Joe Rogan Experience #1757 with Dr. Robert Malone Transcript

Joe Rogan: So, first of all, thanks for coming and, uh, very nice tie.

Dr. Robert Malone: Thanks – Christmas present, actually Ryan Cole is the one that first got these and my wife has been jealous ever since. So this is what I got for…

JR: Where does one get a Covid tie?

RM: I don't know – she looked it up on Amazon or someplace and found it.

JR: You gotta love how industrious some of these folks are – they're just, you know, they find a niche, like, I know what I wanna sell: Covid ties! And there you go.

RM: I gotta have a tux for an event that's coming up in Texas in a couple of months, and so my wife is writing to the guy that does the ties to see if he can make a bow tie that's got the virus on it.

JR: Are you, I mean, are you tired of this…?

RM: Tired…

JR: …dealing with this, do you feel a duty to talk about this? Like, we should just say, because historically, we should just state what's happening here. So today is the 20, no, the 30th of December and yesterday you were kicked off Twitter, correct?

RM: True.

JR: Um, we scheduled this in advance. It's just coincidentally that you were kicked off Twitter. What were you kicked out… first of all, before we even do this, please tell everybody what your history is and what your degrees are and what you do.

RM: Okay, so, I'm going to do the short version, okay? Some, you know, this can last for an hour if we go into the whole history of mRNA vaccines and all that kind of stuff. My history, I was originally a carpenter and a farmhand in the central coast of California and decided that I wanted to go back to school, and did two years of computer science, then decided that I didn't want to spend the rest of my life looking at a computer monitor in a basement. Bad decision. And I decided that I wanted to try to become an MD, which was a hard thing to try to do in the late 70s, so that was a real stretch objective.

I went to UC Davis after two years of undergrad at Santa Barbara city college, and wanted to work on this new tech space called molecular biology; in particular, on cancer – my mother was deathly afraid of breast cancer, and so I looked around and found a laboratory at UC Davis with a

guy named Bob Cardiff and another guy named Murray Gardner that were working with retroviruses and their links to breast cancer. And it just happened that, while I was in there, (this is circa 83/84) this whole thing cut loose in San Francisco with the immunodeficiency syndrome in men – and the lab ended up right at the forefront of that. You know, Davis is just down the street basically from San Francisco, and at the Davis primate center, they had discovered that there were monkeys that had immune deficiency. So I was there in the lab as an undergraduate, as a total bench rat, when Preston Marx and Murray Gardner and others made the first discovery of a retrovirus basis for emitter deficiency in primates. And then Murray went to the Pasteur and brought back the virus literally in his pocket. He went there with Bob Gallo, met with a guy named Luc Montagnier that you may know, and that kind of kicked off the whole vaccine effort for aids. So that's kind of what I cut my teeth on, and so I came out of that. I, you know, I was, it was really bold to think that I could get into medical school and I kind of overshot the mark. I got an MD-PhD scholarship at Northwestern University in Chicago and so I went from having grown up in Santa Barbara with my wife (we were high school sweethearts), to Chicago, and that was kind of an abrupt transition.

So we decided I would do my graduate work at San Diego and I'd been accepted into a program at UC San Diego that had two of the top gene therapy specialists I really wanted to do gene therapy with; retroviruses – that was what I thought was going to be my life. And so we moved down to San Diego and I started working in the laboratory of Inder Verma, which is in the molecular biology and virology labs at the Salk Institute and this is a place where graduate students normally aren't allowed to go. It was… there were seven Nobel laureates at the time, plus Jonas, a really intense competitive environment. I carved out a little niche that I was going to work on for my graduate work, which was asking questions about how retrovirus RNA is packaged, and from that I had to develop a series of technologies to manufacture RNA and structure it, and eventually put it into cells.

Through a cascade of events being at the right place the right time, asking the right questions, surrounded by geniuses, led to the series of discoveries that now performs the basis of the RNA technology platform that gives rise to these vaccines and 10 issued patents; they were all filed in ‘89. So, that's kind of my origin story as it relates to this virus and vaccine. But since then, I went on and finished my MD, did two fellowships at UC Davis – top pathology for years – set up a gene therapy lab, had many other discoveries, came out to the east coast, and created the technology platform that is now the basis of the company called Inovio. We actually originally founded Inovio in the United States – this is pulsed electrical fields – they have one of the DNA vaccines for Covid. Then the planes hit the Towers, the investors pulled back and I went to work for a company called DynPort Vaccine Company that had the prime systems contract (as “government-speak” for all the biodefense products for the Department of Defense for advanced development, which is to say, clinical trials through licensure. And that's my kind of transition from being an academic to focusing on actually making things that work in people and the big epiphany there was that the world is full of these academic “thought leaders” that publish in big

journals and stuff, but that doesn't really lead to products and I really wanted to make products that would help people.

And so, since then, for the last I guess about 20 years, I've been focused on actually doing stuff: regulatory affairs, clinical development, getting necessary training, etc. I completed a fellowship at Harvard University Medical School in global, as a global clinical Scholar, to round out my CV and I've run, you know, over 100 clinical trials, mostly in the vaccine space, but also in drug repurposing. I've been involved in every major outbreak since AIDS. This is kind of what I do. I've won literally billions of dollars in federal grants and contracts. I'm often brought in by NIH to serve as a study section chair for awarding, you know, 80 to 120 million dollar contracts in vaccines and biodefense. I've spent countless hours at the CDC at the ACIP [CDC's Advisory Committee on Immunization Practices] meetings. I have multiple friends at the CDC; I work closely with Defense Threat Reduction Agency, which is one of my favorite clients, teaming partners, and I work with the chem biodefense group… there's other branches, including the other…this is not the branch that funded the Wuhan labs; that's another branch of DTRA…I've got many friends in the intelligence community so I'm kind of a pretty deep insider in terms of the government.

I know Tony Fauci personally, I've dealt with him my whole career, and then we had this particular outbreak and I was tip of the spear on bringing the Ebola vaccine forward that we now call the Merck Ebola vaccine. I'm the one that got Merck involved.

JR: Now, when the pandemic broke out previous to that, I mean, you're kind of thought of as a heretic now in some strange way…

RM: Pariah.

JR: Yeah, it's probably a better word, and the fact that you've been banned from Twitter is – it's very confusing because I've been following your tweets and I've been reading all the things you've written and I don't understand how it justifies a ban. I don't know what was the particular tweet – did they tell you what the particular tweet was or what the offense was that…?

RM: They never tell you.

JR: They never told you.

RM: Well, they never tell anybody.

JR: They removed you for not going along with whatever the tech narrative is because tech clearly has a censorship agenda when it comes to COVID – in terms of treatment, in terms of the whether or not you're promoting what they would call vaccine hesitancy – they can ban you for that they can ban you for in their eyes what they think is a justifiable offense and they're doing this and I don't know who these people are that are doing this, but they're doing this. One of the

most important things about you, reading out your history, like, that is of one of the most qualified people in the world to talk about vaccines.

RM: Well, thank you for that. I think that that's so. One way that some people put it is – and of course since this has happened I've been contacted by multiple lawyers that are looking at filing a suit just like Alex Berenson has one against Twitter – and the point is made just with what you just made, if so the point that I think is kind of succinct on this is, if my voice, if there's no merit to my voice being in the conversation, whether it's true or not, whether I'm factually correct or not, let's park that just for a minute – whether or not I'm right in everything I say – and I freely admit no one's perfect. I'm not perfect, it's one of my core points is people should think for themselves. And I try really hard to give people the information and help them to think, not to tell them what to think. Okay, but the point is, if I'm not, if it's not okay for me to be part of the conversation even though I'm pointing out scientific facts that may be inconvenient, then who *can* be? And whether you're in the camp that says I'm a liar and I didn't invent this technology, despite the patents – when there's a whole cohort that no one can debate, dispute that I played a major role in the creation of this tech – and virtually all other voices that have that background have conflicts of interest – financial conflicts of interest; I think I'm the only one that doesn't. I'm not getting any money out of this so I think that it starts to touch on some fundamental constitutional principles about rights of free speech. I suspect that's kind of where you're going on that.

JR: Well, most certainly… but also how disturbing it is for someone who's not an academic, like myself, to watch people like you get silenced and silenced in this platform of social media where people are exchanging information. They're posting up studies and you're discussing different parts of this pandemic that are in the news and what the issues may lie in. And where your background and your expertise allows you to explain this in a way that maybe it's not being explained because of the narrative that's being discussed in the mainstream news, and to watch you get silenced – first of all to watch you get ostracized: I've seen that, I've seen people distance themselves from you. I've seen people call you a crazy person and criticize you but with no specific thing to point to. It became like a tag they put on you. Like, “Oh, *that* guy.” Like, I brought you up to someone and he goes, “Oh, that guy's crazy.” I go, “How so?” There was no answer.

RM: Yes, so…

JR: Okay, so this is a thing – you're gonna just say someone's crazy when they say something that's inconvenient or say something that makes you uncomfortable, because you've decided to accept a certain narrative. Did Twitter warn you?

RM: No.

JR: Were there any tweets where they said that this is misleading or anything?

RM: No, no, they never do.

JR: Do you have any idea what the final tweet was or what the context was?

RM: I think I do, and there's no way to confirm it until the lawyers, you know, do their lawyering. Now I did have, in the case of when I was banned from LinkedIn –remember this happened…

JR: I wasn't aware of that.

RM: Yeah, I was de-platformed from LinkedIn many months ago and it was, there were actually two events of de-platforming in LinkedIn, and in both cases, I was able to get an explanation for what the specific crimes were, the thought crimes, and in in the first one it was a LinkedIn posting in which I pointed out that the chairman of the board of Thomson Reuters also sits on the board of Pfizer… and I simply wrote, "Does this look like a conflict of interest to you?" And this gets to your core question about tech: it's not tech, it's the horizontal integration across all major industries now, under the control of common funds – all of these industries – the harmonization of the tech censorship, the interests of pharma, big media, etc. and governments, all being harmonized in their messaging globally. I mean I travel a lot, okay, I see the same… and I have physicians coming to me all the time about what they're experiencing, the same playbook is going on every continent.

But getting back to LinkedIn: so this is the first event and Steve Kirsch intervened, called up a vice president of LinkedIn and…

JR: Steve Kirsch is a tech guy right?

RM: Yeah, yes, he's a Silicon Valley entrepreneur who – you may or may not recall that I was on the Brett Weinstein "Dark Horse" podcast with Steve; that kind of lit this whole fire up…months and months…

JR: That's right, okay, that's where I first saw him.

RM: Yeah, so he has great network connections in Silicon Valley – he invented the optical mouse – and so he called this vice president at LinkedIn. The guy looked into it – meanwhile, people started dropping off of LinkedIn in protest and there were major press articles all over the world and then they reinstated me. And I actually got a very kind letter – this is unprecedented –a personal letter from this vice president apologizing and saying and saying specifically that they didn't have the talent to fact check me and then therefore they were gonna let me go now. Then subsequently I got dropped again and a phone call was made and they got put on.

In that case, the sin was that some one of their fact checkers — because, remember, this is Microsoft – one of their fact checkers had identified the *Atlantic* monthly attack article was

written about me and concluded that I was an anti-vaxxer and therefore I should not be allowed on LinkedIn. Now the context for that that's fascinating is that *Atlantic* monthly attack article that is often cited by my detractors and it's a fascinating read…we could go down that rabbit hole but no reason… it was written a few days after Peter Navarro and I came out with an op-ed in the Washington Times in which we criticized Biden policy on vaccines and said that they should be reserved for those that need them the most and not used universally, and we said some other things about the need of testing and tools so that people can assess their true risk. It was a political retaliation intended to take me off the map as I was starting to interact in more of a public policy sphere.

Now with this Twitter event, my wife and I have racked our brains about what was likely to have been the tweet that triggered this, and you know, you never know – the last two that I can think of that went out were one that was on our sub stack, in which we referred to a fantastic video that has been put out by the Canadian COVID Care Alliance group that summarizes all the malfeasance and data manipulation, misinterpretation, associated with the Pfizer vaccines and their clinical trials. It's a super video and of course that's, I guess, that is interpreted as something that would cause people to become vaccine hesitant. That's the sin in general, is saying things that cause people to become vaccine hesitant.

The other thing that I put out immediately before that, was a post a link to a website for the World Economic Forum that lays out their entire strategy for how they manage media, how they're managing COVID 19 and all of their core messaging. It's a fascinating website with links. Those are the only two things I can think of that would meet the criteria.

So, you know my position all the way through this comes off of the platform of bioethics and the importance of informed consent. So my position is that people should have the freedom of choice, particularly for their children, and that in order to appropriately choose to participate in a medical experiment, they have to be fully informed of the risks as well as the benefits. And so I've tried really hard to make sure that people have access to the information about those risks and potential benefits, the true unfiltered academic papers and raw data etc. And the policy that's being implemented is one in which no discussion of the risks are allowed because by definition they will elicit vaccine hesitancy, so it can't be discussed. But that's the fundamental background – that's the backbone of informed consent – so informed consent is not only *not* happening, it's being actively blocked. That makes sense?

JR: It does make sense, and it's unprecedented. I mean, I can't recall a time ever where people weren't able to discuss the side effects of medication, whether or not the studies are accurate, whether or not people should universally take these things, or whether it should be done on a person-by-person basis. This is…it's a very strange time and so when someone who's an expert like yourself has a dissenting opinion and you see that dissenting opinion immediately silenced, or at least immediately criticized, and then these attempts at silencing it, it just signifies

how confusing and how troubled the times we're in are. When Covid first hit, when the lockdown started happening in March of 2020, what was your position on all this?

RM: So you're kind of asking my origin story with Covid?

JR: Yes, I mean, were you initially… have you taken the COVID vaccine?

RM: So the answer is yes. I've also been infected twice.

JR: After you took it.

RM: Once before I was infected at the end of February, because I was attending an MIT conference on drug discovery and artificial intelligence – so this is pre-lockdown, February 20. But it goes back further than that. There's a CIA agent that I've co-published with in the past named Michael Callahan; he was in Wuhan in the fourth quarter of 2019. He called me from Wuhan on January 4th. I was currently managing a team that was focusing on drug discovery for organophosphate poisoning, ergo nerve agents for DTRA, Defense Threat Reduction Agency, involving high-performing computing and biorobot screening, high-end stuff. And he told me, "Robert, you got to get your team spun up because we got a problem with this new virus."

I worked with him through prior outbreaks and so it was then that I turned my attention to this, started modeling a key protein, a protease inhibitor of this virus when the sequence was released on January 11th as the "Wuhan seafood market virus," and I've been pretty much going non-stop ever since – to that point with drug repurposing – so I'm the one that originally discovered famotidine as an agent, because I was self-treating myself after I got infected with agents that we'd identified through the computer modeling.

JR: So February of 2020 you get infected, and how bad is your case?

RM: Bad. I thought I was going to die. You got to remember I was up, up, up on all the latest information from China and everywhere else. I knew all about this virus, I knew, you know, I've been watching the videos of people dropping in the street. My lungs were burning until I took famotidine and that relieved that.

