same sort of fear-mongering prognostications in Germany that Ferguson had made in England. For instance, in relation to the alleged SARS crisis that was being given prominent media space in 2003, Drosten had stated: "… if the epidemic cannot be pushed back in the near future, there may be repeated cases of SARS." However, according to WHO data, since the first appearance of SARS in 2003, there have only been 8,096 cases of SARS worldwide, 774 of whom died, and only nine of these deaths occurred in Germany.

For anyone to die of a given disease is tragic. Nonetheless, Drosten had been completely wrong about the idea that SARS constituted some sort of epidemic that was going to devastate economies.

Drosten's penchant for exaggerating or misrepresenting the actual character of a situation again showed up during the 2009 Swine Flu debacle just as Ferguson's inflationary rhetoric did. At that time, Drosten stated that: "The disease is a serious common viral infection that produces significantly more side effects than anyone can imagine from the worse vaccine," and he went on to urge everyone to get vaccinated against the Swine Flu.

The predicted pandemic never took place. Moreover, while millions of dollars worth of vaccines were eventually ordered, most people never took them despite Drosten's strong urging for the public to do so, and much of the foregoing resistance to the issue of taking a vaccine had to do with the fact that a great deal of evidence had accumulated which showed that the vaccines were causing far more damage to people than was Swine Flu.

One further facet of Christian Drosten's manner of conducting himself that pertains to the credibility – or lack thereof – of the alleged PCR test supposedly developed by Drosten concerns his business arrangement with Olfert Landt who is owner of the Berlin biotech company TIB Molbiol Syntheselabor GMbH.

Prior to the issue of Corona, they had jointly developed PCR tests to be used with SARS in 2002-2003. In 2011, they developed another PCR test for EHEC (Enterohemorrhagic Escherichia Coli). A further such test was developed in 2012 in conjunction with MERS. In 2016, they put forward another such test for Zika, and in 2017, they continued on the process and extended it to Yellow Fever.

According to a *Berliner Zeitung* article, Landt claimed that at the heart of their business model was the following principle (if one can call it that): "The test, the design, the development came from the Charité. We just immediately converted that into a kit form. When you don't have the virus, which was initially available only in Wuhan, we can make a synthetic gene (i.e., using computer modeling) to simulate the virus genome. We did that very quickly."

The foregoing is an extraordinary statement. In essence, it indicates that Drosten and Landt merely created or invented an arbitrary gene as a way of simulating an alleged virus genome, and, yet, there was nothing to indicate that the invention of such a synthetic gene had anything to do with the actual genomic structure of the viral genes which, supposedly, Drosten and Landt were trying to model.

Furthermore, Landt was quite wrong when he claimed that the virus was available only in Wuhan. As I will show a little later, no one – not scientists in Wuhan or anywhere else – had access to an isolated virus of the kind for which any of the artificial genes had been invented.

Depending on the quality – or lack thereof – that is, or is not, generated through a given computer modeling process and which is used to generate the aforementioned synthetic gene, the latter artificial gene could be an entirely arbitrary entity which has no empirical link to the actual character of the genomic sequence of the viral entity that, allegedly, is being modeled. If the foregoing sort of mismatch between invented synthetic gene and the genetic character of some given target organism turns out to be the case, then, the PCR tests that Landt and Drosten put together for SARS in 2002-2003, or EHEC in 2011, or MERS in 2012, or Zika in 2016, or Yellow Fever in 2017 or coronavirus in 2020 are all useless markers … that is, those synthetic or artificial genes that are generated thorough the process of

computer modeling to which Landt is alluding don't actually reflect the character of what is being measured or sought.

If the foregoing is true, then, the PCR test that was used by my wife in conjunction with her illness to determine whether, or not, she had COVID-19 was nothing more than a delusional artifact of an untenable testing methodology. If so, then, what the nature of the illness was with which my wife had been battling remains uncertain.

Chapter 7 – The Fraudulent, Theoretical, Computerized Game of Virology

The fact of the matter is – which I hope to soon demonstrate – is that since the work of John Enders in the 1950s, virologists have been engaging in a fraudulent game (maybe, in some cases, intentionally or, maybe in other cases, because they have never bothered to really critically reflect on what they were doing) in which virologists attempt – as Geppetto did (at least in fictional terms) with Pinocchio and Dr. Frankenstein did with his own creation – to give the impression that they have discovered the basic structure and nature of a given entity (e.g., virus) when all they have really done is go through a algorithmically-driven process of computer modeling in which everything that is generated through that process is nothing more than a theoretical invention or conceptual placeholder which virologists seek to instantiate with actual existential qualities that are not theoretical in nature … and, therefore, virology is, to a considerable degree, just a matter of pretense.

For instance, Jeffrey Taubenberger's alleged "discovery" concerning the genetic sequence and structural character of the H1N1 virus that, supposedly, was at the heart of the 1918 Spanish Flu epidemic follows a script similar to that of Landt and Drosten. In lieu of having access to a real virus with a specific sequence that underwrites the functioning of real genes, Taubenberger, like those who worked before him as well as those who came after him, constructed a set of artificial, synthetic genes based upon arbitrary considerations and, as a result, the entire structure of the H1N1 genome – like that of SARS-CoV-2 -- is an invented, theoretical, computerized structure, and hopefully, the remainder of the present chapter, along with several of the following chapters will lend credence to the foregoing claim.

The CDC article: "The Deadliest Flu: The Complete Story of a Virus Pandemic Influenza" -- begins with a Transmission Electron Micrograph of the alleged virus that, supposedly, caused the 1918 pandemic known generally as "the Spanish Flu" despite not necessarily having its origins in that country. However, the micrograph does not constitute proof that the bodies depicted in the image are either infectious, lethal, or even a virus.

A micrograph, after all, is a static rather than a dynamic depiction of something about which claims are being made. This remains the case even if one were to concede that the bodies being depicted in the micrograph actually constitute a virus or even if one were to concede that the entities in the image constituted the same virus that many individuals believe was so lethal in 1918, and this latter contention is not necessarily a foregone conclusion.

The CDC article operates on the assumption that the proper explanation for the 1918 phenomenon is that it involved a viral agent that was both highly infectious and highly lethal. As a result, the CDC article argues that the 1918 event provides valuable data and insights concerning how to prepare for future viral pandemics, and this assertion is also not necessarily tenable.

Early on, the CDC article maintains that "an unusual characteristic of this virus was the high death rate it caused among healthy adults 15 to 34 years of age." Such a statement makes a number of assumptions.

For example, the foregoing statement presupposes – but does not prove -- that the people who died in 1918 all died from the Spanish flu virus (and there is considerable evidence to indicate that this might not be the case). Moreover, the aforementioned claim also operates on the assumption that the people who died were actually healthy individuals … as opposed to individuals who were outwardly apparently healthy but who might actually have had underlying health problems of one kind or another which had not, yet, shown up in the form of symptoms, and, therefore, while a viral agent of some kind might have played some role in the demise of certain individuals, there may have been a number of factors aside from the presence of a given virus which was responsible for the death of various people.

According to the CDC article, a dedicated group of researchers were able to: " … search for the lost 1918 virus, sequence its genome, recreate the virus in a highly safe and regulated laboratory setting at CDC, and ultimately study its secrets to better prepare for future pandemics." The CDC article purports to be a "complete" account of the history to which the foregoing process of research gives expression.

The story being provided through the CDC paper begins with a small, ocean-side Alaskan village known as Brevig Mission. In 1918,

the village contained approximately 80 adults, consisting mostly of Inuit indigenous people.

The article goes on to say that there has been some degree of controversy concerning just how the inhabitants of that village became infected. Some individuals believe that the virus was transmitted by a local member of the postal service, while others contend that the virus arrived in the village via one, or another, trader who travelled to Brevig Mission via dog sled.

Notwithstanding the foregoing considerations, if one doesn't know how the virus was introduced into a community, then, one can't necessarily be sure that the virus is what killed those individuals. All one can say is that something happened in 1918 which resulted in the death of 72 of the 80 inhabitants of that village, and one does not necessarily know why the 72 individuals who died were vulnerable to whatever happened, or why 8 people were able to survive.

One also one does not know if the latter eight individuals got sick and, then, recovered, or whether they ever became ill. Furthermore, if the latter possibility is the case, then, why didn't they get sick?

What one does know is that all of the deaths took place within a six day period, lasting from November 15th to November 20th in 1918. The bodies were all buried in a mass grave near the village and remained that way until 1951.

In 1951, Johan Hultin, a Swede, was doing doctoral research in microbiology at the University of Iowa. He sought, and received, permission from village elders in Brevig Mission to excavate the bodies from 1918 because he believed that he might be able to find remnants of the 1918 flu in tissues of the bodies that had been buried and preserved in a frozen state while having been entombed in the permafrost for more than three decades.

Hultin was able to procure lung tissue samples from five of the excavated bodies. Nonetheless, back in his laboratory at the University of Iowa, he was unable to induce what he believed were viral entities to become active when he injected his collected lung tissue samples into chicken eggs in order to try to get the virus to grow.

In 1997, nearly a half century later, Hultin read an article by Jeffrey Taubenberger, and others, that appeared in the journal *Science*.

The article was entitled: “Initial Genetic Characterization of the 1918 ‘Spanish’ Influenza Virus.”

Taubenberger is a molecular pathologist who, at that time, was working within the Armed Forces Institute of Pathology in Washington, D.C. . He, together with other members of his research team, had been able to obtain a lung tissue sample from an apparent victim of the 1918 flu who had been stationed in Fort Jackson, South Carolina at the time of the alleged pandemic.

The soldier had been hospitalized on September 20, 1918 with a diagnosis of influenza and pneumonia. He died less than a week later on September 26, 1918, and a sample of lung tissue had been taken from him and stored for possible subsequent examination.

Before proceeding further, perhaps, the following observation would not be inappropriate. More specifically, making a clinical diagnosis of influenza gives expression to a judgment that is made by a physician with respect to various symptoms that are being observed.

What is causing those symptoms is a separate, although, obviously, not an unrelated issue. However, electron micrographs that were capable of capturing images of possible viral-like entities would not be possible for nearly another two decades, and, consequently, to maintain in 1918 that symptoms of influenza or pneumonia were caused by a viral infection would be an entirely speculative perspective (This is a point that is touched upon in passing toward the latter part of the CDC article being discussed here.) .

Physicians treat the clinical presentation of symptoms. The cause of those symptoms might not ever be known until an autopsy is performed, and, perhaps, not even then.

Furthermore, the issue of autopsy findings is somewhat of a moot point in 1918. Very few autopsies were performed in conjunction with determining the cause of whatever might be causing the deaths that transpired in 1918.

Putting the foregoing considerations aside for the moment, Taubenberger’s research group had been able to sequence nine relatively small remnants of single-stranded RNA chains from the aforementioned soldier’s lung tissue sample. Those nine fragments

were alleged to be from four of the purported eight gene segments that were theorized to make up the genome of the 1918 influenza.

One problem with the foregoing account is that since human cells – including samples from the lungs – often contain single-stranded RNA sequences of many different kinds, one cannot necessarily be sure that any given RNA fragment which one is able to acquire from a human cell is necessarily from a virus. Moreover, even if the single-stranded RNA sequence were from a virus, there is no guarantee that the segment will be from one particular kind of virus (i.e., 1918 Influenza) rather than from some other virus that might have been in the lung tissue of the soldier who died in 1918.

Virologists contend that the Influenza A viral genome consists of eight, single negative-strand RNAs that can range between 890 and 2340 nucleotides long. Each RNA segment is believed to encode one to two proteins … including the glycoproteins -- hemagglutinin and neuraminidase – which is where the 'H' and the 'N' come from in the H1N1 subtype that is believed by many virologists to constitute the 1918 influenza virus.

There are thousands, if not millions, of RNA fragments that are to be found within the conglomeration of materials that, supposedly, are being used to culture the foregoing sort of virus. So, the question becomes, how does one know that the "nine relatively small remnants of single-stranded RNA chains from the aforementioned soldier's lung tissue sample" actually constitute fragments from the 1918 influenza?

Notwithstanding the foregoing issues, Taubenberger's research group maintained that the RNA which it had sequenced constituted a novel form of influenza A – namely, H1N1. This virus was alleged to belong to a subgroup of viruses that tended to inhabit pigs and human beings rather than birds.

After reading the Taubenberger article in *Science*, Johan Hultin, wrote to Taubenberger and inquired about whether, or not, Taubenberger would be interested in what might be discovered if Hultin returned to Brevig Mission and, once again, tried to obtain some lung-tissue samples from the interred bodies that had died during the 1918 phenomenon. Taubenberger said he would be interested in such a venture, and, consequently, Hultin returned to the village which he had visited in 1951.

During this return journey, and after, once again, receiving permission from village elders, Hultin unearthed the body of an Inuit woman who was buried some 7 feet deep in the mass grave. Her lungs had been extremely well-preserved due to the permafrost in which they had been entombed.

After placing the lungs in an appropriate kind of preserving fluid, Hultin later sent the excavated biological materials to Taubenberger. Word subsequently came back to Hultin from Taubenberger "that positive 1918 virus genetic material had indeed been obtained from" the lung tissues that had been sent."

Nothing is said in the CDC article at this point about what made the RNA sequences from the Inuit woman's lungs positive with respect to the 1918 virus. In other words, one does not know what the RNA sequences from the Inuit woman's lung tissue cells were being compared against in order to permit someone to be able to conclude that, in fact, some of her RNA had come from the 1918 Influenza virus that supposedly had caused the woman's death.

Putting aside the foregoing sorts of issues, the CDC article proceeds to state that in February of 1999, a paper entitled: "Origin and evolution of the 1918 'Spanish' influenza virus hemagglutinin gene" appeared in the *Proceedings of the National Academy of Sciences*. The article was written by, among others, Anne Reid, who was part of Taubenberger's team of researchers and Johan Hultin had been given credit as being one of the co-authors of the article.

The Hemagglutinin gene is hypothesized to help make possible the entry of the influenza virus into the interior of a healthy cell within the respiratory system of a human being and, thereafter, go about replicating itself. The foregoing claim is actually only a theory about how a virus gains access to the interior of a cell since no one has actually seen or proven how the breeching process take place, just as once a virus is alleged to have gained entry to the interior of a cell – no one has seen, or knows how the virus is able to take control of the cell's replication machinery or how it sets in motion a series of events that lead to the death of an allegedly infected cell. Everything which is said about such a virus – or viruses in general -- is part of an elaborate theoretical framework that is based, in large part, on computer-

generated data, and, in to a considerable degree, on speculations concerning how to interpret that data.

At this point, the CDC article offers an illustration of what virologists believe the influenza virus looks like. One needs to understand that the illustration in the CDC article is someone's rendition of the virus since there are no electron micrographs that are capable of verifying that such an illustration accurately depicts something that is a virus.

The hemagglutinin – HA – protein that was the subject matter of the aforementioned Reid article is a surface protein which is believed to aid the virus to gain access to the interior of a human cell. Once inside a cell, the virus proceeds to infect a healthy respiratory tract, but, so far, nothing has been said in the article to indicate how this infection process takes place or why it can be so lethal.

The fact that an entity of some kind might be able to gain entry into the interior of a human cell doesn't, in and of itself, prove anything. One needs to understand the dynamics taking place within human cells, but this is difficult to do in conjunction with objects that are the size that viruses are said to be, and, therefore, such accounts tend to be heavily theory-laden.

The aforementioned HA component is one of the features of the virus that is believed to be targeted and tagged by antibodies. One theory underlying flu vaccines is built around the idea of finding a way to target, and, then, neutralize, the HA surface protein of that virus, and, in the process, undermine the putative means by which such viruses are believed to gain access to the interior of human cells..

The CDC article goes on to indicate that the 1999 Reid – et. al. – study was able to put together a proposed sequence structure for the hemagglutinin surface protein. This structure was based on combining fragments from the lung tissue samples drawn from the woman unearthed in Brevig Mission, as well as from the soldier who had died at Fort Jackson, along with remnants from a service member who had been stationed – and who died -- at Camp Upton in New York in 1918.

The foregoing amalgamation of data constitutes a theoretical construction. The aforementioned study did not isolate such a protein

in any of the bodies, but, instead, inferred its existence on the basis of genetic data drawn from three different people.

According to Reid and others, the 1918 virus had initially invaded human beings sometime between 1900 and 1915. Since the HA gene was believed to have various mammalian – as opposed to avian – adaptations, and, therefore, was more human-like or swine-like -- "depending on the method of analysis" -- the virus was placed within a mammalian clade.

More specifically, Reid and Taubenberger maintain that the purported 1918 virus sequence that had been constructed is most closely related to the oldest classical strain of swine influenza – namely, "A/sw/Iowa/30. Moreover, they note that the former viral sequence seems to be quite different from current avian influenzas but, also add that no one is certain about what avian influenza viruses might have looked like back in 1918.

How closely related the purported 1918 virus sequence is to the oldest classical strain of swine influenza is not specified. Furthermore, precisely what the considerable differences are that differentiate current avian influenzas from the alleged 1918 viral sequence that was constructed is also not spelled out in the CDC article.

Nonetheless, Reid and Taubenberger believe that the HA component of the virus originated from an avian viral source. However, they are uncertain about the extent to which the virus might have been undergoing changes within a mammalian evolutionary framework before it assumed the form that led to a pandemic.

There are a number of points to note with respect to the foregoing claims. First, one might highlight the acknowledgment by Reid and Taubenberger that whether a researcher considered the HA component to be swine-like or human-like depended on the nature of the method of analysis which was used, and, therefore, one needs to recognize that conclusions concerning the precise mammalian nature of the HA protein might be more a reflection of a given method of analysis than any intrinsic feature of the HA protein.

Secondly, because Taubenberger and Reid are uncertain about how long the HA component of the virus might have been undergoing evolutionary changes within a mammalian environment before

emerging as something capable of bringing about a pandemic, they are not certain about how the virus came to possess its – alleged -- lethal qualities … or what the nature of such lethality actually involves. In fact, they can't even be certain if the virus is what was actually responsible for the deaths of so many people.

In addition, although they believe that the HA component of the virus ultimately came from an avian source, they have no data to demonstrate how the virus component might have been able to jump species. The alleged link between an avian source and a mammalian version of the virus is entirely speculative.

Finally, the so-called mammalian adaptations to which Reid and her associate authors allude are not necessarily expressions of evolutionary change. Those differences might be nothing more than artifacts of the computer program that is used to construct the theoretical version of the HA protein. In other words, as the computer programs that are used in such research are run a number of different times, the available base pairs and fragments that have been detected in a given culture are put together according to an underlying pre-fabricated template for – in this case – a given protein, but, nonetheless, differences will show up during each run as a function of the program and, therefore, one cannot suppose that differences which show up in a constructed model of a protein are due to evolutionary changes over time rather than being expressions of the way the computer program constructs things on any given occasion.

Reid and her fellow authors also indicate that the alleged 1918 virus' HA1 protein exhibited four glycosylation sites. Virologists believe that glycosylation sites play a critical role in influenza viral functioning, but one should probably keep in mind that the foregoing belief is part of a theoretical framework in which the notion of "an influenza virus" is embedded within a theory about viruses rather than being an expression of experimentally observed performance involving those glycosylation sites.

Current HA proteins associated with human beings exhibit anywhere up to five additional glycosylation sites when compared with the alleged 1918 virus's HA1 protein. These extra sites are believed to be the result of a process of "antigenic drift" which constitute small changes that are introduced into a component – in this

case a protein – that occur as a result of errors that take place during the process of being copied to form the next generation version of that component.

These instances of antigenic drift are believed to be adaptive in nature as a given kind of virus adjusts to its animal hosts. However, the foregoing perspective is somewhat presumptuous because one cannot automatically assume that any particular copying error that might occur will necessarily give rise to a functional adaptation.

Such instances of antigenic drift are cited as being one of the reasons why there is a new flu season every year or why someone might be able to become infected with an influenza virus on more than one occasion. Nonetheless, once again, this is like putting the cart before the horse because one cannot be certain that any given case of influenza that might occur in the future is necessarily infectious as a result of such changes.

Perhaps, somewhat more importantly, Reid and the other authors of the aforementioned article did not come across any sequence changes for the HA protein that might account for why the 1918 influenza virus was, supposedly, so virulent. For example, unlike modern avian influenza A viruses involving H5 or H7 variants which exhibit "cleavage site" mutations that are associated with added virulence due, allegedly, to the way in which those sites supposedly permit a virus to grow in tissues outside of its usual host cells through the insertion of amino acids in the aforementioned cleavage sites, the 1918 virus did not contain any sequences that coded for amino acids which could become inserted into the cleavage sites in its HA proteins.

Because Dr. Reid and her associate researchers could not identify any biological markers associated with the HA protein that might have been capable of generating the sort of enhanced virulence that supposedly was exhibited by the 1918 influenza virus, the researchers maintained that there were probably a number of factors which might have synergistically interacted with one another to give expression to enhanced virulence, and, therefore, lethality during the 1918 pandemic. However, the foregoing claim concerning the multifaceted nature of virulence really amounts to little more than an admission that the researchers actually had no idea why the 1918 influenza might have been capable of doing the damage that it was perceived to

have done, and whether, or not, that virus was even responsible for what took place in 1918.

The aforementioned research group wrote a second paper in June of 2000. This article focused on the neuraminidase gene which codes for a surface protein known as NA and was entitled: "Characterization of the 1918 'Spanish' Influenza Virus Neuraminidase Gene."

The NA protein is believed to enable a virus to escape from an infected cell, and, therefore, helps the virus to spread to other cells. According to immunologists, antibodies arise in conjunction with the NA surface proteins of viruses, and while such antibodies do not prevent infection, such antibodies are believed to help stem the tide of viral spread from taking place within human beings.

Unlike the genetic sequence for the hemagglutinin surface protein (HA) which needed to be pieced together using data from tissue samples that came from three different human bodies, the research group that was working with the tissue samples that had been sent to them by Hultin which had been obtained from excavated cadavers in Alaska, the researchers were able to work out a genetic sequence for the neuraminidase using tissue samples from just one body. Nonetheless, whether one is working with tissue samples from three bodies or one body, the process of generating a genetic sequence from such samples is pretty much the same and, consequently, such a process depends on using a computer program (set of algorithms) involving a theoretical template that is related to whatever viral component in which one is interested in order to be able to make allegedly educated guesses about whether the RNA fragments that are present in a given tissue sample contain a sufficient number of the right kind of fragment sequences that might have underwritten the expression of a certain kind of surface protein … in this case, the neuraminidase protein.

In short, the hypothesized genetic sequence for the neuraminidase protein that many virologists believe to have been present in the 1918 influenza virus – along with the genetic sequence for the hemagglutinin (HA) viral surface protein -- is a theoretical construct. Neither the protein nor its purported genetic sequence was found intact inside of a virus that had been properly isolated but, instead, such models of a virus were put together by running a variety of RNA

fragments that were present in tissue samples through a computer program to see whether, or not, those fragments could be put together in a way that was capable of matching -- to varying degrees – the theoretical template being used in the underlying program.

This is like taking the scattered letters of an alphabet that are within a sample of some sort and, then, running those letters -- along with various fragmented, short combinations of those letters -- through a computer program containing templates of certain words – say, the words: "hemagglutinin" and "neuraminidase" – in order to see whether, or not, one might be able to come up with a set of possible alphabet sequences that were capable of matching up with the program templates. One's understanding is being filtered through the lenses of a theoretical framework, and, as a result, one might, or might not, be introducing some degree of obfuscation into the process of trying to understand whether such words were actually present in the sample or one merely had discovered a way to come up with such words using the alphabetic fragments that were available in a given sample.

To claim that such words actually were present in the original sample -- but simply had degraded over a period of time -- is a problematic contention. After all, the foregoing two words (i.e., "hemagglutinin" and "neuraminidase") were not actually found intact in the sample one was studying but, rather, those words had to be constructed as possibilities based on what is known about the presence of various kinds of exemplars from an alphabet that were found in a given sample that contained both single instances of the alphabet along with various fragments of combined components of that alphabet from which the foregoing words might be constructed.

In any event, once again, just as was true in conjunction with the constructed hemagglutinin gene sequence in which Dr. Reid and her fellow researchers were not able to identify anything in that sequence which might have enabled the proposed 1918 flu virus to be especially virulent, so too, the researchers came to the conclusion that their constructed sequence of the neuraminidase gene did not exhibit any properties that might suggest, or were known to be associated with, a capacity for enhanced virulence or lethality that was assumed to exist in the 1918 influenza virus.

For instance, there is a certain amount of evidence to indicate that the loss of a glycosylation site in the neuraminidase gene at amino acid 146 is associated with an increase of virulence in certain current influenza viruses. However, nothing of this kind was detected in the gene sequence of the neuraminidase surface protein from the 1918 tissue samples from Alaska, and, in passing, one also might note that correlating certain features in gene sequence with enhanced virulence is not the same as demonstrating that those gene sequence features are the cause behind observed increases in virulence.

According to the phylogenetic analysis conducted by the aforementioned research group, the neuraminidase gene sequence from the 1918 tissue sample was classified as being intermediate between mammals and birds. What exactly is entailed by the notion of "intermediacy" is not spelled out, but such considerations notwithstanding, the researchers contend that the intermediary status of the neuraminidase viral protein indicates that the virus was, most probably, introduced into human beings at some point just prior to the 1918 pandemic and that the source of the change in virulence is most likely rooted in an avian source of some kind. Yet, the CDC article also goes on to note that the research group was not able to trace the precise nature of the pathway that led to increased virulence.

So, once again, one is talking about theories of virulence and phylogenetic transitions that are bereft of the sort of concrete, detailed evidence which is necessary to be able to demonstrate that such a theory has credible empirical legs. Correlational possibilities and plausibilities are not the same thing as empirically demonstrated causality.

The CDC article proceeds to mention further facets of the 1918 influenza research project that led to the appearance of articles focusing on six more of the eight genes that are believed to be present in the 1918. Thus, in 2001, a paper published in the *Proceedings of the National Academy of Sciences* was authored by Christopher Basier and other individuals which provided an account of a nonstructural gene (NS) that was believed to be present in the 1918 influenza virus, and this was followed, in 2002, by a paper from an Ann Reid led research group which appeared in the *Journal of Virology* and dealt with the matrix gene that was alleged to be present in that same virus.

In 2004, a further study was published in the *Journal of Virology* that put forth an account of the nucleoprotein – NP gene – which is believed to have been present in the 1918 influenza virus. Finally, a year later, Taubenberger, et. al., wrote an article that was published in *Nature* and focused on different polymerase genes which also are considered to have been a part of the 1918 influenza virus.

All eight of the genes that are believed to make up the genome of the 1918 influenza virus are theoretical constructs. None of those genes were actually discovered by examining the sequences of a genome that had been located within a virus that had been isolated from all other aspects of the tissues and cultures that served as the basis for the research that was being carried out by Basier, Reid, Taubenberger and their associates … research that was being published in a variety of prestigious scientific journals.

Following the publication of the foregoing papers, a program was set in motion that was intended to create a live version of the 1918 virus. The first step in this process of going "live" involved the creation of plasmids, and this was done through the work of microbiologists Peter Palese and Adolfo Garcia-Sastre, both of whom worked at the Mount Sinai School of Medicine in New York City.

A plasmid consists of a tiny, circular strand of DNA. Such strands are capable of being amplified through means of laboratory controlled forms of replication.

The plasmids that were generated by Palese and Garcia-Sastre would be utilized in a process of reverse genetics that researchers hoped might enable them to study the possible relationships between viral structure and function. In turn, the foregoing sort of studies could help lay the basis for moving to the next phase of producing viable forms of viruses which will be discussed shortly.

Once the foregoing plasmids had been created, they were shipped to the CDC. Because researchers at the CDC were going to use those plasmids during the process of generating allegedly live versions of the 1918 influenza virus, the CDC instituted what it considered to be rigorous protocols for ensuring that such research would take place within an environment that exhibited the necessary qualities of biosecurity and biosafety … and these enhanced set of protocols turned out to constitute what is known as BSL-3, one level lower than

the maximum conditions for biosecurity and biosafety that have been established in conjunction with BSL-4.

Dr. Julie Gerberding -- who is now the executive vice-president for strategic communications, global public policy & population health, as well as the chief patent officer, for Merck & Co., Inc. but at the time of the proposed 1918 influenza reconstruction project was the Director of the CDC (and, therefore, is a very good example of the revolving door policy that links – in financially incestuous ways – the CDC and pharmaceutical companies) appointed a microbiologist, Terrence Tumpey, to be the individual who would be solely responsible for working within the BSL-3 containment facility in conjunction with the attempt to recreate a live viral version of the alleged cause of the 1918 influenza pandemic. The foregoing proposal also had been approved by the National Institute of Allergy and Infectious Disease (NIAID) under the authority of Anthony Fauci.

The project actually got under way in the summer of 2005. The plasmids which had been sent to the CDC -- and, previously, had been constructed by Dr. Palese for each of the eight genes that were theorized to constitute the 1918 Influenza virus and -- were introduced into human kidney cells by Terrance Tumpey. Once inserted into the kidney cells, the plasmids induced those cells to generate what the members of the reconstruction project believed were a complete set of RNA sequences for the 1918 virus.

There is some question, however, as to whether, or not, the RNA sequences that are being alluded to in the foregoing claim actually captured the structural and functional properties that might have been present in the alleged agent of the 1918 pandemic. After all, Taubenberger and Reid -- together with their associate researchers who had been involved with the various studies that produced the 8 genes that, supposedly, made up the composition of the 1918 influenza virus -- had acknowledged, as noted earlier, that they saw nothing in the 8 genes that might be considered to be a possible causal source of the virulence that was thought to be present in the 1918 influenza virus.

If the reconstructed edition of the 1918 influenza virus had no obvious capacity for inducing infectious lethality in its hosts, then perhaps, something is missing from the reconstructed, alleged version

of the 1918 influenza. Indeed, one should keep in mind that each of the 8 genes that had been created by Taubenberger, Reid and others were, actually, all computer-generated constructs that were based on various kinds of programs, algorithms, templates and the like in order to produce what was presumed -- on the basis of an array of theoretical considerations, assumptions, and calculations – to be an accurate re-creation of the 1918 influenza virus. However, absent the presence of a causal mechanism for infectious lethality in such a model, then, perhaps, the researchers should have exercised some degree of scientific caution concerning precisely what it is that had been created and whether, or not, such a creation has anything to do with the agent that supposedly led to a pandemic in 1918.

An article, entitled: "Characterization of the Reconstructed 1918 Spanish Influenza Pandemic Virus" appeared in the October 7, 2005 edition of *Science*. Following the publication of the foregoing article, the researchers undertook a series of experiments which was conducted in order to assess the pathogenicity of the reconstructed entity.

In other words, the researchers wanted to evaluate the capacity of their creation to infect and disrupt the healthy functioning of organisms into which their reconstructed agent was going to be introduced. This process of evaluation involved conducting a number of experiments involving mice.

The CDC article proceeds to give an overview of the experimental procedures that were used and, in the process, indicates that one set of mice were infected with the reconstructed agent, while other sets of mice were exposed to various combinations of the eight genes that constituted the reconstructed agent that had been combined with various strains of influenza A viruses (H1N1) that affect human beings on a seasonal basis. These latter concoctions are referred to as "recombinant viruses."

There might, or might not, be problems surrounding the character of the foregoing experimental setup. For example, nothing is specifically mentioned in the CDC article about how the different sets of mice were infected or just what it was that constituted the vector that was being introduced into those mice.

To begin with, living organisms come into contact with potentially infectious agents by interacting with the surrounding environment. Therefore, unless the various experimental sets of mice were being exposed to a possible infectious agent via air, water, food, or through their physical interaction with the environment, then, one is using a mode of vector introduction into the test subjects which is of questionable scientific value.

Secondly, there are a number of questions that should be raised in conjunction with the nature of the precise contents of the potential infectious agent to which the test animals were being exposed. For instance, since the CDC reconstruction project supposedly had succeeded in generating the RNA sequences for the complete genome of the purported 1918 virus, then shouldn't they have been able to produce completely isolated versions of the entities to which such RNA sequences give expression … versions that would be uncontaminated or unadulterated by the presence of any other components such as would happen if one were to embed the reconstructed virus in some sort of culture which, supposedly contains said agents but, in addition, also often tend to contain a number of other components, as well, that are considered by researchers to be necessary to maintain a viable culture but which also might have pathogenic properties.

The term "viable" in the foregoing means something that serves the purposes of a group of researchers rather than something that necessarily reflects what is likely to happen outside of a laboratory. If the potentially infectious vector which is being introduced to experimental groups of mice consists of anything except a purified compilation of the reconstructed virus, or anything but a purified amalgamation of various kinds of recombinant viruses in control groups, then whatever other components are being mixed in with the reconstructed virus or mixed in with recombinant viruses that are being used as control groups might have the capacity to obfuscate the character of the biological dynamics that are taking place within organisms in conjunction with the possibly infectious agents to which they are being exposed?

According to the account provided by the CDC article concerning the foregoing experiments, there was a marked difference between the

impact of the reconstructed version of the 1918 influenza virus on mice and the nature of the impact which the recombinant viruses had when they were introduced to various control groups of mice. For instance, mice that had been given the reconstructed version of the 1918 influenza virus contained quantities of the replicated virus that were 39,000 times higher than were produced through one of the recombinant viruses.

One question that might be asked in conjunction with the aforementioned claim in the CDC article is the following possibility. Given the claim that mice which, somehow, had been exposed to the reconstructed version of the 1918 influenza contained 39,000 times the amount of that reconstructed version of the alleged virus than did mice which were not exposed to the reconstructed version, then, how does one know that all the entities which are being claimed to be exemplars of the reconstructed version (some 39,000 times some given amount) are what they are said to be? In other words, have samples from the set of entities that arose in conjunction with the fully reconstructed edition of the 1918 influenza virus been opened up, properly isolated, and shown to contain intact RNA genomes that are the same as the reconstructed version from which the large quantity of replicated entities supposedly arose and which also can be shown, when re-introduced to other mice, to produce the same kind of patterns of replication?

According to the CDC report concerning the reconstruction project for the 1918 influenza virus, another indicator of the virulence of their reconstructed agent -- beside the degree of replication that is observed -- concerned the possible lethality of that agent. More specifically, the reconstructed edition of the 1918 influenza virus was said to be 100 times more lethal than “one of the other recombinant viruses tested.”

In addition, one also wonders whether the foregoing claim means that the recombinant viruses were also lethal but 100 times less so than the fully reconstructed edition of the 1918 influenza virus, and, if this is the case, then why would such a recombinant virus be lethal? Furthermore, one might entertain various questions in relation to the extent of the lethality to which the article seems to be alluding in conjunction with the recombinant viruses which are not specified, as

well as have questions about the nature of the mechanism of lethal pathogenicity that might be involved in those deaths.

In other words, if one accepts the premise that the fully reconstructed edition of the 1918 virus was 100 times more lethal than "one of the other recombinant viruses tested," then, just how lethal was the latter recombinant virus? How many mice in this group died, and what was the cause of death in those mice?

Moreover, there is a certain amount of ambiguity present in the CDC article with respect to experiments involving the reconstructed virus which indicate that the fully reconstructed version was 100 times more lethal than "one of the other recombinant viruses tested". In other words, does the foregoing claim in the CDC article mean that other versions of the recombinant viruses were associated with higher degrees of lethality than the one recombinant virus, in particular, that was tested and which, apparently is being referenced in the quoted statement. Or, alternatively, were the other recombinant viruses found to be more lethal than one of the recombinant viruses that was tested but were, to varying degrees, less lethal than the reconstructed edition of the 1918 influenza virus, and, if the latter is the case, then, once again, what is the extent to which such recombinant viruses are associated with dead mice and why do such deaths occur at all?

The impression is given in the CDC article that it is the H1N1 virus which is killing the mice and that such a virus kills at a rate which is 100 times greater than the mice with recombinant genes. However, the precise nature of the cause of death for mice in the experimental group was not really made clear because, among other things, we don't actually know what is being introduced into the mice in the experimental group since the H1N1` genome has never been properly isolated/purified, sequenced, and proven to be infectious outside of computer models. That which is being given to the mice in the experimental group does not consist of just a purified pool of virus bodies and nothing else, but rather that concoction consists of many things that are a function of the culturing process through which experimenters claimed to have generated a virus "isolate" but, in fact, what is being called an "isolate" has not actually been shown to contain nothing but a properly isolated, purified amalgamation of something that been proven to be the H1N1 virus and nothing else.

Conceivably, the concoction that was given to the mice in the experimental group might have been lethal. However, conceivably, such lethality could have been a function of what was in the "isolate" concoction as a result of the culturing process and not necessarily because there were any H1N1 virus bodies present in that "isolate".

For example, perhaps, on the one hand, the cytopathic event in the cell culture that led, supposedly, to the accumulation of an alleged "isolate" which, subsequently, was introduced into the experimental group of mice might have contained various kinds of toxic proteins that, say, either were being produced by bacterial and fungal microorganisms that had begun feeding off the decaying contents of the cytopathic event, or, possibly, on the other hand, the material from the culture that was introduced into the experimental group of mice contained decaying substances that, when given to the experimental group of mice, led to the awakening of bacteria or fungi in those mice and induced those microorganisms to generate toxins that caused the death of such mice. There are many forms of toxic substances that are capable of killing mice besides the presence of an allegedly lethal form of virus.

The CDC article does indicate that the HA or hemagglutinin gene from the fully reconstructed edition of the purported 1918 flu virus seems to play a critical role in rendering the virus to be lethal. The evidence for such a claim rests with an experiment in which the gene from the fully reconstructed edition of the 1918 gene was removed, while the seven other genes from the reconstructed virus were combined with a seasonal influenza virus labeled as: "A/Texas/36/91" or in more abbreviated form: "Tx/91."

The latter recombinant virus did not result in the death of any mice. Furthermore, such mice did not undergo any sort of weight loss, whereas many mice exposed to the supposedly fully reconstructed rendition of the 1918 virus not only died but, as well, some number of the latter group of mice lost up to 13% of body weight within two days of being exposed.

The foregoing experiment involving "TX/91" is described in a somewhat ambiguous manner in the CDC article. Presumably, the only difference between, on the one hand, the recombinant virus that combined seven genes from the fully reconstructed version of the

1918 virus with the "Tx/91" control virus would have centered around the absence of the HA gene. However, since nothing was said in the CDC article about the number or kinds of genes that might have been present in the "TX/91" to which the seven genes from the fully reconstructed version were being added, one is not really certain if the only difference between the fully reconstructed virus and the recombinant "Tx/91" virus is the presence or absence of the HA gene, or whether there were other differences in genomic structure as well.

