Speaker 1 (00:00):

Well, so let, let's pause there for a second, cuz I want, I want to, there's a couple of questions that come up based on, on what you were just describing. Uh, one of the questions that's gonna come up is, you know, and, and your, the second question kind of nullifies, but assuming the vaccine, the original vaccine has efficacy, um, for the variant of the coronavirus. Uh, so assuming it, it had some efficacy, you know, in somebody's mind or model the idea of the pressure that's being put on the virus that's causing it, you know, causing these other variants to be emerge would, uh, I think they're trying to assert well that original vaccine is still effecti against these variants. Is that false?

Speaker 2 (00:43):

Um, yeah, if you actually look at the data, how these variants, uh, are associated with resistance to the vaccines, and they're showing again that the more these variations occur in the spike, the less they are responsive to the vaccines. And Pfizer has already said, look, we know this is gonna, the CEO said that this is okay because we've changed things advisors. So that within 91 days, if we have something that the vaccines aren't working for, we can make a new vaccine,

Speaker 1 (01:12):

But wouldn't, I have to go through a process of approval. Again, if it's a new vaccine, as compared to saying, we're just gonna keep

Speaker 2 (01:17):

Giving it well under the current rules and, uh, the current mechanism, it, yeah, I would argue there wasn't much of a, a review by the FDA to begin with. So I don't know. Well, even

Speaker 1 (01:27):

Pretend, but I mean, even pretend they can't just distribute it. I mean, they still have this.

Speaker 2 (01:30):

Well, you know, the interesting thing is that they've got everybody in this sense, uh, of fear mode so that they can pretty much all get done what they want to whenever they want to. And then the, the for Magna, I, I couldn't believe it when I heard the lady talk about this, the director of their vaccines for Madurah actually when, during the panel where they were talking about the boosters mm-hmm <affirmative> actually said that T-cells were not important for immunity. Oh my gosh. Yeah. And so I, I thought you, you're the director of vaccines for modern and you don't think T-cells are okay, so you, I don't know how you got that job.

Speaker 1 (02:16):

You shouldn't, you shouldn't have that job, but so let me, so is this a, a correct perspective? Basically the vaccine program has created this sort of evolutionary pressure on the virus, which is causing all these other variants and the other variants seem to be a whole lot more threatening than the original virus. And when they start to talk about a booster, they're literally doubling down on, on the thing that's creating the problem in the first

Speaker 2 (02:40):

Place. Exactly. And then there's all the questions about what's really you in the drug vaccines that they have, because if you do the analysis of the actual vaccines themselves, it turns out that they are not identical to the genetic code for the spike protein of hu one they're

Speaker 1 (02:58):

Different. Wow. All right. So now the next, uh, question I have it, it, you know, something that is a point of controversy, at least at the time of this recording is that there are people who are, you know, basically promulgating, uh, that especially with some of the data coming out of Israel, that natural immunity is a whole lot more effective than the vaccine induced, you know, so-called immunity.

Speaker 2 (03:23):

Um, and, but there's other people who are trying to make arguments. And I think there's recently a paper outta Yale, you know, trying to, uh, assert with no real data though, but they're trying to assert that no, the vaccine immunity is actually superior. So that's question one. You, do you have a, a thought around that and then question two, which will be the, the follow up, is that, is it possible that someone who has natural immunity then gets vaccinated, that it can compromise their natural immunity? Yeah. So two good questions. Um, so you'll find out that I don't give my opinion on very many things. I mean, if you want opinions, you've got friends and relatives to go talk to <laugh>. Yeah. There's way too many people out there giving their opinions and using the heck outta people. So I tend to only respond with science and, and publish data.

Speaker 2 (04:07):

And what I know is going on, I would like to think that is a key critical difference between myself and many other individuals, including the fact that I won't go along the popular party lines of, of either side to make anybody comfortable. So the published data shows that, uh, to begin with take that last paper I talked about, it's the nuclear cap that we do our best job of building immunity to, right? And that's not in the drug vaccine. So by virtue of that fact, you even make the best defense humans have use V2. Number one, number two. So the real benefit of natural immunity is that people are making both T-cell and antibody responses to all the parts of the virus, whether it be spike protein or the envelope, or the, or the, uh, hum gluten or the, or the nuclear cap and the nuclear cap, the data now shows the, is what humans make our best response to.

Speaker 2 (05:04):

And that's not even in the vaccines for people to get the benefit of. So that's one clear benefit of natural immunity. And the other benefit is that if you look at the papers that have been published, and again, they're on my website on FL method dot, and you can go PDFs of presentations, there's spy types of antibodies. There's I G D and IgE, which are not so applicable here. There's I GM, which is the acute phase. You know, it's a big one that you make up front. Then IG is that longer lasting one. And then IGA and IGA is critical because that's your lungs and your gastrointestinal tract, which is where this virus and fat, right? So you don't hear anything about that from, from the drug vaccines, no discussion, no data. And yet we know from the natural immunity studies that I G G I G M and I G a are all produced in people who undergo natural immunity person to person spread.