JR: And what is famotidine?

RM: It's otherwise known as Pepcid, so just on this tangent since I've said it, I've got some good news to announce – first time here today – we believe we should have the first patient enrolled in our clinical trials of the combination of monitoring and Celecoxib for treating SARS-CoV-2. This is trials being run by the company Lidos, which is one of my clients that I've helped design, that's based on my discoveries. They're funded by a Defense Threat Reduction Agency so this is another drug combination. Now I work with all these folks like Peter and Pierre that I know you know.

JR: Peter McCullough, Pierre Cory.

RM: But I haven't pushed this drug combination. I just felt it was inappropriate until we got the trials running, but they're now open – and we've passed through the FDA screening process by the way. We tried to get…we had data showing that adding ivermectin further improves the combination but the FDA created such enormous roadblocks to us doing an ivermectin arm that we had to drop it. And what I'm saying is the FDA created so much grief that the DOD decided that the juice wasn't worth the squeeze and they just dropped that arm.

JR: Why do you think that is, what do you think is going on with the pushback on ivermectin?

RM: So, it's not just ivermectin, its hydroxychloroquine, and just to put a marker on that, there are good modeling studies that probably half a million excess deaths have happened in the United States through the intentional blockade of early treatment by the U.S. government that is familiar.

JR: Half a million.

RM: Half a million. That is a well-documented number, okay, and it's the combination of hydroxychloroquine and ivermectin. Now, when you ask me why, you're asking me to get into somebody's head. What I can say as a scientist is what I observe, the behaviors, the actions, the correspondence, these bizarre things like, you know, "Don't you know it's a horse drug, y'all," right? Which is amazingly pejorative. I live in Virginia, okay, I can tell you the people around me – I live in a rural county and I raise horses – that was deeply offensive, to use that language in that way. But there's clearly been an intentional push and Zeb Zelenko, who's a buddy– the guy that came out with the original protocol – Zlanco protocol – and was the one, by the way, that wrote the letter to to Trump advocating for hydroxychloroquine, okay? Kind of important to put that together. He's put together a great little video clip in which he clearly documents the conspiracy between Janet Woodcock and Rick Bright to make it so that physicians could not administer hydroxychloroquine outside of the hospital.

JR: And who is Janet Woodcock and who's Rick Bright?

RM: Rick Bright was the head of BARDA – the Biomedical Advanced Research Director, which is the group that, for instance, funded the JNJ vaccine and Operational Warp Speed, etc., so they're the big-ticket funder in health and human service of biodefense products.

JR: And who is she?

RM: Janet Woodcock was head of Operation Warp Speed for drugs and until very recently, head of the FDA. She is known as the person who kind of gets the credit, let's say, for the opioid crisis for her role at the FDA.

JR: So between the two of them, was there was some sort of a concerted effort to suppress the use of hydroxychloroquine?

RM: Rick Bright, on videotape, [had] explicitly spoken about how they conspired to cook up a strategy using emergency use authorization to make it so that hydroxychloroquine could only be administered in the hospital, which, by the way, is too late for when hydroxy should be used.

JR: And why do they do that?

RM: That is what is the unknown, and there's so many why's in-house behind this. I like to say there's a stack of stuff that doesn't make sense; it's about this high now. There is – I can't prove, I can't get into Rick's head – I know Rick quite well. I don't know what he's currently working for the Rockefeller; he did a whistleblower case and then he left the government, but all I know is they did this and Rick admits on it on videotape that he did it. And he states that the reason was that he believed there was no evidence of hydroxychloroquine being useful for this virus. Now, that's false. Hydroxychloroquine was known to be effective against SARS-1 that…

JR: Wasn't that regular chloroquine?

RM: Hydroxy – hydroxy and chloroquine are closely related molecules. Hydroxy is slightly less toxic, by the way. One of the nice things we had actually filed in during Zika [outbreak]: I did a lot of drug repurposing, I filed patents on the use of hydroxy in Zika. One of the reasons is because hydroxy is one of the few molecules that have antiviral activity that are safe in pregnancy, and you remember Zika was a pregnancy issue.

JR: Yeah.

RM: So hydroxy's been out there for a long time as having antiviral effects, and the other part of Rick's story that kind of doesn't make sense, that there was no data on efficacy, is that I was the guy that first acquired because I had Chinese connections. The Chinese protocol for treating this virus, I got it in late February and I sent it in to my buddies at the CIA and at DTRA, at the Assistant Secretary for Preparedness and Response. The government had those documents when Rick made those determinations, so the assertion that there was no data on hydroxychloroquine at the time when this decision was made is just patently false. It's there. So, what is the motivation? You're right, none of this makes sense. The only thing you know: this is a journalist problem, and you know the classic guidance is “follow the money.”

JR: Yeah.

RM: And so it is bizarre that Merck would come out with these explicit statements about the safety of ivermectin. Both ivermectin and hydroxy are on the WHO list of essential medicines. They have been administered for millions and millions of doses. They're among the safest medicines we know when administered within this acceptable window, pharmaceutical window.

The ivermectin is even safer than hydroxy, so Merck coming out of the blue and saying ivermectin isn't safe is really inexplicable.

Now another thing is that I sit on the Active Committee for Drugs as an observer. What is the Active Committee? This is the NIH committee that's guiding the clinical trials for these various repurposed and novel drugs. I saw, listened to, heard, witnessed the representative of Merck that's on the committee – because the committee is full of pharmaceutical representatives even though it's an NIH public committee – explicitly attack the decision for the federal government to test ivermectin. She said there's no reason to do this now. What's happened since then is [they] are still testing ivermectin and they've had to go to a higher dose because, as we pointed out, essentially their initial trial design was designed to fail. It was a short course with inadequate levels of drug, and so now they've upped it to, I think it's five days and 600 micrograms per gig – that's the current dosing in active tests but there is clearly a concerted effort on the part of multiple players in the pharmaceutical industry, in concordance with the federal government, to kill ivermectin as a potential alternative early treatment strategy.

JR: And if you're going to follow the money, the problem is there's not a lot in ivermectin because it is a generic drug and any compound pharmacy can make it and…

RM: It's fairly cheap because it's easy to make and, you know, you can get ivermectin and, you know, in bulk at less than a penny a dose.

JR: Wow, so the original SARS was, is it 90 [%], similar to SARS-CO-V2?

RM: It's that those terms 90 or 96 or 98, those are really not – they're kind of irrelevant, you know, that you can have something that's 99.9[%] similar and the difference is all the difference.

JR: But if chloroquine worked on the original SARS, or it showed efficacy in original SARS, is it safe to assume, like, without adequate tests that hydroxychloroquine would work on…?

RM: It's the decision that was made by the Chinese government, okay? That's my point. I got the original Chinese protocols; this is what they were using.

JR: And they were using it effectively.

RM: Yeah.

JR: Yeah, so were they using ivermectin as well?

RM: No.

JR: No, but other countries have, like Japan and India and…

RM: Uttar Pradesh, as you know, has crushed COVID.

JR: Yeah, can you explain what they did to do that, because it's kind of fascinating.

RM: It's not clear what are the drugs, so what they did do – what we do know, and there's some backstory to this that we could go into if you want to, but the observation is there was a decision made… the virus was just ripping through Uttar Pradesh – it has almost the same population as the United States, it's huge, okay, dense, urban, poor – all the characteristics of the stereotypes of the Indian countryside, and the virus is just ripping through there and causing all kinds of death and disease. And the decision was made out of desperation in that province to deploy early treatments as packages widely throughout the province, and it included a number of agents; the composition has not been formally disclosed. It was done in coordination with WHO and whatever was in those packages was rumored to include ivermectin, but there was a specific visit of Biden to Modi and a decision was made in the Indian government not to disclose the contents of those packages that were being deployed in Uttar Pradesh – which they're still there and Uttar Pradesh is flatlined right now. The rest of the world is yelling about Omicron and in hospitalizations, well, South Africa isn't but Uttar Pradesh is still flatlined in terms of deaths.

JR: So they were visited by someone in the Biden administration?

RM: There's a meeting between Joe Biden and Modi, and that, out of that meeting – I don't know what they said, I wasn't invited – all I know is that immediately afterward there was a decision not to disclose the contents of what was being deployed in Uttar Pradesh.

JR: It's so crazy to imagine that in the middle of a pandemic there's one place, one area of India that's extremely successful in combating the virus and they're not going to say how they did it. I mean that's nuts.

RM: That's, you know, so that's where I kind of, my stance in all of this, is to say here are the facts; here are the verifiable data – draw your own conclusion.

JR: Okay, now, February of 2020: you catch it; what did you take?

RM: Famotidine.

JR: Famotidine and anything else?

RM: No, there's nothing else available.

JR: So this was so early on the pandemic, how did they… did you want to be hospitalized?

RM: Nope.

JR: No.

RM: I did have – I did develop lung COVID and people always, I always get the, "Why did you take the vaccine?" Well, I took it fairly early on. I took Moderna because that's what the national guard was deployed in my very rural county in basically central-northern Virginia…

JR: Isn't there some evidence that the vaccine actually helps people with long Covid? That was the rumor at the time.

RM: That was, then that was – I took it for two reasons: I had long Covid, it was supposed to help with that, and I knew I was going to have to travel internationally to France and Portugal in the near future.

JR: Now, is there any evidence that the vaccine helps against long Covid, or is there anecdotally, is there anything?

RM: Anecdotally there was, and I have not seen a peer-reviewed solid publication or preprint that supports that now, but that was the act of rumor at the time. And since then, what we do know for sure, well documented: if you've got prior COVID and natural immunity, you have a higher risk of adverse events from the jab. Now, the other part of my story that often gets overlooked – so I took two doses of Moderna. With the second dose, I developed stage three hypertension with systolic blood pressure of up to 230, okay – I'm lucky to be alive. You know what it means is I've had a stress test of my aorta and my cerebral vascular system and I didn't have a stroke and I didn't tear my aorta all to shreds. But it's a good thing I had irregularities of heartbeat, incredible hypertension, pot syndrome, narcolepsy, restless leg syndrome – these are all known side effects that are associated with the vaccine. They're relatively less frequent than the myocarditis in the children, in male children in particular, but they're all known on the list of adverse events and it's very clear that people that have natural immunity have a much higher risk factor for this whole spectrum of adverse events. But even if they get jabbed…

JR: Even though that's known, there are so many people out there telling people who've just recovered from COVID to get vaccinated.

RM: There is a number of things here that are not supported by the science, I'll say gently. To be less gentle since we're on the Joe Rogan show, I can speak freely: it's nucking futs – this is just wrong. It's not consistent with the data.

JR: Well, it doesn't make sense either. What we know about natural immunity is that natural immunity – at least according to that study in Israel, which is like what 2.5 million people – I think they said that it's between 6 and 13 times more effective than the vaccine.

RM: That is six or 13 times more effective in hospitalized – preventing hospitalized COVID. It's more like 20-or-more-fold or, yeah, 27-fold better at protecting against developing the disease. Remember, infection does not equal disease.

JR: Right.

RM: And that's only one of over 140 studies that document that natural immunity is superior to vaccine-induced immunity and oh, by the way, as a vaccinologist and an immunologist, I wouldn't expect anything different.

JR: But the CDC recently disputed this…

RM: It was a fascinating play, so the CDC, for most of us that are at all objective in the science world, look at what's going on at the CDC aghast. I mean, the CDC has just compromised it – what they did with that was a very small study with intrinsic bias all over the place – much, much smaller than the Israel I study that you're citing; much less rigorous, less statistical power, and they pushed that out as their justification for their position concerning natural immunity, but…

JR: WHO funded that study.

RM: CDC – it would be the federal government.

JR: So they funded this study. They did it themselves, and do you believe they did it with the intent of coming to the conclusion…

RM: You're asking me to apply intent, and I've had too much time with lawyers and I'm not going to do it good for you…

JR: So either way, there are many many, many studies that point to the fact that natural immunity is superior.

RM: Absolutely.

JR: Having recovered from COVID…

RM: Like over 140.

JR: …and also multiple studies that show that people who have had COVID who get vaccinated after the fact have a higher risk – I think it's between two and four-fold, right?

RM: You're on top of the data.

JR: …two and a four-fold risk of adverse side effects.

RM: Increased risk.

JR: Yeah, increased risk, so for you – you did not know this when you got vaccinated?

RM: No.

JR: What was your thoughts, I mean, since this was a technology that you were a pivotal part of the creation of and so you're getting this vaccine, you probably were thinking, “Look at this – all my hard work come to fruition. It's gonna protect me from the virus.”

RM: I actually said to the nurse when I took the first jab, I bragged a little bit –I usually don't – I'm usually, you know, keep it on the down-low. I don't like to wear it on my shoulder, but I did say, “You know, I invented this tech.” She's like, “Oh, that's really cool. Can I take a selfie?”

But…

JR: She aspirate before she shot it into you?

RM: I have that whole aspiration thing, yeah, I'm sure she did… yeah, yeah, she's a well-trained Nurse.

JR: When you say “that whole aspiration thing”…

RM: Any skilled medical practitioner, when I inject my horses, right? I breed horses. I've got 20 on the farm, okay, I give them drugs all the time. I always aspirate.

JR: But I saw the shot where Joe Biden got it on TV and they didn't aspirate them. they just…

RM: I don't know what to say.

JR: I’ll tell you what to say.

RM: Yeah, so… so…

JR: That's not the way to do it.

RM: Yeah, and was that really a vaccine, right? Then we go down that whole rabbit…

JR: That's my favorite rabbit hole, because of the fake set, remember?

RM: Yeah, so, you know, there is… there it’s okay, so you know, Joe, you're in media, I guess. What we're experiencing is coordinated media warfare, the level of which we have never seen before. And I and my peers who were experienced in multiple outbreaks have never seen this level of coordinated propaganda.

JR: Is this because there's never been an outbreak that coincided with the use of social media? Because there really hasn't been – I mean, H1N1 was…was it 2009 that that broke out?

RM: I was pretty active through Zika.

JR: But, okay, and that was…?

RM: I don't remember the years, but I was on LinkedIn and Twitter all the time.

JR: The thing about what's going on now, it's, there's a heightened aspect in terms of, like, it's the influence on society that social media has; that is, it's stronger now than it was two years ago; it's stronger two years ago than it was two years before. It's ramping up exponentially in some sort of a strange way that's affecting society. And then the censorship aspect of it, which has kicked in and, as you said, that they're stepping in line with tech – doing it with the pharmaceutical companies, doing it with the government – they're all sort of on the same page when it comes to the messaging.

RM: Yes, so now you're going to the next level of, you know, WTF…

JR: Yeah.

RM: Um, how to open that can of worms… first off, you don't see –you're aware of the Trusted News Initiative?

JR: Yes, can you explain it to people?