Furthermore, the phrase: "lost up to 13% of body weight" which appears in the CDC article sounds like a lot of late-night television advertisements which indicate that if one buys a certain product, then, one can save up to "x" amount, or if one uses a certain product, then one's condition can improve by up to "x" amount, but, in reality, the amount which can be saved, or the benefit that actually accrues, turns out, in most instances, to be substantially less than whatever the indicated "x" amount might be, and, yet, the original statement would not constitute a lie because there were some cases in which "x" amount was saved or "x" benefit accrued. Consequently, to say that some mice "lost up to 13% of body weight" doesn't necessarily provide one with much information or provide any insight into what the nature of the dynamic that might have caused such a loss in body weight.

One would like to know how many experimental mice exhibited the foregoing loss in body weight. One also would like to know how many mice in the experimental group exhibited little, if no, weight loss, as well as how many mice in the control group exhibited some degree of weight loss, even if not substantial.

Aside from the issue of numbers involving various kinds of weight loss, one might also like to know something about the causal issues underlying such weight loss. Why did some mice experience more weight loss than others, and what factors might have affected how much weight, if any, was lost?

Apparently, according to the CDC account of the reconstruction project, the presence or absence of the HA gene had a marked effect on the symptoms that arise. However, exactly what role the HA gene plays in the nature of the symptoms that arise, or do not arise, is not actually spelled out.

The CDC article describing the experiments involving the fully reconstructed gene version of the purported 1918 influenza virus also indicates that within four days of being exposed to the aforementioned reconstructed edition, mice displayed various forms of inflammation in their lungs that were reminiscent of, or similar to, the sorts of lung tissue inflammation that had been observed in conjunction with many human beings during the alleged 1918 pandemic. In other words, apparently, the lungs of the exposed mice filled up with fluids, or exhibited signs of pneumonia, or had some other kind of lung inflammation.

However, the term "similar" that appears in the CDC article is somewhat open-ended. As a result, one remains unsure as to the extent or degree of similarity between the sorts of lung complications that emerged in conjunction with the mice that were exposed to the fully reconstructed version of the purported 1918 virus and the kind of lung complications that were fairly common among the human beings who were said to be infected with the 1918 virus.

The CDC article also describes a set of experiments that were run using a human lung cell line referred to as "Calu-3 cells". More specifically, measurements were taken at 12 hours, 16 hours, and 24 hours following exposure of those cells to the alleged fully reconstructed edition of the 1918 virus, and, then, these measurements were compared with measurements that were made following the exposure of the human lung cell line to various forms of recombinant viruses involving different arrangements of certain genes from the fully reconstructed form and various kinds of seasonal flu viruses that supposedly affect human beings.

According to the CDC article, the reconstructed version replicated rapidly within the human lung cell line into which they had been introduced. In fact, the reconstructed virus produced "as much as 50 times" the amount of virus as various forms of the recombinant viruses did (and, once again, one needs to ask: What, exactly, is being counted as a virus and how does one know that what is being counted as a virus actually constitutes a virus?)

Moreover,, the notion that one virus produces "as much as 50 times more" of that virus than does another kind of virus doesn't really explain how frequently this maximum of 50 times greater production

actually occurred. Rather, the statement only indicates that there were some cases in which this sort of rate of multiplication was observed, but there also were other instances in which this kind of differential in production was not observed, but no details are given concerning the latter sorts of cases.

The CDC article goes on to state that one of the conclusions drawn from the aforementioned sorts of experiments is that the polymerase genes that were present in the reconstructed viral form also appeared to play a significant role in the pathogenicity (i.e., virulence and capacity for infectivity) that was observed when human lung tissue was exposed to the fully reconstructed edition of the alleged 1918 virus. Nonetheless, what the nature of that enhanced role might be is not really spelled out, nor is it shown that the entities that, supposedly, were generated during such experiments were actually HINI viruses.

In addition, what takes place in a laboratory Petri dish is not necessarily an accurate reflection of what takes place in the much more complex environment of a living organism. Do the dynamics occurring within a laboratory dish point to certain possibilities in conjunction with life in the wild? Possibly … however, there is a potential for many a slip twixt experimental cup and living lip.

As noted earlier, Taubenberger and Reid were of the opinion that the 1918 influenza virus might have derived certain gain of function properties from an avian source … properties that were theorized to have made a species jump at some point prior to the onset of the pandemic. The researchers had reached the foregoing point of view because they felt that the reconstructed influenza virus had segments in its genetic sequence that seemed to be much closer to avian influenza A viruses (H1N1) than they were to various kinds of H1N1 mammalian influenza viruses, but what precisely was entailed by the notion of appearing to be "closer" to avian influenza A H1N1 viruses than to H1N1 mammalian editions of such viruses was not really specified or explained.

In order to test the foregoing thesis concerning the possible origins of the alleged 1918 influenza virus, 10-day old fertilized chicken eggs were exposed to the CDC reconstructed virus (or exposed to what was alleged to be such a virus) and, then, those results were compared with results from experiments that exposed the same kind

of eggs to various editions of a modern human influenza A virus (or what were alleged to be such viral entities) that contained different combinations of the two, five, and seven gene recombinant viruses that had been created by Dr. Tumpey during earlier stages of the series of experiments that were being run through the CDC concerning the alleged 1918 influenza.

According to the CDC article, the fertilized chicken egg experiments indicted that the reconstructed version of what was assumed to be the virus at the heart of the 1918 pandemic had a much more lethal effect on the chicken egg embryos than did any of the recombinant versions of the human influenza virus (Why? What was causing this?). In fact, none of the recombinant viruses seemed to have the same degree of lethality in conjunction with the fertilized egg embryos as the fully reconstructed version did, but the CDC article is unclear about whether, or not, the presence of any of the recombinant viruses led to symptoms of one kind or another in the fertilized chicken embryos.

Furthermore, the pathogenicity of the fully reconstructed edition of the 1918 influenza virus in relation to fertilized chicken eggs was said to be "similar" to the kind of pathogenicity that was observed when fertilized chicken eggs were exposed to various kinds of current H1N1 editions of avian flu viruses (or what were claimed to have been such avian flu viruses). However, the nature of the alleged 'similarity' between, on the one hand, the fully reconstructed edition of the putative 1918 virus and, on the other hand, contemporary versions of avian flu viruses was not specified, nor was there any discussion in the CDC article concerning whether, or not, similar sorts of pathogenetic outcomes might have been produced in more than one way. Yet, if there were multiple possible paths to similar sorts of pathogenic effects in the chicken embryos, then, one couldn't necessarily conclude that the reason for such similar outcomes is necessarily due to the role that avian flu viruses (or what were claimed to have been avian flu viruses) might have played in the theorized gain of function that supposedly showed up in the virus that is alleged to have caused the 1918 pandemic.

In addition, although the researchers believe that the foregoing experiments with chicken egg embryos showed – as the researchers

also had concluded with respect to the human lung cell line experiments – that both the HA, or hemagglutinin gene, as well as the polymerase genes of the reconstructed influenza virus played significant roles in enhancing the virulence of the alleged 1918 influenza virus, once again there was an absence of details in the CDC article concerning just what the nature of those roles might have been, or how such capabilities actually came into being (rather than theoretically might have come into being according to computer algorithms), and why such features would have generated the kind of pathogenicity that had been observed in 1918.

Although much speculation within the CDC article, as well as elsewhere, has been focused on the possible mechanisms of pathogenicity to be found in conjunction with any given form of influenza virus, one should keep in mind that not all mice died in the CDC experiments when they were exposed to such viruses, nor did all mice lose 13 % of their body weight within a couple of days following that exposure. Consequently, one must also take into consideration the characteristics of the organisms that are being exposed to a putative virus in order to try to account for the differential outcomes that occurred in such experiments despite being exposed to precisely the same reconstructed virus.

Death, like life, involves a dance between environment and organism. Why, despite being exposed to the same set of environmental features, some organisms die, while other organisms live, is an issue that cannot be reduced down to only questions of pathogenicity concerning a given virus, but, as well, one must take into consideration the degree of vulnerability, if any, that exists in various organisms and just what is entailed by such vulnerability. In short, one can't talk about the lethality of a viral agent or entity without simultaneously exploring the susceptibility of an organism to certain kinds of difficulties that might arise when engaged in various ways by various elements within a given environment.

In fact, given the foregoing considerations, one might ask: Is the pathogenicity that is observed in such circumstances a function of the virus or is it a function of the organism? Where is the locus of causality to be set?

If an organism is immune to the presence of a certain entity (say, some sort of viral agent), then, in reality, the latter entity has absolutely no pathogenicity relative to such an organism. So, if another organism of the same kind displays various kinds of biological difficulties when exposed to the same sort of environmental agent, can one really say that it is the entity's pathogenicity that causes such difficulties or is the causal dynamic much more complex than assigning pathogenicity to a entity such as a virus?

Perhaps, the reason why researchers have had such difficulty in delineating the causal process with respect to the 1918 pandemic is because their analysis should have been looking for something beyond the idea of an agent or entity that has some sort of capacity, all by itself, for generating pathogenicity in an organism. In other words, perhaps, they should have been looking into the complexities of how organisms interact with the environment and what both sides of the dynamic bring to the life, death, and well-being equation.

Finally, the research conducted by Taubenberger, Reid, Tumpey, and others that is, to a degree, delineated in the CDC article and which has been the focus of the present essay, hasn't actually demonstrated that the reconstructed genome that arose through their efforts was the same as the viral agent that supposedly played such a devastating role in the events of 1918. Although they believe they have demonstrated that their reconstructed version is correlated with certain kinds of results in various sorts of experimental contexts, nonetheless, by their own admission, they acknowledge that their reconstructed genome does not seem to display any features which have been empirically demonstrated to be capable of generating the sort of virulence or pathogenicity that is believed to have been characteristic of whatever transpired in 1918.

They talk about a possible mechanism for entry into a cell (e.g., hemagglutinin – HA gene) as well as a possible means of being able to exit from cells (e.g., neuraminidase – NA gene). In addition, they allude to the possible role that various polymerase genes in their reconstructed entity might have had in conjunction with the process of successful replication as well as possibly enhancing, in some way, the virulence of the alleged 1918 virus, but the capacity to enter, exit, and

replicate do not necessarily give expression to a causal account of how such a virus generates its lethality within a human host

Consequently, the foregoing CDC account lacks causal concreteness. They cite experiments that were conducted at the CDC concerning the potential pathogenicity of their reconstructed creation, but none of those experiments demonstrate that their re-created entity is identical to what supposedly was at the heart of events in 1918, and, in fact, only indicate that in some fashion their reconstructed genome can be correlated with certain kinds of experimental results without being able to spell out what the precise causal dynamics were which underlay those experimental results.

Once can agree with the authors of the CDC article when she, he, or they conclude: "… that more work needs to be done." Whether the future work to which the CDC article is alluding will enable researchers to be able to causally prove that their computerized constructions constitute accurate recreations of the agent that, supposedly, was responsible for the public health crisis that occurred in 1918 remains to be seen.

Chapter 8 -- Jeffrey Taubenberger's 1998 PBS Interview Concerning the 1918 Influenza Pandemic Seems Strangely Familiar

Before being employed by the National Institute of Allergy and Infectious Diseases, Jeffrey Taubenberger used to work for the Armed Forces Institute of Pathology (AFIP). The Institute has been in existence for about 130 years and began its operations during the Civil War as the result of an executive order by Lincoln which instructed the Army Surgeon General to study diseases that were connected to the battlefield.

The foregoing executive order was issued because more people were dying from various forms of pathologies that arose in conjunction with military conflicts than actually died as a result of the weapons that were being deployed during those engagements. Consequently, the Institute became a venue for collecting and studying samples taken from surgery as well as autopsies involving both human beings and animals that had roles of one kind or another within the military.

Taubenberger is a specialist in molecular pathology. This discipline develops methods for making diagnoses based on changes in genetic composition rather than -- as is the case in conjunction with traditional methods of pathology -- using microscopic examination of biological samples to do so.

Pathology samples are generally fixed in chemicals such as formaldehyde, and, then, embedded in wax. This makes the process of isolating DNA and RNA difficult to accomplish because the genetic material found within the samples that are fixed in the foregoing ways tends to become quite degraded over time.

RNA is much more fragile than DNA is. However, Taubenberger indicates that researchers have developed techniques which permit pathologists to help optimize – as much as possible – recovery efforts concerning the two aforementioned molecules, and, consequently, the alleged 1918 flu virus served as an opportunity for using, exploring, and

developing the kind of recovery techniques to which Taubenberger was alluding earlier that involve various kinds of molecules which are of interest to researchers.

Nevertheless, whatever the nature of the foregoing sorts of recovery techniques might be, unless one can show how those protocols are capable of zeroing in on RNA that is uniquely from alleged viral bodies rather than from other biological sources, then one is faced with a problem. More specifically, why should one suppose that whatever RNA is recovered through the foregoing sort of techniques is necessarily from viral bodies rather than from other biological components – such as tissue cells that have died and released their genetic contents into the samples that have been preserved?

Taubenberger said his recovery project was intended to "get a first direct look at the virus." However, for a number of reasons (some of which are noted in the following discussion), one might wish to question whether, or not, his research group actually ever came in contact with the alleged virus, and, therefore, in order to investigate such a possibility, let's take a look at various facets of Taubenberger's research that are touched upon in the 1998 Taubenberger interview.

According to Taubenberger, there were some 70 samples that were present in the Institute's archives that had been drawn from people who supposedly died from the influenza in 1918. These samples had been fixed in formalin and paraffin, and half of them were selected arbitrarily or randomly for purposes of study.

People died in different ways during the so-called Spanish Flu event of 1918. Some individuals died very quickly following the onset of symptoms, and this was quite different from the way people were believed to normally succumb to past cases of influenza.

Given that there were differences in the length of time that passed between, on the one hand, instances in which symptoms first began to appear, and, on the other hand, the point when life processes ceased in various patients, one query that could be explored is whether all the people who were dying in 1918 were

necessarily dying from the same underlying pathology. For example, over the years, there have been a number of theories based on various kinds of evidence which suggest that whatever deaths occurred during 1918 might have been due to something other than -- or, perhaps, in addition to -- a suspected influenza virus.

Among the theories which have arisen over the years, are the following possibilities. (1) The forms of vaccines and medical treatments that were in use in 1918 often were injurious to patients in one way or another and, as a result, people might have died from the medical treatments they received rather than from a virus; or, (2) what had been diagnosed as cases of influenza were, instead, actually due to the work of the bacteria that is responsible for tuberculosis – something that was endemic in many places during the era of the "Spanish Flu and which can give rise to symptoms that are very similar to ones that are present in cases of influenza and, consequently, medical practitioners might have improperly diagnosed the nature of the problem with which they were dealing; or, (3) many people might have been developing bacterial infections of one kind or another due to the masks that were being worn to (supposedly) protect them against the alleged virus; or, (4) the pathology that was being referred to as the Spanish Flu might, actually, have been a form of poisoning that occurs when susceptible people are exposed to excessive amounts of certain kinds of electromagnetic radiation; or, (5) conceivably some combination of the foregoing possibilities came together in a sort of perfect storm of lethality, but, subsequently, were all subsumed in an undifferentiated fashion under the category of "death due to influenza" (much as has been, and is being, done, in conjunction with alleged COVID cases over the last several years).

To be sure, the aforementioned observed differences concerning the time intervals between symptom onset and death might have been a function of the extent to which individuals within the affected population could have possessed varying capacities of resistance to the pathology or pathologies

to which they had been exposed. Nonetheless, as intimated previously, another way of accounting for the foregoing kinds of differences in temporal intervals between symptom onset and death is that an array of lethal causes might have been involved in the events of 1918, and some of those maladies might have been more lethal than others, and, if this were the case, then this might explain why some individuals died far more quickly than other individuals did.

Besides the issue of rapid rates of morbidity, another oddity concerning some of the people who became sick during 1918 had to do with the onset of pulmonary edema in which the lungs of patients would fill up with fluids generated by, among other things, the blood from hemorrhaging tissue. Such people died by drowning in their own fluids.

What was odd about the foregoing feature is there was very little, if any, inflammation which had been observed prior to, or during, the rising, deadly onslaught of such bodily fluids. The presence of pulmonary edema together with the absence of inflammation was not ordinary when compared with cases of influenza that had occurred in past years.

A third, somewhat unique aspect of the patient histories that were being studied by Taubenberger in conjunction with the 1918 “Flu” had to do with the age of the individuals who were succumbing to whatever the pathology might have been that was stalking people during that time. Most of the cases he studied involved people who had been healthy and were young, rather than consisting of the sorts of elderly individuals who normally fell victim to influenza.

Therefore, in summary, there were at least three properties associated with some of the 70 cases that had been archived from 1918 that distinguished those cases from what might be considered to have been “normal” instances of influenza based on past clinical experience. First, the time interval between the onset of symptoms and the occurrence of death was extremely rapid in various cases; secondly, many of those cases involved pulmonary edema without being accompanied by any kind of inflammation, and, finally, many of the people who were dying

were much younger in age than the individuals who normally were vulnerable to the ravages of influenza.

So, presumably, any explanation that proposes to account for what is transpiring in cases such as some of the ones that were occurring in 1918 will entail putting together a causal framework that might be capable of providing a degree of insight with respect to those cases that were exhibiting properties or characteristics that departed from what previous clinical experience had indicated was the normal course of events involving influenza. Such an explanation would need to answer at least the following questions – namely: Why was pulmonary edema showing up in 1918 patients without simultaneously being accompanied by inflammation, or why were some people succumbing quickly in 1918 relative to what seemed to have happened in the past with cases of influenza, and, finally, why did whatever was happening in 1918 seem to affect – in atypical fashion relative to cases of influenza in previous years -- young people rather than the elderly?

The foregoing questions will be re-visited toward the end of this essay. However, let's leave aside -- at least for the time being -- the foregoing considerations and continue on with exploring the information that is being transmitted through Taubenberger's 1998 PBS interview.

For instance, according to Taubenberger, influenza viruses are believed to replicate very quickly. Yet, why – or how -- the foregoing characteristic is made possible is not addressed by Taubenberger.

What is said is the following: The process of rapid replication allegedly takes place within the cells of lung tissue, and, then, in about five day's time, viral bodies supposedly withdraw from the foregoing cells and move on to infect other cells and/or individuals. Consequently, according to virologists, after about a week one will not find any viral bodies present in lung tissue cells that had been infected previously by those alleged viral bodies.

As a result, Taubenberger wanted to examine samples of "influenza" patients who died in 1918 that -- according to the

archived medical records -- had died within one week, or less, from whatever pathology had befallen them. In theory, such samples might provide him with an opportunity to access some of the replicated RNA material before it disappeared from a cell's interior.

One of the cases that met the foregoing conditions was accompanied by a sample that displayed strong histological features. In other words, when one looked at the tissue sample with a microscope, one could detect evidence that had been interpreted by some to have been the result of primary influenza pneumonia.

Virology theory contends that the influenza virus consists of eight RNA fragments. These fragments supposedly vary in length, and are believed to run from approximately 1000 to 2500 base pairs per fragment.

In his PBS interview, Taubenberger indicates that the sizes of the fragments that he was able to recover from the 1918 patient lung tissue sample were only about 150 to 160 base pairs long. He admits in the interview that his research project consisted largely of trying to find ways to piece together different RNA fragments that were recovered from the sample being studied and, then, eventually, he hoped to arrive at a stage of research through which he would be able to come up with a model for the entire genome of the influenza virus.

Taubenberger's research is, to some extent, based on assumptions concerning the number and type of genes that are contained in different kinds of alleged influenza viruses. In other words, the number of genes (supposedly eight) is based on a theory about gene structure and function rather than being based on discoveries concerning the actual number, structure and function of genes "in the wild" that have been isolated, characterized, and sequenced in a rigorous methodological manner.

In the PBS interview, Taubenberger indicates that his research group first looked at segments of five different genes in order to attempt to develop a sense of what the overall genomic properties of the influenza virus might look like. However, given

what has been said earlier in this essay, Taubenberger and his associates weren't necessarily looking at subsections of the actual genes of an alleged influenza virus, but, instead, might only have been looking at theoretical constructions of those genes … theoretical constructions that might, or might not, accurately reflect the structure of certain facets of the contents that could have – possibly -- originally existed within the cell tissue samples being studied.

Taubenberger states that after completing the foregoing sorts of preliminary studies, his group began to narrow its focus on what was considered to be – at least theoretically -- one of the primary surface proteins of the influenza virus. The aforementioned protein supposedly is coded for by the hemagglutinin gene, and virologists believe that the hemagglutinin protein is the means by which influenza viruses gain access to the interior of a host that is allegedly being infected by such an agent.

Nonetheless, once again, all Taubenberger -- as well as his research associates -- might have accomplished is to have engaged reality through the lenses and filters of the theoretical framework to which virology gives expression. After all, among other things, no one, yet, has been able to capture the dynamics of a virus entering a cell through the activity of a hemagglutinin surface protein.

Consequently, one cannot be certain that the aforementioned sorts of cellular access events actually take place. Alternatively, if the foregoing dynamics actually do occur, one still does not know the details of those dynamics and whether, or not, the character of that activity accurately reflects the theory which virologists have put forth concerning how they believe influenza viruses are structured and function.

Notwithstanding the foregoing considerations, Taubenberger maintains that his research group has succeeded in putting together the genetic sequence that is alleged to code for the hemagglutinin protein. The sequence is said to be about 1800 bases in length.

However, as noted earlier, all one can really say is that the research group has come up with a "possible" sequence which is highly theoretical in nature. This is because Taubenberger and his associates have never actually isolated an influenza virus but, instead, have put forth various hypotheses concerning the nature of those sequences that is based on various theoretical principles for which there is a consensus, of sorts, by a certain number of practitioners within the field of virology.

Yet, science requires more than consensus. One must be able to empirically demonstrate that the working hypothesis which is being used to explain certain kinds of phenomena can be verified independently by means of real world data that is capable of being replicated in a variety of experimental circumstances.

Unfortunately, in many respects, virology gives expression to a set of theories concerning the way its proponents believe certain dimensions of reality operate. As a result, virology doesn't necessarily accurately capture the facet of reality to which its theories are alluding.

As an addendum to the foregoing claim, one might note in passing that despite a lot of early hype on the matter, nonetheless, virology failed miserably to come up with a defensible viral theory of cancer during the 1970s and 1980s. Moreover, as the Perth Group in Australia -- along with Peter Duesberg, Kary Mullis, and others -- has shown, through a variety of empirical venues, virology also struck out with respect to being able to provide a verifiable explanation for precisely how HIV causes AIDS, and, yet, despite such a monumental failure, many virologists continue to engage life through their best, blustery, Wizard of OZ, knob turning, lever pulling, smoke generating, pay no attention to the man behind the curtain modes of behavior.

Furthermore, since the HIV causes AIDS debacle (which led to the deaths of millions of people in Africa and elsewhere through the ill-advised use of poisonous anti-viral medicines such as AZT), many virologists have been making a very good living promoting various modalities of fear-porn as they sought

to transmit their alleged concerns to fellow human beings with respect to all manner of alleged imminent viral pandemics [such as: West Nile Virus (1999), SARS (2003), Swine Flu (2009), MERS (2012), Avian Flu (2013), Zika Virus (2015-2016), and COVID (2019)] that, supposedly, were, or are, invading humanity. Moreover, virologists and other researchers were not shy to recommend that everyone urgently needed to be treated by means of one brand, or another, of virology-based vaccinations and pharmaceuticals despite the fact that none of their pronouncements – either with respect to the alleged pandemics or the proposed treatments for those putative pandemics – accurately reflected what actually transpired in the real world during the aforementioned time periods.

During his PBS interview, Taubenberger stated he felt that the complete reconstruction of the entire set of genetic instructions for the influenza virus (and not just the hemagglutinin gene on which he was focused prior to 1998) is likely to take years to complete since the fragments being studied are so small that the process of reassembling them is very time intensive. One should point out once again, however, that the foregoing sorts of efforts will not necessarily involve reassembling the actual genetic sequence of some viral entity (For example, the previous chapter of the present book is a critical reflection on a CDC paper that purports to provide an account of the subsequent work of Taubenberger and others concerning their contention that they have "discovered" the viral agent that, supposedly, was responsible for the 1918 flu).

Instead, as intimated previously, he appears to be interested in developing a theory about what he and his associates believe such a sequence might look like, and this assumes, of course, that such an entity actually exists. In short, Taubenberger's research group is engaged in a process of interpreting certain kinds of data and, therefore, the group is not necessarily pursuing a course of research that is capable of uncovering the actual nature of the dynamics that give expression to the 1918 phenomena which they are seeking to explain.

In many respects, Taubenberger and his associates appear to have become entangled in a game of conceptual will-o'-the-wisp. If so, then the foregoing sorts of understanding which are guiding his research team could be nothing more than a series of variable glimpses into a mist of elusive data that is heavily shaped by theoretical considerations that could be distorting the nature of what actually might have happened in 1918.

According to Taubenberger, his research group believes that it can assert, with some degree of definitiveness, that the entity which they believe they have been studying is an influenza virus. More specifically, they claim that the agent they have been studying is a type A influenza and belongs to the subtype H1N1 where H and N stand for proteins that supposedly permit such an alleged virus to, respectively, be able to gain access to (i.e., infect), as well as to be able to exit (and, thereby supposedly kill), a given cell on its way to infecting other cells or organisms.

Virologists maintain that there are three types of influenza viruses – namely, A, B, and C. These types of influenza are further sub-categorized according to the kind of hemagglutinin (H) and neuraminidase (N) proteins that are believed to be present on the surface of any given influenza virus.

While such influenza types and subtypes give expression to virology theory, nonetheless, no one has seen viruses entering or exiting cells via, respectively, H and N proteins. Therefore, there appears to be an absence of the requisite kinds of data which might be able to definitively verify any of the aforementioned theoretical pronouncements of virology.

Currently, virologists claim there are 14 different kinds of hemagglutinin protein subtypes and 9 different subtypes of neuraminidase proteins which differentiate one type of influenza from another type of influenza. The virus that is believed to have been present in the lung tissue samples from patients who died during 1918 is thought to be the H1N1 subtype, and this belief rests on the sorts of antibodies which were found in people who had been alive during 1918 but were able to survive whatever took place at that time.

Although there are theories within virology and immunology about how, and why, antibodies emerge, there is no reliable empirical data which actually captures the process of antibodies coming into existence. The evidence all has to do with finding antibodies at one point in time but not another, and, then, coming up with a theory for why such antibodies are found at one time but not another, or why those antibodies exist in some people but not others.

Virologists not only believe that influenza viruses infect human beings, but, as well, such individuals also are of the opinion that those presumed viral agents are able to infect chickens, ducks, and a variety of birds as well as pigs and horses. Furthermore, based on the study of serum drawn from human beings who lived during 1918 and were able to survive whatever transpired during that year, virologists maintain that the antibodies in circulation in those individuals are a closer match to alleged swine influenza bodies that virologists believe were discovered in the 1930s than the aforementioned 1918 antibodies were a match to the human influenzas that were supposedly discovered in the 1930s.

Unfortunately, during the interview, Taubenberger does not spell out what is meant by the idea that the so-called "matches" between certain types of influenza and antibodies circulating in the blood stream are a better fit when considered in conjunction with alleged swine influenza bodies of the 1930s rather than in relation to presumed human influenza bodies of the 1930s. Antibodies can be quite promiscuous with respect to the kinds of entities with which they manifest some degree of affinity, and, therefore, one cannot be certain – as some virologists seem to be -- that the reason why there is a some amount of affinity between antibodies from 1918 and swine influenza bodies from the 1930 is necessarily because the 1918 antibodies were formed due to, or response to, an encounter with some sort of swine flu entity either just prior to, or during, the events of 1918.

In fact, if -- contrary to current theories and models of virology -- one were to entertain an hypothesis that the 1918

influenza virus did not necessarily exist, then, one would have to come up with a different theory to account for why antibodies of a certain kind might exist at one time rather than another. After all, if the 1918 influenza virus did not exist, and if influenza was caused by something other than a virus, then, making the sort of claims that some virologists seem inclined to make concerning the alleged significance that is supposedly demonstrated through the presence of alleged matches between particular kinds of antibodies and certain kinds of swine viruses becomes something of a problem.

Among other things, the foregoing conceptual crisis would force one to search for some alternative reason or set of reasons to account for why antibodies of a particular kind can be found in the serum of some people but not others. In other words, one would have to ask: Why do certain antibodies arise if this is not in response to the presence of some sort of viral agent?

Notwithstanding the foregoing considerations, Taubenberger and his research associates believe that the aforementioned purported antibody-swine flu match indicates that the 1918 flu did not come directly from avian sources but, instead, arose through some sort of mammalian connection. In other words, they believe that the path of viral transmission might have started with avian organisms, and, then, emerged, at some point, within mammalian organisms -- such as swine -- and, then, somehow, got passed on to human beings.

However, at the present time, there is no detailed account that is capable of providing a viable explanation for the supposed process through which various genetic fragments might be able to make the jump from avian hosts to swine hosts, and then, subsequently, to human hosts. Although, in general terms, the foregoing sort of transition phenomenon is presumed to have transpired through some modality of recombinant DNA or RNA processes, nonetheless, this presumption is unaccompanied by any sort of account concerning a demonstrable, step-by-step dynamic that gives expression to the proposed series of transitions in genetic material that runs from avian, through swine, and, eventually to human beings.

The foregoing issue is crucial. In other words, based on antibody data (which, as previously suggested, does not necessarily mean what some virology researchers believe that data signifies), Taubenberger stipulates that prior to 1918, viruses had been circulating within human populations in a relatively non-lethal form except in conjunction with a small fraction of individuals who, for various reasons, might have been susceptible to those kinds of influenza agents, and, therefore, one needs to ask the following questions: How did the 1918 influenza virus acquire its alleged lethality, and what was the nature of the biological or molecular mechanism that underlies such supposed lethality?

According to Taubenberger, viruses tend to be genetically unstable, and, as a result, undergo regular transitions with respect to certain aspects of their structure and function. Taubenberger describes such transitions as "… presumably an adaptation of the virus, to evade the host immune response, so that the influenza virus that was circulating last year is not the same as the influenza virus that is circulating this year" and concludes by saying: "So they're very clever in that sense."

To be sure, changes in genetic sequences might give expression to some form of genetic instability, but determining the cause of those changes tends to be quite another matter. One cannot assume – as Taubenberger seems to -- that changes in the genetic sequence of a virus are due to some sort of, apparently, intentional or logistical viral strategy which seeks to adapt to a host's immune response by bringing about changes that enable successive generations to evade that same kind of immune response.

Viruses are not necessarily "very clever" in the foregoing sense." More specifically, if one were to assume that changes in genetic sequence occur among viruses, then, although some of those changes might confer a "novel" advantage of some sort, nonetheless, other changes might not necessarily confer any kind of advantage, or those changes could introduce something that is decidedly a disadvantage to the virus.

Therefore, whether or not a presumed virus acquires some sort of new "trick" that permits the immune responses of a host to be evaded will depend on the nature of the changes in genetic sequence that either do, or do not, occur. Yet, such changes do not necessarily have anything to do with some kind of adaptive strategy of 'cleverness' that is supposedly actively transpiring within a given viral entity.

In other words, changes in genetic sequence within a proposed virus could be a reflection of nothing more than – to use Taubenberger's way of stating things -- the inherent genetic instability of those entities. If so, then, as previously indicated, whatever changes occur in genetic sequence do not necessarily have anything to do with cleverness or adaptive, evolutionary strategies but merely give expression to the alleged virus's on-going susceptibility to genetic instability which arbitrarily moves the genome of the alleged virus in one direction rather than another … sometimes with felicitous results, and sometimes with problematic results, and, sometimes with the sort of variance that has no appreciable impact concerning issues of adaptability.

Taubenberger maintains that while mutations do tend to occur on a regular basis, most of these changes will not lead to substantially different structural or functional forms. However, he believes that every so often, substantial changes do occur, and this takes place he supposes as the result of some sort of recombinant exchange dynamic that takes place between two different species.

As a result, he maintains that the foregoing sorts of recombinant changes could give rise to a form of virus that has not previously been encountered. Furthermore, he believes that this sort of virus might pose a threat for any species that did not have the capacity to defend against the presence of that kind of an agent.

Of course, not all changes in genetic sequence will necessarily give rise to a variant that carries potential lethal implications in conjunction with human beings. Moreover, for a virus, the essence of adaptation is a function of being able to

replicate and continue on, and such a capacity is quite independent of any potential that might bring about biological mayhem in the organisms that are being engaged by the virus.

In short, the capacity of a virus to inflict pathology on its host – or, in conjunction with some degree of vulnerability or susceptibility in a host to the properties of a virus that will generate a dynamic that results in death or disease -- is not necessarily adaptive. On the other hand, the capacity of a virus to be able to replicate is quintessentially adaptive in nature.

Although there is considerable evidence indicating that recombinant processes do occur, nonetheless, the notion that those recombinant processes will necessarily give rise, at some point, to something that is, on the one hand, capable of evading the capacity of organisms to defend against the presence of such entities, and, on the other hand, will be capable of being highly lethal in relation to its impact on a given organism is really nothing more than a conjecture. Consequently, even though Taubenberger – along with other researchers -- has put forth a hypothesis which contends that the foregoing sort of 'substantial' recombinant event occurred in connection with 1918, nonetheless, he has not provided evidence which demonstrates that such an event actually did occur.

In fact, during the PBS interview, he indicates that he actually is searching for the foregoing sort of evidence. Consequently, although – as noted earlier -- he does refer to a certain amount of data involving antibody titers in blood serum that had been drawn from people who lived during -- but survived – the 1918 event, nevertheless, at best, that sort of data is only suggestive – and can even be ambiguous with respect to its significance concerning the possible relationship between swine influenza viruses and human beings -- and, therefore, given the aforementioned degree of promiscuity that often characterizes the activity of many kinds of globulin proteins – i.e., antibodies -- the presence of the sorts of antibody data to which Taubenberger is alluding does not necessarily support his contention that the existence of those antibodies means that

they came into existence as a result of earlier encounters with swine flu antigens.

During the PBS interview, Taubenberger refers to three alleged pandemics – namely, events in 1918, 1957, and 1968 – which he believes give expression to the possibility that some sort of recombinant set of events occurred which gave rise to novel viruses of one kind or another that had lethal properties in all three of those instances. However, in each case, Taubenberger fails to put forth any evidence to persuasively demonstrate that what he believes was responsible for those three events – namely, changes in genetic sequence due to recombinant dynamics – is what actually happened.

Furthermore, one might note in passing that there is a certain amount of evidence to indicate that the events of 1918, 1957, and 1968 might not have been due to a viral agent at all. For example, in the book: *The Invisible Rainbow: A History of Electricity and Life*, Arthur Firstenberg puts forth considerable evidence in support of the possibility that the three "pandemics" cited by Taubenberger (as well as a number of other outbreaks of "influenza" that occurred prior to 1918 and after 1968) might have been due to various kinds of changes in electromagnetic radiation that were being introduced into the Earth's environment at those times.

For example, numerous new sources of powerful radio frequencies had come on line in many geographical locals just prior to and during 1918 and were being beamed throughout the world. Or, in the case of the 1957 pandemic, there were many powerful radar facilities that were being deployed in various parts of the world. Moreover, in the case of the 1968 pandemic, numerous communication and intelligence satellites had been, and were being, launched by various military groups as well as by an array of corporations and, as a result, such technology was bathing the Earth – and its life forms – in an array of electromagnetic radiation.

Radiation poisoning has been demonstrated to be capable of producing many of the same sorts or symptoms that are present in cases of influenza … symptoms that, for nearly a hundred

years, have been attributed to a viral agent of some kind. In fact, although abundant evidence currently exists which is capable of demonstrating that electromagnetic radiation can bring about flu-like symptoms as well as many other kinds of pathological conditions (see the work of, among others, Samuel Milham, Olle Johansson, Martin Pall, and Devra Davis), nonetheless, to date, no one has been able to properly isolate an influenza virus which can be shown to be infectious or lethal (and the notion of "isolates" that appears in the virology literature is a bastardized version of the sort of rigorous methodologies that are needed to properly isolate, sequence, and demonstrate that such isolated agents actually exist as well as that they are actually infectious and lethal).

The foregoing considerations give expression to a very critical issue. If viruses, of one kind or another, cannot be shown (following proper isolation and sequencing) to be the cause of, say, influenza, then, one must look to some other sort of environmental trigger (e.g., chemical, electromagnetic, and/or biological) to account for the existence of those maladies.

Yet, if something other than a virus plays a role in the onset of influenza, then, the nature of the dynamic with which human beings are presently faced changes in substantial ways. For instance, instead of trying to come up with some kind of virology-based vaccine or virology-based pharmaceutical elixir, and, then, insisting that people – as a matter of public health – must become vaccinated with, or must ingest, such an anti-viral concoction, then, perhaps, the proper way of treating such maladies lies in another direction.

More specifically, if viruses do not have a causal role to play with respect to the occurrence of diseases such as influenza (and, to date, the viral theory of influenza rests on evidentially problematic grounds), and if, furthermore, viruses do not have a role to play in pathologies like SARS, MERS, Zika, COVID, and so on (and, once again, there has been no proper process of virus isolation that identifies different kinds of viruses as causing the foregoing maladies), then public health in those circumstances

need not depend on discovering and mandating certain kinds of virology-based vaccines or pharmaceuticals.

Instead what is required is a shift in the nature of the paradigm through which those diseases are explored. In other words, if the nature of the problem with respect to the foregoing sorts of maladies is not a function of the role that different kinds of infectious agents of a viral nature play, then, perhaps the problems associated with, for example, influenza, might be better resolved if one were to suppose that the diseases mentioned previously might be due not to viruses but, instead, could be due to, for example, the impact that different kinds of electromagnetic and/or chemical poisoning are having on the environment along with the ecologies that reside in the environment.