Speaker 2 (05:59):

So we know that that's there. We also, it's kind of silly to be looking for antibody levels in people because you don't make antibodies when you don't need 'em, you don't, it's a waste of energy. It's a

waste of resources. And if you need antibodies to everything you'd ever been exposed to your blood would be so BIS it wouldn't flow. It'd be thick. It it'd be clotted. So you don't do that. You make memory cells, mm-hmm, <affirmative>, you make memory cells. And that's the function of drug vaccines anyways, to make memory cells so that when you get infected notice, because vaccines don't keep you from getting infected or spreading it, what they do is they make, get you to make memory cells so that when you get infected, you have a shorter period of time for your body to respond, because you've already seen it.

Speaker 2 (06:44):

So we know from natural immunity that you've got these, these memory cells, and you've got I G G I G IgM. We also know that some people who've been who've had influenza or cytomegalovirus have natural immunity to SAR two already. We know that. So that's the perks of natural immunity. We know from the drug vaccine, biologics, that when that's given by or the others, that it interferes with the development of our immune response. So for example, the innate level we're interfere on is made, which is, it means it interferes with the production of viruses. So it's called interferon pretty clever, right? Science, um, that's blunted with these drug vaccine biologics, um, T helper, two cells, which are critical to, uh, because that's one of the latter parts of the innate immune system. And those cells have to attach to the B cells, the antibody making cells, and they do it with a three prong mechanism.

Speaker 2 (07:44):

All three parts of those two cells have to match to say, yes, this is in fact the virus. Yes. This is the right antibody. Yes. Make this antibody well, T helper, two cells are suppressed. So, you know, it's kind of hard to make a real good argument for this is a good method. And so maybe it's not surprising that none of that data is in the emergency use authorization documents. They make clever little statements that say antibodies are made in such and such percentage. Right. But there's no antibody data. There's no T-cell data. I mean, they've got tons of tables in there about all these comorbidities, which as a research scientist I look at and I go, Y okay, well that could have all been in one table. How about the tables that really tell us that there's an immune response? Oh, we don't have those well, isn't that critical to, uh, a drug vaccine, biologic mm-hmm <affirmative> that it makes immune response because everything else is kind of, did somebody think you had COVID okay.

Speaker 2 (08:46):

Well, great. So you had a positive PCR test, which is a good test when done properly and a, and a meaningless test when not done properly. Cause like my patent, you know, if you do my patent wrong, if you don't take on, carry out all the steps, it's not gonna work it's you have to do it. Right. Carrie mul said, PCR testing 20 cycles gives you 1,044,555 replication. So, okay. I shouldn't have that number to that's how many times I've had this conversation with people. Okay. That's enough. After that you're making artifact, you're making background noise. It's completely meaning. And it just tells you there's a genetic sequence. It doesn't, that's why, that's why you have doctors, doctors go to medical college. They learn how to take tests and symptoms. You get tests, you come in, you seen, and then the doctor looks at you and said, well with this test and these symptoms, that means you have this. Right. But see the test, doesn't tell you that. And the symptoms don't tell you that it's putting it all together, that tells you that. So just because you've got that genetic sequence doesn't mean, it just means you've been exposed and you have that genetic sequence, that's it. End of discussion. Okay. Um, and all the symptoms that they use on top of that could be for any viral infection, any bacterial infection, any fungal infection, it could be from cancer. So it's not really discriminatory the way they did that. You,

Speaker 1 (10:09):

You brought up the, uh, PCR test and, and Carrie MOS who invented it. And, uh, you basic, uh, uh, are you, you, were you surprised that the FDA basically said at the end of this year, you're starting next year? Uh, no more PCR testing when that was what they were using, uh, as the criteria to shut down our lives economy and everything else. Right?

Speaker 2 (10:28):

Because they've come up with a different testing mechanism. Haven't they? Well,

Speaker 1 (10:32):

Tell me about it. What have

Speaker 2 (10:33):

They come up with? It's happened. It I've got it. So there are three patents that you need to be aware of. Okay. Three steps that you need to be aware of. One is a patented test for now diagnosing COVID 19. The next step is a patent that everybody gets wrong. Um, where, you know, people are talking about nanotechnology in the vaccines. Let me tell you, there are no, there's no nano technology in the vaccines. Mm-hmm <affirmative> there are no little creatures in the vaccines. I know that because we've been looking at that. Okay. We, we have, we know exactly. We have looked at it. We, you know, there's a lot of garbage out there. A lot of misinformation, all this graphing outside now, on sense, you, you just wipe it outta your brain. Vaccines have had graphing oxide for some time. And graphine oxide actually interferes with the virus being able to, to attach to yourselves.