RM: Yes, so there, the BBC announced to the world last fall that this organization, that they had led the development of which, ties together big tech and big media in service of the government and was built expressly for the purpose of protecting the democratic voting system – you know, small "d" on the democracy – and in voting integrity from undue influence from hostile offshore players through media information campaigns – which you'll recall was the claim that was made against Russia. And so this was the response of the Western nations to build this new structure called the Trusted News Initiative that would survey all information about elections and prevent the intrusion of foreign information into the democratic process and creation of undue influence by foreign actors.

Shortly after it was created, it was…there was an awareness in the pharmaceutical industry that this could be used to address a particular devil challenge that they had, which was the pejorative label "anti-vaxxers" that's also been deployed against climate skeptics, okay? So "anti-vaxxers," you'll recall, is the label that is used to basically take anybody out that is raising any concerns about vaccine safety. It's the pejorative that's applied and it makes it really easy for the media to basically take off the table anybody that's saying something that is contrary to the interests of the, really, the vaccine industry.

JR: Right.

RM: So there was a decision that this same toolkit – this same integrated international media and high-tech organization led by the BBC – would be pivoted to resisting vaccine misinformation and disinformation. And they put out a proud press announcement last fall that this is what they're gonna do, and they defined these things – misinformation and disinformation – as anything which was going to lead to vaccine hesitancy and which was contrary to the official statements of the World Health Organization or their respective national health organizations. So if CDC says the world is flat then the world is flat and there will be no discussion about whether or not the world is flat.

I'm using obviously a simplified, silly example, so whatever the CDC or Tony Fauci or Tedros, etc. says is truth by definition – and any information or discussion which is contrary to that truth will be suppressed. It will be deleted and those people will, that are expressing these opinions that would lead to vaccine hesitancy – which to some eyes would be informed consent and decisions by an individual that they believe the risk/benefit ratio doesn't matter, doesn't make sense to them – that information will not be allowed. And those people that are spreading that information will not be allowed to interact in the public sphere, in social media, okay, so that's this kind of…if you want to unpack this whole thing, it starts by understanding the Trusted News Initiative. And we've got great links about that, that have been put out explain – explanatory links. For instance, I put out a Substack [posting] recently that talks about the Trusted News Initiative and the censorship, in which I link to both the BBC's Trusted News Initiative website –so you can see what they have to say – and a video that describes the Trusted News Initiative from my point of view, as somebody who been on the receiving end of the Trusted News Initiative.

Now, that's the starting point, but it doesn't explain the global coordination, because TNI is mostly Western and it doesn't cover a lot of the other, you know, Latin America, for instance, or Spain or Israel, and the only way that I can understand how all of this messaging censorship, you know, what it really is, is "canceling," and Bobby Kennedy makes the point that the first real example of "cancel culture" that we can track is Tony Fauci canceling the esteemed virologist Peter Duisberg because he was raising questions about the origin of HIV and its role in the disease calls it called AIDS. I remember when that happened, I was a…

JR: I had Duisberg on my podcast a long time ago and it was the first time I ever got, like, extreme pushback from people that were, like, I mean, this is after protease inhibitors had been used, so it didn't even make sense. And people are saying, "You have blood in your hands. People are going to die because of this podcast," and I'm like, "What are you saying," right? Like this is a guy who's a biologist, University of California, Berkeley.

RM: Full professor.

JR: Yeah, I mean, a brilliant guy.

RM: Yeah, totally one of the best virologists of his generation, full stop.

JR: And very controversial opinions, but the only way to find out if someone's controversial opinions are valid is to ask questions, talk to them, and let them express themselves. And then I wanted to have someone come on and debate him. I could not find anyone willing to do that, no…

RM: It's… this is covered in detail in Bobby Kennedy's book about Tony Fauci. It's one of the great case studies – now we have a more recent example of this cancel culture as it's played by NIH and by Tony in the emails that came out recently, when you have Cliff Lane, Tony Fauci and the director of the NIH, Francis Collins…

JR: Yeah.

RM: …basically coming out and saying that they're gonna ridicule and destroy fringe epidemiologists – and what was their sin, these fringe epidemiologists, that warranted a concerted effort on the part of the federal government to destroy them? Their sin was raising questions about the effectiveness of vaccine lockdowns, okay? And who were these fringe epidemiologists as stated by Francis Collins, who by the way, has no background in epidemiology or public health, okay? He's a sequencing guy – that's his claim to fame, as the human genome project and the cystic fibrosis transmembrane regulatory protein; he has no background in immunology, no background vaccinology, no training in public health… but who are these three fringe epidemiologists? Well, they happen to be full professors from obscure universities; Oxford, Harvard, and Stanford, okay?

JR: They were warning about lockdowns.

RM: They were warning about lockdowns in the Great Barrington Declaration, that's what prompted that.

JR: Can you explain the Great Barrington Declaration?

RM: So, these three esteemed high-profile academic epidemiologists came together and said and did a comprehensive analysis about everything that was known about lockdowns and their impacts during infectious disease outbreaks. And they came out with a specific statement. You can find it on the web; look up Great Barrington Declaration. And they came out with a specific statement that these lockdowns were going to cause more harm than help, which was contrary to the messaging that was being put out by Tony, and so Tony decided that they had to be destroyed. And then you had Francis Collins recently coming on Fox News after these emails were FOIA'ed and brought out into the open, and saying that if we had followed their advice, millions of people would have died. This is the fallback anytime you criticize these guys. What they say is, "Oh, you're killing people" I mean, they do it to me too.

JR: So, if they had just done what Sweden had done and some other countries where they didn't institute lockdowns, and they sort of let people just live their lives and make their own choices, they were saying that millions of people would have died?

RM: So it would… so it seems.

JR: But time has shown that Sweden actually had a more effective take on the virus. I mean, it was highly criticized in the beginning. People were really concerned that they weren't taking it seriously enough, and then there was also some concern that it wasn't, you couldn't compare, they weren't comparable because the way Sweden is, it's like small towns – they're separated from each other; it's not a high-density situation like New York or Los Angeles or Chicago, but overall, in time we've seen that this respiratory disease spreads – period. No matter what. It just, it seems to make its way to people no matter where you are. And what it's done in that country is, it's kind of burned through the population and their mortality rate is lower than most places, their infection rate is lower than most places, and it didn't do the devastating economic damage and the devastating damage to children that were forced to isolate and not be with their friends and not go to school and not socialize.

RM: So, here's an even more fun one, okay, that just cuts right to it: you know the pejorative these days is the country's name is actually "Pfizreal." It's no longer Israel, the Israeli people are very compliant with their government and the government has a financial deal with Pfizer, okay, and they only have Pfizer vaccine and they're now on jab number four. There's a natural experiment that's occurring in the Palestinian territory in the surrounding states – those surrounding states in the Palestinian territory do not have that level of vaccine uptake at all. The mortality in the surrounding states in the Palestinian authority is substantially less from this virus than the mortality in Israel.

JR: Now is that factored by age? Is it, like, what is.. so, what are the variables?

RM: Good question, and this is akin to this mystery, sorry, of what's going on in central Africa and the malaria belt, where you have really low levels of mortality and what you're hitting on appropriately, or getting right to the core of the issue, is confounding variables and, in general, the Israeli population is a little bit older than the Palestinian territory on average, so, that's a lower risk. Neither one of them are associated with high rates of mortality, of morbidity, of obesity, and so that variable seems to be out. That may be one of the major variables in Africa, is that in that malaria belt, people generally aren't fat. They happen to also be taking ivermectin and hydroxychloroquine for the indigenous parasites that they have to deal with. So, a lot of people were saying, well, that must prove that hydroxy and ivermectin protect. Well, not so, as you point out, there's a lot of moving parts here.

And so this is why, you know, I'm glad you didn't ask me, "Well, why is that, Robert?" Because I would have said, "I can't say, because there are too many confounding variables,"

However, it is a fascinating observation that we have this intensively vaccinated cohort in Israel, and in much, much less vaccinated cohorts in the surrounding states and – you can look it up on Worldometer; you don't have to, believe me, you know your audience is smart enough, they can go on Worldometer and look it up – and look at the mortality and morbidity in these different countries and figure it out for themselves.

JR: Is the rate of infection comparable?

RM: Hard, you know, rate of infection is a really hard variable because it's a function of the density of testing. And so, you know, this is one of the situations where the more you look for it the more you find – which is why you really can't use that as a denominator, is the incidence of infection, because the incidence of infection is totally contaminated by the frequency of testing and the density of testing. So you have to rely on things – the only, really, the only thing close to a decent outcome indicator that isn't subject to all this bias that's all over in the system –except in a few states – Iceland, the Scandinavian states, generally have relatively clean data; the UK to some extent, has cleaner data. It's now clear that the Israeli data set is contaminated by all kinds of a monkey business in terms of what gets deleted, but the only thing that seems close to a reasonable outcome variable is all-cost mortality. So, because people get kind of wrapped up around this, and they say "Well, you know that this vaccine, these deaths…" That was, I mean, this is the…and everybody argues both sides of the coin with the VAER System: "Oh, that means nothing" and then, "Oh, well, the CDC uses it, means everything," right? And it's okay for them to use it for the numerator, but it's not okay for anybody else to use it.

JR: And for people who don't know: we're talking about the Vaccine Adverse Event Reporting System – that's VAERS.

RM: Which is what the FDA explicitly said in the licensure packet for Comirnaty: is inadequate to detect rare adverse events – that's why they're forced… if they ever market Comirnaty in the United States, they're gonna have to do a bunch of clinical trials, which I think is one reason why they're not doing it. Because the FDA has told them that VAERS is basically junk, but it's the best we got, okay? So, you know, when you look at these ratios, you – the argument is, well, just because somebody died within X number of days of receipt of vaccine, it doesn't mean their death is vaccine caused. It's vaccine correlated, that's fair, but it's the only variable we have, and it's consistent in that we've had that variable in that outcome measure for decades.

Okay, so then we can look at trends, but what we see is this explosion of vaccine-associated deaths – and you tend to kind of pick that apart… people say, "You know, well, if you had a car accident or a bullet to the head and you went to the hospital and they tested you with a PCR test that's non-specific, and they ran it up to 42 cycles and they said, "Oh, look, there's the virus," – and by the way, they have a financial incentive to do that – that results in a false-positive death; true, but the other side of the coin is that if somebody's having brain fog or they have a stroke

while they're driving the car, and they crash and die and they've had it within, you know, 48 hours of when they took the jab (and we know the jabs cause blood clotting and strokes), well, then, it could well be that an auto accident is vaccine-related, catch my point?

Yeah, so all of these kinds of things – you can't sort out what's what, you just kind of have to take the aggregate value and hope that you have a large enough sample size that it corrects for all that stuff, all that noise that's inherent in the system.

JR: Now you just glossed over the financial incentive to report a COVID death. What is that? What is the financial incentive? Because there's all these rumors that you would hear about – what a hospital gets paid per COVID death, and that the government gives them money and that they're incentivized to make something, mark it down.

RM: It's not rumors.

JR: It's not rumors.

RM: Well, now, I don't have the specific numbers at the top of my head – I'm not a hospitalist. I'm not a hospital administrator, but that the numbers are quite large… there's something like a three thousand dollar, basically, death benefit to a hospital if it can be claimed to be COVID. There's a financial incentive to call somebody COVID-positive the CDC made a determination in year one – this is why all of our baseline data is junk.

JR: What is the financial incentive to say that they're COVID-positive? That's why the PCR cycles are ramped up so high?

RM: I.. again, you're asking causation. I can tell you that the hospitals receive a bonus from the government – I think it's, like, three thousand bucks – if someone is hospitalized and able to be declared COVID-positive. They also receive a bonus – I think the total is something like 30,000 – in incentive if somebody gets put on the vent; then they get a bonus if somebody is declared dead with COVID. Okay, so they have an incentive at the front end to declare somebody COVID, a COVID case. The CDC made the determination that they were going to make a core assumption: if PCR-positive and you die, that is death due to COVID, and so the extreme example just to show the absurdity: if the patient comes in with a bullet hole of the head and they do a nose swab and they come up PCR-positive, they're determined to have died from Covid when in fact they died from lead poisoning.

JR: That's real?

RM: Yeah.

JR: So they've really done that with gunshot victims?

RM: I don't know about, yeah, for sure trauma and other things.

JR: I, I've seen that said, but I've always thought, that's ridiculous, there's no way a hospital would do that.

RM: It's, it's not, it's not… it's not a question of what hospital would do; it's a question of med codes.

JR: So the code is set that if you swab that person and – you are, you're supposed to swab them?

RM: And, and you get a positive signal and…

JR: Are you obligated to swab them, no matter who they are, if they come in with an injury?

RM: I believe it's the common practice. I don't know whether there would be an obligation; that would be a hospital-by-hospital policy.

JR: So that it really is true that if someone has a gunshot wound and they're dying of that gunshot wound, and you check them for Covid and if they're COVID-positive and they die – they mark it off as a COVID death?

RM: That is by definition from the CDC. That was a decision that was made early on.

JR: That seems insane.

RM: That there is, that there is…that's why so many of us are so much up at arms. And I'm really pretty aggravated about what's going on, all the way through this, is the information. Let me put it this way, Joe; part of the reason – I know you're somebody who is really committed to bringing everybody together, and the idea that we're really one America, we're one people, we shouldn't be divided like this…

JR: I'd like that for the whole world.

RM: Amen, yeah, amen, okay, we're aligned.

JR: We're just humans.

RM: Thank you, okay, but we've been divided in this way, and it's all been politicized and the data have been so thoroughly manipulated that it's hard for any of us to make sense out of it. And all the way through our government, at least – I can't speak to great Britain or Germany – but our government has had a series of checkpoints where they have a job to do, and I know this because this is what I do for a living, right? I do regulatory affairs and clinical development. We

wouldn't be having all of this conflict about what is true if the FDA had done its job. What the FDA didn't do was force the pharmaceutical manufacturers to do their job.

Now, we can wrap around, you know, well, maybe, it was just they were all in a rush, we were all panicked; but the bottom line was, they didn't do their job and they didn't force pharma to do its job. And they didn't employ the standard requirements for testing and verification that pharma was doing its job that I would expect to experience as a clinical researcher on one of my studies, okay? What's gone on with Pfizer, if the whistleblower comments hold true, and, for instance, the Maddie Degary case: this young woman who was listed as having a stomach ache that participated in the Pfizer trials, when in fact, what she had was a seizure – and she's now wheelchair-bound with a nasogastric tube, one of a thousand subjects.

JR: This is a 13-year-old girl, right? That was a part of the study and they wrote it down as what?

RM: Gastric distress.

JR: That's literally what it says in terms of the adverse effect, gastric distress? Like what is gastric distress?

RM: Stomach ache.

JR: That's it? But, what, how do they account for all the other injuries?

RM: They don't. They take her off the study.

JR: How's that possible? That's totally unethical. Who's signing off on that? How are they allowed to do that?