If the latter possibility were the case, then the onus of responsibility for combating those pathologies would no longer be a matter of trying to foist off some sort of mandated vaccine or pharmaceutical program onto the people and, then, proceeding to try to argue that resolving those health crises requires individuals to do their civic duty and take their medicine in order to protect others. Instead, the responsibility for combating the aforementioned diseases shifts to those who are poisoning the environment through chemical, electromagnetic, and/or biological means, and, therefore, what must be mandated are not various kinds of vaccines or pharmaceuticals but, rather, mandates should be issued which require various environmental polluters to cease and desist with respect to the activities which are poisoning human beings.

Toward the latter part of his 1998 PBS interview, Taubenberger returns to the idea of evolutionary adaptation. For example, after mentioning how there are many bacteria which can be found on our skins and within various parts of the gastrointestinal tract that are well-adapted to the surrounding biological environment and which actually perform many useful functions for their hosts – such as generating vitamin K – he goes on to allude to different kinds of bacteria and viruses that are not well-adapted to their hosts and, as a result, those

entities take on what Taubenberger believes to be is an adversarial relationship with their hosts.

Taubenberger does not explain how bacteria and their hosts came to work out adaptive solutions which serve their mutual interests – or how they discover ways that, at least, do not adversely affect one another. Furthermore, he does not mention the fact that there are many different kinds of agents that have been found on, say, human skin – such as staphylococcus aureus – that, under the right circumstances, are potentially harmful but which, for unknown reasons, are not always active, and, therefore, contrary to what Taubenberger claims, do not automatically take on an adversarial relationship with their hosts.

In any event, Taubenberger indicates that if an agent -- virus 'x' -- were to behave in an overly aggressively manner with respect to their hosts, then, the infected individuals will die too quickly. As a result, this sort of aggressive activity would tend to prevent that virus from being able to move on to other hosts.

Taubenberger alludes to the idea that the alleged 1918 virus seems to have avoided the foregoing sort of problem and, instead, was able to work out a good evolutionary strategy. In other words, although he believes that the virus killed a lot of people, nevertheless, it somehow managed to constrain its activities in ways that only lethally affected somewhere between 2 and 5 percent of the population.

According to Taubenberger, by behaving in the foregoing manner, such a strategy provided the virus with an opportunity to move from host to host and, thereby, spread all over the world since only a relatively small percentage of the host population succumbed to the alleged onslaught of that virus. One wonders, however, whether the aforementioned 2-5% solution is the product of an evolutionary strategy that emerged in some inexplicable manner or whether that percentage merely reflects the possibility that 2-5% of the population is, for whatever reasons, vulnerable to the presence of certain kinds of agents and, therefore, the 2-5% figure might have nothing to do with some sort of viral evolutionary strategy but, instead, just

gives expression to the manner in which viral agents with certain kinds of properties interact with susceptible biological systems in a given set of contingent circumstances and, in certain instances, leads to a series of complex interactions that result in the demise of some of those organisms.

Taubenberger maintains that as a virus is transmitted from locale to locale in different regions of the world, people eventually would have developed an effective immune response to the virus. He further contends that such a state of affairs of general immunity would have placed the virus under "enormous pressure" to undergo mutation so that it could change some facet of its genetic composition – such as the part of the genome that gave expression to one or another protein on its surface – in order to be able to find new ways of infecting human hosts.

Notwithstanding Taubenberger's foregoing account, one might suppose that mutations either occur, or they don't. One does not need to assume that there is some sort of "pressure" that is present which induces a given virus to mutate in certain directions.

Taubenberger's use of the term "pressure" might merely be his way of framing the discussion by means of a theory which seeks to advance the possibility that there is some kind of "force" in existence which is capable of inducing organisms to move in – or mutate in -- new directions that will prove to be adaptive. However, over a period of several billion years, the primary lesson of life on Earth would seem to be that, sooner or later, almost all species tend toward extinction irrespective of whatever changes might, or might not, take place with respect to their genomes.

As far as we know, to whatever extent viruses exist, they consist only of a glycoprotein coating which houses either an RNA or DNA-based genomic reservoir which codes for a small number of genes that, under the right circumstances, supposedly enable those viruses to go about the business of replicating themselves by hijacking the machinery of a host cell or organism. Whether the foregoing entities can be considered to be alive in some sense is a debatable issue, but irrespective of

their existential status, there is nothing in their molecular or genetic composition which would seem to suggest that there is some underlying force or pressure within them, or working through them, that requires mutations of a certain kind to emerge … namely, mutations that would allow those entities to find new ways to infect and/or inflict damage on a host.

However, Taubenberger resorts to the idea of viruses operating under an 'extreme pressure' to bring about adaptive mutations of certain kinds in order to account for why, after 1918, the alleged pandemic did not continue on but, eventually, petered out. Presumably, the virus had undergone some sort of mutation that would permit it to continue to circulate within the human population but, in the process, had – due, perhaps, to the immune responses of host organisms – lost the ability to have anything more than a limited capacity for lethality with respect to all but a small percentage of human beings who were somehow vulnerable to such a viral presence.

Yet, to suppose, as Taubenberger does, that a virus must mutate if it is to continue on is not necessarily true. Indeed, until one knows why some people are either more vulnerable than others -- or vulnerable at all -- to the presence of a viral agent, one cannot necessarily suppose that the virus will have to mutate in order to continue to be able to infect a host.

Thus, irrespective of whether, or not, antibodies arise in conjunction with the presence of a given viral agent -- and leaving aside the issue of whether, or not, the presence of those antibodies helps confer sufficient immunity to prevent all of a virus's genetic potential from being able to express themselves -- it might be that some small percentage of a previous viral population will continue to exist even if such entities were to have lost their capacity to act in a lethal manner with respect to most individuals within a host population. A virus – to whatever extent it exists – has certain capabilities that (given the right opportunity) will be expressed, but in other circumstances might just remain inactive.

If the right kind of conducive circumstances do not arise, then, even if the virus was not able to fully express itself,

nonetheless, it might continue to exist for an indeterminate or indefinite period of time quite independently of whether, or not, a host actively engages – or is engaged by -- such an agent. The entity just wouldn't replicate, and since viruses – to whatever extent they exist – are not necessarily "alive," then whether or not replication continues to occur is not necessarily a matter of "life and death" for such an entity.

The life cycle of a virus – to whatever extent it exists -- is digital in nature. It is either on or off … that is, it either replicates or it doesn't.

Whatever else happens with respect to such an entity – in the way of lethality or infectivity or pathology – will be a matter of the particular manner in which a given virus and a given host interact with one another during the time in which the two are in contact. Conceivably, a virus could remain inactive or dormant even though the circumstances that are necessary for replication are not present, and, yet, such a body might still continue to inhabit a host just as bacteria like staphylococcus aureus can be found in human beings in a non-active or non-problematic state.

Consequently, Taubenberger's notion that viruses must mutate in order to continue their existence is little more than a conjecture. While the possibility that he mentions is consistent with the theory of viruses as well as an evolutionary framework, there is not any evidence which is capable of definitively demonstrating the truth of the conceptual thrust of his conjecture concerning the existence of some sort of pressure that induces a virus to continue to mutate in ways that are increasingly adaptive in some sense of the word.

Indeed, one might suppose that developing some sort of capacity for lethality is actually counterproductive for a virus's continued viability. Viruses appear to complete their life-cycle via replication and not through inflicting pathology.

There is no evident evolutionary purpose that appears to be served by enhancing the capacity of a virus to inflict pathology. Being able to gain access to the interior of a cell or to be able to find a way out of that cell or to be able to borrow some of a cell's

potential to replicate does not necessarily require the virus to be able to "infect" that cell in pathological manner and, thereby, cause some sort of disease anymore than DNA or RNA needs to inflict damage on a cell in order to be able to replicate.

Taubenberger's 1998 PBS account of the 1918 pandemic leaves unanswered a number of questions. For example, what was the specific nature of the recombinant event(s) involving -- at least, possibly, initially -- birds and mammals (such as swine) and, then, how did the process of species jumping continue on by, allegedly, making the transition from the foregoing sorts of mammals to human beings? One also would like to know the precise character of the dynamics of lethality that supposedly arose in an unknown manner, and, therefore, one might ask whether the lethality came from birds, or mammals, or, in some unanticipated way, emerged during the time when the jump was made to human beings? Finally, one might also ask why and how such a lethal agent suddenly appeared to vanish.

Apparently, Taubenberger is putting forth nothing more than a narrative which has been woven from various assumptions and conjectures based on a hermeneutical engagement of different kinds of empirical data. Indeed, in many respects, virology – and any discipline (for instance, molecular pathology) that has a potential for contributing to the development of virology -- appears to be nothing more than a theoretical narrative which seems to be masquerading as a set of scientific discoveries.

Taubenberger states that: "Historically, it seems that most new influenza viruses emerge in Asia, in the Far East, which is another thing that's unusual about the 1918 virus because everything we know historically suggested that it actually originated in the United States." One might wonder, however, about why different kinds of influenza supposedly have such an inclination to begin in Asia.

Could the foregoing sort of asymmetry in racial or ethnic susceptibility be a function of certain kinds of environmental conditions (e.g., electromagnetic, chemical, as well as biological)? Or, could such a racial or ethnic asymmetry be due

to some sort of genetic vulnerability that is more pronounced in Asians relative to other racial and ethnic groups? Or, perhaps such an asymmetry might be due to some sort of systemic iatrogenic issue in which various kinds of pneumonia and respiratory diseases are being misdiagnosed as, or confused with, influenza, and, as a result, one is being given a distorted impression of what is actually taking place or whether there is any actual kind of asymmetry in susceptibility to influenza that is present.

Nonetheless, notwithstanding the foregoing sorts of considerations, Taubenberger's claim that the 1918 event started in the United States is not necessarily capable of being verified. More specifically, there is a considerable body of evidence (e.g., see *Virus Mania* by Torsten Engelbrecht and Claus Köhnlein, as well as *The Invisible Rainbow* by Arthur Firstenberg) indicating that large numbers of people were dying all over the Earth from influenza-like maladies at roughly the same time in 1918, and, indeed, even Taubenberger states during the PBS interview that the spread of influenza took place with an incredible rapidity that occurred "within a period of a month or so in the fall of" that year.

Consequently influenza-like deaths were taking place in many locations around the world in a fashion that seemed to be faster than could be accounted for by any possible route of surface transmission that was available at that time (e.g., horses, automobiles, trains, or ships). On the other hand, the seemingly inexplicable rapidity of disease transmission in 1918 would be quite consistent with the possibility that the deaths being attributed to the "Spanish Flu" were actually due to the generation of electromagnetic frequencies that were poisoning people all over the world in a, more or less, simultaneous fashion at roughly the speed of light.

The explanation which Taubenberger offers as a way of trying to account for why influenza tends to emerge in Asian societies rather than in Western nations is zoonotic in nature. In other words, he contends that the cultural eating habits of many

Asians involves going to so-called wet markets where various exotic life forms are available for purchase and consumption.

Presumably, somewhere along the line -- during or following the aforementioned visits to the so-called wet markets -- influenzas supposedly made a species jump from birds to mammals of one kind or another, or, a species jump allegedly transpired between mammals of one kind to other mammals such as human beings. Yet, as intimated previously, Taubenberger really doesn't appear to have any concrete evidence that is capable of demonstrating the validity of his zoonotic hypothesis.

Taubenberger goes on to indicate that during the 1950s "influenza viruses could be cultured and characterized in the laboratory." Technically speaking, however, viruses are not living and, therefore, do not need to be cultured. Indeed, short of a fully functioning host, there is no medium in which one could place a virus in order to help it grow and replicate.

In fact, if a given virus is functional, then, one does not need to place such a virus in some sort of medium culture. All one has to do is take a virus that has been properly isolated – and, therefore, separated from everything else including a culture medium of some kind – then, expose a potential host to that isolated virus and, finally, just wait to see what takes place.

This is what transpires in the wild, so to speak. Introducing cultured mediums into the research process merely obfuscates the character of whatever pathogenic dynamics might follow.

According to Taubenberger, various attempts were made to exhume bodies of individuals in Alaska and elsewhere who supposedly died of influenza during 1918. However, while those exploratory expeditions were able to bring forth live bacteria through the use of various kinds of culture mediums, no one had been able to induce influenza viruses to surface.

In passing, Taubenberger mentions the work of a Canadian researcher, Dr. Kirsty Duncan, who has been attempting to locate the bodies of individuals who had died from influenza in 1918 but who had been buried in very cold – i.e., frozen –

conditions. He notes that she is hoping to be able to uncover functional viruses from the foregoing sorts of cold storage exhumations.

Taubenberger contends that he feels the aforementioned research venture is not likely to succeed. He goes on to indicate that influenza viruses are quite fragile and that although bodies frozen in permafrost might retain some fragments of viral RNA, nonetheless, those samples would be unlikely to contain "live" or viable viral entities because of – as previously noted -- the fragile character of the influenza virus.

While Taubenberger mentions the extremely fragile nature of influenza viruses in the foregoing overview, nonetheless, he doesn't actually go into any sort of detail about the kind of environmental conditions that are necessary in order for a virus to be able to "survive" – i.e., be in a position to replicate when conditions are right. Presumably, the understanding which the aforementioned sort of missing information might help engender would be of value if one wanted to try to figure out the nature of the dynamic through which influenza viruses and human beings tend to engage one another, and, furthermore, such information also would be of value if one wished to determine what kinds of conditions might be more conducive or less conducive to such alleged viruses becoming active within a host – human or otherwise.

Taubenberger believes that, generally speaking, societies in 1998 are in a much better position than they were in 1918 to be able to deal with potential pandemics. He feels this is the case because, among other things, "…we know that influenza viruses exist, and we can analyze them and watch their emergence and evolution." In addition, Taubenberger maintains that societies also are better prepared to deal with potential forthcoming pandemics due to (1) advancements in medical treatment such as drugs that, supposedly, are able to thwart the capacity of influenza viruses to, for example, replicate, as well as due to (2) the emergence of influenza vaccines which Taubenberger claims "are obviously the most important factor of our current armamentarium against influenza viruses."

However, as noted previously, neither Taubenberger, nor anyone else, has actually gone through the necessary set of rigorous procedures which are capable of properly isolating, characterizing, or sequencing the alleged 1918 influenza virus, nor, in addition, has he or other researchers also been able to go on to reliably demonstrate that such isolated virus are both infectious as well as lethal. Moreover, the antiviral treatments that are used to treat various viruses have proven, quite frequently, to be quite hazardous in their own right (for example, consider the deadly impact that the use of AZT had on the treatment of alleged cases of HIV or the impact that remdesivir is having on the people to whom it is administered).

Finally, notwithstanding Taubenberger's foregoing claim to the contrary concerning the alleged essential role of vaccines, there is considerable evidence that flu vaccines (e.g., see *Jabbed* by Brett Wilcox; *The Vaccine Court* by Wayne Rohde; Dissolving *Illusions: Disease, Vaccines, and the Forgotten History* by Dr. Suzanne Humphries and Roman Bystrianyk; *Vaccines: A Reappraisal* by Dr. Richard Moskowitz, *Vaccine Epidemic*, edited by Louise Kuo Habakus and Mary Holland, as well as *What Really Makes You Ill? – Why Everything You Thought You Knew About Disease Is Wrong* by Dawn Lester and David Parker) are neither safe nor effective. In this respect, one might consider, among other possibilities, the fiasco that arose in 1976 with respect to so-called swine flu in which hundreds of cases were documented in which human beings suffered from Guillain-Barré Syndrome, instances of transverse myelitus, or death as a result of the flu vaccines that were given in 1976.

One might also note in closing – and as was intimated to be a topic that would resurface toward the beginning of this article -- that early in the PBS interview Taubenberger listed a number of features that were atypical with respect to cases of influenza that had been encountered prior to the 1918 event. More specifically, he indicated that: (1) the death of many individuals took place very rapidly following the onset of symptoms; (2) a substantial number of the cases that occurred in 1918 exhibited

signs of pneumonia edema without any accompanying inflammation; (3) a large proportion of the cases he studied involved individuals who had been healthy and were young, rather than the sort of elderly people who, in the past, normally fell victim to influenza; (4) the "influenza" that occurred in 1918 seemed to emerge, more or less, simultaneously in different parts of the world rather than following some sort of epidemiological path that moved from one location to the next via individuals who were traveling by foot, or via horses, trains, or ships.

Nothing which Taubenberger stated in the 1998 PBS interview is capable of providing an answer to any of the foregoing anomalies that he, himself, introduced into the discussion and which seemed to differentiate the 1918 event from previous bouts of influenza. While he offers a lot of conjectures during his interview, nevertheless, he does not provide much in the way of substantive, definitive information that is capable of addressing the four aforementioned anomalies that apparently were uniquely characteristic of the 1918 "influenza" event and do so in a satisfactory manner.

Finally, as indicated earlier in this essay, during the 1998 PBS interview, Taubenberger attempted to describe some of his research concerning the hemagglutinin gene and, in the process, sought to link that work to the events of the 1918 "Flu". However, at best, his research only appears to advance a theoretical narrative, of sorts, concerning what he believes transpired in 1918 rather than giving expression to a fully delineated account of the 1918 phenomenon that is capable of being empirically substantiated.

Chapter 9 – Christine Massey's Work plus Some Related Considerations

Christine Massey is a Canadian Biostatistician (M. Sc) who lives in the Province of Ontario. For nearly two years now she has been engaged in a Freedom of Information project (and she has since been joined by a fellow researcher from New Zealand – Michael S. -- who is using the same Freedom of Information process) to elicit information from various government agencies, universities, and research institutions about whether, or not, any of the foregoing establishments can provide documented proof concerning the alleged existence of the SARS-CoV-2 virus.

When either Christine, or her New Zealand colleague, approaches someone for purposes of making inquiries about the purported existence of the SARS-CoV-2 virus, they are quite careful to clearly state exactly just what kind of information they are seeking. For instance, whenever requests for such information are sent, those overtures contain the following sorts of specifications: "Can you please clarify if you have any records of the separation of SARS-CoV-2 from everything else (known as isolation and purification). … Please use the Merriam-Webster dictionary's common definition of isolation."

At this point in her request she would give the definitions offered by the Merriam-Webster dictionary for three words – namely, "isolation" (noun, the action of isolating, the condition of being isolated; "isolated" (adjective, occurring alone or once; unique); "isolate" (to set apart from others; to select from among others especially: to separate from another substance so as to obtain pure or in a free state).

Sometimes, in response to the foregoing sort of request, an agency, institution, government body, university, or individual might respond in the following manner. 'The definition of "isolation" provided in the request is outside what is possible in virology, as viruses need cells to replicate, and cells require liquid food. However, the SARS-CoV-2 virus may be isolated from a human clinical specimen by culturing in cell culture, which is the definition of "isolation" as used in microbiology.'

Consequently, such a response indicates that virology or microbiology is not capable of isolating SARS-CoV-2 to such a degree that the virus can be shown to have been isolated from everything else

(including the cell culture and liquid food that is used to maintain the culture that are used to, allegedly, help the virus replicate). Moreover, the foregoing sort of response stipulates that the very meaning of "isolation" in microbiology and virology is limited to contexts in which a virus is believed or considered to be part of the mix in such a culturing process but which, nonetheless, cannot be proven to be present.

In short, one takes a clinical specimen from a person who is sick. One runs that specimen through a culturing process, and the end product of that culturing process is said to contain (for reasons to be explored a little later) the virus that is believed to be responsible for whatever symptoms are present in the individual from whom the aforementioned clinical specimen had been taken.

On occasion, respondents will provide electron micrographs of entities and claim that the objects being depicted have been located in the bowels of the conglomeration that results from the culturing process, and, as a result, often go on to conclude that such EM images depict the presence of a virus. However, unless one can actually show that those imaged entities actually give expression to something that contains roughly 30,000 base pairs (the purported size of the SARS-CoV-2 virus) that can be shown to be genetically sequenced in a way that is unique to, and reflective of, an independently isolated form of SARS-CoV-2 (that is, one which is free from all traces of the culturing process), then, really, virologists and microbiologists are guilty of a massive sort of circular thinking.

Such researchers assume – or hold as a hypothesis -- that a virus exists in a given clinical specimen that has been taken from a person who is ill. They culture that specimen in a way that never permits one to isolate any purported virus that might be contained within such a clinical specimen and, thereby separate such an entity from the other ingredients of a culturing process, and, instead, they call the cultured conglomeration – which might, at some point, have undergone a process of filtration) an "isolate" which, almost by definition, means – at least as far as most microbiologists and virologists are concerned -- that a virus of some kind exists within such a conglomeration. Then, on occasion, Electron Micrographs are provided of something that is roughly viral-like in size and which has been found to be present in the

cultured stew, and one is asked to accept – without any sort of independent proof – that the EM images depict the very virus which was claimed to be present in the clinical specimen that had been taken from an ill human being.

Apparently, no one thought to gather or probe – in some fashion – the entities that are being depicted in the EM and try to determine what the nature of their interiors might be. Do those imaged entities contain approximately 30,000 base pairs of genetic material as has been estimated by various virologists and microbiologists in conjunction with their theories concerning SARS-CoV-2? If such base pairs are present, can one show that they have a genetic sequence that uniquely differentiates the entities found in the clinical specimen from all other species of viruses, and, therefore, establishes that one is dealing with SARS-CoV-2 and not some other form of virus? Finally, how does one obtain an independent exemplar that can serve as a basis for comparison between what one finds in a given clinical specimen that has been cultured and what one knows, from independent sources, to constitute a clear and unambiguous instance of properly isolated and sequenced SARS-CoV-2?

Beyond the foregoing considerations, there are a variety of conditions that would have to be satisfied. This has to do with the protocols set forth by Thomas M Rivers in 1937 that were intended to update – or extend – the protocols set forth by Robert Koch in 1884 for determining whether certain microorganisms might be responsible for a given disease.

At the time that Koch put forth his postulates concerning an array of microorganisms, the notion of a virus was, at best, rather vague and iffy. When Rivers came up with a set of postulates that were somewhat similar to the ones that had been advanced by Koch, Rivers wanted to be able to add viral entities to the sorts of microorganisms (many orders larger than the alleged realm of viruses) with which Koch had been concerned and, thereby, be able to have a method for determining whether, or not, some given virus of a lesser size or microorganism of a larger size might be responsible for the existence of a certain kind of illness.

In 1919 clinical experiments had taken place in both Boston and San Francisco in which healthy individuals were exposed to

individuals who were in all different stages of the so-called Spanish Flu. The exposure ranged from having sick people: Breath on, cough on, and expectorate on healthy individuals, to: Taking clinical specimens from sick individuals and transferring that material to healthy individuals.

Surprisingly, not one of the healthy individuals engaged in this series of studies ever came down with the Spanish flu. If that flu was so infectious and contagious why weren't the individuals who had semi-volunteered for the studies getting sick.

Similar sorts of studies were carried out by a team of researchers led by Nancy Padian with respect to the whole HIV causes AIDS narrative. During the time of the study, Dr. Padian was the Director of International Research for the AIDS Research Institute at the San Francisco campus of the University of California. The results of her study were published in a 1997 edition of *The American Journal of Epidemiology*.

The foregoing study lasted ten years. The purpose of the study was to try to quantify the rate of transmission of HIV among heterosexuals.

Therefore, the research sought to determine the number of incidences of HIV that might occur among individuals who had not tested positive for the presence of HIV but who did live with individuals who had tested positive for HIV – all of whom had agreed to participate in the study. Yet, across the ten years during which the study continued, not one non-positive individual ever became positive or showed any signs of either HIV or AIDS.

In any event, returning to Koch and Rivers, if one wants to demonstrate that some given microorganism or virus is responsible for the existence of a given disease, then, one has to show that if one actually isolates – in the true sense of isolation – such an entity from the culturing process, then when that entity is transferred to a healthy individual, the latter will become ill with precisely the same kind of illness as had been observed in the individual from whom a clinical specimen was originally taken. Moreover, one would, then, have to once again isolate – in the true meaning of the word – the entity that had been transferred to a healthy organism (that became sick following the transfer of material) and proceed to demonstrate that

when such an entity was transferred to, yet, another healthy organism, the latter organism would also become sick in ways that were fairly similar to what had transpired earlier with the other organisms involved in such a study.

If one continues to insist as most microbiologists and virologists do that only a cultured conglomeration of materials constitutes an isolate, then, one really is not in a position that would permit one to be able to perform the necessary experiments that would enable one to clearly separate out, or control for, an array of alternative, causal possibilities through which one could narrow one's methodological focus to be able to identify a given virus as the causative agent in a particular disease. The so-called isolates of microbiologists and virologists are simply too compromised with extraneous materials to be able to assist one to single out what might be a causal agent for some given disease that might, or might not, be present in such a cultured conglomeration of biological materials.

On March 3, 2021, Christine Massey received a response from the CDC concerning her request for information about the existence of SARS-CoV-2. The CDC response to her inquiry contained the following paragraph:

"SARS-CoV-2 is the virus that causes coronavirus disease 2019 (COVID-19). Active infection with SARS-CoV-2 is detected by diagnostic tests. Currently there are two types of molecular tests that detect the virus's genetic material and antigen tests that detect specific proteins on the surface of the virus."

When Cory Mullis worked at the NIH in the 1990s, one of his first tasks was to write a paper on the HIV-AIDS issue. He wanted to start out his article with a claim that would have been similar to the foregoing claim of the CDC that SARS-CoV-2 causes coronavirus, but his claim would have been that HIV causes AIDS.

He began to do research in search of evidence that would support the claim that HIV causes AIDS. He could find no paper, article, or document that was capable of sustaining such a claim.

As a result, he began to make inquiries concerning the issue with all manner of researchers, academics, medical authorities, and other

scientists. None of the people he asked could provide him with the information that he sought – namely, that HIV caused AIDS.

He even cornered Luc Montagnier who had been part of a team that had won the Nobel Prize for their collective work concerning the alleged discovery of HIV. Apparently, Montagnier became upset with the conversation, but, the end result was that he was not able to provide Mullis with information or a document or an article that demonstrated that HIV causes AIDS.

The CDC claims that SARS-CoV-2 causes coronavirus. What is the empirical basis that demonstrates the truth of such a claim? The CDC contends that there are two kinds of tests which are capable of detecting the presence of the SARS-CoV-2 virus.

One test is a molecular one that supposedly detects the presence of the virus' genetic material. Yet, no one has been able to demonstrate that, for example, the EM images of entities that have been located within the cultured conglomeration that microbiologists and virologists misleadingly refer to as an "isolate" actually give expression to images of something that, independently, have been shown to consist of roughly 30,000 base materials of genetic material that have a sequence which has been demonstrated to be unique to SARS-CoV-2 and to no other virus.

The very purpose of Christine Massey's inquiries over the last several years has been to ask for whether or not a given agency, university, institution, or government body has evidence to indicate that such a unique exemplar of SARS-CoV-2 has been unequivocally found and that such a discovery has been documented. More than a hundred such Freedom of Information responses have been received by Christine Massey and her New Zealand colleague, and not one of those responses indicates anything other than that the individuals and institutions to which she wrote do not have such documented proof or evidence for the existence of SARS-CoV-2.

The inquiries went out to institutions and agencies all over the world – including the United States (for example, the National Institute of Allergies and Infectious Diseases which is run by Tony Fauci) , Canada (e.g., Health Canada), England (e.g., Prime Minister's Office, as well as the Government Office of Science), Europe's Center for Disease Control, India, Portugal, Norway, Ukraine, Spain, Scotland, Slovenia,

the Republic of South Africa, New Zealand, Uruguay, Wales, The Republic of Ireland, the Netherlands, the Czech Republic, Denmark, Australia, Brazil, and Columbia. In each and every instance, the response was always in the negative – that is, none of the respondents had any documents that were capable of showing or demonstrating that SARS-CoV-2 had been isolated in the sense to which Christine Massey was alluding.

One also might note that in addition to responses concerning the existential status of SARS-CoV-2, Christine Massey also received back information concerning any number of other kinds of viruses that were alleged to be associated with: HIV, measles, Zika, polio, 2003 SARS COV, Ebola, MERS, HPV, and the so-called common cold. In each case, the response indicated that such and such an agency or institution had no documented evidence capable of verifying that viruses supposedly responsible for the aforementioned diseases had been isolated and shown to cause those diseases.

With respect to the foregoing, one might note that during a June 7th, 2021 response to Christine Massey, The CDC stated:

"A search of our records failed to reveal any documents pertaining to your request. Specifically, the National Center for Immunization and Respiratory Disease apprises that CDC does not purify or isolate any "virus" addressed by any vaccine on either the childhood or adult U.S. "immunization schedule" virus in the manner he requested describes."

All of the foregoing suggests that, perhaps, the alleged viral causal counterparts to any number of conditions for which vaccines are offered to children and adults might be nothing more than a set of fictions designed to convey a narrative that might induce individuals to assume that vaccines are capable of protecting them against viruses which have never been properly isolated or proven to exist.

The other test mentioned by the CDC in its response to Christine Massey for allegedly being able to detect the presence of SARS-CoV-2 were antigen tests that, supposedly, were capable of detecting the presence of specific kinds of proteins that were said to be present on the surface of the virus. Once again, such a response constitutes little more than a form of misdirection because, as noted earlier in this book, globulin proteins are often quite promiscuous with the sorts of antigens in which they hook up, and, consequently, the presence of an

association between a given antigen and a given globulin protein does not necessarily demonstrate that there is a unique relationship between a given antigen and a given globulin protein (i.e., alleged antibody).

Moreover, the number of antibodies present in someone's system may elevate due to various forms of oxidative and nitrosative (oxides of nitrogen) stress to which a person's immune system is being exposed over a period of time. For example, if an individual's immune system is being buffeted about due to extended exposure to various kinds of environmental toxins, psychological turmoil, nutritional deprivation, or drugs (whether legal or illegal), then one is likely to observe an elevated presence of antibodies in a person's system which are attempting to help repair damage caused by the aforementioned sorts of stressors or to assist in a processes of detoxification with respect to those kinds of stressors.

In fact, although those who are in favor of vaccines use the elevation of antibodies in serological titers as an indication that said vaccines have helped to immunize a person with respect to this or that disease, this interpretation might not be correct. Such an elevated presence of antibodies could be just the body's way of responding to the oxidative and/or nitrosative stress that are being caused by the presence of various ingredients (e.g., adjuvants) within the aforementioned vaccines that are being introduced into a person's body.

Furthermore, in the light of the considerable number of Freedom of Information responses presented by Christine Massey indicating that there is no one apparently – at least, to date -- who can confirm that they are in possession of documented evidence demonstrating that an approximately 30,000 base pair genome has been discovered that gives expression to a sequence that can be shown to uniquely belong to the alleged SARS'CoV-2 virus, then, how does one know that the antigens used in the tests to which the CDC is referring (in its aforementioned letter to Christine Massey) are uniquely responding to the presence of the SARS-CoV-2 virus rather than exhibiting behavior that is typical of many antigens in the sense that they can be quite promiscuous in their activity or in the sense that such antibodies might arise because a person's immune system is, for whatever reason,

being placed under oxidative or nitrosative stress and, as a result, antibodies or globulin proteins are capable of linking up with any number of antigens that are present in a person's body in a manner that might not have anything to do with antibody specificity for a given antigen.

Where is the independent – and not assumed -- proof that such antigens have a specific affinity for SARS-CoV-2, or some aspect thereof? The fact is there is no such proof.

Like Drosten and Landt have done time and time again, enterprising people come up with some sort of artificial or synthetic artifact that they believe – on the basis of questionable computer modeling and analyses – has something to do with the virus for which they are searching (in this case, SARS-CoV-2). Moreover, if such enterprising individuals get some sort of connection between a given antigen and a person's body, they conclude that the artificially constructed antigen can be said to have detected the presence of the sought for virus, when, in actuality, all they have shown is that one can demonstrate that such an antigen is capable of hooking up with one, or another, facet of a person's biology, and, despite the presence of such an affinity, the test actually does not have any way to independently demonstrate that the reason for that affinity is necessarily due to the presence of the SARS-CoV-2 virus.

The CDC response to Christine Massey goes on to assert that: "Evidence of SARS-CoV-2 infection can be found in a study entitled, "Pathology and Pathogenesis of SARS-CoV-2 Associated with Fatal Coronavirus Disease," which includes electron microscopy images of SARS-Co-V2 in infected lung and upper airway tissues as well as staining of lung and upper airway tissues using an antibody against SARS-CoV-2. The specimens analyzed in this study were from patients with common signs and symptoms associated with COVID-19, including fever, cough, and shortness of breath. All patients had abnormal findings on chest radiographs." However, there are a number of problems and questions that can be raised in conjunction with the sort of perspective being forth by the CDC.

For example, the fact that there were abnormal findings present on all chest radiographs of the patients being studied says absolutely nothing about what caused those abnormal findings. Furthermore, the

presence of a fever, cough, and shortness of breath could be indicative of a lot of different kinds of pathology, and, consequently, such symptoms are not sufficient to rule out all possibilities except for COVID-19.

In addition, the CDC's claims that there were electron microscopy images of SARS-CoV-2 in affected lung and upper airway tissues is an exercise in framing the situation. One doesn't have to dispute the existence of such images in order to point out that the study in question never actually showed, in any independent fashion, that such images depicted a roughly 30,000 base pair genome (the purported size of the alleged SARS-CoV-2 virus) that had a genetic sequence which could be shown to be unique to SARS-CoV-2 virus and no other entity.

Because the images recorded through electron microscopy were of entities that, at some point, were found during, or following, the process of culturing the clinical specimen taken from individuals who had certain kinds of symptoms that have been associated with a condition to which the label "COVID-19" has been affixed, an assumption was made by the CDC – without any evidence to substantiate such a presumption – that such entities or objects demonstrate the presence of the SARS-CoV-2 virus, and, they claim, that it is this virus which is responsible for the abnormal features that are present in the chest radiographs.

Moreover, one can acknowledge that the staining of the lung and upper airway tissues to which the foregoing paragraph of the CDC response to Christine Massey refers might have been accomplished through the use of an antibody or protein of some kind which the CDC letter claims to be against SARS-CoV-2. Nevertheless, there actually is no independent evidence indicating that such an antibody is specific to SARS-CoV-2 (i.e., and this could only be done by isolating a 30,000 base pair genome that has a genetic sequence that can be shown to be unique to SARS-CoV-2) nor is there any evidence indicating that such an antibody couldn't enter into any number of promiscuous interactions with an array of different kinds of proteins and other artifacts that were present in the lungs and upper airway tissues that were being studied and which enabled such a staining process to go forward.

If SARS-CoV-2 does not exist, then the so-called antibody against SARS-CoV-2 is a complete fiction. Furthermore, if SARS-CoV-2 does not exist, them there might be any number of reasons why a certain protein could be used in a process of staining, but none of those reasons necessarily has anything to do with SARS-CoV-2.

The entire CDC position consists of nothing more than Will-O'-The-Wisp theoretical material. There are assumptions, claims, and an absence of evidence that can substantiate any of those assumptions and claims, and all of this is done in a manner that cannot actually be tied to a 30,000 base pair genome which has a genetic sequence which can be shown to be unique to SARS-CoV-2. Therefore, the entire CDC edifice just flits about, in an empty, arbitrary, flashing, elusive, gaseous sort of way, within letters and pronouncements like the one they wrote to Christine Massey.

When Christine Massey contacted NIAID (Tony Fauci's plaything within the NIH as well as the government agency that constitutes the source of his oppressive control over much that does, or does not, take place in the realm of research within different government agencies, universities, hospitals, and an array of private laboratories) with a Freedom of Information request, she received back the response: "We have previously queried our Division of Clinical Research for records responsive to similar requests. Your request is properly directed to the Centers for Disease Control and Prevention (CDC) as they are the ones who did the isolation." Obviously, the people at NIAID are as ignorant about – or as duplicitous concerning -- the SARS-CoV-2 issue as is the CDC.

Chapter 10 --A Partial, Retrospective Look at Research Concerning SARS-CoV-2

The observations and comments in the previous chapter concerning the work of Christine Massey and her New Zealand colleague with respect to seeking evidence that the SARS-CoV-2 virus actually exists is somewhat passive in nature. In other words, while Christine Massey accumulated considerable documentation in which a variety of institutions, research centers, hospitals, universities, government agencies, and the like all admitted that they did not possess any evidence or material that was capable of demonstrating the existence of SARS-CoV-2, nevertheless, the absence of evidence surrounding the SARS-CoV-2 hypothesis does not necessarily mean that her findings constitute evidence of absence with respect to the possible existence of SARS-CoV-2.

In order to address the latter issue, one must take a much more direct and active approach. One needs to show how and why the methods of virologists are incapable of demonstrating that the SARS-CoV-2 virus exists.

Although there are variations that permit certain degrees of freedom to be exercised in developing protocols for culturing a virus and generating what is termed an “isolate”, nonetheless, all of those variations work off an underlying methodological template which has not really changed since the mid-1950s when John Enders began to do such work.

The normal format for a professional research paper consists of a number of sections. These include: an abstract; introduction; methodology; results; discussion, and, finally, conclusion.

While each of the foregoing sections has a role to play, one of the most important features of such a research paper lies within the section on methodology because the methods that are used will have a pervasive impact on the structure and content of all of the other sections of the paper. To get a sense of a paper, many people will read its abstract, but the real measure and value of such articles tends to be found within the section on methodology because that is the section of the article that actually informs a reader what any given experiment is actually about.

Let's consider some research that was conducted in late 2019, or early 2020, and was led by N. Zhu, et. al. For example, the title of one paper (Reference #1) is: "A Novel Coronavirus from Patients with Pneumonia in China," and it was published in the *New England Journal of Medicine* (382), pages 727-733, 2020. The title of a second paper (Reference #2) that was authored by L.L Ren and others) is: "Identification of a Novel Coronavirus Causing Severe Pneumonia in Humans: A Descriptive Study," This latter study was published in the *Chinese Medical Journal* (English), pages 1015 -1024, 2020).

The title of the first paper – (Reference #1) -- indicates that a Novel Coronavirus was discovered in conjunction with some patients who had pneumonia in China. The title of the second paper – Reference #2 – claims (more forcefully) that a novel form of coronavirus has been discovered that is capable of causing severe pneumonia in human beings (rather than being just something that correlates with the presence of pneumonia).

The Discussion section of Reference #1 states that the researchers have discovered a species of coronavirus that is "likely" to have been the cause of severe pneumonia in the patients that were being studied in Wuhan, China. The Discussion section goes on to assert that:

"Although our study does not fulfill Koch's postulates, our analysis provides evidence implicating 2019-nCoV in the Wuhan outbreak."