Speaker 2 (11:29):

Okay. I did better wet mounts in second grade than what I'm seeing these people do. Okay. Which is sad. Um, and, and, and it's, it's kind of this squirrel phenomenon. There are so many people that are saying, look here, look here, look here. I mean, it's very no wonder everybody's having a hard time wrapping their brain around this. I get it. I mean, I do fully understand it. The only difference is that I won't allow myself to get distracted. Mm-hmm <affirmative> that's, you know, that's what 53 years of being a researcher will do for you. It's like, no, I'm not gonna look at garbage. I'm gonna stay focused on the issue. You can all go talk about stuff that doesn't matter. This is where the issue is stay focused. Then the other issue has to do. Um, so the second patent is really following people.

Speaker 2 (12:16):

You don't need anything inserted into people's bodies to follow them. Okay. You got a cell phone. Yeah, you're following. All right. Unless there's somebody like me, who has a cell phone with a physics degree where I change the inside of the cell phone. So you can't track it serious. You don't need to inject anything to track anybody when they're already doing it for you. Thank you. I mean, didn't the college students last year, show us this. When they went on spring break and everybody said, well, look, you know, there's there's tracing. And then they kinda had to fess up that they were actually tracking people. Remember that? Yeah. Yeah. So you don't track us, but you kind of did. Huh. And that was back last year. Um, so that's the second patent, which is the sequence for knowing how to, how to track people. Right?

Speaker 2 (13:03):

And then the third one is the immune response that people are getting from these drug vaccines cannot exist if they're using the drug vaccines that are just this spike protein to do that. And to get the immune response that they are getting requires, what's called self amplifying mRNA, which means they have to include the replicate or to replicate genetic sequence of the virus to do this. How do we know that? Because papers have been published on this mm-hmm <affirmative> and we also know that there has been more what's called transmissible and transferable vaccines. Mm-hmm <affirmative> so transmissible is when you inject somebody and transferable is when you put a topical on it. Now, how do we know that there's any research on this? Well, amazingly enough, the bat is the animal that they did. Most of this research on it. However, with stars co too, the animal model isn't fat or mouse or, or dog or sheep, you wanna guess what? The animal model that they, that they published the data on for stars. CO2 is

Speaker 1 (14:06):

Can't venture, uh, penguin, <laugh> human, human. They tested

Speaker 2 (14:11):

On humans publish. Wow. Okay. We're the animal model. Okay. So you have a method for diagnosing it. You have a method for tracking people, and if you just vaccinated somebody, you know who they are and people that aren't vaccinated will show up by their cell. Thank you for them. Now, if you wanted to transfer that vaccine, all you would have to do is take somebody who's newly vaccinated and have them just kind of get next to the UN vaccinated. So,

Speaker 1 (14:50):

So let's, uh, so basically, and

Speaker 2 (14:53):

That's shedding, I guess, is so BA so, right. So shedding looks like it's the spike protein that that's, uh, coming off in exosomes, uh, which is, you know, again, there's a lot of confusion about exosomes. We've known about exosomes for 15, 20 years. There are nothing more than the release. I mean, look, cells communicate with each other by a variety of ways. They communicate with what's called cytokines. They communicate by interferons. This is not cytokines release syndrome or cytokine storm. By the way, if anybody's told you that they have a misunderstanding, just because some of the chemicals are the same that we can measure doesn't mean it's the same thing. So Cy syndrome is a name that big pharma gave to an adverse effect to drugs that it gave to people. Well, what was, what, what were those drugs? They took the T-cells outta people.

Speaker 2 (15:44):

Okay. The innate immune system, they theyd them. They changed them much like the virus <affirmative> so that they would recognize the cancer. And then they injected that back into people. That's called car T-cell. Okay. And then that caused a reaction in the body because they shouldn't be that bad. Right. Mm-hmm <affirmative> so all these chemicals get released as the cells are communicating doctors didn't like that. It was bad. People were having bad outcomes. So what happens if you don't have a name for it? People get nervous. Right? So big pharma gave everybody a name, cytokine release syndrome or cytokine storm. Oh, we have a name for it. Mrs. Jones. You're just having cytokine release syndrome. Here's some drugs for that. We'll give you steroids or whatever. Right. So is big pharma of changing your cells and injecting it back into your body. Right? Mm-hmm <affirmative> the theory I put

together in 1994, explains what happens when your body's functioning like it should, but it's being attacked by something outside too much cholesterol, too much fat, too much damage, too much virus or bacteria, caus reaction.

Speaker 2 (16:51):

That's called flam thromb response because it's inflammation and blood cloting and yes, it releases many of the same chemicals, but one is a natural occurring phenomenon to addressing an invader. And the other one is acute C name given by big pharma to justify it's okay. You're having problems with the drug we gave you just ignore the fact that we changed your cells and injected them back into your body. Okay. So that's one of the things to explain off to people and the fact that people aren't more tuned to that, or have that down shows that they don't really have that fundamental knowledge they need to have. And that's, that's kind of why when I address myself, sometimes they I've started at my talks, PhD MD, JD PhD, figures out problems, MD treats, problems, JD causes problems. <laugh> um, got.