RM: So, the way the rules work in regulatory affairs, so this is law, right? This is regulatory affairs law in common practice at the FDA, and globally, there's all kinds of treaties and things that regulate how these things are supposed to be done. The rule is – it used to be – that a pharmaceutical company could kind of offload all the liability for bad stuff that might happen in a clinical trial and be mismanaged, etc., onto the performer, the subcontractor. Used to be that pharma actually did the trials themselves, and then they found it was cheaper – more efficient – and they could push off their liability if they engaged companies like I've been working for decades – contract research organizations, clinical contract research organizations – and so that was done for a while and if anything went bad in the trial, then the pharma could say, “Oh, it wasn't us, it was those guys.”

Now over the last few years, the FDA got wise to that and they made policy that the responsibility rests with the sponsor. That's fancy regulatory-speak for it's… pharma owns it.

Okay, so you ask the question: whose responsibility is it to ensure that the data isn't contaminated and manipulated? The answer is: Pfizer.

JR: Wow, so they're responsible for the data; they're allowed to say that this was just some sort of a gastric distress.

RM: And the job of the FDA always is to ferret out monkey business, which happens all the time, whether intentional or unintentional, and there's all kinds of ways you can craft clinical trials and craft clinical trial study reports, final study reports, to hide the bad stuff and highlight the good stuff.

JR: So, in this clinical trial that this young lady was involved in, how many children were involved in the study?

RM: It's 2000 approximately, but they're split into placebo and experimental groups, and so she was in the treatment group.

JR: Now, one of the things that people have said in response to the vaccine injuries is that it's approximately one in a thousand that are getting these significant injuries like myocarditis, and so you think…

RM: There's a, there's a, well, it's important when we talk about these things to make a distinction between an event that is clinically significant and might result in hospitalization versus something that might be undetected unless you did a laboratory test or, you know, maybe like, for instance, myself when I started to experience those things that I experienced after Moderna [vaccine]. I was confused – it was not listed as among the side effects. I thought I just suddenly developed rampant hypertension until the data started coming out and I, you know, Fortunately, I had an astute cardiologist that got me into control and got me under medical management. And then I looked into it – oh, this is one of the known side effects – and then time went by and it became more and more clear. So the point is that what gets reported in a study is often biased by how the study is structured, because one list – when you write the study protocol, you list expected adverse events and so people… if those things happen, often times they get checked, but I guarantee, one of the expected adverse events was not seizure and paralysis. Okay now, what they did, one of the things – there's all kinds of tricks you can play with the data if you're so inclined – and that's why it's so important. People like me that do clinical research for a living, we get drummed into our head bioethics on a regular basis. It's obligatory training, and we have to be retrained all the time so that… because there's a long history of physicians doing bad stuff, monkey business, and the most notable of course in common knowledge is the Tuskegee experiments.

But so it happens there's all kinds of financial incentives to make bad stuff go away and highlight good stuff; makes the sponsor happy and then you get another contract. These are not

little contracts, you know – a modest clinical trial is 20 million dollars. A big one is 100 million or more. Okay, so, these are big money deals; you want to keep that money flowing and you want to keep your sponsor happy. So that's what's come out with the whistleblower with Pfizer, is that the contractor, I think it's here in Texas, that ran a bunch of those clinical trials appears to have manipulated data in a variety of ways. And this is done at the level of checking the data and reconciling the data and deciding which things go into the database and which things don't go into the database and whether or not, well, if somebody had an adverse event after shot one and then they're dropped because they won't take shot two, you know, do we drop them out of this overall study analysis? That's why there's…we have all this specific language that we use in our business – the intent-to-treat cohort, the per-protocol cohort – these are separate analyses. They describe these differences and how, because it's known that you can manipulate the data in these different ways and it's clear now, and basically this was the subject, by the way, just to bring it back around to our first topic – this is the subject of that presentation that the Canadians put out that I put in that Twitter post – was all the different ways that the Pfizer data was manipulated.

JR: The fact that that is grounds for being removed from Twitter is so astonishing it's just… it blows my mind that that's the number one platform for distributing information right now and that things like that are happening there, because it is, I mean, it's essentially a number one that would…and Facebook, I don't know which one's bigger… but for distributing information.

RM: So, what's recently taken place – so, remember looping back, I talked about the interconnectedness at the board level between Pfizer and Thompson Reuters…

JR: Yes.

RM: Okay, Thompson Reuters has become the fact-checker of choice for determining… you know, I quote, "fact-checker"…

JR: Right.

RM: And we know –so we can go into the Facebook lawsuit that recently broke that whole story open – but Thompson Reuters is tied to Pfizer; they have common corporate ownership – and they are the fact-checker of Twitter! Now they're integrated, okay, so it's Thompson Reuters is making the decision, which has connections to Pfizer, about what information will be allowed to be discussed on Twitter.

JR: That is crazy, that is so crazy to even hear, I… and I don't know how we ever pull out of this mess. I mean, I think we are at a 45-degree downward angle, headed into a mountain, I really do. It's so strange to me that no one's up in arms about this other than a few people that have been censored, a few people that have these opposing viewpoints that are, you know, deemed to be something that can't be discussed.

RM: Well, it's, Joe, it's even deeper than that, okay – then there's the hunting of physicians. So, I myself, you know, Peter Mccullough is the textbook example of hunting physicians, right? The guy is $150,000 in debt right now, in the hole, in trying to defend his medical license. This is one of the most highly published authors in the world. He's an exceptional researcher, you know, and apparently a pretty good podcaster too.

JR: The guy's published more in his field than any other physician in history.

RM: And Baylor's trying to take him out – and it's not only Baylor, it's some entity outside of Baylor that's come in and is financing the attacks on him. But just to bring it home in a really… not to make it all about me, but to be able to speak in the first person, okay, so I went to Maui with a bunch of physicians a few months ago and we gave talks and did training about early treatments. We didn't talk about vaccines. There's only one hospital on Maui, in the island of Maui. It's owned by a… it's basically a Kaiser Permanente satellite, okay, so we went there, we gave that talk. That hospital and the hospitalists associated with it are actively involved and have kicked out Kirk Milhoan because he's giving early treatment with the "horse drug" ivermectin okay? Now who's Kirk Milhoan, you know, and why is he in this hospital? What is he qualified? Okay, he's an MD Ph.D. pediatric cardiologist with his Ph.D. training at UC San Diego in vascular inflammation. He is among the most qualified individuals in the world for managing COVID and commenting on cardiomyocarditis in children. And they've kicked him out of the hospital.

JR: Just for prescribing ivermectin for early treatment.

RM: Okay, he also happens to be a pastor at a local country congregation, he runs a food bank his whole life, he has traveled to emerging economies to provide free treatment – this is the kind of exemplary person that, you know, we all should be in the best of all possible worlds.

JR: And did they give an excuse for this? Are they saying that his prescription of early treatment promotes vaccine hesitancy, like is there anything…?

RM: He's prescribing enough "ineffective" drugs and "putting people's lives at risk" but here's the point – I'm not even there yet, okay, we're just winding up on this one.

JR: Right.

RM: So the other day right before Christmas, three days before Christmas, I get a package from my licensing agency, which – I'm licensed through the state of Maryland – so the state of Maryland medical board sends me a package, and it is a complaint that's been filed against me. I have six days to respond, basically. I end up having to respond on Christmas day, okay, or earlier, to this attack claiming that I should lose my medical license and the citations are that I didn't actually invent mRNA vaccines. The a copy of the *Atlantic* monthly attack article on me claims

that I'm licensed in Virginia – which I'm not – claims that I didn't graduate from Harvard Medical School – which I did – okay, so I have to respond to all this stuff. Now I'm going through it and it's just false, false, false, false, all coming, and [it] pulled a bunch of stuff off Twitter and Linkedin and sent it in… and saying, well, this is the reason why this guy should lose his license, okay? Because he is responsible for millions of deaths – he said it straight out, okay – I'm responsible for millions of deaths because of what I've said on social media.

Now who is it that's filing this? It turns out it's the Director of Recruitment and External Affairs of this hospital in Maui. This guy felt that it was necessary to send this little package of happiness right before Christmas to my licensing board to try to get my license taken away. That's what we're seeing across the United States and across the world – it's the hospitals and the hospitalists that are attacking outside physicians.

JR: Do you have any knowledge as to why they're doing this, other than speculation?

RM: If I was to follow the money – I'm gonna put it that way, okay? Again, I can't get into their heads, of course I don't know what's making them do this. It's crazy, okay, never been done before, right? It's happening, you know, we went and did a presentation in Alaska and the same thing was being done for the physicians that came out and spoke about early treatment in Alaska. And fortunately the Alaska licensing board put out a very terse statement that they don't want to get involved in politics in this kind of tit-for-tat, and that this is outside of their role as medical licensing boards for this kind of stuff. [They] are usually involved in making determinations about somebody's suitability because of drug abuse or sexual activity or other things which are outside or malpractice, overt malpractice, okay, this kind of political weaponization of medical licensing boards is new. Now here's the observation that I can make: if we follow the money, is that hospitals are incentivized to treat COVID patients. The thing that ties all this little part of this story together – including the suppression through the government of early treatment – hospitals are incentivized financially to treat COVID patients. If COVID patients are being treated outside of the hospital and prevented from going to the hospital – such as the case in the Imperial Valley where Brian Tyson and George Fareed have saved thousands and thousands of lives of indigenous Latinos that are coming across the border and working the fields – I mean, they're breaking their backs to save the poor. Amazing story there with early treatments, and I guess they're left alone because they're in the Imperial Valley – nobody cares, they're all poor. But in these urban environments, there's all these incentives for hospitals to treat COVID patients, and if people are giving treatments that are keeping those people out of the hospitals, then they're not getting that revenue.

JR: So, your speculation, if I just could unpack this – that doctor in Maui who was giving early treatment – you think that the reason why he was targeted was because he was directly costing the hospital money because people weren't going in.

RM: I'm not saying… I'm saying that the observation is that early treatment keeps people out of the hospital and that hospitals have financial incentives, including death incentives…

JR: …to discourage early treatment.

RM: And the, in the other data point is: these that are doing the attacking are almost universally hospital administrators and hospitalists.

JR: So these aren't physicians these aren't…

RM: By hospitalists I mean hospital-based physicians.

JR: Okay, what does that mean then? What, why, are they doing it – because they're part of that system of that hospital system, the administrators, they would be doing…

RM: …that because they're making, but they're making, so, again, I don't want to make accusations, right? I'm observing facts.

JR: Right, I want to bring this back to something we were talking about earlier, but we kind of moved past it: we were talking about the one in a thousand statistics.

RM: Right, so a recent paper out of Hong Kong, a comprehensive analysis, cardio, myocarditis in boys hospitalized, okay, that makes sense – that's…

JR: Yes.

RM: …that's a word string, so, that's the data analysis, so that's saying the myocarditis was so bad after vaccination – and these are all verified post-vaccination – the myocarditis was so bad that you went to the hospital – incidence rate is 1 in 2700. Now the… there's all kinds of hand waving that, oh, myocarditis is mild and they recover from it, okay? Those statements aren't, let's say gently, based in fact – the historic incidence of death post-myocarditis is about 27%. Now the assertion is, well, this is a different kind of myocarditis and therefore it's not going to kill these kids or young adults. Okay, but that's being said in the absence of data. It's pure speculation.

JR: Right. And why are they doing that? Because they keep saying that the instances of myocarditis are mild. I keep hearing that it's mild myocarditis and that it eventually goes away but not citing any studies. And I don't think there are any long-term studies of children that are vaccinated.

RM: No, there can't be.

JR: There can't be, right?

RM: By definition.

JR: Right, right.

RM: Because we haven't done what we have always done, okay, so let me say, this person asks me, "Robert, you're the inventor of this tech; you're a vaccinologist; why are you speaking out?" This was the whole topic of the *Atlantic* monthly attack article, you know – why has this person become a vaccine skeptic? Did they talk to you extensively and the three days before this thing came out, the journalist who's – it's a fascinating young man; he previously publishes basically on woke issues in the Chronicle of Higher Education. This is his first big article, okay… he was clearly hired, and they explicitly say the article was funded by the Robert Wood Johnson Foundation, the Zuckerberg-Chan Initiative, okay? Robert Wood Johnson is the major shareholder in JNJ and Zuckerberg-Chan of course is Facebook, okay? So Facebook and Zuckerberg-Chan have funded this attack article by this guy that normally writes about wokeness in the Journal of Higher Education and he was totally obsessed over this question: Robert, why are you saying these things? You must have some financial incentive, there must be some reason why you're doing this.

JR: Did you meet with this man in person?

RM: No, just over the phone, okay, and I told him repeatedly: because it's the right thing to do. I get this, you know, this consternation, but see, the thing is, I think I'm maybe the only one that has been involved deeply in the development of this tech that doesn't have a financial stake in it. So for me, the reason is that what's happening is not right. It's destroying my profession, it's destroying the practice of medicine worldwide, it's destroying public health. In medicine, I'm a vaccinologist. I've spent 30 years developing vaccines, a stupid amount of education, learning how to do it and what the rules are, and for me, I'm personally offended by watching my discipline get destroyed for no good reason at all except, apparently, financial incentives – and, I don't know, political ass covering.

JR: Now, back to this number, because we keep going past it and going off on tangents: the number that keeps getting cited is one in a thousand people have adverse events – and including myocarditis…if myocarditis that requires hospitalization, it's one in 2700.

RM: In boys.

JR: In boys. But there's also issues of people that have something like fatigue that has lasted past vaccination… but I mean there's a lot of those – there's a huge number of dysmenorrhea and menorrhagia…

JR: What are those?

RM: This is alterations in menses in women.

JR: Oh, right, there's – that's a huge issue.

RM: There's… and they deny it.

JR: With menses we, menstrual cycles, women going to menopause very young, like, I know a girl who's 36 who got the vaccine hasn't had her period in eight months.

RM: And then there are the women who are post-menopausal that suddenly start bleeding.

JR: Yeah.

RM: So here's the thing about this, Joe, that kind of ties this together. I'm in the business – it's basically the part of what I do is like a detective figuring out because I'm trained in pathology– why is this happening? What are the things that connect these things, okay? So what is it that drives menstruation? The answer is the ovary. The ovary is the controller, okay, through hormones and ovulation, okay? What did we learn early on from the Pfizer data package which, by the way, when that was disclosed by Byron Bridle from Japan and sent to me, was the first thing that really lit me up and let me know that something here was rotten. Okay, and when I got that, I picked out – as Byron had done– I was given the task of independently evaluating it and then I took that package and I gave it to a more senior regulatory professional that I respect and I said, "These are the things I see; this looks really bad." He looked at it and he said, "Oh, you missed this thing, that, the other thing…" Okay, these missing things include reproductive toxicology evaluations of teratogenicity birth defects – standard stuff that's always done. Genotoxicity – not done. What was done was a cobbled-together group of data that didn't even involve the vaccine and used other mRNAs in non-GLP – that's fancy talk for not-done-with-rigor studies, not done according to the rules, all cobbled together and sent in to the regulatory agencies of the world to justify going ahead and giving jabs to everybody under emergency use authorization. That's the truth of it. That's the short version – that's, you know, using common language.