If one has not fulfilled the requirements of Koch's postulates (and, more accurately, if one has not satisfied the requirements of Rivers' updating of the Koch postulates for use with possible viral materials), then, one has not shown that an isolated and purified form of a given entity that supposedly emerged, after culturing, in conjunction with some sort of swab from a patient suffering from a severe form of pneumonia, is capable of inducing other people to whom such an isolate is transmitted to also exhibit the same sort of severe pneumonia. So, one can't help but wonder just why one might suppose that whatever it is that a group of researchers believe they have discovered to be present in the specimen swab taken from a patient ill with severe pneumonia is "likely" to be the cause of the observed severe pneumonia, or what the nature of the evidence is that despite not satisfying any of the Koch-Rivers conditions for determining causality with respect to the etiology of a given form of severe

pneumonia, nonetheless, is said to be capable of implicating 2019-nCoVin in the Wuhan outbreak.

According to Rivers' reformulation and extension of Koch's postulates, a virus must be capable of being shown to be present in every instance of the disease for which it is purported to be a cause. If the disease occurs without the presence of that virus, or if the virus is present, but the disease is not actively being manifested, then, one has a prima facie case indicating that the relationship, if any, between a given virus and a given disease is problematic if not questionable.

Rivers also maintained that one needed to be able to completely isolate a given virus from a person's body and from all other products associated with a given disease process in order to be able to ascertain that it is the virus which is causing a disease and not some other artifact that might be part of the disease process. Rivers goes on to stipulate that the virus must be grown in a pure culture, and, as we will soon see, this really isn't something that virologists are able to do.

Finally, one must be able to demonstrate that an isolated/purified virus is capable of producing the same disease as the one which is associated with the swab that has been taken from an ill person. If one were to purify a virus, and then, expose, say, animals to that virus, and, yet, those animals did not exhibit any of the sorts of severe pneumonia that had been observed in the patient from whom a swab had been taken, then, once again, one has reason to question the nature of the relationship, if any, between an alleged virus and a given form of pathology, such as severe pneumonia.

In the discussion section of Reference #2, one finds the following words:

"These findings primarily indicate that the novel CoV is associated with the presence of severe pneumonia. However, it remains to be determined whether this novel CoV is capable of causing similar diseases in experimental animals." Yet the title of the paper in which the foregoing quote appears is: "Identification of a Novel Coronavirus Causing Severe Pneumonia in Humans."

There is a considerable disconnect between what the title of the article asserts and what actually is confessed with respect to the absence of any Koch-Rivers confirmation concerning the capacity of a

given form of CoV to be able to cause severe forms of pneumonia in humans during the Discussion section of that same paper. Unfortunately, many academics, researchers and medical doctors who are often pressed for time might tend to look only at the title of a paper, and, perhaps, its abstract before moving on to other things. Anyone who had limited themselves to doing things in the foregoing manner and, therefore who has failed to actually read the paper in its entirety, would be under the impression that some researchers in China had proven that CoV caused severe pneumonia when by the admission of the authors themselves in the paper's Discussion section, nothing of the sort had been demonstrated.

Let's consider – in more detail – another paper entitled: "The Pathogenicity of SARS-CoV-2 in hACE2 Transgenic Mice." The paper involved research by Bao and others. It appeared in *Nature*, Volume 583, in the July 30, 2020 edition of that journal.

The title of the paper makes a claim. It states that the pathogenicity of SARS-CoV-2 can be shown to be actively present in hACE2 transgenic mice.

Mice do not usually express ACE2 receptors. Consequently, one has to breed transgenic versions of those mice that are capable of expressing ACE2 receptors.

Such transgenic processes tend to lead to alterations in other aspects of the physiology of mice that extend beyond a capacity to manifest ACE2 receptors. Therefore, due to the presence of such alterations, the nature of whatever parallels are believed to exist between transgenic mice and human beings is uncertain.

There were two control groups in the Bao study. One group consisted of mice that had not been bred through a transgenic process and, therefore, were without a gene that was capable of being expressed in the form of ACE2 receptors.

Another alleged control group was referred to as being mock-infected. The mice in this group were also transgenic, but they were not given the concoction that supposedly contained whatever was causing the sort of illness that was observed in the individual from whom a swab of some sort had been drawn originally, and, instead, they were administered a phosphate buffered solution.

However, the foregoing mock-infected test subjects do not really constitute a true control group. To qualify as such a control, the transgender mice in this group should have been given bodily fluids of some kind that came from a healthy organism.

The study indicates that the non-control group of transgenic mice was "given" the virus. However, this actually obfuscates what is taking place.

Materials were taken from an ill organism and transferred to the transgenic group of mice. There was no evidence that what was transferred contained a virus, nor was there any evidence that even if present, such a virus was responsible for whatever illness was being observed.

Other materials were added to whatever was taken from an ill patient. Among other things, the resulting concoction contained Vero kidney monkey cells.

Vero kidney cells are a line of cells that were developed in 1962 in conjunction with African Green Monkeys. They are used in the culturing process because of the high degree of homology between monkey cells and human genomes, and, as such, they are believed to be able to serve as a sort of credible stand in for what might take place in human cells.

In addition to the Vero kidney cells, the process of culturing a virus also contains a number of other ingredients. Among these extras are: DMEM (Dulbecco's Modified Eagle Medium, a growth medium); fetal bovine serum; streptomycin, penicillin, or other antibiotics such as gentamicin and, sometimes, anti-fungal agents (e.g., amphotericin B) – all of which can be quite poisonous to Vero kidney cells.

Thus, when one considers the process of culturing a virus, one should understand that whatever swab of material comes from an ill organism (and quite independently of the issue as to whether such a swab does, or does not, contain viral material of some kind), that swab is co-joined with an array of other materials. These other materials have properties that are capable of obfuscating and confusing a person's understanding about whether, or not, viral particles actually exist in such a concoction.

A more rigorous way of trying to determine whether viral particles exist in the original swab that is taken from an ill organism would be to follow something akin to the following protocol. First one would need to filter the lung fluid in the original sample in order to remove cell-sized objects since the objects for which one is searching are far smaller than a cell.

Next, one would want to run the filtered material that was derived in step one through a density gradient centrifuge process. This will result in particles that have the same density being bound together in tight bands that permit one to distinguish such bands from other chemicals and particles that possess different density properties.

Third, one would need to identify the kind of density band in which one felt that viral particles of a certain kind were most likely to be found. Then, one would use a pipette or syringe to gather together whatever was in the density gradient band in which one was interested.

If one believed that such and such a density gradient band contained the virus in which one was interested, then, the final step would be to take that band which had been removed via a pipette or syringe and transfer the material, through one method or another, to the transgenic mice in the experimental group. Once that material has been transferred, one would wait to see whether, or not, any form of pathology or illness emerged and whether, or not, the nature of that illness or pathology was similar to whatever the nature of the disease process that had been present in the ill individual from whom test swabs had been taken originally.

Clinical manifestations were recorded in conjunction with the three groups of mice during the Bao experiment being outlined. The symptoms that were observed consisted of various degrees of weight loss and instances of slightly bristled fur, and, moreover, less than half of the mice in the study developed any symptoms at all.

Presumably, weight loss and slightly bristled fur are not typical symptoms associated with COVID-19. None of the mice in the study exhibited coughs or had any sort of respiratory problems, and, yet, experimenters had been claiming that what took place in the mice was evidence capable of demonstrating – as the title of their paper

stipulated – "The Pathogenicity of SARS-CoV-2 in hACE2 Transgenic Mice."

On June 8, 2020, the *Lancet* had published an article that provided some details about autopsies that had been performed in conjunction with 38 patients who had tested positive for COVID-19. Given what already has been established concerning the lack of credibility that surrounds the whole process of PCR testing, let's put aside that aspect of the *Lancet* and focus on some of the results of those autopsies.

Among other things the autopsies revealed that many of the patients exhibited diffuse damage to the system of alveoli sacs in the lungs (where oxygen and carbon dioxide are exchanged). In addition, there was considerable interstitial edema (congestion of fluids); necrosis of pneumocytes (these consist of several types of surface epithelial cells of the alveoli); metaplasia (involves a transformation of normal adult cells into abnormal forms of those cells); hyaline membranes (a form of lung injury that involves a deficiency in a surfactant – consisting of 6 lipids and four proteins – that is responsible for helping to maintain surface tension and providing stability for the alveoli), as well as an array of blood clots in small arterial vessels within the lungs.

Now, irrespective of whether, or not, the foregoing set of problems noted during the autopsies was due to SARS-Co-V-2 is a separate issue. Nonetheless, many people were labeling such a list of effects as indicators of the presence of COVID-19 (primarily because such individuals had been misled by the presence of a positive PCR test that had been assigned to such deaths … tests that were actually meaningless).

Yet, even if we were to suppose that the foregoing findings of the 38 autopsies that were performed in Italy were due to the presence of SARS-CoV-2, what has any of that got to do with the Bao paper that is being discussed and which, on the one hand, had a title claiming that it was presenting evidence which demonstrated the pathogenicity of SARS-CoV-2, and, yet, on the other hand, all the results which were reported in that paper merely indicated that some of the mice (in all three groups) exhibited some degree of weight loss, while others showed signs of bristled fur, and less than half of any of the mice developed any symptoms at all.

Anyone who just read the title of the paper might believe that here was another piece of evidence in which not only had SARS-CoV-2 had been proven to exist, but, in addition, SARS-CoV-2 has been shown to be a virus that had a certain kind of profile of pathogenicity to which that virus gave expression. Unfortunately, the paper by Bao, et. al., was devoid of any such proof or evidence.

Autopsies of the mice in the Bao study were done. Unlike the 38 autopsies of humans performed in Italy, no edema of any kind was detected in any of the mice. There were no hyaline membranes found in the mice. There had been no indications that metaplasia occurred within any of the mice. There was no evidence of blood clots of any kind within the mice.

If one looks at the alleged culturing process of any given virus, one comes into contact with a standard methodological template that has been used by virologists and microbiologists since the time of John Enders in the mid 1950s. The general character of this methodological template for such a culturing process has already been touched upon in the previously discussed Bao experiment.

One takes a sample or swab from a diseased organism and introduces that swab/sample into a culturing process. The latter process consists of taking a Vero kidney monkey cell, adding some sort of growth medium, mixing in a soupçon of fetal bovine serum, throwing in a few antibiotics that often are poisonous to the Vero kidney monkey cells, and putting the whole conglomeration in a minimal nutritional state.

What occurs next is a cytopathic event. In other words, one observes the death of the Vero cell, and for decades virologists and microbiologist have attempted to claim that such an event is proof that the swab/sample from the ill person contained a virus that was introduced into the culturing process and is necessarily responsible for the death of that cell. This end product of the culturing process constitutes the isolate in which, supposedly, the virus has been induced to assert its lethal presence.

Stefan Lanka has done something relatively recently that most virologists and microbiologists have never done. He decided to run a controlled experiment in which everything would be exactly as it had been during the standard culturing experiment in virology (i.e., Vero

kidney cell, growth medium, fetal bovine serum, various antibiotics would all be present, and the whole mixture would be subjected to a condition of nutritional starvation), but instead of introducing a swab/sample from an ill person, he added a swab/sample from a healthy individual.

The same cytopathic event took place in conjunction with the swab frm a healthy person. In other words, the cell being cultured died.

However, because there was no swab/sample from an ill person that had been introduced into the culturing process, one couldn't blame the death of the cell on the presence of a virus that had been hypothesized to be present in the swab/sample from an ill person. The reason that the cell died in both instances was because the components that made up the culturing process were responsible for the death of the cell and not because there had been any kind of exogenous organism or viral bodies that had been introduced into the culturing process.

Back in the mid-1950s, John Enders actually had run the same sort of controlled experiment as Stefan Lanka did relatively recently. Enders too had discovered that the reason why the cells in the two culturing processes (one involving material from an ill person, and one involving material from a health person) died had nothing to do with the presence of a virus but was due to the cytopathic nature of the culturing process in and of itself independent of the presence of possible viral agents.

Unfortunately, subsequently, virologists only seemed to want to remember the part of the Enders experiment that involved taking samples/swabs from an ill person, culturing that material, and, then, observing that there was a cytopathic effect which – seemingly, enabled virologists to conclude that the manifestation of such an effect (i.e., the death of the Vero monkey kidney cell) proves that there was some sort of virus present which was responsible for that cytopathic event. Yet, simultaneously, they also seemed inclined to want to forget or ignore (probably because to remember that John Enders also demonstrated that the same cytopathic effect occurred when added swabs from healthy people into the culturing process undermined their narrative concerning the idea of viruses) that if one performed

the same process of culturing with material from a healthy person as has been done with a swab/sample from an ill person, and, thereby, established a control group for the first part of the experiment involving a swab/sample from an unhealthy person, the result of running the control group gives rise to the same cytopathic effect – that is, kidney cell dies, lyses, and releases all of its biological contents due to the toxic nature of the culturing process and not because of the presence of a virus.

This is really a case of willful blindness. Such people are only willing to see what they want to see and the reality of the original Enders experiment (which has been confirmed by Stefan Lanka) be damned.

When the cytopathic effect takes place in the Vero monkey kidney cell and the cell lyses, the contents of that cell are emptied into the cultured conglomeration. In addition, one also has additional sources of biological content coming from the fetal bovine serum that was part of the culturing process, plus whatever cellular and biological material came from the swab/sample that was taken from either a healthy or ill individual.

As noted in earlier essays, electron micrographs are often recorded in conjunction with certain products or objects or entities that come forth during the process of lyses that takes place during cell death. Small particles can be observed in these electron micrographs, and after a research person circles some of those particles or draws arrows to highlight their presence in the EM imagery, the claim is often made that such objects constitute the virus (e.g., SARS-CoV-2, or chicken pox, or polio, or measles, or whatever other virus one believes to be present) and, yet, the very same objects/entities could be seen if one were to go through the same culturing process and a Vero kidney cell dies in conjunction with a healthy swab/sample (rather than from an unhealthy source) that has been added to a culturing process which is inherently toxic and the actual reason why the Vero monkey cell dies irrespective of whether the swab/sample that is added is from an healthy or unhealthy individual or organism.

The many particles that can be imaged following the aforementioned cytopathic event in the cultured sample are believed by virologists to be the result of a viral replication process that is

enabled by the presence of the culturing medium. According to theory, a virus needs either the living tissue of a host (say in the area of the lungs) or a culturing environment in order to be able to replicate itself, and the particles that are depicted in various Electron Micrographs are said to give expression to the end result of the viral replication process.

Nonetheless, there is no data in the EM which demonstrates how the particles being depicted actually arose. There is no experimental evidence (but there are lots of theories) which purportedly demonstrates how a virus supposedly gains entrance to cells (whether in living tissue or a cultured medium). There is no experimental evidence (but, again, there are plenty of theories concerning this issue) which shows how a virus takes over a cell's capacity to replicate, and, then, proceeds to replicate until sufficient numbers of viral particles have been produced to lyse the cells in living tissue or lyse the Vero monkey kidney cell, nor is there any actual experimental evidence (although there are considerable theories concerning such an issue) to show how a virus actually goes about the process of cell lyses.

Specialized genes have been proposed for all of the foregoing functions (e.g., the ability to gain access to a cell's interior; the ability to take over a cell's machinery of replication; the ability to engage in the process of cell lyses in order to be able to exit from one cell and move on to other cells within a given instance of living tissue). And, yet, unless one can demonstrate that such genes are actually contained within however many base pairs make up the genome of a given virus, then, all of the foregoing is nothing more than a theoretical account of how things supposedly work.

Electron Micrographs are static images. If virologists had something more than such static images -- that is, if they had been able to capture dynamic images of the genes of a virus accessing, entering, taking over replication, and, then, exiting a cell (whether being cultured or in actual tissue) -- those virologists wouldn't just be showing people EMs and, then, trying to interpret what is being depicted in that static image.

The sort of evidence – i.e., EM – that is being presented by virologists actually reveals the weakness of their perspective. If they had the sorts of dynamic imagery that are being alluded to above,

(which would constitute a form of rigorous evidence that strongly supported claims concerning the presence of a virus in living tissue or a cultured cell, as well as documented proof concerning the actual nature of their activity with respect to cells in living tissues or in conjunction with the culturing process), virologists wouldn't have to restrict themselves to presenting static EMs and, then, trying to convince viewers that the particles seen in those images are actually virus particles.

Circling, or pointing toward, or highlighting particles in an EM does not, in and of itself, actually prove anything about the actual nature or identity of the particles that are being singled out. One needs to examine those objects through whatever methods are available in order to try to determine what the nature of their internal composition might be.

Do those particles harbor some given number of base pairs that are capable of uniquely identifying such particles as instances of one kind of virus rather than another? Or, is the internal compositional nature of those particles indicative of some other kind of particle -– such as endosomes (tiny – viral sized -- intracellular organelles that might play a role in storing and/or transporting and/or cleaning up various materials within a cell) or exosomes (tiny – viral sized – organelles that tend to be membrane bound and could have arrived from the extra-cellular environment surrounding a cell and is either in the process of being absorbed by a given cell, or such a particle could be in the process of being released by a cell to serve purposes beyond the membrane of the cell to which the exosome is temporarily bound).

If the particles or objects in the Electron Micrographs to which virologists are pointing were, say, SARS-CoV-2, then, one should be able to discover that, yes, the particles under consideration all consist of 30,000 base pairs of genetic material (this is the theoretical estimate concerning the alleged size of the SARS-CoV-2 virus). Furthermore, one should be able to sequence such a genome and identify those aspects of the sequence that are unique to SARS-CoV-2 and, thereby, which differentiate it from all other species of virus.

Surely, virologists have succeeded in doing all of the foregoing. Surely, they have shown that when one examines the particles depicted in the EM, then, one discovers an approximately 30,000 base

pair genome that can be sequenced to show that, say, SARS-CoV-2 has a unique structure that in some way differentiates that virus from all other viruses (and this unique feature would be the very thing that any credible test for the presence of SARS-CoV2 would have to be able to detect and which the Drosten PCR test cannot demonstrate can be satisfied in any credible manner and which is why the PCR test is completely useless and meaningless).

Some people have claimed that they have sequenced the whole genome of SARS-CoV-2. Recently, Stefan Lanka ran a series of tests – and is running further entries in that series – to determine whether such a claim is defensible.

Lanka took a cell culture to which no materials from an ill or healthy person had been added, and therefore, there was no possibility that any virus was present in the culture. The culture contained the usual materials consisting of a Vero monkey kidney cell, fetal bovine serum, a growth medium and antibiotics of one kind or another. In addition, according to standard procedure, the culture was placed in a minimal nutritional condition (i.e., it was starved).

The culture underwent a cytopathic event and, as a result, broke down and released its contents. In one of the experiments conducted by Lanka, he added mRNA to the foregoing concoction.

The mRNA was from an easily accessible form of commercial yeast. There was no virus present in the yeast.

The concoction to which the mRNA was added contained various fragments of the broken-down Vero cell that were the result of the cytopathic event that had taken place in the Vero cell. In addition, the concoction contained fetal bovine serum, antibiotics or antifungal agents of one kind or another, some limited or minimal level of nutrients.

Lanka next examined the contents of the foregoing concoction of materials, in order to try to detect the presence of an assembly (presumably via the activity of the mRNA that came from the yeast) of 30,000 base pairs (the letters of the genetic code) that gives expression to the SARS-CoV-2 genome. He did not find such a genome, nor did he discover any sort of set of 30,000 base pairs that had a

sequence which could be shown to be uniquely specific to the alleged SARS-CoV-2 virus.

In fact, nowhere in the entire history of virology has anyone ever been able to take a cell culture similar to the one with Lanka was working and demonstrate that one can find in such a culture – once it undergoes a cytopathic event – the base pairs for a viral genome that can be sequenced to show that such a sequence is unique to a given virus and, thereby, differentiates it from all other forms of viral material. Moreover, if one looks at any of the experiments that were reported early on in China, Canada, Australia and elsewhere concerning claims that they had located and sequenced the SARS-CoV-2 virus, one will not find any evidence is those experiments which shows that some 30,000 base pair genome had been discovered in their cultures and, then, went on to be properly sequenced and, subsequently, shown to be both infectious and lethal.

Those papers (like the Zhu, Ren, and Bao papers examined earlier in this essay) are all smoke and mirrors. Paper titles are presented that claim one thing, but when one actually examines the sections covering methodology, results, and discussion, there often is a game of bait and switch taking place, and, presumably, the authors of such papers are counting on the laziness and time constraints under which many researchers operate and, therefore, the authors might make claims in the title or the abstract section that cannot be substantiated with actual evidence.

Chapter 11 -- Virologists Attempt to Save Appearances

At this point, virologists go through a sort of pseudo-methodological process in an effort to save the appearances of their viral theories. They claim that at the present time we do not have the necessary techniques or technological advancements to detect the 30,000 base pairs of, say, the SARS-CoV-2 genome that they believe to be present in the cytopathic residue of a cultured cell, and, consequently, they have devised another technique which they believe provides evidence that the purported virus is present .

The process to which the virologists are alluding (And I am indebted to the explanatory efforts of Dr. Andy Kaufman, Dr. Thomas Cowan, and my medical friend who sought to help me long distance during my recent bout of illness and with whom I have many long conversations, for quite a few years now, concerning all of the issues that are touched upon in this essay) is referred to as: "Unbiased De Novo (Anew) Next Generation Sequencing". Apparently, the meaning of the term "unbiased" in the foregoing is intended to convey the idea that the process is not being affected by the likes and dislikes of the investigator, but, as we shall see during the following discussion, the entire process seems to give expression to various biases and assumptions that virologists tend to carry and which also shape much of what takes place through the pseudo-methodological that is about to be described.

So, the question that needs to be asked is the following. How do virologists make the transition from: (1) a concoction consisting of human genetic material (in the form of a swab/sample taken from a ill or healthy individual), as well as consisting of materials from other kinds of genetic fragments arising from the Vero monkey kidney cells and fetal bovine serum that are used during the culturing process, in addition to, possibly, the genetic material that is present in whatever – if any – viral entities that are present (all of which would give rise to millions, if not billions, of genetic fragments from an array of: Human, bovine, Vero monkey kidney cells, and, possibly, viral sources) to: (2) some sort of credible claim that one can methodologically engage all such genetic materials and end up with only the fragments that belong – allegedly – to, say, SARS-CoV-2?

Virologists begin to sort all of the different kinds of DNA and RNA that are present in a cell culture that has undergone a cytopathic event. Step one seems to involve the idea of removing all DNA fragments from the foregoing concoction.

The reason that tends to be given for the foregoing step has to do with the belief that SARS-CoV-2 is not a DNA virus. However, if one asks for the empirical basis that substantiates such a claim, virologists really have no independent way of justifying such a claim or step.

If someone tries to cite the particles being depicted in various Electron Micrographs as being non-DNA instances of SRS-CoV-2, then, the thinking becomes circular. This is because one starts out with certain assumptions about what is being depicted in such EMs, and, then, such assumptions bias the nature of the conclusions which one draws about what is, and is not, relevant to one's search for the presence of SARS-CoV-2.

Is SARS-CoV-2 a DNA virus or is it an RNA virus? How does one demonstrate this independently of the allegedly "unbiased" Next Generation Sequencing process, because one would have to have such an independent confirmation of the nature of the genetic material in SARS-CoV-2 prior to the process of sequencing in order to justify eliminating all of the DNA fragments that one might find in the materials that are contained in the conglomeration of particles and fragments that are left behind in the cell culture that has undergone a cytopathic event.

The next step of the Unbiased De Novo Next Generation Sequencing process involves removing all of what are believed to be the RNA fragments that can be matched up with human or known microbial sequences. However, if one doesn't know what the actual sequence of SARS-CoV-2 is, then, one is no position to empirically establish whether any given RNA sequence comes from SARS-CoV-2, Vero monkey cells, human tissue, or fetal bovine serum since, among other possibilities, there could be various genetic sequences in the alleged SARS-CoV-2 virus that are held in common with RNA sequences from other organisms. What is the scientific principle that permits one to determine from where a given fragment of RNA might come?

Once again, a source of potential bias is being arbitrarily introduced into the De Novo Next Generation Sequencing process. Allowing such a bias to stand unchallenged has the capacity to affect the nature of the conclusions one might reach using such a method, and, as a result, the process is no longer unbiased and objective but is being shaped by certain kinds of assumptions that are being made but which cannot be scientifically justified.

After eliminating the DNA fragments and the RNA fragments that the virologists feel are irrelevant to, and even capable of obfuscating, their search for SARS-CoV-2, virologists will take the RNA fragments that remain had cut them up into fragments that are a certain number of base pairs-long. Purportedly, the purpose for proceeding in the foregoing fashion is so that, subsequently, researchers will be able to amplify different instances of those fragments by mixing in primer sequences that are capable of attaching to such fragments in the cultured materials that have broken down, and, then through the PCR process, the quantities of those fragments can be increased through various cycles of amplification.

At this point virologists add the entire set of genetic sequences that come from a previous corona virus so that it can be used as a comparison marker, of sorts, for detecting the degree of homology that might be in the viral genetic material (supposedly SARS-CoV-2) that could be somewhere in the ingredients that have undergone a culturing process and, then, a cytopathic event that causes the various biological ingredients in the culture contents to break down into a vast array of fragments, particles, and the like which the virologists are hoping will contain genetic material that will match up – to a degree – with some of the structural and sequential features of the previous corona virus However, there are several problems inherent in the foregoing step.

First, aside from the questionable tenability of having removed various kinds of DNA and RNA from the culture without any real good scientific reason for having done so, one would like to know the etiology of how the entire set of genetic sequences that allegedly are from a previous corona virus came into being. Did someone discover or uncover an approximately 30,000 base-pair (A-T, G-C or G-U)) long sequence of actual molecules (in the form of adenine, guanine,

thymine, or cytosine – in the case of DNA – and uracil instead of cytosine in the case of RNA, along with a certain kind of sugar molecule (different sugars for DNA and RNA) as well as a phosphoric acid molecule that is covalently linked to the rest of the components) that make up the nucleotides that form the backbone to which a genetic sequence is attached that give expression to such a corona virus?

The answer to the foregoing question is: No, someone did not find an actual existential approximately 30,000 base-pair molecular entity matching the foregoing description. Every alleged viral sequence is entirely computational in nature in the sense that each of them has been generated through an algorithmic program (such as "Muscle") that runs through an array of interpolative, extrapolative and other sorts of possible interpretations of available data (in the form of molecules that are in the cultured conglomeration that has broken down following a cytopathic event, and in the process, such a computation supposedly produces a "best" estimate of what a given viral sequence might look like given related sequences that already have been worked out previously in similar sorts of algorithmically driven computations (e.g., an earlier edition of some other kind of a corona virus).

Libraries of the foregoing sorts of computations are maintained. The entries in those libraries are used for purposes of comparison with other on-going computations, and, as indicted in the present 'Unbiased De Novo Next Generation Sequencing' process', an entry from one of those libraries has been introduced into the culture breakdown products (following the arbitrary removal of various kinds of DNA and RNA) to serve as something of a template for determining the extent of the complimentary matches that might arise.

In legal-court terms, I believe such a process would be referred to as leading the witness. The corona sequence from one, or another, library is actually framing the manner in which the computational-algorithmic process being used in the "Unbiased De Novo Next Generation Sequencing" goes about it processes of interpolating, extrapolating, and interpreting available fragments with respect to how they might have fit together prior to the cytopathic event that led to the cultured products breaking up into millions, if not billion, of molecular fragments, and, as such, the process is hardly "unbiased"

since the presence of an "earlier" corona template is shaping the character of what transpires during the computation that currently is being conducted.

If the cultured conglomeration that is breaking down contains millions, if not, billions of fragments of RNA material, and if such fragments are further sliced up in accordance with the protocols of the "Unbiased De Novo Next Generation Sequencing" process, then, why wouldn't a "reasonable" person assume that one is highly likely – on just a random basis – to be able to produce a genetic sequence that has a fair degree of homology with the sequential nature of the corona template that has been introduced into the cultured products that are breaking down – not necessarily because any such extended genetic sequence existed in the cultured conglomeration prior to the cytopathic event but because if one is only working with four genetic letters, then, the possible sequential combinations which might be assumed by those letters is likely to include the genetic sequence of the earlier template for an alleged corona virus that is being introduced into the culture – and, this is especially the case if the RNA fragments that are present in the cultured breakdown products are being helped to do so by the presence of a library template that tends to push the computational or algorithmic process in the sequential direction of such a template.

If one had introduced a different kind of priming template into the cultured conglomeration – say, polio, or measles, or small pox – one would have produced different results during the "Unbiased De Novo Next Generation Sequencing" process. However, a corona template was introduced into the cultured conglomeration precisely because the virologists were searching for the presence of SARS-CoV-2, and, consequently, by so doing, their results were biased by the presence of that priming template.

The parts of the computational process involving the cultured products breakdown that are homologous with the library template will be cited as proof that there is a close genetic connection between what had been added (from the library) and what is being computationally put together (constructed) during the process of so-called "Unbiased De Novo Next Generation Sequencing". The aspects of the two computations that do not match (one from the library and one

from the present algorithmic computation involving the current contents of a cultured conglomeration that has broken down following a cytopathic event) will be taken as evidence which indicates that aspects of the unique nature of the new edition of coronavirus has been constructed through a computational, algorithmically driven process, and, consequently, in time, will be entered into a library so it, at some point in the future, can be used in a similar way with some cultured conglomeration that has broken down and is believed to contain some other edition of a coronavirus.

At no point during the "Unbiased De Novo Next Generation Sequencing" process is any actual 30,000 base pair corona virus actually found. Whatever is found is the result of a computational, algorithmic invention that is entirely theoretical in nature and which has been heavily influenced by the sequential structure of the corona library template that has been introduced by virologists into the breakdown products of the cultured conglomeration that has undergone a cytopathic event.

Are real genetic molecules present in the foregoing analysis? Yes, they are, but the sequence of those molecules is a reflection of the computational methodology being used and, therefore, does not constitute proof that such a sequence of genetic molecules had been present and intact in the cultured conglomeration prior to the cytopathic event that took place and the ensuing computational process.

In fact, there is absolutely no evidence which establishes the existence of viruses independently of the foregoing sort of computational process. All claims concerning the existence of viruses (with the possible exception of bacteriophages) are artifacts of a process of computational invention, and such claims are not based on any virologist having empirically uncovered an actual viral genome that can be sequenced independently of the computational/algorithmic processes being discussed above, and, therefore, such claims are entirely theoretical in nature.

Virology, for the most, is largely a theoretical system for arranging and interpreting the results of an array of computational/algorithmic forms of analyses that cannot be shown to be tied to any actual, instances of viral genomes that can be shown to have actual

ontological status in the wild. As such, virology is about the theoretical entities that different virologists seek to project onto the world while simultaneously being devoid of any empirical proof that those projected theoretical entities actually exist independent of the theories of virologists.

Consequently, virologists tend to be the sorts of people who are not able to sway people with actual evidence. As a result, in accordance with the old adage that if one doesn't have evidence, then, one must resort to trying to dazzle people with bullshit … that is, a complex of theoretical entities that are organized into libraries of arbitrarily invented sequences that are apropos of nothing real but which give expression to computational and algorithmic techniques that are so technically shiny that people are misled into believing that those techniques are capable of producing results that are substantive and credible but which are not actually able to do either.

In a series of recent experiments, Stefan Lanka has been able to document important elements of the foregoing discussion.

He used the PRC priming technique that is employed by virologists. The PCR amplification process gives rise to an optical change (e.g., color or luminosity) that enables an individual to see whether the sequence carried by a primer is present in the culture conglomeration that has broken down into fragments and, then, subsequently, sliced up a bit more so that the PCR protocol can be used.

One can't PCR the whole culture at once because the PCR process only works with sequences of a limited length, but one can use certain primers that are based on short sequences in the corona template that virologists have taken from one of their existing libraries of sequences and fragments and which has been introduced – as previously noted – into the culture being investigated. Once the amplification process indicates that there is a match between the sequence on a given primer and the some aspect of the contents of the cultured conglomeration being studied, then that match can be amplified and becomes visible through the PCR protocol.

In one experiment, Stefan Lanka amplified the primer sequences being used twelve times (that is, twelve rounds of doubling such sequences). He found 20% of the purported sequence of the SARS-

CoV-2 genome (and, remember, the purported sequence of the SARS-CoV-2 genome is entirely theoretical in nature and has never actually been found independently of these sorts of computational analyses).

In the next experiment, Lanka increased the number of amplification or doubling cycles to 30. Nothing was added to the cultured conglomeration during this time.

He discovered that after 30 cycles of doubling, the primers matched up with 98% of the alleged SARS-CoV-2 genomic sequence. Once again, one must keep in mind that the foregoing genomic sequence is based on a computational-algorithmic methodology that has not been shown to have any independent connection with an actual 30,000 base pair genome that has been found in nature.

One should keep in mind that all of the foregoing activity took place without anything being added to the cultured conglomeration that had broken down. The only difference was the number of cycles of PCR amplification that were used.

Why did Lanka "find" only 20% of the alleged genomic sequence of SARS-CoV-2 at 12 cycles? Why did he "find" 98% of the alleged genomic sequence of SARS-CoV-2 after 30 cycles of amplifying cultured fragments?

As Cary Mullis has made clear on many occasions following his invention of the PCR protocol, the very nature of the PCR process is to to be able to create a series of new sequences through that process. Given all the RNA fragments that were present in the cultured conglomeration being studied, if one runs the PCR process through enough cycles, one can reproduce almost any sort of sequence for which one might be searching based on the primers one is using.

None of the foregoing proves that SARS-CoV-2 was originally present – as a substantive, existential entity -- within the cultured conglomeration being investigated. Rather, Lanka's ability to reproduce 98% of the theoretical sequence of the SARS-CoV-2 genome was entirely an artifact of the PCR process when it is used in conjunction with certain primers (based on an earlier theoretical sequence concerning an alleged corona virus) that, in effect, biases the direction in which the PCR process goes.

Lanka goes on to indicate that 78% of the fragments and pieces that were "found" in his experiments were the result of the way the PCR process takes place. The PCR process is capable of rearranging sequences and fragments depending on an array of factors involving the sort of enzymes that are used, or the temperature at which things are run, and numerous other factors that are explored in the MIKE Guidelines previously touched upon during the earlier discussion of some of Stephen Bustin's work concerning Quantitative PCR, and, if one will recall, during that discussion, I indicated how one of the issues with which Bustin was concerned had to do with the tremendous differences in results that were possible as a result of the foregoing sorts of considerations, and, therefore, researchers often encountered difficulties trying to have their own work verified or to be able to verify the accuracy of the work of others.

Lanka's experiments had been set up in a way that precluded the possibility that SARS-CoV-2 could have been present in the cultured system that he had established and which, then, underwent a cytopathic event. Nonetheless, he had been able to reproduce 98% of the alleged sequence – a theoretical sequence – as an artifact of the PCR process that was arbitrarily biased – via the primers that were used that were based on a theoretical corona sequence that had been taken from a library -- to move in the direction set by the primers and not because SARS-CoV-2 had been present in that cultured system from the beginning.

The computational-algorithmic process that is used to piece together the different fragments through various modes of interpolation, extrapolation, and other forms of filling in the empirical gaps that are left by the limits and characteristics of the PCR process that are stitching together – or inventing – a new sequence, but that sequence cannot be shown to be capable of being independently tied to an actual particle of SARS-CoV-2 that has precisely the genomic sequence that virologists have theoretically claimed it has. At no point has empirical reality been shown to meet up with the theoretical claims of virologists – either with respect to SRS-CoV-2 or any other alleged virus.

As noted previously, if one had used a different set of primers based on sequences in the theoretical libraries of virologists that had

to do with measles, or polio, or some other alleged virus, then, despite the fact that there was no possibility that such entities had been in the original cultured conglomeration, nevertheless, after running the PCR process through 30 cycles, one would be able to generate sequences that were a 98% match with the alleged genomic sequences of such purported viruses from the library of genetic sequences. Once again, such results would be an artifact of the methodology being used, and the title of that methodology notwithstanding – namely, an "Unbiased De Novo Next Generation Sequencing" – the entire process is nothing but a series of biases that are being implemented, all of which undermine any claims concerning the reliability of the results that are have been, and are being published, by one virologist or another concerning the genomic sequences that they are supposedly discovering, but it turns out that such discoveries are only in their imaginations.

During an earlier portion of this book, I wrote several essays concerning the alleged pandemic that took place in 1918. One essay (Chapter 8) was entitled: "Jeffrey Taubenberger's 1998 PBS Interview Concerning the 1918 Influenza Seems Strangely Familiar," while the other essay (Chapter 7) critically explored a CDC article whose title proclaimed: "The Deadliest Flu: The Complete Story of a Virus Influenza Pandemic".

I did not – and do not -- feel that the CDC account concerning the 1918 flu constituted a complete account of what transpired in 1918, The foregoing material was complemented by the discussion in Chapter 8 which, among other things, examined some of the available data that tended to suggest there were many things that took place in 1918 which cannot be reconciled with the idea that what occurred then was necessarily due to presence of an allegedly highly infectious virus.

One such point-counterpoint had to do with experiments that were run in both Boston and San Francisco during the year of the so-called pandemic. "Volunteers" – they were really individuals who were in trouble with either the military or the law or both and who had volunteered to participate in the experiments in exchange for certain considerations of leniency or forgiveness being made in their respective cases – were exposed to patients who were in various

stages of whatever illness it was that they had (and was presumed to be some form of a virulent flu).

Materials were taken from ill patients (who might just have become sick, or who were in more advanced stages of their disease process, or who might be on the verge of death), and those materials were transferred to the volunteers. Sometimes the transfer took place through the patient coughing and breathing in the face of a volunteer who was just a foot, or so away, or ill patients might have sprayed spit or sputum on such individuals, or mucous discharges of the patient's would be put into various bodily openings of the volunteers (ears, noses, and so on).

Despite the foregoing experiments with – all told – probably 100 volunteers across an array of experiments in several studies in different parts of the United States -- none of the volunteers got sick. If the alleged 1918 influenza was so virulent and infectious, how does one account for what took place in the foregoing studies?

My essay (Chapter 8): "Jeffrey Taubenberger's 1998 PBS Interview …" critically examined Taubenberger's account of his efforts to reconstruct the H1N1 virus that he believed was as the heart of the 1918 Influenza pandemic. According to Taubenberger, the H1N1 influenza genome that he believes was active in 1918 consisted of 8 genes.