One of the studies they did do was administer these lipid RNA complexes to rodents and showed the distribution of the synthetic lipid component – that's the fats that package the RNA that let it slip into your cells; it's a synthetic chemical, positively-charged molecule, it's a fat with a charge on the end. It goes to the ovary at a very high rate, like 11% of the lipids. Now, this wasn't supposed to happen. It was supposed to stay in the arm where it got jabbed but it doesn't; it goes all over the body. And one, it goes to two places that are really kind of anomalous: bone marrow and ovaries. Now the overarching signal is really clear, because it doesn't happen in testes now, so now, you got a molecule – synthetic molecule– going to an organ, the ovary, that controls menstruation in a non-clinical model – rodent – and subsequently it's deployed widely in humans. And you have this phenomena of alteration in menstrual cycle.

Now one of the things that was fascinating, I was asked to testify to the Hasidic Jew Rabbinical Court in New York; a lot of interesting things happen with that. It's like sitting around with 15 different Gandalfs – one of those bucket list things, I guess. I'm talking to him – it turns

out that the rabbis in the Hasidic Jew community carefully monitor – we don't need to go into how the menstrual cycle of the fertile women in their congregations, closely monitor it, because there is strict guidance about cleanliness and intercourse, and they had a major problem because they – these, you know, these are all 60-plus up to 80, long beards, right here, that had exquisite understanding about the menstrual cycle in all the women in their congregations. And they all knew that these menstrual cycles were being disrupted all the time, and for them, this was a major crisis because it meant that if you're in the Hasidic community, increasing the size of the population of Hasidic Jews is kind of important to you. It's centrally important to them and this was a major threat to reproductive health in their communities. Now, they took all this testimony, they thought about it, and they came out with a clear statement that children should not be vaccinated.

This has the power of law in this community: should not be vaccinated. In adults, it's strongly discouraged, and part of the reason is because of these alterations in reproduction. And again, the point: what's the common variable is the ovary. This is why I say in my little statement that's gone all over the world, this little four-minute clip that's kind of gone viral and triggered governments to attack me now – like Israel and Spain and Italy – in the same systematic pattern of, you know, trying to demean me and delegitimize me – that's why I say in that, think twice about giving these jabs to your kids, among other things. Your girls are born with all the eggs they will ever have and these lipids are going to the ovaries and they appear to be affecting menstruation in some way. But menstruation is just one of these adverse events; you picked out some of the other ones – the fatigue, brain fog, all kinds of things.

JR: …and to be fair, people get that from COVID as well…

RM: True, absolutely true. And that's another fascinating variable is we have Covid, we have, mRNA genetic vaccines and we have DNA virus-administered genetic vaccines – that's the JNJ, here in the United States, adenovirus, okay, and they all have these symptoms of clotting, brain fog and other things, okay? And so, as you know, this is basically: does it walk like a duck and quack like a duck? What is the common variable between those three very different systems – natural viral infection, mRNA genetic vaccines and DNA genetic vaccines? Now, we don't see these problems… by the way, adenoviral vectored vaccines have been in development for my entire life, 30 years, they're licensed adenoviral vector vaccines; they don't have these problems, okay? So it's something that's not intrinsic to the platform. What is it? The common variable is spike, just to cut to the chase.

JR: Spike protein.

RM: Yeah.

JR: And so the spike protein is probably causing all these problems with people who have caught Covid, and also people who are getting the vaccine. But then the lipo- what is it, lipo-nano particles?

RM: That's fine, that's a good term.

JR: How do you say it?

RM: I call them lipoplexes. Lipid nanoparticles is another.

JR: Nanoparticles. So these are the ones that are affecting the ovaries?

RM: No, it's the lipid part of it in particular that goes to the ovaries, not the RNA.

JR: And that aspect of it is not affecting men, but with men you have a higher instance of myocarditis – and why is that?

RM: Good question. What is driving the myocarditis… so, there's a couple, there are a variety of hypotheses about this. What we do know is that both the virus and these vaccines are associated with – here's another fancy medical term: micro coagulation, or micro coagulopathy – the latter one being a disease of micro coagulation – small blood clots. There are multiple ways in which that can happen. It's clear that spike is associated with a variety of mechanisms that cause, that trigger, coagulation, including an autoimmune one. Okay, so there's something about this protein spike is, whether it's in the vaccine or not, it binds to the surface of key cells through a key regulatory protein called ACE2. ACE2 is involved in controlling blood pressure, vessel blood vessel tone, all kinds of stuff. If you activate ACE2 on the little tiny smooth muscle cells that wrap around your capillaries – that control your vascular tone – that's your blood pressure locally, okay? The ability of blood to go through those tubes, okay, that's controlled basically… you've got these little muscle cells, cellular muscles, that control the contraction. It's kind of like peristalsis – if you know what that is. That's the kind of process that can move something down a tube, like in our gut – you know, the way we move food and waste material through our gut and eventually excrete it. That's peristalsis, the thing that brings it down through our esophagus.

Same thing happens with your blood vessels. And when ACE2 fires off, when it gets activated, it causes the contraction, peristalsis, and blocks these micro vessels. And if you get stagnant blood in blood vessels, it clots like that. That's what it does, okay? It's a normal homeostatic mechanism. So there's that. There's the whole cast – so there's the effects on the local tissue and there is direct effects triggering coagulation through a number of pathways.

Now what can cause myocarditis, pericarditis? A number of things: autoimmune processes which we also know are involved in some of the coagulation problems. And this kind of process of clamping down on blood vessels, which we know is happening.

JR: And the autoimmune response – is this also in response to spike protein? Like, what is causing the autoimmune response in people?

RM: It's observed that it is happening and it's happening with these RNA vaccines. It's happening with the adenoviral vectored vaccines. I don't know, I don't recall literature that it's happening with the virus itself, but it may very well be.

JR: I know quite a few people that have had viral outbreaks post [infection] like, things like shingles, herpes outbreaks.

RM: That's another one, okay, so now you're opening the puck, the compartment. Before we were talking about cardiac and blood vessels. And we talked a little bit about the brain. We didn't talk about the strokes. We talked about the brain fog and it's known that spike will open the blood-brain barrier… is this kind of concept, it's a little loose but it has to do with the structure of the cells that line the blood vessels in your brain, and what it allows to go through and doesn't go through. Spike causes that to become more like an open sieve – so things can go into your brain that shouldn't go into your brain. So that can trigger brain inflammation and that is one of the… that is the risk that people like Luc Montagnier are concerned about with neurofibrillary tangles – and that's why they talk about prions or Alzheimer's-like symptoms. That's part of what happens when brain gets inflammation because it's got stuff going on in there that it's not supposed to have.

JR: Hence the brain fog.

RM: The brain fog could be due to microvascular blockade. It could be due to this clamping of blood vessels that I was talking about. It could be due to leaky blood vessels – that's the blood-brain barrier breaching. Hard to say…multifactorial. All we know is that it's happening.

JR: And that's also something that's happening to people with COVID as well.

RM: Correct. I've experienced it myself, okay, when I had…when I wasn't sick… and not only brain fog. You can remember the broadcaster Cuomo, when he had COVID, he was talking about seeing hallucinations. That is a common consequence of primary COVID infection, is not just brain fog, but overt hallucinations.

JR: Now, after the vaccines started to be administered, it was a couple of months later, I believe, that the Salk Institute published their paper on spike proteins.

RM: Right. And I cited that in the Brett Weinstein Dark Horse Podcast and was immediately attacked by Reuters for spreading disinformation, because I was speaking that the spike protein was a toxin. And there's actually…that's one of many papers that have come out since then or before, and I didn't say the spike protein *in the vaccine* – I said the spike protein. And Reuters basically took my words, twisted them, and then attacked me about it.

JR: Is the spike protein in the vaccine different than the spike protein in the virus?

RM: The answer is yes. In a way that matters? [That] is the question. So, the difference is – now, we're going to get into molecular virology; I'm sorry, but you asked the question – so, spike: kind of, you can think of it as having a stem part and a head group you could point to… your time… and then, yeah, right, just these things sticking out here. But I wanted to illustrate that it also has this little – it's like a catcher's glove, that sits on top – that is the receptor binding domain, okay? So it's got these elements that are really important to understand it. And this, this part of the spike protein that is kind of straight and thin, the stock, is responsible for the business part of what spike does. Spike causes fusion between the virus and the cell. It's what enables the virus to infect the cell, and it's a complex set of events and it changes its structure as it goes through those. It's fascinating stuff if you're into this. Okay, you can lock it into the pre-fusion conformation; you can make it so that it will not trigger cell fusion after binding – with two little, tiny mutations, substituting proline in the S2 domain – and that'll make it so that it can never trigger fusion, which is one of the things that it can do to bake toxicity.

That has nothing to do with whether or not it can bind two up here, whether or not that catcher's mitt will grab on to ACE2 – by the way, spike exists as a trimer, like a treble hook, you know, on a fishing lure – so these two mutations are in this S2 domain that's kind of the stem, and it makes it so that it can't fuse. And that's what's in the vaccine.

But the rest of the spike is the natural spike and yes, it does get cut off and it does go in the circulation; that's all been proven. And so what matters about that is, all the things I've been talking about – about spike interacting with ACE2 and turning on ACE2 – that can all still happen. None of that's changed.

Now, one of the attacks that's made against my staying, this is, “Oh, no, they engineered spike so that it's non-toxic.” Okay, that fails two tests. Number one: at the time they did this engineering – I've carefully reviewed the papers, okay, it's all about making it more immunogenic – there is nothing in there about making it less toxic, okay? And by definition, it will make it less toxic as a fusing fusion protein, but it won't do anything about the other parts of spike in its activities. Then there is this fundamental logic flaw, in clinical development and non-clinical development. In safety and pharmacology, I like to say, the French judicial system applies. What that is, is: you're guilty until proven innocent. It's the job of the pharmaceutical companies to prove that their engineered spike is safe. They never did that. And so, all of this pressure that comes back, you know, from folks like me saying, “Hey, this isn't right, okay?” And it looks like a duck and it walks like a duck and it quacks like a duck – it's probably toxic. Because it's the common variable. I get criticized because, “Oh well, you know, well, prove that it's not safe.”

I'm sorry, that's not the way it works. It's pharma's job to prove that it *is* safe, not my job to prove that it's not safe. I'm observing the safety signal is there. It is associated with vectors that

express spike, whether it's the vaccine, the virus or the adenovirus, you know – the mRNA, the virus itself or the adenoviral vectored spike. Those toxicities are there and the common variable is the spike protein. And the comment, "Well, it's not a toxin" – I'm kind of in the Forrest Gump school of toxicity: you know if it causes toxicity, it is…right, it is a toxin by definition. It is, you know, "Toxin is as a toxin does," and, you know, we can argue about the meaning of toxin – just like so much of the rest of our language, has been perverted during this – but the simple explanation, you know, the simple definition is: does it cause toxicity in people? I think the answer is pretty clear now: it does. The question that we're all arguing about is how often and how bad.

JR: This is the question. So why do so many people take the vaccine and have no adverse effect at all?

RM: Great question, and that is a normal situation in any drug. We talk about bell curves – there's a response curve. Humans are genetically complex and they're phenotypically complex. I am not a jiu jitsu champion. I am not the same body mass index as I was when I was 25. It seems that the common factor across many people that get both the vaccine adverse events and the disease – and, by the way, there's a great paper out that tried to dissect long COVID and differentiate it from post-vaccination syndrome, which is what we're talking about – and they did statistical analysis, a large cohort of patients. Basically, they're indistinguishable, long COVID and post-vaccination syndrome, in terms of the spectrum of the syndrome, their incidence, that kind of stuff – they're indistinguishable. They're the same thing. So why? One of the factors that seems to be common is this kind of hyperglycemic-index people that are not necessarily diabetic but they may be pre-diabetic, or they have problems with carbohydrate metabolism, or they're eating too many sugars, or whatever the thing is, so they've got elevated hemoglobin A1C, etc. People that have high glycemic index indices seem to be particularly susceptible to these effects. Now, that is a syndrome associated with an inflammatory state in blood vessels. So, you know, this what you're asking again and again, because you are who you are, is, in plain language, the big, you know, picture issues that are sitting out there that haven't been adequately addressed.

JR: Not only haven't been adequately addressed, but when you do address them, you get demonized, even if you're just asking questions, as far as, like, what are the numbers? What is the data? Where can I see this data?

RM: If you're an academic, you get run out. Now, we've talked… I don't want to avoid, you talked about some of the other adverse events and you started talking about the ones that relate to immune response. And that is the tip of the iceberg that most people are familiar with, is the common...CDC never talks about it…but it's clearly there in the literature, you know, in places – even New England Journal of Medicine – it's clearly there in the VAERS database – is latent virus reactivation, and the most obvious one is shingles. I mean, if you get shingles – I've had shingles. It hurts. You don't miss it when you get it. But Epstein-Barr virus, other herpes viruses,

cytomegalovirus, what are these all in common? They're latent DNA viruses. So, what latent DNA viruses? Well, we have a bunch of DNA viruses that basically hide inside our body and they are kept suppressed. Matter of fact, there's a whole thread in vaccinology – we talk about immunosenescence, the aging of the immune system. Part of that has to do with the thymus and its shrinking – that's what educates T-cells – by the way, that's one of the reasons why children basically shrug this disease off – is they haven't had that thymic involution. But one of the things that happens is your T-cells become increasingly focused on suppressing the DNA viruses that we've all been parasitized by, like cytomegalovirus. And so, you can watch over time the diversity of T-cells in a person's body who's infected by CMV over time: as they get older and older, their T-cells get more and more and more focused on just trying to keep CMV in the box and not let it out, okay? So when we see DNA viruses, you know, Pandora's box is opening and they're jumping out of there, okay? Well, the thing that keeps Pandora's box closed is T-cell responses.

And then we have – you know, I hope someday you get a chance to have Ryan Cole on, pathologist, deep understanding of this…as he points out, he's seeing referrals from oncologists of cancers that are unusual. They're occurring early, they're behaving irregularly, they're behaving very aggressively. Now, right now, this is still anecdotal. I don't want to get the audience all wound up, "We're all going to die of cancer!" No. Dr. Malone is not saying we're all going to die of cancer. But this is another of those little uh-ohs, because the thing that keeps cancer suppressed is T-cells. Then we have the laboratory data that we're seeing: abnormalities in the key signaling molecules that T-cells use to talk to each other – toll-like receptors that are associated in particular with the mRNA vaccines. So something is happening, okay, that is causing release of T-cell suppression, reactivation of latent DNA viruses, maybe some signals relating to oncology, some changes in T-cell signaling behavior.

And then there's this increasing awareness that there's some window of time, not sure how long, after vaccination when you're actually more susceptible to infection. And this may have something to do…so not only is the vaccine efficacy waning, but the multiple-jab strategy is actually creating more and more windows where people have this period of T-cell suppression. So there's a whole lot in this box of immunology and what are the jabs doing to our immune system and how long does it last, that is, let's say gently, a little worrisome to some of us that have a background in these things.

JR: This T-cell suppression – are there any studies on the amount of time that it takes before your system rebalances itself post-jab, and is it a cumulative, like, if you're dealing with three shots or four shots?

RM: That's…this is the, I'm sorry, this is the obscenity for me of this whole, "Well, we're going to give four shots because we don't really know, but we know we need to do something." I like to talk about the metaphor as a father – I don't know if you've had kids; I'm a grandfather,

okay? You give a three-year-old a hammer and everything becomes a nail. Okay, that's kind of a simple way of saying people that aren't well trained, given a powerful technology or tool, will abuse it and overuse it. In this case, there's multiple reasons not to do the multiple jabs. The simplest one for everybody to understand is: when your son develops seasonal allergies to ragweed pollen or whatever, and it's so bad that he can't go to school, his eyes are running, he can't play in sports, whatever… you're like, "Oh, we got to do something about this. I'm going to take him to a rheumatologist, an allergist, and see what they can do." Well, they do a bunch of tests and they say, "Oh, your son is allergic to ragweed pollen" or whatever the thing is, okay? What do they do? Well, they give him shots. What are those shots? They're high doses of antigen that are administered repeatedly to your child, and what it does is induces something that, as immunologists, we call "high zone tolerance." High zone tolerance basically amounts to an ability, by giving multiple injections at high levels of antigen, to shut down T-cells against, in an antigen-specific fashion, so there's that. The other thing with the multiple jabs is that these are multiple jabs that are mismatched, okay? They don't fit.

JR: Can I pause for a second before you continue? So, you're saying that by.. if, like, if someone is allergic to things and they go to an allergist and they start getting shots – those shots shut down T-cell response?

RM: Correct.

JR: So those shots… by doing so and shutting down T-cell response, the idea is that it kicks your immune system in and it's supposed to fight off these things?

RM: No.

JR: Does it make you more vulnerable to other diseases?

RM: Because they're using that antigen, okay, the ragweed pollen, right? It's causing deletion or down-regulation of the T memory population responsible for responding to ragweed pollen. So what it's doing is selectively shutting down the T response against that antigen.

JR: But what about everything else?

RM: No. I won't say it won't affect it, but it, the effect on the overall immune response is negligible, in that this is done clinically routinely. So there's those two things – there's this short term issue: we don't know how long it lasts. There's the high zone tolerance issue, and then there is, with the multiple jabs that are mismatched for the current circulating virus. That's akin to repeatedly taking a flu vaccine from two seasons ago and hoping it's going to protect against this flu.

JR: Well, that's one of the more confusing things about this push for people to get boosted now with Omicron, because they keep saying with Omicron we need to get… but that's a vaccine escape variant isn't it?

RM: Yeah, among other things. Do you want to open that can of Omicron?

JR: Well, I want us …what we know so far is – at least Peter Mccullough said this, and I believe several other people have said this as well – that the immunity that you may have had to the Alpha variant or the Delta variant, it does not seem to work very well against Omicron.

RM: That's true.

JR: Nor does the immunity imparted by vaccines.

RM: By the way, since we were down this little rabbit hole, let me just say one thing: Peter called me – he said, "Robert make sure you talk to Joe and make it clear that although I spoke clearly and forcefully about one and done when I was on his show, that was before Omicron."

JR: Yeah.

RM: And so, Peter wanted me to make sure that your audience knew.

JR: Yes, we've actually talked about that, because I have several friends right now that have tested positive for Covid for a second time and that is post that podcast with him. He was pretty sure that if you got Delta you would never get it again, but I know people that have had – not, I honestly, I don't know anybody who had Delta, which was the last phase – I know people had the original version of Covid who have now gotten Omicron.

RM: In my case, I had the original Wuhan strain and I got infected with Delta and I had the disease for about three days and that's after taking the two jabs.

JR: And then how far after taking the two jabs was it?

RM: About four months.

JR: Four months?

RM: Yeah, four or five months.

JR: So that's still inside the window of efficacy?

RM: Uh, that window of efficacy seems to keep shrinking – that's another thing.

JR: Oh, that is another thing. When you were vaccinated post your infection, how long after your infection were you vaccinated?

RM: Nine months.

JR: But you still had a horrible reaction to it?

RM: Totally.

JR: And then even that – this is pure speculation, the waning efficacy of the vaccine – does that have an effect on your natural immunity that you have?

RM: So you're now opening up the big can of whoop-ass.

JR: Is that the ADE?

RM: ADE. So that's a whole other rabbit hole, and I like to call it vaccine-enhanced infection or disease because ADE is just one subset of that. But there are signs in some data – and we were talking about this just before the broadcast – from Denmark, among other places, of negative efficacy against Omicron as a function of the number of vaccinations up, to three. So negative efficacy/positive efficacy means it protects you – negative efficacy means your probability of being infected is higher if you've taken the vaccine and it's compared to unvaccinated. It seems to be somewhat higher if you've had one jab. Even worse, even more likely to get infected, if you've had two jabs, even more likely to get infected if you had three jabs. Now don't jump straight to ADE because the problem, just to illustrate this confounding variable problem, which is what all the statisticians argue about endlessly, is that there's all kinds of things that can complicate this interpretation. I'm going to give you the simple one: if somebody feels that they're fully vaxxed and they're living, you know, their young person in Denmark or whatever in Europe, okay, they're more likely to go engage in risky behaviors, such as maybe they're gonna go out clubbing, whereas before they may have said, "No, I'm not gonna go out clubbing, you crazy?" Now they feel like they're Superman – they've got a shield, right, and so they engage in more risky behaviors and so there's an example of a confounding variable, one of many. So I want to caution that I'm not saying that this shows that we're having vaccine-enhanced infection; I'm saying that this is a risk which the FDA knew about, explicitly identified, told the vaccine manufacturers they should set up studies to detect whether or not it's happening. But didn't force them to do it. This is another one of the huge FDA fails here – they had the right and responsibility to ensure that we had good data about this and they took a pass. They said vaccine manufacturer, we think you should do this, but you know it's optional and so they never did it. No surprise. That's like first rule of clinical development when you're in big pharma – you never ask a question that you don't want to know the answer to. Unless you're absolutely forced to do it. That's why the FDA is supposed to do its job, but in this case, with enhanced disease a known risk of all prior coronavirus vaccine development efforts including veterinary chronic

complication with those efforts, the reason why I focused on drug repurposing instead of vaccine development at the start of the outbreak, when I got the call from Michael Callahan, I said, "Hmm, past history ADE… this is going to take a long time. We're going to need drugs. Best way we can get drugs is drug repurposing. Yay!" And then I got my team to focus on that. That's why we did that. So, FDA's known that this is a risk. All the vaccinologists know it's a risk. It's in the literature. We've all been kind of watching carefully. I have is, this risk going to manifest.

JR: Can I pause you for a second? When you're saying statistically, it seems that one jab makes you more likely to get Omicron than unvaccinated. Two jabs even more so. Three jobs more. So where is this data coming from?

RM: It's a series of analyses. There's a really active group of biostatisticians worldwide, and are, you know, that are picking apart the primary data that's coming out. There was a paper that was published from the Netherlands, as I recall, that had…or it was a publication from official publication by the government, that had the primary data and then this primary data has been analyzed, re-analyzed, discussed on Sub-stack, blah, blah, blah… torn apart and re-built. Now we put out a Sub-stack statement that summarizes some of this that you can easily find from us. But it's an ongoing debate. But the effect size is now – what the statisticians are arguing about – is, well, whether or not they had the right number for the denominator of total cases. This gets back to my point that the databases are all contaminated, because the incidence of the virus in the population is a function of testing. In other words, you don't look for it, you don't see it, then you assume you're not having it, right? And in the Netherlands, they have one of the best testing systems, so they have rigorously testing everybody for whether or not they're getting the virus. And so those numbers are a little. you know. Sketchy. and that's what everybody's arguing about, is: should we be looking at only the 12 and above cohort, you know. it's all this is. But the effect size is so large that it's… we can argue about these confounding variables until the cows come home, but it's a big effect. It's going to be hard to account for, otherwise it is not in peer-reviewed publications. This kind of stuff is wicked hard to publish these days and it takes months.

JR: So would the assumption be that there's something that's happening to people that are vaccinated where it makes them more susceptible to this particular strain of Covid because this particular strain of Covid, this Omicron, is a vaccine escape variant – meaning that it's sort of tried to find its way around the protection of the vaccine and selected for that?

RM: So now you're trying to impose… what you're doing is generating a hypothesis – which is good, and one of many possible hypotheses, and so in a world, a proper world, where we are allowed to debate these things and do these kinds of studies and examine these kinds of variables without being right in social media, we would have a very active discussion about this hypothesis and many others. Now that's my way of not answering your question.

JR: I understand. Well, is there a mechanism that would point to one of two things – whether it is a decrease in an immune response of a person who's been vaccinated or some opportunity…

RM: So let me throw out, so you just hit… let me go down the rabbit hole of that first comment you made, okay? So what we're doing is, with administering a mismatched vaccine is, we're driving the effector and memory cells, B and T, towards a population that is focused on a virus that no longer exists. So it's not in immune response; you don't get everything and with what I think, you know, you didn't ask me the question, but I'm going to answer it anyhow: What is your hypothesis for the poor durability of the vaccines? My answer is, it looks to me like original antigenic sin. Well, that's kind of a cool terminology; what that means –let's unpack original antigenic sin. I think what could be happening with these data, as you're just following your hypothesis you just shared. consistent with that is that we're driving the immune response towards responding to an antigen receptor binding domain, a spike that no longer exists with Omicron. Now it has become clear – it was initially denied but it's become clear – that all of us have a background immune response against Beta coronaviruses. These are naturally circulating cold coronaviruses that have significant immunologic cross-reactivity with SARS-CoV-2. And the problem with that, in original anagenic sin, is that those existing memory cells will dominate the immune response when you get infected and when you get vaccinated.

Let me unpack that in a way that kind of makes sense for the common person. We all know that in war the homily is, we're always best prepared for the last war. Okay, in your life you're the sum of your prior life experiences, biases, how you respond to – I mean in your martial arts, you must know this right, deeply – what you've experienced in the past, in prior fights, is gonna bias how you respond to a new opponent, okay? Same happens with your immune system. Does that make sense?

JR: Yes.

RM: Okay, super. You now understand original antigenic sin, okay? Because the prior exposure of your immune system to an antigen that is closely related to a new antigen, you know? If you are having martial arts competition with us, a person of a certain ethnic background or physical characteristics or whatever, and they have certain strategies that they use, the next time you encounter somebody that looks like that and seems to move like that, you're going to say, "Oh, they're going to use the same kind of strategies." Your immune system acts the same way with viruses. And it could be that they've got a whole different toolkit and you're busy fighting this war and they come in and, boom – you're dead, right? Same kind of thing, okay? So we've got a new pathogen, but it's got a series of overlaps with the old ones that we've seen before, and our immune system is biased to respond as if it's the old one. Now, to make matters worse, we're taking the spike protein – only one of the proteins, the dominant immunologically dominant protein, and we're jabbing everybody multiple times, and driving memory cells and effector cells that are to a virus that is not the one we're encountering. So it could very well be that as you're taking more jabs, you're further skewing your immune response in a way that's dysfunctional for infection to Omicron, compared to somebody that is immunologically naive –they only have – presumably, they've either recovered from an earlier – because we got to

remember the baseline group, the non-vaccinated group, is actually complicated because it's got those that haven't had the virus before but they've had Beta coronaviruses, and those that have had prior infection and are naturally immune. So you can appreciate that looking at these things kind of gets squirrely. There's a lot of moving parts. But when you see a signal this strong it's saying something's going on, you ought to pay attention to it, in my opinion.

JR: What is the difference between the spike protein that's generated from the injection of the vaccine versus all of the variables that your body encounters when it's been infected by Covid?

RM: That is another brilliant question. I'm not saying this to butter you up, and thank you for asking. That's, it was a very broad question and this is a peel-the-onion layers situation. I mean, you said, what are the differences; so let's start at a high level. When you get infected or I get infected, it's typically nasal or oral pharynx. It's coming in through the mucosal membranes of your head, okay, and by the way, that's one of the other things that's kind of cool about Omicron in a good way, is that the prior strains infect mostly deep lung. And there's really fascinating data from Hong Kong suggesting that Omicron is infecting upper airway more. That is a characteristic of less pathogenic influenza viruses and hopefully, what we know about Omicron is, even though it's more infectious and replicates the higher levels, it's less pathogenic. It's a paradox, well, that could explain it, okay? So there may be some good news in Omicron.

But getting back to your question: when you take the jab, you get a, I don't know how say, a spike of spike; you get a bolus, a peak – fairly rapidly – of this viral protein and it's in your body, and it's circulating in your blood. We know that. There's a Harvard study, Brigham and Women's nurses, spike protein circulation after vaccination.

JR: Can I pause you one second? When you test for Covid you go in through the nose. If someone is getting Omicron, are they less likely to test positive because you're swabbing their nose?

RM: More. All of these are initially coming in here.

JR: So it still would exist in the nose, even though it's affecting the back of the throat.

RM: It seems to be, well, it's clearly producing equal or higher levels. Delta was significantly higher in the nose by PCR, with all of the caveats about the problems with that cycle number, and Omicron seems to be even higher, significantly higher. Okay, so hits your nose and then it goes down, okay?

JR: Okay, and it's affecting the throat for some reason. A lot of the people that I know that got Omicron had a throat ache, a throat… a soreness of the throat before.

RM: That is, paradoxically, really good news by the way – it's called primary data, anecdotal primary data – but it beats modeling data from the CDC, which is what the *New York Times* has

been reporting that we're all have by this point – we're all supposed to have, 70 or 80 percent of all the virus in the United States is supposed to be Omicron. That is based on what is now known to be erroneous modeling, and all of us that were inside when we saw this come out, we knew the group in the UK that did the modeling, and we were like, "Oh, these guys have over-promised – they have basically put out scare modeling all the way through this outbreak and we should take this with a grain of salt. And now the press is all backpedaling, and the CDC is backpedaling, saying "Oh. I think we got it wrong, and there's still a lot of Delta in the population." But, you know, your buddies… if it's circulating here in Austin and you're hearing people that are having more of the sore throat and runny nose and less of the, my chest is burning and I've lost taste and smell, just to kind of open that up a little with H1N1 influenza… just to take one example, we have high-pathogenicity and low-pathogenicity versions of H1N1. What that means is some of them will kill you and some of them won't, more or less. The difference seems to be, the virus – the receptor, the nuances of the receptor that the virus is hitting and using to initially infect cells – and the low-pathogenicity H1N1s infect the upper airway and the high-pathogenicity H1N1 is infecting deep lung. The prior SARS-CoV-1 have been hit in deep lung, so this report that you're giving me from your buddies that you think is probably Omicron is consistent with the Hong Kong data and it all fits into a box. And we know from South Africa for sure that Omicron and –where, you know, the WHO made the statement, "There are no known deaths associated with Omicron in the world" – now, there may be a couple somewhere.