An important piece of data to keep in mind with respect to the foregoing is that no one has ever been able to discover – either in the tissues of ill people or via various cultured scenarios – the actual molecular genome of the alleged H1N1 virus. Both the H1N1 genome and its alleged 8 genes are theoretical constructs concerning how virologists believe that alleged virus is structured and operates.

No one has witnessed those 8 genes do in a living organism what theory claims takes place in conjunction with such genes. During the 1998 PBS interview, Taubenberger indicates that his research group took a look at five genes in order to try to get a sense of what the overall genetic properties of the alleged virus might look like, but the genes at which they took a look had not been found as genetic, molecular structures in nature but, instead, had been constructed through various kinds of computational-algorithmic programs of the kind that have been critically examined by Lanka and others.

For instance, during the 1998 PBS interview, Taubenberger indicates that his research group had been able to piece together the 1800 base-long components of the hemagglutinin gene (the H in H1N1) and which supposedly codes for one of the proteins which is said to be present on the surface of the alleged H1N1 virus. However, what Taubenberger means by the idea of piecing together is that his research group came up with a theoretical computer model for such a gene.

Similarly, the foregoing sort of thinking also extends to the neuraminidase gene that – according to theory -- codes for another surface protein that appears on the surface of the purported virus. Neuraminidase is the N in the H1N1 configuration.

However, since no one has ever isolated and purified an actual ontological instance of the H1N1 virus and, thereby, been able to demonstrate the actual nature, character, and sequence of such an alleged entity, Taubenberger and his research associates could not prove that their theoretical computer model of either the five aforementioned genes or the overall genomic sequence they were trying to work out for H1N1 was reflective of anything more than a theory. Both the hemagglutinin and neuraminidase genes (and resulting proteins) are nothing more than theoretical constructs that have been put together through various kinds of computer modeling.

According to theory, the hemagglutinin gene produces a protein that enables the alleged H1N1 virus to gain access to the cells and tissues of living organisms. The neuraminidase gene, on the other hand, produces a protein that supposedly enables a virus to exit cells once the virus has – presumably through its other 6 theoretical genes – been able to take over the replication machinery of a cell and generate as many copies of the virus as are deemed necessary (and one wonders about how the alleged H1N1 virus determines that the necessary number of viral replications has taken place).

Yet, none of the foregoing dynamics have ever been empirically demonstrated to actually take place. Obviously, one must clearly delineate between what the H1N1 theory of viral action claims takes place and what actually has been empirically demonstrated in this respect – which is really nothing at all.

According to the 1998 PBS interview, Taubenberger claims that there are 14 different subtypes – or variations on a theme – of the hemagglutinin gene, to go along with 9 different subtypes of the neuraminidase gene. Taubenberger maintains that the H1N1 subtype combination played a key role in the 1918 flu crisis, and, yet, all of Taubenberger's claims are predicated on the various facets of the computer model that he and his colleagues put together when, literally, they invented or constructed the alleged H1N1 virus.

All of the foregoing considerations concerning Taubenberger are consistent with what has been said throughout the earlier analysis of how virologists go about making claims that they have discovered and sequenced SARS-CoV-2 (which is why I consider what Taubenberger said in the PBS interview to be "strangely familiar" when considered in the context of claims that have been made in conjunction with SARS-CoV-2). In both cases, virologists are confusing – in what seems to be a very delusional manner -- the process of producing computer models and theories with the process of actually being able to generate hard-core empirical proof that such theories and computer models are capable of accurately reflecting the character of concrete, molecular, and genetic reality. Lacking real empirical proof for their theories, they treat the concepts that give expression to their theories as if they possessed the same ontological status as such empirical proofs would be able to establish, and, as a result, theory is projected onto reality like some sort of palimpsest arrangement and, and, as a result, reality becomes obfuscated and covered over by a purely theoretical narrative.

Chapter 12 -- Dr. David Martin's Patent Research – Its Underlying Significance

Dr. David Martin is the President of M-Can Innovation Risk Management which he established in 1998. Since 1998 Martin's corporation has been the largest underwriter of intangible assets used for financial transactions in 168 countries, and his business focuses on issues of innovation and the financing of that innovation all around the world.

While being interviewed by Reiner Fuellmich, Dr. Martin talked about a research project he was conducting in which he discovered a series of documents that involved applications for patents that claimed to be novel genetic sequences of coronavirus (more than 4,000 patents have been reviewed that pertain to the notion of a SARS-CoV-2 entity). This series of patents began in 1999, and, therefore, not only are the recent 2020 claims that coronavirus constitutes a novel virus incorrect with respect to announcements made early in 2020 by W.H.O. and others, but, according to Dr. Martin, such claims of novelty actually have been incorrect for several decades.

More specifically, Dr. Martin maintains that based on his analysis of the patent records there are over 120 pieces of patented evidence which undermine the claims of early 2020 that the world was faced with the emergence of a novel corona virus. Whatever was emerging – if anything – in late 2019 or early 2020 was other than novel, and, in fact, there were alleged corona virus sequences being reported in 2020 that could be tied to corona virus sequences that had been cited in patents dating back to 1999.

Early instances of patent activity concerning coronavirus were restricted to the realm of veterinarian sciences. For example, on January 28, 2000, Timothy J. Miller, Sharon Klepfer, Albert Paul Reed, and Elaine V. Jones applied for, and eventually, were assigned Patent #6372224 which concerned a spike-protein-based treatment that was directed toward a canine version of the corona virus.

On April 19, 2002, another patent application was filed involving the National Institute of Allergies and Infectious Diseases which had to do with something that the NIAID had claimed to have constructed – namely, an infectious, replication- deficient coronavirus. The construct was intended to target human lung epithelia tissue, and, therefore, Dr.

Martin indicates that an agency of the American government was responsible for having created – or, as we shall see shortly, for having claimed to have created -- a form of SARS, or severe acute respiratory syndrome that, supposedly, was caused by a coronavirus.

A patent was awarded to the foregoing April 19, 2002 application. The number of that patent is 7279327.

According to Dr. Martin, originally, the foregoing patented entity was being conceived of as a process for delivering some sort of HIV treatment. This kind of treatment and delivery system apparently would have been in the form of an injection of some kind.

However, if one goes back to the January 28, 2000 application that, eventually, was turned into, as noted earlier, Patent #6372224, one learns that the individuals who had filed the application were claiming that: "The present invention provides the amino acid and nucleotide sequences of a CCV spike gene and compositions containing one or more fragments of the spike gene and encoded polypeptide for prophylaxis, diagnostic purposes and treatment of CCV infections," where CCV stands for Canine Coronavirus and what had supposedly been invented – and which, now, had been patented – involved a canine coronavirus S or spike gene.

All of the foregoing information and related documents are available to be read and verified by any member of the general public. That information and documentation exists within the public archival records and can be found through what is known as the Public Pair at the United States Patent and Trademark Office.

Dr. Martin goes on to assert that "… three days after CDC filed the patent on the SARS coronavirus in 2003 , Sequoia Pharmaceuticals, on the 28th of April 2003, filed a patent [or, perhaps, an application for a patent] on anti-viral agents for treatment and control of infections by coronavirus." Eventually, Sequoia Pharmaceuticals – along with another company known as Ablinks Pharmaceuticals -- became part of the proprietary holdings of Pfizer Pharmaceuticals, Crucel, as well as Johnson & Johnson.

Dr. Martin indicates that the foregoing activities – involving the patenting process with respect to coronavirus – satisfies, in his opinion, the definition of what he considers to be expressions of

criminal conspiracy, racketeering, and collusion. As a result, he believes he is putting forth evidence that would lend support to a RICO case of one kind or another with respect to research and patenting activity involving the coronavirus.

The National Academies of Press Publication reported the following statement from February 12th, 2016:

"We need to increase public understanding of the need for medical countermeasures such as a pan-corona virus vaccine. A key driver is the media, and the economics will follow the hype. We need to use that hype to our advantage to get to the real issues. Investors will respond if they see profit at the end of the process."

The foregoing statement was from the director of the EcoHealth Alliance, Peter Daszak, a zoologist. A little over four years later, Daszak was attempting to support the Chinese claim that there had been no lab leak of coronavirus – accidental or otherwise – at the Wuhan Institute of Virology.

According to Dr. Martin, the issue of a leak is irrelevant. He believes the patent evidence indicates (and Dr. Martin has documented many more than two patents to give expression to such evidence) that there had been an "intentional bio-weaponization" of spike proteins so that those patents might play a central role in a subsequent program of mass injections … the sort that has transpired over the last ten months, or so.

Consequently, quite apart from whether, or not, Peter Daszak was correct about the issue of leaks at the Wuhan Institute of Virology, Dr. Martin believes that Daszak is, nonetheless, being disingenuous because in 2016 the zoologist was promoting the idea "of the need for medical countermeasures such as a pan-corona virus vaccine" – something that was fully consistent with the patents which already had been awarded -- more than a decade earlier -- for just such alleged countermeasures. Moreover, in 2020 and beyond, Daszak had played a key role in getting the media to hype such countermeasures … just as he had advocated needed to be the case in 2016.

During the Reiner Fuellmich interview, Dr. Martin returned to the subject of Patent #7279327 that – as previously noted -- had been awarded to the U. S. government's National Institute of Allergies and

Infectious Diseases, which is a division within the National Institute of Health and has been headed up by Anthony Fauci for some 35, or so, years. The aforementioned patent -- which had to do with a recombinant version of a lung-epithelial tissue targeting coronavirus – was transferred **from** the University of North Carolina at Chapel Hill (where Ralph Baric – a long-time associate of Tony Fauci – is a microbiologist and epidemiologist, as well as teaches and does research involving coronaviruses) **to** the National Institute of Health in 2018 so that the government had control over, perhaps, the single most important patent that was key to establishing a subsequent injection mandate (and this is before the so-called COVID-19 crisis began).

Furthermore, Dr. Martin also indicates that there are some 117 patents which identify the ACE2 receptor as being one of the primary targeting mechanisms of the SARS coronavirus. He states that such research can be traced to publications that go back to 2008 with respect to, among other things, a number of the 'weaponization' conferences that took place in Slovenia and elsewhere in Europe, and such research also has figured prominently within certain facets of DARPA's research activity as well.

According to Dr. Martin, the script, so to speak, for all of the foregoing talk of a spike protein vaccine already had been written on January 6th, 2004 by Merck when they introduced the notion of the "new normal". The foregoing meme was enthusiastically promulgated by: The World Health Organization; the Global Preparedness Monitoring Board, which was the agency on which the Chinese Director of the Center for Disease Control served; as well as by Dr. Christopher Elias of the Melinda and Bill Gates Foundation, and Anthony Fauci.

The notion of the "new normal" was a propaganda campaign. The "new normal" project was designed to induce the public to become in favor of a universal, pan-influenza, pan-coronavirus vaccine that – or, so "experts" would claim – would offer the only way out of the alleged threat of what subsequently would become known as COVID-19 some sixteen years later.

Dr. Martin concludes his interview with Reiner Fuellmich by indicating that no pharmaceutical company has done anything to deal

with the actual corona virus. Instead, their efforts have all been directed toward developing systems that are capable of injecting the spike protein in as many people as possible – a protein that is known to be harmful to human beings.

The foregoing information only touches on a limited aspect of the patent research that has been carried out by Dr. Martin. However, before putting forth my own comments on his perspective, I wanted to provide an uninterrupted overview concerning some of the highlights of his patent research project, and, so, the last four or five pages have consisted of nothing more than a summary of his work, devoid of any comments of my own.

Previously in this book (see Chapters 7-11) , a considerable amount of time was spent investigating the idea that virologists actually have no evidence which can be independently confirmed through controlled experiments that is capable of demonstrating that the SARS-CoV-2 virus actually exists. If the foregoing position is true, then, the patents to which Dr. Martin refers become rather mysterious because the entities being identified in the patents do not refer to actual 30,000 base-pair genomes that have been isolated or purified by virologists and, then, subsequently, properly sequenced to show that there is a genetic sequence which is unique to SARS-CoV-2 and permits that alleged virus to be distinguished from all other species of coronavirus.

As has been noted previously, all virologists have ever done is to invent computational-algorithmic fictions that purport to reflect the structure and character of supposed real world viral entities that, for whatever reason, virologists have not been at all successful in proving to exist as ontological entities in their own right and which – if they were discovered -- would be instrumental to the process of confirming that the computational theories of virologists are correct with respect to, say, the structure, nature, and their computer-generated sequences for SARS-CoV-2.

The “objects” to which the various patents that Dr. Martin is making reference during his interview are entirely theoretical in nature. They don’t exist except as a function of a computational-algorithmic process that cannot be proven to have any counterpart in the real world.

Moreover, no experiments have been done which show that such a computational-algorithmic entity is infectious, or that if infectious, it possesses some kind of lethal dimension to it with respect to living organisms. In addition, there is no actual proof that such entities – which have not been proven to exist outside of a computer program – are capable of gaining entrance to cells and tissues via, say, the ACE2 receptor, any more than Jeffrey Taubenberger's alleged hemagglutinin surface proteins on the so-called H1N1 virus have been shown in actual experiments to be able to gain entrance to cells and tissues through that protein or the neuraminidase protein in the alleged H1N1 flu virus has been shown to be able to exit from cells. Just as everything in Taubenberger's rendition of the H1N1 influenza virus is entirely computer generated and constitutes nothing more than a model which has not been shown to actually exist, be infectious, or lethal to human beings so too, the entities that have been patented in conjunction with coronavirus are entirely theoretical.

If the foregoing contentions are true, then, what would be the purpose of patenting something that doesn't exist? Presumably, there is "something" that is present in such patents that patent holders appear to be interested in preserving. For instance, the following quote was cited in conjunction with the earlier mention of Patent #6372224:

"The present invention provides the amino acid and nucleotide sequences of a CCV spike gene and compositions containing one or more fragments of the spike gene and encoded polypeptide for prophylaxis, diagnostic purposes and treatment of CCV infections,"

and that patent was applied for on January 28, 2000, some 20 years prior to the rise of the CVID-19 crisis.

One might also note that the NIAID Patent #7279327 referred to the construction of a recombinant form of an infectious, replication deficient coronavirus. The infectious dynamic of that theoretical entity supposedly targeted the epithelial tissue in the lungs of human beings, and, according to numerous patents that were researched by Dr. Martin, the proposed route of the foregoing kind of infectious activity involved a spike protein's engagement of, say, ACE-2 receptors.

Yet, if the SARS-CoV-2 virus does not exist – and virologists have never shown that such a virus has an ontological status outside of a

computer – then, the whole edifice of Patent #7279327 is really duplicitous. Whatever was constructed by the NIAID was based on a theory which could not be shown to have any actual counterpart in reality anywhere except in a computer, and, therefore, the entire mechanism of infectivity was nothing more than a theoretical perspective that was inherent in a computer model of an alleged SARS-CoV-2 entity.

In Patent #6372224, as well as in Patent #7279327, what is being preserved is the idea of an element– say, a spike protein – that can be used in medical treatments that supposedly are capable of countering various aspects of the dynamics of SARS-CoV-2. However, as has been fairly well established during earlier critical reflections concerning the issue of a SARS-CoV-2 virus, such a virus has not been shown to exist anywhere except in the computational-algorithmically driven programs that invent arbitrary genetic sequences for fictional/phantom viral entities. So, if such viruses do not actually exist, then, neither Patent #6372224, nor Patent #7279327 contains an idea that credibly pertains to providing a way to treat people who might be exposed to an allegedly infectious viral agent which cannot be proven to: Exist, or be infectious, or be lethal, or is capable of being engaged -- and, thereby, infect -- the epithelial cells of the lungs via ACE2 receptors.

So, if those patents have nothing to do with anything that can be proven to be real, what is their purpose? Perhaps, they serve as a way to try to justify why someone would want to inject a toxic spike protein cocktail into human beings since virologists are operating under a delusion concerning the existence of SARS-CoV-2 -- or, more darkly, virologists are being entirely duplicitous about the idea that there exists an alleged SARS-CoV-2 virus against which human beings need to be protected.

One cannot emphasize the following fact enough, and, indeed, the reason why this point has been stated again and again during the last few pages, as well as elsewhere in this book is because virologists for more than 70 years have been actively seeking, through a massive process of mental programming, have been actively seeking to entrain and shape the minds of the public to accept a false narrative concerning the nature of reality. More specifically, alleged viruses like

SARS-CoV-2 (or alleged polio, measles, mumps. HIV, flu, or HPV viruses) have not been proven to exist outside of the arbitrary sequential inventions of various kinds of computational-algorithmic programs. In other words, no one has located in the wild, so to speak, or demonstrated within the confines of a tortured culturing process, that a particle exists which contains the theoretically estimated number of base pairs (30,000) which is supposed to make up the genome of the alleged SARS-CoV-2 virus (or to make up the number of base pairs that allegedly characterize polio, measles, mumps, flu, HIV, or HPV viruses) which possess unique genetic sequences that differentiates it (them) from other kinds of alleged viruses, or that such genetic sequence are infectious or lethal to human beings.

In a very real sense, a fraud is being perpetrated on the people of the world. Virologists claim that human beings are in danger from, among other purported viruses, the ontological presence of the SARS-CoV-2 virus – a virus that has not been proven to exist anywhere but in theoretical models. As a result, virologists propose a form of medical intervention involving a spike protein that will supposedly enable the biology of human beings to be able to learn how to cancel out the activity of a spike protein which, according to theory, plays a central role in an alleged virus that has not been proven to exist (i.e., SARS-CoV-2).

Virologists want people to be injected with a spike protein that serves no actual purpose in a human being. And, the reason why such a protein has no purpose being in a human being is because the entire scenario concerning the alleged threat of SARS-CoV-2 is entirely without merit, and as a result, people are being injected with a toxic protein that has no provably useful medical function.

There is nothing but bad faith that is present at the heart of the two aforementioned patents (bad faith directed toward both canines and human beings alike), as well as any other kind of patent that is predicated on the delusional notion that the SARS-CoV-2 exists and is an infectious threat to human beings. Patents involving SARS-CoV-2 are being applied for because the fictional coronavirus entities that are at the center of such applications provide a limited hangout or poorly rationalized justification for introducing pretend solutions (such as in the form of a spike protein injection) for non-existent problems

(namely, the ontological absence of, among many other alleged viruses, SARS-CoV-2).

Consequently, I believe that Dr. David Martin is incorrect – or only partially correct – when he claims that SARS-COV-2 was a gain-of-function laboratory experiment. One cannot do gain-of-function experiments on a virus that does not exist, and, moreover, such an alleged virus cannot be said to exist because no one has, yet, properly isolated, purified, and sequenced an actual, real-world, roughly 30,000 base pair entity which can be shown to have a unique genetic sequence that differentiates it from all other virus and, then, gone on to show that SARS-CoV-2 is either infectious or lethal.

Something has been invented, but it is not an actual gain-of-function virus. What has been invented is a fraudulent narrative that claims that SARS-CoV-2 exists in any form other than as a theoretical, computerized concept. The whole point of the patents was to give the impression that the SARS-CoV-2 virus actually existed so that the spiked protein facet of that imaginary virus would be seen as a real biological threat against which canines and humans would, eventually, have to be defended by a gene therapy that, like Mighty Mouse, would come to save the day for humanity.

The only part of the SARs-CoV-2 narrative that has an actual existential counterpart is the spike protein which has now been instantiated within various injectable concoctions manufactured by Moderna, Pfizer, and others. This is not because such a protein can actually be found in a real-world exemplar of SARS-CoV-2, but, rather, the spike protein exists because that is what has been brought into existence by various forms of GMO methodology and nanotechnology with the help of, among others, Anthony Fauci and, perhaps, some of his colleagues at the Wuhan Institute of Virology.

I still wonder what Charles Lieber -- the former head of the Chemistry Department at Harvard and an expert in nanotechnology -- was doing with the Wuhan Institute of Virology when he was arrested by the FBI. My Spider-sense is telling me that something more than failure to report finances was the underlying sin, but, perhaps, like the case of Al Capone, individuals are charged with what has a chance of being proven in a court of law and not necessarily for what other

crimes might have been committed in conjunction with such alleged financial malfeasance.

Toward the end of Dr. Martin's interview with Reiner Fuellmich, Dr. Martin states:

"There is no such thing as an alpha or a beta, or a gamma or delta variant …. There has not been in any of the published studies on what has been, reportedly, the delta variant … a population R-naught calculated which is the actual replication rate. What has been estimated are computer simulations.

But, unfortunately, if you look at GISAID – which is the public source of uploading any one of a number of variations -- what you'll find is that there has been no ability to identify any clinically altered gene sequence which has, then, a clinically expressed variation. And, this is the problem all along. This is the problem going back to the very beginning of what's alleged to be a pandemic is we do not have any evidence that the gene sequence alteration had any clinical significance whatsoever.

There has not been a single paper published by anyone that has actually established that anything novel since November of 2019 has clinical distinction from anything that predates November 2019. The problem with the 73 patents that I describe is that those 73 patents all contain what was reported to be novel in December and January of 2019 and 2020 respectively.

So, the problem is that even if we were to accept that there are idiopathic pneumonias … even if we were to accept that there are some set of pathogen-induced symptoms, we do not have a single piece of published evidence that tells us that anything about the sub-clade SARS-CoV-2 has clinical distinction from anything that was known and published prior to November 2019 in 73 patents dating to 2008. … There is no evidence that the delta variant is somehow distinct from anything else on GISAID. The fact that we are not looking for a thing doesn't mean that it is a thing, because we are looking at fragments of things, and the fact is that if we choose any fragment, I could come up with, you know, variant omega tomorrow [My Note: In late November of 2021, the omega or omicron variant was introduced], and I could say that I am looking for this sub-strand of either DNA or RNA or even a protein, and I could run around the world

going: “Oh my gosh! Fear the omega variant”, and the problem is that because of the nature of the way in which we currently sequence genomes – which is actually a compositing process … it’s what we’d call in mathematics an interleaving (a mixing together of different components) – we don’t have any point of reference to actually know whether, or not, the thing we’re looking at is, in fact, distinct from either clinical or even genomic sense, and, so, we’re trapped in a world where, unfortunately, if you go and look – as I have – at the papers that isolated the delta variant, and actually ask the question: Is the delta variant anything other than the selection of a sequence in a systematic shift of an already disclosed other sequence?, the answer is: It’s just an alteration in when you start and stop what you call the reading frame. There is no novel anything.”

Not only is there “no novel anything” when it comes to the corona virus, but the very entity that is supposed to serve as the template against which all alleged variants are to be calculated and through which they are to be distinguished in some fashion from the original corona virus template – namely, the genetic sequence of SARS-CoV-2 – does not, itself, actually exist. In other words, all of the 73 patents to which Dr. Martin alludes in his interview refer to the alleged corona virus genomic sequence template of SARS-CoV-2, and this does not exist, but has been invented as a phantasmagoria involving the manipulation of conceptual smoke, mirrors, and distortions of alleged light.

Like all of the possible variants that one might dream up as alleged variations of SARS-CoV-2, SARS-CoV-2 is also nothing but a composite of RNA or DNA fragments drawn from a culture --- fragments that have been cobbled together by a set of computer algorithms and, in the process are, like Pinocchio, written into existence as computer-generated entities which didn’t necessarily actually exist in the culture from which the aforementioned fragments were drawn.

Everything about SARS-CoV-2 is an exercise in making composites from an array of frame reading dynamics involving culture fragments to which computer algorithms are applied, and in the process, arbitrary, composite sequences of RNA or DNA are invented. The only thing novel about SARS-CoV-2 or any of its alleged variants is that they all give expression to different forms of algorithmically driven

computer fictions which have no real counterpart in the world beyond the virtual reality that has been created by those algorithms.

Chapter 13 -- The Testimony of John O'Looney

Bad faith does not only rear its ugly head in conjunction with the issue of the patents discussed in the previous chapter and what really seems to be entailed by those documents. Such bad faith, in all of its unseemliness, is also inherent in other facets of the Covid-19 crisis.

Consider the testimony of John O'Looney. A few months ago in 2021 he was interviewed by Australian Max Igan.

John has been a funeral director in England for fifteen years, including throughout the Covid-19 crisis, in a place called Milton Keynes. Ten of the foregoing 15 years involved working for one of the biggest funeral providers in England by the name of Co-Op Funeral Care, and, then, about five years ago he started his own funeral service because he had become somewhat dissatisfied with the way things were being done at Co-Op Funeral Care where people seemed to be seen merely as sources of revenue rather than being treated with the respect and care that they deserved when having to deal with a death in their families.

In 2019 he was engaged by a family who lost a loved one in the neighboring borough of North Hampton. The family requested Mr. O'Looney to go to Northampton and collect the body of their family member, and they informed him that the hospital in Northampton had not permitted the family to see their loved one.

When Mr. O'Looney went to collect the body, he asked people working in the hospital's mortuary there why permission to see the body of their loved one had been denied to the family. The hospital mortuary workers opened a door to the chapel or the viewing room, and inside was a very large, inflatable pandemic mortuary.

The mortuary workers told him that they had been informed that something very terrible was alleged to be on the verge of occurring. This was the reason why the family was denied permission, because, apparently, to have let them see the body also would have revealed the presence of the large, inflatable mortuary in the viewing room ... something that might stand in need of having to be explained to the family.

As he later discovered, this was John O'Looney's introduction to COVID. This event took place during the end of November or the

beginning of December in 2019, and one might note that such an inflatable mortuary had been set up in advance of there being any sort of announcement in Wuhan, China concerning 6 patients who were exhibiting an undiagnosed and unexplained form of a severe respiratory disease of some kind.

So, one wonders who it was that informed those hospital mortuary workers to obtain and establish such an inflatable mortuary for a coming crisis. One also wonders how whoever it was that informed the mortuary workers in North Hampton about a coming crisis knew that such a crisis was going to be the case when, at that time, there was no real evidence to indicated that anything of the sort might be forthcoming.

However, shortly after Christmas 2019, news was forthcoming concerning the Wuhan wet market, which had been in existence for hundreds of years, had experienced some sort of species jump of an influenza virus from a bat to humans. Of course, such allegations are often made, but, unfortunately, there apparently are no virologists who are capable of providing experimental data under controlled conditions that is capable of demonstrating how, or even if, such a jump actually can, or does, take place.

Science by assertion is not science. In order to be scientific in some sense, one has to put various assertions to the test through the rigorous application of an array of methods, followed by a process of critical reflection concerning the reliability of the outcomes that occur as a result of using different methods of inquiry.

In any event, hysteria seemed to be mounting as a result of what appeared to be taking place in Wuhan. Early on during 2020, John O'Looney was contacted by a local BBC affiliate.

Soon thereafter a BBC team arrived at his doorstep. They had brought a camera man and a lady who briefed him in a fairly intense manner concerning the sorts of things they wanted to ask, but they also indicated in no uncertain terms that they were looking for particular kinds or responses or answers.

The BBC also asked him to be interviewed while wearing full PPE medical regalia. John was reluctant to do this because, although all

funeral directors use aprons and gloves, masks were not usually part of their work dress.

John had worked seven years for the coroner. The only time that he wore a mask during that period of time was when a body had been undiscovered for an extended period of time and, then, subsequently discovered. On such occasions, he would put on a mask and apply Vicks to it in order to protect against the smell of a decaying body.

Nonetheless, he points out that a mask is not really capable of protecting a person against anything (except, maybe, if Vicks is present, bad smells.) He adds that masks are useless against something the size of a virus.

John adds that during the early stages of the alleged pandemic, he was someone who believed that COVID was real. If he went to a hospital to collect a body and was told that the individual being collected had had HIV or tuberculosis, these were all things that he would treat in a serious manner, and for him, at that time, COVID was one of the things that he took seriously, and, therefore, he tried to be as prudent concerning such issues as he could be.

The BBC people got the sort of interview they had desired. The piece became part of a media arsenal that were used to promote hysteria in the general public, and as a result, John is critical of himself for having gone along with their manipulation of information because he came to the realization after a bit of time and additional experience that none of what the BBC was saying concerning COVID was true.

Very early on in 2020, John indicates that funeral directors had begun to become concerned somewhat because the death rate for COVID that was being hyped by the media did not seem to be taking place. Deaths were being labeled as COVID deaths when there was no evidence to warrant such a label, but, instead, whatever the nature of the re-labeling process might be, there was no comparable rise in excess deaths – that is, deaths that would be in excess (such as during an alleged pandemic) of what one might expect under, more or less, "normal" circumstances), and every funeral director with whom John spoke was corroborating John's experience in this regard.

I might point out in passing that I had listened in on a number of phone calls that a young woman from London, Ontario had recorded

during 2020 while contacting various funeral directors in her local area, as well as in places such as Toronto, Manitoba, and even a few places in the United States. She would ask each of the funeral directors the same thing – how would you rate the number of deaths that you have seen in 2020? Are they more, or less, than previous years?

The answers that she received from all of those funeral directors invariably indicated the fact that the rate of deaths in 2020 was pretty much the same as had been the case the year before. There had been no surge of excess deaths taking place, and, therefore, her findings, as unofficial and non-rigorous as her investigation might have been, were inconsistent with what government officials, many hospitals, and the media were trying to claim was taking place in Canada and the United States, but her results – derived quite independently of what was transpiring in England – were, nonetheless, quite consistent with what funeral directors in England were discovering in a much more systematic manner.

One funeral director that the foregoing, young woman contacted sought to encourage the woman's efforts. He indicated that he thought she was on to something important with her inquiries.

During the early part of 2020, John was approached by a family that had lost a young child of six who had been suffering from some sort of cancer. They had wanted to see their girl, but the death occurred during a time when many funeral directors were taking body bags and coffins to the hospital, sealing them into such receptacles, and foregoing any sort of dressing, viewing, and the like due to COVID protocols.

John believed that the foregoing sorts of arrangements were not fair to the people who had lost loved ones or to the loved ones that had been lost. Requiring people to only be able to view someone's passing via a Zoom call or through the barriers of a hazmat suit did not sit well with John.

The aforementioned family members that had engaged his services were very afraid that he wouldn't wash and dress their loved one if the latter had been labeled as someone who had died of COVID. He assured the family that he would wash and dress their loved one, and, in fact, this became his policy throughout COVID … he washed and dressed each and every body that he collected because this is the kind

of respect and treatment that his clients – both the living and deceased -- deserved.

At that point, John decided that he was going to give people the opportunity to view their loved ones. He felt that a crucial part of his job was to look after the emotional and psychological needs of the individuals who came to him for assistance, and if that means that he keels over from illness in the process of carrying out what he considered to be duties of care toward his clientele, then, so be it, and a result, he has washed and dressed everyone throughout COVID.

John did have some concerns about whether, or not, he was exposing himself to COVID through his work and given that everybody's death was said to be due to COVID. Yet, he never got sick, nor did his wife get sick despite the fact that she assisted him in different ways with his work, nor did his embalmer get sick who is 55 and a heart-attack survivor of ten years.

The process of labeling deaths as COVID deaths had become streamlined. Doctors were not in attendance, and the police were not in attendance.

Instead, whoever is on the scene of a death rings the doctor, and people were told by the doctor to release the body. As a result, John was often collecting bodies that were still warm rather than body's that were cold or that had been keep in refrigerated conditions and, therefore, any virus that such individuals might have had would have long-since disappeared.

If the people he was collecting who were still warm and who were being labeled as COVID deaths actually had died of COVID – a disease that, supposedly, was highly infectious, then, John feels pretty certain that he would have contracted the disease because he did not wear a mask on any other kind of protective gear on any of those occasions.

Yet, soon, every death that took place was being labeled as due to COVID. This even extended to a person who had been run over by a car which was not really a COVID death.

For example, John talked about a person who had been at a care home, was 95 year old, and had a full life. There had been no doctor in attendance at the time of death, and there had been no COVID test

given to that individual, and, as a result, the passing away of the elderly gentleman really wasn't a COVID death.

On another occasion, John picked up a person who had been staying at a local hospice before passing on. This individual had terminal cancer.

Yet, in each case, someone decided that the deaths of the two foregoing individual were due to COVID. The people who were labeling the cases as COVID said that they were told there had been other cases of COVID in the nursing home or the hospice, and, therefore, they felt obligated to reach the conclusion that the two individuals described above must have died of COVID.

During March and April of 2020 John notes that he and other funeral directors had witnessed a brief spike in deaths. He further stipulates that in England, society is very good at "inducing" people to pass away in hospitals and care homes.

Generally speaking, if John had ten collections to make, 8 of them would be from hospitals, one would be from a care home, and one would be from a residential home or a hospice where people go to die with palliative support. However, an announcement came over the media that an effort was going to be made to try to protect the most vulnerable people who were living in care homes.

Yet, somehow, despite all the words about protecting the most vulnerable in care homes, it was precisely those homes that were being hit the hardest by – so everyone was told – COVID. John sensed something strange was going on.

Viruses don't target just care homes. He believes – or, at least, he believed at the time -- that viruses were equal opportunity entities and tended to spread death around rather than focus on just a single group of people.

On the other hand, nursing or care homes are filled with people who can't say no. The residents of those homes are at the mercy of whatever the people working around them decide to do with, or to, them.

For three weeks, John was being called to care homes every night. This occurred at a time when Matt Hancock, who has since been dismissed, was transferring all manner of old people from hospitals

into care homes. Such transfers were all being labeled as COVID cases – irrespective of whether, or not, this was true in any sort of objective terms.

Mr. O'Looney subsequently discovered that there had been a 1000% increase in the amount of midazolam (a short acting form of benzodiazepine which can be lethal at certain dosages) that had been procured by government officials during that period of time. He indicates that there is a considerable paper trail that is capable of verifying the foregoing claim.

John indicates that he had worked for one of the big funeral providers for ten years that had a 60% market share. Throughout those ten years he had never been called to a care home on three consecutive nights, so, for John – who was now just a small family undertaker – to be summoned night after night after night, for three weeks, exclusively to care homes had a strange sort of quality to it.

During this period of going to care homes night after night, he never saw a doctor in attendance. In addition, he never saw a COVID test result, nor did he see any ventilators, so there was no need for the people in the care homes to be sedated prior to being put on a ventilator because there was no evidence that ventilators were being used.

He began to suspect that thousands of people in the care homes were being euthanized through the use of midazolam (a short-acting benzodiazepine which, when given in sufficient amounts, can lead to death). He began to see small, empty vials near the beds of people in the care home who had died, and, actually, at a certain point in time, he had begun to look for – and found – more such evidence in the care homes.

He indicates that there was a twelve-week "cull" which occurred during 2020 in which many, many people in some of the care homes died. Moreover, Mr. O'Looney does not use the term "cull" loosely, because his experience with what was taking place in those care homes indicated that the number of deaths was statistically aberrant.

John mentions a funeral that he did, and he indicated that one of the members of the family whose loved one had died worked in a pharmacy in a local hospital. Mr. O'Looney asked her if midazolam was

being brought into care homes, and she confirmed that this was the case.

Following the end of the foregoing culling process in the care homes during the early part of 2020, there had been a pandemic guy who contacted John and who had introduced himself as a government-sponsored pandemic investigator. His job was to contact all of the funeral directors in the area, and his task was to collate the numbers of the deceased that had been collected by different funeral directors.

He wanted to know such things as how many bodies could be accommodated in John's funeral home. Or, he was interested in how many bodies had been collected during a given week as well as how many of them were COVID deaths.

As a result, the man often contacted John pretty nearly every Monday following their initial chat. During these conversations John would indicate that there was nothing out of the ordinary that was taking place and would provide examples of this.

Although the conversations that he had with the government pandemic individual were not that long (perhaps 30 seconds or a bit longer sometimes) those discussions usually followed the same format. However, during one such conversation, the man sort of confessed to John that he – the man – didn't know why he was carrying on with his job of contacting funeral directors concerning the alleged pandemic because the people that he was contacting (i.e., all of the funeral directors in the area) were all saying pretty much the same thing. There were no COVID deaths -- or no excess COVID deaths -- that were taking place in that area of England.

Although John was still doing funerals throughout 2020, and despite the 12-week culling that occurred in care homes during 2020 when someone (presumably in government) was seeking to try to inflate the alleged COVID numbers via the use of midazolam, John stipulates that the number of funerals in 2020 were actually less than had been the case in 2019 when the alleged pandemic had not been – supposedly -- ravaging England.

95% of the funerals that are done in England involved cremation, whereas only 5% involved burials. However, when he went down through the numbers, those figures did not support the notion that

England was in the throes of a pandemic, and his numbers were typical of what was transpiring across England.

John began to suspect that Englanders were not being told the truth about what was actually going on. He intimated to others that when the jab began to be given in January, he suspected that the death rate would rise.

At the time he revealed the foregoing suspicions, people laughed at him. They believed that such a possibility was ludicrous.

The jabs began to be given on the 6th of January 2021. From that point onward, the death rate was so extraordinarily heavy that Mr. O'Looney had never witnessed anything like it previously in his life as a funeral director of fifteen years, nor has anyone else with whom he has spoken to about the matter.

He refers to the beginning of the jab as the start of the second wave of deaths in England. The first wave of deaths had to do with the twelve-week period of culling that took place during 2020 when many people in care homes died as a result of – not COVID – but from the midazolam that had been administered to them by staff members in those care homes, but those care home deaths – which were due to midazolam and not COVID -- were being used to give the impression that England had been hit by a deadly pandemic.

The second wave was very different than the first wave. The first wave consisted mostly of older people in care homes, whereas the second wave involved people of all ages who died in a variety of settings, from: Hospitals, to: Residential homes … although many of them did die in hospitals.

The second wave of deaths did give expression to pandemic-like numbers. However, the number of deaths only began to climb precipitously when people began to receive the jab and not prior to that period of time.

The authorities attributed such deaths to COVID. Nevertheless, it seemed clear to Mr. O'Looney that the vast majority of those deaths were likely to have been due to some sort of adverse reaction to the jabs.

On the other hand, he considered the possibility that some of those deaths might have been due to a continued use of midazolam in

either hospitals or elsewhere. In addition, John also indicates that the manner in which the medical system often practiced a "blatant neglect" of people in their charge also might have been a contributing factor in a certain number of deaths.

For instance, he talks about the many stage-four cancer patients that he met, or about whom he knew, who often ended up dead. This occurred because no one in the medical system would tend to them due to the way in which the obsession with COVID was, and had been, draining all of the resources and time of most medical personnel.