JR: I thought it was just the United States. I didn't know they were saying, "for the world." Yeah, because there was a…we just read something that said there were several that were associated.

RM: Now, there's, as I said, over time, there will be deaths associated. Remember we talked about the difference between causal and association?

JR: Yeah, okay, and also the fact that 95% of the people who have died from COVID had an average of four comorbidities.

RM: You're on it, and now it's been documented, at least two cases when they were reported deaths from Omicron and people actually went back, they got picked up in the legacy media and circulated as, "Oh my God, it's going to kill us again." More fear porn. Then people went, again, like they did with the ivermectin story, remember about the hospital – it was all full of ivermectin toxicity? And then someone bothered to call the hospital – same story, "Sorry, nope, those weren't Omicron deaths." Just something that got reported and amplified in the legacy media. So regardless, the mortality of Omicron is remarkably low. I think we can all agree on that.

JR: It's essentially like a cold.

RM: That's the list of symptoms from Omicron published in *Nature,* I think recently, are pretty much 100 percent overlap with common cold.

JR: And there are coronaviruses that are common colds?

RM: That's the Beta coronaviruses that I was talking about when I was talking about original antigenic sin.

JR: So if you test positive for the common cold, do you test positive for a coronavirus? Like, if you take a Covid test…

RM: The common cold is a generally…

JR: That's not common?

RM: No, it's a grab bag of stuff, right? Okay, it's rhinoviruses, it's coronaviruses, it's influenza, you know, it's a lot of things. There's a lot of respiratory viruses that are floating around. But getting back on track with Omicron, it is absolutely looking like Omicron is a mild variant. It is absolutely able to escape prior vaccination, the control of prior vaccination, typically with mismatched vaccine. It seems to be also able to infect a subset of people that are naturally immune – probably less than the subset that get infected with vaccination. But – and this is a kind of a key message to your audience – the reproductive coefficient – that's more fancy language – the reproductive coefficient… but many of your audience is going to know that that's the "R-naught." The R-naught of the original Wuhan strain was about two to three: that means that if I'm infected, on average, without any other interventions, I'll infect two to three other people, okay? And for Delta, the R-naught was more in the range of five to six. If I'm infected, no vaccination, no social distancing, no masking, blah, blah, blah, the average rate of transmission would be, I would infect five or six people. In the case of Omicron, the – naught, the base reproduction coefficient, is the range of seven to ten, okay, that is wicked high. That is measles territory. What that means, I'm going to translate that into simple language – we are all going to get infected. Whether you use masks or not, use social distancing or not, unless you're going to go live on your trail and not talk to anybody when you pass them, you're going to get infected. So this gets to the key point, you know: find a doc that'll administer early treatments – and you know what they are – and you just had the expert on – Peter McCollough.

JR: It's incredibly difficult to get the stuff now, that's what's incredible.

RM: And then, as if that isn't bad enough, we've got the Federal government monkeying around with availability of the monoclonal antibodies.

JR: That was the next thing I was going to ask you about: why would they do that when – what is the percentage of Delta versus Omicron out there, and how do we know?

RM: So here, that's… I just alluded to that a minute ago, and this is another fascinating story and it's kind of being covered up. It's starting to be covered by the press, but they're not going back to the cause. Okay, remember I said that there was a group in the UK Imperial College,

didn't give the specifics before? There's a group in the UK that does modeling and they came out with some modeling projections that basically the entire UK hospital system was going to be inundated with Omicron shortly – basically Christmas time. And a lot of us looked at that and went, "Yeah, those are the same guys that have predicted that we're going to have, you know, millions and millions and millions of dead and they're going to be bodies stacked up and, you know, coolers in the UK." It sure looks like they may have overshot again. The CDC seems to have taken those modeling projections and those models and they put out – you remember in mid-December, right before Christmas," Merry Christmas. Oh, you're all going to get infected by Covid and it's going to sweep through and we're going to have 80 percent of Covid by this time of this month?"

JR: Well, how about that ridiculous press release from the White House that said we're the winter of the unvaccinated death, you're gonna experience a winter of death and overwhelming hospitalizations.

RM: All I can say is that the political genius behind that should be taken out in the behind the woodshed and given a good whooping, because that was just horrible political messaging.

JR: Horrible, and in the terms of Omicron, so inaccurate.

RM: Yeah, but it doesn't matter, and that's the core thing of this chronic angst of what the heck is going on. This doesn't make any sense at all, you know? I don't want to get too off your topic, but our government is out of control on this, and they are lawless. They completely disregard bioethics. They completely disregard the Federal common rule. They have broken all the rules that I know of that I've been trained on for years and years and years.

These mandates of an experimental vaccine are explicitly illegal. They are explicitly inconsistent with the Nuremberg Code. They're explicitly inconsistent with the Belmont Report. They are flat out illegal and they don't care. And the only thing standing between us and – it's too late for many of our colleagues, including my, you know, the unfortunate colleagues in the DoD. Hopefully, we're going to be able to stop them before they take our kids.

JR: What's wrong with the DoD?

RM: The mandated vaccines for everyone in the DoD. So, you know what's going on in the White House is a whole another hour's talk.

JR: Yeah, I'm sure it is. Back to Omicron and Delta: how do we know? When I was tested – and I came out positive for COVID – I have no idea what I got, I assume it was Delta, because that's what I'd heard was going around; but when they release these numbers, where are they getting that data from?

RM: So in terms of this specific one, I'm sorry I got off track, so, I was talking about Imperial College modeling. Then the CDC seemed to pick up on that, yeah, and the last data they had – it's actually Peter that sent me the data – we did a podcast about it, so he sent me the modeling data, and he sent me the documentation that the modeling data that the CDC was putting out in the New York Times. And the press and all amplified, you know, when we all said, "Oh, we're going to have 70 or 80 percent Omicron in the population by this time of this year," the only actual data they had was up to about December 4th as I recall, and it showed only a tiny fraction of Omicron in the population. But then they applied their mathematical models that they apparently got from Imperial College and they said, "Oh, the curve is going to look like this, and therefore that's where we're going to be at this point in time, and therefore we're going to have 70 percent infection." And the press all picked it up and they just assumed that that was based on real data, not modeled data, okay? What I'm hearing from docs in the field again and again – and you know I had a bunch of people call me before I came on your show – everybody was like, "Robert, say this to Joe," but you know you're so important that everybody wants to get their angle in. But what I'm hearing in the field is that Delta is still dominant and these are hospitalists and people treating disease, and so they're seeing a skewed population – but it's important to remember that when the CDC says those kinds of numbers, they're talking about incidents – that is the moment you know how many have actually been infected at that slice of time. But what you see in the hospitals – and this is something that press misses all the time – so you're hearing all this fear porn about how the hospitals have filled up in New York City and blah, blah, blah, blah, okay? Omicron causes a short-term limited illness. Delta is wicked bad and it puts you in the hospital. When it puts you in the hospital you can be there for a month to two months, okay? What you're seeing in hospitalized cases right now appears to be dominantly Delta, because the CDC overestimated the fraction of the population – that was, they overestimated how aggressively Omicron was going to move into the U.S. population. Maybe that means our social distancing and masks are working, I don't know; but it's not moving in as fast as they had been projecting, and the bulk of the disease that the docs that I'm talking to are seeing in hospitals appears to be Delta.

JR: Wouldn't that be because the people that are catching Delta are the ones that need to be hospitalized versus the people that are catching Omicron?

RM: Precisely. But here's the rub – and you… I'm looping back now to your antibody point, okay, is the geniuses in our public health system said, "Oh, no, Omicron – based on this modeling data – is going to be moving into the population, it's going to dominate things, we need to pull the monoclonals that are Delta-specific and only administer, only allow people to use, the monoclonals that are Omicron-specific, because it's going to drive further evolution otherwise. I guess that's their logic.

JR: But I haven't heard that logic at all. All I've heard is that the monoclonal antibodies are ineffective against Omicron.

RM: You're saying the same thing.

JR: But I've never seen any data that the monoclonal antibodies.

RM: There are data.

JR: Where is that?

RM: It's in peer-reviewed literature now.

JR: That it's ineffective against Omicron?

RM: I wouldn't say ineffective – less effective, based on laboratory neutralization assays.

JR: So in vitro?

RM: Correct. So, you know Joe Lapado, surgeon general in the State of Florida, has put out public statements now on, I think it's Twitter, among other things, decrying what the Federal government has done of pulling all of the regular monoclonals. What I'm hearing from frontline docs is those, you know, older Regeneron monoclonals etc. are still very effective in their hospitalized population, presumably because it's still predominantly Delta. And yet they're no longer able to get it.

JR: So the government has literally stopped the distribution of medicine, effective medicine, for a disease that exists currently. When has that ever happened before?

RM: Hydroxychloroquine and ivermectin.

JR: Yeah, but on this level? Where, like, hydroxychloroquine and ivermectin were off-label uses, this is something that has emergency use authorization. This is wild.

RM: It is. Are they brain dead?

JR: Are they trying to, just, are they encouraging vaccination? Is that what all this is a money grab? Okay, what is that?

RM: So here's another version – I mean, there's that when you see this kind of decoupling of a public policy from logic, then it causes thinking people like yourself to say, “What the hell's going on here?” and then we go down the rabbit hole… is it this, that or the other thing? One of the things in that spectrum of what's going on is that the emergency use authorizations are predicated on policy determinations that were in a state of emergency. Those are now two years old. They're expiring. I'm not saying this is what's going on in their head, but there is another perverse incentive here to amplify the fear porn and to amplify – if you buy into the hypothesis that for some reason there are incentives for the government to maintain the state of emergency –

that is one explanation given that those declarations are expiring and will have to be re-implemented. Because if they're not, then all of this emergency use authorization vanishes like dust.

JR: So are you saying, are you implying, that perhaps one of the reasons why they're removing monoclonal antibodies is to enhance the amount of people that are sick?

RM: I'm saying it is in the spectrum of the range of possible, just the same as the withholding of early treatments is inexplicable.

JR: And this is inexplicable in that we know that they're very effective. I have personal evidence that they're very effective. They worked great on me. The fact that they're removing this and that you would even consider that the reason why they're doing it is to extend the emergency use authorization is insane. That's terrifying.

RM: It's hard for me to reconcile the behavior of the government and its public health decisions with the data. And it's like there's two bins: is it incompetence or malfeasance? Is there some ulterior political motive or are they just dumb stupid?

JR: If there's some political motive, if that's written anywhere, someone's going to jail. I mean, if that comes out – if that somehow another gets leaked – (...), that's scary.

RM: I wish it was so.

JR: I wish it was so too. I'm saying that and I might be completely wrong, I may be totally naive.

RM: But the lab leak. You know the… for me, the disclosure of emails that Cliff Lane, Tony Fauci, and Francis Collins actively conspired to destroy any discussion of the appropriateness of lockdown strategies – and in the mainstream press hardly covers it and there are no consequences. The document trail having to do with the gain of function research and the implication of NIH and – by the way, DTRA, in that, having absolutely no consequences for anybody, we're in an environment in which truth and consequences are fungible. This is modern media management and warfare. The truth is what those that are managing the Trusted News Initiative say it is.

JR: That is wild and for me personally, it's so confusing that I find myself in a situation where I feel compelled to have people like you on, because I don't know where else this is gonna get out.

RM: So thank you, on behalf of, you know, in my case, I'm the president of the International Alliance of Physicians and Scientists – we're over 16,000 people from all over the world, physicians and scientists, and you can find our website at www.globalcovidsummit.org. We are

gobsmacked about what's going on and we are shut down, censored, demeaned – fill in the blank – all over the world.

JR: And over a period of two years, the world's completely changed in that regard.

RM: And they're taking our licenses and license to practice medicine because we are speaking about these matters, and you can label me however you want to label me, I don't care, I've done what I've done in my career – I'm at a stage at 62 years old, I've got a farm, it's almost paid off, I raise horses, I love my wife, you know, I've been married a long time, my kids are both married, I got grandkids, you know, I don't need this. There's this claim I'm doing all this because I seek attention – trust me, this is not a fun thing to be doing at this stage.

Physicians at FLCCC in senior positions highly, like Peter McCullough, people at the culmination of exceptional careers. Paul Merrick, an exceptional physician by any standards – run out of his hospital, demeaned, destroyed, actively attacked, trying to take his license. This medicine is being destroyed globally. People are losing faith in the whole system. They're losing faith in the scientific enterprise. They're losing faith in our government. They're losing faith in the vaccine enterprise. I mean, what is going to be the long-term consequences of public health when you have a large fraction of the population who wasn't "anti-vaxxer," that pejorative, before? They're now saying, "Oh my God, if this is how these people make decisions, I don't want anything to do with it. I certainly don't want it jabbed into my kid."

JR: Well, that's one of the more disturbing things. The opposite of that, is one of the more disturbing things about this pandemic, is how people have just decided – because they're scared and because they want a solution – that the pharmaceutical companies have their best interests at heart and that they're not these machines that are designed to make money. And they sell drugs and the drugs are often beneficial, but their main goal is to make money and if they can fudge the data, if they can move the numbers around, if they can delete negative consequences…

RM: Pfizer is one of the most criminal pharmaceutical organizations in the world, based on their past legal history and fines. What do those fines include? Bribing physicians. Okay, it is a cost benefit analysis in the pharmaceutical industry about misbehavior. They are not grounded in the ethical principles that you and I as average people believe in. They don't live in that world. As you appropriately point out, they are about profit/return on investment. And furthermore, the overlords that own them – BlackRock, Vanguard, State Street etc. – these large massive funds that are completely decoupled from nation states – have no moral core, they have no moral purpose.

Their only purpose is return on investment. And that is the core problem here. That and the fact that we as a society have become grossly fragmented through social media, electronic appliances, the stress of what we've experienced, and this leads into this whole issue of mass formation psychosis that Matthias Desmond at the university of Ghent has promoted. That for

many of us, when Matthias, a, you know, psychologist and statistician – interesting combination – made public… a lot of us, as we listened to Matthias, we said, "Oh that makes sense" – that that was like the brain – that's what happened when I encountered the Trusted News Initiative: I said, "Oh." I don't know if you saw the Brett Weinstein podcast with me and Steve Kirsch where that lit this whole fire all over the world. Brett ends with the, basically, the question – if you listen to the long version of what's, how does this happen? How do we have this emergent phenomena?...the "how" question, right? And, you know, behind the "how" question is the "why" question…that the "how" question of a third of the population basically being hypnotized and totally wrapped up in whatever Tony Fauci in the mainstream media feeds them – whatever CNN tells them is true.

Let me illustrate that: the other day, I was looking through *New York Time's* recent articles about Omicron and pediatrics in preparation for this and for making some slideshows, and I saw this headline in the *New York Times* – an epidemiologist and a vaccinologist – and the title was "How You Should Think About Children and Omicron." It was blatantly saying, this is how you should think – we're going to tell you how to think, okay? People kind of got to get that in their head. That's the world we're in right now. Now what Matthias Desmond has shared with us – brilliant insight – is another one of those, "Aha, now that part makes sense," which is that this comes from, basically, European intellectual inquiry into what the heck happened in Germany in the 20s and 30s, you know? Very intelligent, highly educated population, and they went barking mad. And how did that happen? The answer is mass formation psychosis. When you have a society that has become decoupled from each other, and has free-floating anxiety in the sense that things don't make sense, we can't understand it, and then their attention gets focused by a leader or series of events on one small point… just like hypnosis, they literally become hypnotized, and can be led anywhere. And one of the aspects of that phenomenon is the people that they identify as their leaders – the ones typically that come in and say, "You have this pain and I can solve it for you: I and I alone, okay, can fix this problem for you," then they will follow that person through Hell. It doesn't matter whether they lie to them or whatever; the data are irrelevant. And furthermore, anybody who questions that narrative is to be immediately attacked; they are the "other." This is central to mass formation psychosis and this is what has happened – we had all those conditions. You remember back before 2019 everybody was complaining the world doesn't make sense, blah, blah, blah…and we're all isolated from each other, we're all on our little tools, we're not connected socially anymore except through social media. And then this thing happened and everybody focused on it. That is how mass formation psychosis happens and that is what's happened here.

Now, there's ways to get out of it. Matthias's recommendation is, you got to get people to realize that what we've got is a situation of global totalitarianism. In his experience in Europe, making people realize there's a bigger threat than the virus can cause a separation, psychologically, in this fusion, this hypnosis that has happened. The problem is, then you're just substituting a bigger boogeyman for the current one, and somebody else can come in and

manipulate *that*. The real problem – and it gets back to your core point – we're sick as a society and we have to heal ourselves. And one of the things we have to do is come together; we have to recreate our social bonds, we have to buy into integrity, the importance of human dignity, and the importance of community. That's how we get out of this and I think that this insight of Matthias Desmond is really central to kind of making sense of all of this crazy. We got a world in which the press is incentivized to push a storyline because they're all controlled by the same large funds that Pfizer is, and so is tech. I don't know how we're going to get out of it, but it's got to start with us – all of us – finding common ground.

JR: I think one way we're going to get out of it is by realizing what it is, and, by the way, you just explained it, and the way Peter Mccullough explained it – and he was on the podcast as well – this mass formation psychosis that we're currently experiencing, most people are unaware of this even happening. All these events take place and it's this perfect storm of the social media aspect of it, the fact that we are disconnected, the Covid the separation, the isolation from society, the lockdowns…also coming off of the four years of Trump, where we're so polarized politically– and this, it's become very, not just common but accepted, to other people to point at those the others, whether it's the Republicans or the Democrats or the independents, whatever you choose – or the unvaccinated; that was I was going to get to, yeah. And that's one of the things that I find very bizarre about the tribal aspect of this, is that people want me to get vaccinated and, like, my friends who've been vaccinated want me to join the team – like, "Go ahead get the tattoo!" – like, what are you saying? And I'm, like, I've gone through the virus; I have immunity. I also have antibodies; I just checked them last week. Like, I could show you the test…a matter of fact, I have it right here. There it is.

RM: And I had to be tested when I came in the front door at your shop here.

JR: Yeah, we test everybody. But the point being is, it doesn't make any sense for me to get vaccinated; but they want me to join.

RM: It's worse than that: it puts you at higher risk, okay – they're asking you to take more risk for your health in order to join their club.

JR: That's what it is, that's what it is… and it's a tribal formation and it's people who don't have personal sovereignty and people who aren't confident with standing by their own thoughts and objectively analyzing things outside of an ideology, outside of the tribe. Those people are very susceptible right now and those are more common than not.

RM: So, Joe – again, this is not me buttering you up, but this is why you're providing such a service to your country and humanity, because you're one of the few voices that has an audience that is not Democrat or Republican, or black or white, or vaccinated or unvaccinated – all these dipoles that we create artificially – and you are trying to speak to that persuadable middle and do so with an open heart and an open mind, and in a world in which all of the information is being

so carefully manipulated and so pervasively distorted. And I'm grateful, sincerely. My colleagues are grateful, and I think the world should be grateful for your leadership.

JR: Well, I'm very grateful that there's courageous people like yourself that do put your reputations and your careers on the line by speaking out against the stuff when it is very difficult, and when you do get deplatformed for doing that, they know that by censoring you they're not just censoring you – they're also making others like you self-censor.

RM: Absolutely. I've been self-censoring for months. I mean, every morning when we post on Twitter, my wife and I have this active dialogue: "Um, can we post this? You know, how do we say this so we're not going to get de-platformed, blah, blah, blah, blah, blah…" We're constantly self-censoring.

JR: And it's crazy, because you're self-censoring about your area of expertise, which is insane. Because the people who are censoring you don't have any education in it.

RM: Yes, I agree it's insane. It's the world we're in.

JR: I'm just hoping that that clip where you explained this mass formation psychosis makes the rounds and I think everything you laid out today is about as clear and as rational and as well documented as I could have hoped and more. So thank you very much for being here, thank you very much for everything that you've done, and, Jesus Christ – Twitter, put the (...) guy back on.

RM: It's… okay, you know, so you do martial arts and so you get the idea of using your opponent's energy against him, okay? I was immediately contacted by multiple lawyers. This could be an excellent examplar case.

JR: I think it is between you and Alex Berenson…

RM: Who's already filed one. I've been through the legal grind; I don't want to sue anybody, Frankly, but it just sucks the blood out of you, not to mention your financial resources. I mean, it's just an ugly process. I hate it, but there's two hills that are willing, I'm willing, to die on: one is stopping the jabs and the children, and one is, you know, resisting the erosion of free speech. Which is the fundamental principle on which our democracy, our society, civilized Western culture, is built on. I like to say when I give rallies, "Do you remember back a couple of years ago when you felt sorry for the people in the People's Republic of China because their internet was filtered, they weren't allowed free speech, their government told them what to do and think? Okay, now here we are. And the next thing that we all feel sorry about – social credit system, okay? Wake up folks."

JR: Wake up; it's coming. If we give in to this, we give in to vaccine passports, and having an app on your phone that shows everything you're doing in terms of your medical history – and they've even offered people extra credit; there was an article on Yahoo about having access to

your browser history, and they framed it in this very positive way, that having access to your browsing history may allow you to receive extra credit, so you would be available… you'd have credit available to buy a home or a car.

RM: So, bingo! Okay, we already know what social credit systems feel like; we call it our credit rating agencies, okay, and you know what those guys do. It doesn't matter whether or not… if it's on your record, doesn't matter whether or not you did it or what the extenuating circumstances were. It's in their algorithm and you will get your score and your score basically will determine the tax on your access to credit in the form of the interest that you pay on the money that they have been given by the Federal government. That's the way this ecosystem works – they get that money at a huge discount, and then they decide how worthy you are to receive it if you want to have credit. And so, if you want to understand a little tiny version of the social credit system, it's right there in your credit score.

JR: I think the only thing that helps us here is that this may be the one subject where everyone loses. People on the left, people on the right, people in the center – everyone loses if they impart a social credit system, if there is some sort of social credit app that you have to carry around on your phone that determines where you're allowed to go, what you're allowed to do… we're all going to lose.

RM: No, I disagree: the oligarchs win.

JR: A very small percentage of the population wins, yes, right. But I mean, the general public, the people that are divided about Covid, the people that are now "othering" each other and, you know, you losers who got the jab and, look at you unvaccinated plague rats – this nonsense that's going on, maybe this would be the one thing that unites us because we'll realize that this is tyranny.

RM: Or if it won't, welcome to the new boss, you know? Welcome to the new overlords, guys, and it's your choice. I'm gonna be dead, you know – I'm 62.

JR: You look good.

RM: Thanks, you're kind.

JR: You got some years in you, bro, settle in.

RM: It's our children.

JR: Yeah, it is our children, it's our, you know, I mean they're challenged uniquely already because they're growing up with social media, they're growing up with Tik-Tok and these invasive apps that are tracking all their movement and everything they do and buy and see and what they look up. And they cross-platform, they share this data across platform; it's very

sketchy stuff, and that the fact that it's happened and it happened so quickly and that our data, which seemed to be nothing, became one of the most valuable commodities in the world. And then that data is used to manipulate all the people on the planet.

RM: So we're touching on some deep stuff about the kids, and forgive me for an unabashed promotion for the Unity Project which I serve as chief medical and regulatory officer for, so that's unityprojectonline.com. We're totally focused on the kids, and if you go on that site, you'll see a podcast that I did with a pediatric psychiatrist out of LA and a pediatric cardiologist who's also a Ph.D. in vascular inflammation, Kurt Millham, and I got those two guys on to talk about what's happening to our children – in particular, the psychological damage of these lockdowns, this mask use, the school policies, the bullying of children who are unvaccinated; the psychological damage is huge. We're having a worldwide epidemic of suicide in children. We are having a huge surge of drug abuse in adolescents. We're having demonstrable drops in IQ and fundamental developmental milestones in the very young, like 20 IQ points, okay? Children have to see faces to learn how to speak and to interact socially. You're talking about social intelligence, which you're deep in, and connectedness. We're raising a generation of children that have been blocked from their ability – because their brains are developing extremely rapidly at this age – the ability for their brains to assimilate the information necessary for them to become functional citizens and parents. We're destroying it without a second thought, and the damage is going to last for generations.

And as if that's not bad enough, we're allowing the state to insert itself into the family and make decisions by mandating vaccination. This is why these childhood vaccines mandates are obscene. We're setting up a situation in which children are going to see peers who have been vaccine damaged as a consequence of the policies that their teachers and their government have forced on them. The damage here is going to be with us for generations. I'm not being Chicken Little here – this is deep, profound stuff… it's way beyond myocarditis and no one seems to care, no one talks to children. There was a big breakthrough we all celebrated a week ago: Face the Nation, on the annual roundup of stories that have been under-reported – one of the speakers got up, a journalist, and said to the other group, I think, "One of the most underreported stories has been the damage that's happened to our children."

JR: I saw that, yeah.

RM: And did you see what happened with other journalists? Nobody said a word. They moved on. It was hardly covered in the media.

JR: Well, she even glossed over the damage by the vaccines.

RM: Agreed. How could she speak about the vaccines? I suspect she may lose her job. She's not going to be invited back on that program again. I mean, how could she speak about the damage of the vaccines?

JR: She really just briefly touched on it.

RM: Yeah, so, the point…

JR: Is because it's dangerous…

RM: …insanely dangerous to speak truth to power right now.

JR: Before we wrap this up, why is the vaccine uniquely dangerous to children?

RM: Good question. I'm not complete… so, the data – here's the problem with the myocarditis bias in children: in the data set, particularly boys, okay, one of the things there is clearly an androgen component to the risk of both the vaccine and the disease of the virus. And that's why anti-androgens – by the way, Pierre Kory, shout out to him for a champion of anti-androgens being added to his math plus protocol – okay, particularly for men...so why are boys…? There's probably a component of that that has to do with an artifact in the data, that being that when us old codgers, in general as a population, have a much higher risk of cardiac events and so if there's a heart attack in one of us, it's really hard to say: is it just because we're old, or is it vaccine-related, okay? So then, the vaccine: if there are vaccine-related events buried in that, we're not going to see them statistically; it's really hard to pull it out. Whereas, kids don't have heart attacks and they don't have strokes, so you can see those things really clearly against the background of virtually nothing. So that's it – may be partially an artifact of reporting and bias, because of confounding variables, and it may be their other effects.

In terms of your over…broader question, moving outside the myocarditis, why are children more susceptible to these adverse events? I think they're not. I think the problem is that we're seeing it in the kids but it's present in the adult population also. I think there is a significant reporting bias going on against reporting adult vaccine injury. I think that we have more in… and why would I say that? Oh, because I'm a vaccine denier, I'm a bad guy, and I have some perverse incentive to have that media hit me. Um, no. We have these reports from hospitalists and nurses, the ones that…often it's the nurses that are able to speak; for some reason the nurses are disclosing things that they're seeing in their hospitals and the physicians are all shutting up. Is it because they have financial incentives or because they're all owned? Because they have such debt burdens? I don't know. But the nurses are speaking out and they're saying, “Hey, we're seeing strokes and heart attacks” and these other types of problems that are known to be associated with the jabs. Well, it's hard to say, because we got the virus and the vaccines overlapping, you know? Is it chicken or egg? We know that they're happening. We know that the deaths are happening. That's like the excuses that are made about the sudden deaths in high-performing athletes that are being observed all over the world, particularly in footballers – that where they're just suddenly dropping. Is it because they've been infected or they – because they've been jabbed? And I think it's a mixture of both. But if it's from the vaccines, the thing about the vaccines is, that's in… you know, we have this principle – we used to – of “Do no

harm." And if a virus naturally infects you and you have a damage from it, I haven't caused that damage as a physician. If I'm recommending that you take a drug, an intervention they didn't need to have – you may or may not have gotten infected – and it causes damage, well, I gotta kind of own that as a physician, as a representative of the medical industrial complex and a participant in it. And so, for whatever reason, there's an underreporting bias, clearly, in the adult population. And I think that people being… be a little more sensitive to adverse events and deaths in their children.

JR: Robert, thank you for everything. I really appreciate you, appreciate you being here. If people want to read more of your work, now that you've been banned from Twitter, where are you? Are you still on LinkedIn?

RM: I'm still on LinkedIn. I'm really cautious on Linkedin. I'm on Gettr, and I'm on Substack – so that's RW Malone MD.

JR: Substack's probably the best place though, right?

RM: The problem with Substack – yeah, it is least censored, and I would love more Substack Subscriptions – but I have a financial conflict of interest there, so I don't want to pump it but that is…I try to use Substack for more in-depth intellectual pieces, thought pieces – not just, I mean Alex, bless his heart, he blasts everything out as if Substack is Twitter. That's not my style, right, so I'm going to be using Gettr for that thread.

JR: Gettr – what is that?

RM: That's a Twitter alternative.

JR: Oh, never heard about Gettr. Been waiting for one though.

RM: I'm using Gettr and, again: @rwmalonemd

JR: Is it spelled like g-e-t-t-e-r?

RM: G-e-t-t-r

JR: Do you want it, Jamie? No? G-e-t-t-r.

RM: Yeah, so Gettr is branded as the "Twitter killer"; it is explicitly a Twitter alternative.

JR: Is it all right-wing, crazy people?

RM: No, it's a lot of people that have been…

JR: It's a lot of people that have been kicked off of Twitter.

RM: You know, they are committed to not censoring.

JR: Beautiful! Well, I support that entirely. I mean, I just did… there's a problem with some of these that they do get infected by people that were shit-posters – you know what shit-posters are?

RM: I mean, I've been on social media a long, long time… I'm sure I used to be on Yahoo stock chat boards – that's kind of where I cut my teeth.

JR: Well, Robert, thank you very much, just, thank you for everything, and I hope this helps.

RM: Thank you, thank you, so, seriously, thank you for your service to your nation and to the world, Mr. Rogan.

JR: My pleasure. Thank you, thanks for everything. Bye, everybody.