The foregoing pattern involving the second wave continued on until April of 2021. At that point, the number of excess deaths began to decline, and, in a sense, it was like entering the eye of a hurricane because he indicates that in terms of the number of deaths that were taking place, he had entered into one of the quietest periods that he had known in the last five years.

John indicates that the foregoing phenomenon was not unique to him. Toward the beginning of the alleged pandemic, he had joined a number of groups involving other funeral directors with the idea that they needed to find ways of lending support to one another, and many of those individuals were experiencing the same sorts of conditions as John was.

However, John goes on to indicate in his interview that about three weeks ago – at some point following the period of quiescence – the number and rate of deaths began to pick up again. The people who were dying are, almost exclusively, recipients of one kind of COVID jab or another in which people of all ages are experiencing sudden heart attacks, strokes, blood clots, as well as scenarios involving multiple organ failure.

The four foregoing kinds of death have formed a consistent pattern over time. The individuals who are dying from the four foregoing kinds of death are coming from all age groups, including relatively young adults in their twenties.

Whereas earlier during the alleged pandemic, the BBC had been interested in prying whatever information they could from John and other funeral directors that might fuel the hysteria surrounding COVID, now, that John was expressing various concerns about a

pattern of death that could be tied directly to the emergence of the jab, nobody in the media wanted to talk to him. He further stipulates that the so-called "Delta" variant of SARS-CoV-2 was widely acknowledged within the National Health Service to be nothing other than vaccine injuries writ large.

People in England were being lied to by both government and many medical/health authorities that a dangerous, highly contagious virus was present in their country that was killing people and from which they needed the alleged protection that was being made available through the jab. In reality, however, John – and other funeral directors were discovering that there was no substantial evidence that people in England were dying from COVID, and in fact, the spike in deaths that occurred in early 2020 was from care homes where there was considerable evidence that old people were being euthanized through the use of midazolam and not dying from COVID even as such deaths were all automatically being labeled as COVID deaths.

Families in England that would come to John were mostly unaware of what was taking place in their country. When those people came to him, John would ask them if their recently deceased loved ones had received the jab, and they, invariably, responded in the affirmative and confirmed that their loved ones had been double jabbed prior to death, but those same individuals would also tend to respond that the jab couldn't possibly be the reason for death because they had received that jab eight, or so, weeks prior to dying.

Nonetheless, there is no empirical evidence indicating that the components within the COVID jab are incapable of causing damage to recipients at any point following the injection, whether immediately, or within 48 hours, or a week, or eight weeks, or months later. Although government and medical/health authorities have been attempting to dominate and control the COVID injection narrative and, as a result, are claiming that whatever deaths ensue after receipt of a COVID injection have nothing to do with that injection. Notwithstanding their blanket exoneration of all things linked to the process of COVID injections, their verbiage is nothing but rhetoric because it is not backed up with the kind of qualitatively sound evidence that would be capable of justifying such an assertion. Their words are devoid of anything substantive in nature.

John indicates that the authorities are using the idea of new variants of the alleged SARS-CoV-2 as a way to continue to put forth the idea that there are an unending series of infectious agents present in the environment against which people must be protected through the so-called genetic therapy injections (and all of this is done without such authorities being able to prove that SARS-CoV-2 exists, is infectious, is lethal, or capable of giving rise to so-called variants), and, recently, they have begun to extend the injection process to young children.

According to Mr. O'Looney, the likely end result of all of the foregoing Machiavellian machinations on the part of delusional government and medical/health officials is that children who receive the jab will get sick as a result of having been injected, and some of them – perhaps many of them – will die … and the authorities will continue to vociferate – sans evidence -- that the deaths of those children have nothing to do with the injections.

John's foregoing predictions or suspicions were made a number of months before the idea of inoculating children was openly discussed by alleged medical and health experts. His concerns – both about the issue of inoculating children and them dying – are already being realized … he said before the fact that such events would occur, and, now, they have.

Since Mr. O'Looney has gone public with his account of COVID, approximately 46 funeral directors have contacted him and not only provided information which corroborates what he is saying but which indicates that they are becoming increasingly fearful of the fact that England is being controlled by people – both within government as well as with the fields of medicine and public health -- who are not only willing to murder its citizens – whether through midazolam or toxic injections – but who might be prepared to go even further in seeking to impose their conceptual and cult-like pathologies of control onto the rest of society.

John stipulates that the evidence shows that there is no COVID pandemic that is taking place in England. The entire COVID narrative was invented in order to trick people into taking an injection that cannot possibly help them in any way but, at the same time, is

propagandized as constituting a threat to the health and bodily existence of the general public.

He points out that when one examines the records of all of the funeral directors within, say, a 50 or 60 mile radius of where he carries out his work, there has not been one child who died of COVID since the so-called beginning of the pandemic. He further stipulates that if this sort of event had occurred within his region, he would have known about it.

Of course, he realizes that the authorities, at some point, are likely to invent one, or more, children who supposedly have experienced a horrible death from being – allegedly -- infected with COVID. However, given that SARS-CoV-2 has never been proven to exist, or to be infectious, or to be lethal, and given that antibodies cannot form with respect to a non-existent antigen, and given that the PCR test has been shown to be meaningless, there actually isn't any scientific or medically credible way for such authorities to prove their claim that a child had died of COVID, and, consequently, such claims would be empty and used purely for purposes of promoting fear-porn that is intended to induce parents to allow their children to be injected with toxic substances that have no medically useful reason for being in someone's body – especially the bodies of children.

He goes on to point out that government and medical authorities are applying pressure to twelve years old in order to induce them to consent to receiving a dodgy injection, when children that young are not permitted to, or are considered unable to, consent with any degree of understanding to activities involving: Sex, drinking alcohol, marriage, and voting. The emotional, intellectual, social, biological, political, and spiritual abuse that is present in such attempts of "persuasion" is criminal and, quite frankly, psychopathic in nature.

Mr. O'Looney indicates that there are many people in the National Health Service who agree with the perspective concerning COVID that is being given expression by him during his interview with Max Igan. John indicates that there have been a "plethora" of doctors, nurses, staff from various hospitals, and other public health practitioners who are connected to the National Health Service who, among other things, all agree that the deaths that have occurred since the introduction of the jab are responsible for a large percentage of the deaths that have

occurred in England since January 2021 when COVID injections started to be given.

John collects the bodies of the people who have died as a result of the injections. However, the members of the National Health Service have to deal with the suffering of people who experience many kinds of adverse reactions – and not just deaths – that have been generated by the COVID injections.

Some people don't die. Instead, as a result of having been injected with the alleged COVID elixir, they become paralyzed, or develop various kinds of severe palsy, or begin to have heart problems, or start to experience blood clots, or they become blind, or encounter instances of multiple organ failure.

One medical specialist that John looked after in 2020 because the former gentleman had lost his partner indicated to John that the injections were extremely dangerous. The specialist indicated that during preliminary trials involving the COVID-jab, 200 Rhesus monkeys a week were dying due to the injections they were receiving, and, as a result, they stopped animal testing.

However, while the pharmaceutical companies might have stopped slaughtering Rhesus monkeys, those same companies have continued to experiment on human beings and, now, are in the process of slaughtering members of the public through injections which have no proven value except to the bottomless line of pathological greed and desire for control exhibited by the members of those pharmaceutical companies.

John mentions the massive holding centers that already have been built, or are in the process of being built, in different parts of the world. He points out that prison reform has been bandied about for decades with nothing being done, and, yet, now, despite the fact that economies across the world are in shambles and on their last breaths, super prisons (capable of housing 30,000 people) or internment camps costing hundreds of millions of dollars are being built especially for all those who are designated to be ill with COVID or for those who refuse to be vaccinated, as well as for those who seek to resist the oppressive policies of the government and medical system in one fashion or another.

He refers to one of the aforementioned internment camps that is relatively local to him and is known as HMP Wellingborough. The buildings are X-shaped, and the capacity of the prison or internment camp is of the order of 30,000 people.

John notes that another one of these super internment facilities is reported to exist in a place called Glen Parva near Leicester. Since the average yearly prison population in England is listed to be roughly 80,000 people, and while some of the existing prison facilities might be over crowed, nonetheless, one can't help but wonder what sort of agenda lies behind the construction of such mammoth structures that have both mortuaries and crematoriums associated with them.

Toward the end of his interview, John O'Looney indicates that the Hippocratic Oath was recently revised in England. The words "Do no harm" were removed from that Oath, and, yet, if one reflects on what the number one duty of care that a medical practitioner owes to a client or patient involves doing no harm, one can't help but be puzzled that such a principle no longer seems to be a duty of medical practitioners.

He has had conversations with nurses who have told him about instances in which they were called into the room of a patient and told by a senior physician to fill a syringe with 60 milligrams of midazolam (which is a fatal dose) and inject it into patients … patients who, apparently, are not really dying or near death but who have been labeled as being COVID active from a testing process that is not worth the paper on which its results are recorded.

Chapter 14 -- Ideological Psychopaths

There are two kinds of psychopaths in the world. On the one hand, there are those individuals whose genetic and biological character seems to be locked into – from birth onward – a way of life that give expression to an array of behavioral qualities that lack few, or any, signs of conscience, empathy, character, or remorse for the damage that those behaviors inflict on the lives of others. In addition, such individuals seem to lack any sort of impulse control with respect to indulging the foregoing sorts of behavioral inclinations, and, consequently, often seem willing to lie, deceive, or manipulate other human beings in order to rationalize or hide the presence of those impulses, yet, they will respond with irritability and aggressiveness if such impulses are resisted or thwarted by whatever human beings these sort of psychopathic individuals might be engaging under any given set of circumstances.

Whether the foregoing sorts of individuals have any degree of control – or could learn to have some degree of control – over their behavioral and emotional set of anti-social tendencies is an unanswered question. On the surface it seems that such people cannot escape from what they are and that whichever choices are made by them are issued in compliance with what their biological, genetic, and cognitive structures permit within the confines of the problematic set of behavioral and emotional options that appear to govern their lives.

The other kind of psychopath is someone who – as a result of commitment to some sort of ideology (social, political, economic, scientific, philosophical, sexual, military, financial, or religious) chooses his, her, or their way into a way of life that resonates with many of the qualities – or lack thereof – that exist in what might be referred to as a natural born psychopath. In other words, like the latter sorts of individuals, an ideological psychopath will pursue behaviors that have devastating consequences for other people but, nonetheless, will do so without any apparent sign of conscience, character, empathy, or remorse for what is taking place. In addition, like their natural born counterparts, ideological psychopaths will cheat, manipulate, and deceive others in order to service their impulses or desires to abide by the perceived requirements of their ideological commitment irrespective of what the costs of doing so might be for

others. Furthermore, like their natural born counterparts, when human beings try to resist their desire to act in such a fashion, ideological psychopaths will become irritable and aggressive toward anyone who seeks to thwart what ideological psychopaths are seeking to do.

One might note in passing that many corporations tend to qualify as ideological psychopaths. The nature of the ideology which underlies the corporate tendency toward psychopathy has to do with the financial, economic, political, and other sorts of commitment that drive the corporation to do what it does irrespective of how its actions might adversely affect other individuals.

In fact, the very legal structure of a corporation is intended to shield any of its members from being held directly responsible for whatever problematic behavior might be forthcoming from such a legal entity. Corporations became a way for one, or more individuals, to do whatever their ideological commitments required them to do while operating under the impression (and, recently, that impression has been challenged, sometimes successfully, in the courts) that one of the reasons for starting a corporation is to provide its members with the legal degrees of freedom that are necessary to accomplish what they seek to do without having to worry about issues of accountability.

Whereas, as noted previously, individual human beings who are natural born psychopaths have poor impulse control, corporations don't have impulses per se, but they do have corporate policies and agendas that are similar in character to impulses and which, like the impulses of natural born psychopaths, are often poorly controlled if not default actions.

For instance, consider the case of Ford v. Dodge which was decided in 1916. In 1906 Horace and John Dodge invested $10,500 dollars to help Ford establish his automobile company, and as part of that investment process, both brothers became shareholders in the Ford company, and, as well, John Dodge became a member of the board for that company.

Ford paid his workers beyond what they could earn elsewhere. Moreover, he wanted to help people purchase his Model T vehicles and, therefore, he would often cut the prices of those cars to make them more affordable to the public and, as well, because he felt that

too much profit was being made from the sale of such cars, and, consequently, he would often cancel the payment of dividends to the shareholders.

The Dodge brothers seemed fine with this arrangement for a decade, or so, but in 1916, they decided that they wanted to build an automobile of their own. In addition, they wanted to use the proceeds from the Ford shareholder dividends that were on the horizon, but Ford interfered with their plans by cancelling the dividend once again.

This time, following the resignation of John Dodge from the board of directors of Ford's company, the Dodge brothers took Ford to court. The essence of their legal argument was fairly simple and straightforward.

Shareholders were entitled to whatever profits were earned. Consequently, Ford had no right to take what belonged to the shareholders in order to give customers breaks on the prices of vehicles.

The presiding judge in their court case agreed with the Dodge brothers. Managers and directors of a company have a legal duty to ensure that the interests of the shareholders are served before, and above, all other considerations, and are considered to be in 'the best interests of the corporation.'

I'm not sure that the judge got it right. There is nothing in the Constitution that requires the foregoing point of view to prevail such that the best interests of a company are necessarily to be equated with the amount of money that is to be received by the shareholder via dividends.

Maybe the interests of the shareholder are best served when a stable company that serves a productive and constructive role within society by ensuring that workers get paid well so that they can afford cars and ensures that the prices of cars are within the means of people in the general public. Maybe well-paid workers will help lead to less crime and, therefore, fewer costs to the courts or the prison system. Maybe, well-paid workers and affordable cars will help lead to better communities and school systems.

Contrary to the totally arbitrary use of the notion of a legal fiction in relation to treating corporations as persons (and the use of legal

fiction and persons in the same sentence is oxymoronic), corporations are nothing but charters which give expression to a set of permissions and conditions. The state – within reason – can set any sort of an array of permissions and conditions that it believes might be in the best interests of society, and this need not automatically mean that the most important condition of such a charter is that shareholders are entitled to profits in the form of dividend payments rather than being entitled to a society that serves the political, educational, artistic, and cultural interests of those shareholders. In short, money is not the only good that can accrue to a shareholder and be in that shareholder's best interest.

However, because the judge in *Ford v. Dodge* ruled as he did, he condemned corporations to operate in accordance with an impulse or corporate policy/agenda that demanded corporations serve the financial interests of the shareholder irrespective of whatever damage such a policy might impose on the rest of society. The legal decision seems rather short-sighted, and, unfortunately, was one of many legal decisions that helped corporations to work their way to having a potential to be little more than ideological psychopaths.

Furthermore, when the desires or impulses of such corporations are resisted by this or that human or group of humans, such corporations tend to become very aggressive toward whoever stands in the way of what they wish to do. Power –- whether financial, and/or economic, and/or political, and/or legal – will be leveraged by corporations in the most abusive of ways, and, of course, if necessary, whatever lies, deception, or modes of manipulation are deemed to be necessary will be used – just as is the case with natural born psychopaths – by ideological psychopaths whether these be individual human beings, corporations, or groups of human beings who share a set of common ideological commitments.

Ideological psychopaths – just as is the case with natural born psychopaths – tend to lack any signs of compassion, empathy, or remorse with respect to whatever adverse impact their actions might have on others. As such, they are unwilling to accept responsibility for the problematic influence they are having on the lives of other, and despite whatever statements are issued by such entities that it is most unfortunate that some people are suffering, nevertheless, ideological

psychopaths will continue to do what they do irrespective of how its actions might affect others.

For instance, almost all of the major pharmaceutical companies have been involved in cases that involve criminal and civil sanctions (to the tune of billions of dollars) being levied against them. Yet, for the most part, none of the individuals who are members of those corporations are ever held accountable for their role in propagating such criminal and civilly liable actions (The Sackler family – along with the FDA – which were both responsible (each in their own way) for the deaths of thousands of people due to their collectively irresponsible campaign which pushed the mantra that opiates like Oxycontin are non-addictive and, as a result, helped turn people seeking relief from pain into drug addicts who oftentimes destroyed themselves, their families, and their communities are poster children for people not being held accountable for their ideologically psychopathic actions).

The CDC – that is, the Center for Disease Control – is an institution which is part corporation and part quasi-governmental agency that has all of the earmarks of an establishment that qualifies as an ideological psychopath. For instance, aside from (1) having a role in helping to cover up – by delaying public acknowledgement concerning -- what had happened in the Tuskegee Alabama experiments in which (between 1932 and 1972) approximately 400 black prisoners were given Syphilis without their knowledge and consent and were observed for a period of forty years without treating their condition, and aside from (2) the role that the CDC had in obfuscating the many medical issues surrounding the use of Agent Orange and its effects upon American service people, and aside from (3) the role that the CDC had in perpetuating the myth that HIV caused AIDS, or obscuring the fact that drugs such as AZT were what was actually killing people, not some virally caused condition known as HIV or AIDS, and aside from (4) the fact that William Thompson, a CDC whistleblower, testified that the CDC had actively hidden – for more than a decade – that thimerosal (a form of mercury) – notwithstanding all of the CDC's many denials to the contrary – was directly implicated in causing an excess of cases of autism in young black boys following vaccinations of one kind or another, and aside from the fact (5) that the CDC has, again and again, promised to run controlled experiments in conjunction with

vaccine studies in order to determine, once and for all, whether vaccinated or unvaccinated individuals fared better with respect to the issue of immunization, and, yet, the CDC has continued to renege on its promises to run such experiments, and aside from the fact (6) that the CDC refuses to run studies about whether vaccinated or unvaccinated individuals are healthier (and all such studies that have been done independently of the CDC have demonstrated that unvaccinated individuals have far fewer health problems and chronic forms of diseases than is the case for vaccinated individuals, and aside from (7) the fact that the CDC is rife with all manner of conflicts of interest because many of its members have patents for various treatments that the CDC is also recommending to be pushed off onto the American public, and aside from the fact (8) that the CCD has a revolving door policy with the pharmaceutical companies of the world that is of an financially incestuous nature and, as a result, has adverse consequences for the American public because it simply is not possible for the CDC – which, supposedly, has responsibilities of oversight involving the behavior of pharmaceutical companies – to properly exercise those responsibilities of rigorous oversight in relation to companies that are willing to hire members of the CDC who exhibit the right sort of attitude and voting record to later go to work for the pharmaceutical companies, and, therefore, what happens is that the CDC ends up protecting the pharmaceutical companies and their interests – aside from all of the foregoing considerations and many others that could have been mentioned but were not, the CDC is now engaged in a propaganda war which clearly states on their website that all of the COVID vaccines are safe and effective despite the fact that neither of those claims is true.

Although the numbers are always changing in an ever-increasing upward direction as time passes, the VAERS system – that is, the Vaccine Adverse Event Reporting System – which has been recording the reports of adverse events associated with the different COVID jabs indicates that, as of November 5, 2021, not only have 19,513 people died in conjunction with the administering of those vaccines, but as well, there have been 922,363 adverse events (with many of those events becoming permanent forms of disability) that have arisen following people's receiving of one, or more, of the COVID jabs. What makes the foregoing numbers even more frightening is that various

studies have been done (such as the Harvard Pilgrim study) which suggest that the number of reports that are actually sent to VAERS may only be between one tenth to one hundredth of the actual adverse reactions that are occurring in relation to the various jabs that are being given.

The CDC's response to the tens of thousands death reports that have followed the COVID jab or the thousands of reports of permanent injury that have emerged in conjunction or the thousands of reports of deaths in the unborn children of pregnant women, or the hundreds of thousands of other medical emergencies that have occurred in relation to the administering of the COVID jabs is that one cannot necessarily assume that such occurrences have been caused by the COVID jabs … such reports are just that: reports, and those reports – as they stand – have not been properly investigated in order to determine what is causing such events.

While what the CDC says is perfectly true, what the CDC is not saying is actually deafening. The CDC has no active program for rigorously examining such cases, and rather than abide by a principle of caution that would demand the suspension of all COVID jabs until one had a credible and reliable understanding of just what such VAERS reports meant, the CDC insists – despite a lack of evidence capable of supporting its position – that the COVID jabs (notwithstanding all of the hundreds of thousands of reports concerning adverse reactions in association with those jabs) are completely safe and effective.

Not only is the CDC trying to ignore all the evidence indicating that the COVID-jabs are not safe (and how can the CDC conclude otherwise until it thoroughly investigates every last adverse reaction and demonstrates that all adverse events have nothing to do with the COVID jabs), but those jabs are not effective, and couldn't possibly be effective.

Initially, the COVID jabs were touted as a way to mitigate some of the lesser symptoms that were alleged to be part of a COVID diagnosis. Those COVID jabs had not been shown to be capable of stopping someone from contracting COVID, nor had they been shown to be capable of preventing people who had been vaccinated from passing COVID onto other people, nor had those jabs been shown to protect people from actually getting sick or being hospitalized or even dying.

As a result, booster shots became all the rage. Yet, the only reason for suggesting the need for booster shots is because the original jabs were not up to the job and had failed to offer recipients anything in the way of actual effectiveness.

If a person receives a COVID jab and doesn't become ill with COVID, how does one know that it is the jab that has made this possible? How can one be sure that it wasn't something inherent in the individual's natural immune system that was protecting the individual rather than the jab?

The problem is that as been demonstrated in earlier chapters of this book, the so-called PCR test is meaningless because no one has shown that the primers used in conjunction with such tests are able to zero in on unique genetic sequences of SARS-CoV-2 simply because no one has ever successfully isolated the alleged 30,000 base pairs of that entity's genome, and, then, sequenced such an actual, concrete entity to show that it does, indeed, have a unique, identifying genetic sequence associated with it that could be latched onto – in complimentary style -- by the primer that is being used to search for it in a given swab or sample Furthermore, no one has shown that SARS-CoV-2 is infectious or deadly.

If the SARS-CoV-2 virus has not been existentially/concretely isolated and purified, then, one cannot automatically suppose that there have been any antibodies that have formed to indicate the presence of a virus which, at best, is nothing more than a phantom which cannot be proven to exist outside of the confines of a computer's computational-algorithmic theoretical and entirely invented representation of such an alleged real-world entity. In fact all of the antibody tests that are taking place in conjunction with the alleged presence of SARS-CoV-2 have not been independently verified as having anything to do with such an alleged virus, because, once again, if such a virus does not exist (and, thus, far, no one has shown that it does exist) then, whatever investigators or researchers believe they have discovered with respect to, say, increases in a certain kind of monoclonal antibody, or T-Cells, and so on, might only be artifacts of something else that is taking place in a person's body and, as such, are incorrectly being interpreted as constituting something (i.e., detection of the presence of the SARS-CoV-2 virus) other than what they actually

are (i.e., lack of evidence for the detecting the presence of the SARS-CoV-2 virus but, possibly, evidence of something else unrelated to COVID that might be transpiring in someone's body).

Whether one examines the breakdown of the adverse events in the European Data Base (EudraVigilance) that occurred following receipt of the COVID jab or one examines the breakdown of the adverse events that have been recorded in the VAERS system in America, the trends taking place in both tend to be roughly similar – namely: EudraVigilance documents (28,103 deaths and 2,637,525 injuries as of October 31, 2021) and the VAERS documents in America (19,513 deaths and 922,363 adverse events as of November 5, 2021). The European Data Base only includes reports from the countries in Europe that are part of the European Union (27 countries), and, as a result, given that there are 50, or so, European countries, there are 23 further countries in Europe that are not being reflected in the aforementioned data base.

In any event, the foregoing deaths .have been associated with all of the following conditions that are being reported as adverse events: (1) Blood and lymphatic system disorders; (2) cardiac disorders; (3) endocrine disorders; (4) eye disorders; (5) gastrointestinal disorders; (6) immune system disorders; (7) musculoskeletal and connective tissue disorders; (8) nervous system disorders; (9) renal and urinary disorders; (10) reproductive system and breast disorders; (11) skin and subcutaneous tissue disorders; (12) vascular disorders; (13) infections and infestations; (14) injury poisoning and procedural complications; (15) metabolism and nutritional disorders; (16) pregnancy puerperium and perinatal conditions; (17) psychiatric disorders.

As of October 1, 2021 -- and the numbers have changed since then -- there were 1,969 fetal deaths following the receipt of one COVID-19 jab or another. The CDC can be proud of the fact that they said that the jabs were safe and effective for pregnant women and the would-be offspring of those women.

According to Thomas Renz, an Ohio-based attorney, a whistleblower has come forth indicating that American Medicare data is capable of documenting that more than 45,000 deaths occurred within 14 days of receiving a COVID-19 shot. The foregoing data refers

only to people who are in the Medicare data base, and, therefore, the foregoing data reflects what might be happening among only 20% of Americans.

More specifically, during July of 2021, a person who works as a health care analytics data computer programmer came forth and made a declaration under threat of perjury. The individual indicated that there were at least 45,000 deaths that are linked – possibly causally – to the COVID-19 shots.

The 14-day period noted above is important because according to the CDC (and its rather arbitrary and nonsensical way of doing things), if an individual dies within 14 days, then such an individual is not considered to have been vaccinated. This allows the CDC to talk out of both sides of its mouth – and, thus, give expression to its ideological psychopathy – by saying that it is the "unvaccinated" who are dying even as such people have been jabbed and may be dying not because they are unvaccinated but because they received a toxic jab of materials that have led to their deaths.

A further, independent study that seeks to provide some sort of quantitative orientation concerning the number of deaths that have ensued from the rolling out of the various COVID jabs was published in September 2021. Steve Kirsch, a Silicon Valley entrepreneur, assembled a team of mathematicians and scientists that studied 6 population and surveillance databases (including VAERS).

After subjecting that data to 8 different methods of analysis, the researchers concluded that 150,000 individuals had died between January 2020 (when the inoculation process begun) and September 2021. Kirsch is so sure of the foregoing study's reliability that he has offered a million dollar bounty to anyone who successfully can demonstrate that errors were committed during the analysis and calculations that were carried out by his group of researchers.

There have been many tens of thousands of people who have died in Brazil following COVID-19 jabs. There are more people dying in Taiwan in relation to the jab than are dying in relation to COVID-19.

The personal testimonies of individuals who have been permanently injured after receiving one, or another, of the COVID shots are heart-wrenching. I have watched many of those videos.

How could anyone in the CDC who is not giving expression to the characteristics of an ideological psychopath turn away from the fact that thousands of people are testifying to their experiences of adverse events in conjunction with the COVID jabs and claim that those injuries are only correlational in nature and cannot possibly be causal in character (why not?). Yet, the members of the CDC were so convinced that everyone who died in America in 2020 and 2021 must have died of COVID that they ordered doctors to change the way they filled out death certificates to reflect the theology being espoused by the CDC.

Like their natural born psychopathic counterparts, many of the people in the CDC are quite prepared to prevaricate, deceive, cover-up, distort, and manipulate (and the CDC has a long history of dong precisely this as was itemized a few pages ago during this essay). Many – if not all of the individuals who work at the CDC – are true believers who accept the gospel of virology despite the fact that none of the alleged viruses against which they issue recommendations for injecting this or that set of materials – and this is true with respect to the CDC's position on COVID-19 jabs – has ever been isolated, properly sequenced, and shown to be infectious and, possibly, lethal.

In light of the data from VAERS, Medicare, EudraVigilance, Brazil, and elsewhere, how could anyone be so devoid of empathy, compassion, conscience, and character as to refuse to put a halt to the continued program of injecting people until all relevant causal possibilities have been thoroughly and rigorously resolved in a determinate fashion? The fact that the people at the CDC are not operating in accordance with the cautionary principle demonstrates that the individuals in the CDC who are responsible for this lack of proper oversight are nothing more than ideological psychopaths who are seeking to impose their medically-tinged theological beliefs on everyone else irrespective of the harm that appears to being done to the public in the process … and the CDC appears to be doing so without any sense of conscience, character, empathy, or remorse – a classic sign that we are in the presence of one, or more, psychopaths (whether natural born or ideologically generated).

The claim -- despite considerable evidence to the contrary – that the COVID-19 injections are safe and effective reminds one of what transpired during the Oxycontin crisis of the late 1990s and the first

several decades of the 21st century. Like the CDC's "safe and effective" meme concerning the COVID-19 jabs, the comparable meme during the Oxycontin crisis was that only 1% of the population was likely to be vulnerable to some form of addiction through the use of opiates.

The 1% meme was accepted everywhere without question. It was accepted by doctors, hospitals, researchers, journals like *Scientific American*, different facets of the public media, the CDC, the FDA (which twice actually gave Oxycontin a safer labeling rating category than the drug deserved), and a host of other decision makers, but no one bothered to search for what was the nature of the empirical source that might be capable of verifying that such a meme was based on a properly validated scientific claim.

Finally, someone did some digging, and discovered that the 1% claim was traceable to something that had been published in the *New England Journal of Medicine*. This something was not the conclusion of a scientific study or based on any well-controlled experiment, but instead, was based on a one paragraph letter to the editor that had been written in 1980 and was merely an observation concerning a very small group of people and which, subsequently, as one of the authors of the letter indicated, the observation was never meant to serve as a conclusion concerning the risks of long-term opiate use.

Similarly, many people – including the FDA, the NIH, various medical doctors, hospitals, public health agencies, governments, various labs, universities, and the media have all joined in with spreading the meme that the COVID-19 jabs are safe and effective. However, not one of the people who are helping to spread the "safe and effective" meme is capable of demonstrating the truth of that claim with rigorous empirical evidence, any more than all of the so-called experts could verify that only 1% of people were likely to become addicted to opiates because the actual facts indicated otherwise. However, in the case of both of the foregoing memes, few people have actually engaged in any sort of rigorous research concerning those issues.

Memes are so much easier on the conscience than searching for the truth. The CDC would rather have the public passively spread the CDC's mindless propaganda than become involved in demanding the CDC (as well as the ideological psychopaths at the FDA, NIH, and the

NIAID) be held accountable for their roles in the deaths of tens of thousands, if not hundreds of thousands of people, and the injury (many of which are permanent) of millions of other individuals through injections that are not necessarily either safe or effective.

Instead, people like Rochelle Walensky -- the current director of the CDC -- often alludes to all the studies that she claims are substantiating whatever point she is trying to make. (minus, of course, any specifics that might be challenged). As she is doing so, she seems to have forgotten – or never understood -- something that Marcia Angell, a physician and the first woman to serve as editor-in-chief for the *New England Journal of Medicine* once said. More specifically, after many years of experience that dealt with critically reflecting on the quality of research – or lack thereof -- that was taking place in many places around the world, including the United States, Dr. Angell stated:

"It is simply no longer possible to believe that much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in reaching this conclusion, which I reached slowly and reluctantly over my two decades as an editor of the *New England Journal of Medicine*."

There are several other pieces of data which provide evidence that, unfortunately, the problem of ideological psychopaths is not limited to agencies like the CDC, the FDA, the NIH, and the NIAID. At least some of (perhaps many of) the members of Congress have been busy little workers on behalf of the pharmaceutical industry. For example, one could begin with the National Vaccine Injury Compensation Act that was passed in 1986 which not only shields vaccine manufacturers from any financial liability with respect to their products (at least those that are on the pediatric schedule), but as well, requires the United States government to serve as a legal pimp of sorts for the pharmaceutical industry by using legal resources of the government (being paid for by U.S. citizens) to resist whatever claims for injury relief from the public that are forthcoming due to vaccine injury. Despite such legal resistance, more than 4 billion dollars (which has actually been paid – at least in part – by the people of the United States on behalf of the pharmaceutical companies) has been awarded to American citizens who have successfully demonstrated via a set of

legal proceedings that tend to be stacked against them that vaccines – contrary to the meme – are neither necessarily safe nor effective.

In 2003-2204, the U.S. Congress passed legislation passed the Project Bioshield Act. This act created a largely indefinite funding source for the pharmaceutical industry since any time that there was a declared public health emergency or a bioterrorism attack (such as when the U.S. Army's own weaponized anthrax was used by person or person's unknown to attack a number of U.S. citizens shortly after 9/11), pharmaceutical companies – via the Project Bioshield Act would not only be given access to untold amounts of money to use as they pleased, but the U.S. government would also guarantee to buy the products of the pharmaceutical companies if they couldn't sell them anywhere else in the world.

However, the pharmaceutical companies were not satisfied with all of the largesse that they were receiving from the U.S. government and its citizens. They wanted to be shielded from any sort of accountability that might be associated with all the bioterrorism products that were in the pipeline, as well as for any deaths or injuries that might arise in conjunction with adults (those companies were already shielded from liability with respect to children as a result of the 1986 National Vaccine Compensation Act).

As a result, in 2005 Congress passed, and George Bush signed into law, the Prep Act. PREP stands for the Public Readiness and Emergency Preparedness Act.

In essence, the Act gives expression to an almost total form of liability shield for the pharmaceutical companies of the world with respect to any of the products that they put forth and which are used should there be any sort of emergency declaration by the government concerning public health. Even if those pharmaceutical products can be shown to be causing death and injuries to untold numbers of people, if a public health emergency has been declared – as was in the case in the early stages of COVID during the Trump administration, and was one of the reasons why one began to see so much of, among others, Tony Fauci and Deborah Birx on television – then such pharmaceutical companies are completely shielded from any sort of legal proceedings involving the issue of product liability.

As such, the PREP Act was named inappropriately. Instead of bearing the title of The Public Readiness and Emergency Preparedness Act, it should have been called The Pharmaceutical Readiness and Emergency Preparedness Act that covered all manner of liability.

In any event, on December 17th, 2005, at 11:20 p.m. on a Saturday night, Dr, Bill Frist, who was the Senate Majority Leader for the Republicans from Tennessee, walked over to the House (after its members had retired for the evening following their discussion of the 2006 Defense Appropriation Bill) and handed the Speaker of the House a 40 page Bill which was to be tacked on to the 423-page 2006 Defense Appropriations Bill and named "Division E". As a result, when the 2006 Defense Appropriations Bill was eventually voted into law, very few people, if any, were aware of what had been tacked on to that Bill in the form of what would come to be known as the PREP Act (A similar, unethical sort of political trick occurred prior to Congress voting on the Patriot Act in 2001).

The foregoing account constitutes a condensed version of what Representative Dave Obey, a Democrat from Wisconsin, had said on the Floor of the House on December 22, 2005. At the time of his statement, he was the ranking member of the House Appropriations Committee. For whatever reasons – or lack thereof -- Representative Obey took no further steps to resist the passing in to law of the Prep Act that had been added as an attachment (Division E) to the 2006 Defense Appropriations Act and which very few, if any, members of Congress actually had read or discussed before voting on the 2006 Defense Appropriations Bill and its secretly added, Section E –i.e., the PREP Act

The Prep Act far exceeds the protections that were afforded to pharmaceutical companies and vaccine manufactures through the National Vaccine Injury Compensation Act, The PREP Act gives pharmaceutical companies and vaccine manufacturers complete freedom from any sort of accountability or liability for all drugs, vaccines, and biological products, as well as any form of technology or software that might be used during a declared national emergency.

In other words, once the PREP Act is invoked through an emergency declaration involving public health (which Alex Azar -- who, at that time, was the Director of the Department of Health and

Human Services -- declared on February 4th, 2020 and was officially acknowledged in the Federal Register on March 17th, 2020 and remains in effect until the President declares that the emergency declaration is no longer in effect), then, anything that is produced by a pharmaceutical or vaccine manufacturer which is considered to be a public counter-measure will be shielded from any sort of liability.

When a public health emergency was declared in conjunction with COVID-19 on February 4, 2020, the PREP Act was activated, and the pharmaceutical and vaccine manufacturers were protected from being held accountable for pretty much anything they did (unless willful and knowing misconduct could be proven by the U.S. Attorney General involving the creation of a product that was intentionally designed to harm people). However, even if one could show that such companies produced products under less than sanitary conditions or used poor quality controls that left various kinds of contaminants in their products which led to the death or injury of people, those companies could not be held accountable.

The PREP Act allows pharmaceutical and vaccine manufacturers to fast track any product. This is what was accomplished through "Operation Warp Speed" when it was unleashed on the public by Donald Trump, and, as a result, those pharmaceutical companies, among other things, didn't have to do animal studies prior to field testing their products on human beings, and could run experiments on people without the informed consent of the latter which violates the Nuremberg Code.

Whether any of the foregoing accommodations are Constitutional is another issue. All such accommodations by Congress would seem to violate the First Amendment in which Congress has been prohibited from establishing any law "respecting religion or prohibiting the free exercise thereof".

More specifically, in effect, the very nature of The National Vaccine Compensation Act, and/or the Project Bioshield Act, and/or the PREP Act constitutes an attempt to impose a total religious-like belief system on the American people. For example, the technocratic theology of virology -- none of which can be proven to exist in reality -- not only serves a religious-like purpose in as much as Congress is dictating how people must relate to, or engage, what is considered to be the nature of

their relationship with existence or Being (i.e., that it must comply with what Congress is dictating).

Indeed, via the aforementioned acts, Congress is insisting that citizens have a sacred duty to observe such laws (and what is this but another manifestation of what constitutes religion), and, as such, seeks to undermine – and, therefore, prohibit – the free exercise of religion when it comes to, among other things, the mandating of such products. In the process of proceeding in the foregoing fashion, not only is the federal government acting in contravention of the First Amendment, but, as well, the federal government is running rough shot over a person's Ninth Amendment right to informed consent – one of many unspecified rights that, contrary to the requirements of the Ninth Amendment – are being denied and disparaged by both the federal as well as by many state governments.

One might also note in passing that what Dr. William Frist did in conjunction with his surreptitious process of attaching the PREP Act to the 2006 Defense Appropriations Bill -- knowing that most members of Congress would never be aware of the presence of the PREP Act precisely because of the way it was attached to a Bill that already had been discussed and vote on – was in violation of Article 4, Section 4 of the Constitution which guarantees to every state in the union a republican form of government. Furthermore, what Frist did does not constitute or qualify as a republican form of government because it lacks the qualities of character that must be present in the moral philosophy of republicanism

Moreover, the federal government does not have the Constitutional authority to deny and disparage the right of the people to seek to hold corporations – or other agencies -- accountable for the damage that they do to the public. This is another aspect of the Ninth Amendment rights of people that is being denied and disparaged by the federal government.

More recently, one should be cognizant of an very good article that was written by Robert L. Kinney III entitled: "Congress Made Crucial Changes to Vaccine Definition Weeks Before COVID-19" (*LifeSite News*). The foregoing article provides an overview of how changes concerning the definition of a vaccine were made by Congress a few weeks prior to the eruption of the COVID-19 crisis. More specifically,

in order for a vaccine to become approved, companies must submit a 'Biologic License Application' to the federal government since, according to U.S laws, vaccines are subsumed under the category of "biological products."

Up until pre-COVID 2019, the definition of the notion of a biological product was described in the following manner:

"The term 'biological product' means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound) applicable to the prevention, treatment, or cure of a disease or condition of human being,."

However, in December 2019, the Further Consolidated Appropriations Act of 2020 introduced the following change into the definition of a biologic: "Section 351(i) (1) of the Public Health Service Act [(42 U.S.C. 262 (i) (1)] is amended by striking "except any chemically synthesized polypeptide." In other words, the definition of a biological product that existed until December 2019 – and which was quoted above in its entirety -- remains the same with one notable difference – namely, the only exception that was listed in the pre-COVID definition of a biological product (i.e., "except any chemically synthesized polypeptide") was removed from the foregoing definition.

Why was such a change introduced so conveniently just prior to the declaration of a public health emergency in the United States? The answer is pretty straightforward.

Both of the mRNA COVID-19 jabs (that is, the Pfizer and the Moderna injections) use processes that chemically synthesize the SARS-CoV-2 Spike protein. In short, each of those jabs involves the synthesis of a nucleoside modified technique that will generate a Spike protein which consists of a series of polypeptides – exactly the sort of thing that was excluded in the pre-COVID definition, and, therefore, would not have satisfied the conditions necessary to be considered the sort of biological product for which one could file a Biological License Application in order for a product to be considered a vaccine.

The foregoing change appeared on page 595 of a 716-page Bill. The likelihood that all of the members of Congress noted, and understood, the significance of the change in definition with respect to "biological products" prior to the advent of COVID-19 and prior the announcement of 'Operation Warp Speed' and prior to the FDA's willingness to extend emergency authorization status to both Pfizer's and Moderna's experimental mRNA products, is virtually nil.

Consequently, the whole process of changing the definition of "biological products" so that Pfizer and Moderna would be able to call and promote and distribute and administer their jab products as "vaccines" reeks of the very sort of deceit, duplicity, and manipulative behavior that is characteristic of both natural born, as well as ideological, psychopaths. Indeed, all of the foregoing considerations (from: the 1986 National Vaccine Injury Compensation Act, to: The Project Bioshield Act of 2004, the PREP Act of 2005-2006, and the Further Consolidated Appropriations Act of 2020) all bear the mark of either natural born psychopaths or ideological psychopaths … people who are indifferent to, feel no remorse about, nor have any empathy for the many thousands of people who will die from or be injured from such products.

The liability shielding process that has become law is nothing less than an attempt to constitutionally instantiate the aggressive resistance that is characteristic of psychopaths – whether natural born or ideological -- who oppose any attempt to be be held accountable for, or be willing to accept responsibility for, anything that they do. Congress, as well as members of the CDC, the FDA, the NIH, and the NIAID have shown (each in their own way) their psychopathic tendencies by lending active support to the ideological psychopaths – if not natural born psychopaths – who operate many pharmaceutical companies. Such members of the federal government have, literally, paved the way for psychopathy of one form or another to actively corrupt the fabric of American society, and in doing so, they are all in violation of, among other things, the First and Ninth Amendments, as well as Article IV, Section 4 of the Constitution which requires the federal government to guarantee a republican form of government to each of the states.

The psychopathic quality of all of the foregoing activities becomes eminently clear when one comes to understand that the alleged SARS-CoV-2 virus has not been proven to exist, or shown to be infectious, or demonstrated to be lethal. Consequently, the mRNA jabs of Pfizer and Moderna, as well as the DNA-directed jabs of J&J and AstraZeneca are all geared to produce a Spike protein that has nothing to attack in the human body except the body itself (because no one has shown that the alleged SARSCoV-2 virus actually exists outside of theories and computer programs).

Things don't get much sicker than this. Proposed remedies that do not treat disease and do not cure disease and do not protect against disease – because there is no viral disease to treat, or cure, or protect against -- and, therefore, such injections have no useful function in the human body, and, indeed, their only purpose seems to be one – whether done intentionally or unintentionally – that gives expression to a process of wreaking havoc on human beings – both in the short term (for which there is considerable evidence) as well as in the long term scheme of things (which might give rise to massive tragedies that await, and haunt, us in the future). This is the stuff of nightmares, both dreamt and lived.

Chapter 15 -- COVID Decoded (?): The Invisible Rainbow -- Part 1

On March 25, 2021, Arthur Firstenberg, author of *The Invisible Rainbow*, had been receiving indications from people he knew in Santa Fe, New Mexico, as well as elsewhere in the United States and Canada, that they had not been feeling well and/or had not slept well on the previous evening.

He considered, and rejected, a few possible explanations for why people with whom he talked might have felt the way they did. For example, he thought about how solar activity might be playing a role in such physical uneasiness, but found out that solar activity was low and, therefore, unlikely to be generating and sending to Earth the sort of ionized energy that might cause a lot of people to feel physical discomfort.

After conducting a bit of further research, he learned that on March 24, 2021 – the day before he spoke with people -- Elon Musk's company SpaceX had launched 60 satellites earlier in the day, while OneWeb had launched a total of 36 satellites later on in the evening. Furthermore, according to individuals who were beta testing the SpaceX service and were leaving on-line reports, the speed of its satellite internet connections had been increased to 400Mbps.

Arthur Firstenberg experiences on March 25 had been similar to the people with whom he talked. As a result, he let people know through his *Newsletter* that a number of individuals had been experiencing various kinds of physical discomfort on or around Wednesday and Thursday, the 24th and 25th of March, 2021.

In response to the foregoing report, he received a thousand replies which came from every continent. The responses were from people in heavily populated areas where cell towers were plentiful as well from individuals living in rural areas where cell towers might be few and far between.

Moreover, the responses came from both those who consider themselves to be electrosensitive as well as from individuals for whom the issue of electrosensitivity had not previously been a problem. The responses also came from people who have made efforts to shield their homes and who do not use wireless technology, as well as individuals who are trying to coexist with 5G antennas outside their

places of residence or who have been saddled with smart meters being attached to their houses.

While all of the responses he received were remarkably similar, some accounts were more detailed than others. Many of these latter sorts of reports came from individuals who kept journals.

Although many people who responded indicated that they had not been feeling well for several weeks, some of the people who kept journals indicated that prior to the 24th of March, the time between March 3rd and March 10th had been particularly difficult or physically trying. Firstenberg did some research and discovered that SpaceX had launched 60 satellites on each of those occasions.

However, on March 24th, 2021 the physical discomfort seemed to have reached new heights. People – irrespective of whether, or not, they had experienced some sort of illness prior to March 24th – seemed to be encountering an intense form of discomfort. The reports he was receiving often indicated that not only had the people communicating with him been feeling sick, but an array of their neighbors, coworkers, clients, and children were also feeling out of sorts, irritable, tired, and/or were experiencing trouble getting to, and staying, asleep.

Individuals reported an array of symptoms. For instance, some people who were having difficulty sleeping took melatonin but still couldn't sleep. Others felt weak and had difficulty standing or walking.

Various people reported experiencing pain, itching, or burning sensations in different parts of their bodies. Many reported that the foregoing sensations often occurred in their legs and feet, but, sometimes those sensations took place in conjunction with the top of their heads.

Some individuals experienced various kinds of skin rashes, or had irregular heartbeats. Others felt dizzy or nauseous, while other individuals had stomach aches and/or diarrhea.

A few individuals had – relative to what normally might be true – either very high blood pressure, or very low blood pressure. Quite a few felt anxious, depressed, or suicidal.

Interestingly enough, one communication that Arthur Firstenberg received from Maine (the state where I live) indicated that Maine Center for Disease Control had reported that there had been more

cases of COVID-19 diagnosed on March 24th, 2021 than at any point in the previous two months. Firstenberg did a bit of further research concerning the foregoing issue and discovered that all across the world that there had been the most cases of COVID-19 diagnoses compiled on March 25th, 2021 since January 8, 2021 and, overall, the cases registered on that day were the fifth highest overall since the beginning of the pandemic … at least up to that time.

The flow of the electrical fields connecting the human being with the Earth and the atmosphere tend to begin with the head, and, then, runs downward through us and exits to the earth or ground via our legs and feet. When the natural electrical fields connecting human beings to their environment are disturbed by the electric circuits that, among other things, are raining down on via millions of different kinds of frequencies associated with thousands of satellites, then, one might anticipate that people – and some more than others – might experience some sort of physical malaise in conjunction with such disturbances.

In *The Invisible Rainbow*, Arthur Firstenberg makes a very compelling case for entertaining the possibility that many outbreaks of influenza can be correlated with, and, perhaps, caused by, different sorts of technological advancement (?) that were made in conjunction with different aspects of the Electromagnetic spectrum. However, in order to provide some context for the foregoing perspective, one might want to reflect on some of the following considerations.

For instance, early on – during the 18th century – many people who were experimenting with different forms of electricity found that the effects of exposure to electricity depended on a number of variables which could result in people experiencing either some kind of therapeutic/neutral effect or some sort of negative, non-therapeutic effect. In other words, people who were experimenting with electricity or were being treated with electricity, often either experienced some kind of positively stimulating sensation that felt restorative in some fashion or they experienced a debilitating kind of impact upon their system.

Various early pioneers who had been exploring the foregoing sorts of frontiers in electricity had to discontinue their work because of the debilitating effect that such work seemed to have upon him. For

instance French botanist Thomas-François Dalibard confided to Benjamin Franklin that electrical shocks had attacked his (Dalibard's) nervous system to such a degree that he experienced tremors in his arm that made bringing a glass to his lips difficult.

Franklin, himself, experienced a chronic neurological condition that emerged during the time when he experimented with electrical phenomena. The aforementioned condition sometimes lasted for months during which his head seemed to be swimming, and, as a result, he felt giddy. Moreover, he sometimes saw "faint twinkling lights" which disturbed his vision.

While the foregoing malady of Franklin might have been caused by other factors, the fact that the neurological condition emerged when he was doing electrical experiments seems significant. Furthermore, Franklin was not the only one who appeared to have been adversely affected by experiments with electricity.

Something that was understood by most researchers into electrical phenomena during the 18th and 19th centuries is that people vary greatly in the degree to which they are sensitive to the presence of electrical discharges. This sort of understanding is much less common today.

Electrical sensitivity is a real phenomenon. Not everyone feels or conducts electricity in the same way.

However, the issue of electrical sensitivity notwithstanding, every human being conducts and generates EMF waves through an extensive circuitry that operates in different parts of the body (see the next chapter for further details), and this is why EKGs are able to record useful information concerning the heart and EEGs are able to provide data concerning some aspects of the electrical activity of the brain.

Whatever some researchers in the 18th century might have experienced as they were exposed to electrical discharges of one kind or another, this is nothing compared with what many people in the world today are exposed to on a daily basis. For example, Firstenberg says in this regard:

"The average cell phone … deposits about 0.1 joule of energy into your brain every second. For a one hour phone call, that's 360 joules.

Compare that to a maximum of only 0.1 joule from the complete discharge of a one-pint Leyden jar."

And, of course, our cell phones are just one of the many sources of EMF waves in which we are immersed every day. The aforementioned satellites of Musk and others are raining down on us night and day, and, to that we can add all the other electrical devices (desktops, laptops, iPads, kindles, and so on to which we are exposed on a daily basis.

During the middle of the 18th century there was a conceptual divide between two investigators into electricity that was a harbinger of the sorts of discussions that are taking place today. One of the two was a fellow by the name of Morin who stopped doing electrical experiments in 1748 because he knew from his own experience and the experience of others that the use of electricity seemed to have a destructive or problematic effect upon them and, as a result, he was opposed to the idea of using electricity for medical purposes.

On the other hand, Nolet, who was Morin's antagonist in this argument concerning the alleged health benefits of electricity, was not electrically sensitive to the presence of electricity in the manner that was true of Morin. Nolet felt that electricity could be distributed in beneficial and efficient ways, while Morin was horrified about what might happen to bystanders who experienced the presence of such distributed energy and, as a result, developed illnesses of one kind or another.

In 1956, the International Society for Biometeorology was established. In 1980 Felix Gad Sulman, a medical doctor who was chair of the medical school's Bioclimatology Unit published a 400-page monograph that carried the title: *The Effects of Air Ionization, Electrical Fields, Atmospherics and Other Electric Phenomena on Man and Animal*.

Sulman had studied 935 weather-sensitive individuals for a period of 15 years. He discovered that 80% of those individuals were able to correctly identify changes in weather some 12-48 hours before such changes actually took place, and the individuals he studied could do so because they were all sensitive to the ionic changes that were occurring in the atmosphere during the lead up to transitions in weather.

If there are people who are sensitive to changes in electrical patterns that ripple through the atmosphere, what sort of impact would the incessant flow of ions from power lines, computers, cell towers, and power lines have on the lives of those people? Moreover, even if a person was not sensitive in the foregoing ways, can one necessarily conclude that if we do not feel the presence of such ionic disturbances that this means that those disturbances cannot adversely affect the bodies of those individuals who are not sensitive to such ionic discharges but are in the line of fire of those sorts of electrical disturbances on a daily basis?

In the fourth century B.C. the book *Yellow Emperor's Classic of Internal Medicine* appeared. If one considers "Qi" to be a form of energy or electricity and that "Yin" and "Yang" refer, respectively, to negative and positive forms of energy which connect human beings to the heavens (Yang) and to the earth (Yin) and that there is a circuitry that flows from heaven to earth that affects human and animal biology, then, one begins to realize that the idea that human beings have an intimate connection to flows of energy taking place within and around them has been known –or suspected -- for a very long time.

Although the telegraphic electrification of Europe had begun in 1839, the City of London was transformed in 1859. The streets, stores, and residential dwellings of two and a half million people became enmeshed within 280 miles of wires that serviced 120 telegraph stations on the south side of the river and, eventually, amalgamated into the London District Telegraph Company, as another 120 miles of wires were added to the streets, stores, and houses on the north side of the river.

One year later, the Universal Private Telegraph Company commenced operations and soon went on to lay down more than 2,500 miles of cable that contained up to 100 wires each that were headed for different destinations. Whereas the London District Telegraph catered only to public businesses, the Universal Private Telegraph Company rented telegraph equipment to businesses and individuals for private uses.

America, led by Samuel Morse, began its own program of telegraphic and other forms of electrification. In 1829, the Tremont House in Boston had run wires through 170 guest rooms that

connected with a series of signaling bells. In 1844 Telegraphic materials were strung along certain portions of the Baltimore and Ohio's railroad tracks between Baltimore and Washington.

Every continent in the world – with the exception of Antarctica -- began to be electrified with thousands of miles of telegraph lines, including 22,000 miles of such wires in the United States, and 4,000 miles of telegraph wires in India. By 1875, 30,000 miles of cables had been laid down in some of the oceans of the world, and soon 700,000 miles of copper wire had been spread over the face of the Earth like some giant network of electrified spider webs.

The electric fields beneath the earlier editions of telegraph wires had been measured to be 30,000 times stronger than the natural electrical fields of the Earth which measured 7.8 Hz. The pulsing that took place in those wires as a result of the telegraph operators tapped cadence produced a wide variety of radio frequency harmonics that not only traveled along the wires, but as well, also travelled through the air, and spread out along the ground on either side of those wires.

Morse, himself, had calculated estimates of the magnetic fields associated with the thousands of miles of telegraph wires. The magnetic flux of a single telegraph wire was found to exceed the natural magnetic field of the Earth, and this excess would have extended outward between 2 and 12 miles on either side of the wire.

The Earth's natural electrical and magnetic fields were being polluted. The natural electrical and magnetic connection between human beings and the Earth was being overrun and undermined.

Amidst all of the foregoing sorts of electrification of the world, a young medical graduate, George Miller Beard, wrote an article about a newly emergent disease that he had begun to study in his neurology practice. The article was published by the forerunner of the *New England Journal of Medicine* in 1869 which at that time was known as the *Boston Medical and Surgical Journal*.

Beard did not know what caused the disease that he called "neurasthenia." However, he suspected that it might be a by-product of the different forms of stress which modern civilization was creating.

Although no one seemed to die from neurasthenia, it appeared to involve some sort of a weakening of a person's nervous system.

Moreover, there seemed to be no rhyme, nor reason, why some people appeared to be vulnerable to the disease, while others seemed immune.

Three years prior to the publication of Beard's paper, a medical textbook was authored by Austin Flint. The book devoted two pages to describing a disease that was given a name (namely, nervous asthenia) which was very similar to the one with which Beard came up (i.e., neurasthenia). Flint's textbook indicated that people who suffered from this disease indicated that they experienced a sense of lassitude, were often depressed and fatigued – which might have been due to the difficulty they had in going to sleep at time – and complained that their arms and legs often ached.

At the age of 46, Margaret Cleaves, who had obtained her medical degree in 1879, was diagnosed with neurasthenia in 1894. Prior to that diagnosis, she had been a psychiatrist and gynecologist who had decided to specialize in various forms of electrotherapy.

One year after her diagnosis of neurasthenia, she established the New York Electrotherapeutic Clinic. Within a matter of months of opening her clinic, she experienced what she claimed had been a complete breakdown.

She later wrote a book about her experience. The symptoms that she described in her book reflected what both Flint and Beard had said earlier concerning the disease. She (1) suffered insomnia, (2) could not bear to be touched, (3) was constantly fatigued, (4) went through periods of brain fog during which she could not cognitively function, (5) became extremely sensitive to sunlight to the point where she could only venture outside at night, and, as well, (6) she was so tuned into atmospheric electricity that the pain in her sciatica and her face from the presence of such electricity permitted her to be able to predict changes in weather 24 to 72 hours prior to those events happening.

People such as Margaret Cleaves were not the only individuals who seemed to experience physical problems after being exposed to various kinds of electricity for a period of time. A number of telegraph operators also underwent a form of "telegraph sickness" that involved insomnia, headaches, depression, fatigue, and memory loss …

symptoms that were similar to the ones experienced by Cleaves and other individuals who were being diagnosed with neurasthenia.

In addition, there were hundreds of telephone operators who suffered from bouts of dizziness, headaches, tinnitus, and heart palpitations. They also experienced extreme fatigue, tremors, had difficulty sleeping, and were often depressed.

One might also note that many passengers in trains, as well as the personnel that were operating those trains, often complained of a malaise that involved headaches, nausea, heart palpitations, fatigue, weakness, depression, vision or hearing problems, and a constant sense of irritability. Such a list of symptoms that reflects so many of the complaints associated with neurasthenia might appear to be somewhat anomalous until one realizes that by 1862, virtually every train line was running between or beneath one, or more, telegraph lines for the entire length of that line.

Not all people who worked with electricity, or were telegraph or telephone operators, or rode the rails or worked on the trains experienced the foregoing malady. The people who did not seem to be sensitive to the presence of electricity often dismissed such complaints as mere flights of imagination, whereas the people who experienced those difficulties had to deal with dysfunctional bodies, minds, and emotions.

In 1894 Sigmund Freud wrote about neurasthenia. He listed all of the symptoms that had been associated with neurasthenia since the mid-1860s, but he relabeled the malady as “anxiety neurosis” and considered the problem to be psychogenic in nature rather than being due to an environmental toxin generated through the wayward frequencies of an electrified world.

Thirty-five years later, Russians were investigating what they referred to as “radio wave sickness”. The early stages of radio wave sickness were replete with all of the symptoms that were being experienced by those individuals who earlier had been diagnosed with neurasthenia.

The Russians were discovering by experiments – long before such research began to be pursued in America – that the electro-magnetic character of the nervous system, as well as other such systems in other

parts of the body, were vulnerable to being poisoned by various kinds of environmental toxins including those that include being exposed to external electromagnetic fields that disrupted the natural flows of the electrical circuitry that existed in human beings.

To the telegraphic electrification of the world were soon added forms of electrification via the telephone (beginning in 1876) and the electric light industry. In America, Edison invented DC forms of electricity that were heavily dependent on being hooked via wires with centralized DC suppliers.

Although there soon were different ways of generating alternating currents prior to Nikola Tesla, it was his polyphase AC motor, patented in 1888, that let loose the genie in the bottle and enabled the world to use alternating currents not just for lighting streets but for the generation of power that could be distributed widely to industry, commercial enterprises and residences alike.

In 1889, amidst all of the foregoing additional forms of electrification that were taking place, a strange disorder seemed to emerge in Europe, Africa, Australia, Asia, and the Americas. The disease ran its course over a four year period and was alleged to have killed a million people.

The disease was called “influenza”. It was called that because its appearance and disappearance were said to be a function of the influence of the stars.

As late as 2001, several Canadians (including two physicians from British Columbia and the astronomer Ken Tapping) had become the latest researchers to demonstrate that for at least 300 years, influenza pandemics were most likely to occur during peaks of solar magnetic activity. Since 1889, however, influenza epidemics and pandemics began to take place independently of such peaks in solar activity.

In 1836 Heinrich Schweich made the observation that every physiological occurrence produces electricity and, then, put forth the hypothesis that electrical disturbances in the atmosphere might play a role in preventing one’s body from discharging the electrical fields that are being created through physiological processes. This is a hypothesis that, since that time, has neither been proven to be true nor proven to be false.

In conjunction with the foregoing hypothesis, Schweich also repeated a belief that he shared with many other people of that time which holds that the symptoms of influenza were caused by the accumulation of electricity in the body that could not be discharged. While Schweich did not say the following, nonetheless, one might extend his foregoing perspective by noting that it is not only electrical disturbances in the atmosphere that might interfere with the body's ability to discharge an accumulation of electricity that had been generated within the body, but, as well, why not consider the possibility that the electrification of the world through ever new forms of technology (e.g., the telegraph, the telephone, DC electricity, and AC electricity) might also play a role in preventing the body from discharging the electricity that was being generated through various physiological processes?

Influenza didn't seem to be transmitted through a process of person to person contagion. In fact, the 1889 the influenza pandemic reached geographical areas faster than could be accounted for by supposing that person-to-person contagion spread the disease via hitching rides on trains, ships, or other modes of relatively rapid transportation. Moreover, sailors at that time were often attacked by influenza months removed from their last port of call, and when they reached their destination, they would discover that influenza had already been running rampant in such locations despite a lack of contact with the outside world.

As Firstenberg notes in *The Invisible Rainbow*: "The speed at which influenza travels, and its random and simultaneous pattern of spread, has perplexed scientists for centuries, and been the most compelling reason for some to some to continue to suspect atmospheric electricity as the cause" of such a malady. Now, in addition to looking at atmospheric electricity as being such a cause of influenza, one must also consider the possibility that the electrification of the world through artificial means might also be a cause of various forms of influenza.

Furthermore, one should factor in the two previously noted studies that were done in Boston and San Francisco during the 1918 flu pandemic -- when experimenters did their best to use sick flu

patients to infect their "volunteers". None of those subjects ever came down with flu.

So, this is another piece of data which points in the direction that influenza is not necessarily a function of person-to-person contagion. Instead, there is considerable evidence to indicate that influenza might be a function of whether there are natural or artificial electrical-magnetic forces that are interfering with (and, therefore, constitute environmental toxins) that are capable of determining whether, or not, the electricity that is produced via various physiological process is able to be discharged – and, when such physiological by-products are prevented, in some way, from being discharged, influenza of one kind or another, might occur.

Jacques-Arsène d'Arsonval was an established physician who in 1890 served as director of the Laboratory of Biological Physics at the Collège de France. Among other things, he introduced a new kind of medical treatment that was called: "darsonvalization".

This treatment involved the use of radio waves that were sufficiently low in power that they did not produce any heat in the body. However, they did produce an array of salutary effects that he began to discover in the early 1890s.

In addition, he invented an induction machine that could generate perfectly smooth sine waves. These sorts of waves – unlike the ragged "jerks or teeth"-laden character of most artificially produced electrical waves that are, among other things, endemic in all manner of the digital technologies of today --- were not injurious to his patients and did not cause them pain, but, on the contrary, offered an array of constructive benefits.

d'Arsonval also was interested in finding out how different forms of life were affected by high frequency forms of electricity. He subjected human beings and animals to currents of between 500,000 and 1,000,000 cycles per second either through direct contact or via induced contact from a distance.

He discovered that electricity of such high frequency was capable of penetrating deep into the body of the organisms he studied. Among other things, he found that when subjected to such high frequencies, the blood pressure often dropped precipitously in human beings

although such individuals had no conscious awareness that this was occurring.

In 1897, Marconi built a tall structure – called "The Needles – on the Isle of Wight. It would be the world's first radio tower.

The radio station was generating electricity at the rate of approximately a million cycles per second. This frequency was very similar to the number of cycles per second that d'Arsonval had been using in his experiments.

Although previously healthy, the 22-year old Marconi began to have bouts of elevated temperatures or fevers following a year and a half of experimenting with radio equipment in his father's attic. These bouts of fevers continued on throughout the rest of his life.

His problems with his health, however, didn't stop with life-long bouts of fever. He experienced a sort of delirium over a period of four months in 1906.

From 1918 to 1921 he had become immersed with developing various kinds of short wave equipment. During this period of time, he suffered from numerous encounters with suicidal depression.

Furthermore, there was a three year period running from 1934 to 1937 when he was working on microwave technology. While so engaged, he suffered a series of heart attacks, and the final one ended his life at the age of 63.

By the time that Marconi married in 1905, he had built 28 radio towers hundreds of feet high at Cape Briton, Nova Scotia. These were the counterpart to the facilities he had built at Cornwall, England.

The towers were connected by antenna wires. The whole complex of towers and wires was built around and over the Marconi residence.

As soon as Marconi's new bride moved in, her ears began to ring. A number of months later, she was suffering from a severe case of jaundice.

Marconi removed his wife from the facility at Cape Briton and moved her to the facility at Poldhu Bay in Cornwall. In Cornwall, as in Cape Briton, she was required to live beneath a canopy of a set of electrified towers and connecting antennae.

She became pregnant, and most of that pregnancy was spent being bombarded by high-frequency electrical waves. Marconi's wife delivered her baby in London, but the stages of fetal growth of her child had been spent, for the most part, being subjected to the high-frequency electrical waves of the Cornwall facility.

The child only lived a few weeks. The cause of death was said to be "unknown".

Queen Victoria had a residence at Osborne House located at the north end of the Isle of Wight where Marconi had constructed the world's first radio tower. On January 22, 1901 – just as Marconi was turning on a new and more powerful transmitter 12 miles from where Queen Victoria was staying, she experienced a cerebral hemorrhage and died.

Oh, and in 1904, the bees began to die on the Isle of Wight. Surely, however, any connections between Marconi's own life long encounters with an assortment of health issues, or the illnesses of his wife, or the death of their child not long after birth, or the death of Queen Victoria, or the dying of the bees had nothing to do with the electrical impulses that Marconi was generating on the Isle of Wight, or through his facilities in Cape Breton, Nova Scotia, or Cornwall, England and which d'Arsonval – based on a series of experiments with high-frequency waves similar to what Marconi had been generating for decades – previously had discovered were capable of having such penetrating problematic impacts on living organisms. ,

The knew-jerk response that many people who are not sensitive to the manifestation of various forms of EMF tend to offer – without any real proof – id that the foregoing sorts of health problems couldn't possibly be due to the toxic effects that electrical phenomena might be having on the biological systems of human beings – or, at least, some of them. This is similar to the sort of knee-jerk response that Dr. Suzanne Humphries talked about earlier in this book when she pointed to compelling data indicating that flu shots were causing adverse events in the kidneys of some of her patients – namely, that such adverse events supposedly couldn't possibly be caused by the administering of vaccines.

There is a technocratic theology that -- despite considerable evidence to the contrary -- seeks to camouflage the toxic impact that

electricity can have on our lives. Similarly, there is a technocratic theology that – despite considerable evidence to contrary – seeks to claim that all vaccines are necessarily safe and effective.

Although after a time, the bees on the Isle of Wight seemed to adjust to the electrical activity that was taking place on the island, something happened in 1917 that radically altered the character of the process of electrification that was being imposed on the world with each round of new technology that sought to exploit different facets of the EMF phenomena. More specifically, as the United States entered World War I, the American military underwent an expansion of radio broadcasting that rivaled the expansion in electrification that had transpired in 1889, and, one of the early casualties of this technological breakthrough is that, once more, bees began to die on the Isle of Wight.

Thirteen powerful American radio stations were sending all manner of messages around the world. There were another 50 high-powered radio stations that circumscribed the United States sending messages to Navy ships that had been newly equipped with low, medium and high powered transmitters.

Between April 6, 1917 and early 1918, the Navy had constructed and had begun to operate the world's largest radio network. In 1917, 30-kilowatt arcs were being installed on Navy vessels, and these totally outstripped the capacity of transmitters of ships operating for most other countries.

A 500-kilowatt arc was installed and turned on at Annapolis, Maryland. An even more powerful alternator had been designed and built in New Brunswick which became the most powerful station in the world and was the first station capable of transmitting both telegraphic and spoken messages and which were capable of reaching many places around the world.

The so-called Spanish flu was "born" during this period of time. One of the first instances of massive cases of influenzas occurred at the Naval Radio School in Cambridge, Massachusetts in early 1918. By March of 1918, influenza was spreading too many Army camps where the Signal Corps were being trained in the use of wireless technology, and this included Camp Oglethorpe in Georgia (2,900 men contracted

influenza) and Camp Funston in Kansas (1,127 men contracted influenza).

Soon, influenza was spreading to civilians. These civilians were located in different countries all around the world.

One of the inexplicable symptoms associated with the influenza of 1918-1919 was that many of the people suffered episodes of bleeding of one kind or another. This ranged from simple nose bleeds, to heavy forms of hemorrhaging that were occurring in people's brains, stomachs, kidneys, lungs, intestines, as well as through their skins. Some individuals would recover from various respiratory problems, and, then, die of a brain hemorrhage.

Whatever was happening seemed to involve a lowering of the body's ability to coagulate blood. This was confirmed following the testing of blood samples from a large number of patients as early as two days into the disease process, and as late as 20 days following recovery from pneumonia, and the results of the blood tests concerning the issue of coagulation were the same across this entire period of time.

The foregoing finding is consistent with what has been known about the effect that electricity can have on the blood's ability to coagulate. The aforementioned finding also is consistent with what is understood about the sort of impact that radio waves can have on blood.

There were often few instances of people reporting runny noses, sort throats or other sorts of symptoms that are usually associated with the sort of respiratory diseases that flu is often considered to be. On the other hand, many people who seemed to have some form of influenza exhibited all manner of neurological disorders – from: stupor and insomnia or dulled perceptions, to: various kinds of paralysis involving the eyes and other muscles, as well as various problems with their hearing.

Moreover, the speed with which many people died during the 1919 epidemic was uncharacteristic of how viral diseases supposedly manifested themselves over time – usually taking a week to ten days for some sort of secondary pneumonia to develop before the onset of death. Yet, there were numerous cases in 1919 in which someone

would appear to be healthy in the morning and would be dead by nightfall. Many individuals were dying within hours from whatever was afflicting them rather than going through an extended period of illness before either getting well or dying.

Not only were their substantial outbreaks of influenza associated with the advent of the telegraph, but, as well, influenza emerged during the great electrification process of 1889 and the substantial powering up of military radio transmitters that occurred in 1918. In addition, there were several more outbreaks of influenza that took place in conjunction with substantial increases in the geographical distribution of several other kinds of new technology.

For example, between 1954 and 1958, the construction of radar stations began to explode. Initially, there had been a line of 39 stations – known as the Pinetree Line – which had been activated by 1954 that ran coast to coast across southern Canada and, then, from Nova Scotia north to Baffin Island. Between 1956 and 1958, hundreds of new radar domes were added that spread across high latitudes in Canada, sprung up in Alaska, and were sprinkled along different vantage points intended to scan both the Atlantic and Pacific Oceans.

Moreover, the Mid-Canada line covered 2,700 miles extending from Dawson Creek, British Columbia in the west to Hopedale, Labrador in the east. The line contained a series of 98 Doppler radar stations that were located approximately every 30 miles which had been begun being constructed in 1956 and were completed by 1958.

In addition, the Distant Early Warning system – the DEW Line – ran 200 miles north of the Arctic Circle from Baffin Island to the Northwest Territories, and, then, over to Alaska. The 33 stations that constituted the DEW Line utilized a system consisting of two beams that had peak powers of 500 kilowatts and operated at frequencies between 1220 and 1350 MHz. There were an additional 25 stations that were considered to be gap fillers which ran continuously at 500 MHz

Construction of the foregoing stations began in 1955. They were all operational by July of 1957.

The Dew Line was extended by using nine radar-bearing Navy ships (four in the Atlantic and five in the Pacific) as well as by a covey

of radar equipped aircraft that cruised at altitudes of between 3,000 to 6,000 feet during shifts that lasted 12 to 14 hours. The foregoing complex of ships and aircraft scanned areas covering out to the Azores in the Atlantic and, then, from Kodiak Island to Midway in the Pacific, and the entire arrangement was fully operational by July 1958.

Furthermore, each of the 195 radar sites that had been located in different places within Canada also had to be able to transmit vital information over considerable distances. Consequently, they were all equipped with powerful transmitters that operated in the microwave spectrum.

There were also components that were added to the foregoing complex of radar equipped stations, ships, and aircraft. For example, there were three "Texas Towers" that were permanently embedded in the ocean floor off the east coast of the United States that went activated in 1957.

The so-called Asian influenza pandemic emerged in February 1957. It lasted for approximately one year, and the preponderance of the deaths that took place during the pandemic were in the period 1957-1958 when most of the aforementioned radar facilities were being built and were becoming operational.

As previously noted, influenza pandemics had occurred in conjunction with the introduction of the telegraph, as well as in relation to the scaling up of the process of world electrification that took place through the telephone and powering of the world via DC, and, then, AC technologies. The influenza pandemic of 1919 arose amidst the explosion of powerful radio transmitters that were built by the U.S. military during the latter stages of the First World War, and, now, there had been another data point which tied the wide spread use of a new EMF technology – namely, radar – to the emergence of the Asian flu pandemic.

Were the foregoing correlations anything more than coincidence? Or, is one seeing a causal nexus involving different kinds of EMF-based technologies and the emergence of influenza pandemics? Furthermore, one might want to keep in mind that outbreaks of influenza had been linked for hundreds of years to peaks in the magnetic activity of the sun.

To the above data points, one can add, yet, another such entry. More specifically, 28 military satellites that had been launched into the Van Allen radiation belt, some 18,000 nautical miles above the Earth, and became operational on June 13, 1968, and the so-called "Hong Kong" flu pandemic began in July of 1968 and lasted for several years.

If EMF-based technologies are causally linked to the emergence of influenza pandemics, then, one might ask why do such pandemics end because, obviously, the technologies continue to be operational. Perhaps, like the bees on the Island of Wight that had begun to die after Marconi set up "The Needles" radio tower on the Island – the one that might have created a cerebral hemorrhage in the brain of Queen Victoria – there came a point in time of biological transition when the bee population on that island stopped dying and, apparently, made some sort of livable adjustment or accommodation with the EMF-waves that continued to bombard them, so too, it might be that pandemics come to end because the human beings that are still alive have learned to make an appropriate sort of biological adjustment to the continual bombardment of EMF waves that is taking place.

There are two further considerations to critically reflect upon in conjunction with the foregoing possibility. Firstly, even during influenza pandemics, not everyone seems equally vulnerable to undergoing a biological breakdown as a result of – possibly -- being exposed to new dimensions of EMF-based technologies and, as a result, becoming ill with influenza, and, perhaps, dying from the sorts of diseases to which electrification of the world might be giving rise. This sort of vulnerability could be explained, in part, by supposing that the first wave of deaths during such pandemics could be among the people who are most sensitive to the presence of the newly instituted forms of EMF technologies that are becoming operational at a given time Secondly, it might be that the trade off for people who survive a pandemic and, subsequently, make certain biological adjustments to defend against the presence of newly introduced forms of EMF-based technologies could show up in chronic forms of vulnerability that require people to detoxify from yearly bouts with less deadly bouts of influenza, even though, unfortunately, thousands of people who might have become (but might not have been originally) overly sensitive to the presence of newly introduced EMF-based technologies continue to

die during the so-called flu season that runs from September to March. In other words, the yearly flu season might be a continuation of pandemic activity but in slow motion and restricted to certain times of the year.

As Arthur Firstenberg points out in *The Invisible Rainbow*, there appears to be an intimate relationship between, on the one hand, the Schuman resonances given off by the Earth and its atmospheric envelope (and which run from between roughly – a little less – than 8 beats a second (or 8 Hz) to higher resonances consisting of 14, 20, 26, 32, and so on beats per second, and, on the other hand, the wave patterns that characterize human brain activity.

Thus, the most prominent form of brain wave activity from infancy to adulthood is the alpha wave that ranges between 8 and 13 Hz in an adult human and between 7 and 13 Hz in a newborn child. The foregoing range of brain activity is bounded by the initial two Schuman resonances.

One of the dominant forms of brain activity in many animals is similar to what takes place in human beings. That is, during states of relaxation, a wide range of animals display patterns of brain activity that run between the first two Schuman resonances – i.e., 8 and 13 Hz, with some slight variations among different animals.

However, there is a form of brain wave activity that runs below the first two Schuman resonances – i.e., the Delta rhythm – that tend to be irregular, high amplitude waves running at approximately 3Hz which are correlated with many diseased states or disturbed states in human beings.

In 1953, König, Schuman's student, conducted an experiment involving 50,000 people who were attending a Traffic Exhibition in Munich. He demonstrated that when Delta-wave like phenomena were present in atmospheric dynamics, the reaction times of people were considerably slower than when the atmospheric dynamics were running near the Schuman resonance of 8 Hz.

Twelve years later in 1965, James R. Hamer published a paper entitled "Biological Entrainment of the Human Brain by Low Frequency Radiation." His work not only confirmed the aforementioned experiment of König, but also indicated that human

beings were able to differentiate among frequencies that were slightly different from one another as long as such signals were in the vicinity of 0.0038 volts per meter.

In 1954 Reinhold Reiter, after compiling the results from a number of population studies that involved one million people discovered that, among other things, suicides, rapes, traffic accidents, deaths, work injuries, and complaints of a heightened sense of pain among amputees as well as people with various kinds of brain injury all increased when atmospheric dynamics were characterized by the presence of currents involving Very Low Frequency (VLF) activity. The VLF condition of a given environmental location tends to regulate many kinds of biological rhythms in both human beings and animals, and slight changes in that VLF environment can be detected by human beings and animals.

In *The Invisible Rainbow*, Arthur Firstenberg goes on to map out in considerable detail the complex and multi-faceted character of the electrical interactions and transactions that take place between human beings or animals (as well as plants) and their environment. He also points out how artificial, jagged, pulsed forms of EMF-based technologies have been, and are, interfering with the foregoing natural dynamics, and the phenomenon of influenza pandemics might be just one manifestation of such electrified interference.

One of the areas into which he delves has to do with porphyrin. He points out that porphyrin is essential to life because wherever electrons flow, porphyrins are present, and whenever electricity interferes with cellular metabolism, porphyrins are being adversely affected.

Porphyrins are pigments that are sensitive to the presence of light. In animals, a porphyrin that is bound to iron is known as heme which plays a central role in the hemoglobin molecule that transports oxygen to our lungs. In addition, porphyrins play an essential role with the protein myoglobin that delivers oxygen from blood to muscle cells.

Heme is also integral to the activity of cytochrome c and cytochrome oxidase. These are two enzymes that are involved in the transport of electrons that derived from the metabolism of nutrients that are carried to oxygen and through which cells can draw energy.

In plants, the porphyrin known as chlorophyll is bound to magnesium. This helps make the process of photosynthesis possible.

Porphyrins stand at the heart of a complex set of arrangements that make life possible. They regulate the manufacture and recycling of oxygen between plants and animals, and they also regulate the uses to which oxygen is put in animals with respect to, among other things, the generation and transport of electrons during the processes through which some forms of energy are materialized.

Chemical toxins in the environment as well as environmental forms of EMF toxicity can have a profound, dysfunctional impact on the efficacy with which porphyrins function. Diseases such as MERS, SARS, and now COVID-19 might be a function of the manner in which EMF toxicity is capable of generating such dysfunctional interference with the activity of porphyrin molecules.

During the early part of the 1990s, Dr. William E. Morton, who at the time was a professor of occupational and environmental medicine at Oregon Health Sciences University, discovered that up to 90% of the people who were said to be suffering from multiple chemical sensitivity, were found to be deficient in one, or more, of the enzymes that are related to porphyrin activity. In addition, he also discovered that many individuals who had been diagnosed with some form of electrical sensitivity were also found to be deficient in a number of the enzymes that are intimately connected to porphyrin dynamics.

Morton looked for, and established, that there was a genetic basis surrounding the phenomenon involving enzyme deficiencies that are linked to porphyrin activity. Based on his research, he believes that between 5-10 % of the world's population might have genetic deficiencies in this regard.

However, what if – genetics aside – it was possible to disrupt the activity of porphyrin molecules through toxic doses of EMF-based technologies? What if, under the right circumstances, everyone, whether genetically predisposed or not, could become vulnerable to EMF modalities of toxicity that are present in the environment?

For instance, consider the following possibility. Every atom or molecule has a resonant frequency that is capable of absorbing, with

100% efficiency whatever energy might be directed at it or which might engage such an atom or molecule.

The resonant frequency of oxygen – that is, the point at which it is capable of absorbing the presence of such energy with 100% efficiency – is 60 GHz (60 billion cycles a second). As the oxygen molecule absorbs that energy, the absorption process interferes with the orbital spin behavior of the two shared electrons in diatomic oxygen – i.e., O_{2}..

When this occurs in a biological context – say in human beings – the relationship between oxygen and hemoglobin tends to be disrupted. Hemoglobin and oxygen have difficulty binding to one another, and, as a result, among other things, the oxygen level will drop.

60 GHz is within the range of millimeter waves (30GHz to 300 GHz) that are associated with 5G and the coming 6G technologies. In Wuhan China, prior to the announcement that 6 cases of a severe respiratory illness of unknown origin were being studied, 5G was turned on in all its glory.

One doesn't have to suppose that such 5G was running at precisely 60GHz in order to be able to entertain the possibility that there could have been some sort of energy absorption taking place in oxygen molecules that might have interfered – at least to a degree – with, among other things, the way in which the spin of the electrons in a diatomic molecule of oxygen took place and, this, in turn, could have undermined the way in which hemoglobin and oxygen interacted – or failed to do so – with one another.

Alternatively, one might wish to entertain the possibility that when 5G became operational in Wuhan, the omnipresence of such frequencies might have interfered, in one way or another, with the activity of porphyrin, or its related enzymes, or the manner in which porphyrin plays an essential role in the transport of electrons from nutrients to oxygen during the generation of certain kinds of energy. If this were the case, then, the functionality or efficiency with which the heme molecule operates could have been affected, and this, in turn, would impact the process of respiration.

If the extent of EMF environmental toxicity – in the form of 5G – that took place in Wuhan during December of 2019 had been extensive

or if that EMF toxicity were to have taken place in conjunction with someone who was extremely sensitive to its presence, then, one might anticipate that it could have led to what would have been considered by many physicians as something that presented or manifested itself as a case of severe acute respiratory syndrome of an idiopathic nature – that is, of unknown origin … just like was reported in Wuhan with respect to 6 patients.

What is important here as far as the issue of differential diagnosis is concerned is that the foregoing scenario – which is not an implausible one and is buttressed by considerable evidence – opens up additional branches in the decision tree that gives expression to the process of differential diagnosis. For instance, among other things, one can no longer automatically suppose that any sort of idiopathic form of a severe acute respiratory syndrome must necessarily be due to the presence of a virus such as SARS-CoV-2. In fact, given that there is absolutely no evidence (and this has all been discussed previously on numerous occasions during the course of this book) that the SARS-CoV-2 virus actually exists, one might want to conclude that anyone who diagnosed the 6 cases in Wuhan – or whatever other cases emerged in Italy or Iran or the United States – as being due to the presence of a virus might have taken a diagnostic turn that had disastrous consequences for the world.

If SARS-CoV-2 does not exist – and no one has shown that it does, or that it is infectious, or that it is lethal – then what transpired from January 2020 onward might have been nothing less than a colossal example of an iatrogenic caused catastrophe because from the beginning what was transpiring was misdiagnosed as a viral disorder when considerable evidence was available to indicate that something else might be transpiring, and, as a result, many doctors mistreated patients based on a faulty diagnosis, and as a result, thousands of people died needlessly … and this doesn't even take into account the tens of thousands of people who seem to be dying and being injured (many of them permanently) as a result of the use of injections that have nothing to constructively offer in relation to a medical problem that is not necessarily being caused by an alleged SARS-CoV-2 virus.

Such a possibility cannot simply be dismissed out of hand. After all, a number of different studies have indicated that the medical

system is responsible for the deaths of anywhere from 300,000 to 750,000 people a year for treating thow who have died in accordance with standards of care that were not appropriate for the people who died because doctors didn't understand what they were doing or how what they were doing would adversely impact their patients.

Chapter 16 -- Decoding COVID (?): The Circuits of Life– Part 2

Dr. Jerry Tennant went through medical school and, eventually trained as an ophthalmologist. At a certain point in his adult life, while practicing as a doctor, he developed encephalitis.

His particular case was extremely serious. He started to experience significant memory problems, as well as had uncontrollable spastic movements, and, for a while, had a bleeding disorder.

In addition, he lost, for the most part, about seven years of his life (1995-2002) when he began to sleep for 16 hours a day. During the remaining eight hours of his day, he had difficulty focusing on much of anything, but he did have approximately a three hour window within the 8-hour daily period when he had sufficient cognitive faculties at his command to be able to read a newspaper.

He sought the assistance of medical experts at Harvard and the National Institute of Health. However, they were baffled by his condition.

Dr. Tennant is of the opinion that he contracted encephalitis from one of his patients on whom he was performing Lasik surgery and who was also suffering from leukemia. He believes that a virus, of some sort, escaped from his patient's eye, made its way through his mask, and, then, entered his brain after travelling through the nasal canal.

His account might be correct. Nonetheless, there is no way of confirming what actually took place, and his account is, in the absence of any supporting evidence, nothing more than a narrative.

Given that a number of medical experts were puzzled by his condition, one might entertain the possibility that, perhaps, the etiology of his illness could have been something other than what he supposed had been the cause of his condition. In fact, in certain ways, his illness had many of the earmarks of someone who had undergone an encounter with some form -- or forms – of EMF toxicity that either was (were) acute in nature or had accumulated over a period of time, and when his biological terrain was most susceptible, his body broke down, and he began to suffer an array of neurological and blood-related problems.

Whatever the etiology of his illness might have been and in the absence of any kind of medical expertise that might have helped him, he started to reflect on how to escape from the pathology that had consumed so much of his life in such fundamental ways. Yet, he only had about three hours a day in which his brain seemed to work well enough for him to be in a position to try to figure what to do.

One of his first thoughts was that he believed that all cells of the body worked in a similar fashion. If he could find a way to heal one cell, then, he might have found a way to heal all of his cells.

With that possibility in mind, he purchased some 10-15 books on cellular biology. One of the principles that emerged from his research with respect to those books is that all cells appear to be designed to operate within a pH range of 7.35 to 7.45.

In effect, he felt that pH describes a form of voltage in liquid form. In other words, within cellular liquids, electrons had the opportunity, depending on circumstances, to either donate or receive electrons.

The movement of electrons gives expression to physics. From such physics, chemical transactions arose, and, so for him, he felt that physics might have a role to play in relation to resolving his physical problems.

For Dr. Tennant, a pH reader really serves as a voltage meter. Thus, a pH of 7.35 translates into a voltage of -20 millivolts involving the movements of electrons that are being donated, whereas a PH of 7.45 gives expression to a voltage of -25 millivolts that are generated through the process of electrons moving as they are being donated to one or another atom or molecule.

By convention, if a particular solution tends to receive electrons, a plus sign is placed before the voltage that is being generated. On the other hand, if such a solution tends to donate electrons, then, a minus sign is placed before the voltage.

Voltage can be converted via a logarithmic scale that will produce results ranging from 1-14. And, as indicated previously, cells operate optimally when the pH of those cells stays between a pH of 7.35 (-20 millivolts) and a pH of 7.45 (-25 millivolts).

In order to maintain the foregoing sorts of cell voltage, cells need energy. -25 millivolts are needed for cells to be able to operate

properly, and -50 millivolts of energy are needed for the formation of new cells.

Different cells within the body tend to wear out at different rates. When such cells wear out, they have to be replaced.

For example, cells in the nervous system tend to turn over every 8 months. Liver cells need to be replaced every 8 weeks, while skin cells go through replacement cycles that take place every 6 weeks, or so.

Obviously, energy is needed in order for such replacement processes to be able go forward. Moreover, prior to their replacement, in order for cells to be able to last until they are replaced, energy is also required to keep such day-to-day functioning operational.

For Dr. Tennant, all chronic disease involves, in one way or another, the presence of an inadequate voltage to be able to underwrite or accommodate cellular energy needs. Consequently, whatever the ultimate cause of Dr. Tennant's disease might have been, the bottom line is that according to his perspective, his disease condition emerged as a result of – somehow -- inadequate voltage being present in certain cells, tissues, organs, and so on.

In addition to the energy that is required to maintain cells and to help subsidize the replacement process, energy is also needed to tend to the problems that are caused by environmental toxins such as the glyphosates that come from certain pesticides, or the heavy metals that are present in many products or which are by-products of different manufacturing or industrial processes (for example, the mercury that is given off as an emission when certain kinds of coal are burned).

Such toxins constitute constant sources of stress on biological systems. As my medical physician friend pointed out to me at the very beginning of the consultation process concerning my recent bout of illness, most Americans suffer from adrenal insufficiency because their biological systems or terrains are constantly under stress from all the toxins that are being dumped into the environment – including EMF-based environmental toxins.

According to Dr. Tennant, the human body is a movable electronic module. Therefore, it needs access to battery packs that can supply it with the energy it needs to, among other things, move about the world.

He identifies four such battery packs in the human body. To begin with, the muscles in our bodies serve as rechargeable battery packs.

The fascia -- or band of connective tissue (usually consisting of collagen) that surrounds muscles) give expression to an extensive wiring system that runs throughout the body. Piezoelectricity – which arises when mechanical stresses are placed on a given substance and generate a flow of electrons – plays a major role in the energy dynamics of the muscles.

Each organ has its own battery pack as a result of the system of muscles that run from our toes to our head. In effect the fascia that surround muscles form semi-conductors.

A semi-conductor is an arrangement of molecules which conduct a flow of electrons in only one direction at the speed of light. These semi-conductors are at the heart of the battery pack recharging system that helps serve the energy needs of the organs which those semi-conductors are associated.

There are six loops of circuitry involving the system of battery packs that are entailed by the networks of muscles, and surrounding fascia that are found throughout the body. The nature of such circuitry is fairly complex, and every stack of battery batteries can be associated with an acupuncture meridian.

For instance, the Stomach-Spleen battery pack supplies the energy that underwrites the activities of the endocrine system. In addition, the aforementioned battery pack supplies the energy for the reproductive systems in both females and males, as well as supplies energy for the macula of the eye and various kinds of cognitive processes in the brain.

Notwithstanding the complexity of such circuitry, there is a process akin to the sort of differential diagnosis process that a car mechanic might go through to figure out where voltage is not being maintained within a computerized vehicle. For instance, one might have to check the levels of the thyroid hormone T3. This hormone plays a key role in regulating the voltage of every cell membrane in the body.

Or, maybe one will have to check the levels of the T2 thyroid hormone. This hormone has an intimate relationship with what

transpires in the mitochondria, and there are many other such checks that can be performed.

A second rechargeable battery pack system is located in cell membranes. These battery packs exist in the form of a network of capacitors.

Capacitors are able to store energy. The membranes of cells consist, among other things, of two opposing layers of fat cells or phospholipids.

The phospholipids are made up from constituents that form two conductors separated by an insulator. By definition, this constitutes a capacitor which is capable of storing electrons.

A third battery pack system exists within the mitochondria that uses a complex process of electron transfer involving the dynamics of energy formation via ATP (adenosine triphosphate) and energy expenditure via ADP (adenosinediphosphate). When this battery is charged, reference is being made to the presence of ATP, and when the battery stands in need of recharging reference is being made to the fact that ADP has resulted from the donation of an electron to some cellular process and, therefore, needs to undertake a journey back to ATP (i.e., its recharged state).

The recharging process is known as the Citric-Acid or Krebs cycle. This cycle consists, for the most part, in sending fatty acids through a series of transitions that generate and transfer electrons along the components that make up the cycle, and if oxygen is present during the various steps of the cycle, then, for each unit of fatty acid that is processed by the Krebs cycle, 38 ADP batteries are recharged.

A fourth form of battery recharging comes through DNA. This involves the dynamics of scalar forces (which, in turn, seem to be connected to the golden mean -- 1.618 – as a function of distance between units that are make up the structure of the helix) that are used by DNA to complete its various tasks of replication, transport, and assembly.

According to Dr. Tennant, chronic disease arises when there is one, or more, failures in any of the foregoing systems of rechargeable battery packs. In other words, such systems cannot sustain an electric charge of the requisite sort (i.e., -20 to -25 millivolts) within the cells

of those organ systems. However, there might not be any reason to suppose that various kinds of acute diseases – and not just the sort of chronic diseases to which Dr. Tennat refers -- might also arise as a result of, for whatever reason, some sort of loss of voltage in one, or more, of the four battery pack systems within the human body that has arisen as a result of the presence of some kind of environmental toxin – such as tend to be generated through EMF-based forms of technology that spill dirty or jagged, pulsed forms of electricity into the environment on a constant basis.

Dr. Tennant notes that the energy recharging stations of the body are wired up like many circuit boards in computers. Many of the latter circuit boards make use of Tesla resonating circuits.

A Tesla resonating circuit consists of a capacitor (energy storage) and a coil (conductor), and each is wired in parallel. When such an arrangement exists, the circuit has the capacity to communicate (in the language of electro-magnetic interactions) with other such Tesla circuits – whether these are part of some sort of external form of circuitry or they are part of the circuitry involved in the energy recharging stations of the body.

Consequently, there could be resonance interactions that occur between what is transpiring electronically outside the body and what is taking place electromagnetically within the body. Such resonance interactions could play a role in undermining the way the energy recharging systems in the body operate and could be part of the reason why voltage might be lost as such systems are engaged by environmentally toxic systems of EMF-based technology in problematic and destabilizing ways.

There is considerable amounts of quality work that has been done concerning the biological toxicity that is being generated through EMF-based forms of technology by, among others: Arthur Firstenberg (and all the many individuals about whom he writes in *The Invisible Rainbow* who have made fundamental contributions to this work); Elana Freeland (*Under and Ionized Sky* and *Geoengineered Transhumanism*); Robert Becker and Andrew Marino (e.g., *Electromagnetism and Life*); Daniel T. DeBaun and Ryan DeBaun (*Radiation Nation*); Samuel Milham (Dirty Electricity); Dr. Devra Davis (*Disconnect: The Truth About Cell Phone Radiation, What the Industry is*

Doing to Hide It), as well as the work of Olle Johansson, Dr. Martin L. Pall (who has shown how EMF adversely affects human and animal biology by interfering with voltage gated calcium channels) and many, many others.

However, just as certain forms of electricity are harmful to, and destructive of, biological processes, there also are forms of electricity that can have constructive impacts on helping the body to repair whatever might be causing a loss in voltage within various battery packs. For example, Dr. Tennant has invented what is known as a BioModulator which is capable of recharging the ATP-ADP battery pack process. He also indicates that different muscle battery recharging packs can be treated by using various kinds of patches on the bio-terminals of what is known as a BioModulator.

In conjunction with the foregoing, I should note in passing that my physician friend makes successful and constructive use of some of the foregoing instrumentation. Unfortunately, because of the distance that separates us and because my illness would not have travelled well across that distance, I had to make do with what could be done at a distance.

When the cells in tissue are damaged by, for example, some form of EMF-based toxicity, the tissue goes to -50 millivolts which is well outside the parameters of optimal cell functioning. This in turn causes the arterials running through such tissues to dilate, which, in turn, gives rise to the symptoms of inflammation (such as temperature heat, swelling, redness, and pain).

If the battery charging system associated with adversely affected tissue cannot provide the necessary voltage which is capable of underwriting the energy costs of repairing damaged tissue, then a person might transition from some sort of acute condition of disease to a more chronic form of that disease as a result of a continued absence of the voltage that is necessary for healthy cell, tissue, and organ functioning.

As voltage is dropping, oxygen levels also will begin to lower. The efficiency with which metabolism takes place is, to a large extent, controlled by the relative presence or absence of oxygen, and the amount of oxygen that might be available is controlled by the degree of voltage that is present, and as a result, this can have problematic

consequences for the amount of ATP that is available for subsidizing the biological activity that takes place with the cells of tissues and organs.

When the body is healthy, oxygen levels help to suppress the tendency of the bacteria within us to generate digestive enzymes that will dissolve cellular material in order for the bacteria to be able derive the nutrients that such bacteria need. As voltage and oxygen levels drop, bacteria tend to lose their cell membranes and become cell-wall deficient organisms – or stealth pathogens – which begin to generate various kinds of toxins that are capable of damaging the cells and tissues with which those toxins come in contact.

Such toxins can produce a variety of symptoms. These symptoms range from: Headaches, and a fever, to: Vomiting, diarrhea, as well as different kinds of joint pain, depending on the tissues being affected by the presence of such toxins.

If the voltage becomes sufficiently low –- say in the vicinity of +30 millivolts) other entities begin to show up. For instance, this might involve the emergence of cell-wall deficient fungi which present their own problems for a struggling biological terrain.

Consequently, what starts out, for instance, as some kind of EMF-based form of environmental toxicity, could, in time – as a function of the loss of voltage, along with the emergence of toxins that bacteria or fungi might produce -- lead to a whole host of other problems that are capable of affecting different systems within one's body -- neurological, respiratory, blood processes, metabolism, energy/voltage levels, and so on. All of the foregoing issues start – whether acutely or chronically – with a loss of voltage which EMF-based technologies (and other kinds of environmental toxins) are capable of bringing about under the right set of circumstances.

Chapter 17 -- Full Circle – Differential Diagnosis Redux

The series of essays in this book began with a brief look at the process of differential diagnosis. Unfortunately, much of the medical environment has been polluted to such an extent that it is difficult to distinguish fact from fiction when it comes to the issue of what COVID might be, and what it is not, if it is anything other than a study in social engineering.

Many people in the medical community were incentivized to stray from rigor, science, reason, methodology, integrity, and the like, for the better part of two years. For instance, many companies received money for manufacturing, distributing, and running PCR tests that were completely arbitrary and without any credible experimental or empirical foundation capable of validating such tests.

Hospitals received money for positive results on those tests. Hospitals also were given money for putting people on ventilators in conjunction with positive PCR tests, and, as well, hospitals acquired money for deaths that occurred that were said to be due to COVID.

The media, hospitals, much of the medical community, universities, various research institutes and facilities, presidents, prime ministers, the W.H.O., the CDC, the FDA, the NIH, and the NIAID all joined in pushing the medical system to blindly -- and, perhaps, with considerable willful blindness -- follow their compromised leaders into a chasm of deep conflicts of interest and medical doublespeak that began to see anything and everything as a manifestation of COVID-19 or as an expression of one of its many alleged variants. Among other things, changes were made – for no good reason -- in the way death certificates were filled out, and as a result, everything was being viewed through a glass darkly known as COVID, and, oftentimes, no autopsies were performed to confirm, or disprove, that such deaths were definitely due to the impact that a virus was responsible for such deaths.

Indeed, on July 2, 2020, Rosemary Frei and Patrick Corbett wrote an article entitled: “No one has died from the coronavirus”. The article reviewed findings that had been presented by Dr. Stoian Alexov, President of the Bulgarian Pathology Association in conjunction with a May 8th, 2020 webinar. Among other things, Dr. Alexov stipulated that “autopsies that were conducted in Germany, Italy, Spain, France, and

Sweden" did not show that the deaths being investigated were due to the presence of a lethal coronavirus.

However, the world went in a different direction. If someone had a cough, it was a symptom of COVID. If someone had the sniffles, it was definitely COVID. If someone had any kind of respiratory ailment, it, undoubtedly, indicated the presence of COVID. If someone had no symptoms at all, they had COVID as long as someone had a positive PCR to go along with it.

In many ways, the whole COVID fiasco was, from almost the very beginning, driven by the presence of a test supposedly invented by Christian Drosten, a German virologist, who, along with other colleagues, described a process in a paper that went through (in a rather questionable, problematic, and non-peer reviewed manner) the alleged steps that, supposedly, would permit the world to be able to differentiate between who did, and who did not, have COVID. One of the problems with the methodology – or lack thereof – of that paper is that he and his co-authors were unable to show how the test would be able to identify genetic sequences that were unique to any actual, concrete sample of SARS-CoV-2 because the template that they used for their PCR primers was a function of purely theoretical considerations and, as the authors admitted, they did not base their technique on any sample of SARS-CoV-2 that had been isolated and purified, and, then, shown to be infectious and, potentially, lethal.

When my wife took her PCR test, which came up positive, the test was useless as a diagnostic tool. Instead, the problem with the PCR test from the very beginning had been that no one had shown that the primers and probes used during such tests could be empirically and experimentally tied to sequences of genetic material that had been shown to be unique to a real-world genome (and not a purely theoretical and computer-generated version) of SARS-CoV-2

Furthermore, since no one has been able to successfully isolate and sequence an actual real-world (and not a computer generated) exemplar, then all of the monoclonal antibody tests that allegedly are capable of indicating the presence of the SARS-CoV-2 are of dubious status because no one actually knows why certain kinds of globulin proteins are present when such tests are done … that is, no one really knows what the meaning is of what they are looking at when the

presence of certain kinds of globulin proteins are found … although there is a lot of theoretical chatter that surrounds such findings.

In the absence of a reliable PCR or antibody test, there is no way to confirm or deny that someone has COVID. All one has are a set of unhelpful symptoms.

SARS stands for Severe Acute Respiratory Syndrome. Having a cough cannot necessarily be equated with such a condition, and, similarly, having a slightly elevated temperature, or experiencing a loss of smell, or feeling tired do not necessarily give expression to SARS, but such symptoms could be tied to any number of a wide variety of possible conditions.

In fact, since one of the operative words in SARS is acute, one might suppose that if someone comes down with a cough, a slight temperature, a certain amount of fatigue, as well as a loss of smell which persists for a while, then none of those symptoms taken individually or collectively would seem to give expression to what would be called a severe and acute respiratory syndrome.

When my wife went through her worst symptom – a collapse that landed her on the floor, perhaps with a few convulsions thrown in, along with a sense of disorientation that followed such an experience – none of her symptoms reflected what could be called Severe Acute Respiratory Syndrome. Whatever she had, it was not that.

She was suffering from something else. However, many people – the so-called experts – would have diagnosed her as having COVID, and they would have been wrong. As a result, if they had a chance to do so, many of them – perhaps, all too many of them – would have begun to treat her in accordance with a standard of care based on the theology of viruses that would have been inappropriate to her condition.

If she had been taken to the hospital following her collapse, they could well have put her on what might be termed “the assembly line of death”. In other words, she, probably, would have been isolated and considered to be contagious on the basis of no evidence whatsoever. She likely would not have been permitted much contact with loved ones in the outside world

More importantly, she would have been treated as if she had some sort of viral disease. Among other things, this might have led to her being put on remdesivir which would have destroyed her kidney function, and, maybe, a certain amount of her liver functioning.

As her kidneys failed, her lungs would have begun to fill up with liquids that her kidney couldn't process. Although she might appear to some as if she were suffering from some kind of severe, acute, respiratory syndrome, and possibly, a secondary pneumonia, then, as a result of such "appearances", she likely would, at that point, have been put on a ventilator –Ka-Ching, Ka-Ching -- until she died and the cause of death would have been listed as COVID and another financial bonus would be awaiting such an intrepid announcement.

My condition would have been even more likely to land me on the assembly line of death. My neurological collapse was fairly profound, and its aftershocks were felt for the next four weeks as I experienced considerable cognitive fog along with a marked and extended period of fatigue that left me, for the most part, sitting in a chair, unable to care for myself.

By the Grace of Allah – as manifested through the loving support of my wife and the assistance of my physician friend – I was kept alive. If I had gone to the hospital, I think there is a good chance I would have, at some point, been transported to a funeral home because they would have misdiagnosed me and, as a result, mistreated me on the basis of a standard of care (involving viral theology) that did not apply to me.

My physician friend had read the situation correctly. My adrenal system had crashed as the result of nearly two years of constant stress and, in addition, I was suffering from severe adrenal sufficiency because all of the other environmental toxins – including a constant barrage of EMF-toxicity from: Thousands of satellites, an array of cell towers, and all of the other electronic devices and Wi-Fi systems that surround me (my own computer is hard wired and does not employ Wi-Fi, but this doesn't help me as far as all the other people in my neighborhood concerned who are using Wi-Fi and which is capable of penetrating my home.).

He didn't prescribe an artificial, synthetic form of steroid. He prescribed hydrocortisone – the same thing that is produced naturally

by my adrenal system. He was trying to reset my adrenal system … to jump start it out of the condition of adrenal insufficiency that had led to the onset of my symptoms.

A week, or so, later – after I had finished the initial round of steroids that had been prescribed, my temperature – which had been normal while I was taking the aforementioned steroid – spiked some 3-4 degrees. As a result, my friend prescribed a tapered steroid protocol in order to try, once again, to help my adrenal system get out of its doldrums, and, as well, in order to guard against any sort of infection that might have emerged within me he also prescribed a broad spectrum antibiotic.

When I finished the tapered steroid protocol, there was no spike in my temperature. My adrenal system, apparently, had begun to function properly on its own.

The rest of the treatment protocol that my physician friend prescribed was entirely directed toward trying to help my body return to a healthy state of functioning. Since my cough is largely gone, and since I have had no temperature for weeks, and since my cognitive fog has lifted, and since my sense of fatigue and weakness has largely (but not entirely) disappeared, and, once again, I have begun to walk a mile every couple of days, then, I am inclined to risk claiming that most of my malady is only visible in the rearview mirror that scopes out the past.

Why did my wife and I seem to follow the same course of disease as far as symptoms are concerned? We both had gone through a similar, nearly two-year period of stress from the many tragedies that were transpiring in society with respect to COVID and, as a result, we both had been trying to come to grips with, among other things, the lives that had been, and were being, unnecessarily destroyed as a result of the mistakes that many doctors and government officials had been, and were continuing to, make in diagnosing, treating, and responding to the various maladies that were being imposed on people medically, socially, economically, legally, spiritually, financially, and politically. As a result, both off our adrenal systems had been taken a beating, and, as a result, each of us, in our own way, was in a condition of adrenal insufficiency. Consequently, each of us began to develop a variety of symptoms indicating that our respective systems were not

adequately dealing with the collection of stresses that were impinging upon us.

Temperature, cough, fatigue, loss of smell, and a neurological collapse are quite consonant with a diagnosis of adrenal insufficiency aggravated by an array of environmental toxins that were further exacerbating our respective conditions. A slightly elevated temperature, a low-grade cough, some fatigue, a loss of smell, and a neurological collapse are not indicative of any sort of severe acute respiratory syndrome.

I was concerned that the people with whom my wife worked – many of whom had been vaccinated – were shedding a toxin of some kind in the environment that might be transmitted to me and affect my condition. My wife was worried that the person who had come to her place of work in violation of the protocols that had been worked out for COVID had transmitted something to her (i.e., my wife) – possibly a virus – to which she was now going to expose her husband.

It was the adrenal insufficiency that engaged such stresses that did us in, and not a virus. Our cases were part of a cluster of cases of people who, very likely were breaking down all across America (as well as around the world) due to a condition of adrenal insufficiency following nearly two years of fear porn, as well as due to whatever forms of environmental toxins to which they had been exposed during that time frame, including a substantial amount of EMF-based forms of radio frequency poisoning.

This is the stuff of differential diagnosis. Diseases have patterns, and the task of differential diagnosis is to try to identify what that pattern is and, then, use certain tests to confirm or rule out such a diagnosis, and, continue to proceed in this fashion until one feels fairly confident that one has identified the nature of the problem with which one is dealing and, hopefully, has a course of treatment that will lead a person back to health.

Unfortunately, in many respects, the whole process of differential diagnosis had become compromised in a variety of ways, not only in the United States but in many other parts of the world as well. Virtually everything was being called COVID, and oftentimes the things that weren't considered to be COVID weren't treated, and, as a result, numerous individuals were condemned to having their medical

problems (e.g., cancer treatments or various kinds of surgery) put on a back burner because those maladies weren't COVID, and COVID cases had arbitrarily been given priority in many hospitals since – based on a catastrophic misunderstanding of what was taking place – cases, on the basis of a useless PCR test, were being misdiagnosed as a viral disease when there was no real evidence to substantiate such a diagnosis.

None of my serious symptoms matched up with a severe acute respiratory syndrome. Although, my condition of illness was severe and acute, due to the sudden nature of its onset, nonetheless, for the most part, I really wasn't experiencing any sort of severe acute respiratory syndrome.

My oximeter readings did get down into the low 80s/high70s. However, I was not cyanotic, nor was I having difficulty breathing.

On the basis of conversations I had with my physician friend, in the nearly two years prior to getting sick, I learned that he had been engaging people in his local practice who, among other things, were cyanotic, and he had been treating them successfully. Nonetheless, such individuals were not necessarily suffering from a viral infection.

EMF-based environmental poisoning can affect all of the battery recharging stations of the body – involving the muscles, cell membranes, the mitochondria, as well as the scalar energies associated with DNA. Consequently, such poisoning can affect brain functioning, the quality of blood flow, respiration, the muscle activity associated with any number of organs, as well as adversely affect the biological dance that is constantly taking place between voltage and oxygen that, among other things, controls metabolism.

Discussions were taking place in various circles that if such things as ivermectin and hydroxychloroquine were part of a systematic process of early intervention, thousands of lives would have been saved, and people could have been treated at home instead of in hospitals. The problem was, and is, that one didn't really know what sorts of maladies were being treated with ivermectin or hydroxychloroquine or any number of other off-label protocols, nor was it at all clear that if people got well after being so treated that it was necessarily such drugs that were curing them of whatever it was that they had..

The whole idea of being able to administer early home treatments to fend off COVID's life-threatening potential seems oddly inconsistent with what the letters of SARS stand for. The disease was supposed to be acute and attack the respiratory system with such severity that people's lives were put in sudden jeopardy, and, so, how does one propose to claim that early intervention with drugs such as ivermectin or hydroxychloroquine actually would have been capable of preventing SARS from taking place?

In order to validly be able to make such a claim, one would have to put those drugs through a controlled experiment in which some people who had not, yet, developed serious symptoms of SARS would be given such drugs (the experimental group), and a matched control group that also had not developed any serious symptoms of SARS would not given those drugs. Then, one would wait to see if there was any significant difference between the two groups as far as developing some form of actual severe acute respiratory syndrome was concerned.

However, given that the PCR test doesn't work because it has not, yet, been tied to genetic sequences that uniquely identify some entity as an actual, real-world exemplar of the allegedly 30,000 base pair SARS-CoV-2 entity, and given that the monoclonal antibody tests that allegedly identify the presence of SARS-CoV-2 can't possibly detect the presence of such a virus if that virus can't be shown to be capable of being isolated, purified, sequenced, and demonstrated to be infectious and lethal, and, therefore, real, then, one is not in a position to be able to set up the foregoing sort of controlled experiment that was suggested in the previous paragraph because we have no way of identifying who has such a virus – if it exists at all – and who doesn't.

My wife took no treatments. Her case was not mild, and, at one point, she suffered a neurological collapse, and, yet, she got better.

I did go through a medical protocol – or, at least, part of it. My case was anything but mild because I not only suffered a neurological collapse, but I was so fatigued that I had very little energy to do much of anything for about three weeks, and during this time, my cognitive functioning was impaired in a variety of ways.

I did get better as well. Nonetheless, unlike my wife, I do not think I would have survived if not for the medical intervention that I

received from my physician friend, and, as well, I feel fairly certain that if my wife had not been there to look after me night and day for an extended period of time that with or without the medical intervention side of things, I do not believe I would have survived because I could not have looked after myself and done for me what needed to be done in order for me to be able to stay alive.

Throughout the COVID crisis, all too many doctors and hospitals around the world failed to do a proper differential diagnosis on the individuals who were coming to them and seeking medical assistance concerning their state of illness. There was a branch at the beginning of the differential diagnosis process that often was left unexamined – namely, the severe and acute cases of pneumonia-like respiratory diseases that were emerging in different parts of the world were only being viewed through the lenses of virology when there was another branch of inquiry which also should have been pursued and given serious consideration – namely, that the respiratory diseases of an idiopathic nature which were occurring in different parts of the world could have been caused by the presence of a variety of environmental toxins – singly or in combination – and should have included the possibility that what was taking place was a function of the way in which EMF-based technologies are, and have been for quite some time, poisoning the world with the sort of dirty, jagged, pulsed electro-magnetic waves that are destructive – in so many different ways – to the biology of plants, animals, and human beings.

On the one hand, there is almost, if not, zero evidence to support the viral hypothesis. On the other hand, there is a great deal of evidence to support the notion that many of the serious cases of idiopathic severe acute cases of respiratory and other kinds of organ failure are caused by an array of environmental toxins – including EMF waves of an artificial and man-made kind – that are assaulting human beings all over the world.

If a sufficient number of doctors and hospitals had had the courage to take the road less travelled when they performed their differential diagnosis, this might have made all the difference. But, they did not do this, and, as a result, we ended up with complete social chaos and an iatrogenic disaster. Whatever excess deaths occurred during the COVID crisis have been largely due to the sins of the medical

practitioners who arbitrarily gave the wrong set of theoretical ideas priority (the claims of virologists), and did so at the expense of pursuing an appropriate form of differential diagnosis.

COVID-19 is not a crisis that was caused by a virus. COVID-19 is the cognitive, emotional, social, economic and spiritual disease that was caused by an amalgamation of delusional doctors, hospitals, universities, media know nothings, research institutes, incompetent academics, power-hungry politicians, several American presidents, as well as agencies such as the WHO, the CDC, the FDA, the NIH, and NAIAD that created -- not necessarily as a gain of function project -- but as a massive venture into the depths of a sustained form of ignorance, greed, arrogance, and cowardice that, allegedly, were going to resolve a problem by leading in only one direction – the manufacture of a spiked protein that, as far as health is concerned, began at no beginning and worked toward no constructive ends. This is because the entity against which that injectable spiked protein was supposedly opposed didn't actually exist, and, therefore, injecting such an entity into people served – and serves -- no useful purpose but, unfortunately, might very well enable a much darker purpose (envisioned by relatively few natural, born or ideological psychopaths but never imagined by an all-too trusting public) due to the destructive impact that such injections have had, and are having, on human beings and which the people responsible for such carnage refuse to rigorously investigate because they have been awarded freedom (via the PREP Act) for all liability involving the ill effects of those injections … thank you Congress, and thank you Supreme Court, and thank you all too many state governments because you have all played fundamental roles in helping to create the mess in which the world presently finds itself.

I'm not naïve. The delusional pathology concerning COVID that has, like the coils of an Anaconda snake, been wrapped around, and, then, become progressively tightened, around the minds and hearts of many people in the world and, as a result, has squeezed out most of whatever reason and sensibility that might have been present.

Consequently, there is now, and will continue to be into the foreseeable future, considerable, deep-rooted cognitive dissonance concerning the whole issue of COVID that has become entrenched in

large segments of the population. Such people – to ease the tensions and pain inherent in their cognitive dissonance – will either delve deeper into the delusional narrative that they have been fed for nearly two years, and, as a result, out of a irrational state of perpetual and arbitrary fears, will become committed to acts that, ultimately, will prove to be self-destructive (such as a willingness to accept ever more injections and booster shots of materials that will only do them harm along with a willingness to adamantly resist anyone who engages them in ways that run contrary to the narrative that, now, defines their lives), or such people, somehow, will have to muster the courage and strength of character that will be necessary to disengage from the condition of medical, educational, political, financial, social, economic, and spiritual abuse that they have been maneuvered and manipulated into accepting as the "new normal".

Nothing really rides on, whether, or not, substantial portions of the population will be able to wake up from the form of mind control into which they have been enticed. Nothing rides on any of this except, perhaps, the fate of mankind.

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